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A Comparison of African American Elderly Women Abstainers and Light to Moderate Consumers of Alcohol

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A COMPARISON OF AFRICAN AMERICAN ELDERLY WOMEN ABSTAINERS AND LIGHT TO MODERATE CONSUMERS OF ALCOHOL

by

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The purpose of this study was to examine the differences that may exist between two identified groups of older African American women: (1) light to moderate consumers of alcohol, and (2) abstainers from alcohol. Within these two groups are four subgroups of women that were studied: (1) abstainers with high social support, (2) abstainers with low social support, (3) light to moderate consumers of alcohol with high social support, and (4) light to moderate consumers of alcohol with low social support.

Through a contact-and-referral technique, a purposive sample of 97 African American women who were 65 years and over living in a moderate size Midwestern urban community was investigated during the fall of 1999. Measures utilized in this study consisted of one sociodemographic questionnaire and four self-report assessment instruments: the *Mini-Mental Status Exam* (MMSE), to assess a person's cognitive mental status; the sociodemographic form, developed by the researcher to gather demographic data; the *Center for Epidemiologic Studies–Depression Scale* (CES-D), to measure depressive symptoms; the *Michigan Alcoholism Screening Test–Geriatric Version* (MAST-G), to determine alcohol consumption levels; and the *Inventory of Socially Supportive Behaviors* (ISSB), to assess how often individuals received various forms of social support during the preceding month. Two-tailed

t tests and chi-square tests were used in the study. For each analysis, the level of statistical significance was set at $p \leq .05$.

No significant differences emerged between older African-American women who were light to moderate consumers of alcohol and those who were abstainers in levels of depressive symptomatology, levels of social support, perceived health status, marital status, living arrangements, and income levels. In the present study, both abstainers and light to moderate consumers of alcohol report low levels of social support and high scores of depressive symptomatology.

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CHAPTER I

INTRODUCTION

Although the overall prevalence of drinking problems is lower during later stages of the life cycle, adults tend to drink more frequently but in smaller quantities. While African American women over 65 years of age on average drink less than White Americans, they tend to be more likely to become alcohol dependent. Higher levels of alcohol dependency are thought to result from circumstances such as social isolation from family and friends. According to Bienefeld (1987), this leads to loneliness and depressed mood. The combination of alcohol, depression, and social isolation can lead to dysfunction in a person's life.

The proportion of the population of the United States that is over the age of 65 has been increasingly rapidly and will continue to increase during the 21st century (Gomberg, 1995). Individuals who are 65 and older will place new demands on society to maintain and enhance the physical, emotional, and subjective well-being of older Americans. The availability and diversity of all human services will need to be expanded. These services will need to address not only such basic needs as food, shelter, and medical care, but also less tangible needs for social and intellectual stimulation and continuing participation in society.

Gwinack (1997) estimated that by the year 2030 nearly one fifth of the total population of the United States will be over 65. Dillard, Campbell, and Chisolm (1984) provided an even higher estimate for the same time frame, suggesting that by 2030 approximately one American in four will be a senior citizen. In terms of

absolute numbers, it is estimated that in 2030 there will be over 50 million elderly individuals in the U.S. (Statistical Abstracts of the United States, 1997).

Ethnic minorities comprise 14% of the population over age 65 (Gwinack, 1997). In 1994, 13% of all Whites but only 8% of African Americans and 5% of Hispanics were age 65 and over (Gwinack, 1997). The difference results primarily from the higher rates of fertility and higher mortality rates among the non-White population under 65. By 2050, 32% of the population of the United States will be non-White (U.S. Bureau of the Census, 1992a). The predicted percentage of elderly among the African American population will be smaller than among its nonminority counterpart. The young outnumber the old in the African American population, due primarily to the higher fertility of African American women and Blacks' higher mortality at midlife (Jackson, Burns, & Gibson, 1992).

The experience of social isolation and loneliness is not uncommon among the elderly. In a study of the prevalence of psychological impairment in advance-aged populations, "the strongest predictor of low psychological well-being was low social interaction" (Luke, Norton, & Denbigh, 1982, p. 114). Low psychological well-being and social isolation is a common trait among depressed people and among alcoholics. Depression is most commonly brought on by "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 impacted 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). "Most elderly who have been admitted to . . . treatment programs drank at home, alone, and in response to depressive states" (Schonfeld & Dupree, 1994, p. 6). Social support has been shown

to be key in the prediction of depressive symptoms (Cohen & Wills, 1985; Kessler & McLeod, 1985). Such disruptions in the support system may take the form of actual reductions in the social support network or just perceived loss of social support, but the psychological repercussions are likely to be significant in either case (Cohen & Wills, 1985).

Research over the past several decades has shown that social networks and levels of social support affect health and general well-being (Cassel, 1976; Cobb, 1976; Kaye & Monk, 1991; LaGary & Fitzpatrick, 1992). Oxman, Berkman, Kasl, Freeman, and Barett (1992) examined the effect of both social network and social support characteristics on depression in older adults. They found that interpersonal relationship variables and depression are significantly and negatively correlated. Oxman et al. (1992) also reported that the effect of social support accounted for a greater proportion of the variance associated with depression than social network variables. The extent of cross-cultural research examining the relationship among depression, social support, and mental health has, thus far, generally been quite limited (Kaplan, Adamek, & Calderan, 1999).

Actual social network changes among the elderly often stem from the diminished ability to use the telephone, use public transportation, or drive a car. Restricting these types of activities may cut off individuals from friends in the community or reduce the frequency of contacts with family members (Martire, Schulz, Mittelmark, & Newson, 1999).

Concurrent with challenges of social support and network issues, the elderly are likely to experience disruptions in their lives due to alcohol consumption. Alcohol abuse and dependence are serious disorders, especially in elderly persons, and are associated with depression or suicide (Atkinson & Schuckit, 1983; Holroyd &

Laurie, 1999). Alcohol is associated with 25%–50% of all suicides and is the second most frequent comorbid factor after depression (Blume, 1994).

Though the incidence of alcohol abuse by older persons is on the rise, it is largely overlooked as a condition worthy of study. As the elderly population continues to grow, this phenomenon will become more obvious and problematic for all of society (Schonfeld & Dupree, 1994). When the additional factor of gender, particularly that of women, is combined with concerns of excessive alcohol consumption and depressed states, one is hard-pressed to find literature that addresses the special characteristics of this diagnostic picture.

Data reported by most alcohol and drug treatment centers would appear to suggest low rates of problem drinking and drug abuse among elderly African American women (Adams, Yuan, Barbouak, & Rinm, 1993). However, the small numbers of elderly African American women reported as receiving services at organized alcohol and drug treatment centers may not reflect the actual greater numbers who are more frequently served in medical centers with physical and/or emotional problems for which alcohol abuse and drug dependence are cited as contributing factors. The absence of comprehensive data makes it difficult to obtain an accurate estimate of the magnitude of the problem. These issues are extremely important in light of the rapid increase in the ethnic elderly population and the limited knowledge of these issues (Gwinack & Hoffmann, 1992).

As the "baby-boom" generation rapidly approaches late adulthood, society will likely see a similar increase in the incidence of alcohol abuse among elders. Older women, in particular, may be more prone to this behavior because women, on average, enjoy a longer life span than their male counterparts and, therefore, endure more loss and grieving that so often leads to depression (Warheit, 1979). For older

women, the abuse of alcohol in combination with depression is a complicated yet common clinical picture. Even though the extent of problem drug and alcohol use among women is considerable and is believed to be on the increase (Oppenheimer, 1991), recent literature reveals that most research, policy, and treatment initiatives in respect to substance misuse have focused on men; women substance misusers have received little attention.

Statement of the Problem

In comparison with the overall population, elderly ethnic minority persons have not used the mental health system frequently (Butler, Lewis, & Sunderland, 1991). Depression has been documented as one of the most prevalent mental health problems among the elderly (Blazer, Hughes, & George, 1987; LaVecchia, Lucchini, & Levi, 1994). Prior studies have examined data from elderly populations in general and have not considered gender differences in depressive symptomatology among African American elderly. Blazer et al. (1987) reported 70% of older adults are suffering from mild dysphoria. The National Institute of Health (1993) study indicated that nearly 27% of older persons reported at least some depressive symptoms. Although gender differences were noted for the samples as a whole, the data were not analyzed for elderly African Americans or for gender differences in specific risk factors for depressive illnesses. Overall, there is a paucity of research concerning gender differences in depression among older African Americans despite studies that have indicated how the disproportionately experienced circumstances of low income and economic hardship have influenced the constellation of social and economic roles occupied by African American men and women throughout their lives (Brown, 1988).

Research on older African American women who are abstainers, light to moderate consumers of alcohol, or alcohol abusers is very limited. This situation exists despite the recognition of alcohol abuse among African American seniors and the increasing numbers of older adults of ethnic minority backgrounds. Although the body of knowledge about women's drinking behavior and drinking problems is growing (Herd, 1988; Holmia, 1992; Kalant, 1980; Wilsnack & Beckman, 1984), these studies have yet to directly address older African American women and their alcohol consumption or abstinence with important variables such as depression, social isolation, health status, marital status, income, and church attendance.

Purpose of the Study

The main purpose of this study was to examine the differences that may exist among two identified groups of older African American women: (1) light to moderate consumers of alcohol, and (2) abstainers from alcohol. Within these two groups of older African American women are four subgroups of women that were studied: (1) abstainers with high social support, (2) abstainers with low social support, (3) light to moderate consumers with high social support, and (4) light to moderate consumers with low social support.

Research Questions

The study proposed was designed to answer the following questions:

1. Is there a significant difference in the level of depressive symptomatology scores between light to moderate consumers of alcohol and abstainers as measured by the Center for Epidemiologic Studies–Depression Scale (CES-D)?

2. Is there a significant difference in the social support scores between light to moderate consumers of alcohol and abstainers, as measured by the Inventory of Socially Supportive Behaviors (ISSB)?

3. Is there a difference in social support scores as measured by the ISSB between light to moderate consumers of alcohol and abstainers who attend church weekly?

4. Is there a difference in perceived health status levels (good, fair, poor) as reported on the sociodemographic questionnaire (SQ) between light to moderate consumers of alcohol and abstainers?

5. Is there a difference in social support scores as measured by the ISSB between light to moderate consumers of alcohol and abstainers with different marital status?

6. Is there a difference in social support scores as measured by the ISSB between light to moderate consumers of alcohol and abstainers who live alone or with someone?

7. Is there a difference in income levels as reported on the SQ between light to moderate consumers of alcohol and abstainers?

Null Hypotheses

1. No significant differences will exist between levels of depressive symptomatology scores for light to moderate consumers of alcohol and abstainers, as measured by the Center for Epidemiologic Studies–Depression Scale.

2. No significant differences will exist between social support scores of light to moderate consumers of alcohol and abstainers, as measured by the Inventory of Socially Supportive Behaviors.

3. No significant differences will exist in social support scores as measured by the ISSB between light to moderate consumers of alcohol and abstainers who attend church weekly.

4. No significant differences will exist between perceived health status reported for light to moderate consumers of alcohol and abstainers, as reported by the SQ.

5. No significant differences will exist in social support scores between light to moderate consumers of alcohol and abstainers with different marital status, as measured by the ISSB.

6. No significant differences will exist in social support scores between light to moderate consumers of alcohol and abstainers who live alone or with someone, as measured by the ISSB.

7. No significant differences will exist between income levels of light to moderate consumers of alcohol and abstainers, as reported by the SQ.

Definition of Terms

The field of alcohol and drug abuse research literature reports considerable variation regarding terms such as *alcohol use, misuse*, and *abuse* in the literature. For the purpose of this study, the following definitions will be employed.

Abstainers—Respondents who answered "no" to all of the questions on the MAST-G were classified as abstainers.

Light to moderate alcohol users—Respondents who answered "yes" to 1–4 questions on the MAST-G were classified as light to moderate consumers of alcohol.

Heavy users—Respondents who answered "yes" to 5 or more questions on the MAST-G were classified as heavy consumers of alcohol.

African Americans—Blacks born and raised in the United States of America and self-identified as African American.

Alcohol abuse—Maladaptive pattern of alcohol use manifested by recurrent and significant adverse consequences related to the repeated use of alcohol. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems (American Psychiatric Association [APA], 1994).

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).

Alcohol use—Drinking or consumption of an alcoholic beverage, regardless of the purpose or intention of the drinker.

Comorbidity—The presence of any distinct additional clinical entity that has existed or that may occur during the clinical course of an individual who has the index disease under study (Davidson & Ritson, 1993). In this study, comorbidity is the coexistence of alcoholism and depressive symptoms.

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).

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, feeling of worthlessness, altered cognition or concentration, and recurrent thoughts of death (American Psychiatric Association, 1994).

Elderly—The terms *elderly* and *older persons* will be used for those 65 years and above in chronological age (Riley, Johnson, & Foner, 1972).

Kin—Relational contact with children, grandchildren, and siblings.

Nonkin—Individuals who are friends of the subject.

Oldest Old—Age 85 and over (Riley et al., 1972).

Old Old—Age 75 to 84 (Riley et al., 1972).

Young Old—Age 65 to 74 (Riley et al., 1972).

Social support—Support accessible to an individual through social ties to other individuals, groups and the larger community (Ensel, 1992).

Limitations of the Study

The study included the following limitations:

1. The study was restricted to African American females who were at least 65 years of age; thus, it may be difficult to generalize beyond this population.

2. Subjects for the study were elderly African American women who attended church on a regular basis in a moderate size Midwestern urban area.

Assumptions of the Study

The study included the following assumptions:

1. All self-reports of subjects, as obtained from the sociodemographic form, the Mini-Mental Status Exam, Center for Epidemiologic Studies–Depression Scale,

Michigan Alcoholism Screening Test–Geriatric Version, and the Inventory of Socially Supportive Behaviors, were true and accurate statements.

2. The Mini-Mental Status Exam accurately measured and quantified the subjects' cognitive mental status.

3. The Michigan Alcoholism Screening Test–Geriatric Version accurately measured and quantified the alcohol consumption of subjects.

4. The Center for Epidemiologic Studies–Depression Scale accurately measured and quantified the subjects' perceptions of depressive symptomatology.

5. The Inventory of Socially Supportive Behaviors accurately measured and quantified subjects' perceptions of social support.

Organization of Remaining Chapters

This study was designed to investigate possible differences and similarities between older African American women who are abstainers and African American women who are light to moderate consumers of alcohol. A review of the literature related to this study is presented in Chapter II. A discussion of procedures utilized for data collection, along with a summary of the characteristics of subjects, is provided in Chapter III. The analyses of data and findings are presented in Chapter IV. Chapter V includes the summary, findings, conclusions and implications, and recommendations for future research.

CHAPTER II

LITERATURE REVIEW

It has been estimated that two thirds of the adult American population drink alcoholic beverages (Inaba, Cohen, & Holstein, 1997). Conservative estimates reveal that 1 of every 10 Americans is dependent upon mood-altering substances, including alcohol. Dependence, according to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*, 4th edition; APA, 1994), is diagnosed when at least three of nine symptoms have lasted for at least a month, or have occurred repeatedly over a longer period of time. By the *DSM-IV* criteria, an estimated 10.5 million Americans are alcoholics (Vandor, Julian, & Leone, 1991). Alcohol and drug abuse is one of the largest health problems in America. Although older individuals drink less and report fewer alcohol-related problems than do younger individuals, alcohol use and abuse are significant health issues for older adults, specifically for African American women (Dufour & Fuller, 1995).

Prevalence of Use

Alcohol Use Among the Elderly

Despite obvious problems in estimating the prevalence of alcohol use, many researchers indicate that alcohol abuse and alcoholism are extensive among the elderly (Inaba et al., 1997). Estimates of the prevalence of significant alcohol difficulties vary from 2% to 10% in community living groups to as high as 26% in

hospitalized older adults (Beresford, Blow, & Brower, 1990). Alcoholism and other types of drug abuse constitute major health and social problems among the elderly, as well as other segments of the population (Dufour & Fuller, 1995; McCuan, 1992).

Inaba et al. (1997) reported that 2.5 million older adults are addicted to alcohol, drugs, or both. Zimberg (1978) indicated that between 10% and 20% of older adults over age 60 suffer from alcohol problems. Gomberg (1995) suggested that between 2% and 10% of community-based older adults abuse alcohol. Bienefeld (1987) reported that 10% of people over age 65 have drinking problems, and 8% are alcohol dependent. In a study conducted by the Mayo Clinic for alcohol and drug dependency (Finlayson, Hurt, & Davis, 1988), 41% of persons over age 65, with symptoms of alcoholism, reported that those symptoms began after age 60. This corresponds with findings by Herd (1988) that approximately one third of the older alcoholics in their study did not develop the disease until after the age of 60.

Alcohol Use Among Women

Alcohol abuse is a major health issue, not only among the elderly but also among women. Sixty percent of women over the age of 18 consume some amount of alcohol (Ravenholt, 1983). Approximately 55% drink moderately (Lipton, 1994). Moderation is characterized as having fewer than three drinks per week. Five percent of those over the age of 18 who drink are considered heavy drinkers. Heavy drinking is characterized as having four or more drinks per week (Ravenholt, 1983). Of the 43 million women who work outside the home, 10% are estimated to be problem drinkers (Suddah, 1991). Problem drinking is defined by a combination of symptoms and consumption problems. Kofoed (1984) found that 2% of women over 60 are chemically dependent. In their 1981 survey, Wilsnack, Wilsnack, and Hiller-

Sturnahoefel (1994) found a higher percentage of drinkers among women 35–64 than in all but one previously published survey. Even so, Wilsnack, Vogeltang, Vickers, and Kristjanson (1999) reported that, compared to other female age groups, a higher percentage of women ages 50–64, across surveys, were classified as heavy drinkers. Wilsnack et al. (1994) characterized heavy drinking as the consumption of six or more drinks of wine, beer, or liquor in a single day. When heavy drinking consumption occurs in middle-life (35–64), this may predict even higher levels of consumption after age 65.

Morgan (1985) found that social, cultural, and psychological factors are related to patient perception and identification of problems. Women have greater difficulty in defining problems as alcohol-related (Thom, 1986), even though they are able to recognize and identify vague symptoms of distress (Thom, 1986). The stigma associated with female drinking may partly account for the difficulty women have in defining themselves as alcoholics and rationalizations that drinking is not the real problem (Thom, 1986).

Although information regarding women's pattern of usage during the 17th century is limited, it is known that alcohol was the drug most widely used for medicinal purposes (Galbraith, 1991). During the 18th century, alcohol in the form of patent medicines was used generally for ailments associated with "female problems" (Sorrell, 1988). During the 19th century, alcohol usage decreased, due to rising stigma associated with acceptable practices and female behavioral norms (Worth, 1991). During the second half of the 19th century, addictions continued to fluctuate, due to the preponderance of prescribed medications in injection form, especially sedatives. Sorrell (1988) estimates that from 1850–1880, the number of American women addicted to alcohol and other drugs increased, yet because of the stigma

surrounding such usage, the real incidence is difficult to ascertain. Alcohol usage as well as polydrug usage among women has continued to flourish in the 20th century.

Women use drugs to self-medicate; to block out feelings of isolation, powerlessness, and despair (Galbraith, 1991); and to enhance social interaction and relieve stress and tension (Vandor et al., 1991). During the period of 1920–1940, drug abuse tended to decline, corresponding with the advent of a more independent status and increased resources for women to meet their needs. Contrastingly, during the 1990s, increased responsibilities for females and changing social expectations have resulted in increased societal pressure resulting in increased alcohol use (Galbraith, 1991). Worth (1991) suggested that the use of drugs is reflective of America's power structure, repressive social and sexual roles, male-dominated medical systems that address anxiety with prescriptions, and racism as a situation that allows repressive conditions to continue.

The extent of the effect of alcohol and other drugs on women's lives and bodies is not fully understood. Traditionally, addiction has been regarded as a problem of men, rather than women (Galbraith, 1991). In the past, studies regarding the reaction of the human body to alcohol most often used male subjects, and researchers believed that the reaction of women's bodies was identical to that of men. A comprehensive review of longitudinal studies revealed that the majority of these studies excluded female respondents (Filmore, Hartka, & Johnstone, 1991). Little research focused on physiological, psychological, and sociological aspects of women's use of alcohol and other drugs until the mid 1970s (National Council of Alcoholism and Drug Dependence, 1987). Only 8% of the subjects in studies of alcoholism and drug dependency treatment published between 1970 and 1984 included women (Harrison & Belile, 1987), and the first comprehensive national

survey on women's drinking patterns did not occur until 1981 (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 1993). Despite some increase in the focus on women's issues, knowledge of specific needs in prevention, intervention, and treatment of chemically dependent women is largely lacking (National Council on Alcoholism and Drug Dependence, 1987). This is particularly problematic considering the increase in women's alcohol use and alcohol problems during the last half century (Blume, 1994).

Similarly, very little research has been conducted on the use and misuse of alcohol by older women of color. A large gap exists in the literature due to the lack of data on this population. Researchers readily admit that more alcohol research on women is urgently needed, specifically groups such as women of color and older women (Kilbourne, 1991).

Alcohol Use Among African Americans

There is a paucity of information on alcohol consumption problems of elderly African Americans. Even less data are available on elderly African American women. Concern is raised that data collected may be unreliable because much of the information is based on statistics gained from patients who have sought formal health care. Since African Americans are known to typically underutilize medical and mental health services, reported data may grossly underestimate the prevalence of alcohol consumption problems among African Americans. Because of these issues, there is no accurate composite picture of issues associated with older African American women and alcohol consumption.

Research on race and alcoholism is limited; thus, little is known about the relationship among ethnic variables, drug usage, and treatment (Brown & Altherman,

1994; Gomberg, 1991; Herd, 1985). Most drug abuse theories do not account for the cultural diversity of ethnic minority populations (Arredondo, 1993).

It is reported that African Americans remain overrepresented in health statistics for life-threatening diseases. Life expectancy for African Americans is 69.5 years, as compared to 75.3 years for Whites (Statistical Abstracts, 1997). Brown and Tooley (1989) state that alcohol abuse is a primary health problem contributing to the reduced longevity in the African American community, and yet recognition of the impact of this problem has not translated into research on alcohol use among African Americans. Also, the quantity of research that has been conducted on the use and abuse of African Americans has not been proportionate to the size of the African American population in America.

Approximately two thirds of all African American women abstain from use of alcohol (Herd, 1988; National Institute on Drug Abuse, 1990) and approximately 68% of older African American men abstain (Meyers, 1985). Based on the preceding findings, it would seem that the majority of the women would be classified as abstainers or nonproblem drinkers. As the older adult minority population continues to increase at a faster rate than that of the majority population, it is predicted that by the year 2025 African American women over the age of 55 will number 2,964,000 (Statistical Abstracts, 1997). Kola and Kosberg (1981) suggested that as the number of elderly increase, so will the number of older adults that will be classified as having drinking problems. Since the fastest growing segment of the elderly population is that of ethnic minority older adults, due largely to the increased life expectancy of women, it is reasonable to assume that there will also be an increase in the number of older African American women who are classified as problem drinkers.

This assumption is supported by findings of other researchers. According to Stevenson (1996), African American women over 65 drink less than White American women; however, a larger percentage of elderly African American women drinkers become alcohol dependent. Alcohol dependence findings of other investigators ranged from 1.5% to 5% of all women over 65 (Clark & Midanik, 1982; Dunne, Galatopoulos, & Schipperheijn, 1993; Schuckit, 1990). Wilsnack et al. (1994) found in a national study that the peak volume of consumption by African American women is after age 40. Herd (1988) also found that middle-aged African Americans women drink more frequently than younger women and concluded that large numbers of older African American women who are frequent drinkers will become heavy drinkers and develop the disease of alcoholism. Clark and Midanik (1982) found that those African American women who do consume alcohol tend to become alcoholic more rapidly than their White counterparts. There are some very obvious gaps and inconsistencies in the information about the prevalence of alcohol problems. Also, a lack of uniformity in definitions exists in the studies, which is most pronounced in the information on the elderly. Not only are there inconsistencies in definitions of alcohol abuse, alcoholism, and problem drinking, but the age ranges used to denote middle-age, elderly, or older are not consistent. This inconsistency can also distort information about the actual prevalence of drinking in certain populations.

Alcoholism and Depression

Alcohol abuse and depression, singly 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). At higher doses and with prolonged abuse, especially among older adults in whom it takes less alcohol to produce harmful results, the physical and functional effects are many and varied. Depression, besides encouraging an overall depressed affect, can act to bring on somatic symptoms including patterns of sleep, appetite, and libido; negative self-evaluation including lowered self-esteem, self-blame, suicidal ideation, guilt, despair, and an overall gloomy outlook (Warheit, 1979); and memory and concentration problems (Molinari, 1990).

Cook, Winokur, Garvey, and Beach (1991) cite statistics of depression rates varying from 3% to 98% among alcoholics. There is no argument that alcohol and depression are related; their precise causal relationship, however, is very much disputed (Dunne et al., 1993). Three possible explanations exist: (1) alcoholism precedes depression, (2) depression induces alcoholism, and (3) the two are comorbidity-related disorders in which neither is the cause of the other.

Rates of alcohol abuse and 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).

Schonfeld and Dupree (1994) 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 (1978) 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 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 effect "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 & Olsen, 1995). In addition, many researchers warn of the common mistake many physicians make in diagnosing depression in alcoholics, when so-called depressive symptoms are simply viewed as a "transient state of alcohol withdrawal" (Blow, Loveland-Cook, Booth, Falcon, & Friedman, 1992, p. 994); Keeler, Taylor, & Miller, 1979).

Like the younger population of women who are susceptible to alcoholism and depression, elderly women, too, have unique characteristics that make them vulnerable to the hazards of comorbidity. Higher occurrence rates were discovered with this population because women, on the average, outlive 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 elderly woman. Warheit (1979) asserted that persons who experience a high degree of loss also have a significantly higher degree of depression, while Luke et al. (1982) stated that the strongest predictor of low psychological well-being is low social interaction and isolation. 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.

According to Stanford and DuBois (1992), African Americans are likely to experience more depression than Whites. The adjusted prevalence of depression in the African American population has been reported at 23% (Eaton & Kessler, 1981), whereas this rate among African American elderly persons was 15.6% (Stanford & DuBois, 1992). This high rate of depression among young and middle-aged African American persons compared to older African Americans is an indication that future generations of African American elderly persons might be much more depressed than the current African American aged population.

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). There is a need for further research and understanding of this problem.

The Role of Religion as Support

Religion is a unified system of beliefs and practices united into one single moral community called a church. Durkheim (1965) viewed religion as inseparable from the church, therefore defining religion as a collective entity. Religious phenomena are categorized as beliefs which are states of opinion, consistent of representations, and as rites which are the determined modes of action. Those states of action or behavior are based on the beliefs or states of opinion held by the church.

Generally older adults express a higher degree of religiosity than their younger counterparts (Greeley, 1989). Quarles (1987) made it clear that religion has been an important element in the lives of African Americans from the first days of slavery. Billingsley (1992) noted that the "the black church is at the leading edge of its families" (p. 349). Billingsley and Caldwell (1991) have estimated that there are nearly 76,000 African American churches in the United States, and Lincoln and Mamiya (1990) estimated that there were nearly 24 million members of African American churches in 1989.

Organized religion has proven to be a major institution in African American culture. The church has historically served a unique role in the African American community. It has assisted in the development and expression of leadership, served to reinforce feelings of self-worth, and offered spiritual sustenance and hope for a better life through periods of pain and turmoil (Arredondo, 1993; Heisel, 1992). Clinebell (1965) noted three aspects of people's fundamental religious needs: (1) a need for an experience of the numinous and the transcendental, a spiritual union with a

supernatural being; (2) the need for a sense of meaning, purpose, and value in one's life which corresponds to some of the positives associated with group affiliation; and (3) a need for a feeling so deep, trust, and the relatedness to life. These three fundamental needs historically have been met by the church in the African American community. Religion continues to serve as an agency of moral guidance and social control (Arredondo, 1993).

Having a Black religious heritage and religious involvement has been important because so few avenues for social participation have been open. Even though avenues have increased in recent years, religion is still perhaps the primary institution in African American communities (Taylor & Chatters, 1988), thereby filling secular as well as spiritual needs (Cone, Niessen, & Hunter, 1994). Religion and religious involvement possess unique political, cultural, and historical social meaning critical to understanding Black people (Baer & Singer, 1992; Lincoln & Mamiya, 1990).

There is a substantial body of empirical research which suggests that participation in church activity and self-rated religiosity are related positively to the life satisfaction of elderly African Americans. The historical role of the Black church in providing social welfare services to the African American community has provided church members with extensive opportunities for involvement in social services activities. These activities have been particularly important for elderly church members, because they enable older persons to remain involved in the community (Carter, 1982; Taylor, Thornton, & Chatters, 1987). In addition, these activities allow African American seniors to develop networks of friends to whom they can turn for emotional or tangible support when necessary (Taylor & Chatters, 1986). Steinitz's (1980) study reported that churches provide both tangible assistance and

psychological support for elderly Blacks and Whites. The study concluded that the role of the church was particularly crucial for elderly members who do not have families living near them.

Because religion has always been a powerful force in the lives of African Americans, the church has become a supportive resource for elderly African Americans. In addition to social spiritual fulfillment, a considerable number of elderly African Americans find economic support from their congregation, although Catholics are less likely to receive aid than Protestants (Taylor & Chatters, 1988). Also, those with higher incomes and those from rural areas were less dependent on the church for assistance.

Several articles have suggested that the church is the focal point of supportive networks for older African Americans, involving the exchange of material goods and services as well as emotional aid (Taylor & Chatters, 1986a, 1986b). Taylor and Chatters (1986a) examined the influence of church members as the providers of informal support to older African Americans. Their results found that the frequency of church attendance emerged as a significant predictor of both the frequency of assistance and the amount of aid provided to older African Americans. Their results also indicated that adult children facilitated the provision of assistance to older parents.

A study by Hatch (1991) indicated that there is an interaction between religious participation and informal social support patterns among elderly African American women, such that religious involvement is associated with greater provision and utilization of social support. Hatch employed samples of 126 African American women aged 60 and above drawn from the National Survey of Families and Households (NSFH). The dependent variables employed in the study were six factor-

based scales measuring (1) reliance on one's children for help in an emergency, for financial assistance, or for advice; (2) reliance on nonrelatives for help under the same circumstances; (3) self-reported help actually received from children during the month preceding the survey in the areas of transportation, home or auto repairs, other work around the house, or emotional support; (4) self-reported help actually received from nonrelatives over the same period in the same areas; (5) self-reported help provided by the respondent to her children during the month preceding the survey; and (6) self-reported help provided by the respondent to nonrelatives during the same period.

Hatch's (1991) analyses yielded significant race by religious social activity interactions for four of six dependent variables. With respect to reliance on children for help, the significant interaction indicated that religious social activity was a more important predictor for African American women than for White women, with more frequent attendance associated with lower likelihood of relying on children for help. With respect to reliance on nonrelatives for help, religious social activity was again a more important predictor for African American women than for White women. In this case, however, the African Americans who attended religious social events more frequently were more likely to rely on nonrelatives for help than were women who attended less frequently. Based on Hatch's study, it would appear that African Americans and Whites differ in the relationship between participation in religious social activities and patterns of informal support.

Walls and Zarit (1991) provided a detailed description of the perceptions of older African Americans regarding the amount and type of support they receive from their church. The investigators interviewed 98 elderly African American church members who were residing in an urban community in central Pennsylvania. They

measured perceived social support received from family and church, as well as self-rated religiosity, well-being, health status, and functional ability. Walls and Zarit found that 40% of the individuals who were named as close associates of the respondents were members of the respondents' churches. Fifty percent of those nominated were members of the respondents' families. The results indicated that perceived overall support from church members was related significantly to well-being. Although the respondents reported receiving somewhat more social support from family and friends than from church members, the support they received from the church members was related significantly to subjective well-being, while that received from family members was not. Thus, it is clear that the church and religion have been and continue to be important aspects of the lives of elderly African Americans.

Gallup and Castelli (1989) found that African Americans continue to show higher rates of church attendance and religious faith than any other group in America Even though gerontological studies have indicated convincingly that older adults as a group are highly religious (Koenig, Mobert, & Kvale, 1988) and that the significance of religion and religiosity increases with age, little attention has been paid to patterns of religiosity among older ethnic populations (Chatters & Taylor, 1989; Taylor & Chatters, 1991). The research team of Chatters and Taylor is an exception. Although Moberg (1965) concluded that church attendance declined in the later years, Taylor and Chatters (1986), in their analysis of African Americans 55 or older, found that 80% of those responding reported active involvement in church activities. This high level of religious identification corresponds with findings of Taylor (1993) that only 4% of respondents surveyed stated that they had no religious affiliation. Jackson (1993) found that relatively more African Americans over 65 than in any other group

identify with formal religion. Strong indicators of religious participation have been church attendance, marital status (being married), and gender (being female) (Taylor & Chatters, 1988). Prominent models of gender and religion suggest that religious orientation is compatible with the social status, roles, and experiences of women. Female socialization experiences frequently reflect attitudes, external control orientations, and emotional regulations that are compatible with a religious orientation (Levin & Taylor, 1994).

The Influence of the Church on Alcohol Use

Women have used alcohol and other drugs for centuries with varying degrees of acceptance by the general population. Since the Law of Hammurabi, cultures have permitted the use of alcohol and other drugs and have prescribed different rules for men than for women (Blume, 1994; Sandmaier, 1980; Van Den Bergh, 1991).

The denominational churches take various positions regarding the use of alcohol. These positions may then be transmitted to members and impact the development of attitudes and behaviors associated with specific practice areas. Due to the centrality of the church in the lives of older adults, such positions take on even greater significance. A violation of these perceived norms can result in stigma. Such negative stereotypes and associations can result in a perceived need to conceal the existence of a problem if one exists (Blume, 1994). Due to the significance of the church in the lives of older African American women, the church's position on alcohol use is important. For the older African American woman, who has historically served in integral roles in the Black church, the church adds purpose and value, enhancing a feeling of connectedness, meaning, and purpose to life (Clinebell, 1965).

With increased age comes the designation of responsibilities to "mothers" of the church. This designation is accompanied by increased social status, prerogatives, and rewards. Mothers of the church also enjoy larger spheres of influence and decision-making with those over whom they have authority, as well as greater social recognition. Due to the increased status within the church and the pressure of group conformity, any acknowledgment of a violation of age/gender-related drinking norm will be limited for mothers of the church.

There has been little study regarding specific differences among congregations in the outlook on drugs, including alcohol (Royce, 1985). There is no such thing as a single "religious view" about alcohol and alcoholism. Thus, multiple perspectives exist regarding use, misuse, and abuse, depending on the particular denomination. Overall, there continues to be a diversity of views among churches regarding the status of alcohol use.

The Baptist Church Covenant reflects the need to "abstain from the sale and use of intoxicating drink" by those who enter into the covenant. The covenant is not explicit regarding the ramifications of use or sale of "intoxicating" drink or the impact of usage in reference to continued church affiliation or involvement (Wuthrow, 1989).

Methodists condemn the use of alcoholic beverages and feel it is imperative to minister to those persons who are victims of alcohol. In 1968, The United Methodist Church relaxed requirements of total abstinence, but in 1980 reaffirmed its stand in favor of abstinence as a policy. A similar attitude is espoused by other denominations such as Holiness Apostolic and Pentecostal Church of God, The Church of God in Christ, and The Assembly of God–Pentecostal Church, which evolved from

Methodism during the last century (*Book of Discipline of the Christian Methodist Episcopal Church*, 1990).

Presbyterians have put much thought and effort into their program on alcohol and other drug usage. Alcohol consumption is not viewed as sinful, because the drinking of wine is cited in the Bible. Alcohol abuse is considered sinful, due to its violation of the health and wholeness of the body (Alcohol Use & Abuse, 1986). The Presbyterian position is that a combination of prevention and control, measured with a variety of treatment approaches, should be encouraged and supported to deal with alcohol-related problems (Alcohol Use & Abuse, 1986).

The Catholic Church condemns not the use of but the excessive consumption of alcohol (United States Catholic Conference, 1993). The Catholic Church also urges serious consideration of alcoholism as a disease.

Jehovah's Witnesses condemn drunkenness and, based on the biblical passage in 1 Colossians 5:11–13, justify their stance that "the unrepentant or habitual drunkards" are to be expelled from the congregation (*Insight on the Scriptures*, 1988).

Other Sources of Informal Support

Research findings on race difference in the quantity, quality, and type of social support are ambiguous (Antonucci, Akiyana, & Adelman, 1990). Some researchers hold that social networks of ethnic minorities are quantitatively different from those of Whites; that is, they are more extensive, with more frequent interaction (Bengtson & Mangen, 1988; Butler & Lewis, 1982). Other researchers have found race-related differences in social interaction and support. Chatters, Taylor, and Jackson (1985), using the National Survey of African Americans data, found several intra-Black

group differences. For example, informal support increased as income and education increased. African Americans in middle and late life draw from a more varied pool of informal helpers than Whites and are more likely to reach for help beyond spouses and children to friends, neighbors, and church members. African Americans, in addition, are more versatile in substituting these helpers one for another as they approach old age. Whites, in contrast, are more likely to limit help seeking to spouses in midlife and to replace spouses with a single family member as they approach old age.

Another consideration is that elderly African Americans receive less support than is commonly assumed. Jackson and Gibson (1985) reported that African American elderly are less likely than others to have spouses and living children; thus, they are missing two important sources of informal support. Secondly, a large number of African Americans aged 65 and over live alone.

Research regarding the type of support and circumstances under which informal support is likely to be ameliorated is contradictory and fragmented (Brown et al., 1992). In one study, Mui (1993) detected no significant relationship between social contact and number of informal helpers and depression. Dressler's (1991) study indicates that ties with extended kin provided help associated with a decreased risk for depression. Yet, Husaini and colleagues (1991) reported that lower levels of social attachment, guidance, and reliability were related to higher levels of depression among elderly women.

Mutran (1985) found that African American elderly received more aid from their families than did White elders when socioeconomic differences were taken into consideration. Shanas (1979) found that in African American families children and grandchildren were more likely to aid the grandparents than in White families.

Even if grandparents and grandchildren do not live in the same household, there is still a great deal of contact and interaction. Taylor and Chatters (1991) record that "elderly Black adults . . . reported frequent contact with family members, close affective bonds with family, satisfaction with family life, and relatively close residential proximity to immediate and extended family" (p. 213).

While the African American family remains the principal agent of support for the African American elderly, neighborhoods also play an important role in sustaining not only the childless but elderly African Americans in general. Neighborhoods often feature strong networks of mutual aid (Jayakody, 1993). Friendship networks that develop within neighborhoods sometimes resemble kin configurations.

Several researchers have suggested that nonkin associates are particularly critical among certain subgroups of the African American population and assume a dominant and influential role in informal networks (Kennedy, 1980; Ladner, 1971). Friend relationships are sometimes regarded in kinship terms, which serves to solidify feelings of mutual obligation and to extend the rights and responsibilities of kin status to support participants (Kennedy, 1980).

Limitations of Prior Research

Alcohol use and abuse has been investigated in various studies with a wide variety of findings. According to researchers, the prevalence of alcohol use and abuse varies depending on the population studied, research methods used and criteria chosen to detect alcohol-related problems (Barnes & Welte, 1988; Williams & DeBakey, 1992). The accuracy of data on women's alcohol use is questionable. Current feminist researchers advocate for the development of improved drinking survey methodologies (Wilsnack & Cheloha, 1987). As previously noted, most long-

term longitudinal studies have excluded women respondents. Those studies that do sample women, however, frequently have limited numbers of heavy and problem-drinking women, thus limiting multivariate analyses. This particular situation is illustrated by a national sample conducted by Wilsnack and Chiloha (1987). Their study of 2,000 respondents contained only 30–60 women who drank as heavily as 14 drinks per week. One additional problem is that those longitudinal studies that do include women focus on the immediate context and correlates of drinking behavior, with little attention being paid to long-term influences on women's drinking. These same problems of inadequate survey methodology, as well as specific age-related issues, are relevant to accuracy of detection and diagnosis of alcohol related difficulties among older adults. These issues have contributed to a paucity of accurate information related to this population.

Since no universal criteria exist in screening and diagnosing abuse of and dependency on alcohol, the study of alcohol problems among the elderly is more difficult to research. Many scales used to diagnose abuse and dependency measure the prevalence of legal, social, and job-related problems rather than alcohol use or abuse. Such scales are not always applicable for the elderly who have retired, do not drive, or who are isolated from friends and family. A review of the literature reveals one study that evaluated assessment tools used to screen the elderly (Willenbring & Spring, 1990). This evaluation resulted in a favorable rating for only one screening test, the Michigan Alcohol Screening Test. This instrument appears to have excellent sensitivity among the elderly and is easy to use (Bienefeld, 1987; Johnson, 1991). Another scale that appears to have merit was constructed by Graham (1986), who analyzed the applicability of five measures of alcohol abuse among older adults: levels of consumption, alcohol-related social and legal problems, alcohol-related health

problems, symptoms of drunkenness or dependence, and recognition of problems. In the literature, several researchers take issue with level of consumption being used as an indicator of alcohol abuse unless it is used in combination with other measures (Bienefeld, 1987; Goist & Sutker, 1985; Mishara & Kastenbaum, 1980). They note that one cannot use as criteria the amount of alcohol consumed, because the lean body mass decreases by 10% from age 20 to age 70. As a result, water accounts for smaller percentages of body mass. Due to physical changes, the increasing of blood concentration can result in the older drinker experiencing intoxication without an increase in the actual amount of consumption. The interpretation of illness behavior or problem definition also has an effect on the accuracy of self-reported data. Such information is significant, because much of the information on prevalence and use patterns comes from self-reported data.

In Thom's (1986) study, three fourths of the sample stated that they had drunk heavily for 5 years before seeking treatment for the first time. Reluctance to disclose alcohol problems was associated with the negative image of an alcoholic and the perception of the alcoholic also being identified as mentally ill. This corresponds with research findings that indicate that due to the stigma associated with alcohol use, women are less likely than men to report drinking-related problems (Clark & Midanik, 1982). Drinking-related problems not reported included physical, emotional, and social difficulties. There continues to be stigma associated with mental illness in the African American community. Neighbors (1985) found that even when emotional problems were severe, subjects tended to attribute cause to a physical factor resulting in an overutilization of physician services when the problem was clearly emotional or psychological in nature.

In an older adult population, self-reported problems associated with drinking may be inaccurate due to memory deficits suffered by the older adults and low levels of recognition of alcohol problems among the elderly (Dufour & Fuller 1995; Graham, 1986). This lack of recognition of symptoms of alcohol abuse may also be a result of inaccurate interpretation of alcohol symptoms as being related to aging. This corresponds with findings by Kola and Kosberg (1981), Lipton (1994), and Schonfeld and Dupree (1994) that older people sometimes think that problems or symptoms associated with alcoholism are actually physical problems or responses to aging. These misconceptions can result in underreporting of alcohol problems in older populations (Mishara & Kastenbaum, 1980). All of these factors suggest that alcohol-related morbidity in this population may go undetected. Inaccurate or inappropriate survey data, memory deficits experienced by the elderly, as well as stigma experienced by minority, female, and aged populations affect estimates of prevalence and patterns of use among these populations.

Advances in assessment technology have led to the development of procedures for screening and diagnosis. Screening is an important preliminary step in the diagnosis of alcohol use disorders. Key properties of screening instruments are validity, reliability, and sensitivity. The validity and reliability of self-report procedures are of concern to both clinician and researchers. Although primary care physicians are in a key position to make early diagnoses of alcohol use disorders, they often misdiagnose or underdiagnose elderly individuals. The coexistence of alcohol use disorders and psychiatric depression also can complicate the diagnosis.

CHAPTER III

METHODS

This study examined the differences that may exist among two identified groups of older African American women: (1) light to moderate consumers of alcohol, and (2) abstainers from alcohol. Within these two groups are four subgroups of women who were studied: (1) abstainers with high social support, (2) abstainers with low social support, (3) light to moderate consumers with high social support, and (4) light to moderate consumers with low social support.

Procedure

Several churches and one community agency agreed to serve as sites for the research project. All sites confirmed that understanding with a letter of verification (see Appendix A). Pastors and the community agency program director communicated to potential participants at church services or within regular scheduled program activities about the opportunity to voluntarily participate in the research (see Appendices B and C). All potential participants were given a flyer that included the researcher's telephone number to call if interested in participating in the study (see Appendix D). The researcher was available at each meeting or church service to answer questions and/or provide information about potential participation in the research. Potential subjects were informed of the specific kinds of information that would be collected, and volunteers were asked to sign a consent form (see

Appendices E and F). In addition, all participants were given a list of counseling and crisis intervention referral sources at the beginning of the interview (Appendix G).

Personal contact was made with each subject at her home, church, or community center. The purpose of the study was explained and confidentiality was assured. Prior to data collection, the researcher again informed participants that they may refuse to participate at any time and that it would not have any effect on the relationship or services that they receive from the church or community agency. After subjects granted consent, they were screened using the Mini-Mental Status Exam to determine whether there was cognitive impairment present. The sociodemographic questionnaire and three remaining instruments were administered in the following order: Michigan Alcoholism Screening Test–Geriatric Version, Center for Epidemiologic Studies–Depression Scale, and the Inventory of Socially Supportive Behaviors. The researcher read instructions for the sociodemographic questionnaire and instruments for each participant on an individual basis and recorded subjects' responses. The administration of the sociodemographic questionnaire and four instruments was completed in a single 45-minute to 1-hour session. The entire data collection process for the study was completed in 3½ weeks.

Codes were assigned to each subject. A code was placed on each participant's self-report instruments and sociodemographic questionnaire. All collected and analyzed data will be destroyed after 5 years.

Description of Sample

All subjects were from five churches and one community agency in a moderate size Midwestern urban community. Selection criteria for inclusion in the study required that each subject be between the ages of 65 and 99 years and an

African American female. A total of 136 subjects volunteered to participate in the study. A final sample of 97 subjects was included in the study. A total of 39 subjects were eliminated from the study due to not completing the study and/or not meeting the criteria of either abstinence or light to moderate consumption of alcohol. Fifteen participants with scores of 5 or more (high levels of consumption) on the MAST-G were excluded from the study. Twenty-four subjects were excluded because they did not complete one or more instruments. No subjects were eliminated due to cognitive impairment based on results of the Mini-Mental Status Exam. A total of 40 subjects were classified as abstainers, and 57 as light to moderate consumers of alcohol. Table 1 contains the demographic characteristics of the 97 subjects.

Description of the Instruments

Measures utilized in this study consisted of one sociodemographic form and four self-report assessment instruments. Permission to use the Mini-Mental Status Exam, Center for Epidemiologic Studies–Depression Scale, Michigan Alcoholism Screening Test–Geriatric Version, and The Inventory of Socially Supportive Behaviors was given by the respective author(s) (see Appendix H).

Mini-Mental Status Exam

All respondents were screened utilizing the Mini-Mental Status Exam (MMSE). The MMSE, which requires 5–10 minutes to administer, consists of 11 items designed to assess cognitive mental status. The MMSE is reported to be reliable on 24-hour or 28-day retest by single or multiple examiners. When the same examiner re-administered the MMSE 24 hours later, the correlation by a Pearson

Table 1

Demographic Characteristics of Sample

Characteristic	Total	
	n	%
Abstainers		
No	57	58.8
Yes	40	41.2
Total	97	100
Social Support		
Low	65	67.7
High	32	32.3
Total	97	100
Depression		
Low	34	35.8
High	63	64.2
Total	97	100
Age		
65–69	58	59.8
70–74	20	20.6
75–79	8	8.2
80–84	4	4.1
85 and above	7	7.2
Total	97	100
Educational Level Obtained		
Less than high school graduate	43	44.3
High school graduate	38	39.2
Some college or bachelor's degree	13	13.4
Beyond bachelor's degree	3	3.1
Total	97	100
Income		
Less than $12,000	18	18.6
$12,001–$30,000	21	21.6
Greater than $30,000	29	29.9
Withheld information	29	29.9
Total	97	100

Table 1—Continued

Characteristic	Total	
	n	%
Occupation Before Retirement		
Managerial/professional	9	9.3
White collar, not professional	5	5.2
Service	38	39.2
Blue collar	39	40.2
Homemaker	6	6.2
Total	97	100
Currently Employed		
No	71	73.2
Yes	26	26.8
Total	97	100
Hours Work Per Week (outside home)		
None	72	74.2
1–10	2	2.1
11–20	6	6.2
21–30	0	0.0
31–40	10	10.3
Greater than 40	7	7.2
Total	97	100
Marital Status		
Not married	31	32.0
Married	29	29.9
Widowed	37	38.1
Total	97	100
Religion		
None	6	6.2
Other	11	11.3
Baptist	44	45.4
Methodist	28	28.9
Presbyterian	2	2.1
Catholic	4	4.1
Jehovah Witness	2	2.1
Total	97	100
Health Status		
Good	47	48.5
Fair	40	41.2
Poor	10	10.3
Total	97	100

Table 1—Continued

Characteristic	Total	
	n	%
Medical Condition Present		
No	47	48.4
Yes	50	51.6
Total	97	100
Children Living Within a 25-Mile Radius		
None	15	15.5
1–3	48	49.5
4–5	24	24.7
6 or greater	10	10.3
Total	97	100
Contact With Children Living Within a 25-Mile Radius		
Daily	53	64.6
Weekly	24	29.3
Monthly	4	4.9
Yearly	1	1.2
Never	0	0
Total	82	100
Children Living Outside a 25-Mile Radius		
None	33	34.0
1–3	46	47.4
4–5	13	13.4
6 or greater	5	5.2
Total	97	100
Contact With Children Living Outside a 25-Mile Radius		
Daily	10	15.6
Weekly	31	48.5
Monthly	14	21.9
Yearly	7	10.9
Never	2	3.1
Total	64	100
Sibling Living Within a 25-Mile Radius		
None	47	48.5
1–3	32	33.0
4–5	11	11.3
6 or greater	7	7.2
Total	97	100

Table 1—Continued

Characteristic	Total	
	n	%
Contact With Sibling Living Within a 25-Mile Radius		
Daily	8	16.0
Weekly	31	62.0
Monthly	8	16.0
Yearly	1	2.0
Never	2	4.0
Total	50	100
Sibling Living Outside a 25-Mile Radius		
None	43	44.8
1–3	34	35.4
4–5	11	11.5
6 or greater	8	8.3
Total	96	100
Contact With Sibling Living Outside a 25-Mile Radius		
Daily	2	3.7
Weekly	14	25.9
Monthly	13	24.1
Yearly	16	29.6
Never	9	16.7
Total	54	100
Living Alone		
No	45	46.4
Yes	52	53.6
Total	97	100

coefficient was .887 (Folstein, Folstein, & McHugh, 1975). The MMSE is a valid test of cognitive function, separating individuals with cognitive disturbance from those without such disturbance. With a total possible score of 30, Folstein et al. (1975) reported mean scores of 9.7 for patients with dementia; 19.0 for those with depression with cognitive impairment; and 25.1 for uncomplicated affective disorder, depressed. The mean score for normals was 27.6. Thus, a higher score indicates better cognitive functioning. Individuals were required to score above 19 on the

MMSE, the cut-off criterion for participation in the present study. No individuals scored below 19; thus, no one was eliminated as a participant in this study.

Sociodemographic Questionnaire

A sociodemographic questionnaire was designed to provide descriptive information, such as the participant's age, education, income, occupation during working life, current employment status, hours work per week if currently employed, marital status, religion/church attendance, health status, medical condition present, children or siblings living within or outside a 25-mile radius, frequency of contacts with children and siblings, and household composition (see Appendix I).

The Michigan Alcoholism Screening Test–Geriatric Version (MAST-G)

The Michigan Alcoholism Screening Test–Geriatric Version (MAST-G) was the instrument used to determine alcohol consumption levels of respondents. The MAST-G is a 24-item questionnaire that has been used by the University of Michigan Alcohol Research Center with an older adult population, including older African American women. The instrument appears to be attuned to the importance of ethnic- and gender-sensitive wording. The MAST-G has been shown to have high validity with scores accurately discriminating between alcoholics and nonalcoholics based on independent evidence of problem drinking (Blow, 1991; Dufour & Fuller, 1995; Selzer, 1971).

The Center for Epidemiologic Studies–Depression Scale (CES-D)

The Center for Epidemiologic Studies–Depression Scale (CES-D) was used to measure depressive symptoms. The CES-D is a 20-item scale that utilizes a 4-point

Likert scale ranging from "none" to "most of the time." The validity and utility of this scale for use with community-dwelling older adults has been demonstrated in the literature (Berkman et al., 1986; Gatz & Hurwicz, 1990; Radloff, 1977). The CES-D is effective in the identification of depressive symptoms in clinically depressed older African Americans (Eaton & Kessler, 1981; Roberts, Stevenson, & Breslow, 1981), as well as older persons (Murrell, Hummelfarb, & Wright, 1983). Predictions regarding test-retest correlations depend on several factors. The CES-D scale was explicitly designed to measure the current level of symptomatology, which is expected to vary over time. Changes over time are more likely to be cyclic in at least some individuals, and the phase of cycles may vary across individuals. The scale demonstrates good convergent and split-half reliability, yielding a Cronbach alpha of .85 and a Spearman-Brown correlation of .84 (Brown, Milburn, & Gary, 1992; Radloff, 1977; Radloff & Teri, 1986).

The Inventory of Socially Supportive Behaviors (ISSB)

The ISSB is a 40-item self-report measure that was designed to assess how often individuals received various forms of assistance during the preceding month. Subjects were asked to rate the frequency of each item on a 5-point Likert scale. The internal consistency reliability has been consistently above .9 (Barrera, 1981; Barrera, Sandler, & Ramsay, 1981; Cohen & Hoberman, 1983; Cohen, McGowan, Foaskas, & Rose, 1984; Stokes & Wilson, 1984). Over a 2-day interval, the test-retest reliability was .88 (Barrera et al., 1981).

Statistical Analysis

Bivariate analysis and descriptive statistics including frequency distributions provide information about differences between abstainers and light to moderate consumers of alcohol. Two-tailed *t* tests were conducted for Hypotheses 1, 2, and 3. Chi-square tests were used as an inferential statistic for Hypotheses 4, 5, 6, and 7. For each analysis, the level of statistical significance was set at $p \leq .05$.

CHAPTER IV

ANALYSIS OF THE DATA

The hypotheses of the study are presented, followed by the outcomes of the data analyses. For each analysis, the level of statistical significance was set at $p \leq .05$.

Results of the Hypotheses

Hypothesis 1

Hypothesis 1 stated that there would be no significant difference in levels of depressive symptomatology scores between light to moderate consumers of alcohol and abstainers as measured by the Center for Epidemiologic Studies–Depression Scale (CES-D). As shown in Table 2, the *t* value for this comparison was .660 with a resulting probability of .511, which was not significant. Therefore, Hypothesis 1 was accepted.

Table 2

Scores of Light to Moderate Consumers of Alcohol and Abstainers on the Center for Epidemiologic Studies–Depression Scale (CES-D)

Instrument	Abstainers		Light to Moderate Consumers of Alcohol		*df*	*t* value	Probability
	Mean	*SD*	Mean	*SD*			
CES-D	19.80	9.15	18.62	7.96	95	.660	.511

Hypothesis 2

Hypothesis 2 stated that there would be no significant difference in social support between light to moderate consumers of alcohol and abstainers, as measured by the Inventory of Socially Supportive Behaviors (ISSB). As shown in Table 3, the *t* value for this comparison was 1.066 with a resulting probability of .289, which was not significant. Therefore, Hypothesis 2 was accepted.

Table 3

Scores of Light to Moderate Consumers of Alcohol and Abstainers on the Inventory of Socially Supportive Behaviors (ISSB)

Instrument	Abstainers		Light to Moderate Consumers of Alcohol		*df*	*t* value	Probability
	Mean	*SD*	Mean	*SD*			
ISSB	47.3	29.74	41.1	24.77	92	1.066	.289

Hypothesis 3

Hypothesis 3 stated that there would be no significant difference in social support scores as measured by the ISSB between light to moderate consumers of alcohol and abstainers who attend church weekly. As shown in Table 4, the *t* value for this comparison was .563 with a resulting probability of .576, which was not significant. Therefore, Hypothesis 3 was accepted.

Hypothesis 4

Hypothesis 4 stated that there would be no significant difference in perceived health status levels (good, fair, poor) as reported on the sociodemographic

Table 4

Social Support Scores as Measured by the ISSB Between Light to Moderate Consumers of Alcohol and Abstainers Who Attend Church Weekly

Instrument	Abstainers		Light to Moderate Consumers of Alcohol		*df*	*t* value	Probability
	Mean	*SD*	Mean	*SD*			
ISSB	51.80	29.61	47.36	25.56	58	.563	.576

questionnaire (SQ) between light to moderate consumers of alcohol and abstainers. As shown in Table 5, the χ^2 value for this comparison was 5.893 with a resulting probability of .053, which was not significant. Therefore, Hypothesis 4 was accepted.

Table 5

Perceived Health Status Levels (Good, Fair, Poor) of Light to Moderate Consumers of Alcohol and Abstainers

Instrument	*N*	*df*	χ^2	*p*
SQ	97	2	5.893	.053

Hypothesis 5

Hypothesis 5 stated that there would be no significant difference in social support scores as measured by the ISSB between light to moderate consumers of alcohol and abstainers with different marital status (not married, married, widowed). As shown in Table 6, the χ^2 value for this comparison was 5.604 with a resulting probability of .061, which was not significant. Therefore, Hypothesis 5 was accepted.

Table 6

Social Support Scores of Light to Moderate Consumers of Alcohol and Abstainers With Different Marital Statuses (Not Married, Married, Widowed)

Instrument	*N*	*df*	χ^2	*p*
ISSB	97	2	5.604	.061

Hypothesis 6

Hypothesis 6 stated that there would be no significant difference in social support scores as measured by the ISSB between light to moderate consumers of alcohol and abstainers who live alone or with someone. As shown in Table 7, the χ^2 value for this comparison was 1.118 with a resulting probability of .290, which was not significant. Therefore, Hypothesis 6 was accepted.

Table 7

Social Support Scores of Light to Moderate Consumers of Alcohol and Abstainers Who Live Alone or With Someone

Instrument	*N*	*df*	χ^2	*p*
ISSB	97	1	1.118	.290

Hypothesis 7

Hypothesis 7 stated that there would be no significant difference in income levels as reported on the SQ between light to moderate consumers of alcohol and abstainers. As shown in Table 8, the χ^2 value for the comparison was 2.123 with a

resulting probability of .346, which was not significant. Therefore, Hypothesis 7 was accepted.

Table 8

Income Levels Between Light to Moderate Consumers of Alcohol and Abstainers

Instrument	*N*	*df*	χ^2	*p*
SQ	68	2	2.123	.346

CHAPTER V

SUMMARY, FINDINGS, CONCLUSIONS AND IMPLICATIONS, AND RECOMMENDATIONS FOR FUTURE RESEARCH

Summary

The present study was conducted to investigate the differences that may exist between two identified groups of older African-American women: (1) light to moderate consumers of alcohol, and (2) abstainers from alcohol. Within these two groups are four subgroups of women that were studied: (1) abstainers with high social support, (2) abstainers with low social support, (3) light to moderate consumers of alcohol with high social support, and (4) light to moderate consumers of alcohol with low social support.

The study sample consisted of subjects from five churches and one community agency in moderate size Midwestern urban area. A final sample of 97 subjects was included in the study. Measures utilized in this study consisted of one sociodemographic form and four self-report assessment instruments: the Mini Mental Status Exam, the Michigan Alcoholism Screening Test–Geriatric Version, the Center for Epidemiologic Studies Depression Scale, and the Inventory of Socially Supportive Behaviors. The researcher read each instrument and recorded subjects' responses.

Selection criteria for inclusion in the study required that each subject be between the ages of 65 and 99 years and an African American female. No subjects scored below 19 on the Mini-Mental Status Exam; therefore, none was eliminated

from the study. Fifteen subjects scored 5 or above on the MAST-G and were eliminated from the study. A total of 24 subjects did not complete responses to one or more of the instruments due to fatigue.

Findings

Seven hypotheses were formulated and tested. Hypotheses 1, 2, and 3 were tested by application of a two-tailed *t* test. The chi-square test was used for Hypotheses 4, 5, 6, and 7. The data indicated no significant differences between light to moderate consumers of alcohol and abstainers in elderly African American women on the variables investigated; therefore, the data supported accetptance of the seven null hypotheses.

Conclusions and Implications

The results of the present study appear to provide support for the conclusion that there are no real differences in levels of depressive symptomatology between abstainers and light to moderate consumers of alcohol. The two groups are very similar in terms of levels of depression. The mean score of 19.80 (SD = 9.5) for abstainers was not statistically different from the mean of 18.62 (SD = 7.96) for light to moderate consumers of alcohol. Interestingly, approximately 64% of both abstainers and light to moderate consumers of alcohol reported high levels of depressive symptomatology as measured by the CES-D. Based on race and gender, levels of depression in this study are consistent with those reported by Murrell, Himmelfarb, and Wright (1983). The high depressive symptomatology scores could be attributed to the psychological distress that racial or ethnic minorities experience

and, in particular, older African American women. (Kemp, Staples, & Lopez-Aqueres, 1987; Kessler & Neighbors, 1986; Linn, Hunter, & Perry, 1979).

Contrastingly, Lipton's (1994) general population cross-sectional study of depression across the lifespan found that light-moderate and moderate drinkers had lower depression scale scores than those in other drinking categories, such as abstainers and heavy drinkers. Welte and Mirand (1992) reported that the general population of elderly respondents failed to show any relationship between alcohol consumption and characteristics such as depression, lifestyle activity, and physical symptoms. Neither the Lipton nor the Welte and Mirand study appears to support the position that abstinence of alcohol lowers one's likelihood of experiencing depressive symptomatology. However, the findings in this study suggest that African American women who are abstainers or light to moderate consumers of alcohol are at higher risk of experiencing depressive symptoms than other groups of persons based on age, gender, or race.

If the Inventory of Socially Supportive Behaviors accurately assessed supportive behaviors, the results of the present study suggest that the levels of social support received by abstainers and light to moderate consumers of alcohol are very similar. Substantial evidence supports the critical role that adult African American children assume in providing assistance to their elderly parents (Chatters & Taylor, 1993; Petchers & Milligan, 1982). Surprisingly, both groups of women reported somewhat lower levels of social support than found in the general population of elderly males and females of all races and ethnicities. The present finding may, in part, be explained by the characteristics of the sample: the majority live alone (53.6%), are single/widowed (70.1%), had above-average incomes (51.5%), and had obtained at least a high school diploma (55.7%). Taylor (1986) found that education was

significantly related to the frequency of help that African American elderly adults received from the extended family. The fewer the years of education, the more frequent the support.

There is some speculation that persons with supportive relatives and friends may be less likely to resort to excessive alcohol consumption when experiencing stress. The majority of respondents from the present study reside in close proximity to immediate family members, thus making access to one another relatively convenient. Similarily, reported research indicates that urban African American families often reside in several households located in the same neighborhood or apartment complex (Aschembrenner, 1975). Subjects in the present study are from a small urban community in the Midwest of 59,459 individuals, including 8,442 African Americans. Lee and Cassidy (1985) reported that among older Whites, persons living in large cities had a higher likelihood than rural residents of living within 10 miles of at least one child. Although urban older African American adults tended to live closer to their immediate family, other research found that rural African Americans were more likely to indicate that they relied on immediate family for help during illness (Chatters, Taylor, & Jackson, 1985).

The somewhat atypical lower levels of social support reported in the present study raise important issues concerning the heterogeneity of familial relationships among older African Americans. Although many elderly African Americans have support networks, not all older adults are members of extended families or have children who provide for their care and assistance (Jackson, 1980). Continued study of this area may help answer basic questions regarding the determinants of family relationship factors and support provision within African American families and may

begin addressing problems (e.g., social isolation) that occur when supportive networks are inadequate in meeting the needs of elderly African American women.

The present study lends support to the notion that light to moderate consumers of alcohol and abstainers who attend church weekly experience similar levels of social support. According to Taylor and Chatters (1986a), frequency of church attendance is a critical indication of assistance received and the amount of aid provided. Their study indicated that an interaction existed between age and the presence of adult children. For those elderly persons with adult children, advance age was associated with more frequent assistance from church members. Among childless African American women, however, advanced age was associated with a decrease in the frequency of support by church members. The findings from the present study suggest that African American women who attend church weekly and are abstainers or light to moderate consumers of alcohol receive the same type of social support.

Analysis of the hypothesis related to perceived health status between light to moderate consumers of alcohol and abstainers did not significantly differentiate between the two groups of women. The findings of the present study suggest that both groups are very similar in terms of their subjective health assessment. The general perceived health of the subjects in this study was considerably better than that of reported studies with sick, impoverished, and/or underserved populations. According to Welte and Mirand (1994), health orientation is not a strong predictor of heavy drinking among older persons, which would tend to support the findings of the present study. Objective health status and subjective health assessment bear a positive relationship to each other (Ferraro, 1980). Both types of health measures have been found to be significantly related to the subjective well-being of African American

older adults (Ball, 1983; Markides & Martin, 1979; Okun, Stock, Harring, & Witter, 1984).

If the ISSB accurately assessed levels of social support, then the present study supports the notion that marital status does not differentiate between light to moderate consumers of alcohol and abstainers. In the present study, light to moderate consumers of alcohol and abstainers have similar social support scores. Meyers, Hingson, Mucatel, Heeren, and Goldman (1985) reported that married older people are less likely to abstain than nonmarried individuals. Also, they suggested that widows and widowers are more likely to abstain than married individuals. Barnes (1982) found in an Erie County, New York, general population survey that among the elderly respondents there was no correlation between heavy drinking and marital status. Thus, consumption of alcohol may actually be greater when persons are in committed relationships.

Among consumers of alcohol, researchers have found only one marked variation in drinking behavior of divorced or separated older adults in the general population (Meyers et al., 1985). Researchers found that divorced or separated older adults are more than twice as likely as others to have two or more drinks per day. Similarly, in the present study, of the approximately 70% of subjects not married or living with someone, 56% reported light to moderate alcohol consumption.

The inherent difference in dyadic relationships seems to affect the quality and quantity of social support. Differences can be traced to the general configuration of the American family system. Through the family life cycle, the marital relationship receives the dominant value emphasis. Husbands and wives are expected not only to fulfill one's instrumental needs but also provide social and emotional support. The lower levels of social support reported in the present study may be related to the fact

that only 29.9% of respondents in the study were married. Thus, the data from the present study indicated that subjects' alcohol use or abstinence was unaffected by whether they lived alone or with someone.

Analysis of the hypothesis related to individuals who live alone or with others provides support for the conclusion that there are no real differences related to social support scores for abstainers and light to moderate consumers of alcohol. Without controlling for race and gender, Brown and Chiang (1984) found that alcohol abuse was associated with living alone. Approximately 70% of subjects in the present study were not currently married or living with someone. Yet these elderly African American women overwhelmingly reported abstinence from alcohol or light to moderate consumption of alcohol, indicating that alcohol played a minor role in their daily life.

The results of the present study support the view that income levels are not significantly different between light to moderate consumers of alcohol and abstainers. Contrastingly, previous studies, such as Meyers et al. (1985), indicate a direct relationship between older people's incomes and alcohol consumption. Meyers et al. reported that persons with low annual incomes were more than three times as likely to abstain as those with incomes of $25,000 or more. Twelve subjects in the present study reported incomes under $12,000, 21 subjects reported incomes between $12,001–$30,000, and 29 had incomes greater than $30,000.

Previous research is generally inconclusive as to the impact of socioeconomic status on kinship relations for both African Americans (Taylor, 1985) and Whites (Lee & Cassidy, 1985). Among older African Americans, income was positively associated with receiving support from family members (Taylor, 1985).

It is important to keep in mind in the present study that both abstainers and light to moderate consumers of alcohol reported high levels of depression and low levels of social support. In order to identify older African American women who are at risk for experiencing depression and social isolation, and to get help for these women, we must focus greater attention on community level intervention. Because families, churches, friends, and service providers who work with the elderly are more likely to observe changes in the older African American woman, programs that serve these groups have the potential for effectively helping more older African American women than intervention programs targeted just to the older person.

Mental health professionals and clergy who have knowledge and skills are more likely to intervene earlier with older African American women at risk for exhibiting symptoms of depression. As the older African American population increases, the need to know about mental health concerns in later life will continue to grow. Bereavement overload, depressive illness, and social isolation are significant mental health concerns that can affect an older person's functioning. To increase the well-being of older African American women, greater effort must be directed to prevention and education about these mental health concerns. One advantage educational programs have over other intervention strategies is their nonintrusive nature. Many African American women who will not seek counseling or directly contact the mental health program will attend a program labeled education. Such a program can be a springboard for a person to get needed information and take action, including seeking mental health assistance.

Limitations

Several limitations existed in the present study. First, the study sample was not fully representative of the elderly African American female population it sampled. In contrast to the general population, participants in the present study reported higher than average income and levels of health. Also, because only noninstitutionalized subjects were eligible to participate, the sample was also likely to be healthier than studies that included nursing home residents. Clearly, institutionalized older adults would experience limitations that ambulatory persons would not encounter.

Secondly, the present study is limited by the self-report nature of the data. Although the same interviewer surveyed the subjects, the data are self-report with no external source of collaboration. Whatever factors influence a respondent to report high depressive symptomatology may also influence and, in some ways, bias the objective reporting of social support. Coyne and Bolger (1990) have demonstrated that social support can be more effective when the subject is not aware of or cognitively processing the support being received. King (1986b) suggests that higher rates of alcohol usage in the elderly are reported when near relatives are asked to supply the alcohol history data. Since coinformants were not asked about depressive symptomatology, social support, or alcohol consumption, such information was not available.

Thirdly, the reliability of alcohol use reports are suspect A great deal of evidence suggests that most misreporting involves underreporting of alcohol use. Reported consumption levels of the subjects in the present study could have been artificially diminished because of misreporting (Cole, Tucker, & Friedman, 1990; Embree, 1993). Thus, conclusions should be cautiously interpreted.

Another limitation of the present study is that the measure of social support assessed support only from the previous four weeks. In future research, it may be valuable to examine the different effects of positive and negative support over longer periods of time and in multiple contexts. For example, some evidence suggests that support from friends may be more critical than support from relatives (Dean, Kolody, & Wood, 1990; Lee & Ishi-Kuntz, 1987).

An additional limitation of this study is the tendency for subjects to respond in a socially desirable way. Thus, response bias may negatively affect the validity of this study. Social desirability has been seen as a major threat to accurate assessment (Jackson & Messick, 1962). Although the sample size was adequate ($N = 97$), this researcher speculates that it was difficult to obtain true light to moderate consumers of alcohol, because a large number of subjects who are active church members were perhaps more prone to underreport their alcohol consumption.

Finally, with regard to participants, this study provides a preliminary glance at the characteristics of elderly African American women in one Midwestern area. Its results are limited by several factors. First, the study is a small one, and a larger sample is needed to further define the characteristics of this population. Further, the subjects in this study were gathered from several churches and one community center. Different characteristics may have been reported by elderly African American women who do not attend church.

Recommendations for Future Research

The current study may stimulate further research in several directions.

1. One suggestion for future research would be to lower the age for elderly participants. The life expectancy of African Americans is significantly lower than for

those older adults in the majority population. Although the Older Americans Act identifies age 60 as the eligibility point for senior services, those individuals who are 55 and over might increase generalizability of the study.

2. Although not the primary emphasis of this research, future survey administration with this population will benefit positively from a shortened, and therefore less burdensome, version of the CES-D. Eliminating items will reduce the total interviewing time considerably and lower fatigue in subjects. In addition, some of the items included in the full Radloff (1977) model may not be conceptually congruent with the group-centered worldview of the African American culture. Although there is not just one but many African American cultures, some characteristics are shared by most African Americans that distinguish them from the majority Euro-Western culture.

3. Another direction to take in future research would be to utilize more open-ended questions. Because of limited validation of the ISSB among older African Americans, researchers might benefit by asking additional questions to elicit descriptions of subjects' household composition, etc.

4. Also, it is recommended that further research take into account complex alcohol measures beyond frequency and quantity issues, such as high consumption drinking episodes and type of alcohol consumed.

Appendix A

Letters of Permission From Data Collection Sites

URBAN LEAGUE
MADISON COUNTY, INC.
Affiliated with National Urban League

1210 West 10th Street
P.O. Box 151566
Anderson, Indiana 46015
Ph: (765) 649-7126

October 18, 1999

Dr. Alan J. Hovestadt, Professor and Committee Chair
College of Education
Counselor Education and Counseling Psychology
Western Michigan University
Kalamazoo, Michigan 49008-5195

Dear Dr. Hovestadt:

The Urban League of Madison County, Inc., has provided a Senior program for approximately twenty (20) years that has included as part of its services:

1. Daily balanced diet meals five days a week.

2. Daily activities such as: games, crafts, bible study, excerise, group discussion and field trips.

3. Periodic health screenings and immunizations.

We have long recognized the physical and mental effects that social isolation and depression have on our elderly African-American women and welcome any new techniques and treatment strategies that might allow this target population to remain viable and self-sufficient for as long as possible.

The League will be more than happy in allowing Ms. Treva Bostic to interact with our senior's on this worthwhile research project.

If you have any questions, please contact me at (765) 649-7126.

Sincerely,

William Raymore
President/CEO

New Hope
United Methodist Church
"The Church Where Everybody Is Somebody"
Reginald E. Lee, Pastor

September 23, 1999

Treva L. Bostic
1902 Colgrove Ave., #214
Kalamazoo, MI 49001

Dear Treva:

Please consider this as a letter of support indicating approval for you to conduct a study at the New Hope United Methodist Church, as a part of your doctoral dissertation in the fall of 1999 and winter of 2000.

Sincerely,

Rev. Reginald Edwin Lee
Sr. Pastor, New Hope United Methodist Church

1503 Louise Street • Anderson, Indiana 46016
Church Office (765) 649-1892 • Fax (765) 649-9824 • Parsonage (765) 643-4420 • E-mail newhpch@aol.com

Friendship Missionary Baptist Church
1510 West Sixteenth Street
Anderson, Indiana 46016
(765) 648-2525

Rev. Edgar M. Woodall
Pastor

Sept. 14, 1999

Treva L. Bostic
1902 Colgrove Ave. # 214
Kalamazoo, MI 49001

Dear Treva:

Please consider this as a letter of support indicating approval for you to conduct a study in our church, as a part of your doctoral dissertation in the fall of 1999 and winter of 2000.

Sincerely,

Rev. Edgar M. Woodall
Pastor

E.M.W.
(mvw)

Anderson Zion Baptist Church, Inc.
P.O. BOX 2323 2008 LOUISE STREET ANDERSON INDIANA 46018

CHURCH PHONE 644-3668

September 23, 1999

Ms. Treva L. Bostic
1902 Colgrove Ave., #214
Kalmazoo, MI 49001

Dear Ms. Bostic:

Please consider this as a letter of support indicating approval for you to conduct a study in our Church, as a part of your doctoral dissertation in the fall of 1999 and winter of 2000.

Sincerely,

Deacon Mack Rease,
Chairman Deacon Board

jah

PROGRESSIVE TEMPLE OF FAITH

Reverend Roosevelt Boyd (Pastor)
2026 Hendricks Street
Anderson, Indiana 46016

September 22, 1999

I Reverend Roosevelt Boyd give Treva Bostic permission to conduct study for her dissertation for data.

Rev Roosevelt Boyd

Pastor Rev. Roosevelt Boyd

WALLACE TEMPLE A.M.E. ZION CHURCH
1518 Forkner Street
Anderson, Indiana 46016
REV. DR HENRY C. TUTT, PASTOR
(765) 643-6854 - Church (765) 649-0012 - Office (765)649-0037 - Fax
BROTHER CHARLES HOBSON, Chairman of Trustee Board
BROTHER WILLIE TOWNSEND Chairman of Steward Board
SISTER KAREN BONAPARTE Church Secretary
SISTER MARY ALICE BELL Church Clerk

September 27, 1999

Ms. Treva L. Bostic
1902 Colgrove Ave. #214
Kalamazoo, Michigan 49001

Dear Treva,

Please consider this as a letter of support, indicating approval for you to conduct a study in our organization; as a part of your Doctoral Dissertation in the fall of 1999 and the winter of 2000.

Sincerely,
Rev. Henry C. Tutt, DD, Pastor
Rev. Henry C. Tutt, DD, Pastor

Appendix B

Oral Recruitment Script and Follow-up Letter to Church

College of Education
Counselor Education and Counseling Psychology

Kalamazoo, Michigan 49008-5196
616 387-5100

WESTERN MICHIGAN UNIVERSITY

Oral Recruitment Script - Church
Script will be read by the pastor of the church

Treva L. Bostic is a Counseling Psychology doctoral student at Western Michigan University. She is working on her dissertation under the direction of Dr. Alan J. Hovestadt, Professor and Committee Chair. She is requesting our assistance in recruiting subjects for her research project. She is doing a study to explore the differences in depressive symptomatology and social isolation in African-American elderly women who are abstainers and light to moderate consumers of alcohol.

Results from the proposed study, which will be presented in the form of a dissertation, will provide researchers and practitioners with useful information regarding alcohol, depression, and social isolation of older African-American women. Results from this study may also encourage and guide future research projects in exploring techniques and treatment of problematic alcohol usage, social isolation and depressive symptomatology with this population. There will be no immediate benefit to you for participating in the study.

Ms. Bostic's research project has been approved by the Human Subjects Institutional Review Board of Western Michigan University. Your participation is entirely voluntary, and you may discontinue at any time. Your participation or refusal to participate will have no effect on the relationship or services you receive from this church. To ensure confidentiality, your name or the name of our church will not be associated in any way with the reporting or presentation of the results of this research project. Any African-American woman who is 65 and older who is interested can either call Ms. Bostic at the telephone number which is provided on the recruitment flyer or see her in person after the this service in the lounge to gain information about potential participation in the research. If you agree to participate, Ms. Bostic can meet you here at our church or, if you wish, meet you at your residence during scheduled times.

If you have any questions, please contact Treva L. Bostic at (765) 649-2138 or (616) 388-4686, or her dissertation chair, Alan J. Hovestadt, Ed.D. at (616) 387-5117.

College of Education
Counselor Education and Counseling Psychology

Kalamazoo, Michigan 49008-5195
616 387-5100

WESTERN MICHIGAN UNIVERSITY

September 14, 1999

Rev. Henry Tutt
Wallace Temple AME Zion Church
1518 Forkner Street
Anderson, Indiana 46016

Dear Rev. Tutt:

I'm writing to follow up on our last meeting regarding participants from your church being involved in my research project. This is just to remind you that I need a letter of verification confirming that you are giving me permission to collect data at your church.

If you have any questions, please contact me, Treva L. Bostic at (765) 649-2138 or (616) 388-4686. Your help and cooperation is greatly needed and much appreciated to make this project a success.

Sincerely,

Treva L. Bostic, M.A.
Doctoral Student

Appendix C

Oral Recruitment Script and Follow-up Letter to Community Organization

College of Education
Counselor Education and Counseling Psychology

Kalamazoo, Michigan 49008-5195
616 387-5100

WESTERN MICHIGAN UNIVERSITY

Oral Recruitment Script – Community Organization
Script will be read by the community organization leader

Treva L. Bostic is a Counseling Psychology doctoral student at Western Michigan University. She is working on her dissertation under the direction of Dr. Alan J. Hovestadt, Professor and Committee Chair. She is requesting our assistance in recruiting subjects for her research project. She is doing a study to explore the differences in depressive symptomatology and social isolation in African-American elderly women who are abstainers and light to moderate consumers of alcohol.

Results from the proposed study, which will be presented in the form of a dissertation, will provide researchers and practitioners with useful information regarding alcohol, depression, and social isolation of older African-American women. Results from this study may also encourage and guide future research projects in exploring techniques and treatment of problematic alcohol usage, social isolation and depressive symptomatology with this population. There will be no immediate benefit to you in the study.

Ms. Bostic's research project has been approved by the Human Subjects Institutional Review Board of Western Michigan University. Your participation is entirely voluntary, and you may discontinue at any time. Your participation or refusal to participate will have no effect on the relationship or services you receive from The Urban League of Madison County. To ensure confidentiality, your name or the name of our organization will not be associated in any way with the reporting or presentation of the results of this research project. Any African-American woman who is 65 and older who is interested can either call Ms. Bostic at the telephone number which is provided on the recruitment flyer or see her in person after the this meeting in the recreation room to gain information about potential participation in the research. If you agree to participate, Ms. Bostic can meet you here at our center or, if you wish, meet you at your residence during scheduled times.

If you have any questions, please contact Treva L. Bostic at (765) 649-2138 or (616) 388-4686, or her dissertation chair, Alan J. Hovestadt, Ed.D. at (616) 387-5117.

College of Education
Counselor Education and Counseling Psychology

Kalamazoo, Michigan 49008-5195
616 387-5100

WESTERN MICHIGAN UNIVERSITY

September 14, 1999

Billy Raymore
Urban League of Madison County Inc.
1210 West 10th Street
Anderson, Indiana 46016

Dear Mr. Raymore:

I'm writing to follow up on our last meeting regarding participants from your organization being involved in my research project. This is just to remind you that I need a letter of verification confirming that you are giving me permission to collect data at the Urban League of Madison County.

If you have any questions, please contact me, Treva L. Bostic at (765) 649-2138 or (616) 388-4686. Your help and cooperation is greatly needed and much appreciated to make this project a success.

Sincerely,

Treva L. Bostic, M.A.
Doctoral Student

Appendix D

Flyer Distributed to Potential Participants

ALCOHOLISM, DEPRESSION, SOCIAL ISOLATION AND ELDERLY AFRICAN-AMERICAN WOMEN RESEARCH PROJECT

CRITERIA FOR PARTICIPATION

- AGES 65 TO 95
- FEMALE
- AFRICAN-AMERICAN

IF INTERESTED CONTACT

TREVA L. BOSTIC
AT (765) 649-2138 OR (616) 388-4686

Appendix E

Consent Form – A

College of Education
Counselor Education and Counseling Psychology

Kalamazoo, MI 49008-5195
616 387-5104

WESTERN MICHIGAN UNIVERSITY

Consent Form – A
Alcoholism, Depression, Social Isolation and Elderly African –American Women
Principal Investigator: Dr. Alan Hovestadt
Student Investigator: Treva L. Bostic, M.A.

I have been invited to participate in a research project about alcohol, depression, social isolation, and older African-American women. The purpose of this study is to explore the differences in depressive symptomatology and social isolation in African-American elderly women who are abstainers and light to moderate consumers of alcohol.

My consent to participate in this project indicates that I will allow Researcher Bostic to read and record information from a sociodemographic form and four questionnaires designed to access my drinking patterns, cognitive mental status, depressive symptomatology, and quality of social support. The questionnaires and sociodemographic form will be administered during scheduled times at my church or residence. The information I provide will make a contribution to others, who may better comprehend the social isolation, light to moderate alcohol usage, and depressive symptomatology among African-American elderly women. Results from this study may also encourage and guide future research projects in exploring prevention techniques and treatments for this population. There will be no immediate benefits to me for participating in the study.

All information will remain confidential. This means that my name will not appear on any of the questionnaires and the sociodemographic form on which this information is recorded. The forms will be coded with a number such as 1-80, therefore my name will not appear on any of the sociodemographic form or questionnaires. Once data are collected and analyzed it will be destroyed after three years. Researcher Bostic will have a copy of the data in a safe deposit box located in Anderson, Indiana. All other forms will be retained for three years in a locked file in researcher Hovestadt's office. No names will be used if the results are published or reported at a professional meeting.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or additional treatment will be made available to the subject except as otherwise stated in this consent form. One potential risk in this project is that I may become aware of sensitive topics that I may want to discuss. If distress occurs, my option will be to talk to my pastor, Ms. Bostic at (765) 649-2138 or (616) 388-4686, or the telephone crisis hotline at (765) 649-5211. Also, I have been provided with a list of additional referral sources to contact for assistance.

I may refuse to participate or quit at any time during the study without prejudice or penalty. My participation or refusal to participate will have no effect on the relationship or services I receive from the church. If I have questions or concerns about this study, I may contact either Treva L. Bostic at (765) 649-2138 or (616) 388-4686, or Dr. Alan Hovestadt at (616) 387-5117. I may also contact the chair of the Human Subjects Institutional Review Board at (616) 387-8293 or the Vice President of Research at (616) 387-9298, if questions or problems arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not have a stamped date and signature.

My signature below indicates that the purpose and requirements of the study have been explained to me and that I agree to participate.

Print participant's name	Signature	Date
TREVA BOSTIC	[signature]	11-3-99
Print name of individual obtaining consent	Signature	Date

Appendix F

Consent Form – B

College of Education
Counselor Education and Counseling Psychology

Kalamazoo, Michigan 49008-5196
616 387-5100

Consent Form – B
Alcoholism, Depression, Social Isolation and Elderly African –American Women
Principal Investigator: Dr. Alan Hovestadt
Student Investigator: Treva L. Bostic, M.A.

I have been invited to participate in a research project about alcohol, depression, social isolation, and older African-American women. The purpose of this study is to explore the differences in depressive symptomatology and social isolation in African-American elderly women who are abstainers and light to moderate consumers of alcohol.

My consent to participate in this project indicates that I will allow Researcher Bostic to read and record information from a sociodemographic form and four questionnaires designed to access my drinking patterns, cognitive mental status, depressive symptomatology, and quality of social support. The questionnaires and sociodemographic form will be administered during scheduled times at the Urban League of Madison County or my residence. The information I provide will make a contribution to others, who may better comprehend the social isolation, light to moderate alcohol usage, and depressive symptomatology among African-American elderly women. Results from this study may also encourage and guide future research projects in exploring prevention techniques and treatments for this population. There will be no immediate benefits to me for participating in the study.

All information will remain confidential. This means that my name will not appear on any of the questionnaires and the sociodemographic form on which this information is recorded. The forms will be coded with a number such as 1-80, therefore my name will not appear on any of the sociodemographic form or questionnaires. Once data are collected and analyzed it will be destroyed after three years. All other forms will be retained for three years in a locked file in researcher Hovestadt's office. Researcher Bostic will have a copy of the data in a safe deposit box located in Anderson, Indiana. No names will be used if the results are published or reported at a professional meeting.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or additional treatment will be made available to the subject except as otherwise stated in this consent form. One potential risk in this project is that I may become aware of sensitive topics that I may want to discuss. If distress occurs, my option will be to talk to Ms. Bostic at (765) 649-2138 or (616) 388-4686, or the telephone crisis hotline at (765) 649-5211. Also, I have been provided with a list of additional referral sources to contact for assistance.

I may refuse to participate or quit at any time during the study without prejudice or penalty. My participation or refusal to participate will have no effect on the relationship or services I receive from the Urban League of Madison County. If I have questions or concerns about this study, I may contact either Treva L. Bostic at (765) 649-2138 or (616) 388-4686, or Dr. Alan Hovestadt at (616) 387-5117. I may also contact the chair of the Human Subjects Institutional Review Board at (616) 387-8293 or the Vice President of Research at (616) 387-9298, if questions or problems arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not have a stamped date and signature.

My signature below indicates that the purpose and requirements of the study have been explained to me and that I agree to participate.

Print participant's name	Signature	Date
Print name of individual obtaining consent	Signature	Date
TREVA BOSTIC		11-8-99

Appendix G

List of Referral Sources

List of Referral Sources

Alcohol Abuse Accredited Treatment Center &
24 Hour Addiction Helpline & Treatment
Anderson, Indiana 46011
1-800-672-3727

Alcohol Abuse First Step To Recovery a 24 Hour
Helpline and Treatment
Anderson, Indiana 46016
1-800-333-2294

Anderson Center of Saint Johns
2210 Jackson Street
Anderson, Indiana 46011
(765) 646-8444

Behavioral Health Care of Anderson
2201 Hillcrest Drive
Anderson, Indiana 46012
(765) 649-8161

Briarwood Clinic
3645 North Briarwood Lane Suite C
Muncie, Indiana 46321
(765) 289-5520

Center for Mental Health
2020 Brown Street
Anderson, Indiana 46011
(765) 649-8161

Crisis Hotline
Anderson, Indiana 46011
(765) 649-5211

Crosspoints Counseling Services
1512 Madison Avenue
Anderson, Indiana 46016
(765) 622-0771

Appendix H

Permission to Use the CES-D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857-8030

Dear Colleague:

Thank you for your inquiry regarding the Center for Epidemiologic Studies Depression Scale (CES-D). We are always happy to have the scale used by qualified researchers. The scale is in the public domain and may be used and duplicated without copyright permission.

If you have any questions regarding the CES-D that are not answered by the information in the packet, please feel free to contact me either by e-mail: "kbourdon@nih.gov", or by telephone at 301 443-1616.

Sincerely,

Karen Bourdon

Karen H. Bourdon, M.A.
Prevention, Early Intervention, and
Epidemiology Research Branch
Division of Mental Disorders, Behavior
Research and AIDS

Appendix I

Sociodemographic Questionnaire

Identification Code_____

Demographic Data Survey

I am going to read you 19 questions. After I read each question please respond by indicating answers appropriate for you. Again, I would like to remind you that you may refuse to participate at any time and that it will not have any effect on the relationship services that you receive from the church or community agency.

Demographic Information

1. Indicate your age _____ years old
2. Indicate your highest educational level obtained _____
3. Indicate total annual income in your household_____
4. Indicate occupation before retirement_____
5. Are you currently employed ____ Yes ____ No
   If yes please specify occupation _____
   If currently employed how many hours do you work per week? _____
6. Indicate current marital status ____ Married ____ Single ____ Widow
   ____ Separated ____ Divorced ____ Never Married ____Living together as a couple
7. Indicate how often you attend church ____ Weekly ____ Monthly ____ Yearly
   ____ Never
8. Indicate religious affiliation ____ Baptist ____ Methodist ____ Presbyterian
   ____ Jehovah Witness ____ Catholic ____ None
   ____Other(specify)_____
9. Indicate current health status ____ Good ____ Fair ____ Poor
10. Specify if you currently have a medical condition_____

A. Family and Social Information

1. Indicate number of children living within 25 mile radius_____
2. Please indicate the frequency of contact with children ____ Daily ___ Weekly
   ____ Monthly ____ Yearly ____ Never
3. Indicate number of children living outside of a 25 mile radius _____

4. Please indicate the frequency of contact with children ____ Daily ____ Weekly ____ Monthly ____ Yearly ____ Never

5. Number of sibling(s) living within 25 mile radius _____

6. Please indicate the frequency of contact with sibling(s) ____ Daily ____ Weekly ____ Monthly ____ Yearly ____ Never

7. Number of sibling living outside of a 25 mile radius _____

8. Please indicate the frequency of contact with sibling ____ Daily ____ Weekly ____ Monthly ____ Yearly ____ Never

9. Number of adult children, grandchildren or other individuals living in the home _____

Appendix J

Human Subjects Institutional Review Board
Letter of Approval

Human Subjects Institutional Review Board

Kalamazoo, Michigan 49008-3899

WESTERN MICHIGAN UNIVERSITY

Date: 26 October 1999

To: Alan Hovestadt, Principal Investigator
Treva Bostic, Student Investigator for dissertation

From: Sylvia Culp, Chair Sylvia Culp

Re: HSIRB Project Number 99-09-17

This letter will serve as confirmation that your research project entitled "Alcoholism, Depression, Social Isolation and Elderly African-American Women" has been **approved** under the **expedited** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 26 October 2000

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