Counselling people with dementia and alcohol problems

Mike Fox explains the challenges, but also the potential, of counselling for people with dementia who also have alcohol problems

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Increase in life expectancy has led to a greater prevalence of dementia. At the same time, the growth of problematic drinking is well publicised. These factors combine to highlight a growing need for interventions that can help people with dementia who also have alcohol problems. Counselling offers one such possibility, and in this article I offer my perspective on this little-known area of counselling.

For several years, I have worked as a counsellor for an alcohol agency in north London. I work in the older persons' service within this agency, and in this role I have encountered a wide range of clients, some of whom have been diagnosed with a dementia, while others have exhibited behaviours consistent with some form of cognitive impairment that may not have been diagnosed, or in some cases even recognised, at the time of referral.

This work presents a particular challenge to professionals: are presenting characteristics such as confusion and memory loss attributable to dementia, to alcohol misuse, or to a combination of both, and are they are temporary or permanent? Sometimes referring clinicians have had relatively brief contact with a client, and so understandably choose to describe the behaviours they have observed, and perhaps also the results of cognitive tests, rather than make a clear diagnosis. For instance, this might be the case for clients who have been hospitalised following a drink related accident, when they are in an unfamiliar environment and may be recovering from both the effects of alcohol and physical trauma. Even when dementia has been diagnosed and the client's personal and medical history is known, the presence of alcohol can still complicate decisions relating to capacity, and hence decisions relating to the individual's ongoing care and welfare.

These issues are significant when trying to decide on realistic potential outcomes from counselling. Each person will require a different approach. The counsellor will of course be working in accordance with the client's wishes, which may mean aiming for reduction or harm minimisation rather than abstinence. Exceptions might be where a client has been detoxified during sectioning under the Mental Health Act and enters counselling under an agreement to try to abstain completely, or where the counsellor works within a system catering only for those wishing to be abstinent.

Older people and alcohol

Older people who develop problems with alcohol are a more varied client group compared to younger people with alcohol problems: there is more variation in the length of time they have experienced alcohol problems, more variation in their patterns of drinking, and more variation in their triggers for drinking. Older people generally, and particularly those with alcohol problems, are more at risk of social isolation. There is also more risk of the drink problem being masked by other conditions associated with old age, such as memory loss and confusion, unsteady gait and reduced mobility, poor co-ordination, falls, and depression or mood swings. Thus recognition of problematic drinking can be delayed by expectation of what is 'normal' in older people. As a result, problems are often recognised at a later stage, when they have become more severe.

Older people metabolise alcohol less efficiently – therefore its effects can be more detrimental, occurring more abruptly and taking longer to pass. Cognitive abilities such as memory and reasoning are more easily impaired. It is more likely to heighten emotions and can therefore exacerbate moods such as irritability and depression or anxiety and panic states. Digestion can be adversely affected, making it more difficult to absorb vitamins and minerals. Co-ordination, and consequently mobility, can also be impaired.

Clearly older people with dementia are particularly vulnerable to factors such as these. It is very important that front-line workers, including clinicians, are encouraged to develop skills and methods that enable them to recognise and act upon signs that might indicate alcohol misuse. The earlier the intervention the better the likely outcome. It is also vital for those involved in the client's care to develop a clear strategy of support as early as possible to prevent unnecessary confusion, both for the client and for those offering help and support.

Effective counselling

How then can the particular needs of people with dementia and alcohol problems be met to allow them to use counselling effectively? In my experience, the work must be genuinely collaborative to be effective. This means that the client must be willing to discuss their situation –

counselling cannot be forced. It also means that others involved in the client's care may have a large part to play in enabling them to participate and benefit from the counselling process.

Some or all of the following may also help to make counselling more effective:
• high quality and accuracy of referral information
• flexibility regarding boundary agreements
• collaboration with other carers

Quantity of referral information
The amount and quality of information that is passed to the counsellor at time of referral can vary considerably. This can occur for a variety of reasons, including:
• the duration, quality and context of the referrer's contact with the client, and hence the depth of information they are able to offer when referring
• the client's ability to describe information relating to their personal and medical history, as well as the history of their relationship with alcohol (people with dementia are less likely to be able to give accurate information on these matters)
• the client's willingness to offer information to the referrer, and also their willingness for it to be shared with a third party.

In my experience clients who have been diagnosed with dementia rarely self-refer, whereas it is not uncommon for older people with full capacity to decide independently that they need help with their drinking and to contact of their own accord. This reflects the greater vulnerability and potential for isolation of those who have dementia combined with an alcohol problem.

Flexibility
Structure is particularly important for people with alcohol problems, but alcohol – by its very nature – resists boundaries. Therefore it is important to consider what agreements will best serve the client's needs and to be even more flexible and creative than usual. Examples might be:
• agreeing to phone to remind before each session
• keeping the same time and day for each session
• varying session length according to the client's ability to concentrate or engage
• negotiating the possibility of sharing some or all of the contents of the session with the client's keyworker, to ensure continuity or to allow them to implement changes that will support the work
• negotiating to allow feedback from carers prior to each session for clients who confabulate (this may be the only way to gain a picture of what happens between sessions).

Much of the factual and emotional content of sessions may never be fully clarified. Even so, the act of witnessing and affirming the client's experience is still very important

Collaboration with other carers
Whether or not the counselling is part of a formal care plan, the involvement of others who are concerned with the client's well-being can greatly improve the likelihood of a successful outcome. For many people, alcohol is inextricably linked to their daily habits: they might drink at certain times of day, alone or with certain people, at home or in a public place, or when involved in activities such as eating or watching television. Clinicians, carers, family members and friends may all offer valuable information regarding a client's activities of daily living, which may in turn throw light upon how they drink and why they drink. Although preferable, it may not be possible to learn such information directly from the client. Others may also help to implement a strategy or treatment plan that has been agreed with a client. Examples of joint working might include:
• substituting activities that do not involve alcohol
• substituting non-alcoholic drinks (very important to find out which ones the client likes)
• being aware of reasoning behind the prescription of medication and supporting it, that is, teaching skills to manage depression or anxiety when medication for these conditions is being reduced, thereby eliminating potential triggers for drinking
• environmental and behavioural prompts (for example, remembering to eat regularly can help to keep blood sugar levels more constant, which can improve mood and reduce craving).

About alcohol counselling

Alcohol counselling differs from general counselling in that clients with a dependency are more likely to expect specialist knowledge and expertise from a counsellor in relation to the subject matter. When working with people with dementia I have found it helpful to adopt a more conversational style and to accept discursiveness and digression, where it occurs, as a natural aspect of the relationship. This tendency, which is often shared to some extent by people with full capacity in the early stages of recovery from alcohol misuse, can also indicate that the client might benefit from help to focus on the matter at hand and sometimes it can be valuable to negotiate this explicitly. Despite such an agreement it is possible that only a small proportion of the session will relate directly to the client's drinking, although often much additional relevant information can be learned within the whole interaction, and any intervention that contributes to the client's well-being may also have a beneficial effect on their drinking habits. There may also be much repetition, which may indicate matters of particular importance to the client, but can also, I feel, be a means of conveying information which contributes to their sense of identity. To repeat can be to affirm.

Within all of this the counsellor will inevitably be making informal decisions about capacity: what can be remembered? What is being understood? What interventions would be most helpful in the light of this? Two other questions apply to everyone with an alcohol dependency: what needs underlie the drinking? How might these be met without alcohol? Dependency results from unfulfilled need.

In contrast to what one might normally expect from a counselling interaction, (which would aim to dispel confusion), much of the factual and emotional content of sessions may never be fully clarified. Even so, the act of witnessing and affirming the client's experience is still very important. It is also important to seek or recognise other ways of understanding. People with dementia often convey their sense of understanding through metaphors. An example would be a highly educated Sudanese client with evident short-term memory loss who soon began to address me as 'my good doctor' conveying, I believe, his understanding that I was someone who was involved in his care and well-being, and also his developing sense of trust. I had introduced myself and my role at the beginning of our work together and felt no need to contradict him.

I have also found that there is more need to work with implied understanding, because a client with dementia may be less able to describe their feelings and experiences, whether current or past. Despite this, strong feeling can be conveyed through euphemism or even silence. One client, who would speak amiably and without apparent intensity about practical matters for the first part of the session, would then become silent for a short period of

time, during which his chin would drop to his chest. When this happened I had the sense that he was looking deep within, and a feeling of sadness permeated the room. After a while he would look up and smile as though something had been shared. I never knew what he was thinking at these times; it did not seem appropriate to ask or even necessary to speculate. However, such moments were clearly meaningful to him, and he later told me that the sessions made him feel peaceful.

Drawing on strengths

Confidence can be drawn, and rapport developed, by finding areas where memory and general cognition are most reliable. A client who attended counselling while under section in hospital was often clearly confused when he arrived at our sessions. Once, after a brief three-way meeting with his keyworker, we began by remembering the names of the football team he supported in his youth, which fortunately I also knew. As well as helping me to learn a little more about his memories and ability to remember, he clearly enjoyed the exercise and it set the tone for the rest of the session. Another client with very little short-term memory had travelled the world singing in seven languages and could talk about this part of her life with both clarity and pleasure. Doing this enabled us to move naturally on to talking about the history of her drinking, and also indicated that the best way to approach her current drink problem was via its past effects.

One final point – above all this work calls for pragmatism. A client whose social life had always revolved around his local pub decided to continue to visit after a seven-month spell in hospital due to drink related illness. As he was clear that he would be abstinent henceforth the landlord and friends with whom he sat all agreed only to offer him only soft drinks, an arrangement with which he was surprisingly comfortable. He felt that the alternative, loneliness and isolation, was more likely to trigger relapse.

In this article I have offered my own experience and that of some of my clients. I have also drawn from many conversations with other healthcare professionals with whom I have been involved through this work. Nothing written is meant to be prescriptive or definitive: successful outcomes depend on an individual approach and a willingness to try different options. I am encouraged to believe that an effective field of treatment can be developed for a client group who until recently might have struggled to find meaningful help.