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Aging and Addiction

by Kathleen Parrish, LPC

Sam is a 73-year-old retiree living in an upscale, gated community located in the Southwest sunbelt. He has enjoyed a long and successful career as a commercial real estate developer. Sam and his wife raised three happy and successful children, though he lost his wife of 45 years to cancer about two years ago. All who know him think of Sam as witty, intelligent, and thoughtful. Sam is also an alcoholic who, for the past six years has been addicted to prescription pain medication.

Sam represents an ever-increasing number of seniors who meet DSM criteria for a substance use disorder. Many clinicians now agree there is a growing epidemic of substance abuse among older adults. It is estimated that up to ten percent of the over 60 population suffers from alcoholism (Jinks and Raschko 1990). In his 2001 study, Henderson also concluded that polysubstance use was a significant problem for adults in the age range of 55 to 79, with substance-related problems being found in up to 20 percent of subjects studied. Henderson goes on to suggest that the rate of substance abuse among individuals 75 and older is comparable to that of persons who are younger than 40. Accordingly, it is predicted an increase in the number of aging individuals who suffer from a substance use problem will occur in the coming decades. Studies also suggest this potential increase might be related to an aging generation of baby boomers, who histories tend to include more substance abuse than do those of members of previous generations (Gfroerer, et.al, 2001).

The elderly present a greater range of physical and emotional complexities than do other age groups, posing a number of challenges for clinicians who provide addiction treatment to this segment of the population. Older adults also experience more serious health concerns related to their use of mood-altering substances. In many cases, by the time the patient is assessed, years of drug and alcohol abuse have taken an irreparable physical toll. To make matters worse, age-related physiological changes—such as a decrease in body mass and lower levels of hydration, result in seniors processing alcohol differently—compounding substance-related damage. Older adults who drink even moderate amounts of alcohol may experience alcohol-related problems that, in younger drinkers, are associated with much higher levels of use (National Institute on Alcohol Abuse and Alcoholism, 2003). Older adults who use alcohol or other substances of abuse are also more likely to experience dementia or be injured in falls (Rigler, 2000). Adults 60 or older can suffer amnesia or experience significant personality changes after consuming even relatively moderate amounts of alcohol—sometimes as few as two drinks! (Lipschitz, 2008).

More Than The Evening Cocktail

In evaluating substance abuse among older adults, clinicians should take into consideration the possible use of drugs other than alcohol. A recent study found older adults use prescription medications three times more frequently than do members of the general population, with an even higher prevalence of the use of over the counter medication (Patterson and Jeste, 1999). Lipschitz (2008) also suggests that the use of heroin and crack cocaine among the elderly will increase as baby boomers age. This is contrary to the long-standing trend that alcohol dependence is the predominant substance abuse diagnosis in older adults. Citing a SAMHSA study, Krantz (2008) describes the changing nature of addiction among people 60 and older, suggesting illicit drug use, including the use of such drugs as heroin and cocaine, has increased dramatically among this subset of elderly.

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Treatment Barriers

A number of barriers prevent elderly alcoholics and addicts from getting the treatment they need. Preconceived and erroneous notions of alcoholism and addiction are often inconsistent with how loved ones view their elderly relatives. To further muddy the waters, the signs of problematic alcohol or drug use can mimic expected age-related difficulties, such as cognitive impairments and problems with balance and gait (Levin and Kruger, 2000). The normal and expected cultural, familial, and community roles assumed by older adults can also make it difficult for concerned relatives to recognize drug use among older family members. And, though research efforts typically focus on trends of substance abuse among the elderly, not enough is being done to develop treatment strategies aimed at addressing the distinct and complex needs of the elderly substance abuser.

To ensure effective treatment, a thorough bio-psycho-social assessment of the elderly patient should be completed prior to initiating any kind of behavioral health therapy. Assessments should include a thorough history and physical examination, a psychiatric evaluation, and a nutritional assessment. Interviews with concerned relatives should also be done to insure the accuracy of any information obtained from the elderly patient. Cognitive screening should be considered if indicated by data in any of these prior assessments. This comprehensive assessment process can then be used as the foundation for subsequent therapy, allowing the clinician to approach the older adult patient from a holistic perspective, with a clear appreciation for all possible factors that might impede the treatment process.

Clinicians providing substance abuse treatment for older adults should also be alert to the possible presence of co-occurring disorders. Koenig, George, and Schneider (1994) report members of the baby boom generation are 3 to 4 times more likely to experience mental health problems than members of the current elderly population. Additionally, King, et. al (1994) report alcohol and mental health problems among the elderly often go hand in hand. This implies clinicians should be well versed in treating co-occurring disorders.

There are a number of factors that can affect changes in the mental health of older adults, including: retirement, the death of a spouse, age-related deterioration of health, "empty nest" syndrome, and reduction in income. Additionally, older adults may have fewer opportunities for meaningful social interaction and sometimes live in isolation as a result of a physical handicap or financial limitations. While many older individuals are able to cope with these age-related life challenges, some seniors experience an exacerbation of pre-existing depressive and anxious symptoms, sometimes accompanied by a re-emergence or escalation of substance abuse. Although some older adults come to the attention of treatment providers, others go on with their lives with little or no outward signs of distress.

Though older adults can approach the counseling process differently than their younger counterparts, denial in this population is still common. Many seniors have difficulty in accepting the need for treatment, and the longstanding use of alcohol or other substances may have impaired the elderly adult's ability to recognize the consequences of their substance use. Planning treatment without regard to the elderly patient's age and developmental status can result in a treatment stalemate (Koch, 2003). However, the work of several theorists, including Erik Erikson, has shown the benefit of using treatment approaches that take into consideration the tasks associated with patients' stage of development.

Erikson suggests certain life-stage tasks for older adults. He identifies the task for later adulthood (age 60-75) as that of *integrity vs. despair*, in which the central life task is introspection. In essence, this task focuses on the acceptance of self and the reality of one's eventual death. Other tasks of this stage include the promotion of intellectual vigor, redirection of energy into new roles and activities, and the development of a point of view about death. Those who complete these tasks successfully are rewarded with a sense of peace and integrity. Erikson believes those 75 and older face a crisis known as *immortality vs. extinction* in which the task is a review of life culminating in an acceptance of one's own mortality. If successful, this outcome is accompanied by a sense of integrity and calm acceptance of one's eventual death (Erickson, Wikipedia, 2006).

Erikson's theories seem to imply treatment interventions for older adults must include opportunities for introspection, evaluation, and a critical examination of thoughts, attitudes and beliefs. This kind of cognitive approach may be a better fit for older adults who often experience difficulty with counseling interventions that are primarily experiential and involve intensive emotional exploration. Older adults' difficulty with more experientially based therapies may be due to era-specific societal norms that have, for older generations, promoted self-sufficiency and stoicism. Contrast this with baby boomers who may prefer treatment interventions that offer more immediate relief. They may enjoy more experiential modalities of treatment that emphasize health and wellness (Krantz, 2008). Whatever approach is utilized it remains critical older adults both recognize and confront the disease of addiction, while embracing the inherent value of their life experiences—sharing these experiences with others in the context of recovery.

While further research is warranted, current indicators suggest a need for substance abuse treatment that is specifically tailored to meet the needs of older adults, who present with complexities that far outstrip those of other age groups. Treatment strategies that highlight education, introspection and individualism will offer immeasurable benefits to the older individual seeking freedom from substance related problems.

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