

**TITLE: TRAUMA AND THE SUBSTANCE ABUSING OLDER ADULT:
INNOVATIVE QUESTIONS FOR ACCURATE ASSESSMENT**

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ABSTRACT:

In the last decade scholarly research and publication have dramatically increased in addressing the impact of trauma events and substance abuse. Despite the vast knowledge of the effects on health and social functioning, how substance abuse and trauma are defined and assessed with older adults in the literature remains minimally addressed and quite controversial. Alcohol, illicit drug, and prescription medication addiction is a hidden epidemic in aging. Additionally, untreated childhood trauma can create serious mental and physical complications later in life. Aging baby boomers will represent one-third of the population in the United States by 2030. This article addresses the integration of content related to aging, trauma, and addiction in professional training, assessment and scale development, and prevention research.

INTRODUCTION:

A review of the literature on substance abuse in the elderly, particularly in the last decade, suggests that identification, theoretical explanations, prevention, and treatment outcomes remain highly controversial. This is due to the lack of standardized criteria specific to older adults and establishing parameters for this wide age span (i.e. 55-60, 61-70, 71-80, 80+). The complexity and diversity of aging and addiction requires clinicians to be knowledgeable and innovative with interventions when addressing “normal” aging issues, adverse medical and psychotropic drug interactions, depression, dementia, addiction, trauma, and other co-occurring concerns (D’Agostino, 2003; Colleran, 2002; Jennison, 1992).

According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2002) the prevalence of substance use disorders is higher among patients visiting a primary care physician. Therefore, health care providers have an opportunity to be on the front line in detecting, initiating, and implementing treatment efforts with this age group. For example, trauma and of crisis intervention centers such as emergency rooms , fire departments, police officers, medical practices, and retirement communities, are among the places older adults are turning to for help (Hungerford & Pollock, 2001).

Numerous studies have been developed reviewing the effectiveness of brief screening instruments identifying the abuse of alcohol, tobacco, prescription, and illegal drugs (Cherpitel, 1997). However, these scales may not be astute to include the medical complications associated with aging and substance use, the diverse affective styles of interviewing, and the unique circumstances of older persons abusing substances. For example, clinicians and physicians not trained in gerontology and substance abuse,

combined with the care giver's lack of training and knowledge of healthy behaviors of older adults creates a defense known as "double denial" (Kagan & Shafer, 2001). These combined factors may hinder recognizing older adults at risk, or may create a perception of substance use as normal for coping with trauma issues and psychosocial stressors common in this stage of life (Colleran, 2002).

This inquiry into prevention, scale, and curriculum development highlights how the prevailing screening interventions currently in use are missing elements in identifying and assessing for substance abuse and trauma in older adults. Several screening questionnaires for identifying substance use disorders exist, but their validity for use with older persons and women is hotly debated (Moore, Seeman, Morgenstern, Beck, Reuben, 2002).

For example, establishing current polysubstance abuse (alcohol, tobacco, illicit and prescription drug abuse) as well as utilizing affective questions that are elder specific is vital to the understanding of substance abuse in older adults. Given the well-developed means of denying, minimizing, and hiding substance abuse, the aim is in asking brief questions that build rapport and trust in older adults as a means to obtain actual facts about past and current substance use. Additionally, another aim is to examine whether or not memories of and responses to traumatic events (past and present) common to older adults (death of spouse or adult children, recent losses, chronic illness) relate to the current abuse of substances.

OVERVIEW OF THE LITERATURE ON OLDER ADULTS AND SUBSTANCE ABUSE

Historically, substance abuse research on best practices and treatment outcomes focus primarily on individuals in early or middle adulthood, excluding children, and older adults. Additionally, what seems missing in the research literature is evidence of healthy behavior change due to prevention and treatment efforts. In other words, there is limited documentation in research publications as to what works in reducing harm from substance abuse in older adults (Purdie & McCrindle, 2002).

Youth and older adults differ from other substance users in a variety of ways including the type of substances used, methods of use, consequences, physical symptoms, and risk factors. Therefore, there is a need for specialized assessments, treatment measures, and training to account for the differences unique to the older adult (Colleran, 2002; Oslin, & Holden, 2002; Rubin & Babbie, 2001).

The National Evaluation Data Services conducted a literature review (Feidler, Pertica, Leary, & Strohl, 2002) focusing on substance abuse among adults ages 55 and older between 1992 and 2002. This review reveals the baby boom generation (individuals born between 1946 and 1964) will soon be reaching older adulthood. This age group will comprise the largest group in this country, and brings a new image to the older adult substance abuser. According to a report by the U.S. Census Bureau, by 2025 an increase of those 60 and older is expected. In 1998 alone, over 23,000 persons aged 60 and older entered a treatment facility for substance abuse in the United States. As the population continues to age, the number of older adults at risk for substance abuse will increase. This growing epidemic is encouraging researchers to explore treatment, and prevention needs, and evidence based outcomes in this population (Owen, 2001).

Florida has the highest percentage of older adults in the nation. As political messages and research data impact various policy issues and social service providers, analysts everywhere recognize Florida is the perfect state to monitor how population growth and generational health issues will be addressed. For example, persons aged 65 and older make up 18 percent of the state's population. By the year 2010, it is estimated that seniors will make up nearly one in five Floridians (Feidler, Pertica, Leary, & Strohl: MacMannus, 2002).

IMPLICATIONS FOR SOCIAL WORK EDUCATION AND TRAINING

In spite of the demographic data published describing those who are substance abuses in the United States, according to Doweiko (2002), researchers seemed surprised to discover that a significant number of older adults abuse alcohol and drugs. In fact, the elderly receive approximately one-third of all prescription medications, many of which are designed to control medical and psychiatric symptoms commonly associated with substance abuse, referred to as dual disorders. Knowing this demonstrates the responsibility of educators to integrate and create course content specific to substance abuse and aging into the social work curriculum.

Alcohol abuse is among the most common of psychiatric disorders in the elderly, surpassed only by anxiety disorders and various forms of dementia. What remains unknown about the use of illicit and designer drug use with this age group such as heroin and ecstasy? In contrast to young alcohol abusers, older adults drink smaller amounts at one time, use drugs prescribed by several doctors, and share medications with friends (licit and illicit), and are more likely to drink and use drugs at home than in public. What is also specific to this age group is unlike younger persons who often seek out drug and

alcohol use for recreational purposes, older adults may be seeking a therapeutic effect, such as relief from grief and pain (Colleran, 2002; Van Wormer & Rae Davis, 2003).

Even though the benefits of using screening tools is highly documented, the field of substance abuse treatment and social work practice has been highly criticized for its failure to use formal standardized assessment instruments. An on line search of the social work literature revealed that of the ten assessment articles published from 1977 to 2000 only one related to substance use, and was non specific to older adults. While health care practioners are routinely involved in conducting assessments, there is obviously limited documentation in professional social work journals on practical assessment instruments to guide practice specific to older adults and substance abuse (King & Bordnick, 2002).

These facts suggest that a vast majority of older adults, who are over represented in the health care system, either abuse or are dependent on prescribed medications. This does not include illicit drug use such as heroin. In spite of all these facts, virtually nothing is known about the older adult substance abuser, specific treatment of this hidden epidemic, curriculum recommendations specific to this content, and prevention efforts (Doweiko, 2001).

PREVENTION AND ASSESSMENT CHALLENGES

While an overwhelming majority of older adults (age 55 and older) see physicians and other professionals often, the literature reports that those at risk for substance abuse (alcohol, prescription misuse, and other drugs) are unlikely to be identified regardless of frequency of contact (Colleran, 2002). Yet, alcoholism among elderly men is the third most present disorder, just behind the more present disorders of anxiety and dementia

(Coogle, Osgood, Parham, 2000). Estimates are also high among hospitalized elders whose signs and symptoms are missed by health professionals.

Failure to recognize and provide interventions for alcohol and drug problems and trauma in older adults is a serious problem. Lack of education and training about the signs and symptoms is one factor (Coogle & Osgood, 1998). Myths, attitudes, and stereotypes about substance abuse, trauma, and aging by health care providers believing elders are too old to change also complicates prevention and harm reduction efforts (Colleran, 2002).

For example traumatic memories can be reactivated by institutional practices that inadvertently victimize and even replicate family of origin abuse issues. Such practices include health care providers ordering older adults to do something they don't want to, or preventing them from doing something they want, or merely guiding an elder by the arm can replicate the essence of abuse from the past (Peters & Kaye, 2002). Such triggers can exacerbate or initiate substance abuse problems exhibited by older adults (Atkinson, & Osgood, 2002).

Additionally, losing a family member by death, moving, and sudden changes in status (medical, financial) can be extremely traumatic for older adults. Shifts from independence to reliance on others are can similar to the impact of Blanche Dubois being raped by Stanley after a night of drinking in the Tennessee William's play: *STREETCAR NAMED DESIRE* (Williams, 1947). Blanche coping with several psychosocial factors including change of status struggles to cope with her sexual trauma by "relying on the kindness of strangers".

As the population increases in older adults, and as drinking and drug use gains greater acceptance, researchers anticipate substance abuse in the population will gain in importance, as well as our image of substance abusing older adults. Aging baby boomers who did not experience prohibition, and who grew up during Vietnam and the drug culture of the 1960's will have had more experience with substance abuse than the current generation of elders. Prevention efforts that integrate rigorous screening plans and challenge biases of health care providers may be the most significant "best practice" intervention in addressing the impending epidemiological trend (Coogole & Osgood, 1998).

Until recently few diagnostic tools were available to help detect substance abuse problems in older adults. Challenges in identifying the "hidden alcohol abuser" are important for those working with or caring for older people. According to a search of the literature, there is a debate as to which screening instruments accurately detect alcohol and drug abuse in the elderly. The prevailing issue is questioning how clinicians have refined screening protocols in older adults for alcohol and prescription medication problems, quantity and frequency of use, and responses to negative emotional states and isolation (Gurnack & Schonfeld, 1998).

Many types of validated substance abuse screening instruments are available. One type includes self-report questionnaires. The other includes laboratory tests that can detect biochemical changes associated with excessive alcohol consumption. The most commonly used self-report instruments such as the CAGE (an acronym for four questions commonly used by physicians, Appendix A), and the MAST-G (the geriatric version of the Michigan Alcohol Screening Test, Appendix B), may not sufficiently discriminate

older adults currently using substances from those with a history of a substance abuse problem (Fingerhood, 2000). For example, one of the CAGE questions asks about “eye-openers” first thing in the morning. Older adults, not having daily routines as working younger adults, may respond to this question, which would target substance abuse problems. While no screening instrument is perfect, research supports the use of formal screening instruments that are age-specific to determine high-risk situations for alcohol and drug use.

Schonfeld and Dupree (1997) summarized the current trends in older adult drinking habits and treatment issues from large national surveys in the United States, United Kingdom, and Canada. They discovered while alcohol consumption tends to decline with age, individuals who were problem drinkers continue these drinking patterns into old age.

Dissemination of education, training, and treatment planning models for social work educators and clinicians who provide a wide range of services for the older adult at risk for substance abuse problems is needed. Future education, training, and prevention efforts include infusing trauma, substance abuse, and older adult content into the social work curriculum, and examining instruments used with this population.

EDUCATION AND TRAINING MODELS

While a variety of factors have been identified in measuring behavior change and compliance to health programs, programmatic influences (e.g., type of activity, instructor) have received the least attention in terms of intervention design (Purdie & McCrindle, 2002). For example, health intervention studies for older adults have identified a number of factors that determine the adoption and maintenance of healthy behaviors. These include the provision of reinforcements for efforts to change, provision of feedback about change, individualized learning opportunities, teaching of relevant skills, access to resources, and demonstrated efforts to individualize the needs of older adults.

This requires health care practitioners and health care providers to increase their competency in working with this population (Peters & Kaye, 2002). Training of practitioners involves not only how practice is affected, but how attitudes and beliefs about practice and the clients they serve (Berg & Shafer, in press; Munro, 2002).

Two models of learning specific to elders are particularly important in implementing healthy behaviors. One is training geared at cognitive differences while the other is the identification of environmental influences (including access to social supports and relationships). Equally important is the training of staff geared towards recognizing and intervening with older adults suspected at having substance abuse problems. For example Coogle, Osgood & Parham (2000) found an increase in interagency referrals resulting from community wide education and training efforts. Staff who received training about substance abuse interventions with the elderly reported

improved knowledge levels, attitudes, and practices among providers who may encounter substance abuse problems with this age group.

Education efforts have increased in including content specific to aging and gerontology. The National Association of Social Workers (1995), the Council on Social Work Education (Kropf & Tompkins, 2002), the American Medical Association (1997), the National Institute on Aging (2000), and the National Council on the Aging (2001) are among the organizations establishing specific guidelines for talking with older adults on issues such as alcohol, drug, and prescription abuse. The Center for Substance Abuse Treatment (CSAT) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have developed Treatment Improvement Protocol, Number 26 (TIP 26) called Substance Abuse among Older Adults. This manual in the TIP series is designed to meet the needs of the busy clinician by providing easy accessed “how to” information. What is additionally helpful is that organizations such as SAMHSA (2002) have also developed guidelines for older persons on how to speak to the doctor and other health care professionals, including identifying what questions to ask regarding prescriptions, etc.

LINKING AND NETWORKING EFFORTS

Coalition building, interdisciplinary collaboration, and dissemination of information about community resources are essential between health providers and older adults. For example, as noted earlier, partnerships between aging and substance abuse programs would increase service delivery, and cross training would improve understanding, awareness, and intervention strategies for all levels of health care providers involved.

Identifying the hidden substance abusing older adult in community based residences such as retirement communities can bring on added challenges. For example, the older drinker and drug user may avoid seeking health care or participate in social events for fear of having the alcohol and drug abuse being discovered. Additionally, many of the cognitive effects of excessive drinking can mimic changes associated with “normal aging”. Even the trained physician can find it challenging to distinguish between late onset of Korsakoff’s syndrome from various forms of dementia (Doweiko, 2001).

For example, Schonfeld & Dupree (1996) emphasize the compelling notion of the utilization of age specific treatment methods with older adults. Assessment and prevention, according to these authors, includes a comprehensive understanding of why older adults in particular, or persons of any age, abuse substances. Incorporating questions that utilize solution building and motivational interviewing, clients take responsibility, learn self-management and cognitive behavioral skills, which reduces the risk for relapse at risk behaviors (Schilling, El-Bassel, Roman, Hanson, 2002).

ASSESSMENT TRAINING NEEDS

Substance abuse in the older adult is often overlooked and unrecognized by health care professionals. This limits early intervention and prevention efforts. Researchers estimate that up to 49% of elderly patients seeking health care have an alcohol/drug related problem (Doweiko, 2002).

Since older persons tend to have more medical problems than younger persons, they tend to seek out more health care professionals and health promotions than any other age group (Hawranik & Pangman, 2002). Physicians are now getting training in medical school about addiction and recovery (Villarosa, 2002). While health care practitioners are beginning to see the importance of brief screening instruments for substance abuse, training remains needed in this topic specific to older adults. How and what questions to ask when risky drug and alcohol use is suspected, such as what constitutes a “drink,” what other substances have been used, the times and locations of the use, and the impact on the physiology can have serious implications for this age group (Colleran, 2002; King & Bordnick, 2002)

Families and health care providers rarely stop to consider the various impact of events that take place in aging, and the toll on the mental health of older persons. For example, depression is a common problem in old age. A major issue, which is debated among researchers, is the assumption that older people who experience stressful life events losses, such as loss of loved ones, health, occupation, and status, are likely to engage in excessive drinking (Jennison, 1992).

This being noted, standardized substance abuse scales may miss subjective assessments of the individual’s perceived quality of life and the role substance use plays in coping with traumatic loss in aging. Variables noted to impact various drinking

practices among the elderly include age, ethnicity, marital status, education, socioeconomic status, occupation, and religious affiliation (Hawranik & Pangman, 2002).

According to D'Agostino (2003), older adults who experience stressful life events are more likely to turn to substance abuse than those who have not experienced such losses, or who have experience them to a less extent. While older people seem particularly vulnerable to losses they experience as they grow older, the individual's propensity to excessive drinking and drug abuse seems more related to the magnitude of losses primarily within the last five years. As individuals get older, they experience more losses more often: lose more of their family, friends, peers, health, and home.

Additional stressors (marital and kinship problems) and multiple crises (economic and health problems) may result in an overwhelming situation in which alcohol, drug, and prescription misuse may begin or increase. Depression can also be a consequence of excessive drinking and substance abuse. Unfortunately, research seems to lack linking the increase in prescription and alcohol use to these factors of trauma in older adults (Colleran, 2002).

For example, it is estimated that 25-50% of elderly suicide victims used alcohol prior to their suicide attempt. According to researchers, for reasons that are not clear, there seems to be a relationship between alcohol abuse problems in early or middle adulthood and the development of depression in the elderly, even if alcohol and drug use is not problematic in later adulthood. Failure to recognize substance-induced depressive episodes can result in misdiagnosis and mistreatment of the older adult's emotional health. According to researchers, this adds to the urgency for accurate assessment,

identification, and determining the sources of depression for interventions with the older adult (Doweiko, 2001).

INTERVENTIONS FOR SUBSTANCE ABUSE IN THE OLDER ADULT

Alcohol, drug, and prescription use and abuse remains one of the most invisible problems with older adults. Too often elders use is dismissed as “the only vice they have left” or “something to help them sleep”. Additionally while use of illicit drugs is rare in older adults, self-medicating with prescriptions is often overlooked by professionals and other enabling and substance abusing family members. According to McInnis-Dittrich (2002), these issues are included in what constitutes problem substance use among elders and is one of the most controversial aspects of determining prevalence.

Additionally, according to Colleran (2002), even when the older adult is referred to substance abuse treatment, few programs are geared to the specific treatment needs of this age group. Unless the special needs of older persons are identified and addressed, the older adult substance abuser is not likely to be motivated to participate in treatment. For example, family members and health care workers need to pay special attention to the impact of age-specific stressors such as retirement, grief and loss, loneliness, and the effects of physical illness. Such issues may require additional case management interventions that address factors such as independent living arrangements, medical care, transportation, and healthy living behaviors specific with this age group.

In terms of detecting elders at risk and treatment efforts with this age group, researchers claim older adult alcoholics respond to treatment better than younger alcoholics (Colleran, 2002; Doweiko, 2001). Group therapy that includes solution building (Smock, 2003) and social support component were thought to be useful in

According to Shafer & Dolan (2003), questions that target healthy aging behaviors may encourage discussion how what is helpful and useful in minimizing and substance use. Many of the questions used in standardized instruments assume a problem exists. Shafer and Dolan (2003) emphasize inquiring how one is coping, thereby increasing behaviors that enhance the aging process.

SUMMARY

Treatment efforts need to provide specific practice skills specific to trauma and substance abuse, which address the more medically compromised aging population. This requires developing strategies for intervention and outreach to find the “hidden” substance abuser, that is, those elders who remain at home and go undetected by the primary care physician, family, and friends. Comprehensive assessment, case management, home visits, and management of emotional problems, relapses, and tobacco dependence are among the interventions recommended for older adult treatment and prevention programs (Schonfeld, et al, 2000).

A cognitive behavioral protocol was the basis of the curriculum developed for late onset alcohol abusers by Dupree et al. (1984). The following topics were addressed in the series: 1) Introduction to Analysis of Behavior, 2) Coping with Social Pressure, 3) Being at Home and Alone, 4) Coping with Depression, 5) Managing Anxiety and Tension, 6) Managing Anger and Frustration, 7) Controlling Cues for Substance Use, 8) Coping with Urges, and 9) Preventing a Slip from Becoming a Relapse. These authors determined that being at home alone, having no activities planned, and feeling depressed are antecedent behaviors for substance abuse.

While the research reports high incidents of alcohol, drug, and medication abuse in the populations served by health care professionals, in service training on this topic specific to older adults is needed with the onset of aging baby boomers. According to a study conducted in Florida (Schonfeld, Rohr, Zima, & Spiegel, 1993), staff indicated proper medication use by older adults as a priority topic for help in their work, in addition to content related to spirituality and trauma.

Qualitative methods may have limitations in agencies or private practices. However, older adults seem to respond differently to approaches like the clinical interview, indicating the need for further research and training making such methods more practical for use (Franklin & Jordan, 1995). Brief interventions such as those identified in solution-focused, and alternative therapies may be examples of such options for at risk elders (Berg & Shafer, (in press); Shafer & Greenfield, 2002).

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