Substance use, misuse, and abuse among older adults: implications for clinical mental health counselors.

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Author: *Briggs, Wanda P.; Magnus, Virginia A.; Lassiter, Pam; Patterson, Amanda; Smith, Lydia*
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Researchers project a threefold increase in substance abuse, inclusive of alcohol, prescription, and illicit drugs, for adults aged 50 or older by 2020, when an estimated 5 million older adults will need treatment for substance abuse problems (Gfroerer, Penne, Pemberton, & Folsom, 2003). This suggests a need for heightened awareness among clinical mental health counselors as they treat this population. This article (a) discusses the prevalence, vulnerabilities, and consequences of misuse and abuse of alcohol, prescription drugs, and illicit substances; lo) reviews age-specific counseling considerations and approaches to assessment, diagnosis, and intervention; and (c) calls for more attention to the subject in training and research.

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It is not unusual for people to lose social and emotional support systems as they age. The aging process often results in social isolation due to the death of a spouse or partner, other family members, and close friends. Similarly, retirement, altered activity levels, disability, relocation of family and friends, and family dissonance may produce feelings of isolation and depression that exacerbate substance use and abuse in older adults (Myers, Dice, & Dew, 2000; Williams, Ballard, & Alessi, 2005). For example, older adults living alone and experiencing isolation, feelings of loneliness, and depression may be more at risk for excessive substance use as a way to manage life stressors.

Most people do adjust to these changes without abusing substances. Many aging adults discover new joys in everyday living, create new friendships in retirement communities, or explore new personal aspects in this phase of life. But unfortunately older adults who do struggle with substance abuse or dependence are often overlooked or misdiagnosed (Blow, Oslin, & Barry, 2002; Colliver, Compton, Gfroerer, & Condon, 2006; Epstein, Fischer-Elber, & Al-Otaiba, 2007; Han, Gfroerer, Colliver, & Penne, 2009).

Over the past 20 years, substance abuse in the elderly has been a vital topic of discussion (Blow, 1998; Dupree, Broskowski, & Shonfeld, 1984; Patterson & Jeste, 1999). The problem

deprives older adults of their health, their quality of life, and indeed their very lives. As the population in the United States ages and the baby boomer generation progresses toward the zenith of life, it is imperative that mental health counselors understand the unique characteristics of elderly populations and the potential for debilitating problems associated with substance misuse.

Researchers project that for adults 50 and older, substance abuse, inclusive of alcohol and drug abuse, will triple by 2020. The increase reflects known predictors of substance abuse and the growth of both the baby-boom cohort born between 1946 and 1964 and the post-baby-boom cohort born between 1965 and 1970; it is estimated that ultimately 5 million older adults will then need treatment for substance abuse problems (Gfroerer et al., 2003). Although research on the need for increased learning, assessment, and treatment of substance-related problems in older adults can be found for medical, nursing, social work, and psychology (Brown et al., 2006; D'Agostino, Barry, Blow, & Podgorski, 2006; Emlet, Hawks, & Callahan, 2001; Finfgeld-Connett, 2004), our review of the Journal of Counseling & Development and three other journals (Journal of Mental Health Counseling, Journal of Addictions & Offender Counseling, and Adultspan) for 1999 to 2009 found only two articles on the subject (Myers et al., 2000; Williams et al., 2005).

There is a significant need for mental health counselors to be informed and aware as they respond to the increasing treatment needs in this population and for strategic efforts to increase training, research, and lobbying to expand access to mental health care through Medicare. This article is intended to initiate that effort by describing unrecognized and underdiagnosed substance misuse among older adults by (a) discussing the prevalence, vulnerabilities, and consequences of alcohol, prescription drugs, and misuse of illicit substances; (b) reviewing age-specific counseling considerations and approaches to assessment, diagnosis, and intervention; and (c) calling for more attention in training and research to help counselors respond to the needs of older adults. Although aging adults described as "baby boomers" typically include those born between 1946 and 1964, for clarity we define "older adults" as those born before 1955, who are now aged 55 and older. People in this age range are planning for retirement, face family transition issues, and may confront physical challenges as they age.

PREVALENCE AND CONSEQUENCES OF SUBSTANCE MISUSE IN OLDER ADULTS

Substance use and misuse place older adults at risk for a variety of clinical and possibly lethal dangers, contributing to heightened use of health care resources and a need for age-specific interventions. Prevalence rates, vulnerabilities, and consequences of various drugs abused are reviewed.

Alcohol

Disordered alcohol use, an important public health concern for older adults, may result in psychiatric disorders, physical disabilities, and social problems for the drinker and society as a whole (Holbert & Tueth, 2004). Older adults who abuse alcohol have a higher medical morbidity rate; emergency room visits and admissions to hospitals and nursing homes are disproportionately alcohol-related. Numerous health conditions coexist with or are

exacerbated by the use of alcohol among older adults--e.g., heart disease, high blood pressure, stroke, gastrointestinal disorder, and diabetes--resulting in medical crises and unintentional injury. Moreover, many deleterious effects of alcohol misuse are masked as characteristics of aging or comorbid physical and mental health disorders, such as memory loss or forgetfulness, confusion, depression, unsteady gait, hostility, and change in personal appearance (Klein & Jess, 2002; O'Connell, Chin, Cunningham, & Lawlor, 2003). Similarities with age-related symptoms can lead to underdiagnosis of alcoholism and other drug dependence (e.g., Blixen, McDougal, & Suen, 1997; Blow et al., 2002; Emlet et al., 2001; Finfgeld-Connett, 2004; Simoni-Wastila & Yang, 2006).

An estimated 15% of noninstitutionalized people 65 and older are at risk for alcoholism and up to 50% of the elderly residents of nursing facilities and continuing care retirement communities drink at least moderately or have problems related to alcohol use (Gunter & Arndt, 2004; Klein & Jess, 2002; Resnick, 2003). Yet 90% of those at risk for alcohol dependence never receive substance abuse services (Gunter & Arndt, 2004). An accurate assessment of substance abuse and dependence among the elderly population is difficult. Older adults are not routinely or systematically screened for substance abuse in most primary care settings, and assessment and diagnostic criteria may not apply or may be unhelpful in older populations, who are more sensitive to substances, have more cognitive impairment, and are often isolated from social interactions (Gunter & Arndt, 2004; Menninger, 2002).

When treatment is deemed appropriate, few programs provide elder-specific services, and the few available are often too distant. Access to treatment is even more difficult when older adults have limited mobility. A recent survey of 13,749 drug and alcohol treatment facilities found only 17.7% that offered elder-specific programs (Gunter & Arndt, 2004).

Society may easily disregard elder alcoholism; however, integration of substance abuse treatment into primary care has been found to be viable and provides promising outcomes using a harm reduction model for older adults that may be as effective as 12-step programs in reducing alcohol intake (Gunter & Arndt, 2004; Lee, Mericle, Ayalon, & Arean, 2009).

Prescription Drugs

Several factors place aging adults at higher risk for prescription drug addiction. First, they consume more prescription and over-the-counter medications than any other age group and are more likely to use medications inappropriately. It is estimated (Culberson & Ziska, 2008) that they consume 25% of U.S. prescribed medications. While younger people most often abuse illicit substances (e.g., marijuana or cocaine), older adults tend to become dependent on over-the-counter and prescription drugs. Second, birth cohorts that had high rates of illicit drug use in youth or young adulthood experience higher rates of use as they age than other groups (Colliver et al., 2006). Third, those in the baby boomer generation are living longer, have more disposable income than previous generations, and have matured in a "quick fix" society (Condon, 2004). These factors, coupled with easier access to prescription medications (e.g., the Internet), and prescription drug advertising on television and in consumer magazines, have decreased any stigma attached to prescription drug use (Condon, 2004).

A literature review indicates a high rate of prescription drug misuse among older adults (e.g., Colliver et al., 2006; Colvin, 2002; Culberson & Ziska, 2008; Lay, King, & Rangel, 2008; Levin & Kruger, 2000; Morgan & Brosi, 2007; Patterson & Jeste, 1999; Saab, Hachem, Sinno, & El-Moalen, 2006; Simoni-Wastila & Yang, 2006). It is also estimated that the number of older adults abusing prescription medications will increase from 1.2% in 2001 to 2.4% by 2020. Moreover, the number of elders using psychoactive medications without a prescription is projected to increase 190%, from 911,000 in 1999 to 2.7 million in 2020 (Colliver et al. 2006). According to the 2005 National Survey on Drug Use and Health Report (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006), opioids account for the majority of prescription-drug-related emergency department visits for persons 55 and older, and the trend is predicted to double as the baby boom population crests into later adulthood. The two classes of prescription drugs most often cited as likely to be misused by older adults are benzodiazepine sedative-hypnotics

and opioid analgesics (Culberson & Ziska, 2008; Simoni-Wastila, & Yang, 2006; Weigel, Donovan, Krug, & Dixon, 2007).

Numerous medical problems are associated with prescription drug abuse. Risks associated with the use of psychoactive drugs in elders include problems due to age-related drug metabolism, interactions between different prescriptions, and interactions with alcohol. The use and misuse of these drugs places older adults at greater risk for institutionalization because the drugs may reduce both physical and cognitive functionality (Levin & Kruger, 2000). Older adult misuse of medications ranges from taking larger doses than prescribed, sharing medications, hoarding, or consuming out-of-date medications to failing to remember to take medications on time, taking them too often, recreational use, persistent abuse, and dependency (Colliver et al., 2006; Emlet et al., 2001; Simoni-Wastila & Yang, 2006).

Women may be particularly vulnerable to prescription drug abuse or addiction. An estimated 11% of women over 59 are addicted to prescription medications (Colvin, 2002), yet of the 1.8 million older adult women who need substance abuse treatment, a mere 1 percent, about 11,000, get the help they need (National Center on Addiction and Substance Abuse at Columbia [CASA], 2006). Alcohol and prescription drugs are the main substance abuse disorders among older women (CASA, 2006). CASA (2006) suggests several life events that may trigger substance abuse: adjusting to retirement, an empty nest, acute or chronic medical problems, inability to continue living independently, or deaths of loved ones. Others include menopause, chronic pain, and limited mobility (Epstein et al., 2007). Older women are also more likely to be caregivers to their own parents, spouses, or grandchildren.

Illicit Drugs

According to the 2005 National Survey on Drug Use and Health (NSDUH) Report (SAMHSA, 2006), illicit drug use may be increasing in a small percentage of the elderly population. Illicit drugs as defined by NSDUH include marijuana, hashish, cocaine (including crack), inhalants, hallucinogens, heroin, and prescription-type drugs used nonmedically. The NSDUH report found illicit drug use by adults 55 to 59 to have increased from 1.9% in 2002 to 5.0% in

2008--a rise that tracks the predicted growth in substance use in the baby boom cohort. As Simoni-Wastila and Yang (2006) noted, illicit drug use by the elderly is linked to long-term drug users; "older addicts may simply represent younger addicts who have survived their drug-use disorder" (p. 383). Colliver et al. (2006) projected an increase by 2020 in illicit drug use by people 50 and older and estimated increases in illicit marijuana use of 2.9% (some 3.3 million people), other illicit drugs by 2.2% (3.5 million), and nonmedical use of psychotherapeutic drugs from 1.2% to 2.7% (2.4 million). Widlitz and Matin (2002) earlier determined that more illicit drug disorders exist in the elderly population than was expected. They also suggest that abuse of illicit drugs and other substances by the elderly may be underdiagnosed and undertreated, describing the situation as "an invisible epidemic" (p. 29).

COUNSELING CONSIDERATIONS AND APPROACHES

One of the most significant barriers to identifying substance abuse problems is the belief of the general public and often health care providers that substance abuse does not occur among the elderly, and that if it does treatment will not be successful (Perkins & Tice, 1999). In fact, family, caregiver, and practitioner complicity may significantly exacerbate substance abuse in older populations. All too often complicated problems are minimized by such statements as "don't take away the only diversion she has left." Such beliefs repudiate the fact that older people have the same desire and need for a good quality of life as younger people and deserve the same kinds of treatment (Crome & Day, 1999; Sorocco & Ferrell, 2006).

Assessment and Diagnosis

A variety of issues need to be addressed to accurately diagnose alcohol abuse and dependence in older adults. For example, many diagnostic criteria for substance dependence may not apply or may mimic signs of physical or mental impairment common in older adults (Menninger, 2002).The diagnostic criteria presented in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) were validated on young and middle-aged adults. Although tolerance of a substance is one diagnostic criterion for substance dependence, it may not apply because of changes related to aging in metabolism of alcohol, greater sensitivity to alcohol, and higher blood alcohol levels, which may result in less alcohol intake with no apparent reduction in intoxication (Menninger, 2002). Similarly, an elderly client with late-onset alcoholism may not experience physiological withdrawal when alcohol use is suspended. Furthermore, a criterion that describes the negative impact of substance abuse on school and job functions may be completely irrelevant for an older client who lives alone. As a result, abuse and dependence among the elderly may be miscalculated. The criterion of relinquishing activities may also be of little use when assessing a retiree who has fewer regular activities and responsibilities to give up (Menninger, 2002).

Clients with psychiatric and substance abuse disorders often present an additional diagnostic challenge because these illnesses may interfere with each other (Blixen et al., 1997). Alcoholism coexists with depression in 30% of older adult problem drinkers, and dementia in 20% of geriatric alcoholics (Hooyman & Kiyak, 2007). Coexisting disorders may make diagnosis more difficult because symptoms can indicate more than one disorder.

Co-occurring mental health disorders may also increase with alcohol abuse and problem drinking and are found in up to 30% of cases of elderly suicide (Holbert & Tueth, 2004). Despite the high prevalence of alcohol-related problems in older adults, the complications often go untreated and unidentified by mental health, substance abuse, and health-care professionals (Holbert & Tueth, 2004).

Among the many other barriers to assessment and treatment of older adults with substance abuse problems are limited transportation, denial and stigma associated with substance abuse, lack of social support, and inadequate financial resources (Sorocco & Ferrell, 2006). As with all substance-abusing clients, successful treatment planning is wholly dependent on accurate screening, assessment, and diagnosis. The complications of the aging client require a skilled and knowledgeable practitioner (see, e.g., Brown et al., 2006; D'Agostino et al., 2006; Emlet et al., 2001; Finfgeld-Connett, 2004).

Treatment Approaches

The complexities of the misuse of alcohol, prescription drugs, over-the-counter medications, and illicit drugs necessitate multifaceted approaches for older adults (see, Blixen et al. 1997; Brown et al. 2006; Gordon et al., 2003; Lee et al., 2009; Perkins & Tice, 1999; Shonfeld et al., 2000). Foremost, appropriate treatments require empathic care and concern when a problem has been identified. Many older adults will deny or minimize problems because of stigma, shame, perceived moral failure, and even fear of losing their independence. They respond better to age-specific treatment that is supportive, adaptive, creative, and less confrontational, and that addresses needs associated with the aging process (e.g., Barrick & Connors, 2002; Finfgeld-Connett, 2004; Simoni-Wastila & Yang, 2006).

Cognitive behavioral and brief interventions. Initially, least-restrictive treatment options have been found to be beneficial, and older adults respond better to age-specific group treatment and cognitive behavioral therapy-based programs (Brown et al., 2006; D'Agostino et al., 2006; Satre, Mertens, Arean, & Weisner, 2004; Shonfeld et al., 2000). In particular, two brief therapies, motivational interviewing and brief advice, have helped decrease alcohol consumption among older adults (Gordon et al., 2003; Sorocco & Ferrell, 2006). A major public health approach--Screening, Brief Intervention, and Referral to Treatment (SBIRT)--is recommended in response to underutilization of treatment for older adults with substance-related problems. SBIRT is a comprehensive, integrated approach to assessment comprised of one to five brief sessions of advice and education, motivational interviewing, and referral to treatment as needed (SAMHSA, 1998, 1999). SBIRT services are typically provided in primary care centers, hospital emergency rooms, and trauma centers, providing vital linkages to community-based treatment systems (Blow & Barry, 2000; Fleming, Manwell, Barry, Adams, & Stauffacher, 1999). Expansion of SBIRT initiatives shows promise of increasing service to older adults with substance related problems within their home or community rather than in major health care settings (Shonfeld et al., 2010). Another successful cognitive-behavioral approach is the Gerontology Alcohol Project (GAP); Dupree et al., 1984). These treatment modules (thoughts, activities, people) provide multidimensional interventions, such as motivational interviewing, teaching components of behavior change, and methods for increasing social interactions and personal efficacy when refusing substances (Brown et al., 2006; D'Agostino et al., 2006; Hanson & Gutheil, 2004;

Finfgeld-Connett, 2004).

Similarly, studies by Satre et al. (2003, 2004) found positive outcomes when a variety of therapeutic approaches is used, including individual, group, and family counseling. At all levels of interaction, education is central to helping older adults with substance-related problems in terms of harm reduction, identification of causes of noncompliance, medication management, and the health and functional consequences of misuse (Brown et al., 2006; D'Agostino et al. 2006; Finfgeld-Connett, 2004; Lee et al., 2009).

Thus the public health sector is developing promising interventions for older adults with substance-related problems and coming to better understand psychological and supportive interventions. Although the body of literature is growing, Williams et al. (2005) remind counselors that "because treatment issues among older adults can differ greatly from those for younger adults, counselors are encouraged to have full knowledge of the aging process before beginning any work with older adults" (p. 16).

Engaging families. Family members often collude in denying that an older relative has substance abuse problems because they are embarrassed by the relative's behavior (Perkins & Tice, 1999). They may attribute the behavior to getting older and justify it as an understandable response to stressors associated with aging (Menninger, 2002). The philosophy of family-based approaches to substance abuse disorders differs from the disease model. The fundamental premise is that a substance abuse problem does not reside solely within the individual but within the context of a larger system (Chan, 2003). Substance abusers have reported that family members exerted more influence on their decision to begin treatment than even legal pressures (Waldron, Kern-Jones, Turner, Peterson, & Ozechowski, 2007). Research has found a strong relationship between family influences and substance use and provides support for the value of family-based treatments (Liddle et al., 2001). Family systems therapy emphasizes the exchange of feelings, mutual support, and facilitation of insight into family relationships (Chan, 2003).

SAMHSA was established in 1992 to help ameliorate the impact of substance abuse and mental illness on society and to promote more effective substance abuse prevention, treatment, and mental health services. After a review of the needs of older adults with substance abuse problems, SAMHSA (1998) recommended guidelines that should be employed when a family-based intervention is used, among them (1) inclusion of adult children if they can play a critical role in the client's treatment; (2) inclusion of friends it is appropriate to involve them in treatment; (3) limitation of participants to no more than two relatives or close associates to reduce the confusion and overwhelming emotionality of the intervention; (4) use of sensitivity and skill in eliciting family relationships; (5) exclusion of younger relatives, such as grandchildren, to avoid increasing shame; and (6) avoidance of labels. SAMHSA further suggests that the communication style should be emotionally neutral, factual, and supportive (SAMHSA, 1998; Sorocco & Ferrell, 2006). The two primary reasons for using family-focused interventions are as valid for older adults as younger ones: family members have stress-related symptoms that deserve help in their own right and involvement of family members has been shown to improve treatment outcomes (Copello, Velleman, & Templeton, 2005). A large body of scholarly work including meta-analyses and systematic reviews of family-involved therapy for alcoholism across age groups (e.g., the

meta-analysis of 21 studies by Edwards & Steinglass, 1995) has shown that social treatment components are very effective. Several of the most supportive approaches give marked attention to the person's social situation and support system (Copello et al., 2005). The axiom that alcoholism is a family disease has been advanced by qualitative data in which family members state that they appreciated the opportunity to talk about and reflect upon their situation and consider how positive change can be achieved (Copello et al., 2005).

Support and self-help groups. Counselor support for older client engagement in ancillary programs such as 12-step fellowships may help relieve isolation and loneliness (Brown et al., 2006). It is important to prepare clients for support groups by demystifying the program, being informed about local meetings and their appropriateness for older clients, and encouraging clients to commit to attending a number of meetings before deciding on their usefulness to the recovery process. Identifying meetings that are oriented toward elderly populations or attended by a large number of older adults may be important for increasing the likelihood of connection and putting the client at ease. The spiritual aspects of 12-step programs may also appeal to some older clients who find comfort in religious practices. Often 12-step fellowships can assist with transportation to and from meetings, provide social support that may mediate denial or ambivalence, and help create structure in daily living practices. Other studies indicate encouraging outcomes for older adults who participate in age-specific focused groups such as Self-Management and Recovery Training (SMART), suggesting benefits from prescribed treatment, longer participation in treatment, and enhanced social and peer support aspects that seem to help prevent relapses (Satre et al., 2003, 2004).

To effectively address the needs of aging adults with substance abuse problems, it is therefore vital that counselors understand the challenges of assessing and diagnosing substance use disorders in light of the unique presentations of older clients. When offered treatment, older adults seem to benefit from agespecific interventions that can reduce unhealthy substance misuse and its deleterious effects on health and well-being.

COUNSELOR TRAINING AND RESEARCH

Given the predicted magnitude of substance use, misuse, and abuse problems anticipated in aging populations and the associated complex medical, behavioral, social, and environmental factors, counselors require increased training and research. Both the American Counseling Association Code of Ethics and the American Mental Health Counselors Code of Ethics speak to the importance of keeping current with scientific and professional information and recognizing the need for continuing training (AMHCA, 2000). The ethical codes also ask counselors to be open to new procedures, remain current in their abilities to work with diverse and specific populations, and take the necessary steps to maintain competence (ACA, 2005).

Specifically, counselors should be aware of and sensitive to substance-related symptoms among older adults, which may mimic symptoms of depression, dementia, stroke, falls and accidents, malnutrition, and possible drug interactions, and to formal and informal expressed concerns of caregivers and family members (e.g., Blixen, et al., 1997; Finfgeld-Connett, 2004; Menninger, 2002). While media attention and public health initiatives primarily focus on

substance misuse in younger members of society, the professional literature indicates that disordered substance use in older populations is under-recognized, under-diagnosed, and under-treated. Consequently, counselor advocacy must be recognized as paramount for the aging populations we serve.

Counselor Training

Speculation about the magnitude of problems associated with the recognition of substance use and abuse in the elderly is abundant, though health and social issues involved with the aging process often impede identification of the problems. Studies such as those of Dar (2006) and Simoni-Wastila and Yang (2006) make it clear that the typical physician, nurse, and other health practitioner would benefit from more training in the signs of substance abuse in older adults. Mental health counselors associated with medical practices or working in hospitals should help educate fellow treatment team members about the prevalence and complexities of substance abuse diagnosis and treatment for older adults.

Counselor education programs must recognize the multifaceted physical, psychological, and social factors related to substance use and abuse by the elderly. More to the point, additional education will help service providers differentiate more readily between the aging process and substance-related problems (Dar, 2006; SAMHSA, 1998; Simoni-Wastila & Yang, 2006). Besides acquiring knowledge about basic substance abuse, counselors should be trained in effective strategies for treating addiction in older populations. Counselors-in-training should be taught strategies for effective advocacy for older clients, especially when opportunities arise to engage with the medical community. Cutting-edge programs in hospital emergency rooms and trauma centers are beginning to explore the efficacy of early counseling interventions (SBIRT) for acceptance of substance abuse treatment by patients who are at risk (Blow & Barry, 2000; Fleming et al., 1999). Promising early results may have major implications for older populations who are admitted with physical trauma related to substance abuse. Counselors who are knowledgeable in substance abuse issues and older clients will be better prepared to provide services in such settings (Brown et al., 2006; D'Agostino et al. 2006; Hanson & Gutheil, 2004; Finfgeld-Connett, 2004; Shonfeld et al., 2010).

Considerable work remains in understanding myths and stereotypes about aging. As the aging population expands, it is important that graduate counseling curricula address successful aging as a process requiring health-promoting behaviors throughout the lifespan. Obviously, not all older adults respond to the challenges of aging by abusing substances. It is therefore important for counselors to understand factors related to wellness, resilience, and happiness in older populations so that those resources can be encouraged and supported.

Counseling students must learn basic skills for communicating with older adults. Throughout their training they need experiential opportunities that are inclusive of diverse counseling populations, including older adults. As counseling programs recognize that providing an interactive, sociocultural learning environment is dynamic, faculty are challenged to adopt teaching-learning strategies that build on a knowledge base that empowers and encourages learning transferability, integrative learning, and meaning that can be congruently linked with

social constructivist learning theory (McAuliffe & Eriksen, 2000). Within this framework, teaching goals in the cognitive domain focus on understanding the stages of use, misuse, and addiction; addiction as a disease process; and how the disease is masked by many clinical manifestations of aging. Basic learning goals must also include an understanding of the pathophysiological and psychosocial needs of addicted persons and the role of stigma, myths, and misconceptions about addiction and allow students the opportunity to become aware of their own attitudes, biases, and fears. Recognizing the need to address the problems of substance abuse, in 2009 the Council for Accreditation of Counseling & Related Educational Programs (CACREP) placed increased emphasis on addictions counseling throughout its standards.

This recent implementation of addiction standards for counselor education programs may imply that many counselors currently practicing did not receive adequate training in substance abuse issues. Current practitioners are therefore encouraged to seek continuing education that specifically addresses substance abuse, especially in older adults. Clinical supervision should include accurate current information about the growing elderly population, especially in terms to substance abuse prevention, screening, and treatment. Supervisors should be reminded of the potential for symptoms to be masked by the normal processes of aging and learn how to sort out ambiguous diagnostic issues.

Research

Currently, the literature in many disciplines recognizes an increasing trend of substance use and misuse by older adults and related health crises (e.g., Blixen et al., 1997; Brown et al., 2006; Colliver et al., 2006; Emlet et al., 2001). Counseling researchers can contribute significantly to our understanding of such problems by focusing on prevention and education for older adult populations who have not yet experienced substance-related physical and psychological crises. Counselors are urged to draw up evidence-based protocols for screening, intervention, and treatment to address the needs of a vulnerable and under-recognized aging population.

Traditional approaches to substance abuse prevention, screening, and treatment should be amended and their applicability to older adults analyzed. Successful long-term recovery from late-onset addiction should be studied to help understand factors that support health and wellness. Research on Americans with different cultural identities, such as aging African Americans and sexual minorities, would help identify unique treatment and support needs. For example, it is estimated that 28%-35% of gay men and lesbians have engaged in some form of recreational drug use, compared to 10%-12% of the heterosexual population (Ungvarski & Grossman, 1999), and their addiction rates are also estimated to be higher. Yet little is known about substance abuse rates or treatment needs for the elderly lesbian, gay, bisexual, transgender (LGBT) population. There are similar questions about the needs of many other subgroups in the aging population.

Research is needed on which to build age-specific assessment tools, including screening instruments, so that alcohol- and substance-related disorders in the elderly can be accurately diagnosed. More affordable age-specific programs are needed to meet the increasing demand that the aging of the baby boomers and their alcohol consumption

patterns will likely place on an already strained substance-abuse treatment system. Hopefully, as aging adults demand more substance abuse services, treatment systems will rise to meet their needs.

CONCLUSION

Increased life expectancy and medical advances in the United States have stimulated continued growth of the elderly population. As a result, common health care concerns associated with aging and the misuse of substances by the elderly are destined to affect service requirements. There is already an increased need for mental health and medical services specific to the unique characteristics of the elderly. Training of professional mental health and medical providers on the physiological, psychological, and social-emotional factors that affect the elderly population is thus critical.

In this article, we have looked at unrecognized and underdiagnosed substance misuse among older adults, discussing the prevalence, addressing the vulnerabilities of this growing population, reviewing promising counseling considerations and approaches, and calling for increased training and research on the counseling needs of older adults with substance problems. Few age-specific studies evaluate psychological treatment efficacy generally; even less attention has been given to marginalized aging adult populations with substance-related problems. Although studies are increasing within some specialized sectors, there is a dearth of such studies in the counseling literature. It is vital that counselors respond to this need to examine, identify, disseminate, and implement evidence-based practices for older adults whose quality of life is threatened in this way. Awareness of conditions that cause human suffering is a prerequisite to change and to better quality lives. Counselors are challenged to stay abreast of current health issues, prevalence, etiology, and treatment options as they help empower older adults to make adaptive changes and achieve optimal personal health.

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Wanda P. Briggs is affiliated with Winthrop University, Virginia A. Magnus with the University of Tennessee at Chattanooga, and Pam Lassiter, Amanda Patterson, and Lydia Smith with the University of North Carolina at Charlotte. Correspondence concerning this article should be addressed to: Wanda P. Briggs, 145C Withers Building, Winthrop University, Rock Hill, SC 29733. E-mail: briggsw@winthrop.edu.