



# Addiction in Older Women: American Health Care's Best-kept Secret

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**ABSTRACT** Older women are not immune from alcohol and drug dependence. In fact, substance use disorders are becoming more common in women over 60 and will become a larger public health issue as the baby boomers reach retirement age. Addicted women in their senior years present special challenges in identification and intervention, and have special needs in treatment. Incidence of co-occurring medical and psychiatric problems is increased. They respond best to a compassionate, nonjudgmental counseling approach.

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**A**s American women age, we are now seeing only the beginning as the baby boomer generation reaches their 60s. Not surprisingly, recent studies have shown that, as the number of people over age 60 increase, issues of alcohol and other drug addiction in this age group are becoming a greater public health issue. It has been estimated that of the nation's approximately 25.6 million women age 60 years and older, 1.8 million have alcohol-related problems. Even more have issues with other drugs, both legal and illegal. Yet, at any time, only about 11,000 of these women are receiving any form of substance abuse treatment.<sup>1</sup>

As women age, their patterns of alcohol and other drug use change, and, therefore, the development, progression, and presentation of their substance use disorders change as well. Social expectations and mores for alcohol use are quite different for women over age 60

as compared to young adult women in college, professional, and other working women in the early and midcareer age groups, or stay-at-home mothers. For example, college women are less likely to drink daily, but much more likely to use alcohol in a binge pattern, drinking to the point of intoxication at social affairs such as dances or football postgame parties.<sup>2</sup>

Professional women, on the other hand, are expected to drink moderately at social affairs, business dinners, or conferences. Women who are stay-at-home mothers and homemakers likewise are expected to drink moderately in social situations. Intoxication is not condoned for women in this age group. After retirement, women are much more likely to drink alone, and to use alcohol for its "medicinal" properties, such as calming anxiety and promoting sleep.<sup>3</sup>

Older women are much less likely than those in the younger age groups to use illicit drugs such as cocaine, marijuana,

and methamphetamine. However, as female baby boomers age, this observation is also beginning to shift, especially with regard to marijuana.<sup>4</sup> Today's 60-year olds were teens during the 1960s, and many of them came of age when smoking pot was more or less socially acceptable. So it is not too surprising to find younger grandmothers are still getting high well into their retirement years. Some new studies are showing that senior citizens are using other illicit drugs in growing numbers, including cocaine, methamphetamine, heroin, and even club drugs such as Ecstasy and ketamine. In these studies, elderly women were significantly outnumbered by their male cohorts, but were still well-represented.<sup>5</sup>

The major drug issues for women over age 60, however, remain prescription pharmaceuticals, primarily opioids and sedatives that they obtain from their physicians as treatment for various chronic pain conditions and psychiatric symptoms, including insomnia, anxiety, panic attacks, etc.<sup>6</sup> These addicted women may, in some cases, have had no prior history of any problems with drugs or alcohol before beginning to take the pain medication or tranquilizer prescribed by their health care provider for their legitimate or imaginary medical condition. More frequently, there was an undisclosed, indeed unacknowledged, history of problem drinking or other drug use, either in the past or currently. In other cases there may be a strong family history of addiction, or some other serious warning sign that was not detected. And, of course, some of these women are already addicted to prescription drugs and are "doctor shopping" to obtain sufficient quantities to satisfy their tolerance, lying to the new health care provider, fabricating symptoms, and doing a masterful job of it.

Some psychiatric conditions do

increase a woman's risk of developing chemical dependency. These illnesses include bipolar and other mood disorders, childhood sexual abuse with post-traumatic stress disorder, and possibly certain eating disorders including bulimia and compulsive overeating.<sup>7</sup> Since these are chronic conditions with symptoms usually emerging in adolescence or early adulthood, one might expect that these at-risk women would be aware of their vulnerabilities. However, because of the stigma associated with mental illness,

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as well as secrecy and shame, especially where sexual abuse is involved, some women reach their senior years without ever having been diagnosed or treated for these illnesses. In addition, many health care practitioners are not aware of the increased risk of addiction in these patients.

Women in this stage of life may not be psychiatrically ill but may still be severely impacted by the many changes that come with aging. Most of these changes involve loss and accompanying grief: loss of closeness with her children as they move out of the home and start lives and families of their own; loss of her own parents; loss of her role as an active, physically healthy participant in her professional and recreational life; loss of a spouse or partner; all of the identity issues and other losses associated with retirement; and for many, loss of the standard of living and

financial security enjoyed earlier in life.

All of these losses can create emotional distress with feelings of fear, anger, sadness, and despair. If a physical injury or illness associated with significant pain, not unusual in this age group, occurs and she is prescribed an opioid pain medication, she may discover that, in addition to relief of the physical pain, the pills take away the uncomfortable emotions with which she has been struggling. This discovery, not always fully conscious, is a setup for problems with the drug because she may continue to take it after the physical injury has healed; she may seek out more of it, developing tolerance so that she needs more and more pills to get the effect she needs. For her, the cycle of addiction has begun.

Another route into trouble can come via the woman's primary care or mental health provider, resulting from an effort to help with her symptoms of anxiety, difficulty sleeping, tension headaches, or other frequent manifestations of grief. Many of the medications commonly prescribed for such symptoms, such as benzodiazepine tranquilizers (lorazepam, alprazolam, clonazepam); sedative sleep aids (zolpidem, eszopiclone); and combination headache remedies containing short-acting barbiturates (butalbital plus acetaminophen), while unlikely to cause problems for the average person, can lead to addiction in persons with genetic and/or acquired predispositions to chemical dependency.<sup>8</sup>

Addictive disease in women of all ages has long been noted to progress more rapidly as compared to the progression of addictive disease in men. Typically women begin using alcohol or other drugs heavily at a later age than men but progress to the later stages of the disease at an earlier age, a phenomenon that has been called "telescoping." This is especially true

when the onset of heavy use is after age 50. The best explanation for this rapid progression involves a combination of physiological differences in the absorption and metabolism of alcohol and possibly other drugs, as well as psychosocial differences in terms of women's chemical use occurring in isolation, not so much for the euphoric effects but for relief.

Whether it involves prescription drugs, alcohol, illicit substances or various combinations, addiction in older women presents special challenges in both diagnosis and treatment. Even more than younger patients, these women are ashamed and afraid to admit their problem or to ask for help. And because they do not fit into most peoples' image of alcoholics or drug addicts, doctors, dentists, pharmacists, and even family members do not think about addiction when interacting with them. A woman's physician, normally on guard against drug-seeking patients, is more likely to believe a tearful, elderly woman who reports having continuing pain beyond the usual healing time. Her dentist readily refills her pain prescription whereas the same dentist might question a younger patient. These professionals can't imagine that such a kind, concerned woman, well-mannered and neatly dressed, who brings Christmas cookies for the office staff, could be a drug addict. Her family members know something is wrong but often don't think of drugs or alcohol as the root of the problem. They view her as depressed, lonely, or maybe getting a bit confused.<sup>19</sup>

Thus, older women are less likely to be diagnosed correctly with substance use disorders. In addition, even when they are diagnosed, they are much less likely to receive the treatment they need. For example, it has been estimated that less than 1 percent of the approximately 2 million women over age 59 who might benefit

from treatment for alcoholism receive it.<sup>1</sup>

Similar estimates have been made for women addicted to other drugs, whether prescription or illicit. The one exception is tobacco addiction. Most women who smoke and who are seen by a health care provider will be counseled about the need to stop and offered alternatives to help them with smoking cessation. The older the woman smoker, the more emphasis her physician, dentist, or other health professional is likely to place on the importance of quitting.<sup>10</sup> Why the

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difference? Most likely the reason is because although it is now recognized that smoking is an addiction to nicotine, it does not carry the same moral stigma as other forms of chemical dependency, and is therefore less uncomfortable to bring up, even with a mature woman.

Once the need for help with chemical dependence is identified, older women have special needs in addiction treatment, starting with detoxification. Because they are more likely to have medical conditions that can complicate withdrawal from drugs, and may be taking medications for other health conditions that can interact with the drugs used for detoxification, careful medical assessment and supervision is required. This can be managed most safely in a residential or in-patient setting. However, such a placement may not be possible, given the lack of financial

resources. Medicare does not provide a benefit for residential substance abuse treatment and inpatient hospital care is restricted to those with severe co-occurring medical or psychiatric disorders.

Some addiction specialists have developed home detoxification programs designed specifically for the older patient who has a supportive family. These programs require that a family member stay with the patient to hold and administer all of the medications; that a home care nurse visit daily to assess the patient's medical condition and progress, as well as to detect any complications, which immediately are reported to the physician; and that the doctor be available for a home visit if indicated. Once the patient has completed a safe withdrawal from the substance(s) to which she has become dependent, and is medically stable, she can begin an intensive outpatient addiction treatment program, IOP.<sup>11</sup>

In the addiction treatment program, whether residential or IOP, older women can be expected to struggle with feeling different than the other patients in the program. They will need special attention and support from the program staff to deal with the drug-related street language and lifestyle issues of the younger patients. Their common resistances will come in the form of minimization, "I didn't drink that much"; rationalization, "My doctors gave me those pills. I needed them for my pain"; and externalization, "It's my daughter's fault. If she hadn't married that guy in California, I wouldn't be so lonely and depressed and need those sleeping pills" — not really that different from the other patients. But they will not respond well to direct confrontation. "Handle with care" is the watch word in working with all older alcoholics and addicts, regardless of gender. It helps if the counselor has had experience work-

ing with seniors and can address the woman's specific defense mechanisms with sensitivity to her shame and fear.<sup>12</sup>

Another area of special need arises in introducing the older woman to 12-step programs, which will be crucial to her ongoing recovery. In Alcoholics Anonymous, many of the longtime women members are in the older age group, and can nurture the newcomer and help her to overcome her fears about attending meetings, relating to other members and finding a home group, — that is, the weekly group of which she will become a member and will begin to take on responsibilities such as setting up the chairs, putting out the literature, making the coffee, etc., where she will feel a sense of belonging.

This works beautifully for the alcoholic woman, but what of the prescription drug addict? Some members of AA, especially older members, have fairly rigid ideas about drugs other than alcohol, and do not think that persons dependent on pills belong in AA. But older women have a very difficult time identifying with members of Narcotics Anonymous, a program where membership tends to be much younger and where most members' drugs of choice were illicit substances such as heroin, cocaine, and/or methamphetamine. At an NA meeting, all that the older woman pill addict will notice is how many members were wearing leather jackets and boots, how many had tattoos, nose piercings, and micro-mini skirts.

In large cities, women may be able to find a few meetings of Pills Anonymous or Prescriptions Anonymous, but usually these are not available and, even if there is such a meeting, it would not provide enough of a program for the older woman in early recovery. What many clinicians have come to rely on is providing individual contacts for their female patients over the age of 60: volunteer women members

of AA who are willing to be in contact with the woman referred by a doctor or therapist, talk with her, arrange to take her to a receptive meeting, and act as her temporary sponsor to guide her through the early stages of her recovery. In many areas, the local AA community has a committee of volunteers willing to help a wide variety of newcomers with special needs; the health care professional only needs to know whom to call to bring the system into action to help his or her patient.<sup>13</sup>

There are some residential programs and outpatient intensive programs that have been designed specifically for patients over the age of 60, and most include special programming and groups for women only, along with the mixed gender groups.<sup>14</sup> For many of the female patients who have been treated in these programs, it was the first time that they felt safe enough to disclose long-held shame-based secrets such as childhood sexual abuse, rape, domestic violence, and/or symptoms of other psychiatric disorders such as bulimia, binge eating, compulsive gambling or shopping, suicidal behavior, and sexually promiscuous behavior. Since many older women with addiction do have co-occurring psychiatric illness, any treatment program to which they are admitted needs to look closely and with great sensitivity to uncover unrecognized problems, including depression and anxiety disorders. When such problems are identified, a plan for their treatment and follow-up is essential in preventing relapse to the chemical addiction.

The good news for older women entering recovery from addiction is that there is a solid support and mentoring system waiting for them in AA. There are many women in their age group who have years of sobriety and stability, and who are willing and eager to embrace the newcomer. If she is open to the warm, nonjudg-

mental acceptance and the promise of spiritual growth extended to her by the women of AA, she has a lifesaving and rewarding voyage ahead of her. ■■■■

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