

1986

Counseling the elderly with drug abuse problems

Helen Juanita Hadley
University of Northern Iowa

Let us know how access to this document benefits you

Copyright ©1986 Helen Juanita Hadley

Follow this and additional works at: <https://scholarworks.uni.edu/grp>



Part of the [Education Commons](#)

Recommended Citation

Hadley, Helen Juanita, "Counseling the elderly with drug abuse problems" (1986). *Graduate Research Papers*. 2466.

<https://scholarworks.uni.edu/grp/2466>

This Open Access Graduate Research Paper is brought to you for free and open access by the Student Work at UNI ScholarWorks. It has been accepted for inclusion in Graduate Research Papers by an authorized administrator of UNI ScholarWorks. For more information, please contact scholarworks@uni.edu.

Offensive Materials Statement: Materials located in UNI ScholarWorks come from a broad range of sources and time periods. Some of these materials may contain offensive stereotypes, ideas, visuals, or language.

Counseling the elderly with drug abuse problems

Abstract

The elderly population is especially subject to adverse drug reactions and interactions since drugs are such an integral part of their life-style (Allen, 1980). As people age, an increasing number sustain chronic conditions and become dependent on drugs in the performance of their daily activities. Whether these drugs are physician-prescribed or self-prescribed OTC (over-the-counter) drugs, there are problems of noncompliance, misuse, and abuse (Krupka & Vener, 1979).

COUNSELING THE ELDERLY WITH DRUG ABUSE PROBLEMS
AGENCY COUNSELING

A Research Paper
Presented to
The Department of Educational Administration
and Counseling
University of Northern Iowa

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by
Helen Juanita Hadley
December 1986

The elderly population is especially subject to adverse drug reactions and interactions since drugs are such an integral part of their life-style (Allen, 1980). As people age, an increasing number sustain chronic conditions and become dependent on drugs in the performance of their daily activities. Whether these drugs are physician-prescribed or self-prescribed OTC (over-the-counter) drugs, there are problems of noncompliance, misuse, and abuse (Krupka & Vener, 1979).

Many experts in the field of aging have noted a lack of research data and knowledge concerning physiological and nonphysiological drug needs of the elderly; and have found only limited information as to the effects of drug therapy on the aged (Foerst, 1979). Studies of more recent research (Raffoul, Cooper & Love, 1981; Brown, 1982; Skolnick, Eddy & St. Pierre, 1984) pointed to drug usage patterns that could be construed as abuse of legal drugs--that which endangers or interferes with normal functioning--among the elderly. These patterns, often difficult to trace, included the prescribing and dispensing of drugs as well as the self-administration and/or noncompliance by the elderly themselves.

In this paper I will examine the effects of adverse drug interactions and reactions on the life quality of the elderly, as they have been presented in recent literature, and alert counselors to the possibilities of drug involvement in their clients'

problems. I will present signs and symptoms of drug misuse, suggest specific interventions that may be used with elderly clients, and discuss implications for counselors as they work with this particular population.

Literature Review

Noncompliance and Other Misuses

White (1980) observed that a number of studies have focused upon the extent of medication noncompliance among the elderly. Medication noncompliance may be defined as failure to follow medication instructions--whether intentionally or unintentionally. Research suggested that drug noncompliance may be the result of the patient's misunderstanding the physician's orders, or decisions to countermand, change, or discontinue them. Patient noncompliance studies have continually astonished investigators by the high incidence of noncompliance (White, 1980).

Research of patient noncompliance, using objective measurement tools such as excretion tests or pill counts, has carried weight, but results of subjective measurements such as patient self-report or estimates made by observers has tended to be questionable. However, studies of clinic outpatients as subjects of noncompliance have been able to make use of the more objective measurements; and White (1980) stated that these monitored results have surprised those who prescribe, administer, or dispense drugs, when confronted with the record of their patients'

medication misuse.

The independent elderly living in their own homes often have their own ideas concerning what parts of their medication are important, what parts may be ignored, and what amount they consider "enough," so they often err on the side of underuse. Raffoul et al., (1981) observed that much of the literature on older patients' noncompliance records underuse as more prevalent than any other type.

Raffoul et al. reported a pilot study conducted by Lunden in 1978, with volunteers over the age 65, living in the community (not connected with a clinic). She inspected medicine bottles for verification of their correct use. 25% of the subjects were not taking their prescription medicines as labeled, and the most common type of inappropriate use was underuse. In addition, she found that none of the subjects appeared to have been given adequate information to insure appropriate use of the medication. Gollub (1978) also reached the conclusion that patient education did improve compliance, and suggested the use of written supplemental instructions for the patient's future reference, to avoid errors.

In terms of legal drugs used, prescription and nonprescription, the elderly are more likely to be at risk of drug misuse than any other age group. Several characteristics unique to the aged contribute to the increased potential for drug misuse;

decreased vision and hearing, organic brain syndrome, and increased susceptibility to drug dosages (Raffoul et al., 1981).

Five common misuses of drugs have been noted as: (a) improper timing and sequencing of drugs, for example, erratic use, using drug when need is over, or discontinuing drug before need is over; (b) taking medication prescribed for another; (c) taking a drug stored in a bottle labeled for another drug or using expired drugs; (d) combining drug with alcohol, other drugs, or incompatible foods; and (e) omission (Gollub, 1978).

Some independent variables have been identified as compounding the misuse: (a) age and household composition (e.g., living alone); (b) cost; (c) total number of medications used; (d) misunderstanding the doctor or the instructions (hearing loss); (e) inadequate information (label reads only "Take as directed"); (f) confusion of receiving prescriptions from several physicians; and (g) confusion of using two or more pharmacies or adding self-prescribed OTC drugs (Raffoul et al., 1981).

Conclusions reached were that the elderly take more medication so the chance for confusion of times and dosages increases; thus an "information overload" (Raffoul et al., 1981, p. 149) could interfere with appropriate drug-taking behavior, since these elderly may be receiving instructions and prescriptions from more than one physician and/or pharmacist. In addition, some of the multiple drugs may be self-prescribed OTC drugs which the

individual obtains for vague aches, pains, or constipation. The interactions of these drugs often have resulted in unnecessary physical distress for the elderly patient (Gollub, 1978; Raffoul et al., 1981).

Guttman (1977) estimated that more than one-third of the elderly are dependent to some degree on prescription drugs for the performance of their daily activities. This conclusion was drawn from his study of legal drug use by older Americans, a U. S. government project. Add to this finding the number of OTC drugs which elderly self-prescribe and it should be evident that drug misuse and abuse of legal drugs by the elderly has a potential to become a serious problem, for the individual and the country.

Drug Interactions and Adverse Reactions in the Elderly

Foerst (1979) found that practitioners were paying too little attention to the physiological changes of aging, and noted the elderly's increased drug sensitivity which she attributed to their decreased ability to eliminate metabolites and their potential for adverse drug reactions and interactions.

Adverse reactions of drugs with nutrition need to be explored as well as multiple drug interactions. According to Weg (1978) "a careful review of nutrition and the later years emphasizes the marginal nutritional status of many older persons" (p. 117). Nutrients are needed to support the mainte-

nance of homeostasis, the capacity for stress response, that will prevent or minimize structural loss (e.g., calcium), and promote mental and physical health all through life. This is even more important for the elderly with their increased stress 'risk' factors. Multiple drugs in use by a large percentage of this population represent a serious threat since "Adequate nutrition is clearly implicated in the capacity to fight disease..." (Weg, 1978, p. 121).

Allen (1980) agreed that the elderly patient has special problems that need to be considered in the administration of their medications. Allen summarized the susceptibility of the elderly to drug reactions by citing three main factors that may decrease the biotransformation and excretion of drugs and increase and prolong the effects of drugs in elderly patients. They are: "...decreased renal function, decreased hepatic function, and altered protein binding" (p. 1475).

If assessment shows that the elderly individual appears not to understand the physician's instructions, questions them, or admits to changing them arbitrarily there is a good chance that this person may be misusing the medication. Lack of understanding can lead to inadvertent overdosing, underdosing, or adverse drug interactions. Lofholm (1978) advised that an interviewer should try to identify those patients who are failing to take responsibility for their medications and take appropriate

action.

When older individuals have several chronic diseases and use several physicians and/or pharmacies, they may be faced with a non-coordinated or non-comprehensive health system. According to Foerst (1979) "Most authorities agree that prescribed therapies for the elderly who have multiple conditions are seldom coordinated" (p. 2002). Busy physicians often fail to check with their elderly patients as to other doctors they may be consulting; and the elderly tend to be reticent about their activities or fearful of displeasing their doctors.

The elderly male client who complains of sexual dysfunction may be suffering from the side effects of drug abuse. Alcohol, narcotics, barbiturates, and nicotine are "drugs with potential for abuse and can be the cause of sexual dysfunction in older men" (Van Arsdalen & Wein, 1984, p. 63).

In commenting on surveys which had shown physicians using different approaches to men and women, Brenton (1982) observed that men who complained of depression or aches and pains were usually given thorough physical examinations, while women complaining of the same things were more likely to receive some soothing words, a prescription, and be sent on their way. This was a comment on the prevalence of prescription drug abuse by women as compared to men. Brenton stated that "It begins with misuse, goes on to abuse, and ends with dependency" (p. 23).

The drugs the elderly abuse are usually depressants (Cohen, 1981). "When stimulants are misused by oldsters, it is in combination with sedatives or narcotics" (p. 329). Cohen (1981) saw the older drug abuser as wanting to withdraw from a frustrating existence and evade life's stresses rather than seeking new experiences of hyperalertness. He advised professionals who treat the elderly to show concern and understanding which, he believed, would result in beneficial effects well beyond the pharmacologic action of drugs.

Signs and Symptoms of Drug Abuse

It has been estimated that the elderly, in proportion to the total population, are the major users of prescription drugs (Skolnick et al., 1984). Physiological changes and multiple prescription regimens coupled with a greater incidence of chronic disease increases the likelihood of adverse drug reactions in the elderly. Consequently, such symptoms as tremors, eating disorders, forgetfulness, weakness, and other indications of disease may be suspected as drug induced (Skolnick et al., 1984).

One of the commonly diagnosed problems of the aged is organic brain syndrome. However, Schuckit (1979) advised that "any drug in high enough doses can cause confusion and disorientation, the hallmarks of an organic brain syndrome" (p. 159). Cohen (1981) supported Schuckit's premise as he also contended

that if older adults have recently become confused, or their condition has suddenly deteriorated, it should be considered a possibility that their present medications may be the cause.

Elderly who are in a specific transition in later life, one which requires significant adjustments, will be especially at risk for drug abuse. These transitions were listed by Glass and Grant (1983) as a late life career change, retirement, death of a family member (e.g., spouse), terminal illness, and/or institutionalization. They recommended that professionals, working with the elderly, should view all their patients as potential drug misusers and many of their symptoms as possibly drug-related.

Specific Interventions

The elderly client tends to be exceptionally suspicious of anyone, other than close family, who exhibits an unusual interest in them. Making use of "life reviews" and reminiscences, during which the therapist shows a genuine concern and interest, may be the best way to enter the client's world without causing undue alarm (Kaminsky, 1984). As the story (reminiscences) unfolds the therapist is led to find a thread of continuity running through the often hidden and fragmentary bits of "patchwork-quilt," which defines the present need and concern of the storyteller. Kaminsky (1984) suggested that we find among the fragments of reminiscences "a recurring configuration of images that manifests a question and a partial answer to it" (p. 13).

He noted the repetition as being the result of "a normative problem-solving process, not of a pathological process such as obsessive rumination" (p. 14). This has a special significance for the elderly since reflections on the meaning of past events and experiences can lead to a rebirth of meaning for life in the present (Kaminsky, 1984).

Assessment and interpretation must be based on a thorough knowledge of the changing physiology of aging, social environmental influences, and possible drug-error involvement of the elderly patient. "Serious errors may have significant consequences" (Lofholm, 1978, p. 22). Lofholm also emphasized the importance of careful explanations of their drug usage to the elderly and continued monitoring by the attending physician.

The counselor may be the one who actually recognizes that the drug problem exists (the busy physician and family often ignore it). With early identification the counselor can alert other professionals so that a problematic situation can be treated and/or changed. Interventions should include efforts to make the aged aware of services available to them in the community. In addition, the individual should be encouraged to become involved in meaningful life relationships, an area in which the elderly, especially the alcohol drug abuser, may have become impoverished (Zimering & Domeischel, 1982).

Cohen (1981) believed that understanding and monitoring

alone were not enough, although he heartily recommended routine, periodic reviews of all medications, prescription and nonprescription. Cohen advised that the family must be considered also and reorientated if members are not therapeutic, so that at least they are not destructive. Finally, he suggested that excessively stressful components of the patient's life should be identified and changed, if possible.

Skolnick et al. (1984) believed that medication compliance presents an educational challenge to health care professionals. They listed concurrent use of several prescribed drugs and nonprescription medication as further complicating the effects of prescribed medication on the elderly patient, and also cited the nutritional status and the disease state as possibly playing a part in the pharmacokinetic process.

Whichever professional--doctor, nurse, caseworker, or other--provided the drug education, Skolnick et al. (1984) contended that special consideration should be given to factors which can influence learning in the elderly. They suggested provision of simple and needed details which may improve problem-solving: taking extra time, since they need more time to process information and respond; associating new tasks with old behaviors to facilitate the learning process, since short-term memory may be expected to decline with age; and mastering an individual learning task, before beginning another, since

simultaneous learning activities may have a negative effect. Further precautions were offered; changes in visual acuity may make it dangerous to refer, for example, to the "blue and green pills;" and diminishing auditory acuity may cause incomplete or inaccurate message reception, so that communication is difficult or interrupted. Lastly, Skolnick et al. (1984) recommended life experience reviews as useful and advised the practitioner to take into consideration the person's cultural background.

Implications for Counseling

Discussion

A primary objective in a first interview with the elderly client is to gather information, assessing the nature of the presenting problem from the client's perspective and the counselor's viewpoint. Individual counseling of the elderly should then emphasize the building of a good relationship, establishing rapport with the client (Wahl, 1980).

The importance of understanding physiological change in the aging process should extend to counselors as they consider the characteristics of senility and the needs of an elderly client. Awareness of drug reactions and interactions, which often mimic certain aspects of senility (organic brain syndrome, for example) may slow counselors' impulse to jump to hasty conclusions and cause them to make further investigation into the possibility of adverse drug reactions and misuse.

For counselors who interact with the elderly client, I can foresee a "gatekeeper" role, since not all elderly clients are carefully monitored by other members of the health care team. Counselors may be in the unique position of monitoring and coordinating the efforts of the health care team, educating other concerned professionals and/or community about the concerns and needs of the elderly drug user, and also acting as advocate for the aging client in drug-related problem situations.

Glass and Grant (1983) predicted that the rapidly growing older population with their lengthening life span will require "the expansion of counseling services..." (p. 210). However, they believed that many counselors were not prepared to work with this special group and warned that it was time counselors and personnel workers became aware of the special concerns of the elderly and started to plan effective ways to help elderly deal with their needs.

The older adult must face major transitions; retirement, disabling illnesses, diminishing faculties, etc. Glass and Grant (1983) foresaw many opportunities for counseling the elderly passing through these transitions. They suggested that counseling should have a preventative/educational objective, and that designing counseling services for the older population would necessitate; assessing the level of vulnerability, defining the factors and characteristics of the individual that determine

that vulnerability, and discovering the type of needs in order to improve or maintain the degree of independence and the response to those needs.

There was, according to Glass and Grant (1983), "a cumulative effect of these factors that rapidly increases the degree of vulnerability" (p. 213); and they cited the number of losses often occurring simultaneously in the elderly. Therefore, counselors should recognize the common thread, running through the servicing of the aging in transition, as facilitating adjustment to change.

Counselors of the elderly should be aware that drugs are probably an integral part of their clients' life-style and be courageous in confronting and questioning clients about the kinds and amounts of medications being taken and reasons for their usage. This can lead to enhanced awareness on the part of elderly clients, thus lessening noncompliance and/or misuse, and may give counselors valuable clues for effective intervention. Hiding from the truth or ignoring it will never solve clients' problems. Denial and resisting change of the status quo may always be suspected (especially of the aged), but need not be accepted as unalterable. Contracts and parameters may be set up and enforced, resulting in the establishment of a therapeutic relationship (Myerson, 1978).

Summary

Drugs are important components of the elderly's life-style, involved even in prolonging it. The intent of this paper has been to explore drug over-utilization, misuse, or abuse in the elderly population. It was found that patient noncompliance is the most commonly recognized drug misuse as perceived by professionals and research studies.

Research also has pointed out that many physicians lack knowledge of the changes that occur in the social life and in the physiologic structure of the aging and fail to consider or learn about the drug actions and interactions specific to elderly patients.

A review of pertinent literature showed a recent (1977-1986) upsurge of interest in the health and drug problems of the elderly. Objective measurements have shown evidence of the broadening of professional knowledge regarding the changing physiology of the aging, and acknowledgement that there are differences in the administration and dosage of drugs for this age group when compared to younger adults.

Much of this knowledge and awareness should now extend to counselors as they work with the elderly clients. In fact, the alertness of counselors to significant signposts pointing to possible drug misuse and abuse may designate them to the role of "gatekeeper" since not all elderly are monitored by the health

care team, especially those who live independently in the community. Counselors can thus be utilized to educate and coordinate efforts of the health care team in the future.

Cohen (1981) believed that we should "suspect all drugs that the patient receives as a cause of sudden decrement in the mental condition" (p. 336). However, he declared that much can be done for the disturbed elderly, and recommended focusing on the individual rather than the age.

This may appear paradoxical as the counselor has just been advised to observe all the physiological changes and consider the special problems of aging; yet I would surmise that the counselor should also focus expectations on individuals and their levels of vulnerability, and should not--because of their age--"automatically anticipate an irremedial decline into decrepitude" (Cohen, 1981, p. 340).

FINE

References

- Allen, M. D., (1980). Drug therapy in the elderly. American Journal of Nursing, 80, 1474-1475.
- Brenton, M., (1982). Women and abuse of prescription drugs. Public Affairs Pamphlet No. 604, 381 Park Ave. South, New York, N. Y.
- Brown, B. B., (1982). Professionals' perceptions of drug and alcohol abuse among the elderly. The Gerontologist, 22, 519-525.
- Cohen, S., (1981). The Substance Abuse Problems. The Haworth Press, New York.
- Foerst, H., (1979). Drug-prescribing patterns in skilled nursing facilities. American Journal of Nursing, 79, 2002-2004.
- Glass, J. C., & Grant, K. A., (1983). Counseling in the latter years: A growing need. The Personnel and Guidance Journal, 62, 210-213.
- Gollub, J., (1978). Psychoactive drug misuse among the elderly. In Ronald C. Kayne (Ed.), Drugs and the Elderly (pp. 84-102). The University of Southern California Press.
- Guttman, D., (1977). A study of legal drug use by older Americans, (No. 0-238-121). Washington, DC: U.S. Government Printing Office.
- Kaminsky, M., (1984). The use of reminiscences: New ways of working with older adults. Journal of Gerontological Social Work,

7, 1-18.

- Krupka, L. R., & Vener, A. M., (1979). Hazards of drug use among the elderly. The Gerontologist, 19, 90-95.
- Lofholm, P., (1978). Self-medication by the elderly. In Ronald C. Kayne (Ed.), Drugs and the Elderly (pp. 8-28). The University of Southern California Press.
- Myerson, D. J., (1978). Organic problems in the aged: Brain syndromes and alcoholism. Journal of Geriatric Psychiatry, 11, 175-189.
- Raffoul, P. R., Cooper, J. K., & Love, D. W., (1981). Drug misuse in older people. The Gerontologist, 21, 146-149.
- Schuckit, M. A., (1979). Drug and Alcohol Abuse. Plenum Medical Book Company, New York and London.
- Skolnick, B. D., Eddy, J. M., & St. Pierre, R. W., (1984). Medication compliance and the aged: An educational challenge. Educational Gerontology, 10, 307-315.
- Van Arsdalen, K. N., & Wein, A. J., (1984). Drug-induced sexual dysfunction in older men. Geriatrics, 39, 63-67.
- Wahl, P. R., (1980). Therapeutic relationships with the elderly. Journal of Gerontological Nursing, 6, 260-266.
- Weg, R. B., (1978). Drug interaction with the changing physiology of the aged: Practice and potential. In Ronald C. Kayne (Ed.), Drugs and the Elderly (pp. 103-142). The University of California Press.

White, P. H., (1980). Psychoactive medication noncompliance in a geropsychiatric outpatient agency. Journal of Gerontological Nursing, 6, 729-734.

Zimering, S., & Domeischel, J. R., (1982). Is alcoholism a problem of the elderly? Journal of Drug Education, 12, 103-108.