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## ***On Co-Occurring Mental Health and Substance Abuse Disorders***

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### **CO-OCCURRING DISORDERS AND THE AGING ADULT**

By Robin J. Gliboff, LCSW

There are many theories that outline the psychological, behavioral and maturing processes that comprise our individual and personal evolutions. Yet despite research on the social, medical and clinical implications of aging, many of these age-related changes vary tremendously among individuals. As such, a comprehensive biopsychosocial assessment that itemizes historical diagnoses, current symptoms and events is critical to the development of an effective treatment regimen.

Individual genetics and early life experiences can have a great effect on one's physical and psychological health across the lifespan. The maturing adult can have an extensive history of prior experiences and dispositions that determine future health outcomes. In fact, adults over age 65 are the largest growing population group in the wake of the "baby boomer" generation.

Substance abuse, particularly alcohol and prescription drugs, is one of the fastest growing health problems facing this aging population. Depression and alcohol abuse, from midlife on, complicate

every single medical and other health issue an individual might encounter. Unfortunately, these problems remain under-estimated, under-identified, under-diagnosed and under-treated.

For example, 85% of adults over age 65 suffer from one or more chronic diseases or conditions and take at least one or more prescriptions daily to treat these conditions. With age, there is a decrease in lean body mass and body water and an increase in body fat. There is a decrease in enzymes in the gastrointestinal tract and an increase in the brain's sensitivity to alcohol, reducing the ability to metabolize drugs and alcohol. Overall, the mechanism of drug and alcohol action and metabolism is greatly altered due to the physiological aging process. This often results in increased sensitivity and decreased tolerance to alcohol and drugs, including prescription drugs. Due to these and other reasons, the use of any drugs and alcohol greatly increases the occurrence of health problems among individuals with comorbid medical disorders. Health status clearly affects one's quality of life.

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## **MID-LIFE AND CO-OCCURRING DISORDERS**

By Tiffany E. Kelsey, Ph.D.

The general population (GP) of individuals between the ages of 45 - 55 years old is often referred to as the "sandwich generation." This heuristic term describes a generation of people who experience psychological stressors associated with the need to assume a multitude of personal and professional roles, and to engage in multiple tasks that require significant competencies.

Healthy adults at this age have significantly different goals and responsibilities than dually diagnosed (DD) persons. While mature adults often provide care for others (particularly family members), dually diagnosed individuals are likely to experience middle age as a time of continued difficulty taking care of themselves. Physical health and other aging issues pose major problems that the average person will not encounter for 20 or more years. While screening tests are available, many DD persons lack healthcare coverage and access to a structured medical care system. Additionally, they lack the self-advocacy or personal organizational skills necessary to seek out prevention screenings.

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Clinicians may need to educate and encourage clients to be proactive and provide them with self-help advocacy skills. As such, early screening and health-care prevention techniques should be a standardized feature of these healthcare plans.

### **Health Factors**

Many of us refer to the period between ages 45 - 55 as “mid-life”, but for the DD client, aging can be premature. At age 50, their bodies may resemble those of octogenarians (persons between 80 and 90 years of age). Years of alcohol and drug use, personal losses, physical pain, and chronic emotional stressors can make anyone in this age group feel much older. Dually diagnosed person is more likely to have histories of smoking, alcohol consumption and obesity; and these lifestyle factors are related to a variety of health problems including heart, digestive and cancerous disorders.

The mortality rates for natural and unnatural causes of death for adults with severe mental illness (SMI) are more than twice that of the GP. Research has shown that those with mental illness often die 10 to 20 years prematurely. For example, one study found that the average age of death for the SMI population was 52 years as compared to the national average of 72 years. The largest single contributor to premature death is suicide, which is 10 to 15 times higher for the SMI than in the average American. Accidental deaths are also much higher among the seriously mental ill. Also contributing to early death are medical disorders that are exacerbated by poor health habits related to poor eating habits and lack of physical activity. These statistics refer only to the SMI population, in general, and not the DD population in particular. One can only speculate that the numbers would be less encouraging when looking only at the dually diagnosed.

It is well known that individuals with SMI are three times more likely to smoke than others groups of people and that dually diagnosed persons are more likely to be overweight or obese. A recent study of SMI individuals receiving outpatient treatment services found that the mentally ill had significantly higher body mass indices (BMI) than a matched sample group. Smoking and obesity can cause lung cancer, diabetes, heart disease, as well as other physical illnesses. Despite practitioners' efforts to discourage risky behaviors, poor health habits prevail. Therefore, primary and secondary prevention strategies are essential tools in reinforcing healthy lifestyle choices.

### **Social Factors**

The majority of women with SMI is mothers and is more likely than males to have parental custody of

children. Whereas women without mental illness are contending with their young adult children developing independent lifestyles, women with SMI may fear losing the supportive and enabling function their children provide them. These children of adult SMI mothers may struggle with the ongoing substance abuse and psychiatric illnesses of their parent. During these times, these children may assume the role of primary caretaker. Furthermore, these children are at greater risk themselves for behavioral and psychological problems and substance abuse, which in turn, creates additional family stressors.

For many people with co-occurring disorders, their parents have served as caregivers well beyond adolescence and young adulthood and must continue to provide guidance and care into adulthood and mid-life. These aging parents may not be able to support their dually diagnosed children in the same financial and emotional ways of the past. Paradoxically, research shows that some of the “developmental delay” associated with SMI may actually be due to the “enabling” of the caretaker parents.

For the DD client, any loss of parental support could contribute to a generalized state of psychological stress and destabilization. Clinicians working with these clients should be cognizant of this generalized loss of a supportive social environment. As parents age, they may have expectations that these adult DD children become more independent and establish their own support system. Thus, talking frankly with clients and their caretakers about this aging process can help alleviate some of the anxiety and fears associated with their need to foster alternative sources of support.

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## **ABOUT THE CO-OCCURRING DISORDERS COMMITTEE**

The **Co-Occurring Disorders Committee** has been in existence since 1990 and is composed of mental health and substance abuse management and direct service staff from the public and private sector in the metropolitan Washington region. The goals of the committee are as follows:

- To promote effective, evidence-based, and integrated treatment services for individuals with co-occurring mental health and substance use disorders.
- To promote interagency and collegial communication and collaboration among public and private treatment programs and their staff providing these services.
- To provide low cost trainings on dual diagnosis topics for professionals providing treatment for individuals with mental health and substance use disorders.



# OPEN FORUM

## COMING TO TERM

By Thomas K.\*

Three months ago, I suffered a cerebral stroke. My six weeks of recovery was spent in a nursing home amongst the elderly, whom seemed to suffer from the great variety of chronic ailments and medical conditions often associated with old age. This was an eye-opening experience for me.

To see these bodies and souls was very much like looking in a mirror and at a reflection of myself. But mostly, what I saw was what the future may be like for me. I also learned a very important lesson while in the midst of these senior citizens. Now at age 48 and on methadone again, I contend with a host of medical problems such as dental problems, digestive disorders, and Hepatitis C. Though I often hear the cruel voice of my age telling me that it's too late, and that everything is lost anyway, yet another part of me knows it's my disease, not time, whispering to me, trying to seduce me into throwing in the sponge. Addiction is one of the hardest of all warts to erase.

Early in life, I knew I was at least a little different from others. As a teenager, I had Attention Deficit Disorder with some hyperactivity and a bit of a conduct problem. This did not seem to cause me any real problems because I was in my own orbit. The word *mischievous* barely begins to describe my daring attitude and boyish nature. Without the fanfare often associated with great quests and adventures, I heard the call to "Go west young man, go west". I was California Dreamin'.

Who else advertises their mental status with a T-shirt logo that says, "Psychopharmacological Research". At one point in time, I thought I could challenge the likes of Timothy Leary. Assuredly, I have encountered and lived with many an enigmatic personality. Life on the road offers an abundance of associates, friends and fiends.

But Arizona State Penitentiary is not the college of choice for many up and coming free spirits. There, I learned that I had an additional diagnosis of Manic-Depression and other associated disorders. However, I also learned that I was a wordsmith and a poet who could articulate his insights into discrete forms and phrases.

But in the end, I was the prodigal son who returns home after an odyssey of travels and misadventures with little but memories to show for his time spent. Many times I've been given the keys to the kingdom, and lost them; throw my fingers, my paradise lost.

Since my stroke, my memory and concentration have been affected. Now I need the structured support of assisted living and enrollment in a co-occurring rehabilitation program with close supervision. I also need the structure of a supportive methadone program—one that will allow me to decrease my dose gradually and help set me free from the tranquilizers that synergizes the methadone and gives me that ghostly sleepiness that feels like a dream within a dream.

Thoughts race through me, each crowding the other, all wanting to be first and foremost. I know I need good people in my life and that much still needs to be done. But it seems that the only thing that keeps me in motion is that thin strip of hope and belief that as long as I don't lie, don't use, and don't drink, that somehow, grander boulevards and larger streets will appear ahead on this my narrow path. Somehow everything will be okay.

My mother serves me up a monumental amount of needed and welcomed support. She has been my landlord, teacher, companion, nurse, and tough-love enabler.

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*Term, continued from page 3*



Moreover, she has been my savior. If there is a heaven, there is a special sanctuary that awaits her dear soul. She is the embodiment of human compassion for me and the reason for my continued hope and efforts to maintain my sobriety and health.

I no longer work against myself or the social service system of others. At this time, I honestly appreciate any and all the support and help I am offered. I am committed to the philosophy of "one day at a time."

What all this means is that I am "coming to term." Ironically, that's the title of a published poem I wrote many years ago about a friend of mine who faced the same problems I face now. The following is the last of three stanzas:

*Rising from the table, she runs a glass of water from the tap, counts some pills and capsules into her hand from the medicine cabinet and washes them down with a toss of her head.*

*The doctors say she's holding up well, that her weight is stable, her blood okay. She worries about losing her hair, about wheeling down a ward full of skeletal queers with brazen sores and oxygen tanks.*

*Of dying alone. But who knows, she smiles—some people hang on for years. Suddenly, she stands and plops unsteadily on my lap, slips her arms around my neck, tucks her cheek against my chest, her warm tears falling down my ribs while I search for ways of saying death will be all right.*

*\*The author's name has been changed to protect his privacy.*

# Upcoming Training Opportunity

## Working with Clients with Co-Occurring Disorders in the Criminal Justice System

Friday, May 6, 2005  
8:30am—4:00pm  
Metropolitan Washington Council of Governments (COG)  
777 North Capitol Street, NE, Suite 300, Washington DC 20002

**Featured Speaker: Gary Lupton, LPC, LMFT, LSATP, CSOTP**

### Participants will be able to:

- Describe the unique characteristics of offenders needing treatment
- Recognize the cyclical nature of offending and its relationship to mental health and substance abuse issues
- Cite effective ways of interaction between treatment providers and the various aspects of the criminal justice system
- Differentiate the roles of the various agencies and learn strategies about how to avoid role confusion

CEUs & Contact Hours Available  
Registration Fee: \$45.00  
Continental Breakfast and Lunch included  
For more information, please call 202-962-3275





Many of the definitions, models and classifications for co-occurring disorders do not account for age-related physiological and social changes. For example, many of the signs and symptoms of alcohol abuse seen in younger populations do not apply to older adults. Because a vast majority of older adults are no longer in the work force, they have smaller social networks and tend to drive less. These factors reduce the potential for recognizing alcohol abuse in older adults.

The most commonly prescribed and abused psychoactive medication for maturing adults are benzodiazepines, antidepressants and opioid analgesics. A major concern with all these drugs is that unintentional misuse can progress into abuse. In these circumstances, overdose, additive effects, and adverse reactions from combining drugs are more likely to occur. Tolerance and physical dependence can develop when some psychoactive medications are taken regularly at the therapeutic doses for relatively brief periods of time.

A critical situation is the "interaction" between different drugs and any combination of illicit drugs and alcohol. Older adults are more susceptible to these adverse interactions. Pre-existing conditions (such as hypertension, diabetes, malnutrition, liver diseases and mental health disorders) can trigger or exacerbate more serious problems. In fact, misuse of medications is the fifth leading health risk and ninth leading cause of death for older persons.

Anxiety and mood disorders are the two major mental health categories that affect the maturing adult. Anxiety disorders are the most frequent psychiatric illness. Phobias are the most common psychiatric disorder in the aging population. These anxiety disorders correlate with chronic medical disorders and their associative conditions. Simply put, anxiety can be a manifestation of physiological changes occurring as a result of a medical illness or reaction to prescribed medication.

Mood disorders are best divided into depression and bipolar disorders. Older adults also experience significant rates of depression characterized by markedly diminished interest or pleasure in activities they once enjoyed. The psychological changes and other personal and social losses experienced in later stages of life can also contribute to an increased level of anxiety as well as a generalized uncertainty about life. Hearing loss, professional retirement,

various forms of social isolation, irritability and neurological changes all play a role in depressive morbidity. Although the diagnostic criteria for either major depressive disorder or bipolar disorders are similar in maturing adults and younger populations, symptom expression can be age dependent. Some older adults may not appear sad or even use the term "depressed." Instead, they are irritable, socially withdrawn and often have multiple physical symptoms.

The suicide rate of persons over 65 years is higher than any other age group and is associated with late onset of clinical depression. Alcohol abuse is a significant correlate with suicide. Moderate to heavy drinkers are 16 times more likely than non-drinkers to die of suicide. It is important to note that more than 70% of elderly suicide victims have seen their primary care physicians within one month of their suicide; 40% within one week; and 20% met with their physician on the exact same day.



The onset of bipolar illness earlier in life, if untreated, becomes more severe, and mood alterations become more frequent in late life. Manic symptoms can also be caused by a variety of physical disorders such as hypothyroidism, infections, Vitamin

B12 deficiency and reactions to certain medications. Euphoria and elation are less common; more typical is dysphoria, distractibility, paranoia and confusion.

Many neurological changes in brain activity as well as decreased brain function may become permanent. This phenomenon is best expressed in the "brain-behavior age quotient" which conveys the developmental fact that there is less potential for "plasticity" and recovery of cognitive functions for the aging brain. This is more obvious for persons who suffer the consequences of strokes, dementia and Parkinson disease. When reality-testing skills become significantly compromised, the treatment interventions, medication management and other rehabilitation services need to be well integrated and medically supervised for primary and secondary therapeutic reasons.

Medical, psychiatric and substance misuse/abuse present challenges to effective treatment. Difficulty in accurately assessing the health status of maturing adults contributes to the pervasiveness of these problems that will dramatically increase among older adults. Our clinical responsibility in assisting this geriatric population adds to the quality of their lives and advances our knowledge base for these disorders.



*Mid-Life, continued from page 2*

### **Providing Guidance**

Dually diagnosed clients did not achieve the developmental milestones and role skills associated with normal maturation. As such, there is a need for a comprehensive lifespan developmental treatment plan. The greater challenge is how to encourage clients in the steps and processes despite any real or imagined fears and concerns. Financial, transportation, and other situational barriers should be identified early. Medical referrals to a primary care physician for general checkups are essential.

A therapist or nurse is in a unique position to take the time to explain why early prevention screenings are important and to address any fears or confusion about following prescribed medical advice. Many DD individuals are poor historians despite having multiple health concerns. Helping the client prepare a list of questions for his physician may empower him to make better use of his appointment time. Clients without insurance or resources need to be referred

to free or low-cost services that are available in the community. Even clients with primary care physicians need encouragement to seek screenings and follow-up treatment.

### **Summary**

For a variety of psychological, socioeconomic, and lifestyle reasons, middle age can be experienced in various ways. While people with multiple, chronic diagnoses may be part of the "sandwich generation," their relationships with children and parents are significantly affected by their illnesses. As parents, they struggle to balance their self-care with meeting their children's needs. As children, they experience the loss of caretakers who have provided financial and emotional support. The dually diagnosed are at greater risk for a variety of illnesses, and the period between ages 45 and 55 is an important time for early screenings and primary medical care. Together with promotion of a healthy lifestyle, we can help increase the quality of life for the SMI and make mid-life a more rewarding period of the life process.

**The Forum** is published twice yearly by the Metropolitan Washington Council of Governments Co-Occurring Disorders Committee.

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