

FACTS ON DRUGS, ALCOHOL AND THE ELDERLY*Edith S. Lisansky Gomberg, Ph.D.*

We are seeing the "greying" of populations in the United States and other Western countries. The proportion of the population defined as elderly, whether 55 and older, 60 and older, 65 and older, gets larger with each decade. How does this segment of the population deal with drugs, whether they are prescribed medications, over-the-counter drugs, banned substances, tobacco, or alcohol?

Prescribed Medications

Although the elderly constitute about 12% of the U.S. population, about 30% of prescriptions written are for these older people. It is hardly surprising that chronic illnesses like diabetes, arthritis, hypertension, and osteoporosis occur more frequently in this age group. There are, however, negative consequences with use of prescription drugs. For example, adverse side effects of drugs occur far more frequently in the aging organism. However, extended life expectancy is based, in part, on advances in medications. The most commonly used drugs by older persons include cardiovascular preparations, antiarthritic drugs, medications for gastrointestinal problems, and antianxiety drugs including antidepressants, sedatives, and tranquilizers.

It is with this last group of prescribed drugs that questions must be raised. Older people are disproportionately more often prescribed psychoactive drugs to solve problems of insomnia, anxiety, depression. There are problems: first, age changes in the pharmacokinetics

(absorption, distribution, metabolism and excretion) of drugs, and age changes in the psychological



response to drugs. Second, older persons are often prescribed several drugs, including psychoactive medications, for different problems. These drugs may combine with each other or with over-the-counter medications to produce negative consequences. Third, older persons may present a clinical picture of confusion, disorientation or apathy which may be a response to other medication. Finally, the issue of drug dependency must be raised, and there is ample evidence that older persons may develop dependence to a psychoactive drug. The question, ultimately, is whether psychoactive drugs really make the losses of old age more tolerable?

Over-The-Counter Drugs

Major medications purchased without prescription are analgesics and gastrointestinal agents such as antacids and laxatives. Some report the elderly as purchasing and consuming a proportionate share

of OTC drugs while others estimate the elderly to be using OTC drugs "excessively." When older persons are asked about the response to "everyday health problems," a third say they ignore such problems and another third treat with an OTC medication, while 15% say they use prescription medication they already have, 13% contact a physician or dentist, and 11% report use of a home remedy such as an herbal tea or chicken soup.

Banned Substances

The older generations are not likely to use drugs like heroin, cocaine or marijuana. Experimenting with inhalants or drugs like LSD is characteristic of youthful drug behavior. While there are some exceptions, (e.g., heroin addicts who survive into old age), older people are less likely to buy street drugs or pursue the street addict's life style. It is unclear whether this is a result of body changes in drug metabolism, a lack of interest in the "highs" and "lows" of street drugs, or the unwillingness to take on the hassles of the life style. Probably all three reasons are relevant.

Tobacco

Men are more likely to be smokers although the gap between the sexes has been narrowing. In 1965, the National Center for Health Statistics reported 28.5% of men aged 65 and older, and 9.6% of women aged 65 and older, to be current smokers. In 1985, these percentages were 19.6% and 13.5%. The figures may reflect the increase in female smoking that occurred during and after

World War II. The increase is reflected in the 1985 report that lung cancer has passed breast cancer as the chief cause of cancer death among women. In studying older peoples' drug metabolism and behavior, the effects of aging, smoking, drinking and other variables are confounded.

Alcohol

There is strong evidence, consistent from country to country and consistent over time, that, as people age, the percentage of drinkers declines. Among men, the proportion who drink alcoholic beverages declines when they are in their fifties and sixties and, interestingly enough, goes up for men in their seventies. Among women, the drop in percentage of drinkers occurs when they are in their fifties and remains relatively low. Why is there less drinking among older people? The answer may lie in physiology, e.g., in diminished liver function. Older persons get higher blood alcohol concentration peaks than younger persons given similar amounts of alcohol. The answer may lie in unique historical experience, a generational response, or in changes that occur during the life span. The negative effects of drinking, such as diminished alertness, may be more important to older people, than the positive effects of alcohol.

The aging process presents the older person with a number of choices: not drink at all, to drink less than before, to drink the same amount, or to drink more. That some persons make the last choice is evidenced by the fact that some elderly problem drinkers are people for whom heavy drinking has begun rather late in life. Elderly problem drinkers include those with a long history of alcohol abuse, and those – a minority – for whom alcohol abuse is a recent behavior. There may be an-

other group of elderly problem drinkers, those who have had heavy drinking episodes at one or more points in their lives, who were not diagnosed as alcohol abusers, and who manifest heavy drinking as a solution to the problems of aging.

Case finding is often difficult because the older problem drinkers may not be employed and may be living alone. Disorientation and confusion, falls and accidents, marked mood swing, and inattention to self-care are some of the signs. There are barriers, such as the denial by the drinker and his or her family, and the nonrecognition of the problem by health care personnel. Where problem drinking is recognized and

treated, prognosis is often good. Detoxification must be skillfully and carefully managed. Social therapies are apparently helpful and effective. The question of "elder-specific therapy" has been raised and, while rehabilitation services are utilized much as they are with younger problem drinkers, it is advisable to have a group of age peers in which the patient can participate. Life review and reminiscence are key processes in therapy with older people, and these are facilitated by participation in a group that has shared the same life experiences. The attitude that the elderly problem drinker should be left alone to "enjoy" his or her late years is destructive. Older problem drinkers need help.

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