

Substance Misuse Among Elder Gay Men

By: Paul D. Zak, LCSW, CAS, BCD, private practice psychotherapist, Palm Springs, CA.
www.pauldzak.com

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Who is an elder?

For the purpose of this article, gay elders or seniors are those aged 60 and older. Most gay seniors, like most straight seniors, lead satisfying lives. They are involved with family and friends, and they are pursuing varied interests which provide life meaning (Grossman, D’Augelli, and O’Connell, 2001; Berger, 1982; Kooden and Flowers, 2000). This article addresses those who are not faring so well—gay elders who are struggling with substance misuse. Gay men have higher rates of substance misuse than their straight counterparts (Gay and Lesbian Medical Association, 2001), and lesbians and bisexual women have higher rates of alcohol problems and drug use than their heterosexual counterparts (McKirnan and Petersen 1989). The focus for this article is elder gay men. The term “misuse” is used to encompass both substance abuse and dependence.

The Problem

The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, DSM IV TR, 2000) distinguishes *abuse* from *dependence*. *Abuse* is a maladaptive pattern of use leading to negative social and interpersonal consequences. *Dependence* is more severe, characterized by building tolerance to the substance, requiring more and more of the substance to get the desired effect, experiencing withdrawal symptoms upon trying to quit, and focusing more and more attention focused on getting and using the substance. One study has shown that among LGBT populations substance abuse occurs in the range of 28-35% (Cabaj, 1996) compared to 10-12% in the general population.

Many of the substance misuse problems encountered by gay seniors occur precisely because they are retired and have more time on their hands. People who may have been functioning addicts, with their addiction under the radar while working, may begin to manifest symptoms in retirement as their substance misuse progresses. This is important because substance misuse creates a risk to physical and mental health. Driving under the influence of alcohol or other drugs places the individual and others at

risk. Of particular concern is the disinhibition produced by alcohol and other drugs, leading to sexual behavior which can increase the risk of HIV transmission as well as other sexually transmitted diseases.

A 2001 telephone survey of gay men by the Urban Men's Health Study (Stall et al., 2001) questioned gay men ages 18 to 80 about their substance use. Multiple drug use (3 or more drugs) decreased as gay men aged, involving only 7% of gay men 50 and over. In a study by D'Augelli, 9% of LGBT adults over 60 were problem drinkers (D'Augelli, 2001).

Epidemiological analyses of substance use do not often ask about sexual orientation. Thus it is difficult to have precise knowledge of which drugs are used by whom. Given the fact that gay elders were socialized into substance use in the "bar culture" of the 60s and 70s, we can surmise that alcohol is the dominant drug of choice for gay elders.

Marijuana and nicotine may also figure prominently with this demographic: marijuana for those who were young in the 1960s and 1970s; nicotine for gay men in the previous generation. A ten year old study of tobacco use among gay and bisexual men revealed that they were more likely to smoke than was the general population—47.8% compared to 28.6% (Stall, Greenwood, Acree, et al., 1999). Even though a cultural shift has occurred regarding the acceptability of smoking, gay smokers of all ages need to be targeted for smoking cessation. Substance misuse programs for gay elders must integrate smoking cessation into their treatment.

So-called "club drugs," MDMA (ecstasy); Ketamine (Special K); Gamma Hydroxybutyrate (GHB); and methamphetamine usually are not an issue with the majority of elder gay men but should be assessed for. As gay men in their 30s and 40s age, treatment providers will likely see an increase in the prevalence of these drugs as well.

Many aging gay men will develop health issues, requiring pain management, and they are at increased risk of problematic use of medications such as Vicodin and Oxycodone. Anxiety and depression are common mental health issues for older gay men (Gay and Lesbian Medical Association, 2001). For anxiety management sedative hypnotics, such as benzodiazepines are effective short-term but also have addictive potential.

Another issue is the amount of alcohol used. Elders may not realize that the amount of alcohol they are able to tolerate in their 70's is less than they might have been able to consume in their 50s. Thus what may have been normal social drinking becomes drinking with more serious consequences.

Medical and Psychological aspects of substance misuse

There are medical consequences to the heavy consumption of alcohol and other drugs. Affected systems include the cardiovascular, gastrointestinal, endocrine, and neurological (Gambert & Katsoyannis, 1995; National Institute on Alcohol Abuse and Alcoholism, 2000). As mentioned earlier, substance misuse can lead to risky sexual behavior increasing the risk of becoming infected with HIV and other sexually transmitted diseases (GMHC, 2010; Gay and Lesbian Medical Association, 2001). Alcohol and other drug consumption can lead to increased risk of falling, resulting in broken bones. Also substances can interact with other medications a person may be taking. Physicians often do not screen older patients for alcohol misuse and may attribute symptoms such as insomnia, frequent falls, and memory loss or confusion to other medical conditions the person may have.

Psychological factors may facilitate substance misuse. Alcohol and other drugs can be alluring to an elder who is struggling with issues such as: the personal losses of friends and partners, ill health, depression due to decreased mobility, anxiety about the future, including death, and feelings of hopelessness and uselessness. Older gay men may often have experienced multiple deaths of friends from AIDS. They may suffer from complicated bereavement due to massive unresolved loss. Many of

those seniors who are HIV positive or have AIDS have felt additionally stigmatized. Substance use can numb the pain in the short run. Assessment and treatment need to take all of these psychosocial factors into consideration.

Since psychological consequences of misuse involve increased risk of depression and anxiety, there is a greater suicide risk, due in part to increased isolation and distorted thinking, alienation of family and friends, and mental deterioration, particularly for those in late stage disease.

Assessment

Providers of substance misuse treatment and other services for gay elders need to be aware that many gay elders avoid seeking treatment because of fear of discrimination. Healthcare environments are often inhospitable to gay elders, either because providers are not accepting or not trained to work with gay elders' issues. It is crucial that providers face squarely their own views of homosexuality and that they receive the training needed to work effectively with gay elders. Working with gay elders requires cultural competency in the same way that working with other minority groups does.

Providers need to be aware of the increase in HIV seroconversions in the over 50 population. Overall from 2004 to 2007 the number of new diagnoses among people aged 50-59 increased 32% (SAGE/MAP,2010, p. 31). Some of this increase is due to having unprotected sex while under the influence of alcohol. A National Council on Aging study reported that 61% of men over 60 are sexually active (1998). In addition to HIV concerns, providers need to take a detailed sexual history in order to assess risk for other sexually transmitted and/or blood borne diseases (Hepatitis B and C). People with HIV may be at increased risk of developing lung, anal, and liver cancers as well (GMHC, 2010). As part of a complete profile gay men need to be assessed for anal cancer and sexually active older gay men should be screened regularly.

The social network of gay elders needs to be assessed. Due to alienation from families of origin over the years, many gay elders have created their own families, composed of friends, professional contacts, and, often, ex-lovers. It is important to accept the gay elder's definition of family and who comprises it. Many gay elders live alone and, while many have a network of friends and created family, often these people are unable to assist with aftercare. For friends who can assist, there are obstacles. Government programs that facilitate long-term care of loved ones presume that the care is provided by a spouse or biological kin and friend caregivers are treated less favorably. One example is the federal Family and Medical Leave Act (FMLA). Unpaid leave is granted to an employee to care for a sick spouse, child, or parent with a serious health condition. LGBT caregivers caring for a life-long partner are often not covered and thus risk losing their jobs if they take time off to care for a loved one (SAGE/MAP, 2010 p. 33). Older gay men may be in need of convalescent care. Providers need to know that some facilities may not be receptive to older gay men and, while they cannot blatantly discriminate, they can subtly make the older gay man feel less than welcome.

Older gay men often are not welcome at agencies and organizations such as senior centers. They experience discrimination from staff and service providers in these venues (Cahill, South & Spade, 2000). Also heterosexual participants in these programs may look down on and avoid gay participants. Often these venues do not provide specialized programming created for gay elders, thus passively excluding gay seniors (Cahill, South, & Spade 2000). This is discrimination by omission.

Many gay men have rejected religion because organized religions have often reinforced anti-gay prejudice by labeling gay people as sinners. However, many gay men have developed an eclectic spirituality that can be a powerful resource in their lives (Johnson, 2004). Assessment needs to consider the spiritual concerns a gay elder has as he ages and prepares for death. Use of the life review can help an aging gay man examine, with support, the whole of his life. This has often felt liberating for those who have undergone the process (Bohlmeijer, 2003; Butter, 1980)

Addicted people practice denial, rationalization and minimization as they come to grips with their substance use. For many older gay men breaking through these defenses is hard not only because the defenses have been employed against facing substance use but also against facing their sexuality. Complicating the defense breakthrough for many older gay men is that gay bars have provided their main social community. Heavy drinking becomes normalized and is integral to socializing. Many gay elders fear losing this important avenue of social connection. Providers need to help these men develop other avenues of forming community, so that it feels safe to give up the bar culture. The treatment community itself can be the beginning of interpersonal connection in sobriety as can affiliation with gay or gay-sensitive recovery groups in aftercare.

Another factor for gay elders is the lifetime effects of internalized homophobia and heterosexism, leading to low self-esteem and depression. Gay elders came of age when homosexuality was considered a crime, sin, mental disorder, security risk, and social taboo. They developed shame about their identity at a crucial period of identity formation. It is extremely important to understand the effects heterosexism, homophobia, minority stress, and ageism on older gay men.

Heterosexism is a prejudice similar to racism and sexism. It is the privilege given to heterosexuality in our culture. It denies, dismisses, and devalues any non-heterosexual form of sexual, emotional, or affectional expression. Heterosexuality is "normal," anything else is not. Homosexuality is "less than," defective, "abnormal" "sinful," according to heterosexism (SAMHSA, 2001; Herek, 1998; Neisen, 1993, 1990).

Homophobia or sexual prejudice is the irrational fear of gay and lesbian persons, based in heterosexism. Internalized homophobia is the introjected loathing absorbed from the culture, leading to shame and low self-esteem about being gay. (Weinberg, 1972) Internalized homophobia is key in understanding substance use issues faced by gay men, especially gay elders.

Minority stress is considered chronic because it results from stigmatization and the accumulated experiences of discrimination and violence (Kuyper and Fokkema, 2009). Much of the isolation, fear, anger, depression, and anxiety gay men experience is due to being a member of a marginalized community. Substances are used to numb the effects of heterosexism, homophobia, and minority stress.

Additionally, older gay men face ageism within the gay community. Older gay men in their 50s and beyond are often invisible in gay culture. Advertising and media normalize and validate young men with perfect bodies. Ageism contributes further to low self-esteem and loneliness. Older gay men may become bitter about this invisibility and the resentment can fuel substance misuse.

There are websites for older gay men and their admirers. These provide opportunity for some connection to others. However, many of these sites are sexualized. Older gay men, by reason of receiving attention in the sexually charged atmosphere of a website, are vulnerable to experiencing negative consequences of sexual activity: HIV and other sexually transmitted diseases.

Gay men of color face additional stressors. The legacy of racism has led to some of the same internal personal consequences as those provoked by heterosexism and homophobia. Lack of acceptance of homosexuality within their own racial and ethnic communities leaves older gay men of color alone and unsupported. At a time of life when family and community are extremely important, often gay men of color are deprived of both. Substance misuse can provide temporary relief. Gay men of color often feel they do not fit into the white gay world. Older gay men of color remain closeted, and this contributes further to isolation, the fertile ground for substance misuse. Cultural competence requires staff to be aware of other cultural views of homosexuality and the additional stigma that gay elders of color have felt (Bell, 1981; SAMHSA, 2001).

Treatment

It is crucial that the treatment environment not mimic the heterosexism and homophobia of the larger cultural environment. Staff needs to be gay sensitive, which requires training for those who are not gay. It is most helpful if some staff are openly gay, to model self-acceptance and integration of gayness into a total personal identity. Many gay elders need this kind of modeling to come to greater self-acceptance. In mixed treatment settings, the gay elder's confidentiality must be respected, allowing the gay senior to come out according to his comfort level. Because of the era in which he grew up and the amount of internalized homophobia he carries, some older gay men may choose not to come out in a group. While this needs to be respected, and worked with over time, it makes individual treatment even more important. There should be a zero tolerance policy for homophobic and heterosexist jokes or comments by staff or clients.

Language in assessment forms needs to reflect gay sensitivity. For example "Sexual preference" should be replaced by "sexual orientation." "Preference" implies choice and sexual orientation is not about choice.

The family assessment should include kinship or created family information not just family of origin material. Likewise a family program as an adjunct to treatment should include members of the client's kinship family.

The facility itself should be welcoming of gay clients. While gay treatment facilities are growing in number, in most parts of the country older gay clients will likely enter mixed treatment situations. Including gay clients in a program's mission statement conveys that gay clients are part of the environment. The presence of the rainbow flag communicates symbolically that gay clients are welcome. Client handbooks which describe a non-discrimination policy against gay clients help provide a safe environment, as long as the policy is enforced promptly and thoroughly. Programs should

implement client satisfaction surveys that provide feedback about how well the program is treating its gay clients.

On a systemic level, there is a need for the development of consistent and comprehensive LGBT standards of care and protocols sanctioned by accrediting bodies. Accrediting agencies need to mandate that all treatment programs adhere to uniform LGBT treatment standards rather than leaving such standards up to each program to develop and follow. These standards could provide the basis for staff training and licensing of treatment programs.

For gay men, sexuality is very important. Many older gay men came of age during the sexual revolution of the 1970s. Sexuality should be discussed openly, allowing the client to discuss sexual activities and practices freely, in an atmosphere of non-judgmental acceptance. Many gay elders have learned to hide aspects of their sexuality for fear of judgment. Staff needs to be knowledgeable about various sexual practices gay men engage in and comfortable discussing all aspects of sexual expression. Providers need to own and work through their own sexual discomfort.

Because of the medical issues many elders face, treatment for substance misuse should be coordinated with medical and social services. Also providers need to be familiar with and refer to gay organizations, gay or gay-sensitive individual providers, and 12-step meetings as part of the treatment plan and aftercare. Since not all programs or referral individuals are gay or gay sensitive, providers need to research which ones are and make appropriate referrals.

For those who do not seek formal treatment, yet use substances at risk to themselves, medical and social service personnel should use brief motivational interventions focusing on health risks and other potential problems (Cummings, et. al. 2009). There is ongoing debate in the substance treatment community about harm reduction, an approach that encourages the client to adjust substance use so as to decrease or minimize negative consequences. Abstinence is not necessarily the goal. For some older gay men harm reduction may be the most effective beginning (Denning, 2000).

Psychotherapists should provide age sensitive treatment. Individual therapy may need to proceed at a slower pace. Cognitive and behavioral interventions are often more effective than psychodynamic work, especially in early recovery. If a client is cognitively impaired, there may need to be more structure provided in individual and group work. Hearing impairment also needs to be provided for, as does mobility impairment.

Conclusion

Older gay men face challenges which can lead them to misuse substances to cope with life. The accumulated effects of heterosexism and homophobia, ageism, racism, and minority stress can feel overwhelming. Add to this social isolation and a bar culture that most elder gay men came out into and that formed their community, and it creates an environment for substance misuse.

However, older gay men possess strengths which can aid them in coming to grips with a substance problem. Having survived and even thrived in spite of discrimination, many gay men have developed “crisis competence.” Crisis competence is the combination of skills and attitudes that gay people develop to surmount and even grow through the experiences of heterosexism, homophobia, and minority stress (Kimmel, 1995). Many gay elders have developed inner strength and resiliency and have “come out” to a place of self-acceptance (Kooden & Flowers, 2000). Unfortunately many of the gay elders who use substances to cope have not fully developed crisis competence, and are still mired in the shame and self-abnegation which are internalized reflections of the broader culture’s pathological view of gay people.

If you are a medical provider, counselor, substance treatment professional, and are working with older gay men, it is crucial that you examine and work through your own biases about gay men so that you can provide a safe treatment environment and experience for gay elders. It is even more crucial that you realize the depth to which gay elders who misuse substances struggle with personal and systemic issues.

At the heart of the recovery process for gay elders is to be able to come to see themselves as valid, valuable, and worthy of living their lives as fully as they can. They can begin to define their lives from the inside out and create meaning during the final one-third of their lives. This is the hope and promise of their recovery (Kooden & Flowers, 2000; Zak, 1998).

Paul D. Zak, LCSW is a psychotherapist in private practice in Palm Springs, CA. He is a Licensed Clinical Social Worker (LCS 17633), a Board Certified Diplomate in Clinical Social Work (BCD 50356), and a Certified Addictions Specialist (CAS 3582). He worked for many years in the San Francisco community mental health system with gay male clients with HIV, mental illness, and substance misuse. His website is: www.pauldzak.com

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