CHAPTER 3

HEALTH TRANSITIONS IN OLDER ADULTS

For age is opportunity no less
Than youth itself, though another dress
And as the evening twilight fades away
The sky is filled with stars, invisible by day.

(Henry Wadsworth Longfellow, American poet and professor)

Reflective Questions

▶ What are some of the physical, mental, and cognitive changes that older adults may experience?
▶ How do transitions in health affect the functional abilities, social abilities, and social contact with others?
▶ How should health and human service professionals assess and intervene with older adults experiencing health transitions?

The quote of American poet and professor Henry Wadsworth Longfellow expressed an important truth about advancing age. Although changes occur in later years, these changes can be meaningful and full of opportunity. That being said, older adults may face more transitional challenges in trying to keep life purposeful and rich. While many adults enter the older life stage in good health, significant numbers of older adults will experience some health problems as they enter their 70s and 80s. Depending upon the nature of the health issues, as well as the degree of disability
that comes from these challenges, older adults may face other transitions related to the health concerns, such as moves from personal homes into assisted living or long-term care facilities. The compounding nature of the transitions can result in profound stress for older adults and demands significant resilience and adaptability on their part. If older adults do not possess this hardiness or adaptability due to extreme health conditions, such as dementia, then added responsibility is placed upon family members and professionals to support them in their health transitions.

Within this chapter we discuss some of the health challenges faced by older adults, such as physical illnesses, chronic illness and pain, addictions, mental illness, and dementias. We propose that life transitions, such as the loss of a spouse, can lead to illness in older adults, such as depression. However, we also suggest that illnesses, in and of themselves, are transitions for older adults; the ability of seniors to manage day-to-day functioning can decrease significantly and may even lead to other transitions, such as a move to a hospital, assisted living, or long-term care facility. While we document the prevalence of various illnesses, as well as symptoms, our purpose in doing so is to emphasize the complexity of the emotional responses to the transition of illness in older adults. Additionally, we address how health and human service professionals may assess and intervene with older adults experiencing significant issues in health.

**Physical Illness: Chronic**

Chronic illness or conditions refer to “long-term diseases that develop slowly over time, often progressing in severity, and can often be controlled, but rarely cured” (Ministry of Health and Long-Term Care, 2007). Common chronic illnesses in older adults include some forms of heart disease, cancer, diabetes, and arthritis. Other common illnesses such as strokes (cerebrovascular accidents) are acute in that they occur suddenly, but after the initial event, the changes incurred generally become constant or chronic. The impact of chronic illness in the United States and Canada, as well as worldwide, is astronomical. Chronic illnesses (also called non-communicable diseases) are a significant cause of death and disability throughout the world, including North America; for instance, according to the World Health Organization (2014), 88% of deaths in North America are caused by chronic illness.

The presence of chronic illness can restrict the activities that older adults can take part in. Chronic illnesses may also lead to involuntary retirement in older adults; that is, some older adults need to retire because
of health issues, rather than by choice. If the senior enjoyed work, cherished the camaraderie with colleagues, and appreciated the purpose and structure work gave, retirement can be a major loss (Smith, 2012). Not only can the cessation of work represent a loss for the older adult, finding an alternate purposeful and enjoyable replacement may be difficult due to the limitations caused by the illness. Lack of purpose in life results in an existential crisis (Frankl, 2006). The older adult may question, “What good is my life anymore?” He may live with chronic sorrow related to coping with the chasm between who he once was and who he is presently (Weingarten, 2012). And perhaps that chronic sorrow is also tied to the fear of who he will become. When chronic illness causes some sort of physical disability, for example, difficulties negotiating stairs due to cardiac problems or arthritis, then a move may be necessary. Older adults may move to a retirement community, a seniors’ complex, or an assisted living facility. While some older adults find that they enjoy the newfound companionship that comes with living in an assisted living facility or a seniors’ complex, others grieve the loss of their home (Pickersgill, 2001). They grieve because home represents much more than physical structure or a place to sleep. For some older adults, a lifetime of memories is ensconced within the walls of the home; the home is where they raised their families, cooked and entertained, cared for ailing parents, and dreamed of the future. Beyond a lifetime of memories, their homes have represented security and may also symbolize freedom and independence. Moving out of the home may be viewed as the first step down a slippery slope toward total dependence and mortality (Gill & Morgan, 2011). And, as will be discussed in Chapter 4, the concept of “home” represents more than simply a physical structure within which to sleep; it possesses a somewhat ethereal quality.

The previous section offered some common problems associated with chronic illness. In the following section, we will provide some statistics and specifically address what it is like for older adults to live with heart disease, strokes, diabetes, and arthritis.

**Heart Disease and Strokes**

Cardiovascular diseases are a significant problem amongst older adults in North America. For instance, more than one in three older Americans suffers from one or more types of cardiovascular disease. According to the American Heart Association (2013), the leading cause of death in older men and women (65 years of age and older) in 2009 was heart disease. Within Canada in 2008, cardiovascular diseases accounted for 29% of all
deaths in Canada, of which 54% were attributed to ischemic heart disease (narrowing of the blood vessels of the heart), 20% to strokes (cerebrovascular accidents), and 23% to heart attacks (myocardial infarction) (Heart and Stroke Foundation of Canada, 2012).

Living with the impact of cardiovascular diseases in older adulthood can be difficult. Heart disease impacts all areas of life for older adults; they experience less energy, debilitating shortness of breath, and severe fatigue. Older adults, particularly those older than 75 years of age, often experience greater physical symptoms of heart failure than their younger counterparts. And emotionally they suffer as well, experiencing fear of becoming a burden, depression, and existential struggles (Falk, Ekman, Anderson, Fu, & Granger, 2013). Within their literature review examining older adults’ experiences of heart failure, Falk et al. (2013) highlighted several studies revealing that symptom management by health care professionals is often inadequate, as is the self-monitoring of symptoms by these older adults. Interestingly, however, motivational interviewing has been found to be useful in improving older adults’ abilities to manage their illness (Falk et al., 2013).

**Stroke**

When older adults are left with functional deficits following a stroke, the sudden catastrophic event leads to life with significant changes. Older adults with deficits following a stroke often experience exhaustion, changes in physical abilities, such as difficulties in utilizing an affected hand for personal care or household duties, difficulties with mobility (walking and driving), changes in cognitive function, aphasia (problems with verbal communication), and changes in vision (Ekstam, Tham, & Borell, 2011; McKenna, Liddle, Brown, Lee, & Gustafsson, 2009; Northcott & Hilari, 2011). These changes can have a profound effect upon older adults’ social lives, lead to a loss of friends, resulting in loneliness, which in turn, can precipitate depression. In their article entitled “Why do people lose their friends after a stroke?” Northcott and Hilari (2011) examined why strokes can damage friendships. The research participants spoke of their challenges following the stroke event, including the experiences listed above. However, they also reported that their friends offered unhelpful responses, such as ridicule, telling them how they should feel, or patronization. With

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1. Motivational interviewing is often used in addiction counseling. It involves ascertaining individuals’ willingness to change and making steps toward change.
all of these challenges following the acute stroke event, the research participants conveyed that they “closed in on themselves.” The difficulties in communicating, exhaustion, and transportation challenges, as well as embarrassment of being seen as unwell, meant that getting together with friends was no longer enticing. Because of how they felt about themselves, as well as the responses of others, they simply withdrew (Northcott & Hilari, 2011).

**Diabetes**

Some older adults living with diabetes have managed their illness for years; for others, diabetes is a new experience. Living with diabetes includes dietary management, administration of insulin or oral hypoglycemics, blood glucose monitoring, and other tasks. Due to the changes of aging, successfully managing diabetes can pose problems that younger adults may not face. As well, co-morbidities (other concurrent illnesses) may impact how older adults deal with their illness. First, older adults may have visual problems that can influence medication administration, particularly the self-injection of insulin. Changes in daily exercise or physical activities can result in lower food intake, which can then result in hypoglycemia (low blood glucose). Developing cognitive impairment in some older adults can affect how they manage blood glucose monitoring, diet, and medication administration (George & Thomas, 2010).

Unstable or erratic blood glucose levels may result in older adults living with constant concern, or even fear, for their lives (Canadian Diabetes Association, 2015). For instance, if an older adult experiences very low blood sugars in the night, he might fear never waking up due to a severe hypoglycemic reaction. This can be especially frightening for the older adult who lives alone. An older woman who enjoys babysitting her grandchildren may have to cancel her cherished activity of looking after her young family members due to dizziness, trouble concentrating, and feelings of confusion caused by very low blood sugars. In both examples, there often are accompanying psychological reactions, such as fear, loss of control, and feelings of worthlessness. Loss of control and living with constant fear may lead to depression. And, unfortunately, depression in conjunction with diabetes may decrease the commitment of older adults to follow through with their daily self-care regimens (Jack, Airhihenbuwa, Namageyo-Funa, Owens, & Vinicor, 2004).

Further, living with diabetes may trigger existential issues in older adults. George and Thomas (2010) interviewed 10 older adults living in
rural America about their experiences with insulin-dependent diabetes. The research participants had been diagnosed with diabetes 7–39 years previously. All had complications from the diabetes and each participant had one or more chronic illnesses in addition to the diabetes. The researchers concluded that the rural participants lived with fear of hypoglycemic reactions and subsequent death, a disconnect between what health care providers told them to do and how they actually managed their diabetes, a somber recognition that the only escape from diabetes involves death, as well as a stoicism to continue on. As the researchers noted, living with advanced diabetes caused older adults to ask existential questions (George & Thomas, 2010).

**Arthritis**

Although there are a number of forms of arthritis, the most common forms of arthritis are rheumatoid arthritis and osteoarthritis (The Arthritis Society, 2015). Arthritis is one of the most common causes of disability in older adults (Centers for Disease Control and Prevention—CDC, 2013); particularly rheumatoid arthritis results in physical disabilities (including problems with mobility and physical activities), decreased energy, and chronic pain (which can be severe in nature).

Understandably, living with chronic pain can result in despair and depression. In a recent study, older women who self-reported greater severity of pain and greater pain interference (the extent to which pain interfered
with activities of daily life) experienced more depression. Additionally, older men and women who had more co-morbidities (other concurrent illnesses in addition to the arthritis) experienced greater depression (Onubogu, 2014). Older adults who experience severe rheumatoid arthritis may live with the existential pain that comes from a lack of control and independence, as well as fear for the future due to the progressive nature of the disease. Depending upon the severity of the physical limitations, some older adults need to transition to seniors’ complexes, assisted living, or long-term care facilities due to their inability to manage in their homes.

**Chronic Pain**

Chronic pain is pain that occurs for more than 12 weeks; it may, however, last for months or years (NIH Medline Plus, 2011a). It may be caused by chronic illnesses, such as arthritis (osteo or rheumatoid), neuropathic pain (related to nerve damage from diabetes), heart disease, and cancer; regardless of the cause, it can be debilitating. Estimates of the prevalence rates of chronic pain in older adults vary according to country. For instance, within Canada it is estimated that 27% of older adults living independently and 38% of those living within long-term care have chronic pain (Statistics Canada, 2010). Prevalence rates in the United States are even higher. The National Institute of Health (NIH) Medline Plus (2011b) reported that about 50% of older Americans living independently experience chronic pain, and the percentage climbs to 75–85% of those living in long-term care facilities.

Considerable consequences ensue from the presence of chronic pain in the lives of older adults. Living with persistent pain leads to problems sleeping, disabling fatigue, and a reduction in what older adults can accomplish in terms of household work and activities (Jakobsson, Hallberg, & Westergren, 2004). And the inability to accomplish household tasks often carries greater meaning for older adults than their younger counterparts; it is not simply the everyday business of getting the house cleaned, doing banking, and other chores, it is the structure these activities give to daily life. Because these activities need to be done, there is a reason to get out of bed in the morning, as well as a sense of a “job well done” when relaxing in the evening. Even more, it is the importance of these tasks to a sense of self—how older adults view themselves, their very personhood. If they cannot complete the most basic of duties—those they have completed since adolescence—what does that say about who they are as people? Older adults
have described the experience of decreased mobility related to pain as not only frustrating, but tremendously humiliating and demoralizing. These feelings of incompetence and humiliation may cause some older adults to sequester themselves within their own homes, in a sense, to go into hiding (Smith, 2012). The loneliness that comes from living in isolation can then contribute to depression. However, when loneliness is coupled with persistent and longstanding pain, it is not uncommon for older adults to become very depressed. A complex entangled web of chronic pain, depression, loneliness, and social isolation may result. Some may medicate their physical and emotional pain with substances such as alcohol; sadly, for some, the end result of this web of despair is suicide (Conwell, Van Orden, & Caine, 2011).

In their review of studies examining barriers to the self-reporting of chronic pain by older adults, Gammons and Caswell (2014) found that there were internal barriers to self-reporting pain, one being older adults’ desire to prevent pain from becoming the focus in their lives. The other barrier pertained to health care professionals and was site specific: whether the older adults lived in an institution or in the community. Seniors living in institutions experienced communication problems with health care professionals and stated that staff did not listen to them, nor understood their pain. Those living in the community also reported communication problems with health care professionals, in that they expected they would receive a prescription, but felt their stories were not heard (Gammons & Caswell, 2014). Additionally, some studies revealed the stoicism of older adults toward pain and that they believe that pain is a normal consequence of aging (Gammons & Caswell, 2014). When older adults do not feel that they can share their physical pain, or their stories about the pain, this can result in emotional pain, loneliness, and an uncomfortable predicament. To share physical pain and have it minimized will trigger emotional pain; however, to keep quiet and not share pain means that older adults are existentially alone with it: a double bind!

Chronic illness coupled with pain can result in suicide in older adults. In one Canadian study (Juurlink, Herrmann, Szalai, Kopp, & Redelmeier, 2004), researchers examined coroners’ records of the suicides of older adults in Ontario, Canada from 1992–2000. They determined that of the 1354 older adults who committed suicide during this time period, a number of these individuals suffered from congestive heart failure, chronic obstructive pulmonary disease (COPD), anxiety disorders, depression (as well as other mental illnesses), and moderate or severe pain. The researchers noted that where individuals had multiple illnesses, the risk of suicide
was higher. Sadly, almost 50% of these older adults had seen a physician in the week prior to committing suicide (Juurlink et al., 2004).

**Mental Illness**

Symptoms of mental illness are surprisingly common among older adults. And mental illness in older age can be heartbreaking for individuals and their family members. While older adults experience the same types of mental illnesses as younger adults do—including depression, adjustment disorders, anxiety, schizophrenia, and bipolar disorder—they may additionally develop Alzheimer’s disease or other dementias.² Because the focus of this book is on transitions in older adults, and not specifically mental illness, we will focus on just depression, anxiety, dementias, and addictions.

**Depression**

Contrary to past societal beliefs, depression in older adults is not normal (NIH, n.d.). Depression may develop from the stress of dealing with a life-changing and gut-wrenching transition, such as the loss of a spouse; it can also occur in those who have had previous experience with depression in the past and in those who have illnesses that impact brain functioning (such as strokes or dementias); it can happen in response to chronic illness and pain; and it may occur as a result of medications (and/or medication misuse) or alcohol abuse. Much more than feeling “out of sorts” or “being moody,” depression involves significant sadness, fatigue, anhedonia (a loss of pleasure in activities once considered enjoyable), concentration difficulties, guilt, and suicidal thoughts (American Psychiatric Association, 2013).

A significant number of older adults experience symptoms of depression (although they may not necessarily meet the criteria for Major Depressive Disorder within the *Diagnostic and Statistical Manual of Mental Disorders*). In Canada, it is estimated that up to 20% of older adults living in the community experience symptoms of depression. This percentage doubles to 40% for seniors living within long-term care facilities (Canadian Coalition for Seniors’ Mental Health, 2009). For aging individuals, living with depression can make life miserable, and for some, even intolerable.

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² We recognize that a small number of adults develop Alzheimer’s disease or related dementias in their 40s or 50s; however, the vast number of individuals affected are considered older adults (Alzheimer’s Association, 2014).
How painful and unbearable life can be for some depressed older adults is reflected in suicide rates of this age grouping. Older Caucasian men in both the United States and Canada have the highest rates of suicide in terms of population groups (CDC, 2012; Public Health Agency of Canada—PHAC, 2010). Further, the rates of suicide among older adults may actually be notably higher than reported. This is because judging the intentionality of the actions of individuals can be difficult. Particularly if the suicide is nonviolent, the death may be wrongly attributed to illness (Juurlink et al., 2004). Also, within Canada, when coroners perform autopsies, they may initially label the cause of death as “undetermined.” However, after an autopsy is completed and the cause of death is confirmed as suicide, the change may not be registered in the mortality database (PHAC, 2014).

Suicide is not the only way in which older adults with depression may eventually die. The impact of depression upon older adults can shorten lives. One study (Reynolds, Haley, & Kozlenko, 2008) examined the effects of depression upon the active life expectancy of older Americans (70 years of age and older) who were living in the community. The researchers found that depressive symptoms decreased the life expectancy of young-old adults (70 years of age) by 6.5 years in men and 4.3 years in women, and by 3.2 years in the oldest-old men (85 years old and above) and 2.2 years in oldest-old women.

Anxiety

Like depression, anxiety is common in later life and can be extremely debilitating. Its prevalence is estimated to be double that of dementia and up to four to eight times more common than major depressive disorders (Cassidy & Rector, 2008). However, it is often not recognized by health and human service professionals and, as such, has been labeled the “silent geriatric giant” (Cassidy & Rector, 2008, p. 150).

What makes anxiety so “slippery” to recognize in older adults? First, anxiety may occur concurrently with other mental illnesses, such as depression. Or, anxiety can be a precursor to, or an initial symptom of, cognitive impairment (Potvin, Forget, Grenier, Preville, & Hudon, 2011). Second, older adults may express anxiety through a fixation on physical symptoms, or they may experience anxiety as a response to health conditions, such as cardiac disease (Grenier et al., 2012) or diabetes (Poulsen & Pachana, 2012). Further, older adults with anxiety often demonstrate anxiety differently than their younger counterparts, exhibiting far more
physical symptoms of anxiety. As such, professionals may then focus on the physical concerns of their clients. Fourth, older adults suffering from anxiety are less likely to seek mental health services than older adults who are depressed (Scott, Mackenzie, Chipperfield, & Sareen, 2010).

The other challenging aspect of addressing this “geriatric giant” is treatment. As older adults absorb, metabolize, and excrete medications less effectively with age, pharmaceutical treatment becomes more challenging. Not only are there concerns about polypharmacy (see later in this chapter), but treatment with anti-anxiety agents, such as benzodiazepines, can lead to confusion and falls in older adults (Hirst, Lane, & Miller, 2015).

**Alzheimer’s Disease and Related Dementias**

Alzheimer’s disease and related dementias have a profound impact upon older adults, their spouses, and their family members. Alzheimer’s disease refers to a progressive degenerative disease that results in memory loss (especially short-term memory loss), inability to make decisions, impaired ability to perform activities of daily living, changes in mood and behavioral problems, and communication problems that may lead to aphasia (loss of speech) (Alzheimer’s Association, 2014). Alzheimer’s disease is believed to be caused by neurofibrillary tangles and neuritic plaques. While Alzheimer’s disease is the most common form of dementia, there are a number of other forms of dementia, including vascular dementia, frontal lobe dementia, Creutzfeldt-Jakob disease, and Lewy Body dementia (Alzheimer’s Association, 2014).

The losses associated with dementias, such as Alzheimer’s disease, are so profound and impact the very personhood of those affected; as such some have labeled the experience of Alzheimer’s disease as “the loss of self” (Cohen & Eisdorfer, 2001). The person with Alzheimer’s disease will eventually not be able to recognize family members or even him- or herself (in the mirror). By the middle stages of the illness, family members usually place the senior into a long-term care facility, as the care demands become too much. Death usually occurs somewhere between 7–10 years after the onset of the illness; however, some individuals live much longer (Alzheimer Society of Canada, 2012).

The stress upon family caregivers is enormous and cannot be overstated. In fact, it is not all that uncommon for a spousal caregiver of someone with Alzheimer’s disease to die because of the stresses of caregiving. In one study (Schulz & Beach, 1999), 392 spousal caregivers were compared to 427 non-caregivers. All of the older adults were between the ages of
66–92 years of age. The results revealed that spousal caregivers had a 63% increased mortality rate over the non-caregivers. Schulz and Beach (1999) concluded that caregivers who experience emotional and mental stress related to caregiving have a greater likelihood of dying than non-caregivers. In situations such as illustrated by this study, Alzheimer’s disease ends up taking two individuals: the older adult with the disease and the spousal caregiver. In our experience, caregiving may not only lead to increased mortality rates for spouses, but at times, spousal caregivers may actually pass away before the partner with Alzheimer’s disease. And, in rare situations, an adult child may pass away before the parent with dementia.

I (AML) remember sitting at the unit desk (on a geriatric mental health unit) one morning reviewing a patient’s chart when a caring psychiatrist entered the unit. She seemed upset. She told me that a particular person had died. I looked up, somewhat distracted, and said words to the effect of, “Well, she was very old.” I was referring to the fact that our past patient was 95 years of age, if not by now, 96 years of age. The psychiatrist looked at me, paused, and said, “No, her daughter died.” I was stunned. I asked what had happened. This psychiatrist then explained the circumstances of this adult daughter’s death and her health challenges. I felt badly for the adult daughter, as well as for the psychiatrist, because the psychiatrist had worked hard to convince the daughter to scale back her efforts at caregiving and to consider placement in a facility, rather than solely providing help within her home. For various reasons, including cultural beliefs, the daughter could not accept help in caregiving and, ultimately, the stress involved in being the only person providing care may have shortened her life.

Grief is so intricately tied to seeing a family member (with dementia) not only progressively lose the ability to care for herself, but also in seeing the personality characteristics, that uniquely defined her as a person, dis-integrate (Rolland, 1993). And that grief is complex and unresolved, in that the person with Alzheimer’s disease has not passed away, but the person the caregiver knew is gone. Pauline Boss (1999) termed this situation “ambiguous loss.” Initially, she coined this term to refer to American soldiers who were missing in action. Although they were presumed dead, family members could not see a dead body. Hence, they were physically absent (presumed dead), but psychologically present to family members. Boss (1999) then applied this expression to individuals experiencing dementias, but flipped the meaning. Because individuals with Alzheimer’s disease or related dementias are not dead, they are physically present. However, as their personalities have changed and they forget who others are, they are psychologically dead (Boss, 1999). This results in complicated grieving
for family members, because they grieve the loss of the older adult with Alzheimer’s disease, but the individual has not yet died. “I lost my mom a long time ago,” is a common sentiment of an adult child coping with her parent’s dementia and the demands of caregiving.

The notion of anticipatory grieving is somewhat different, but also related to the concept of ambiguous loss. Anticipating the death of a spouse with a progressive illness, such as Alzheimer’s disease, can be as painful as the actual physical death of the individual (Rolland, 1993). While awaiting an eventual death, spouses and family members grieve each downward drop in functioning. They often feel as if they are losing their older adults “one piece at a time.” Because the course of Alzheimer’s disease is generally somewhere between 7–10 years, but can be longer, family members live in a state of grief for a long period of time. This is both emotionally and physically exhausting. In our experience, by the time older adults with Alzheimer’s disease pass away, spouses and family members often admit that much of their grieving is done. This is not an indication that a spouse or family members did not love the older adult, but rather, that they carried their grief for a long period of time and now were ready to set this grief down. More will be discussed on the grief associated with ambiguous loss in Chapter 6.

Medication Usage and Addictions

Medication usage, in and of itself, is not a sign of addiction in older adults. However, prescribed and over-the-counter medications can cause
significant problems for older adults, leading to hospitalization or placement in a long-term care facility. Older adults may suffer adverse drug reactions related to physiological changes that come with aging (and hence, a decreased ability to metabolize and excrete medications), and due to inappropriate dosages of medications or interactions between medications (Berryman et al., 2012). The more medications taken by older adults the greater the chances for adverse drug reactions (Rochon, Schmader, & Sokol, 2014). Depending upon the survey, almost 40% to over 50% of older adults in North America take five or more prescribed medications yearly (Canada Safety Council, 2012; CDC, 2010).

Concurrently, older adults consume over-the-counter medications, often to a great extent. Commonly, they consume cold medications, decongestants, antihistamines, analgesics, and laxatives. Older adults may presume that these medications are harmless, as they are sold without a prescription; however, they are not benign for older adults.

For instance, older adults taking antihistamines may experience confusion (Berryman et al., 2012). Medications, particularly the adverse interactions between multiple medications, can lead to hospitalization because of a delirium. Delirium can be life threatening and includes symptoms such as confusion, disorientation, delusions and hallucinations, and agitation. Older adults hospitalized with delirium have a greater length of stay in hospital than their counterparts who are not experiencing delirium, and, tragically, have increased rates of death (Hirst, Lane, & Miller, 2015). While older adults living in the community may experience a delirium, those residing in long-term care are at particular risk. This risk is in part due to the fact that by the time older adults enter these facilities, they are often more frail, cognitively impaired, unable to effectively manage continence, and thus, more prone to infections (another cause of delirium).

There is another significant adverse effect of some medications in older adults. Some medications affect balance and gait and can result in falls in seniors. Falls may cause fractured hips and may lead to disability or death (Huang et al., 2012). Even if older adults survive a fall and possible surgery, disabilities related to that fall may result in loss of independent living and possible transition to assisted living or long-term care.

The preceding discussion about medications, including the physiological changes in older adults that make them particularly susceptible to complications from medications and potential adverse effects, is presented with the underlying assumption that medications are taken as prescribed and that there are no intents to misuse or be psychologically reliant on substances. However, substance abuse can be a problem for some older
adults and, combined with the number of over-the-counter and prescription medications ingested, can be dangerous or even deadly.

Substance abuse is included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM V) (American Psychiatric Association, 2013). And unraveling the reasons behind substance abuse is complicated. Substance abuse by older adults may be an attempt to self-medicate depression, anxiety, sleep problems, physical pain, and boredom; or, substance abuse may have caused depression and other health problems (Reardon, 2012). Like the proverbial cart and the horse, sometimes it is difficult to know which has come first.

There is another possible explanation, however. Aging individuals may abuse substances to deal with existential issues. In an interesting study, Wiklund (2008) explored the experiences of individuals living with addictions, with a focus upon existential issues. She interviewed nine individuals between the ages of 35–46. Although the research participants were not seniors, the findings may be considered relevant to the situations of some aging adults. Some of Wiklund's (2008) participants described experiencing life as meaningless and as a battle between life and death. However, when they took drugs, they felt alive, even if this type of existence was not really who they were as individuals. Could it be that some retired, chronically ill older adults are confused about their identity within a world where youth and productivity are revered, and find that alcohol or drugs not only quells loneliness and emotional pain, but on some level, makes them feel alive? However comprehensible the reasons for using/abusing substances in advancing years, the results can be deleterious and even dangerous.

The most commonly abused substance among older adults in North America is alcohol (Health Canada, 2005; Substance Abuse and Mental Health Services Administration—SAMHSA, 2009). The National Institute on Alcohol Abuse and Alcoholism (n.d.) reported that in 2008, 40% of older Americans drank alcohol. While older adults are generally considered less likely to be heavy drinkers (five drinks or more at one time at least once a month over a 12-month period), some older adults do consume amounts of alcohol considered to be problematic. For instance, in 2003, 12% of Canadian older men and 3% of Canadian older women were rated as heavy drinkers (Turcotte & Schellenberg, 2006). Risk factors for alcohol abuse among older adults includes those who experienced involuntary retirement and have had problems with alcohol abuse in the past (Kuerbis & Sacco, 2012), as well as those with mental health problems.

While the rates of alcohol abuse are not extreme, there is evidence that current rates of older adults abusing illicit substances is significantly
higher than older adults in the early 1990s (SAMHSA, 2010). For example, between the years of 1992 and 2008, the rates of admission to hospital for heroin abuse among older Americans doubled (SAMHSA, 2010). This changing trend is attributed to the aging of the baby boomers (Reardon, 2012); this generation of individuals used illicit substances when younger and has continued to use these substances.

The use of substances such as alcohol or other illicit drugs, in conjunction with other prescription medications, can have dangerous effects. For instance, alcohol has a depressant effect upon the central nervous system (CNS). In combination with other medications, such as benzodiazepines (anti-anxiety medications), which also have a CNS depressant effect, can magnify or potentiate the depressant effect. This can lead to respiratory depression and death (Berryman et al., 2012). Older adults who may have combined prescribed medications, over-the-counter medicines, and alcohol younger in life may not be aware of the dangers of mixing substances in their advancing years. And, if they are bored or depressed due to the activity restrictions from chronic pain or chronic illness, or feeling empty due to forced retirement, they may be prone to use alcohol or other substances to numb their feelings (Reardon, 2012). While retirement or chronic illness does not cause a person to abuse substances, if the inclination to use substances is there and the senior is depressed, lonely, or bored, substances may be used to fill the void.

**Framework Within Which to Understand Illness**

Before presenting a case study and addressing assessment and intervention, we believe it is useful to offer some insights from Rolland’s work on the psychosocial typology of illness (1987, 2005). These insights reveal the degree of challenges and suffering faced by older adults and their family members.

**Psychosocial Typology of Illness**

Rolland’s psychosocial typology of illness (1987, 2005) assists professionals in understanding the unique challenges that come with managing varying illness trajectories associated with some of the diseases previously discussed in this chapter. This typology classifies illnesses according to onset, course, outcome, incapacitation, and uncertainty (1987). In this typology, Rolland differentiated between the demands and challenges experienced with an acute onset illness as compared to those with a chronic illness.
Depending upon the onset, course, and outcome, individuals and families will face specific challenges that will impact how they respond psychologically. For instance, Rolland (1987) included two categories under onset: acute and gradual. An acute onset can include such events as strokes or myocardial infarctions (heart attacks); gradual onset can include such illnesses as Parkinson's disease or multiple sclerosis. In illnesses that present with an acute onset, family members need to mobilize crisis management skills and support in a short period of time. Although dealing with a chronic illness demands just as many psychosocial resources in individuals and family members, the gradual onset of such illnesses offers time within which to adjust to the changes in health (Rolland, 1987).

Rolland (1987) conceptualized the illness course as generally taking three types: progressive, constant, and relapsing/episodic. Alzheimer's disease (and many related dementias) falls under the progressive course. When an individual has Alzheimer's disease, the disease course is usually continuous in terms of experiencing symptoms, but the symptoms worsen over time. Family members experience little relief from the constant caregiving demands; they risk becoming physically and mentally exhausted as they need to take on new demands as the disease progresses. The progressive category is in contrast to the constant course category, where after an initial event, the disease course stabilizes, such as with spinal cord injury. The relapsing or episodic course, that can occur with illnesses such as asthma, involves vacillations between periods of stability and acute flare-ups. While family members receive a break from caregiving during periods of stability, they psychologically live with the uncertainty of when an acute crisis may occur. The demands of this living with impending danger, even within the periods of stability, can be emotionally strenuous for families (Rolland, 1987).

The outcome aspect of illness involves the likelihood that an illness will result in death and the extent to which it can abbreviate someone's life (Rolland, 1987). When family members first receive the diagnosis, what is the likelihood that the illness will result in death? This is a significant question as the expectation of death sets in motion anticipatory grieving in family members, and family members and the ill older adult are caught in the tension of wanting intimacy and trying to pull away from each other. The extreme emotions experienced in trying to deal with an impending death can lead to difficulties in getting the practical day-to-day tasks done. Further, if family members are already conceptualizing their older adult as buried and gone, they may exclude him from important family responsibilities (Rolland, 1994).
Incapacitation

Incapacitation refers to the degree of disability caused by the illness, and may involve impairment in cognition (e.g., from Alzheimer’s disease), in senses (e.g., blindness), and in movement (e.g., rheumatoid arthritis or multiple sclerosis) (Rolland, 1994). The onset of the incapacitation (e.g., spinal cord injury) will determine when the greatest amount of adaptability needs to occur. As an example, incapacitation from a sudden spinal cord injury from a motorcycle accident is severe at onset and requires strong adaptability from the affected individual and family members from the outset of the injury. Other illnesses with a more progressive course toward incapacitation allow for individual and family adaptation to changes at a slower pace (Rolland, 1994).

Rolland (1994) noted one more important form of disability—that arising from social stigma. Whether an illness results in stigma due to facial or bodily disfigurement, such as severe burns, or stigma due to its association with a marginalized group, such as AIDS and individuals who are homosexual or intravenous drug users, stigma can be experienced as a huge handicap for those affected (Rolland, 1994). Even though AIDS does not carry the immediate death sentence that it once did, individuals aging with HIV/AIDS now worry about where they will live when they can no longer care for themselves (as we will discuss in later chapters).

Assessment and Intervention

Assessing and intervening with older adults experiencing transitions involves sophisticated and highly nuanced skills. The process involves digging deeper than the surface level of assessment and intervention. Assessment and intervention are related and are difficult to separate; for instance, by asking questions in assessment, the nurse or other professional is actually also intervening (Wright & Leahey, 2013). The following case study reveals the complexities of unraveling the complications stemming from transitions in an older adult’s life.

Case Example

John is a 75-year-old man who was admitted to a mental health unit in a hospital in Houston, Texas. John has been diagnosed
with depression and suicidal ideation. There have been several events that are related to his depression. First, John retired seven years ago. He loved his work and did not want to retire, but felt that he needed to look after his wife who was deteriorating with Alzheimer’s disease. Second, John’s wife Susan died six months ago. From the time he retired until the death of his wife, he spent most of his time caring for her. Initially, John’s wife lived within their home. He stoically tried to keep her at home, but after several years caregiving, he needed to place her in a long-term care facility, for the following reasons: Not only was Susan voiding in the living room, she no longer recognized John. She also would leave the home when John was asleep and wander. Once, Susan was found wandering on a busy street, only scantily clad, in the dead of winter. John was frantic with worry. His physician was concerned: John’s blood pressure was high, and now he needed medications to calm his frazzled nerves and to sleep. But when Susan entered a facility, John’s caregiving did not stop. He would come daily to feed his wife. Even though he was not concerned about the care given at the facility, he felt that he could spend more time coaxing her to eat. In the years of caregiving for Susan, John lost most of his friends and social contacts. Initially, friends tried to keep in contact with John, but at times he would turn down their invitations because he was too tired. Also, John sensed that his friends really did not understand. They told him that he should “get on with his life,” but John did not feel this was possible. He felt compelled to help Susan even when she did not recognize him or acknowledge his help.

The past six months after the death of Susan were a blur. John felt intense loneliness and lack of purpose. He did not know how to rekindle his prior friendships. John spent his days medicating his grief, loneliness, and boredom with alcohol. While the numbness was not particularly pleasant, John felt it was much better than feeling his pain. As a result of his pain and his attempts to deal with it, John began to become very depressed and even suicidal.

When on the mental health unit, the nurses and social worker began to work with John to examine the triggers of his depression. They agreed with John that the years of caregiving for Susan resulted
in deep physical exhaustion that contributed to his depression. They also noted that John lost his sense of identity when he gave up his work and only seemed to recapture a sense of identity and purpose in life when he devoted himself wholeheartedly to Susan. After about one week on the unit, John began to develop trust in the staff, and made connections between his past experiences and his current depression. John told nursing and social work staff about the impact of the death of his mother when he was in his early fifties. John was temporarily working halfway across the country when his father phoned him to tell him that that his mother was ill.

John’s father asked him to return, but he chose not to when his father stated that the illness did not appear to be too serious. John acknowledged that the unresolved grief and guilt of this situation has haunted him since, as his mother passed without him coming home. Also, John admitted that about a year after the death of his mother, he had a brief affair. Although he confessed this to Susan and they worked to rebuild their marriage and trust, John could never quite forgive himself. And, of great concern to him, his relationship with his son and daughter was strained, in part due to their knowledge of the affair, and in part due to misunderstandings caused by the stress of caregiving for Susan.

John’s situation illustrates some of the concepts described within this chapter. Retirement, the loss of a spouse, social isolation, and loneliness can lead to profound loss, depression, and suicidal ideation in an older adult. Self-medicating with alcohol can exacerbate depression. Further, from a life course perspective, events from the past can have an acute impact on how older adults experience current transitions, even if they are not aware of the connections between the past and present. And, as will be explained shortly, some older adults have a significant need for forgiveness, from themselves, from others, and/or from God (Enright, 1996).

Assessment

Assessment of transitions, such as the death of a spouse, as well as depression related to that transition, necessitates a multifaceted approach. This
approach entails examining the past, insofar as it relates to the present, as well as examining the present and possible future scenarios.

In working with John, nursing staff and the social worker examined past and current triggers of the depression and suicidal ideation. Through the questions asked of John, the professionals were able to ascertain that relatively current stressors included the exhaustion of caregiving and the death of his wife. In posing questions about his past experiences with grief, they found out that John had unresolved issues of grief and guilt related to his mother’s death many years prior, as well related to the affair he had shortly after the death of his mother. By gently asking John whether these experiences contributed to his current experiences of grief, John was able to make the connection between past grief (“ghosts of the past”) and his current grief. In essence, nurses and professionals were connecting the unresolved issues of John’s past encounters with transitions to his present stressful experiences (Krause, 2007). This insight facilitated John’s understanding of why he was unable to accept the advice of friends and family in getting additional help to care for Susan. It might also help John to connect past transitions with ones he will face in the future, assisting him in making healthy choices. With knowledge of the risk of suicide among older adults (Canadian Coalition for Seniors’ Mental Health, 2009), professionals continually assessed John’s level of depression and suicidal risk. This not only provided the staff a gauge with which to determine his progress, but also may have helped John understand the importance of self-monitoring when he returned home. Staff were also aware that examining past issues can be traumatic in and of itself, so they were cognizant to check in regularly with him to assess John’s level of depression and suicidal ideation.

Understanding the importance of examining the reciprocal nature of the influence of the illness upon John and his ability to influence illness (Wright & Leahey, 2013; Wright, Watson, & Bell, 1996), nursing staff asked John to describe how depression has impinged upon his life. As a follow-up question, they asked him if there were things he did that influenced the impact of depression upon his life. For instance, on days where he had appointments or had to help a neighbor, did his feelings of depression lessen?

Professional staff on the mental health unit purposefully posed this question. They were aware that what John believes about the illness, including his ability to exert influence upon its impact in his life, carries significant weight in how he thinks and responds to the depression (Wright, Watson, & Bell, 1996).

While some nursing staff on the unit became frustrated by John’s complaints of physical pain, others were particularly astute in listening
for covert messages in John’s conversation. For example, when John complained about a headache or back pain, they wondered if he was saying, “My head hurts, but I also hurt inside.” Some of the nurses were aware that older adults may have more difficulty in admitting to mental distress.

Growing up in an era where emotional problems were not spoken of and where individuals were expected to “put up and shut up” about internal pain, many older adults incorporated a deep-seated belief that mental illness is shameful. Even though the stigma attached to mental illness has lessened somewhat in the twenty-first century, at the core of their being, many aging adults are unwilling to admit to mental distress (Connor et al., 2010). A number of the nurses on John’s ward were not aware, however, that physical distress and pain can be linked to depression as the same neurotransmitters involved in mood (serotonin and norepinepherine) are also believed to be involved in pain (Marks et al., 2009).

The professionals on the mental health unit also explored John’s support system (Wright & Leahey, 2013). Specifically, who did he have for support, both professional and family/friend/neighbor support? Who could he access for help on a regular basis and what kind of aid would that entail? The staff also explored John’s beliefs about accepting help: Does accepting help from others indicate weakness or an inability to cope? Further, what are his coping methods and which methods were effective and which are not? Staff explored previous coping methods—besides drinking alcohol—to see if he had utilized healthy coping mechanisms in the past and could return to some of these. They also probed about John’s past experiences with illness to understand how he might respond to depression in the future.

As John’s depression started to lift and his suicidal ideation dissipated, staff assessed John’s level of awareness regarding depression. Not only did this entail asking about his knowledge about the illness and medications, but also how he would be able to monitor himself in the future. Specifically, staff asked John how he would know when he was starting to become depressed again. What would he be feeling, doing, and thinking? They also asked who he would turn to if he noticed he was thinking, feeling, and behaving in ways that indicated his depression was back and worsening.

A key part of assessment also involved asking John about what gives him hope and meaning in life (Duggleby et al., 2012). This ties into the existential issues that some older adults face. Nurses asked John about what has given him hope in the past and what now gives him hope. The psychologist even asked John if positive meaning has come from the illness and death of Susan (Kim, Kjervik, Belyea, & Choi, 2011). They assessed
what he can do activity-wise that will foster hope and a sense of purpose and meaning. They asked if John has engaged in volunteer work in the past and if this would give him structure and meaning in his life.

An important aspect of finding hope and meaning, as well as self-acceptance entails self-forgiveness (Ingersoll-Dayton & Krause, 2005). John was finding it difficult to forgive himself for not being present for his mother at her death and for having an affair about a year after the death of his mother. Unfortunately, as is often the case, professionals on the unit felt uncomfortable dealing with the spiritual issues and tried to avoid talking about forgiveness (Ramsay, 2008). What staff did not realize is that for some older adults, particularly those who espouse religious faith, emotional health and spiritual health are inextricably tied (Ramsay, 2008). Nursing staff, as well as John, were also unaware of the potential connection between John's unexpressed feelings of guilt and grief over missing the passing of his mother and the extramarital affair one year later. They did not realize that in the process of “shutting down” the grief and guilt felt over not being present for his mother's passing, John also emotionally shut down to others, such as his wife. This created a context within which he considered and engaged in a brief affair, when previously this kind of behavior was unthinkable to him (McGoldrick, 1993).

Interventions

As mentioned earlier, the very process of assessing through questioning is an intervention (Wright & Leahey, 2013). Questions are a powerful means to encourage older adults, such as John, to reflect upon their lives (Wright & Leahey, 2013), make connections between the past and present, and develop insight (McGoldrick, 1993). Insight allows older adults to make different choices about how they face future transitions and losses.

When John started to feel better and have increased concentration, staff took the opportunity to provide teaching on depression, medications, and the potential of relapse. To increase the likelihood that he could respond differently to future transitions, John needed to understand what depression is, how it can be treated, and how he can decrease the chances of ending up in hospital for depression in the future.

Although nursing and medical staff did not feel comfortable addressing John's spiritual issues, they referred him to the hospital chaplain. This chaplain, who was particularly astute at understanding the importance of self-forgiveness for physical, emotional, and spiritual health, worked
with John to help him address this area. She understood that for some older adults, it is easier to grasp the concept of God’s forgiveness, or the forgiveness of others, than self-forgiveness. Also, she grasped the notion that self-forgiveness involves reconciling differences between real and ideal self-schemas (views of how older adults perceive themselves) (Ingersoll-Dayton & Krause, 2005).

In her assessment of John’s belief systems, the chaplain determined that John does not hold to a specific faith. Her practice was based upon the foundation that the needs of the client determine the intervention (Speck, 1998), and so she did not suggest that John seek solace from scriptures or seek God’s forgiveness for help with self-forgiveness. Rather, she walked John through a process that examined his ability to understand his past regrets within the context of unresolved grief about his mother’s death. Because John was not able to cognitively change his evaluation standards of himself, she focused on helping John to acknowledge this mistake and learn from it, as well as make reparations through a discussion with his son (Ingersoll-Dayton & Krause, 2005). She assisted John in recognizing that self-forgiveness does not mean condoning his previous behavior (Ramsay, 2008), but involves moving forward with new insight into the circumstances that resulted in his behavior and an honest acknowledgment of his efforts to live in a respectful manner toward others.

Although life review therapy was not offered by the occupational therapist on John’s unit, nursing and social work staff informally engaged John in some life review. Life review is believed to be an effective intervention for older adults with depression (Chippendale & Bear-Lehman, 2012). Specifically, they asked John to review aspects of his life of which he is particularly proud, not just his regrets. The staff members were attempting to help John re-story his life in a balanced way, acknowledging his positive contributions to his wife, family, and the community; the purpose was to help him integrate the pieces of his life into the whole of self.

If a life review therapy/narrative therapy intervention had been offered on the unit, the occupational therapist might have worked with John to ask him to write about specific periods of his life or to write about different life themes in the presence of the occupational therapist. The writing could have occurred in individual sessions or within group sessions (Korte, Bohlmeijer, Cappeliez, Smit, & Westerhof, 2012). When writing about negative events, the occupational therapist could have helped participants like John integrate negative experiences into their lives in a meaningful way.
He could have posed questions that helped participants construct alternate stories about their negative experiences, such as how they coped through such events, what they learned, and what good came out of their respective situations. Participants would have been asked to link these written observations to their identity as persons and to future goals. They would also have been asked to write about positive memories; these memories might have been forgotten or subsumed under negative memories (Korte et al., 2012).

Nursing and other professional staff, such as the recreational therapist, engaged John in activities. Not only did this allow the recreational therapist to assess John’s level of concentration and to assess how he interacted with others, but also to reintroduce John to the meaning and enjoyment of structured activities. As part of recreational therapy, John may have learned the importance and enjoyment of engaging in activities or hobbies, with the hope that those learnings would be transferred to John’s home life.

Related to the importance of structured activities, nursing, social work, and recreational therapy staff suggested that John consider volunteer work. They mentioned to John that the importance of volunteer work goes far beyond providing structure and some social contact in his life. Older adults who are active in volunteer work experience self-reported better physical health (Lum & Lightfoot, 2005) and lower levels of depression (Musick & Wilson, 2003). Volunteer work is also associated with lower mortality rates for some older adults (Musick, Herzog, & House, 1999). Some older adults who volunteer even report benefits for their family members; namely, family members are less worried about them and also, family members benefit from the knowledge about information and resources that their older members gain (Morrow-Howell, Hong, & Tang, 2009). Further, an important aspect of volunteer work is that it can foster a sense of meaning and purpose in life and continued growth (Choi & Landeros, 2011).

Meaning and purpose is integral to personhood. Staff specifically suggested that John consider work that is meaningful to him, perhaps work that is related to social causes or areas of personal or professional strength. Ideally, this work would also link to his personal values or spiritual beliefs. In this way, his actions for the good of others would be congruent with, and indeed, an expression of, his beliefs and values (Choi & Landeros, 2011). The sense of “giving back”—with his new understanding of his real and ideal self—could also aid him in forgiving himself for incidents in his life that he had previously tried to forget. Volunteer work could be a
form of empowerment that counteracts the losses he has experienced, as well as the loss of control he may be feeling in other avenues in life (Tang, Copeland, & Wexler, 2012).

Observing his enjoyment of reading, staff also proposed John consider educational pursuits as part of his need for continued growth (Choi & Landeros, 2011) and self-achievement (Cha, Seo, & Sok, 2012). Older adults may take courses, such as university classes or classes focused on activities such as dancing or exercise. Although educational pursuits may result in less significant benefits than volunteer opportunities, in one study, older adults still rated class-taking as valuable (Morrow-Howell, Kinnevy, & Mann, 1999). Presumably, how John chooses to express his sense of personhood—educational versus volunteer pursuits—will be based in part upon what he values and what opportunities are available in his community.

Toward the end of John’s time on the unit, his psychiatrist suggested that John and his family members have a meeting with his nurse or the social worker on the unit. This was in part to assess family dynamics, including how John’s son and daughter relate to him and each other. The professional would also be able to provide teaching about mental illness and supports that could be put into place to help John. However, the purpose of the meeting was also to examine how John and his children wanted their relationship to proceed. John has regretted the strained relationship and expressed the desire to explore with his children if they could resume some contact and what this contact would entail.

### SUMMARY

Physical and mental health problems in advancing years may be considered a life transition, due to the multiplicity of changes that occur and the fact that the illness transition may cause other transitions, such as retirement or changes in living environments. Health and human service professionals who assess and intervene with older individuals need to consider not only these transitions, but also how these older clients have weathered previous transitions and the impact of these experiences on current transitions. Further, understanding that illness trajectories differ according to the progressive nature of an illness, or the eventuality of acute flare-ups within a progressive disease course, will help professionals recognize the enormous burden faced by older adults and their family members.
CRITICAL THINKING EXERCISES

▶ Think about an older adult you know, perhaps a grandparent, who has experienced the transition of a significant illness. How has that individual coped with the illness? What does he or she find most difficult and what strategies has the individual used to address the changes imposed by the illness? What kind of assistance has this individual found most helpful (from professionals and family or friends)?

▶ Reflecting again on the older adult that you know, how has he or she “made sense” of the illness transition? How does this individual express personhood, despite possible limitations of the illness?

INTERESTING WEBSITES

▶ Alzheimer’s Association: http://www.alz.org/
▶ Alzheimer Society of Canada: http://www.alzheimer.ca/en
▶ Canadian Coalition for Seniors’ Mental Health: http://www.ccsmh.ca/en/
▶ Heart and Stroke Foundation: http://www.heartandstroke.com/
▶ Substance Abuse and Mental Health Services Administration: http://www.samhsa.gov/

REFERENCES


