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Gender Differences Among Older Heroin Users

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Abstract

Objectives—This purpose of this study was to explore the following question: Are there gender differences among older individuals with a history of heroin addiction with regard to social and family relationships and health problems?

Methods—Eight gender-specific focus groups were conducted with 38 (19 women, 19 men) older (50+ years) individuals with long-term histories of heroin dependence. Four groups were conducted in a methadone maintenance (MM) clinic and four groups were derived from the Los Angeles community.

Results—Modest gender differences were observed, but mainly in the focus-group dynamics. Women typically described the impact of their addiction on their families, while men typically described their surprise at still being alive. Hepatitis C was the primary health concern in all groups; mental health issues were also discussed.

Discussion—Remarkable gender differences were not apparent in the qualitative experiences of these participants. Instead, we found overriding similarities related to the interactive effects of drug use and aging. Longitudinal studies of this population as they age and interact with the health-care system and other social systems will help to untangle the complicated relationship between aging, drug addiction, gender, and health.

Keywords

heroin; aging; gender; focus groups

INTRODUCTION

The Aging Population and Substance Abuse Treatment Services

Baby boomers who will be reaching their later years by 2020–2030 will place great demand on the health-services system (Gfroerer, Penne, Pemberton, & Folsom, 2003; Knickman & Snell, 2002; Payne, Laporte, Deber, Coyte 2007). It has been predicted that chronic disorders among this population, including substance abuse and mental illness, will confront providers at an unprecedented, possibly even crisis, level. For example, the number of people using any

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illicit drug is projected to increase from 1.6 million to 3.5 million by the year 2020 (Colliver, Compton, Gfroerer, & Condon, 2006). Yet relatively little is known about the health experiences and treatment needs of this aging population of substance users (Crome & Crome, 2005), and treatment capacity to meet the needs of this aging population is severely limited (Koenig, George, & Schneider, 1994; Patterson & Jeste, 1999).

Older Heroin Addicts

In an effort to enhance the knowledge base about aging individuals with addiction histories, this paper describes a qualitative study of older female and male heroin addicts. Although heroin users are a subculture within a drug-using subculture (i.e., the “marginal among the marginal,” Anderson & Levy, 2003), they provide an interesting window into the issues that aging substance abusers are likely to introduce into the health-care system, whether they access services through primary care, substance abuse treatment, mental health treatment, or some combination of these venues. Chances are strong that even an addict who has never been in drug treatment will eventually come into contact with primary care or mental health treatment and will thereby receive some type of treatment that will impact the sequelae of a lifetime of drug use. Accordingly, a deeper understanding of aging heroin abusers, including those who are still using and those who have ceased use, will help in developing approaches that are more sensitive to the unique set of needs that these individuals will likely present to health-care institutions.

Although numerically small (estimates are approximately 600,000 heroin users in the past year), heroin users have been the subject of some of the landmark studies on the longitudinal course of addiction. Most of these studies have found that a significant proportion (approximately 30%) of heroin users continue to use heroin even into old age, i.e., that heroin dependence is a chronic condition, typically marked by periods of abstinence (often incarceration related), periods of use, and accompanying severe health and social consequences (Goldstein & Herrera, 1995; Hser, Hoffman, Grella, & Anglin, 2001; Levy & Anderson, 2005). Paralleling this group of chronic users identified from longitudinal studies of treatment-based cohorts are individuals who abstain from heroin use, typically due to some combination of motivation, treatment, religion, and/or family (Flynn, Joe, Broome, Simpson, & Brown, 2003). Chronic heroin users do not, for the most part, appear to “mature out” of addiction, but, rather, are motivated by a combination of life experiences to either continue using or cease using (Hser, 2007; Termorshuizen, Krol, Prins, & van Ameijden, 2005).

Gender Differences in Addiction Careers Among Heroin Addicts

Despite the growing literature on the chronic nature of heroin addiction, we know relatively little about gender differences in the long-term course of heroin use, treatment, and recovery. Several studies have shown that interpersonal relationships may have contradictory effects for women who are addicts; they can be a source of support, but they can also contribute to ongoing problems and possibly relapse (Grella, Scott, & Foss, 2005; Walitzer & Dearing, 2006). Moreover, women with substance use problems are less likely than men to enter treatment over the lifetime (Greenfield et al., 2007), and men are more likely to be coerced into treatment by external mandates (Grella, Scott, Foss, & Dennis, 2008). Women drug users may also be isolated from other sources of social support by their partners, particularly if they have a history of intimate-partner violence (El-Bassel, Gilbert, Rajah, Folen, & Frye, 2001).

Such gender differences may continue, and even intensify, as addicts age. For example, aging women may face different barriers and facilitators to entering treatment than younger women (Koenig & Crisp, 2008); when younger, their roles as mothers may have impeded their treatment-seeking, while issues around mobility and age-related health problems may be more prominent when older. As aging men and women with addiction histories interact with the

health-services system (Patterson & Jeste, 1999), more needs to be known about potential gender differences in the course of addiction, including patterns of health-services utilization, treatment participation, and recovery.

One way to explore gender differences in addiction and recovery is through narrative, one of the key processes by which people maintain and reconfigure their senses of self, i.e., their identities (Hanninen & Koski-Jannes, 1999; Stetten, 1997), and one of the key arenas for elucidation of gendered ways of experiencing the world (Gilligan, 1982). This paper explores potential gender differences in focus-group accounts of male and female older (aged 50+) recovering and nonrecovering heroin addicts in regard to the following question: Are there gender differences among individuals with a history of heroin addiction with regard to social and family relationships and health problems?

METHODS

Procedures

As part of a long-term follow-up study of gender differences among older individuals with a history of heroin addiction (i.e., dependence), eight gender-specific focus groups were conducted with 38 (19 men, 19 women) older (aged 50+) heroin addicts. All procedures were approved by the UCLA Institutional Review Board. Four focus groups (two all-male, two all-female) were conducted in a methadone maintenance clinic that is associated with UCLA. The clinic director organized the focus groups to provide the research team with male and female groups of “stable” (i.e., not using heroin in his clinical opinion), and “unstable” (i.e., still using heroin in his clinical opinion) clients. All of these clients were currently on methadone maintenance. In order to obtain the community-based sample of older heroin addicts who were not currently in methadone maintenance treatment (MMT), advertisements were placed in free local newspapers, and flyers were posted throughout the community (e.g., in facilities known to host Narcotics Anonymous meetings, community health-care clinics) and interested persons called the toll-free number on the flyer. Callers were screened by a member of the research team, who asked a short series of questions about how long the individual had used heroin and if s/he was currently using heroin or currently abstinent or on methadone maintenance. Four focus groups (two all-male, two all-female) took place at the UCLA research office. Because of the nature of this mixed recruitment process, individuals knew one another in the focus groups that were conducted at the MMT clinic, whereas participants in the focus groups conducted at UCLA with individuals who were not currently in treatment, for the most part, were unfamiliar with each other.

After informed consent was obtained, participants completed a brief, anonymous background survey. The semistructured interview, which was used for all of the focus groups, covered the following topics: overall effects of heroin; influences on cessation, relapse, or continuation of use; turning points in use; effects of heroin use on family; effects of heroin use on physical and mental health; effects of criminal justice involvement on cessation/relapse/continuation; effects of treatment on cessation/relapse/continuation; and potential triggers for relapse, if any. Although the questions were not asked in the same order in each focus group, all questions were asked in all groups. Seven of the eight groups were conducted by the lead author, an experienced moderator. Focus-group assistants recorded field notes particularly on nonverbal aspects of the groups. All focus groups were digitally recorded and professionally transcribed. A light meal was provided at each group, and participants in the MMT focus groups were paid \$50 in gift cards, and those in the community-referral groups were paid the same amount in cash.

Sample

All participants had a history of heroin dependence and were aged 50 or older: 63% ($n = 24$) were 50–55; 16% ($n = 6$) were 56–60; 21% ($n = 8$) were 61 or older. Over half of the sample (55%) was African American, 29% were White, 7% were Hispanic, and 9% were Other. Forty percent had less than a high school diploma, 13% had a high school degree or equivalent, and 47% had some college or a college degree. About one quarter (26%) were currently employed and over half (58%) relied on some form of public assistance. Almost one third (32%) were currently married. Of participants with children, 82% reported that they were in contact with their children.

Almost half (47%) of the participants reported 1 to 5 years of abstinence from heroin, 44% reported 6–20 years, and 8% reported less than 1 year. More than half (55%) reported use of illegal substances in the past year, and about one third (34%) reported use of alcohol in the past year. Of those currently in MMT, 16% had been in treatment for less than 1 year; 40%, 1–5 years; 21%, 6–10 years, 18%, 11–20 years, and 5%, 21 or more years.

Data Analysis

Transcripts were reviewed and edited alongside the audiotapes by the lead author. The transcripts were then analyzed using the constant comparative method of data analysis (Boeije, 2002; Strauss, 1987) within ATLAS.ti, a qualitative data analysis software program that allows for fluid interaction of data across types and sources. Themes were identified across focus groups, and codes were developed accordingly, though particular attention was paid to group differences. After coding the interviews, multiple queries were conducted in order to examine the relationships between the themes, and the codebook was adjusted accordingly in order to achieve axial coding (whereby categories are linked together). These queries were facilitated both through Boolean searches and through network diagrams that allow for the visual depiction of connections between coded segments of text.

RESULTS

Findings are discussed in two areas: (a) the dynamics of the focus groups themselves, which were observed to be highly gendered; and (b) the content of the focus groups regarding the areas of interest: social and family relationships and health issues.

Focus Group Dynamics

We briefly describe the focus-group dynamics (see, e.g., Hollander, 2004) because these dynamics were, in and of themselves, typically very gendered (see, e.g., Weatherall, 2000). The moderator and focus-group assistants observed that the women's and men's interactional styles within the groups differed, with the women often “sharing” with one another and the men often “proving themselves” to one another or focusing only on the moderator and not orienting toward each other. All of the men's groups discussed their perceptions regarding the superior quality of heroin when they were first using as compared with the present, as if to demonstrate and compare their knowledge of the quality. None of the women's groups discussed this issue. In three of the four women's focus groups, some women literally showed one another their scars and track marks. The men did not engage in this bodily display. Men in the UCLA “stable” group (i.e., not currently using) discussed their early use while they were soldiers in Vietnam, whereas none of the women had in common the experience of drug use during wartime.

Each focus group was unique, despite the same interview questions. Participants, though guided by questions, were encouraged to speak about their experiences extemporaneously. This resulted in several variations. For example, in the UCLA “stable” women's group, each

woman took a turn (despite the efforts of the moderator to foster conversation) and told her story for approximately 30 minutes, with little interruption, and at the end, participants reflected that the focus group was like a “really good [12-step] meeting.” In the UCLA “unstable” women's group, participants argued about whether one is always an addict, even with years of sobriety; this argument was prompted by one woman saying, “We're all, I mean, we're all addicts. Okay, and you can deny it. You could say, ‘Well, I'm beyond that now.’ I wish. We're all just one fix away.” Toward the end of the focus group, they were giving each other referrals to good treatment programs, and several participants exchanged contact information. In the MMT clinic “unstable” men's group, participants glorified their early days of drug use and reflected at length on the poor quality of drugs on the street now and what they perceived to be recent changes in drug policies and laws, e.g. the three-strikes law and increased sentences for drug-related crimes. Several men in the MMT “stable” group talked about still using. (The limitations of the composition of the focus groups will be addressed below.)

Themes Across the Focus Groups

Below we discuss several areas of potential gender differences (as well as similarities) on current issues and challenges that aging heroin addicts face with regard to social and familial relationships and health issues.

Reflections on the effects of addiction on relationships—Most focus-group participants reflected at length on the role that their addictions played in their relationships, both social and familial. Many expressed regrets and remorse about the effect of their addiction on their loved ones. For example, in regard to family, one woman said, “I'm hurt by a lot of things my addiction took me through that I put on my children by not being the mother I should have been.”

While both men and women were reflective about the impact of heroin on their lives, women were particularly expressive about the impact on their families: “Heroin is not my desire and I have no desire for it anymore because it's taken so much from me and it was up to me to decide, what do I want? I want to be in my family's life.” Similarly, another said, “I've been a heroin user for 22 years. It's the worst thing that ever happened to me in my life. I almost lost my family. My family is my world, and they stuck by me through my addiction. And they are the cause of me being sober. I've been clean for 5 years now.” Another woman said she had to “clean up” for her mother's funeral, but she wondered why she could not do so for herself: “Why can't I do that for me? Why can't I love myself that much for me? . . . I did that for other people, look good for my own momma's funeral. But I can't do it for [me].” In regard to focus group dynamics, as mentioned above, it is interesting to note that following statements like this, the other women in the groups offered many words of sympathy and support, and in some cases physically embraced the woman who was speaking if she seemed particularly upset.

Women participants discussed losing their children to other family members when they were young mothers, but not typically to the child welfare system, which was not prevalent at that time: “But see like back in the day, you could [have your child] and nobody tested your kids. They just, you know, pulled the little sucker out of you, wrapped it up, and sent you home with your baby. But now, they're testing them.” While most women had children, some did not, and these women often attributed this to their addiction: “I never married. I never had children. I didn't have the courage. I thought, I'm too fucked up.” Many women noted that, in the peak of their addictions, heroin was more important than anything or anyone else in their lives. For example, one said, “It's everything—your friend, your lover, your husband, your wife.” Several women noted with remorse that they did not raise their children:

I was always in jail, or in the street. I was never with [my kids] . . . I was never there for my daughter when she was having a baby, or if she was sick, or whatever. I was

never there to support her . . . You know, when you can't take care of your kids, you be so ashamed. You can't be normal. Like you only be normal for what, a couple of hours? Then you have to go back out again and do the same thing.

Another woman also indicated how incarceration compounds the distance that many women had from their children: "I shot dope for 31 years. That's a long time, really nothing to brag about, and then nothing to brag about going to prison. And nobody can never give me those 5 years. I left two beautiful kids. I did 5 years and I seen my kids four times. That was on my choice. See, when my kids come to see me it just did something to me, and I, I, I couldn't take it, so I didn't see them."

Remarkably, several women were in long-term relationships with their partners, with whom they had used for many years. They described positive and stable lives with their partners: "So, this last time we came both out [of prison] and we got in the program, and me and him—it's been smooth, like velvet." [Did he come to (this methadone clinic), too?] "Oh yeah! We're both clean, so there's no excuse for me to use. We both clean, we both visit the grandbabies. We love our grandbabies. We've been together for 28 years." So, their mutual recovery from heroin use served as a bond to maintain their relationship. However, for others, partners and families did not serve as sources of support. As one female participant noted, "Family can be your worst enemy." Some women's families had "turned against them" as a result of their addiction, and some women's partners continued to use heroin and/or other drugs.

In contrast, when asked about their relationships, male participants typically expressed surprise that they were even alive, as most noted that their friends and family members had died or were incarcerated. These losses had taken a toll on the men's relationships. However, some of the men who were in MMT pointed out that the treatment had allowed them to restore family relationships. One man said that because he was stabilized in MMT, he was able to care for his mother in her last few years of life: "Luckily I was good and I was able to be with her for the last couple of years of her life and that was part of the way that brought me to methadone house, because I got on methadone when I got out [of prison]. I could spend more time at the house and taking care of her than going out in the street and doing what I had to do out in the street, doing my thing." Another man had "repaired" many family relationships, but was still working on his relationship with his son: "My son? I haven't been able to repair that [relationship] yet. But, I'm still alive and so is he, so who knows what's gonna happen?"

Both male and female participants described how their children or other family members had motivated them to stop using heroin. One woman who was still using said that her children never held her addiction against her; she talked about wanting to change for them: "But now they're older and I'm older too, and my health is good. But I have some beautiful kids, you know, that really care a lot about me. So, I got to change, and I am going to change. This time being on this [methadone maintenance] program, it really helped me." Similarly, another woman who was still using said, "[Methadone]'s helping me and my daughter get along now, because you can bet she ain't gonna knock on my door, as long as she knows I'm shooting that dope."

In contrast to the women, only male participants talked about fear of incarceration as a main motivator in getting or staying clean. For example, one said, "Either I am going to die or I am going to end up in prison, or in the hospital, you know what I mean, so I don't want to do that. I want a better life now, you know what I mean? And, and, it's hard, it's very hard. I see my friends, my peers, here that are also trying, and them encouraging me to continue going because I know that I am not alone." Male participants in three of the focus groups noted that fear of incarceration was an impediment to using heroin again, whereas no female participants mentioned this impediment, despite a similar history of incarceration.

Health issues—Hepatitis C was the main health issue raised in all of the focus groups, with participants placing particular emphasis on sharing information about identifying and treating hepatitis C. This discussion did not qualitatively differ between the men's and women's focus groups. Some participants noted that the regular blood draws were difficult because their veins were difficult to access after years of using heroin.

Issues related to mental health were also raised in all of the focus groups, though they were not always identified in terms of “mental health.” Several women did talk specifically about depression as a consequence of addiction. For example, one participant said, “I wanted to say one of the long-term effects is depression—clinical depression—which I am on treatment for, for probably the last 4 years. I'm under treatment for being clinically depressed because of the lack of serotonin in your brain, and I find that a lot of my friends who, you know, we all did coke and stuff like that in the '80s, okay, have clinical depression. Some people go and get treated for it like myself and some don't.” She said that her antidepressant also helped with menopause: “I take Paxil as an antidepressant, which has helped me to get through . . . perimenopause, because I used to have flashes. I think a lack of control of your emotions and a lack of control of your monthly [menstrual cycle] from long-term drug abuse also happens to you.” Several women in the group indicated agreement with this participant's description of these addiction–health connections.

Although many of these older heroin addicts had faced significant loss of loved ones, which could contribute to their mental health problems, for some, their losses prompted them to stop using heroin. For example, one woman said, “Me and their father started using together. And why I stopped [using] you know, that really made me stop after, you know, he died, because that was the world he created for us. And when he left, I had no reason being in that world.” In one of the MMT focus groups, several women talked about quitting after losing loved ones: One had lost her son to addiction, another had lost her girlfriend, and another had lost several siblings to addiction. One male participant in another focus group watched his friend die and subsequently quit using: “After [his death] it kind of sealed my tomb. That day I just asked for relief and God gave it to me and I was able to step off. I stepped off and I haven't done drugs since. I haven't relapsed.” Another man said, “Out of drug use, I lost my baby sister, and my [younger] brother . . . behind drug use. That's the most profound effect it had in my family's life.” Similarly, another man had lost many family members: “I shot dope with my brother; you know? He died a heroin addict. My older brother was an alcoholic, and he died of alcoholism. My father was a drunk, and he died of that, and one of my sisters died about 4 years ago of an alcoholism-related illness.” So, the social isolation that often occurs as part of the aging process, wherein individuals inevitably face the loss of family and friends, is intensified for addicts whose primary social contacts are other substance users.

Health issues were particularly pertinent for the participants in the MMT groups. Participants expressed appreciation for the medication, but some continued to use other illicit drugs, and some complained vehemently about how the medication made them feel (e.g., sore joints). Some of those who complained (both men and women) expressed that they wished they could stop using the medication, but they were too concerned about withdrawal to stop.

Other health issues that participants specifically related to their long-term use of heroin included hypertension (discussed in four groups), dental problems (discussed in three groups), and arthritis (discussed in two groups). The following health issues came up in only one group each: asthma, “liver problems,” and difficulty sleeping.

DISCUSSION

These narratives of older male and female heroin addicts provide a window into some of the issues that this population experiences, seemingly across male and female genders. Not only was the content of the narratives illustrative of compelling issues, but the tone and style of the narratives and group interactions themselves were illustrative of gendered aspects of addiction and recovery. Whereas other studies have looked at the ways in which addicts formulate their narratives (McIntosh & McKeganey, 2000), few have noted specific gender differences. A notable exception is the work of Hanninen and Koski-Jannes (1999), which identified five core stories among those recovering from a range of addictive behaviors: the Alcoholics Anonymous (AA) story, the growth story, the codependence story, the love story, and the mastery story. The authors found gender differences among the stories, e.g., men told the AA story, whereas women told the growth story. Singer, Scott, Wilson, Easton, and Weeks (2001) found that drug users tell “war stories,” or highly stylized narratives of their street experiences. Similarly, Anderson and Levy (2003) found that older injectors were nostalgic for the “Old School” (i.e., their youthful days of addiction) and were unable to transcend their pasts or assimilate into nonusing or nonrecovering social groups. These findings are consistent with ours, particularly for the men who focused on the “glory days” of their drug use.

Also consistent with our findings are the early findings of Rosenbaum (1979), who suggested that women addicts feel guilt and remorse over neglecting their children. Women, more than men, in this study expressed guilt and remorse as they described the toll that their drug use and associated behaviors took on their children. However, for both men and women, a central theme in their narratives was the loss of loved ones. While experiences of loss are not unique to aging drug addicts, it is of particular concern in this population because it could trigger relapse or increased use (Roberts, 1999), as well as precipitate or worsen existing mental health problems (Kraaij & de Wilde, 2001). Some have noted the cumulative nature of loss that drug addicts often face in that they have lost numerous friends and loved ones specifically due to drug-related causes (Ross et al., 2005). Alternatively, as some participants discussed, loss served as the catalyst for quitting drug use. As such, loss can be seen in much the same way as family relationships for drug addicts: It is an often-conflicted terrain, which can be a source of further problems, and/or it can be a catalyst for change.

Two main findings emerged from the focus groups with regard to methadone treatment. First, many older heroin addicts (both male and female) on methadone still used other illicit drugs, and some of these individuals intensely disliked methadone but were too concerned about withdrawal to consider tapering off. Although methadone maintenance treatment is highly effective in reducing heroin use, criminal behavior, and associated high-risk behaviors (Ball & Ross, 1991), many individuals continue to use heroin, alcohol, and/or other drugs while in MMT. Other studies have shown that heroin addicts frequently switch between using, treatment, and abstinence, and often use other drugs while on MMT (Dobler-Mikola et al., 2005). Further study, particularly from the perspective of participants, is needed regarding what makes methadone an unsuccessful or even an undesirable treatment option for many opiate users (Fischer, Chin, Kuo, Krist, & Vlahov, 2002).

In regard to health issues, hepatitis C was the primary concern among the focus-group participants, as indicated by its prominence within the discussions and the participants' requests for basic information. (Participants who had received treatment for hepatitis C shared information with others.) Most expressed confusion and ignorance, rather than strong negative emotions, about having the disease. Clearly, both those at potential risk and health-care providers to this population need more information about all aspects of this disease (Backmund, Reimer, Meyer, Gerlach, & Zachoval; 2005).

CONCLUSION

In conclusion, we have limited evidence to support the existence of considerable gender differences in the experiences of aging heroin addicts. Instead, we found overriding similarities related to the interactive effects of drug use and aging and social relationships. It is important to note that our findings are inevitably limited in their scope by the specific characteristics of the study sample, their location, and point in time. Longitudinal studies of this population as they age and interact with the health-care system and other social systems will help to untangle the complicated relationships among aging, drug addiction, gender, and health.

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