Chapter 13
Older Adults

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Throughout the next century, social workers will be challenged to meet the needs of a burgeoning population moving into late life. The median age of the worldwide population is projected to increase from 26.6 years old to 37.3 years old by 2050 (Lutz, Sanderson, & Scherbov, 2008). These changes mean social workers will need to integrate an understanding of aging into their practice, so they can better serve a graying population.

The field of addiction services is no exception. Substance abuse providers will be treating an aging clientele in coming decades, and treatment providers are already taking note of aging among help seekers. Recent projections suggest that prevalence rates of substance use disorders among people over 50 will rise from an average of 2.8 million from 2002 to 2006 to 5.7 in 2020 (Han, Gfroerer, Colliver, & Penne, 2009), and the number of older adults needing substance abuse treatment will increase from 1.7 million (2000–2001) to 4.4 million in 2020 (Gfroerer, Penne, Pemberton, & Folsom, 2003). Shifts in the need for treatment are not simply about increasing numbers of older adults, but also, generational shifts in attitudes about alcohol and drugs; societal attitudes about substance use have changed over the last 50 years bringing increases in the prevalence of alcohol and drug use.

A complex relationship exists between health and substance use among older adults. These issues need to be considered when discussing substance use with clients, diagnosing substance use disorders, and in our understanding of substance use as a public health problem. Prescription medications are dispensed to older adults at

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very high rates, but use of multiple medications (even addictive ones) by older adults is not necessarily a problem. Alcohol consumption is not necessarily a sign of increased risk for older adults; moderate alcohol use can be a part of, and contribute to, healthy aging including lowering mortality (McCaul et al., 2010), improving cardiovascular health (Mukamal et al., 2006), and lowering risk of dementia (Mukamal et al., 2003) and disability (Karlamangla, Zhou, Reuben, Greendale, & Moore, 2006). Even illicit drugs, such as marijuana, are being used by older adults to alleviate pain (Jaret, 2010). Substance use among older adults exists along a continuum, and social workers need to think holistically and collaboratively about the role of addictive substances among older adults.

Addiction social workers must be mindful of the unique aspects of substance abuse among older adults, while recognizing commonalities with addictive behaviors at earlier points in the life course. This chapter explores the unique aspects of substance use, abuse, and dependence in older adults including the following areas: epidemiology, definitional issues, high-risk subgroups, etiology, assessment and screening, treatments, and generic approaches that social workers may use in practice settings.

Epidemiology of Substance Abuse in Older Adults

Epidemiologic studies suggest that on average, alcohol and drug use decline as people age (Moore et al., 2005). Older adults on average drink, smoke cigarettes, and use drugs at lower levels than their younger counterparts. Among individuals age 65 and older, 45% have used alcohol in the past 12-months, 14% have used tobacco, and 1% have used drugs (nonmedical) (Moore et al., 2009). Still, there is a great deal of variability among individuals with many maintaining substance use, or increasing over time (Brennan, Schutte, & Moos, 2010).

Currently, the vast majority of substance use by older adults involves alcohol and misuse of medications, although evidence suggests the use of other substances may increase in coming years (Blazer & Wu, 2009b). For instance, data on substance-related treatment admissions from 1995 and 2002 found more than a 100% increase in non-alcohol-related admissions among those over age 55 (Office of Applied Studies, 2005). Prescription drugs used by older adults include benzodiazepines, sedative-hypnotics, opioid analgesics, and stimulants. In part, the prevalence of prescription drug misuse may be a function of the fact that older adults have the highest rates of medication use (Kaufman, Kelly, Rosenberg, Anderson, & Mitchell, 2002). Although rare, illicit drugs such as cannabis, cocaine, heroin, and hallucinogens are other drugs used by older adults (Simoni-Wastila & Yang, 2006). Prevalence of DSM-IV (American Psychiatric Association (APA), 2000) substance abuse and dependence are lower among older adults than younger age groups. For men (age 65+), the 12-month prevalence rate of alcohol abuse is 2.38%, and for women, 0.36%. Alcohol dependence rates are lower, at less than 1% for both men and women. Rates of any drug abuse and drug dependence among individuals age 65 and older are 0.2% (Compton, Thomas, Stinson, & Grant, 2007).

Challenges to Classification

The use of diagnostic measures as a means of assessing the problem of drug and alcohol use among older adults has been criticized for a number of reasons. First, the applicability of DSM-IV diagnostic criteria in older adults has been questioned (Atkinson, 1990). Due to the biological aspects of aging, older adults are less likely to report physical dependency and tolerance to drugs and alcohol, and may therefore be less likely to meet DSM-IV criteria. Interrupted social and vocational roles or other consequences may be less likely to occur or less noticeable in old age. For many older adults, aging is associated with a winnowing of these roles (Moody, 2006, p. 21), through retirement or social isolation due to the mortality of age group peers.

Broadly stated, prescription medication issues can be seen ranging from inappropriate use (because of medications that cause over sedation), to misuse (taking extra medication above the prescribed dose), or abuse (the nonmedical use of a prescription drug). Inappropriate use (Beers, 1997) may represent a serious risk to the health of an older adult, even though the threshold for DSM-IV abuse or dependence is not met. Normal side effects of medication may seem like abuse even though the older adult is taking medication appropriately. Problematic drug use in older adults may arise during the course of medical care and represent a process where use drifts from serving as a solution to a problem to becoming the problem itself (Simoni-Wastila & Yang, 2006).

Similarly, changes in body composition and function in old age may lead to greater risk of use of alcohol and drugs, even at levels deemed safe for younger persons, making simple classifications of addiction difficult. This may be a challenge for clients who may not recognize that their normal drinking patterns at 40 may be problematic at 70. Older adults have lower lean body mass, which leads to higher blood alcohol levels even at the same alcohol dose (Vestal et al., 1977). Changes in liver functioning in old age lessen the ability of the body to metabolize drugs and alcohol (Durnas, Loi, & Cusack, 1990). In sum, alcohol, medication, and drug use may be a medical concern in the absence of the hallmarks of addiction.

To address the issue of risk among older drinkers, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (1995) has developed alcohol consumption guidelines for older adults which can be used to assess risk. These limits on drinking include no more than one drink per day, seven drinks per week, and no more than three drinks on any given occasion; guidelines for women are lower. Using this broader concept of drinking risk, rates of "at-risk" use are higher than rates of diagnoses. Blazer and Wu (2009a) identified at-risk drinking in 17% (men) and 11% (women) in a nationally representative sample of middle-aged and older adults. A longitudinal survey of adults maturing into their 70s and 80s found that 27.1% of women and 48.6% of men qualified as at-risk drinkers according to these guidelines (Moos, Schutte, Brennan, & Moos, 2009).

Because of these unique factors in drinking and substance abuse among older adults, specialists in this area have advocated for an even broader conceptualization of alcohol risk in this population (Moore et al., 1999). By including medical

and psychiatric comorbidity, medication use, and psychosocial functioning, it is possible to identify risk among drinkers who fall below criteria and/or consumption thresholds. It is important to remember that alcohol and drug use in older adults needs to be understood in the context of overall health and functioning.

Who is at Risk?

While definitions of risk vary, much is known about who can be considered the most vulnerable. In terms of alcohol, some of the main determinants of risk for older adults is a previous history of alcohol or other substance-related problems (Sacco, Bucholz, & Spitznagel, 2009), male gender (Grant et al., 2004), being divorced or never married (Karlamangla et al., 2006), having friends who approved of drinking, relying on substances to deal with stress, and those individuals with more financial resources (Moos, Schutte, Brennan, & Moos, 2010). The picture of who is at risk for prescription drug use is somewhat different. Overall, health problems, female gender, daily alcohol use, and older age are risk factors for problem medication use (Simoni-Wastila & Yang, 2006). The least is known about older adults who use illicit drugs. A study by Rosen, Smith and Reynolds (2008) of older adults in methadone maintenance found that individuals were mostly male and in late middle age (50–59), had mental health comorbidity (57%) and significant disability. Rivers et al. (2004) found that elders testing positive for cocaine in the emergency department were significantly younger, more likely to be male, and more likely to have a substance use disorder than those who did not test positive for cocaine.

Polysubstance comorbidity is common among older adults (Oslin, 2000). Nicotine and prescription medications are commonly used by older adult problem drinkers (Nakamura et al., 1990). In a study of older problem drinkers, Brennan, Moos, and Kim (1993) found that females were more likely to use psychoactive (e.g., tranquilizers) medications than their male counterparts. Severity of alcohol use is also associated with the likelihood of nonmedical use of prescription drugs (McCabe, Cranford, & Boyd, 2006).

Why Do Older Adults Use Substances?

To help older adults who may struggle with alcohol and drug use, it is important to understand factors that may contribute to use. Many of the causal factors at play in late life alcohol and substance use are the same ones present in early adulthood or even childhood. Genetic predisposition, at-risk personality features, physiologic vulnerability, and substance-related expectancies, which may promote problems with alcohol and drugs, remain important in later life. These risk factors may be amplified or suppressed based on contextual factors in older adulthood (Zucker, 1998, p. 5), and work in concert with create problems.

In combination with known risk factors from early life, the presence of stressful life events and limited coping among some older adults has been theorized as proximal risk factor for substance abuse (Finney & Moos, 1984). Similar to the transition to adulthood, the passage into late life entails new roles and stresses, including retirement, changes in health status, changes in income, potentially changes in mobility, and bereavement (Hunter & Gillen, 2006). Stress itself may not cause substance abuse problems, but may interact with individuals' vulnerabilities leading to alcohol or drug problems. For example, a history of alcohol related coping in earlier in life might lead to continued alcohol-related coping or a resumption of alcohol use in late life (Lemke, Brennan, Schutte, & Moos, 2007).

Assessment and Screening of Older adults

Late life context is also important in assessment and screening of older adults. When social workers assess older adults for addiction, the first challenge is to overcome stereotyped thinking about aging. If a clinician does not believe aging persons have the potential to exhibit a problem, he or she may not recognize the signs and symptoms of a substance use disorder and will not gather the information necessary to intervene. Research suggests that older adults are less likely to be screened for problem drinking (D'Amico, Paddock, Burnam, & Kung, 2005; Duru et al., 2010). In one study, 400 primary care physicians were provided with a list of symptoms related to problematic substance abuse by a hypothetical older female patient, only 1% considered the possibility of a substance abuse (National Center on Addiction and Substance Abuse, 1998).

Unfortunately, published data on rates of screening by social workers are nonexistent. Many social workers outside the field of addiction have indicated they either fail to consider, or feel uncomfortable asking about substance use. Given the vast majority of older adults with substance use disorders never seek formal addiction treatment, having a routine brief substance use assessment regardless of the agency context or setting is important.

Asking About Substance Use: General Considerations

Although there are some different ways of asking about substance use, some general issues apply. Discussions of alcohol and other substance use should occur in the context of an overall assessment. This is crucial for two reasons. First, older adults may be more likely to provide information about potentially stigmatizing behavior if they feel the social worker is interested in their overall well-being. Drug and alcohol use should be evaluated in light of older adults' biopsychosocial functioning. The social worker should bring up alcohol use in reference to the presenting problem and in a matter-of-fact manner. The technique of "Gentle Assumption" should

be considered (Shea, 1998, pp. 401–402). Using this approach, the person is asked about how much they drink under the assumption that they drink. Given the rarity of other drug use, this approach is more applicable for alcohol.

It is reasonable to start conversations about drinking, and then discuss medication use, and finally illicit substances. Rather than questioning the person's judgment (e.g., do you have a drinking or drug use problem?) about their use of substances, the focus should be on the facts of their use. The social worker should ask detailed questions medications (prescription and over-the-counter) under the assumption that this information is important, whether the older adults' use is a problem or not. During this discussion, questions about overuse and misuse can be included in a nonjudgmental way, akin to the "not knowing posture" popularized in Solution Focused Brief Psychotherapy (Anderson & Goolishian, 1992).

For instance, the person could be asked whether they sometimes take an extra pill to fall asleep or to cope with pain. The social worker can ask about potential signs of prescription misuse such as running out of medication early, and losing or borrowing medication. Frequently, older adults see multiple doctors, and may not be aware of the potential dangers of medication interactions. It is key for the conversation to be based on assessing overall health, and not separating "drug abusers" out from a population, because this approach is likely to stigmatize older adults, may engender defensiveness, and is inconsistent with the idea that alcohol or drug use can be problematic in the absence of abuse or dependence.

As practitioners, it is tempting to focus on telltale signs of alcohol or drug problems among older adults as is included in this chapter (see Table 13.1). Be aware that many signs of substance use in older adults can often be attributed to aging or other problems. Heavy alcohol use can cause severe memory problems such as Wernicke–Korsakoff Syndrome, short-term memory impairment due to insufficient Thiamine, but Alzheimer's type dementia is much more common in this population. Similarly, assessing for risk of falls is important in older adults, but only a limited number of older adults fall because of substance abuse. Social workers should conduct a complete assessment and consider overall biopsychosocial functioning.

Brief Screening Instruments

For social workers in nonaddiction settings, screening instruments are a convenient option for assessing level of risk due to alcohol and drugs, as they are less burdensome than obtaining a blood test or drug screen, and they can be administered without impinging on other agency demands. Some screening tools are adaptations of instruments created for younger cohorts, and others have been designed with older adults in mind. Unfortunately, there are no screening instruments for assessing prescription or illicit drug use designed for older adults. The use of biological screening (i.e., lab tests) has limited utility for social workers and can be problematic in older adults.

Table 13.1 Signs of potential alcohol or drug problems

Somatic	Psychological	Social
Sleep problems	Cognitive impairment/ memory loss/ disorientation	Family problems
Headaches	Unexplained persistent irritability	Financial problems
Frequent unexplained falls, bruises, or burns	Anxiety	Social isolation (including changes in social habits, withdrawal from social activities)
Poor nutrition or changes in eating habits	Depressed mood	Legal difficulties
Unexplained seizures		Neglecting responsibilities (e.g., to a plant, pet, or friend)
Slurred speech		Engaging in secretive behaviors
Tremor		
Shuffling gait		
Unexplained vomiting or gastrointestinal distress		
Complaints of blurred vision or dry mouth		
Unusual restlessness or agitation		
Unexplained pain or other somatic complaints		
Headaches		
Incontinence		
Blackouts/dizziness		
Poor hygiene		

Adapted from Blow (1998).

CAGE

The most recognizable screening test in substance abuse treatment is the CAGE questionnaire; the four-question acronym includes the following: (1) Have you ever felt that you should *C*ut down on your drinking? (2) Have people *A*nnoyed you by criticizing your drinking? (3) Have you ever felt bad or *G*uilty about your drinking? And (4) have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (*E*ye opener)? Two positive responses are considered a cutoff for alcoholism (O'Connell et al., 2004). The screening test can be administered through an interview or self-administered. The CAGE has been used clinically since the 1970s and has been studied extensively in adult populations. The CAGE does not distinguish between current and lifetime use, an especially difficult issue among the aging, who may have a history of problematic use without having a current problem. Furthermore, the CAGE questions offer brevity at the expense of a more thorough collection of data about such issues as consumption levels, consequences of use and functional deficits.

Michigan Alcohol Screening Test-Geriatric

Unlike the CAGE, the Michigan Alcohol Screening Test-Geriatric (MAST-G) (Blow et al., 1992) was developed for elderly populations as a modification of the MAST. The instrument contains 24 questions with yes/no responses. Five or more positive responses indicate problematic use. The measure encompasses five symptom domains: Loss and Loneliness, Relaxation, Dependence, Loss of Control with Drinking, and Rule Making. It is also administered in a short form, the Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G), which has ten questions, with two positive responses indicating a problem with alcohol. The MAST-G focuses more on potential stressors and behaviors relevant to alcohol use in late life, as opposed to the MAST, which directs questions toward family, vocational, and legal consequences of use. This screen has many of the advantages of the CAGE, such as ease of administration, low cost, and familiarity to substance abuse researchers and clinicians. It is also more specific than the CAGE in identifying problematic use. While useful as an indicator of lifetime problem use, it lacks information about frequency, quantity, and current problems important in research.

Alcohol Use Disorders Identification Test

The Alcohol Use Disorders Identification Test (AUDIT) was developed by the World Health Organization to assess for current alcohol problems in adult populations (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). Like the CAGE, the AUDIT was validated in adults to detect problematic or hazardous use (Beullens & Aertgeerts, 2004). The test consists of ten questions, pertaining to amount and frequency of use, alcohol dependency and the consequences of alcohol abuse. The screening test can be administered through an interview or self-administered. Each of the ten questions is scored on a four-point continuum with total scores ranging from 0 to 40. A score of above eight indicates problem drinking.

Intervention with Older Adults

Depending on the setting and the severity of problems indicated by screening tools, there is a continuum of treatment options available for older adults (see Table 13.2). Contrary to common perceptions of older substance users as stuck in permanent patterns of use, older adults have demonstrated treatment outcomes as good, or better, than those seen in younger groups (Brennan, Nichol, & Moos, 2003); however, few older adults have access to specialized services for the elderly. A national survey of substance abuse treatment programs found that only about 18% were specifically designed for older adults (Schultz, Arndt, & Liesveld, 2003). Rates of mental health utilization are lower among older adults than any other age group

Table 13.2 The continuum of older adult substance use[†]

Continuum of severity		Continuum of care	
Abuse/dependence	↑ Level of risk	*Specialized treatment approaches*	↑ Level of intensity
Tolerance and withdrawal		Medically monitored detoxification	
Unsuccessful attempts to cut down		Inpatient psychiatric care	
Decline in normal activities		Elder-specific inpatient rehabilitation	
Larger amounts and for longer period than intended		Elder-specific intensive outpatient rehabilitation	
Use in risky situations		Outpatient substance abuse treatment	
Legal problems		Alcoholics or narcotics anonymous	
Continued use despite social consequences		Case management	
Decline in personal functioning		*Care management models*	
Misuse		Case management	
Hoarding or excess medication use		Co-location of services in medical offices	
Use of medications for purposes other than indications		*Brief advice models*	
Alcohol/medication/illicit drug co-use		Physician advice	
At-risk use		Brief intervention	
Use in spite of health/mental health comorbidity		*Prevention models*	
Use in presence of potential medication interaction		Outreach/education initiatives	
Use of alcohol in excess of NIAAA guidelines		Substance abuse screening	

[†]Adapted from Center for Substance Abuse Treatment (1998). Substance abuse among older adults. (Treatment Improvement Protocol (TIP) Series, No. 26). Rockville, MD: Substance Abuse and Mental Health Services Administration

(Bartels et al., 2004). Stigma and shame surrounding substance use and related problems, geographical isolation, inability to pay, or difficulties with transportation are just some of the barriers to specialized treatment for older adults (Blow, 1998; Fortney, Booth, Blow, Bunn, & Cook, 1995). For these reasons, several interventions for prevention of and treatment for substance abuse have been created for implementation in nontraditional settings, such as emergency rooms, senior centers, and primary care offices (Schonfeld et al., 2009).

Screening, Brief Intervention, and Referral to Treatment

The majority of brief interventions in nontraditional settings have focused on alcohol and prescription medication misuse or abuse, and they vary in length from one to five sessions (Barry, 1999; Barry, Oslin, & Blow, 2001). Their purpose is to enhance motivation for change in nondependent drinkers, and connect more severe users with more intensive treatment programs (Blow & Barry, 2000). Most of these interventions use Motivational Interviewing (MI) (Miller & Rollnick, 2002), which encourages a client-centered, nonjudgmental approach to discussing substance use

and encouraging positive, healthy changes to the individual's life. MI aims to reduce ambivalence by assisting the client to identify in his or her own words the pros and cons perceived as relevant to making a change versus maintaining the status quo. For older adults, reasons for change often include maintaining independence, optimal health, and mental capacity (Blow & Barry, 2000). In addition, social workers should provide individualized feedback about how the quantity and frequency of the client's drinking or substance use behavior compares to norms in their age group. Finally, social workers providing brief interventions should also provide guidelines to healthy drinking for individuals in their age group: one or fewer drinks per day and no more than seven in 1 week, and even less for older women (National Institute on Alcohol Abuse and Alcoholism, 1995).

Like brief interventions, case and care management models (hereafter referred to as CMM) also take advantage of nontraditional settings to engage older adults in reducing their use or connecting them to treatments. Often offered in primary care settings or community agencies focused on senior health, CMM interventions take a systems approach, attempting to address the complexity of medical and psychiatric comorbidities common in this population (Blow, 1998), while also connecting isolated individuals to needed community resources. There have been a number of program evaluations focused on case management strategies with older adult problem drinkers, which supports the notion that case management is an important tool in working with this population (D'Agostino, Barry, Blow, & Podgorski, 2006). While some CMM have proven to be marginally more effective than traditional treatment, they may be better at engaging and maintaining older at-risk drinkers in treatment (Oslin et al., 2006). Another advantage of CMM is that substance use interventions are imbedded in a broad approach to addressing health, lessening stigma, and also working towards a likely common goal among older adults: overall better health (Blow, 1998). Because older adults may have medical or mental health comorbidities, efforts should be made to work with the individual's primary medical provider regardless of modality of intervention. This will help address some of the unique needs of older adults such as pain management.

Common Formats for Treating Older Adults

Like for other populations, formal substance abuse treatment for older adults is provided on a continuum of intensity depending on severity of need, ranging from detoxification to outpatient. Due to the unique issues facing older adults, it is recommended that older adults be provided the opportunity for both individual and group treatment, and that all treatment plans be individualized and flexible according to the specific needs of the client. Assuming there is no cognitive impairment, older adults must be able to exercise client choice and be actively involved in the treatment decisions. While group treatment is often the preferred method of providing substance abuse treatment and is often a cornerstone in reducing isolation and shame, the lack of elder specific treatment available in the community may actually enhance feelings of isolation and shame in group context if they do not easily relate

to the other group members or feel uncomfortable discussing their problems with a younger generation. Individual therapy provides a private and confidential forum for older adults to explore their unique issues, without these same risks.

Within the context of formal treatment, regardless of modality, there are numerous approaches to treatments. Two modalities have been explored specifically in the context of older adults: supportive therapy models (STM) and cognitive-behavioral treatments (CBT). STM represent a traditional treatment with age-specific modifications. These approaches arose out of concern about whether older adults could effectively engage in standard treatment (Kofoed, Tolson, Atkinson, & Toth, 1987). Specifically, there was concern that confrontational approaches were ill-suited and disrespectful to older adults, and the unique issues faced by older individuals including health conditions, depression comorbidity, and social isolation went unaddressed (Blow, 1998). Indeed, confronting "denial" in any individual about their drug or alcohol use has proven ineffective in helping individuals modify their behavior to be more healthy (Miller & Rollnick, 2002). STM were designed, therefore, to focus on developing a culture of support and successful coping for older adult substance abusers; supportive therapies concentrate on building social support, improving self-esteem, and taking a global approach to treatment planning through addressing multiple biopsychosocial arenas in the client's life.

CBT focus on identifying and altering sequences of thinking, feeling, and behaving that lead to problem drinking or drug use (Rotgers, 2003). CBT can be delivered individually or in group settings, and there is strong evidence for positive outcomes across populations and age groups (Morgenstern & McKay, 2007). In addition, evidence exists for the effectiveness of CBT with older adults (Dupree, Broskowski, & Schonfeld, 1984; Schonfeld et al., 2000), and the Substance Abuse and Mental Health Services Association (SAMHSA) published a CBT-based treatment manual specific to aging (Dupree & Schonfeld, 1996). The highly structured, didactic approach taken in CBT may be particularly helpful to older adults, because of the tendency to present with memory difficulties (Blow, 1998).

Self-Help Groups

Alcoholics or Narcotics Anonymous and their related groups can also be useful to older adults in reducing isolation, shame, and stigma. Specific meetings may be more or less suited to older adults given variation in the pace of meetings and the general focus of the group. Some experts have recommended traditional self-help groups be modified for older adults, such as slowing the pace of the meeting to reflect cognitive changes in aging, and devoting attention to handling losses and extending social support (Schonfeld & Dupree, 1997). Social workers should be aware of elder-friendly meetings in their geographic area and encourage their older adult clients to try more than one meeting, prior to deciding whether it is a good fit.

Overall Approach or Guiding Principles to Working with Older Adults

Regardless of treatment setting or modality, older adults must be viewed from a client-centered perspective where their wishes and needs are respected and addressed. Social workers working with older adults will find taking a holistic approach to intervention will provide the most ample opportunities for older adults to engage in the process. For example, inquire about individual values and how changing substance use will enhance those values. According to well-established approaches, potential for personal enhancement should include health, hobbies, social networks or relationships and financial stability (Blow & Barry, 2000, p. 118). As with any client, one should work to instill hope.

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