Alcohol Use Disorder in Women

Description/Etiology

Alcohol is a psychoactive substance with dependence-producing properties that has been used worldwide for centuries (WHO, 2015). Alcohol abuse is a pattern of drinking that is harmful to oneself or others. When problem drinking becomes severe, alcohol use disorder (AUD) may be diagnosed (Mesuda, 2014). AUD is an international public health problem affecting millions of persons. In 2015 in the United States an estimated 5.3 million women met the criteria for AUD; the incidence of AUD among women in developing countries is rising rapidly (National Institute on Alcohol Abuse and Alcoholism, 2017).

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was published in 2013, replacing the DSM-IV. The DSM-IV chapter “Substance-Related Disorders” included substance dependence, substance abuse, substance intoxication, and substance withdrawal, and then discussed specific substances (e.g., alcohol, amphetamines). The DSM-5 divides these disorders into two categories: substance use disorders (SUD) and substance-induced disorders (intoxication, withdrawal, and other substance/medication-induced mental disorders). It has removed the distinction between abuse and dependence and instead divides each disorder into mild, moderate, and severe subtypes. Drug craving has been added as a criterion for SUD, whereas “recurrent legal problems” has been removed. In the DSM-5 substance abuse is referred to as substance use disorder or SUD whereas in the research literature and clinical practice it is still commonly referred to as substance abuse, substance dependence, addiction, and, in the case of alcohol, alcoholism (American Psychiatric Association, 2013).

A clinical diagnosis of AUD using the DSM-5 requires that one exhibit a recurrent pattern of use within a 12-month period that adversely affects personal functioning or is causing distress. A severity specifier is then assigned based on the number of symptoms. At least two of the following criteria must be met: alcohol is consumed in larger amounts or over a longer period than was intended; a desire or unsuccessful attempts to cut down or control alcohol use; spending large amounts of time on activities related to the obtaining, use, and recovery from alcohol; cravings; inability to meet obligations at home, work, or school due to alcohol; continued use in the face of social or interpersonal problems; giving up social, recreational, or occupational activities; continued use even when physical or psychological problems result from use; tolerance; and withdrawal (American Psychiatric Association, 2013).

Women metabolize alcohol differently from men; more alcohol is absorbed into a woman’s blood when she drinks. It takes longer for a woman’s body to break down the alcohol and longer for it to be discharged (i.e., metabolized). In addition, the immediate effects of alcohol consumption occur more quickly in women and last longer than they do in men. Excessive alcohol consumption increases the risk of brain shrinkage, adversely impacting memory, and increases the risk of mouth, throat, esophagus, liver, and colon cancer. Women have a higher risk than men of developing alcohol-related liver disease. Women also are more vulnerable to brain damage, and the damage appears within a shorter period of time. The risk of damage to the heart muscle from consuming alcohol is greater for women than men. Breast cancer risk increases for women as alcohol consumption increases. Heavy alcohol consumption can lead to dementia, stroke, and neuropathy and exacerbate mental health issues (Mesuda, 2014).
Alcohol consumption may disrupt a woman’s menstrual cycle and increase the risk of infertility, miscarriage, stillbirth, and premature delivery. No level of alcohol is known to be safe during pregnancy. Drinking alcohol during pregnancy also increases the risk of birth defects, fetal alcohol syndrome, and low birth weight. Drinking during pregnancy increases the risk of sudden infant death syndrome (SIDS). The incidence of SIDS is substantially increased among newborns of women who binge drink during their first trimester. Because sexual risk-taking increases with intoxication, binge drinking can also lead to unprotected sex, multiple sex partners, unintended pregnancy, and sexually transmitted diseases (CDC, 2016).

Victimization by sexual assault is more common among women who drink, especially younger women. Women with AUD are more likely to have personal trauma histories that predate their disorder, including physical and sexual assault and intimate partner violence. Women who consume alcohol are at higher risk than men for having unprotected sex, and riding with an intoxicated driver. The risk of anxiety and affective disorders increases in both women and men with alcohol use disorder. Eating disorders and alcohol problems frequently co-occur among women. Women with AUD also frequently are addicted to prescription pain and sedative medications. A woman’s entire social support system can break down when alcohol abuse is untreated; poverty is an especially devastating outcome.

Treatment for AUD may include psychological therapy (e.g., individual/conjoint/group/family), referral to support groups or 12-step programs (e.g., Alcoholics Anonymous), harm reduction, cognitive behavioral approaches, brief interventions, motivational enhancement therapy (MET), and client education about a healthy lifestyle. Treatment for medical conditions and supportive care during alcohol withdrawal is individualized depending on each client’s mental health and physiologic status.

Facts and Figures
Alcohol abuse is one of the five leading causes of morbidity and mortality worldwide (SAMHSA, 2015). In 2012, approximately 5.9% of global deaths were attributable to alcohol consumption: 4.0% of female deaths were alcohol-related and 7.6% of male deaths were (WHO, 2017). The 2015 National Survey on Drug Use and Health in the United States found that during the 30 days prior to the survey 51.1% of women aged 18 and older had consumed alcohol, 22% had engaged in binge drinking, and 4.5% had heavy use of alcohol; during the year prior to the survey AUD had been diagnosed in 4.2%, and 5.4% had received some form of treatment for AUD; and among women aged 15–44 and who were pregnant, 9.3% had consumed alcohol during the 30 days prior to the survey (NIAAA, 2017). Excessive alcohol use is the third leading lifestyle-related cause of death in the United States (Mesuda, 2014). When compared by age and gender to the overall national population of the United States, the risk of death for alcohol-dependent females is 4.6 times greater and for alcohol-dependent males is 1.9 times greater (John et al., 2013). In Denmark, Finland, and Sweden the average life expectancy of women with AUD is 50–58 years; men and women with AUD die 24–28 years earlier than persons without AUD (Westman et al., 2015).

The culture of binge drinking is associated with underage drinkers; in women binge drinking is defined as the consumption of four or more drinks in two hours or less and for men it is five or more drinks consumed within two hours (CDC, 2015). Higher proportions of White women, college-educated women, and women in higher income brackets consume alcohol compared to women of other races, educational levels, or incomes. Alcohol consumption increases as countries develop, and while this may be of concern it can also be understood in the context of growing gender equality. In South Korea, for example, the number of women who drink alcohol rose 27% over the course of 8 years (from 33% in 1993 to 59.9% in 2001) (Kim & Kim, 2008).

Risk Factors
AUDs are increasing among adolescent girls and older women. Pregnant adolescents aged 15–17 years are at increased risk and are especially in need of prevention services. Drinking before age 15 increases the risk of abusing alcohol (Mesuda, 2014). Risk factors for AUD for older women include recent bereavement, poor health, loneliness, and isolation. Childless, separated, and divorced women are at higher risk for AUDs. Women with little or no social support or no social network are at elevated risk. Lesbian women misuse alcohol with greater frequency than heterosexual women. A common barrier to treatment is denial; many women with drinking problems seek help only when their conditions become chronic.

Women with a parent with a history of an AUD are at greater risk for developing alcohol-related problems. Women with mental health issues, especially depression, and those with stressful lives are at risk. Women from cultures in which alcohol is easily available and alcohol use is common and accepted may also be vulnerable to AUD.

Society judges women with AUD as more deviant than men with AUD. Because of this, women generally will prioritize health- and family-related problems over their alcohol misuse when seeking help. This tactic helps women avoid direct discussions about their alcohol misuse and thus avoid addressing the problem directly. As a result, AUD often is underdiagnosed in women by healthcare professionals.
**Signs and Symptoms/Clinical Presentation**

Smelling of alcohol, having glazed or bloodshot eyes, changes in mood, drowsiness, sleep problems, blackouts, unusual passivity, and argumentativeness can be symptoms of alcohol abuse. Deterioration in appearance or hygiene may be a sign. An intoxicated person may have flushed skin, a decreased ability to pay attention, and may be forgetful.

**Social Work Assessment**

› **Client History**
  - Conduct a biopsychosocial spiritual assessment with the client, covering her developmental, emotional, psychological, and medical history and that of her family
  - Ask about history of use of prescription medications, illicit drugs, and alcohol, and about personal and family medical/mental health history
  - Ask about current stress level and assess for diminished mental status
  - Explore immediate and extended family’s use of alcohol along with familial relationships and personal friendships
  - Ask about persistent physical complaints such as fatigue and cough
  - Ask about mood fluctuations, irritability, depression, feelings of worthlessness, and suicidal ideation
  - Explore whether she considers her drinking problematic
  - Determine whether there is a history of legal problems related to drinking
  - Identify social resources available

› **Relevant Diagnostic Assessments and Screening Tools**
  - The Alcohol Use Disorders Identification Test (AUDIT) consists of 10 questions; it is especially useful for screening women and non-Whites
  - The T-ACE was specifically developed to screen for alcohol use among women who are pregnant; it consists of four questions, one each about Tolerance, Annoyance, Cutting down, and Eye opener drinking
  - The CAGE questionnaire is a popular screening tool because it has four questions that are simple and easy to remember
  - The Michigan Alcoholism Screening Test (MAST) consists of 25 questions and is particularly useful in identifying dependence

› **Laboratory and Diagnostic Tests of Interest to the Social Worker**
  - Depending on the setting, blood alcohol or urine testing may be indicated
  - If the client discloses a long history of alcohol use, her physician may want to conduct liver function testing

**Social Work Treatment Summary**

Assess for AUD, including alcohol use, alcohol intoxication, and alcohol withdrawal. Determine whether the acuity of the disorder requires outpatient services or inpatient hospitalization. Interventions need to be tailored to the individual woman since there often are coexisting disorders. Cultural competence is critical; this is best achieved through a strengths-based perspective, in which the key is to listen and appreciate that clients are the experts on themselves (Miller et al., 2007). Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.

Any history of trauma will need to be addressed through individual and/or group therapy. Women-only groups and meetings may be beneficial since research shows that women with trauma histories have more difficulty trusting male staff (Carlson, 2006). Cognitive behavioral therapy (CBT) addresses skills deficits and assists in the development and rehearsal of new skills, which can also help women with managing stress (Carlson, 2006; González-Premeds, 2008). Spirituality and religiosity can play a role in recovery and are elements of organizations such as Alcoholics Anonymous (AA), although research suggests this approach does not work for everyone (Bliss, 2007; Kaskutas, 2009). Secular Organizations for Sobriety (SOS) is an alternative to AA. Motivational interviewing (MI) creates a positive, empathic atmosphere between the client and social worker that avoids argumentation, facilitates mutual trust, and encourages self-efficacy as the client engages in risk-benefit analysis (Hepworth et al., 2010). In one study, researchers found that Native Americans had better outcomes when matched with MI treatments in comparison to AA (Miller et al., 2007). Interventions that offer childcare help women with children attend programs (Welsh et al., 2008). Motivational enhancement therapy (MET) focuses on less confrontational methods to help the individual acknowledge and accept her responsibility to change the behavior that contributes to alcohol abuse. Harm-reduction strategies embrace several basic social work approaches such as taking an ecological perspective and using a strengths approach, as well as starting where the client actually is in her process of recovery. It is important to note that when designing interventions for women whose histories include depression, a history of trauma, and post-traumatic stress disorder
(PTSD) related to physical and sexual assault or abuse, the confrontational approach used to deal with denial in addiction is unlikely to work. A combination of individual and couples therapy may also be beneficial for women with AUD (McCrady et al., 2016).

Social workers should practice with awareness of and adherence to the National Association of Social Workers (NASW) Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence; and become knowledgeable of the NASW ethical standards as they apply to alcohol use disorder and practice accordingly (National Association of Social Work, 2015, 2013).

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client engages in heavy alcohol use</td>
<td>Determine if criteria for AUD are met</td>
<td>Conduct a biopsychospiritual assessment, use assessment tools</td>
</tr>
<tr>
<td>Client meets criteria for AUD</td>
<td>Client will exhibit a reduction in symptoms of AUD and will either be abstinent or have reduced alcohol intake dependent on treatment model</td>
<td>Screen for severity level of AUD. Provide individual and/or group therapy for any history of trauma. Provide or refer client for counseling interventions that are appropriate (MI, CBT, etc.). Skills training can help client cope with stress. Work with the client on identifying a support network and/or a group that will support her recovery. Refer client to 12-step recovery group if appropriate</td>
</tr>
<tr>
<td>Client is experiencing depression as evidenced by hopelessness, helplessness; client is self-medicating regularly</td>
<td>Reduction in symptoms of depression and improved coping skills</td>
<td>Provide stress management techniques. Help client develop higher-level coping strategies to minimize depression and the need to self-medicate and to prevent relapse</td>
</tr>
<tr>
<td>Client has been extremely isolated over the past 6 months</td>
<td>Client will have an enhanced support system and decreased self-isolation</td>
<td>Educate, connect with 12-step program (e.g., AA or SOS); help client expand available social supports and facilitate access to them</td>
</tr>
</tbody>
</table>

Applicable Laws and Regulations

› The vast majority of countries set a legal age at which individuals can buy and consume alcohol. The most common is age 18, a few countries allow drinking at 16, and a small number of countries, including the United States, have an age requirement of 21. In a small number of countries drinking is forbidden and about a dozen countries have no laws limiting alcohol consumption or purchase by age
› Each country has its own standards for cultural competence and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (e.g., National Association of Social Workers in the United States, British Association of Social Workers in England) and practice accordingly
› Internationally, social workers should practice with awareness of and adherence to the social work principles of respect for human rights and dignity, social justice, and professional conduct as described in the International Federation of Social
Workers (IFSW) Statement of Ethical Principles, as well as the national code of ethics that applies in the country in which they practice. For example, in the United States, social workers should adhere to the NASW Code of Ethics core values of service, social dignity and worth of the person, importance of human relationships, integrity, and competence; and become knowledgeable of the NASW ethical standards as they apply to substance use disorders and treatment and practice accordingly

**Available Services and Resources**

- Substance Abuse and Mental Health Services Administration (SAMHSA), [https://www.samhsa.gov/](https://www.samhsa.gov/)
- Alcoholics Anonymous, [http://www.aa.org](http://www.aa.org)
- Secular Organizations for Sobriety (SOS), [http://www.sossobriety.org/?/sos](http://www.sossobriety.org/?/sos)

**Food for Thought**

- Society can judge women with AUD as more deviant than men. Because of this women generally prioritize health- and family-related problems over their alcohol misuse when seeking help
- Social workers are more likely to identify AUDs in men than in women
- Women with AUDs are more likely to drink alone
- Although social networks generally are considered a protective factor against AUD, in some cases they can be detrimental by encouraging alcohol use
- Women may be less likely than men to seek treatment as a result of lack of childcare and of fear that their children will be taken away if they disclose problems with alcohol

**Red Flags**

- Symptoms of alcohol intoxication and withdrawal can mimic those of many major psychiatric disorders; therefore, accurate screening and assessment is critical
- Harmful use of alcohol increases the risk of contracting infectious diseases (e.g., HIV/AIDS, tuberculosis)(WHO, 2015)
- Alcohol use while pregnant increases the risk of fetal alcohol syndrome and preterm birth complications (WHO, 2014)
- Women with AUD are more likely to experience psychosocial impairment (e.g., difficulty maintaining close interpersonal relationships) and psychopathology (e.g., depression, eating disorders) than women without AUD (Foster & Hicks, 2014; McCrady et al., 2016)

**Discharge Planning**

- Whenever possible, follow up with the client and continue with support; recovery can be a long process
- Ensure that client has access to available support services
- Enlist family and social supports where available to help client with treatment, recovery, and daily life
- Assist client in identifying triggers for alcohol use. Discuss alternatives to alcohol use and identify strategies to improve coping and problem-solving skills
- Provide referrals to substance abuse treatment programs, mental health services, and recovery support groups to support long-term alcohol-free recovery

**References**
