Alcoholism in Women

by VALERY YANDOW, MD

Conservative estimates indicate that at least 6 to 10 million adult American females—6% of the adult female population—have serious alcoholism problems. Of that number, only a small proportion are in active treatment. Many of these women, especially in the younger age groups, are using alcohol in combination with other drugs, both illicit and prescribed. Although there does not seem to be a major increase in problem drinking in females, there are some higher risk sub-groups, such as younger women; never married, divorced, or separated women; and unemployed women seeking work or women with part-time employment.¹

Sixty percent of women age 18 and older drink, while 40% abstain from drinking. Of those who drink, 55% do so moderately, which is defined as fewer than 60 drinks per month. Regular drinking is common among high school girls. Despite these data, women continue to be underrepresented in most alcoholism treatment programs. For example, only about 30% of Alcoholics Anonymous membership is female.

Women's drinking and subsequent problems are highly correlated with the drinking behaviors of significant others in their lives, although it is unclear as to whether women are encouraged to drink more because of the influence of others.

There is no other illness a woman can have that carries such a sense of shame and guilt as addiction.² Even breast cancer does not bring the same feelings of failure, of being bad, or of being an outcast. Women who have been fortunate enough to receive treatment and begin recovery always talk about these feelings—"This couldn't possibly happen to a woman like me; if I were really strong I could do something about it myself. I'm just weak and bad—like my husband and my family tell me I am."

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or vomited into the plastic bag they always kept in their pocketbooks for emergencies. One of the most difficult things for a woman to say is, “I am an alcoholic.” It is not surprising that young women alcoholics are the most frequent suicide attempters. Often, shame and guilt may start the drinking as an attempt to anesthetize these feelings, but the cycle is vicious and the drinking only serves to increase the shame and feeling of failure.  

The recent “coming out” of prominent public women and their ability to talk openly and write about their illness and recovery has encouraged many women to find courage to seek treatment. However, there are still many other women who say, “Well, I can understand how it could happen to her. She was under so much pressure. But I have no excuse. I’m just an ordinary person.” Women still do not understand that alcoholism is not a disease they want to get anymore than they want to get heart disease or diabetes. But once a woman has alcoholism, she must assume responsibility to do something about it. Unfortunately, negative attitudes on the part of many health care professionals continue to perpetuate the stigma, especially for women.

Families and significant others also perceive the problem differently for women alcoholics. Whereas 9 out of every 10 women will stay with their alcoholic partners, 9 out of 10 men will leave an alcoholic wife. Although economics plays a role, the double standard is again apparent. Society has no problem with the hard-drinking man sitting at a bar, but the “nice” woman doesn’t do that. The woman drinker must be kept hidden by the family or else she will be extruded.

**EFFECTS ON CHILDBEARING**

A woman’s role as mother also creates unique problems as related to alcoholism. It was only in the 1970s that clear evidence surfaced that alcohol could damage the fetus. Fetal alcohol syndrome (FAS) probably occurs in one to three cases per 1000 of live births in the United States and is one of the three most frequent causes of preventable birth defects associated with mental retardation. It is still unclear as to what quantity of alcohol may cause damage to the fetus; therefore, women should be advised not to drink any alcohol during pregnancy. One of the major problems is that most damage probably occurs during the first trimester, when many women are unaware they are pregnant. FAS is characterized by a combination of the following:

- pre- and postnatal growth deficiency;
- facial malformations, including a small head circumference, flattened midface, sunken nasal bridge, and a flattened and elongated philtrum;
- central nervous system dysfunction; and
- other major organ malformations.

Even one to two drinks daily may cause decreased birth weight and behavioral problems in the newborn. Because alcohol quickly enters breast milk, nursing mothers should be advised to remain abstinent until the baby is weaned. Unfortunately, some practitioners advise women to drink to “relax and let down the milk.”

The additional guilt carried by a woman who gives birth to an infant with fetal alcohol syndrome or fetal alcohol effects may lead to further drinking or suicide attempts, and may be a major factor that keeps a woman from seeking treatment or that contributes to relapse, since the feelings are so intense that she may want to remain intoxicated so as not to feel anything. Nicotine addiction, highly correlated with alcoholism, is another factor leading to low birth weight infants.

We also know that the woman alcoholic has problems bonding with her infant and providing subsequent nurturing and consistent caregiving to a child. While actively drinking, the closest bond is to the alcohol, and it is not unusual for small children to begin to parent their drinking mothers and to feel that they have been the cause of the drinking and are also responsible to cure it. This is especially true in the single parent home where children may not have a caring and consistent adult. It is easy to speculate as to how these become multigenerational problems. When a child comes home from school to find a mother passed out on the floor in her own vomit, another generation is immediately and severely affected. What does that child do with his or her feelings? It is no wonder that these children do not trust, feel, or talk and that their perceptions of others and the world become badly distorted.

**GENETIC FACTORS**

Although the genetic link in one form of severe alcoholism in men is well established, the genetic and familial factors in women seem more complex. Most early studies were done on all male populations or did not consider men and women separately; these early studies failed to show a genetic predisposition for alcoholism in women. Bohman and colleagues concluded that alcoholism in women was genetically transmitted most often from mothers to daughters. It is unclear as to what extent inherited “susceptibility” (such as personality factors) exists. One high risk factor for the development of alcoholism in women is being the child of an alcoholic. Cohabitation, especially in the lesbian population, is also a risk factor.
for women. This is an area where research is badly needed.

In addition, the progression of the illness may take a different course in women. Where stress and environmental factors play a large role, the illness may begin later in life, although the hypothesis that stressful events cause excessive drinking still needs to be proven. However, the disease seems to be "telescoped" in women as they become sickier faster and may develop medical complications more rapidly than men. Women show a shorter average length of heavy drinking before the appearance of fatty liver, hypertension, obesity, anemia, malnutrition, and gastrointestinal hemorrhage. Women are more likely to develop liver disease than men, even though they may consume less alcohol. Once liver disease develops, women have a higher risk of dying. Because alcoholic women are likely to engage in high risk behaviors, and because immune response is impaired, these women are at higher risk for exposure to AIDS. Even women in 12-Step fellowships are more likely to be in contact with high risk men (sex is sometimes a compulsive behavior that appears in early recovery), and they need education about HIV and AIDS early in treatment.

RESEARCH EFFORTS

Almost all early research in alcoholism was done on male populations, not only because the incidence was perceived as so much higher in men, but also because hormonal changes related to the menstrual cycle make "pure" research so much more complicated in women. There has been much recent interest in the relationship of alcohol use to the menstrual cycle. Women reach higher peak alcohol levels than men in response to a standard dose of alcohol. In part, this is due to a lower proportion of body water and higher fat concentration.

One recent study does not substantiate earlier work that indicated higher alcohol levels were reached during the "premenstrual phase." A typical example is the 45-year-old woman experiencing a sense of isolation and emptiness. She finds alcohol initially gives her a sense of well-being, but she needs to increase the alcohol consumption in order not to feel more alone and anxious. She seeks the help of her family physician or is referred to a psychiatrist who perceives her as depressed and anxious, and may prescribe a benzodiazipine or antidepressant. She is too ashamed to mention the drinking or does not perceive it as a problem. Unfortunately, the alcohol problem may not be addressed until there are serious social or medical consequences.

Numerous anecdotal reports can be found that indicate alcoholic women with severe character pathology show marked global improvement when involved in 12-step recovery programs because these programs provide structure as well as a sense of identity.

Anger in women is a feeling that is often unacceptable to others. For some women, addiction has become a way to express such negative feelings as anger, sadness, or shame. For these women, treatment must help them learn to express these feelings in appropriate ways. No matter what other psychopathology may appear to be present, alcoholism must be treated first. Diagnosis of other major difficulties cannot be accurately made in the face of active drinking.

There is a high association between alcoholism and eating disorders, with a history of eating disorder often leading to later alcoholism. It is important for women’s treatment to be global, since other addictive behaviors such as sex, relationships, gambling, shopping, or exercise may become apparent if not addressed, and it is easy to slip from one addiction to another.

EFFECTS ON SEXUALITY

There has been much interest in the relationship between drinking and sexuality. Although many alcoholic women indicate that they expect greater sexual enjoyment...
after drinking, they have a high level of sexual dysfunction. In fact, research studies show that sexual performance is impaired, even after small amounts of alcohol, although the woman may perceive less inhibition. With heavy drinking a vicious cycle exists with drinking being both the cause and the effect of impaired sexuality.15

There has also been recent awareness that as many as 75% of women in treatment for alcoholism have a history of sexual abuse, usually starting in childhood and frequently continuing until they enter treatment.16 For many of these severely traumatized women, the only way they have been able to engage in sexual activity has been under the influence of alcohol. For many, the memories have been repressed for years, and only with supportive treatment can some of the trauma be recalled. When issues of abuse are not addressed in treatment, relapse is much more common.17

When a history of abuse is identified during treatment, it is important to help the woman realize that resolution and healing of these traumas is going to take a long time, and that during the initial phase of treatment the emphasis must be on establishing long-term sobriety. Once this is established she can begin to work through the abuse traumas. A great deal of support will be required during this period, since sobriety can be very fragile.

MINORITY GROUPS

Minority women face even greater obstacles in identification, attitudes and obtaining appropriate treatment for alcohol problems. Although black women are more likely to be abstainers, when they do drink they are likely to be heavy or escape drinkers, and treatment programs need to help them increase their pride and identification with healthy members of the black community.18 Other ethnic minority women need to have culturally appropriate treatment available.19 For example, Native American women between the ages of 15 and 34 develop cirrhosis of the liver 36 times more than white women. The establishment of mutual help groups for these women would be of great assistance for them in obtaining sobriety. Lesbian women have formed such groups which have aided them in obtaining sobriety.

TREATMENT

Although there are now a number of women-only residential treatment programs, no research has been carried out to indicate whether this makes any difference in treatment outcomes. All programs must address women’s problems with assertiveness and with anger as well as addressing their difficulty in expressing their own feelings and needs. Issues of child care and parenting must be explored, yet few programs exist where infants and small children can also be accommodated.

Family treatment must be integrated into all treatment programs, whether residential or outpatient. Women seem to fare about the same as men regarding abstinence at one year follow-up, although women may show more psychological symptoms if issues such as grief, depression, self-esteem, and abuse are not addressed.

The three greatest barriers to treatment for women are:

- personal denial,
- family denial, and
- problems in responsibility for the care of dependent children.

Less than 20% of treatment programs offer special services for women, and the number providing child care is appallingly small. The greatest needs for adequate treatment for women include child care, gender specific treatment, halfway houses, all-women mutual help groups, attention to the uninsured, adequate training and standards for care providers, and attention to evaluating treatment programs.20

CONCLUSIONS

Because women may develop alcohol problems at any stage of the life cycle, prevention efforts must be focused on women of all ages. Although cigarettes now carry warning labels, it was only in 1988 that legislation was successful in demanding similar warning labels for alcohol, although such legislation was proposed even 10 years ago.

With the distillery industry spending over $1 billion every year, and much of that now being focused toward women, prevention efforts need to be much more vigorous. The amount of money ($110 million a year) to advertise one brand of beer is greater than the entire national research budget for alcohol. By the time a girl graduates from high school, she will have seen 100,000 beer advertisements on television.

The effects of women’s alcoholism are immense, since female alcoholism upsets the homeostasis of the family and community even more than male alcoholism. The emotional and financial costs to the children, family, and community can hardly be estimated.

Alcoholism is a treatable illness. For the clinician, nothing is more satisfying than to work with a woman during the recovery process, to see the emergence of a person with a true sense of identity, well-being, and self-esteem who is able to express her feelings and find fulfillment. The role of the psychiatrist in prompt and accurate diagnosis and referral to appropriate treatment is absolutely crucial.
Until recently, many psychiatrists, physicians, and mental health professionals often have been reluctant to diagnose alcoholism in women, and there has been much over prescribing of benzodiazepines and other tranquilizers (which are then often abused). We must not continue to be "enablers" of the disease.

REFERENCES