Alcohol Use Among Reproductive Aged Women:
The Role of the Clinical Psychologist

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Abstract: Alcohol is embedded in Australian culture and the majority of women of reproductive age drink. Although most women drink at low levels of risk there is a minority who have alcohol use disorders. These women present a particular challenge to health services, given low levels of treatment engagement and the risk to mother and foetus. Alcohol use disorders are highly comorbid with other mental health disorders including anxiety and depression. Clinical psychologists are well equipped to assist women, given their expertise in standardised assessments and application of evidence based psychosocial treatments. They are part of a comprehensive model of care for pregnant women and should be involved in supportive referral to antenatal and other services and refer to drug and alcohol specialist where appropriate.

Keywords: alcohol reproduction, contraception, pregnancy.

Alcohol is embedded in the Australian culture with the vast majority of the adult population reporting recent alcohol consumption (Australian Institute of Health and Welfare, 2014). National data indicates that although the majority of Australians consume alcohol at levels that are low risk to their health, substantial proportions drink at risk levels. The most recent national data indicates over one-third (37%) consumed four or more standard drinks on a single occasion at least once in the past year, about one-quarter (26%) did so at least once a month and one in seven (13.8%) did so at least once a week, therefore exceeding national guidelines for single occasion consumption (Australian Institute of Health and Welfare, 2014).

In the general population, the pattern of alcohol consumption shows distinct gender and age-related patterns. The highest rates of drinking and risky patterns of alcohol consumption occur in adolescents and young adults. National survey data suggests amongst 18-24 year olds, 14.6% of
women drank at levels indicating risk of alcohol-related harm over a lifetime (average of more than two standard drinks per day). Similarly, 9.8% of 25-29 year olds and 9.3% of 30-39 year old women drank at levels indicating lifetime risk of harm. Substantial proportions report drinking more than four drinks on a single occasion on a monthly basis, placing them at risk of alcohol related injury: 24.5% of 18-24 year olds, 15.5% of 25-29 year olds and 8.9% of 30-39 year olds. A recent longitudinal study of Australian women found that ‘no risk’ drinking increased with age, while low risk episodic drinking remained almost constant between ages 18 and 39 years. High risk episodic drinking, however, declined rapidly with age (Powers, Anderson, Byles, Mishra, & Loxton, 2015).

Evidence indicates that biological (sex related) and psycho-socio-cultural (gender related) factors interact with alcohol use in a complex manner and differentially impact risk for men and women (Erol & Karpyak, 2015). Compared to men, more women abstain from alcohol, drink less and are less likely to engage in risky drinking. However, women are more vulnerable to the adverse physical and mental health and social outcomes associated with use. Women progress more rapidly from first use to regular use to first treatment episode for substance use disorders, including alcohol (Greenfield, Pettinati, O’Malley, Randall, & Randall, 2010). The severity of symptoms for women is generally equivalent to men despite fewer years of use and smaller quantities consumed.

Increases in economic independence and social changes for women have resulted in greater acceptability of alcohol consumption for women and some unintended consequences, including increased exposure to alcohol-related harm (Schmidt, 2014). There are a range of reasons why women use alcohol and develop problems with it. Genetic and environmental factors contribute with evidence suggesting that genetic factors play a role in progression to dependence and environmental factors influencing initiation. In women, environmental factors, more than genetic, appear to explain the gender differences in the prevalence of substance use disorders.

Typical gender roles and societal expectations are significant to consumption patterns. Women are typically socialised to be ‘others’ focused and relationships with partners, family and children play an important role in dependence and recovery (Reid & Day, 2015).

**Why Should Clinical Psychologists Consider Alcohol Use?**

Alcohol use disorders (AUDs) are the most common substance use disorders in the Australian general population (Teesson et al., 2010) and comorbid with other mental health disorders, hence clinical psychologists will come into contact with people with AUDs. Recent data from general population studies over the last 25 years shows people with an AUD were 2.1 times at greater risk of having any anxiety disorder compared to those without an AUD and that the risk of having major
depression was 3.1 times more likely for a person with an AUD compared to someone without one (Lai, Cleary, Sitharthan, & Hunt, 2015).

Despite the substantial negative social consequences of AUDs and the availability of effective treatments, there is considerable treatment delay in Australia (Chapman, Slade, Hunt, & Teesson, 2015). Women with AUDs may be more likely to seek help outside of formal alcohol treatment settings (Jakobsson, Hensing, & Spak, 2008), suggesting health professionals in a wide range of contexts, including clinical psychologists, may be in a position to identify these women and assist them with brief intervention, treatment or referral. Women may not disclose their alcohol use if not asked and therefore may not receive appropriate treatment. Disclosure of problematic alcohol use can be difficult; stigma is a well-recognised barrier for people accessing treatment. Women who use alcohol and other drugs have traditionally been more stigmatised than men (Reid & Day, 2015).

**Discussing Alcohol Use**

There have been calls for a variety of health professionals to discuss alcohol consumption with women in the context of general (Brighton, Moxham, & Traynor, 2015) and reproductive health (Breen, Awbery, & Burns, 2014). It is important to acknowledge that some health professionals may experience discomfort asking about alcohol use due to limited clinical training in the management of alcohol problems or low confidence in determining appropriate interventions and pathways to specialist alcohol treatment (Chang, 2014; Pennay, Lubman, & Frei, 2014).

The use of a validated screening tool to assess alcohol consumption is recommended as they are most sensitive at detecting risky behaviour and this standardised approach may reduce the hesitancy of clinicians in screening for and treating these disorders. Both the Alcohol Use Disorders Identification Test (AUDIT) (Barbor, Higgins-Biddle, Saunders, & Monteiro, 2001) and the briefer AUDIT-C, a three item questionnaire (Figure 1) (Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998) are reported to perform well in the general population (Dawson, Grant, Stinson, & Zhou, 2005) and with pregnant women (Burns, Gray, & Smith, 2010).
Embedding questions about alcohol use into routine assessments for reproductive aged women may reduce the stigma and allow women to disclose use regardless of whether a problem is perceived or treatment sought (Substance Abuse and Mental Health Services Administration, 2011). Although the evidence for universal screening is limited, asking all women of reproductive age about their alcohol consumption avoids the clinician making assumptions about the ‘type’ of woman at risk and provides an opportunity to deliver a brief intervention for those without an AUD but who may be at risk.

**What are Effective Treatments for Women with Alcohol Use Disorders?**

There is good evidence for the positive effects of brief alcohol interventions for the general population in primary care settings (O’Donnell et al., 2014). Brief interventions are the proactive
detection of drinking problems with advice and/or counselling at the point of detection. This usually takes no more than 10 minutes, works well with non-dependent ‘at risk’ drinkers and can be useful in helping to engage and motivate those with AUDs. A ten minute intervention has been shown to produce a significant reduction in alcohol consumption in non-treatment seeking populations at 6-12 months follow-up (Moyer, Finney, Swearingen, & Vergun, 2002). The FLAGS mnemonic can be used to guide clinicians (Figure 2; Haber, Lintzeris, Proude & Lopatko, 2009).

Feedback: evidence of harm experienced from drinking, or risks faced if drinking continues at this level

Listen: to whether the client is prepared to consider changing their drinking, or whether perhaps they have tried to change it many times before

Advice: clear advice that they should cut down

Goals: what should they be aiming for?

*Figure 2. FLAGS mnemonic for alcohol use intervention (Haber et al., 2009)*

Overall, the evidence suggests that brief alcohol interventions are effective, with some indications effects may be less consistent for women (Kaner et al., 2007). Despite the less conclusive evidence for women, there are reasonable indications that screening and brief intervention can contribute to the prevention of alcohol or other drug exposed pregnancies (Burns et al., 2010; Chang et al., 2005; Nilsen, 2009; O’Connor & Whaley, 2007; Svikis & Reid-Quiñones, 2003; Tzilos, Sokol, & Ondersma, 2011). A clinical psychologist’s training provides the skills and techniques to deliver brief interventions.

Motivational interviewing is a style of brief intervention which focusses on a person’s readiness to change their behaviour and uses empathetic counselling to address ambivalence (Handmaker & Wilbourne, 2001; Jones & Kaltenbach, 2013) and has been found to be effective in reducing problematic alcohol consumption in women (Floyd et al., 2007; Handmaker & Wilbourne,

Behavioural counselling interventions for adults with risky drinking are another effective approach used by clinical psychologists (Jonas et al., 2012). Behavioural therapies (e.g., dialectical behaviour therapy, acceptance and commitment therapy and community reinforcement approach) that focus on improving interpersonal self-regulation and distress tolerance skills by integrating behaviour strategies, mindfulness practices and reinforcing positive behaviours can be effective for women with alcohol problems (Network of Alcohol and other Drug Agencies (NADA), 2015).

Cognitive behaviour therapy (CBT) used to adjust cognitions, interpretations of events and emotions that lead to ongoing alcohol use are also helpful. CBT can assist with developing better coping strategies, new self-perspective and relapse prevention (Jones & Kaltenbach, 2013; Mills et al., 2009; NSW Department of Health, 2008). In addition narrative therapy, mindfulness approaches, family therapy and self-help groups are also recommended (Network of Alcohol and other Drug Agencies (NADA), 2015).

**Addressing trauma and comorbid mental health.**

There is increasing evidence of the role of trauma in alcohol use and other mental health disorders. Women with alcohol and comorbid mental health disorders may have experienced trauma, abuse and violence (Burns, Conroy, Moore, Hutchinson, & Haber, 2011; Jones & Kaltenbach, 2013; Taylor et al., 2012). A trauma-informed care paradigm recognises and responds to the implications of a history of trauma. This includes considering the impact of violence in women’s lives, providing compassionate care and providing a safe treatment environment (Jones & Kaltenbach, 2013; Poole, 2010). Trauma-specific psychosocial care may also be needed, to address the sequelae of abuse and violence (Jones & Kaltenbach, 2013).

People with comorbid mental health and substance use problems are a particularly high risk group that are more difficult to treat, place a greater burden on service providers and have a more severe illness course (de Graaf, Bijl, Ten Have, Beekman, & Vollebergh, 2004) and guidelines for the treatment are available (Drake, O’Neal, & Wallach, 2008; Mills et al., 2009; Tiet & Mausbach, 2007). There is no ‘one-size-fits-all’ treatment approach but there are a number of guiding principles that include engagement, adopting a non-judgemental attitude and a holistic client-centred approach (Mills et al., 2012); all of which clinical psychologists are well trained to implement.
Contraception.

In the discussion regarding alcohol use in the reproductive years, contraception is often overlooked.

Evidence suggests up to 50% of pregnancies are unintended (Mazza et al., 2012; Naimi, Lipscomb, Brewer, & Gilbert, 2003; Rassi, Wattimena, & Black, 2013; Read, Bateson, Weisberg, & Estoesta, 2009) and unintended pregnancy is associated with increased risk of exposure to alcohol because of later pregnancy recognition, later access to antenatal care and higher likelihood of risky consumption patterns. Consistent and correct use of contraception offers the best prevention of unintended pregnancy.

Contraceptive failure is considered to be a key contributor to unintended pregnancy. Younger women have higher rates and there are also associations between contraceptive failure and more frequent sexual intercourse, use of alcohol and other drugs, and domestic violence (Black, Gupta, Rassi, & Kubba, 2010). The oral contraceptive pill is the most frequently prescribed form of contraception in Australia, particularly for young women (Mazza et al., 2012); however, as a user-dependent method, it has a relative high failure rate of up to 9% for ‘typical’ use (Trussell, 2011). Conversely, long active reversible contraceptives, such as intra-uterine devices and hormonal implants, have very low failure rates (<1%) because, once inserted, their effectiveness is not user dependent (Trussell, 2011). These methods are used at relatively low rates in Australia (Black, Bateson, & Harvey, 2013), due to a range of factors including user and provider knowledge of the benefits, lack of insertion training among providers and higher medical indemnity costs associated for providers (Black et al., 2013; Mazza et al., 2012). Nevertheless, given the very low failure rates and their suitability for use in most women, including nulliparous women (Black, Lotke, Buhling, Zite, & INTRA group, 2012), they may be particularly beneficial for women with an AUD. Furthermore, preconception counselling may be beneficial for all women reporting alcohol use (Rose et al., 2013).

Alcohol Use in Pregnancy

The harmful effects of alcohol exposure in utero are well documented and can result in poor pregnancy outcomes and significant ongoing challenges throughout life (Burns, Black, et al., 2011; O’Leary, 2004; Streissguth et al., 2004). *Foetal alcohol spectrum disorders* (FASD) is a term used for a range of conditions resulting from foetal alcohol exposure including: fetal alcohol syndrome (FAS), alcohol related birth defects (ARBD), and alcohol-related neurodevelopmental disorders (ARND). Features of FASD include: poor growth, facial abnormalities, structural damage to the central nervous
system, neurological damage, reduced cognitive function, impaired executive function, developmental delay, learning disability or intellectual disability.

Prospective longitudinal studies report that individuals with FASD are at increased risk of a range of ‘secondary disabilities’ including increased risk of mental health disorders (anxiety and depression), educational and employment difficulties, substance use disorders, criminal justice involvement and incarceration and inappropriate sexual behaviour (Clark, Lutke, Minnes, & Ouellette-Kuntz, 2004; Sayal, 2007; Sayal et al., 2009; Streissguth et al., 2004; Spohr, Willms, & Steinhausen, 2007).

Determining the prevalence of FASD in Australia is challenging as data required for the diagnosis are not routinely collected (Burns, Breen, Bower, O'Leary, & Elliott, 2013). State- and territory-based studies have reported birth prevalence rates of FAS of between 0.01 and 0.68 per 1000 live births. These studies have utilised passive surveillance systems and it is acknowledged that under-ascertainment of cases is likely. As reflected in the international data, Australian studies have found higher rates of FAS among some Indigenous communities (Bower, Silva, Henderson, Ryan, & Rudy, 2000; Elliott, Payne, Morris, Haan, & Bower, 2008).

There is no known safe level of alcohol consumption during pregnancy (NSW Department of Health, 2014). As evidence suggests a complex association between risk and the timing, pattern and dose of alcohol consumption as well as the influence of individual maternal factors, it is unlikely that a safe level will ever be established (O'Leary et al., 2010). The evidence suggests that the highest risk of harm is associated with high alcohol consumption and that the foetus is at the highest risk during the first trimester (Ministerial Council on Drug Strategy, 2006; National Health and Medical Research Council, 2009). There remains conflicting evidence about the effects of low level consumption. The NHMRC Guidelines recommend that women who drank alcohol before they knew they were pregnant or during their pregnancy should be reassured that the majority of babies exposed to alcohol suffer no observable harm. The risk to the foetus from low risk level drinking is likely to be low (National Health and Medical Research Council, 2009). It is important that women are informed that not all pregnancies exposed to alcohol, including heavy levels of alcohol, will be harmed (O'Leary, 2012). Given this complexity, the Australian guidelines recommend abstinence from alcohol when pregnant (National Health and Medical Research Council, 2009).

Although the Australian guidelines recommends abstinence, studies estimate that between 50% to 80% of women continue to drink in pregnancy (Anderson et al., 2014; Australian Institute of Health and Welfare, 2014). The vast majority of women that continue to drink do so at low risk levels and the proportion of women who drink during pregnancy is declining (Australian Institute of Health
and Welfare, 2014; Callinan & Ferris, 2014). There is some evidence that the proportion of high-risk drinking women in Australia is not decreasing (Cameron, Davey, Kendall, Wilson, & McClure, 2013) and this high risk group requires particular attention. Women who drink in risky ways prior to pregnancy are more likely to continue this pattern into pregnancy and there is poor access to treatment for this group (Anderson et al., 2014; L. Burns, Breen, & Dunlop, 2014). Given this, it is critical that targeted interventions be implemented for these women.

**Comprehensive support.**

Evidence shows that well-coordinated and comprehensive support with early access to antenatal care and specialist alcohol or drug treatment can reduce harm and improve outcomes for pregnant women who have problematic alcohol use, and their babies (Jones & Kaltenbach, 2013). In Australia, a resource has been developed to assist primary care health professionals to support women and identify appropriate referral pathways dependent on individual needs (Breen et al., 2014; Breen, Awbery, & Burns, 2015).

Clinical psychologists are part of the comprehensive treatment model. Given their expertise in assessment and implementing evidence-based psychosocial intervention they are in a prime position to assist women that are drinking at risky levels who may also have other mental health issues. In addition, they can provide supportive referrals to antenatal care, other services (e.g. housing, domestic violence) and specialist alcohol and other drug treatment if required. Psychologists working as lone practitioners will need to establish appropriate referral pathways to assist the individual needs of their client. Key referral pathways to establish include ready access to quality primary healthcare services, psychiatric care, sexual and reproductive health screening and care and child and parenting support agencies among others. Psychologists working as part of a multidisciplinary team in specialist services should establish a clinical coordinator to support the client.

Women who are alcohol dependent and unable to cease drinking, may require specialist medical assistance. Alcohol withdrawal can be dangerous for both for the woman and foetus and medical oversight is required (NSW Department of Health, 2014). In some cases inpatient withdrawal management may be necessary and thus assessment from a specialist drug and alcohol team is paramount. Given the chronic nature of AUDs, ongoing support throughout the pregnancy and into the postpartum period is required to reduce the risk of relapse and exacerbation or development of other mental health issues including postnatal depression.
Understanding and addressing barriers to women accepting care.

As evidence suggests, engagement in treatment improves outcomes, individual health professionals should address their beliefs and work on skills that can support engagement. Reflecting on personal values and education regarding alcohol disorders as a health care issue is important. Stigma is a well-recognised, potential barrier to disclosure of alcohol and other drug use during pregnancy (Chang, 2014; NSW Department of Health, 2014). Disclosing problematic alcohol use can be difficult and this may be heightened during pregnancy as women that are pregnant or who have children may be concerned about child protection issues. Acknowledging an individual woman’s experiences and feelings and addressing the issue within appropriate guidelines is essential (Breen et al., 2015).

There may be a range of practical issues to consider when treating women with AUD, including access to child care and public transport. Flexible approaches to care may be required including longer appointments and flexibility with appointment times, anticipating missed appointments and assertive follow up. An opportunistic approach is recommended whereby appointments with appropriate professionals are made for the same visit.

Conclusion

Clinical psychologists play a critical role in the identification and treatment of women with or at risk of AUD. The comorbidity of alcohol use disorders with anxiety and mood disorders is high and women with AUD may present with other mental health problems. Psychologists are well placed to address these multiple problems with evidence based therapeutic approaches. Importantly, contraception needs to be considered for all women of reproductive age not wishing to be pregnant, especially those drinking at risky levels. When women are alcohol dependent, abstinence may precipitate withdrawal. This can be risky and referral to appropriate specialist treatment is required. Clinicians should acknowledge that alcohol use occurs in context of other health, family and psychosocial factors and these issues need to be addressed.

References


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