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Women and Alcohol-Use Disorders

A Review of Important Knowledge and Its Implications for Social Work Practitioners[1]

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Abstract

- *Summary*: This article reviews the extent of current knowledge, particularly with reference to US sources about gender-specific alcohol-related life experience consequences, and explores the implications of these differences for practice.
- *Findings*: Alcohol affects women in significantly different ways from men. Women's consumption of alcohol is capable of inflicting more severe problems over shorter periods of time with less alcohol consumed. The sequence of alcohol-related life experience consequences also differs significantly between genders. Women with alcohol-use disorders experience gender-specific medical impairments as well as other significant differences and are more likely to be exposed to victimization.
- *Applications*: The purpose of this article is to provide social work practitioners with relevant information about the effects of alcohol on women. It also provides important interviewing strategies for workers who will encounter women with alcohol-related problems. These strategies are intended to enhance the practitioner's ability to broach the subject and initially screen for alcohol-related problems among female clients.

Keywords alcohol abuse alcohol and women alcohol-use disorders screening substance misuse

Social work practitioners encounter clients with alcohol-use disorders in all areas of professional practice (van Wormer, 1995). Considering the extent of the problem, practitioners often lack sufficient knowledge of alcohol-related problems, particularly among women. Most baccalaureate[2] and master's-level social work curricula include little extensive training on substance-use

disorders. For example, although alcohol and drugs were not differentiated, social workers in New England substance-use disorders treatment centers reported significantly lower knowledge and skill levels in the area of assessment than their non-social work counterparts (Hall et al., 2000).

Alcohol-use disorders represent one of the greatest health and mental health care issues in both the US and other industrialized countries, affecting millions of people and costing billions of dollars annually (Maxmen and Ward, 1995; van Wormer, 1995). These disorders have been referred to as 'America's most serious drug problem' (Maxmen and Ward, 1995: 144). Alcohol is the most commonly used drug among America's youth and is the first drug of choice among both adolescents and adults (Schneider Institute for Health Policy, 2001). As a drug, it is the one most commonly causing problems for women (Center for Substance Abuse Treatment, CSAT, 1994).

A projected 7.4–10.5 percent of the US adult population meets diagnostic criteria for alcohol-use disorders (Grant et al., 1994; Royce and Scratchley, 1996). Roughly 1.3–6 million of this group are women (Roth, 1991; US Department of Health and Human Services, USDHHS, 1991). Others suggested the figure meeting criteria for an alcohol-use disorder could be as high as 10.7 million women (CSAT, 1994). The estimated economic cost of alcohol-use disorders in the US in 1998 was $184.6 billion (Harwood, 2000). This included the economic impact associated with crime, lost work productivity, foster care, medical and mental health care, death, and other social problems (French et al., 1998; National Center for Addiction and Substance Abuse, 1998; National Institute of Alcohol Abuse and Alcoholism, NIAAA, 1997, 2000; Schneider Institute for Health Policy, 2001).

As evidenced in the field of child welfare, the majority of social work practitioners' clients are women and children. These practitioners are increasingly involved with women with alcohol- and drug-use disorders (US General Accounting Office, USGAO, 1994, 1998). The purpose of this article is to expose practitioners to some of the pertinent information on gender-related differences in the use and effects of alcohol. Of greater significance, it is also the intention of this author to provide interviewing strategies for social workers who will encounter women with alcohol-related problems. These strategies are intended to enhance the practitioner's ability to broach the topic and initially screen for alcohol-use disorders among women.

Background Information

Alcohol-use disorders are commonly framed in terms of abuse and dependence. They are traditionally defined by frequency of use, amount consumed at any given time, and the inherent negative consequences that result, that is, employment, legal, financial, social and psychological problems, and physical and medical impairments. The ratios of alcohol-dependent men to women have been estimated to range in the US from 2.3:1 to 8:1 (Maxmen and Ward, 1995;

Wilsnack et al., 1994). Recently, this gap appears to be narrowing. For example, Grant (1997) reported that men born in the Vietnam war period were only 1.4 times as likely as women to be given a lifetime diagnosis of alcohol dependence. Data from the National Comorbidity Study revealed a similar trend in the converging ratio of women to men meeting the diagnostic criteria for alcohol dependence (Nelson et al., 1998).

The traditional definitions of alcohol abuse and dependence, that is, quantity plus frequency formulae,[3] have a negative effect on the accurate screening and assessment of women's alcohol-related problems. This prevents many from receiving appropriate, timely help. Development of alcohol-use disorders screening protocols and instruments based on the findings from entirely or predominantly male samples have resulted in a male-as-norm bias in the defining, detecting and studying of alcohol-related problems (Wilke, 1994: 29).

For this article, alcohol-use disorders are considered to be 'when a person's alcohol consumption repeatedly interferes with occupational or social functioning, emotional state, or physical health' (Maxmen and Ward, 1995: 144). This coincides with the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (American Psychiatric Association, APA, 2000) criterion 7 for substance dependence and criterion 4 for substance abuse, referring to continued use despite the knowledge that the said use is resulting in recurrent consequences or impairment. This holds for the International Classification of Diseases (ICD-10) (World Health Organization, WHO, 1992), although there is an overlap between the harmful use and dependence criteria. Furthermore, the National Council on Alcoholism and Drug Dependence and American Society of Addiction Medicine (NCADD/ASAM) (Morse and Flavin, 1992) acknowledged that continued drinking despite adverse consequences serves as an important indicator for screening and assessment. Given this fact and because the terms 'alcoholism' and 'alcoholic' have stigmatizing effects on women (Blume, 1997; Ramlow et al., 1997; Walitzer and Connors, 1997), this article relies on the broader term 'alcohol-use disorders', suggesting the existence of a continuum rather than discrete diagnosis.

This may be viewed as lowering the diagnostic bar for defining alcohol-use disorders. Certainly, for men, chronic heavy alcohol use can result in increased tolerance, loss of control, extended periods of time searching, using or recovering from use, and other DSM-IV-TR, ICD-10 and NCADD/ASAM criteria. The same holds for women on the more severe end of an alcohol-use disorders continuum. However, these particular alcohol-related experiences are not necessarily applicable to women on the less severe end of the continuum. Women often experience impairments and consequences not accounted for by DSM-IV-TR, ICD-10 or NCADD/ASAM. For example, although women and men experience similar life experience consequences during their drinking careers, the sequencing of these events differs significantly (Karoll and Memmott, 2001).

Important Alcohol-Related Gender Differences

Women have symptom profiles from their alcohol use that differ in important ways from men. They experience a telescoping of the physiological effects of alcohol use (Karoll and Memmott, 2001; Randall et al., 1999; van Wormer, 1995). Equal dosages of alcohol consumed by men and women generally result in women having higher blood alcohol concentrations (BACs) (Frezza et al., 1990; Lex, 1991; Lieber, 1997). Women are more likely to experience greater medical harm with less consumed over shorter periods of time than men (Deal and Gavalier, 1994; Fuchs et al., 1995; NIAAA, 2000; Reichman, 1994). These physiological differences may provide a plausible explanation for women experiencing withdrawal symptoms earlier in their drinking careers than men. Intuitively, higher BACs with less used should lead to exaggerated physiological reactions to alcohol, including common hangover symptoms, which are not normal. Those who are social drinkers typically experience one or two hangovers, decide they had too much and do not consume that amount again.

Women may experience problems uniquely related to their reproductive system. The absorption rate of alcohol in women is more variable due to influential effects of progesterone levels that vary across the menstrual cycle, that is, rising in the premenstrual week, after ovulation and during pregnancy (Lex, 1991). Alcohol is absorbed more rapidly during the premenstrual week than the other phases of the menstrual cycle (Jones and Jones, 1976; McGrath Morgan and Kinney, 1996). This results in higher BACs during the premenstrual week than others, even with equal amounts of alcohol consumed during the full course of the cycle. Some women may also be prone to drinking more during the premenstrual week than other times of the month (Allen, 1996), further compromising their health.

Taking medications such as birth control pills will influence peak BAC levels of women because both are metabolized in the liver. When used in concert, alcohol remains in the system longer, thus resulting in higher BACs than women who drink but are not taking birth control pills (Pape, 1993). Intuitively, the use of other medications taken as prescribed and metabolized in the liver will lead to higher BACs due to their monopolizing the liver's normal functioning activity.

Alcohol negatively affects women's reproductive systems in other significant ways than influencing peak BAC levels. Heavier chronic drinking causes decreased gonadal (ovary) mass, increased infertility, painful menstruation, heavy flow, greater premenstrual discomfort, and other gonadal and obstetric problems (McGrath Morgan and Kinney, 1996; Sinha, 2000). Persistent hyperprolactinemia, anovulation and luteal phase dysfunction occur regularly in social and moderate drinkers. Ovarian atrophy, spontaneous abortion, irregular cycles, amenorrhea and early menopause are other reproductive system disorders associated with women's alcohol use (Gomberg, 1993; Lex, 1991; Sinha, 2000).

Other differences must be considered beyond medical aspects associated with women's alcohol use. Significantly, there has been an increase in the proportion of women aged 21–34 who consume alcohol (Gomberg, 1996). Research shows younger women are now involved in increasing numbers of alcohol-related motor vehicle accidents and being arrested and charged for driving under the influence (Wells-Parker et al., 1996). However, as evidence that alcohol-related motor-vehicle problems are important indicators of problematic alcohol use, in a study that compared life experience consequences by gender, women reported experiencing these problems later in their drinking career than men (Karoll and Memmott, 2001).

Women with alcohol-use disorders are more likely to have a history of physical or sexual assault and abuse and domestic violence than those in the general population (CSAT, 1997; Miller et al., 1993; Schneider Institute for Health Policy, 2001; Schober and Annis, 1996; Wilsnack et al., 1997). The severity of violence from partners also tends to be more extensive for women who are affected than those not so affected (Leonard and Quigley, 1999; Miller and Downs, 1993; Miller et al., 1989). A higher prevalence of these various forms of trauma also exists among women with alcohol-use disorders compared with men with the same disorders (Chermack et al., 2000; NIAAA, 2000; Rice et al., 2001; Windle et al., 1995).

The barriers to screening and treatment encountered by women (Allen, 1995; Beckman, 1994; Blume, 1986, 1997; Schober and Annis, 1996; Walitzer and Connors, 1997), and their general help-seeking behaviors (Karoll and Memmott, 2001) differ significantly from men. Because of their belief systems about alcohol, women are more likely to seek help in non-specialized mental health settings than formal substance use disorders treatment facilities (Weisner and Schmidt, 1992). Women's perceptions of problems and their motivation for seeking help are generally associated with health and family concerns rather than alcohol use (Allen et al., 1998). Rather than attributing their personal problems to alcohol use, they associate alcohol-related problems with psychiatric and psychological sources. As a result of these beliefs, they initially seek professional help from psychiatrists, psychologists, social workers, or other health care providers significantly earlier in their drinking careers than men (Karoll and Memmott, 2001).

The significance of women's differing help-seeking behaviors is that they result in their being evaluated for problems not associated with alcohol use disorders. Health care providers are more apt to look for and identify psychiatric diagnoses because of the settings in which women choose to seek help. This leads to the misdiagnosis of alcohol-use disorders among women and their physicians prescribing medications that negatively interact with even small amounts of alcohol consumed (Monroe et al., 1997).

Psychiatric disorders are generally more prevalent than expected by statistical chance among those with alcohol-use disorders (Kessler et al., 1996, 1997; Ross et al., 1997). Physiological dependence on alcohol was found to elevate

the risk for all forms of anxiety and affective disorders. Research has also demonstrated that a significant proportion of women with alcohol-use disorders have co-occurring psychiatric diagnoses, that is, major depression, anxiety, panic disorder, bulimia, post-traumatic stress disorder (PTSD), or borderline personality disorder (Brady et al., 1993; Cochrane et al., 1992; Goldbloom et al., 1992; Helzer and Pryzbeck, 1988; Hesselbrock and Hesselbrock, 1997; Kessler et al. 1997; Lewis et al., 1996; Lex, 1994; Rice et al., 2001; Ross et al., 1998; Straussner, 1997). Men with alcohol-use disorders more often have a co-occurring diagnosis of narcissistic and antisocial personality disorders, bipolar disorder, schizophrenia, impulse disorders and attention deficit/hyperactivity disorder. Further, men are more likely to exhibit such externally expressed alcohol-related consequences as legal, employment and financial problems, while women experience intrapsychic problems (Robbins, 1989). Others reported the tendency for men to experience a greater accumulation of different problems than women, such as more excessive drinking, increased problems with partner or family and greater legal concerns (Bongers et al., 1998).

Notably, history of trauma can lead to the development of PTSD (Miller, 1996), of which anxiety and depression are both symptomatic components (APA, 2000). Women with PTSD are at greater risk for using alcohol to self-medicate and are often prone to polysubstance use disorders (Fullilove et al., 1993; Miller, 1996). Finally, women with alcohol-use disorders are at increased risk for attempting suicide and engaging in para-suicidal behaviors (Gomberg, 1997; McGrath Morgan and Kinney, 1996).

Women with alcohol-use disorders are viewed as more deviant than men in society's eyes (Blume, 1997). Their fear of the negative implications or reprisals that the stigma will bestow upon their family of origin or procreation prevents many from seeking help (Ramlow et al., 1997). Further, stigma often leads to ineffective referrals by professionals wishing to protect the woman's image, hence denying her equal access to more potent forms of referral and suitable care (Loneck et al., 1997). There is clear absence of any proactive interventions in mental health or child welfare systems similar to Employee Assistance Programs (EAPs). The EAP model evolved at male-dominated job sites where alcohol-related problems were identified. Equivalent settings for women, such as child protective services or health care providers, generally lack such interventions. This is unfortunate because these settings are where women are often most likely to be identified as problem drinkers.

Because alcohol results in significant differences between genders in the sequencing of life experience consequences, most alcohol-use disorders screening protocols and instruments are less likely to identify problematic alcohol use among women. This, in concert with stigmatization, prevents many women from receiving effective assistance. This is partially because the current screening instruments fail to examine suitable indicators of problematic alcohol use among women (Blow, 2000; Bradley et al., 1998; Karoll, in press). The protocols and instruments simply do not explore areas specifically relevant to women's

alcohol-related life experience consequences (Ames et al., 1996; Karoll and Memmott, 2001; Russell et al., 1997).

A recent review of current screening instruments suggested, 'gender differences in the signs and symptoms of alcohol abuse warrant differences in the screening methods used, in the way screeners are scored and interpreted, or both' (Russell et al., 1997: 437). Practitioners' screening protocols must compensate for these differences to accurately identify alcohol-use disorders among women. The following presents recommendations proposed to be effective for social work practitioners in detecting problematic alcohol use among women.

Implications for Intervention

The complexity of alcohol-use disorders, particularly gender-related issues, indicates that the need for practitioners' knowledge, insight and compassion is enormous. Effective screening and intervention requires keen self-awareness and personal commitment to change, the ability to interview without evoking denial and defensiveness, competent topic introduction and state-of-the-art knowledge of gender-specific indicators of alcohol-use disorders.

It is understood that bachelors-level curricula in schools of social work in the US are geared more towards educational development than practical application. However, the situations and interviewing techniques presented in this article are equally applicable to general psychosocial assessments and alcohol-use disorders screening protocols. Exceptions relate to introducing the subject of alcohol use and the recommended knowledge of gender-specific indicators.

Self-awareness

Aspects of personal experience will influence how one screens, assesses, intervenes, and guides women with alcohol-use disorders through an agency's system. Workers are encouraged to engage in an honest self-assessment before working with this population (Finkelstein, 1993; Roth, 1991). Any attitudes and beliefs that interfere with a practitioner's ability and effectiveness in working with women exhibiting alcohol-use disorders must be vigorously challenged. We can optimally make use of agency supervision as a mechanism for addressing these shortcomings as a helper.

For various reasons, not all practitioners are emotionally stable enough to work with this population. Data have shown large numbers of helping professionals are children of alcoholics (COAs) (Kinney, 1996). This exposure may affect how practitioners interact with their clients by clouding their judgment concerning expectations and prognosis. Others may support the societal biases that women with alcohol-use disorders are simply more deviant than men, morally weak, or helpless and hopeless.

Fortunately, most are capable of working through personal issues so they

may effectively serve women with alcohol-use disorders. Evaluating one's comfort zone working with women who are affected is essential. Equally important is the acknowledgement of personally held negative biases. Practitioners need to identify the source of these feelings and attitudes. A past involving a family member with the disorder, even a grandparent, often influences the entire family. This is why alcohol-use disorders are described as a family disorder (Wegscheider-Cruse, 1989).

Many practitioners have negative feelings and attitudes towards women with alcohol-use disorders. From a treatment perspective, women who are affected invariably have an exaggerated sense of guilt and shame (Morell, 1997). Their defense mechanisms, or what this author refers to as care strategies (as termed by D'Angelo, 1982), are sharply honed. Clients are amazingly quick to pick up on any negative feelings directed towards them by practitioners, whether intentional or not.

Practitioners' ownership and acceptance of their negative emotions and beliefs is crucial to increase their self-awareness. These unresolved negative attitudes and feelings may often be unintentionally displaced on to the client, intensifying the latter's guilt. Workers and agencies may also perpetuate the stigma to which women with alcohol-use disorders are subjected. Self-awareness and self-change are key to eradicating the stigma sustained by both agency and practitioner as well as clients' mistrust and ill-feelings.

Screening Skills

Social work practitioners are well positioned to effectively screen women for alcohol-use disorders due to their person-in-environment and holistic training (Nelson-Zlupko et al., 1995) and unique biopsychosocial viewpoint (Straussner, 2001). In assisting women who are affected to seek help and develop the desire for change, practitioners can employ approaches that help disarm denial and resistance, that is, motivational interviewing and interventions (CSAT, 1999; Hohman, 1998; Miller and Rollnick, 1991). Offering hope and compassion throughout the process characterizes other significant strategies.

Denial Denial is commonly characterized as the hallmark of alcohol-use disorders. It is generally considered to be 'rationalization, emotional blindness, kidding ourselves, [or] honest self-deception' (Royce and Scratchley, 1996: 96). Conventional screening and assessment protocols for alcohol problems often call for strong confrontation of denial to bring individuals to a point of surrender and willingness to seek healthy changes. This often literally evokes outright denial and glaring resistance (Taleff, 1997). This strategy is perpetuated in the treatment process in mixed-gender group therapy sessions where this confrontation may be seriously detrimental to women with depression or PTSD resulting from physical and sexual assault or abuse (Hanke and Faupel, 1993; Wallen, 1992; Young, 1990).

Social work practitioners need to realize that the development of denial or

resistance is a logical, adaptive consequence of problematic alcohol use. They also need to understand that denial is more than simply being resistant to change. Amodeo and Liftik (1990: 135) wrote, 'practitioners must accept the client's view of reality. Discounting or demeaning the client's views is counter-productive'. Denial needs to be viewed as an unconscious self-protective care strategy rather than a conscious effort to thwart and rebel against change.

From a clinical viewpoint, the presence of denial or resistance is not the client's problem; rather, it is the practitioner's responsibility. Motivational interviewing suggests, 'resistance is observable behavior . . . It signals the therapist that the client is not keeping up' (Miller and Rollnick, 1991: 101). This viewpoint is based on the stages of change proposed in the transtheoretical model of change (Prochaska and DiClemente, 1982; Prochaska et al., 1992). Specifically, those who are precontemplative are either completely unaware or under-aware of any existing problem. They may either be uninformed of the extent of the consequences of their choices, lack any motivation to think about the issue, be discouraged about their capacity to make positive changes, or be defensive against the social pressures being exerted on them for change. Those who are contemplative are fully aware of an existing problem but are unwilling or not prepared to make any commitment to change. However, they intend to make positive changes within the next six months.

Practitioners must suspend all judgment while interviewing women for the presence of an alcohol-use disorder (Copeland, 1997; Russell et al., 1997). Women who are affected often suffer a lack of ego strength, diminished or deflated self-esteem, and exaggerated guilt and shame (Finkelstein, 1993). Any sign of judgment by the practitioner will only result in greater harm and cause her to shut down emotionally. This will manifest itself in signs of resistance or denial.

Motivational interviewing Social work practitioners need to avoid asking why a client drank or engaged in socially unacceptable behaviors. Approaching denial or resistance in a 'care-frontational' rather than 'con-frontational manner' gains client participation and her needed support for change to begin. 'Care-frontation' is the fundamental style of intervention in motivational interviewing (Miller and Rollnick, 1991). Using the elements of client-centered therapy (Rogers, 1951), the practitioner can assess alcohol use in a non-judgmental matter-of-fact manner while avoiding terms that may trigger defensiveness. Listening intently to a client's responses to direct questions about her alcohol use is essential.

Motivational interviewing was developed to identify alcohol-use disorders (Miller and Rollnick, 1991). Theoretically based on the transtheoretical model of change, this technique primarily focuses on the stages of change. Moreover, it integrates Rogers' (1951) concept of client-centered interpersonal relationships. Essential to this strategy is using Rogers' four basic therapeutic elements of unconditional positive regard, empathy, genuineness and concreteness.

Remarkably, these components are useful when interviewing any client, not just those suspected of having an alcohol-use disorder.

Motivational interviewing has been expanded to include a greater variety of interventions applicable for working with this population (CSAT, 1999). These strategies are evidence-based practice in the field of substance-use disorders. Emergency departments (Bernstein et al., 1997), obstetric clinics (Handmaker et al., 1999) and medical settings (Ockene et al., 1997) have demonstrated their effectiveness in motivating clients towards positive changes in their alcohol and drug use and other behaviors. They have also proven successful with populations of African Americans, adolescents, women, clients in short-term residential treatment and group therapy settings (CSAT, 1999).

Avoiding labeling or declaring any problem exists, the practitioner simply reports what the data obtained through the interview seem to indicate. The worker summarizes the findings by reviewing the impairments and consequences experienced by the client, such as any withdrawal symptoms, obstetric and gynecological medical problems, alcohol-related motor vehicle issues, assault and abuse history, and diagnosis of co-occurring psychiatric disorders. Next, the woman is asked whether she sees alcohol contributing to her current situation. It is then suggested she express her perception of what significant others might say based on the current findings of the interview. This is generally effective in helping individuals recognize alcohol problems on their own without harsh confrontation.

Offering hope and compassion Hope and compassion are powerfully effective tools that practitioners can use with women with alcohol-use disorders (Akin and Gregoire, 1997; Copeland, 1997). The absence of confrontation allows someone the dignity to reassess her lifestyle in a safe, supportive environment, based solely on factual gender-specific information on alcohol use. For many, this will be the first time they have considered alcohol as being the essence of their problems. Others have probably contemplated it for some time, but feared frank discussion of this possibility. The ability to discuss such an emotionally charged subject with compassion in a non-judgmental, non-confrontational manner provides the preliminary groundwork for hope in potential recovery. It dispels any expectations of anticipated stigma attached to women's alcohol use. Maintaining poise and compassion positions the worker as a powerful ally when the client is feeling at her most vulnerable.

Offering hope is a diverse undertaking. The practitioner needs to let the client know that she is capable of recovery even if she does not believe it is possible. To this end, the worker can utilize a core value that is embedded within social work, which emphasizes that all people are capable of change. Next, the worker will need to continually reiterate that recovery is possible. Having recovering women available as references and guides through the recovery process should she desire assistance will help overcome this hurdle.

As a social work practitioner, help the client know you will support her

throughout the recovery process. Make yourself available as a safe supportive ally in whom she can confide at any time. Coordinating services and facilitating change help the client realize you are there for her and are prepared to advocate on her behalf. The early recovery from alcohol-use disorder requires having such safe, supportive people being available.

Topic introduction The initiation of questions about alcohol use is difficult for many practitioners. Hesitating because of not knowing how to intervene when a problem is identified, finding it safer not to ask in the first place, or wishing to avoid embarrassment for the client may be the cause of this (Maxmen, 1986). Alternatively, holding negative biases and feelings may provide a plausible explanation for this phenomenon. Either will lead to failed screening efforts. Women with alcohol-use disorders sensing any judgment or negativism concerning their lifestyle will not honestly participate in the screening interview process.

To elicit the most honest responses, directness and specificity of the questions asked in a nonchalant fashion are recommended. A matter-of-fact introductory statement indicating a need to enquire about the client's lifestyle that includes alcohol and drug use is the preferred approach. This reduces the client's shock and possible defensiveness. An uncomfortable practitioner may defer the responsibility for following this line of questioning to supervisors or agency policy requiring the exploration of alcohol and drug use.

It is best to assume clients consume alcohol from time to time. However, cultural aspects need to be considered, such as large segments of Christian and Muslim populations. An opening of 'When you drink' or 'After a drinking episode' will elicit more honest responses than 'Do you drink?'. Using closed-ended questions about alcohol use provides clients with the opportunity to sabotage screening efforts from the onset with negative responses. If negative responses to initial alcohol-related questions are non-defensive, the practitioner may accept them as probably true.

Practitioners need to avoid emotionally charged terms during the interview. Avoid asking if she abuses alcohol or has a problem with it. Never refer to her as an alcoholic. Labeling of any kind during the interview will only cause her to immediately shut down. Once this shutting down occurs, it is most difficult to re-engage her in the interview process.

If defensiveness arises, a practitioner's skills at overcoming it are challenged. Reassure her that the concern is only with possible impairments and consequences and not about frequency or quantity. Remain calm and draw on your knowledge of women's gender-specific alcohol-related issues, then continue with a non-judgmental probe into her response to 'never' drinking. It is highly important to go beyond an initial negative response for several reasons. Some may not consider certain drinks to be alcoholic beverages, such as wine, wine coolers, beer, malt liquor or liqueurs. Others may not consider past use problematic. Finally, individuals presenting with a drug problem often

may not consider drinking alcohol to be problematic. Practitioners easing a client's tension this way will most likely gain an admission of occasional alcohol use. This retraction of non-use is the first positive step towards getting a thorough screening with someone who is unaware, under-aware, or knowingly attempting to conceal alcohol-related problems.

Screening Indicators

Klee et al. wrote, 'An indicator is evidence that a woman has or is developing a drinking problem, and it may be apparent to the woman herself or to others' (1991: 881). Screening for alcohol-use disorders requires knowledge of significant gender differences. Elevated peak BAC levels with less consumed and the influence of hormonal variation caused by menstrual cycles are prime examples. Obstetric and gynecological impairments associated with women's alcohol use are others. Their help-seeking patterns and a higher prevalence of physical abuse or sexual assault or abuse and co-occurring psychiatric disorders among affected women must also be considered in an interviewing protocol. Thus, frequency and quantity formulae are less important than enquiries concerning impairments and consequences.

Significant problem indicators include withdrawal symptoms and medical problems related to obstetric and gynecological difficulties. Telescoping of withdrawal symptoms among women is noteworthy, so it is logical to explore possible alcohol-related obstetric and gynecological impairments. Richmond (1917/1944) and Blume (1985) proposed the need for a separate set of questions related to the menstrual cycle for investigating problematic alcohol use. Past psychological problems are also worthy of investigation. Women's help-seeking behaviors are indicative of this phenomenon.

Exploration of alcohol-related motor vehicle difficulties will also serve to detect problematic alcohol use. While this may be a function of age, all women with alcohol-use disorders are at risk of being involved in alcohol-related motor vehicle accidents or being arrested for driving under the influence. Admittedly, younger women drink more heavily in public settings, thus exposing them to legal intervention. Conversely, because older women were found to experience these problems later in their drinking career than men (Karoll and Memmott, 2001), exploration of alcohol-related motor vehicle consequences is justified.

Finally, a sensitive enquiry into a woman's history of past or current physical or sexual assault or abuse and domestic violence is indicated. This must be conducted in a fact-finding, non-judgmental fashion. It is important to screen for alcohol-use disorders, childhood trauma, adult trauma, or both, and domestic violence whenever either has been identified. This will aid in determining appropriate interventions and effective relapse prevention strategies for the client with this constellation of problems (Bennett, 1995).

It is accepted practice that many of these areas are explored in other sections of intake screening and assessment protocols. By connecting them to

one's alcohol use, a client may draw conclusions for herself about her alcohol-related problems based on their relationship to her past and current situation. Once a connection is made, positive change and growth may earnestly begin.

Conclusion

Alcohol-use disorders continue to be serious health and mental health issues in the US. Society is only beginning to acknowledge that alcohol and other drugs affect women in almost equal numbers compared with men, though stigma persists. Key research indicates that there is substantial evidence of the existence of several significant gender-specific differences in relation to alcohol-use disorders and that all social work practitioners need to recognize these differences. The existing barriers to screening, assessment and treatment and the improper diagnosis of women with alcohol-use disorders need to be overcome.

More importantly, lack of adequate training for practitioners in problematic alcohol use in general, and women's issues in particular, must be addressed. This author suggests using classrooms as working laboratories for social work practitioners where the students may explore their personal negative biases and feelings towards those with alcohol-use disorders. In addition, baccalaureate and master's-level curricula in schools of social work are encouraged to integrate substantive gender-specific information on women and alcohol use. Role-playing the various stages of change in groups will aid students to better understand each one through personal engagement and observation. *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1999) and the work of Patricia Dunn (2000) both serve as excellent educational resources for understanding the stages of change and motivational interviewing. This process may also be integrated into agency in-service programs.

Social work practitioners are called upon daily to conduct psychosocial screening and assessments. They are the front-line workers who provide the bulk of direct services. As such, it is essential that they have sufficient knowledge of alcohol-use disorders so that they may perform their duties effectively.

Notes

1. The author wishes to thank Dr John Poertner, Dr Jay Memmott and Dr Edward Taylor for all their help and support in preparing this article for publication.
2. Outside the US this is known as 'undergraduate' or 'bachelors' level.
3. The 'quantity plus frequency formulae' is a measure of how much alcohol is consumed over what period of time.

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