Midlife women maintaining enriching recovery from alcohol dependence

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Abstract
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MIDLIFE WOMEN MAINTAINING ENRICHING RECOVERY FROM ALCOHOL DEPENDENCE

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This transdisciplinary qualitative action research was initiated to explore why the number of midlife women diagnosed alcohol dependent in Australia had risen from 8% in 1996 to 16% in 2005, with most being non-disadvantaged women, and to propose holistic and gender-sensitive ways for addressing this and preventing further increase.

Method: Two groups of participants were recruited using the Australian media: 25 to 60 year old women who have been alcohol dependent but abstinent for more than two years, and healthcare professionals caring for such women. The research was collaborative using a comprehensive social ecology framework (Hilli 1996). Mixed methods and technologies (eg NVivo 7, OriginLab 7.5 software) were used for data collection and analysis, which was guided by participants’ cross checking, critical reflection, and provision of “care with compassion” (Bourgeois 2005). Results were compared with the findings of two current Australian studies on women’s health and mental health.

Findings: Highlight the need for a greater emphasis on recovery over harm minimisation policies and services, and on the need to transform Australia’s “cultural acceptance of intoxication.” Most medical and health professionals were significantly unaware of the rapid increase among women of alcohol misuse, and associated abuse and its complex mental and physical effects. Few were up-to-date with the current understanding of alcoholism as a brain disorder and with the interrelationships between genetic and environmental risk factors and predispositions. There was also little understanding of the particular barriers for midlife women seeking access to effective health treatments and support such as the stigma and discriminatory attitudes towards “female drunks, especially mothers.”

An “ecology of recovery” (living systems) and transformative learning approach to recovery was designed to address women’s needs and improve professional practice. This neuropsychosocial approach emphasised provision of a safe, nurturing place with time to focus on the women’s self-engagement, embodiment and enrichment (Witthall 2006), and therapeutic peer support to enable them to build resilience and progress towards self-managed long-term recovery. This approach, our improved model of midlife recovery, and proposed mental health practice theory of “integrative change” can support women’s transition through this chaotic chronic illness to fulfilling wellbeing.

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TOBACCO USE AND NICOTINE DEPENDENCE IN A TREATMENT-BASED SAMPLE OF PREGNANT DRUG DEPENDENT WOMEN WITH AND WITHOUT COMORBID PRENATAL ALCOHOL USE

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The majority of pregnant illicit drug dependent women also use or abuse legal substances such as alcohol and tobacco. Both of these substances are associated with a variety of adverse maternal and infant outcomes (e.g., low birthweight, mental retardation, prematurity), yet they are often overlooked by treatment providers who focus instead on the cocaine and/or opiate dependence. The present study examined smoking characteristics and severity of nicotine dependence in a sample of cocaine and opiate dependent pregnant women with and without co-morbid alcohol problems. Participants were 109 pregnant drug dependent women admitted to residential treatment. All provided consent as part of a larger behavioral research project and completed the Addiction Severity Index (ASI) and Fagerstrom Test for Nicotine Dependence (FTND) as part of baseline assessment. Participants had an average age of 29.1 years (SD = 4.4 years) and 87% were African American. Women were categorized as alcohol positive (Alc+): if they reported any alcohol use in past 30 days and alcohol negative (Alc-): if no recent (past 30 days) drinking was reported. Nearly all women reported recent tobacco use (79% daily use past 30 days). While Alc+ and Alc- women reported smoking similar numbers of cigarettes per day (Mean = 17 cig/day, SEM 1.0), a positive correlation was found between number of drinks consumed per day and number of cigarettes smoked per day in the month prior to treatment enrollment (r=0.4). Interestingly, however, Alc- women obtained higher mean FTND scores than Alc+ women (4.5 (SEM 0.2) and 3.5 (SEM 0.4), respectively) (p<.05). Study findings confirm high rates of comorbid alcohol and tobacco use in pregnant drug dependent women. Results also suggest alcohol and tobacco use are related to one another and that treatment providers should address use of both substances during treatment planning as prenatal alcohol and tobacco consumption are associated with negative maternal and infant outcomes.

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NALTREXONE DECREASES ALCOHOL DRINKING LEVELS IN SMOKING CESSATION

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There is some support for the efficacy of the opioid antagonist naltrexone in the treatment of nicotine dependence. One potential unexplored mechanism underlying naltrexone’s effects in smoking cessation may be in its ability to reduce alcohol consumption, as alcohol can be a potent trigger for smoking relapse. Alcohol consumption (weekly drinking levels and binge drinking rates) and liver enzyme levels (AST, ALT) were examined in a sample of 78 nonalcoholic social drinking smokers (34 naltrexone, 44 placebo) enrolled in a double-blind randomized clinical trial of naltrexone in smoking cessation. Naltrexone (50 mg) or placebo began three days prior to the quit date (25 mg daily) and continued for eight weeks (50 mg daily). All participants received nicotine patch and behavioral counseling up through four weeks after the quit date. Baseline drinks per week was similar between the naltrexone and placebo groups (M (SEM) = 7.6 (0.9) drinks weekly). Naltrexone significantly decreased weekly alcohol drinking during the first two weeks after the quit date compared with placebo (4.2 (1.0) versus 6.5 (1.2) drinks weekly, respectively; week x group: beta (se) = 0.266 (0.127), p <.05), but this difference was no longer evident during the ensuing six weeks of treatment. Within the subgroup of regular binge drinkers (N=38, 15 naltrexone, 21 placebo), naltrexone but not placebo significantly decreased binge drinking rates over the majority of the weekly intervals during the eight weeks of treatment (week x group: beta (se) = 1.259 (0.254), p <.001). Further, smoking cessation outcomes were better in binge drinker on naltrexone vs. placebo (80% vs. 52% quit after one month; Y^2 = 2.89, p=0.09). AST and ALT levels were similar at baseline and there was no statistically significant difference in elevations of AST or ALT between the placebo and naltrexone group. In sum, naltrexone appears to increase smoking quit rates and reduce alcohol drinking levels, particularly in heavier social drinkers and during the early stages of smoking cessation treatment. These data were supported by a biomarker of drinking outcomes and indicated that naltrexone at 50 mg daily does not cause significant liver inflammation in smokers.

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INPATIENTS WITH UNHEALTHY ALCOHOL USE: DRINKING AND ALCOHOL CONSEQUENCES AT 12 MONTHS

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Background: In medical hospitals, most patients drinking at-risk amounts meet criteria for alcohol dependence. But the natural history of unhealthy alcohol use and predictors of favorable outcome have not been well characterized.

Method: Medical inpatients drinking at-risk amounts were assessed at baseline and 12 months later on consumption (30-day Timeline Follow-Back) and alcohol related consequences (Short Inventory of Problems). Physical health-related quality-of-life was assessed with the Short-Form Health Survey (PCS score), depressive symptoms with the Center for Epidemiologic Studies Depression scale (CESD) and commitment to change with the Taking Action scale derived from the SOCRATES. For each subject, drinking was categorized as either favorable (defined as abstinence or drinking “moderate” amounts [i.e. less than at-risk amounts] without consequences) or unfavorable (drinking moderate amounts with consequences or drinking at-risk amounts [1-4 drinks/wk or >=5/occasion for men, >7/wk or >=4/occasion for women aged >=66]). Logistic regression adjusting for age, gender, race/ethnicity, PCS score and drinks/day at baseline was used to evaluate predictors of a favorable outcome.

Results: Of the 341 subjects, 84% had complete data at 12 months. They drank a mean (SD) 6.8 (8.9) drinks/day, 70% were men, 78% had alcohol dependence. At 12 months, 33% had a favorable outcome. In the adjusted logistic regression model, no time with heavy drinking (defining a “consequence” as drinking at-risk amounts) was associated with a favorable outcome. In the adjusted logistic regression model, no time with heavy drinking (defining a “consequence” as drinking at-risk amounts) was associated with a favorable outcome. In the adjusted logistic regression model, no time with heavy drinking (defining a “consequence” as drinking at-risk amounts) was associated with a favorable outcome.

Conclusions: Although most inpatients with unhealthy alcohol use continue to drink at-risk amounts and/or have consequences, one third are either abstinent or drink moderate amounts without consequences 1 year later. Less social pressure to drink, receipt of alcohol assistance, and commitment to change drinking are positively associated with this favorable outcome.