



Alcohol use and serious psychological distress among women of childbearing age

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ABSTRACT

Objective: The purpose of this study was to present nationally representative findings on the prevalence and co-occurrence of alcohol use and serious psychological distress among women aged 18–44 years, as well as their access to health care.

Methods: A total of 24,900 women aged 18–44 years participated in the National Health Interview Survey (NHIS) during the years 2003–2005. Using data from the cross-sectional survey, we estimated the prevalence and co-occurrence of alcohol use and serious psychological distress among this population; this association was examined using logistic regression. Health care access among women who used alcohol and had serious psychological distress was characterized by co-occurring status.

Results: During the study period, the estimated annual prevalence was 4.1% for heavier alcohol use, 56.0% for non-heavier use, 39.8% for nonuse, and 3.6% for serious psychological distress among women aged 18–44 years. Women who experienced serious psychological distress were at an increased likelihood for alcohol use, particularly heavier use. Alcohol use and serious psychological distress co-occurred among an estimated 1.1 million women of childbearing age in the United States annually. Most women, regardless of their co-occurring status, reported being treated by clinicians in various health care settings during the previous 12 months.

Conclusions: Alcohol use is common among women of childbearing age who experience serious psychological distress. The findings of this study provide support for enhancing efforts toward integrated assessment and intervention among women who have such co-occurring risk factors.

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1. Introduction

Alcohol use can co-occur with general psychological distress and specific psychiatric disorders, resulting in heightened risks for morbidity and mortality, as well as significant socioeconomic costs (Caldwell et al., 2002; DHHS, 2001, 2002, 2006; Kessler et al., 2005; Li, Hewitt & Grant, 2004). Women, particularly those of childbearing age, have a higher prevalence of psychological distress as compared to men (Ahluwalia, Mack & Mokdad, 2004; Becker & Hu, 2008). In addition, women develop alcohol addiction faster, become intoxicated with smaller amount of alcohol, and suffer more serious health consequences than do men (Ahluwalia et al., 2004; Becker & Hu, 2008; Caetano, Ramisetty-Mikler, Floyd & McGrath, 2006; CASA, 2005; NIAAA, 2004). Women with

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alcohol use disorders are more likely to experience psychological distress than those without such disorders (Kessler et al., 1997), and women with psychological distress often continue to use alcohol despite knowing that they are pregnant and have been advised by their clinician against alcohol use (O'Connor & Whaley, 2006). Not surprisingly, co-occurring alcohol use and psychological distress among women of childbearing age can exacerbate or contribute to a multitude of health and social problems, such as physical and psychological illness; disability and premature death; interpersonal conflicts; violence and legal problems; unemployment; poverty (DHHS, 1999, 2002; Drake et al., 2001; Parks, Romosz, Bradizza & Hsieh, 2008); and a number of hazardous reproductive outcomes, including an alcohol-exposed pregnancy (Diego et al., 2006; Floyd, O'Connor, Sokol, Bertrand & Cordero, 2005; Henriksen et al., 2004; Kelly et al., 2002).

Advances in clinical research during the past several decades have revealed that the key to effective treatment of these co-occurring conditions is the integration of biological, psychological, and social support to form a cohesive and unitary system of care (DHHS, 2002; Drake et al., 2001; Mueser, Noordsy, Drake & Fox, 2003; Ries, 2006; Sciacca & Thompson, 1996; Velasquez, von Sternberg, Mullen, Carbonari & Kan, 2007). To date, dual diagnosis and treatment programs are emerging as a cost-effective, evidence-based practice, and are becoming more widely available in the United States (Drake et al., 2001; Hendrickson, Schmal & Eckleberry, 2004; Mojtabai, 2004; Mueser et al., 2003; Sciacca & Thompson, 1996). However, sufficient evidence exists to show that co-occurring alcohol use and psychological distress conditions not only are still prevalent, but also frequently underdiagnosed and inadequately treated in many health care settings (Hendrickson et al., 2004; Kessler, Chiu, Demler, Merikangas & Walters, 2005; Kranzler & Rosenthal, 2003; Ries, 2006). Although of considerable interest to practicing clinicians as well as public health professionals, substantial empirical data are still lacking regarding alcohol use and psychological distress among women of childbearing age, and their access to health care. Such nationally representative evidence is important in identifying the need and opportunity for clinical practice, as well as informing the potential development of evidence-based strategies for improving public health outcomes among this vulnerable population (DHHS, 2002; Kranzler & Rosenthal, 2003; Mueser et al., 2003; Tsai, Floyd & O'Connor, 2008). For these reasons, we analyzed public release datasets from the National Health Interview Survey (NHIS) 2003–2005 with the primary objective of presenting nationally representative findings on the prevalence and co-occurrence of alcohol use and psychological distress among the general population of women aged 18–44 years in the United States. A secondary objective was to characterize health care access among sampled women by co-occurring status for alcohol use and psychological distress.

2. Methods

2.1. Study population

The NHIS is a multipurpose, nationwide household health survey of the U.S. civilian noninstitutionalized population conducted annually by the Centers for Disease Control and Prevention (CDC) (CDC, 2005a). The NHIS uses a multistage, clustered sample with cross-sectional survey design to produce national estimates for a variety of health indicators. Survey data are weighted by age, sex, and race to be representative of the United States general population (CDC, 2005a). The NHIS sample adult core questionnaire is to collect information on health conditions, activity limitations, health behaviors, and access to and use of health care services from one randomly selected adult 18 years and older per family (CDC, 2005b). Data are collected continuously throughout the survey year in all 50 states and the District of Columbia using computer-assisted personal interviews (CAPIs) conducted in the homes of participants. The final sample adult component response rates were 69.0%–74.2% for the years 2003–2005 (CDC, 2005b). This study included a combined total of 24,900 women aged 18–44 years, who participated in the NHIS during the years 2003–2005. All 3 years of data were combined to increase statistical reliability and to allow the analysis of some population subgroups that otherwise would have been too small to produce statistically reliable estimates (CDC, 2005a; Korn & Graubard, 1999).

2.2. Measures

2.2.1. Alcohol use

The patterns and average volume of alcohol use can affect the outcomes for alcohol-related diseases and conditions among women of childbearing age (Rehm et al., 1996, 2003; Tsai, Floyd, Green & Boyle, 2007a). Among many alcohol use measures, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has indicated that women might be at risk for alcohol-related problems if their alcohol use exceeds 7 drinks per week (Gunzerath, Faden, Zakhari & Warren, 2004; NIAAA, 2005). NHIS screens participants for alcohol use, and collects the quantity and frequency information of typical alcohol use for a 12-month time period before the interview (Schoenborn & Adams, 2002). A recode variable for alcohol use released as part of the NHIS public datasets was adopted in this study (CDC, 2005a). Specifically, women who engaged in heavier alcohol use were defined as having had, on average, more than 7 drinks per week in the past year; women who engaged in non-heavier use were defined as having had, on average, no more than 7 drinks per week in the past year; and women who were nonusers were defined as having had no alcohol drinks at all in the past year.

2.2.2. Psychological distress

Kessler's 6-Question Scale (K6), a part of the NHIS, was used to measure the non-disease-specific symptoms of psychological distress in the general population over a 30-day recall period (Table 1) (Kessler et al., 2002, 2003). A summed score of 13 or more,

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