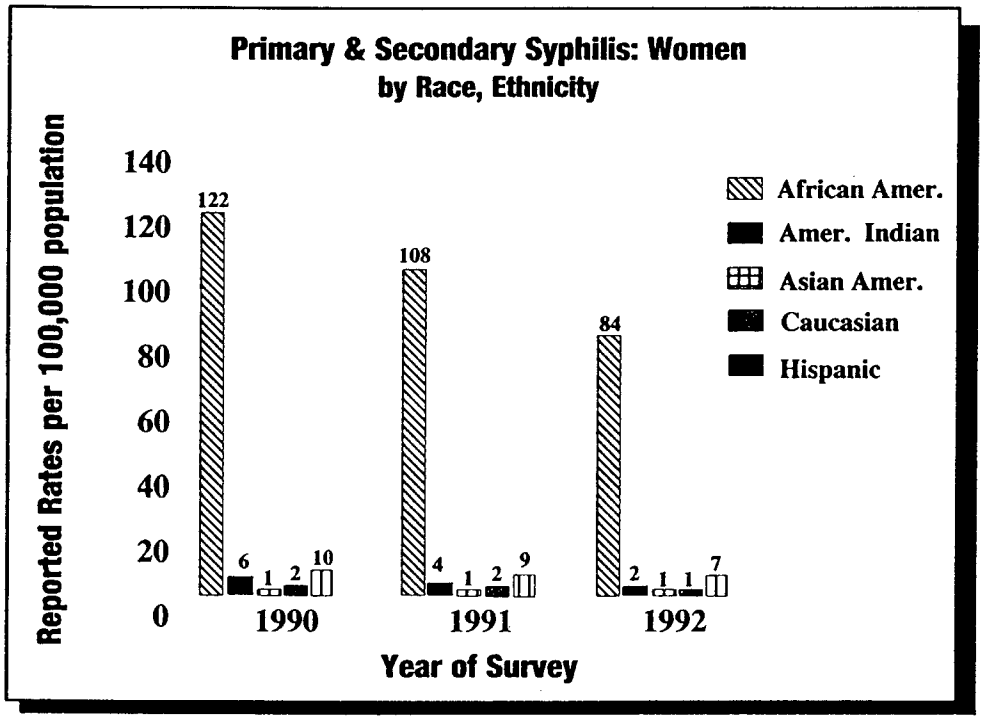
Figure 8



Sexually Transmitted Disease Surveillance 1992, 166-167.

again to 13.7/100,000. The rate of primary and secondary syphilis among women was 17.5, 15.4 and 12.2/100,000 in 1990, 1991 and 1992, respectively.[71] However, the rates for Caucasian women were far lower than those for African American, Hispanic, and American Indian women in the same years, as Figure 8 shows.

While the rate of gonorrhea among women decreased from 247.1/100,000 in 1988 to 175.5/100,000 in 1992, it is still a disturbing incidence. Moreover, as for syphilis, the race/ethnic differences are significant. For example, in 1992, the most recent year for which race/ethnic data are disaggregated for women, the rates per 100,000 population were: 43.0 for Caucasian women, 1,130.8 for African American women, 119.6 for American Indian women, 26.6 for Asian American women, and 92.5 for Hispanic women.[72]

The rate of chlamydia in women, which can result in serious reproductive track complications such as pelvic inflammatory disease, infertility, and ectopic pregnancy, more than doubled in the five year period from 1988 to 1992, from 133.5/100,000 to 270.0/100,000.[73] The rate of congenital syphilis among infants less than one year of age increased from 3.0/100,000 live births in 1980 to 44.7/100,000 in 1990.[74] The rate more than doubled from 1989 to 1990 (to 91.0/100,000 live births),[75] although this is reportedly in large part a result of a change in the case definition used by the Centers for Disease Control and Prevention (CDC). After increasing to 107.5/100,000 live births in 1991, the rate of this STD, which is among the most prevalent, decreased to 94.7/100,000 in 1992.[76]

An important consideration for prevention and treatment programs is that STD rates differ significantly by geographic area of the country. In New York City, for example, a 500 percent increase in reported congenital syphilis was reported between 1986 and 1988.[77] Data are not generally available on the incidence of STDs among women who abuse alcohol or other drugs.

AIDS was the second leading cause of death for American women between the ages of 25 and 44 in 1992,[78] and women constitute nearly 12 percent of cumulative diagnosed cases of AIDS.[79] According to the CDC, as of March 1993, 32,477 women (11 percent of the total diagnosed cases) have AIDS. More than 100,000 women are infected with HIV.[80] CDC reports indicate that 75 percent of women and 80 percent of children with AIDS are members of a racial or ethnic minority population. More than half of women diagnosed with AIDS are African American (53 percent), and 20 percent are Hispanic. Of pediatric cases, 55 percent are African American, and 24 percent are Hispanic.[81]

Although HIV infection is a major health problem for women, many cases may be undiagnosed by physicians because they are unaware of the signs and symptoms in women. The 1992 change in the case definition of AIDS, which broadened the scope of opportunistic infections associated with AIDS, has been an important factor in recognizing the disease's impact on women. However, death rates among women who are HIV-positive are higher than those for men, perhaps because of late clinical identification of HIV infection. It should also be noted that the adverse effects of chronic alcohol use on the immune system may increase rates of progression from HIV to AIDS in women.[82] Since many women die before an HIV diagnosis is made, the numbers of women with HIV may be considerably higher than those reported.

Women who inject drugs and/or who have been the sexual partners of past and present injection drug users are at greatest risk for HIV infection. Nearly half of women with AIDS (49 percent) inject drugs. An additional 21 percent are sexual partners of injection drug users. Of the pediatric cases, 39 percent result from a mother's injection drug use and 17 percent from the mother having had sex with a partner who injected drugs.[83]

Women who inject drugs and/or who have been the sexual partners of past and present injection drug users are at greatest risk for HIV infection.

Although the public health community has concentrated on the relationship between injection drug use and HIV, there is growing evidence of a need to recognize the relationship between the use of any mind-altering substance and high-risk sexual activity. For example, one study in Florida reported a strong relationship among the number of sexual partners, drug use, condom use, and HIV-seropositivity.[84] Among the 50 drug users in the study, only one was injecting drugs. Ninety-seven percent were current users of crack, and, for the group as a whole, about 50 percent had either HIV or AIDS. In fact, numerous recent studies suggest that women who use crack cocaine may be at equal or greater risk for HIV and other

STDs than injection drug users. Accumulating evidence links increases in syphilis rates and HIV infection to the crack cocaine epidemic and indicates that crack cocaine users have significantly higher rates of STDs than nonusers.[85] According to Sterk and Elifson, for example, women who use crack cocaine may have a higher rate of sexual encounters, are more likely to engage in unsafe sex than women who use other drugs, and may trade sexual favors or engage in prostitution to obtain drugs.[86] These women are also more likely to contract STDs, which are linked with high HIV infection rates.

A woman who uses any mind-altering drug (including alcohol) can be at risk for STDs.

A woman who uses any mind-altering drug (including alcohol) can be at risk for STDs (as well as HIV and unwanted pregnancy) because her inhibitions are eased and her decision-making ability is altered. Even if she would otherwise intend to refrain from risk-taking behavior (e.g., multiple partners or unprotected sex), she might engage in such behavior while under the influence of alcohol, crack cocaine, cocaine, marijuana, or other drugs. Moreover, the compulsive use of drugs may increase a woman's risk for STDs if she engages in sex for drugs or for money to buy drugs.

2.3.1.2 Tuberculosis

Cases of tuberculosis (TB), once considered nearly eradicated in the United States, are increasing at an alarming rate for the population overall. According to the CDC, nearly 9,000 women, most between the ages of 25 and 44, were reported with verified cases of TB in 1993. African American women have the highest rates of TB followed by Asian American and Hispanic women.[87] Foreign-born women, who account for nearly one-third of reported TB cases are disproportionately represented. Women with HIV infection and homeless women are at especially high risk for contracting TB. Furthermore, injection drug users have higher rates of TB whether or not they are HIV-positive.[88]

2.3.2 Psychological Effects

The term "dual diagnosis" is applied most often to the co-occurrence with substance abuse of major psychiatric disorders; in women, these are usually depression, anxiety, and other mood disorders. It is important to note that women addicted to alcohol and/or other drugs may, early in the recovery process, present with symptoms of depression, anxiety, and mood disorders. These may be temporary conditions associated with withdrawal symptoms. For clients with bipolar affective disorder, appropriate use of lithium has not been found to interfere with recovery from addiction to alcohol or other drugs.

The concept of dual diagnosis is controversial. This controversy has been fueled by the way alcoholism treatment specialists and mental health providers perceive and treat substance abuse problems. The problem has been exacerbated by a lack of understanding of the nature of co-occurring disorders by many physicians who have prescribed sedatives/hypnotics or tranquilizers to women already experiencing alcohol and other drug problems.[89] Practitioners in both fields are now recognizing that substance abuse and mental health problems often coexist and must be addressed simultaneously, with particular interest "in the relationships between specific psychiatric syndromes and alcohol problems, primarily depression and antisocial personality disorder."[90] Clinical researchers distinguish "between those persons with an alcohol problem who were found to have a preexisting psychiatric condition and those whose psychiatric problem emerged subsequent to the onset of heavy drinking."[91] This distinction is important because in the latter group, many symptoms (especially anxiety and depression) clear within a month of cessation of drinking. Research has documented the rate and pattern of improvement: For those with a primary psychiatric disorder, improvement will be slower and will depend on effectively addressing this disorder.

Substance abuse and mental health problems often coexist and must be addressed simultaneously.

There has been little research to determine the prevalence of dual diagnosis among women. The data that does exist indicate that dual diagnosis is prevalent in the total population. For example, the 1980-1982 National Institute of Mental Health (NIMH)-sponsored Epidemiologic Catchment Area (ECA) survey of more than 20,000 adults in five communities within the United States found that more than 34 percent of the respondents had experienced a form of mental illness or chemical dependency at some time during their lives.[92] Approximately 23 percent of the respondents indicated a history of psychiatric problems, and 16 percent had a substance abuse disorder. These findings suggest that a significant number of those surveyed had two or more conditions. Approximately three out of ten individuals in the survey reporting a psychiatric illness were diagnosed as also having a substance abuse disorder at some time during their lives.[93]

Blume's 1990 discussion of Helzer's and Prybeck's analysis of the ECA concurs with Daley's findings and adds information specific to co-occurring disorders among women. According to Blume, "65 percent of female alcoholics, compared with 44 percent of males, had a second diagnosis."[94] Thirty-one percent of the women with an alcohol diagnosis had drug abuse or dependence as a co-occurring disorder, while men with an alcohol diagnosis showed a 19 percent co-occurring drug dependency.[95] Significantly, Blume also reports that not only were women with alcohol diagnoses more likely than men with alcohol diagnoses to have alcohol-related co-occurring disorders, but there were differences in the types of second diagnoses present. For women, major depression co-occurred in 19 percent (almost four times the rate for men); phobic disorder was diagnosed in 31 percent (more than twice the rate for men); and panic disorder occurred in 7 percent of the women (three and one-half times the occurrences in men). In comparing the rates of mental disorders in women with alcohol-related diagnosis to women in the general population, the rates of these

second diagnoses were considerably higher in the former group (e.g., the major depression rate was nearly triple that of the general female population, the rate for phobias was nearly double, and antisocial personality occurred in 10 percent of women with an alcohol-related diagnosis, which was an astounding 12 times higher than the rate in the general population of women).[96]

2.4 Population Cohorts

This section of the manual presents summary epidemiologic data on several groups of women: older women, pregnant and postpartum women, women in the criminal justice system, homeless women, lesbians, women with disabilities, African American women, American Indian women, Asian and Pacific Islander women, and Hispanic/Latina women. It should be noted that additional information relevant to these population groups is presented in chapters 4, 5, and 6.

2.4.1 Older Women

In this manual, an "older" person is defined as a person 65 or older. Women in this age group who abuse substances have not been the subject of many research studies. The Food and Drug Administration has rarely included older women in studies evaluating medications, nor have drug companies included such women in their clinical trials,[97] in spite of the increasing awareness of the problem of substance abuse among the elderly and the consequent health and socioeconomic problems.[98]

Older people are the most frequent users of prescription medications, accounting for approximately 25 percent of all prescriptions filled, although they comprise only 12 percent of the total U.S. population according to the 1990 census.[99]

The types of drugs that generate the most substance abuse problems in older people are analgesics and benzodiazepine tranquilizers, such as Valium, which usually are prescribed for conditions of chronic pain and/or chronic depression and anxiety. Slow metabolism of a psychoactive drug can lead to interactions with alcohol that can continue for several days after the most recent consumption of the drug.[100]

Variations exist in prescribed drug use among racial/ethnic minority groups. For example, Hispanic women older than 60 years use Valium, Librium, and Tranxene more than do other women in this age group and use these drugs for longer periods and with greater frequency. However, African American women over 60 years of age report little use of psychotropic medications of any kind, in comparison with Caucasian and other women.[101] Access to health care providers who may prescribe drugs is a possible factor in this difference.

The alcohol-related cost of hospital care for the elderly was estimated at $60 billion in 1990.

An estimated 2.5 million older Americans have alcohol-related problems. Studies have shown that 21 percent of hospitalized patients over 60 who are hospitalized have a diagnosis of alcoholism. The alcohol-related cost of hospital care for the elderly was estimated at $60 billion in 1990. Of the 30,916 older Americans whose deaths in 1985 were attributed to alcohol abuse, each theoretically shortened her or his life by ten years. In addition to the loss in human terms, this translates into a productivity loss of $624 million.[102]

Research consistently indicates that alcohol consumption decreases among persons in their 60s. However, this conclusion is largely based on cross-sectional studies that compare the drinking patterns of different age groups at a given point in time. This research method often does not account for the cultural and other influences on differences in drinking attitudes and behaviors that may be present within the various groups

studied. It is possible that longitudinal and cohort analyses would result in different findings with respect to alcohol consumption patterns among older Americans.[103]

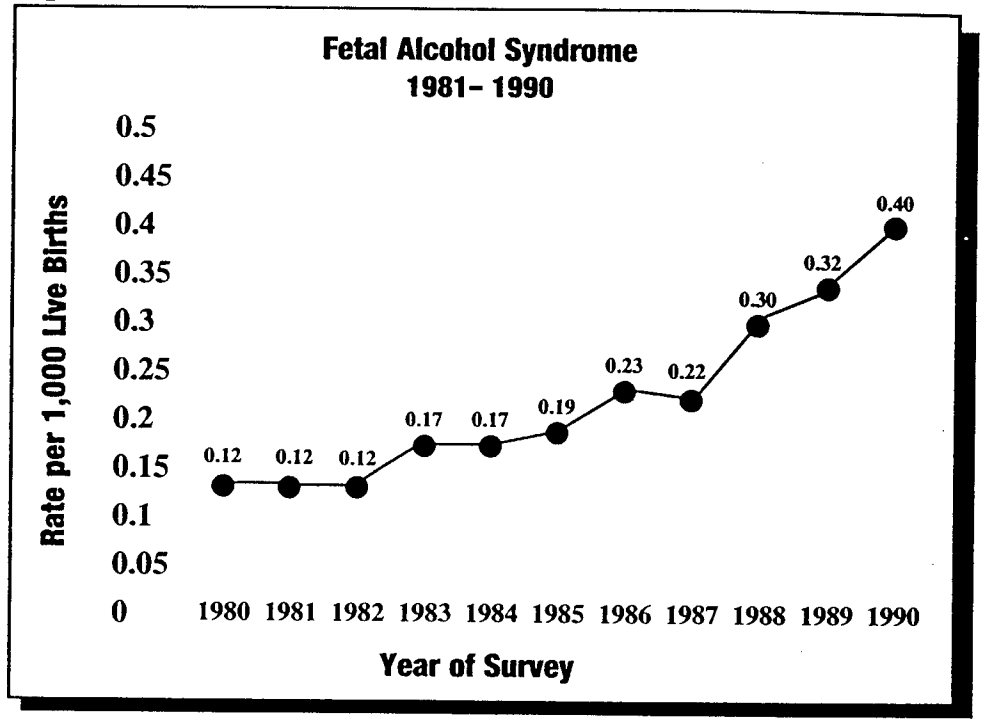
2.4.2 Pregnant and Postpartum Women

Pregnant and postpartum women who use alcohol and other drugs are at risk for dangers to the fetus, HIV infection, STDs, forms of hepatitis, tuberculosis, deteriorating general health, and, in many cases, of becoming victims of violence. Specific adverse effects of maternal use of drugs during pregnancy place the fetus of the pregnant substance-abusing woman at risk for problems, including low birth weight, small head circumference, prematurity, and a variety of other medical and developmental complications. However, in the case of illegal drugs, evidence is not sufficiently broad or consistent to identify with certainty which drugs produce which effects at what levels. Nor is there evidence to untangle the environmental factors (such as poor nutrition, poverty, and lack of access to prenatal care) from substance abuse-related factors and focus on them as determinants of these problems.

More is known about the effects of alcohol consumption than about the effects of illegal drugs on pregnant women. Researchers have estimated that between 20 percent[104] and 73 percent[105] of women consume alcohol during pregnancy, although research indicates that there is no known safe level of alcohol consumption during pregnancy, or any "safe" period of gestation in which alcohol can be consumed.

Alcohol abuse during pregnancy can produce a child with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE), or one with low birthweight, or physical, cognitive, or behavior disabilities. The rate of FAS was 0.40/1,000 live births in 1990, nearly four times the rate in 1980. Although the National Center for Health Statistics reports improved diag-

Figure 9



Health United States 1991, 89.

nostic and assessment techniques using the new FAS International Classifications of Diseases code for FAS, these new techniques alone would not account for the growth in the FAS rate, which more than doubled in the five-year period from 1985 to 1990 (see Figure 9).

Although biomedical scientists have linked alcohol use with gestational problems since at least 1899, FAS was not formally described until 1973. Clarren has summarized the clinical features of FAS:[106]

- prenatal and postnatal growth deficiency;
- central nervous system dysfunction;
- a pattern of deformed facial characteristis; and
- major organ system malformations.