

Reasons for not seeking alcohol use disorder treatment

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Abstract

Background: In Denmark, there is a high prevalence of individuals suffering from alcohol use disorder (AUD). However, of these, only 10% seeks treatment. The aim of this study was to examine reasons not to seek treatment among people who suffer from AUD.

Methods: Participants suffering from AUD were recruited among somatic as well as psychiatric in and outpatients. The study was qualitative, based on semi-structured individual participant interviews. The analysis was narrative.

Results: The participant group consisted of two women and four men. Their average age was 58. The investigation indicated that the participants felt that alcohol added to their quality of life and that they enjoyed using it in social settings. Also, it seemed that there were two major groups of facilitating factors towards rehabilitation: health-related issues as well as relatives and relations. Finally, two major reasons for not seeking AUD treatment appeared: participants did not believe that it was a relevant offer for them and participants wanted to deal with their alcohol overuse issue themselves.

Conclusions: In gaining an understanding of the reasons not to seek AUD treatment, we simultaneously gain an opportunity to adapt prevention campaign strategies and treatment offers to become even more inclusive towards people who may suffer from AUD but do not recognize and acknowledge a treatment need. Here, increased focus on several initiatives might contribute to a decrease of barriers to treatment-seeking and, thus, increase the proportion of people suffering from AUD who consider to and actually do seek treatment.

Background

In Denmark, there is a high prevalence of individuals suffering from an alcohol use disorder (AUD) i.e. excessive use of alcohol or alcohol dependence (1). Alcohol is one of the world's most leading causes of harm to both the individual user and to the society, and users of alcohol can develop dependence as well as physical and mental health problems (2). In many cases, alcohol can cause mortality, either by injuries or damaged physical condition. In fact, alcohol-dependent individuals were found to have an increased risk of all-cause mortality compared to the general population (3). In addition, it is estimated that five percent of all deaths in most Western countries can be attributed to alcohol, and there exists a high prevalence of persons with alcohol problems in the Danish population. It is estimated that 20% are heavy drinkers, 14% have a harmful alcohol use, and 3% are dependent drinkers. This means that approximately 150,000 Danes are defined as dependent drinkers (4).

Despite the high number of persons with alcohol problems in Denmark, the proportion of persons in treatment for AUD is low (5). This is also remarkable as public treatment is free of charge and individuals may choose to be anonymous. In 2013, approximately 15,000 persons over the age of 15 received publicly financed treatment for AUD (6). This means that only around 10% of the dependent drinkers sought treatment.

It has often been proposed that hospitals may be effective platforms for identifying individuals who drink in a harmful way, and recommending them to lower their drinking and seeking treatment for AUD if needed (7). However, a series of attempts to implement systematic use of *Screening, Brief Intervention, and Referral to Treatment (SBIRT)*(7) in hospital settings has not been highly effective in leading patients to seeking specialized AUD treatment (8, 9). It is well-known that hospital staff has been reluctant to systematically screen for and address risky alcohol use among patients (10). Even studies that made use of outreach visits, where therapists from the AUD clinic talked to the patients at the hospitals, did not identify a large effect on treatment-seeking (9, 11).

Furthermore, studies have examined reasons for not seeking AUD treatment and suggested the most common barrier to treatment to be stigma or feeling ashamed (12–19). Other common barriers are described as not recognizing alcohol related problems, denial, and not perceiving a need for treatment (minimization of problem severity)(13, 20). A desire to manage alcohol problems without professional help (treatment delay or self-change attempts) was also an important barrier found in quantitative studies (13, 16). Negative attitude towards treatment and lack of confidence in the treatment system, and effectiveness, are other barriers that also have been recognized (14).

In a recent qualitative study among heavy drinkers, Finn and colleagues (21) also argued that sparse knowledge about treatment influences treatment-seeking. Zero-tolerance, the requirement of absolute abstinence promoted by traditional programs, may hinder individuals who want to reduce the risks associated with heavy drinking, but do not want to quit drinking completely (22). This was, in particular, seen in the young age group 18–34 and functioned as a barrier to seeking treatment (21). In another qualitative study, lack of awareness of available treatment options was also found to be a barrier against treatment-seeking (23). Additional psychosocial factors associated with discarding professional help for addictive behavior are mentioned, for instance, lower educational level, ethnic minority status, or ability to afford treatment (24). However, no one has particularly investigated how hospitalized patients, who suffer from AUD, but have not sought treatment for the AUD, perceive their drinking and treatment-seeking. Thus, the attitude among the target group for *SBIRT* at hospitals is under-investigated.

Kessler and colleagues suggest that most people with substance use disorder eventually seek treatment; however, treatment seeking often occurs a decade or more after the onset of symptoms of disorder (25). Overall, individuals suffering from AUD die prematurely, compared to the rest of the population (26). This illustrates that there is a need for more knowledge to improve early intervention related to AUD.

The characteristics of the non-treatment seeking population suffering from alcohol dependence are not fully investigated. From a public health and clinical perspective, this population group needs more scientific attention, as it is important to understand their reasons for not seeking treatment in order to develop accessible and acceptable treatment. To understand these phenomena more fully and gain insight into how people with alcohol dependence perceive treatment, research with a qualitative approach is required (21, 27). According to the cognition researcher Bruner (28), people think in two fundamentally different ways: 1) paradigmatic thinking, which is expressed by logical arguments, and 2) narrative

thinking, which happens through telling stories. Narrative thinking is particularly used when people strive to understand, explain, and create coherence among incidents and experiences (29). Thus, a narrative approach will be applied to the present study.

Applying a health behavior theory or conceptual framework such as the *Health Belief Model (HBM)* can also be useful in understanding why a troubling number of persons with alcohol dependence do not seek treatment services. In brief, the *HBM* suggests that health behavior is determined by an individual's assessment of threat (perceived susceptibility and severity), costs (perceived barriers), as well as perceived benefits. While several factors at different levels of influence can determine help-seeking behavior, the *HBM*, which is a model of individual health behavior, provides an appropriate lens to understand underutilization of alcohol treatment services among alcohol dependent individuals, given that many efforts aimed at encouraging help-seeking focus on influencing behavior at the individual level (30).

Aim

The aim of this study was to investigate how patients at mental and somatic hospitals, who suffer from AUD but do not seek treatment for the AUD, perceive their drinking and the possibility of treatment-seeking. More specifically, through semi-structured individual interviews and narrative analyses to examine the stories the participants tell with regards to their alcohol use and reasons for not seeking treatment.

Methods

Design

The present study was a qualitative study based on semi-structured individual participant interviews. During the interviews, the participants were asked to describe their use of alcohol throughout their life as well as their thoughts about not seeking AUD treatment.

Participants and settings

Inclusion criteria for participants were: 18+ years of age, native Danish speaking, an *Alcohol Use Disorder Identification Test (AUDIT)* score above 15 (measuring alcohol dependence), or meeting ICD-10 (DSM5) criteria for AUD, and never having sought AUD treatment.

Participants were recruited among somatic as well as psychiatric in and outpatients: one participant was recruited at the Department of Medical Gastrointestinal Diseases at Odense University Hospital (by the means of *AUDIT*); two participants were recruited at Gastro Unit, Surgical and Medical Division at Hvidovre Hospital (pointed out by medical staff as meeting criteria for AUD); and three participants at the

Mental Health Services in the Capital Region of Denmark (pointed out by medical staff as meeting criteria for AUD).

The participant group consisted of two women and four men. Their average age was 58; the women were younger than the men. All of the participants had been using alcohol excessively for many years. One of the participants was living together with a partner, the rest were living alone (as single, divorced, or widowed). Five of the participants had children and two of them had grandchildren. The participants had different educational levels; from unskilled to trained doctor. One of the participants was working, the rest were not (due to retirement, early retirement, or unemployment).

Data collection

Participants were interviewed by the use of open-ended, semi-structured questions formulated in an interview guide. The interview guide can be seen in Table 1. The six interviews took place at the hospital, but the participants had the opportunity to suggest another place. All interviews were audio-recorded and transcribed anonymously in full length. Data is securely stored.

Insert Table 1 here

Data analysis

The analysis was constructed by first defining the basic logic of each narrative: what conception of alcohol use and treatment it reflected. The narratives were then categorized according to how they described the alcohol use during life and by what they presented as the key to not seeking treatment. Eventually, composite stories were constructed, using parts of several original narratives. Mishler has called this method "*constructing the told from multiple tellings*" (31). Often several categories of composite stories can be identified, and in the present material two composite stories were found. The narratives were then analyzed in terms of the emotional, explanatory, and moral meanings and, in particular, in terms of the *HBM*, i.e. the individual's assessment of threat, costs, and benefits in relation to drinking and treatment seeking.

Results

All the plots of the individual narratives in the interviews shared a pattern. This uniformity is probably due to the sample; the participants were all screened positive for alcohol dependence, they had all been drinking extensively throughout most of their lives, in all cases their network had expressed concern, but they had, nevertheless, never sought or even considered seeking treatment for AUD. A few participants had participated in a small number of self-help meetings (*Alcoholics Anonymous, AA*).. Below, the two prominent narrative forms recognized in the material are presented.

Alcohol adds to the quality of my life story

The first prominent story described how drinking alcohol was always part of life since adolescence. Drinking was associated with quality of life. Drinking did not take place during working hours, but during the breaks and after hours, and drinking alone or with peers constituted the normal way of living. The drinking was described as quiet and calm:

"It has always been steady drinking with all too many beers every day. Only beer. I have never drunk spirits" (Respondent 6).

Although the drinking often took place while the individual was alone, it was not hidden to the surroundings or a secret. Alcohol was simply considered to be a natural part of life, - just as natural as breathing, eating, relaxing and watching television, and associated with quality of life. The constant high intake of alcohol, however, raised concern among family and friends. The concern was expressed but did not lead to conflicts. Rather, the individual acknowledged it and felt comforted by the concern from others, but the concern did not lead to stop or decreased drinking. Neither did it lead to treatment seeking. The individual expressed satisfaction with his or her current drinking and felt convinced that the drinking would continue if he or she felt like it, although not necessarily as heavily as previously. The individual was convinced that if needed, he or she would be able to stop drinking. One individual had recently completely stopped drinking, but this was due to health problems because of the drinking.

The reason why treatment was not considered an option in this story was described as *it is just not for me*. The individual did not feel a need for treatment. The individual would rather rely on his or her own ability to reduce his or her intake of alcohol if deemed necessary and rely on support from family. In the moral sense, the individual took full responsibility for drinking in this story. The story's emotional, explanatory, and moral meanings can be seen in Table 2.

Insert Table 2 here

Drinking with friends story

The other condensed story from the material is about how drinking excessively was something that the individual did in social surroundings together with others in social surroundings. Here, drinking was considered a social event; something you do with friends, colleagues, or drinking buddies. Therefore, decreasing the drinking meant removing yourself from a wet network. Similar to the story above, this story described how concern from significant others was received, and the concern led to increased awareness of the alcohol intake. In particular, responsibilities for children and grandchildren led to decisions about changing lifestyle and lowering or stopping drinking, at least for a while.

"All of a sudden I sat there with Maria, my second daughter, and thought:

I don't want to do it (the drinking) anymore, it does not work" (Respondent 4).

Since treatment was not considered to be a relevant option in any of the stories, alternative coping strategies for lowering and controlling the alcohol intake, was described. These strategies included only drinking on specific days (in contrast to every day), eating more, spending more time alone rather than with friends. Talking with professionals and receiving advice about how to cope or receiving therapy was not aligned with a feeling of autonomy. Treatment was associated with restraints and limitations, and even noted as being degrading for the individual. The individual would rather rely on his or her ability to reduce the intake of alcohol or turn to family and close friends for support. In the moral sense, besides the individual taking full responsibility for the drinking in this story, he or she also acknowledged the need for support. The story's emotional, explanatory, and moral meanings can be seen in Table 3.

Insert Table 3 here

Health Belief Model

Summarizing the individual's assessment of threat, costs, and benefits in relation to drinking and treatment-seeking, the conclusion is that it was rather similar in the two identified stories above. Mental and, in particular, somatic health consequences were in both stories considered the most prominent reasons for striving for control over the alcohol use, and even for stopping drinking completely. The direct caring from close friends and near family members was facilitating factors for securing control over the drinking, but also the feeling of responsibility:

"It started to become less and less meaningful to me as I became older, you cannot sit on a bench until four or five in the afternoon when you have a family to provide for" (Respondent 4).

The possibility of seeking treatment was not an option in the stories, and the reasons were that treatment-seeking was seen as hampering the individual's autonomy, a sign of weakness or simply not necessary.

"It was my choice and my assessment that I did not want anything to do with that (...) I have always considered it something I did not need (...) I don't feel the need to enter professional treatment to get rid of the alcohol" (Respondent 6).

Thus, none of the individuals wanted to receive professional help to curb their alcohol use; instead, they all wanted to reach their goals independently.

Discussion

The present study confirms prior studies hinting that hospitalized patients suffering from AUD may not be able or ready to consider specialized treatment for their drinking problem (11). In this study, we found that the narratives told by the six participants were strikingly alike with regard to their perspectives on alcohol use, their strivings to gain control over their alcohol use, their perceptions of health-related issues

as well as relatives and relations as facilitators in obtaining what was strived for, their conceptions of alcohol treatment not being an offer for them, and their feelings towards wanting to deal with their alcohol (*non*)issues independently.

Regarding alcohol use, we found that the participants told stories about how they felt that alcohol added to their quality of life and that they enjoyed using it in social settings. This finding is in line with a qualitative study on service provision for alcohol-related health issues by Haighton et al. (32), where the social element in drinking was found to be a barrier to changing due to concerns about losing the positive aspects of drinking. Also, the participants in the present study had all been drinking for many years, little by little escalating their alcohol use to becoming excessive, and not all of them wanted to stop drinking altogether. This is in line with a study about reasons not to seek alcohol treatment, where Probst et al. (33) found the wish to maintain moderate drinking frequently reported.

Furthermore, two major groups of facilitating factors towards rehabilitation appeared from the stories told by the participants. The first prominent factor seemed to be health-related issues; this is in line with several other studies which found that facilitators to help-seeking included concerns about the risk of fatal illness (32, 34–36). The second noticeable facilitating factor towards rehabilitation seemed to be relatives and relations. In the qualitative study by Haighton et al. (32), it was also found that facilitators to seeking help included motivation from significant people; thus, the participants acknowledged that pressure from family and friends could build an impetus to change their drinking behavior. In addition to this, a narrative study on recovery from addictive behaviors by Hänninen and Koski-Jänes (37) found that reasons for wanting to change (but maybe not succeeding) included becoming unemployed, spousal issues, and self-value problems. However, in those stories, motivation for change appeared when hitting rock bottom and joining AA was decisive for recovery.

Moreover, it seemed like there were two major reasons for not seeking AUD treatment imbedded in the stories told by the participants. The first reason was the fact that the participants did not believe that alcohol treatment was a relevant offer for them. This is similar to a 10-year study of factors associated with alcohol treatment use and non-use, where Chartier et al. (35) found that barriers related to predisposing beliefs and fears about treatment as well as perceptions about treatment need increased during the 10-year period. They saw that the most commonly endorsed reason for not seeking help was related to the respondents' (lack of) perception of treatment need. According to their findings, this reason represented four out of the five top reported barriers and increased during the decade. Also in a latent class analysis of perceived barriers to treatment for alcohol problems (38), Schuler et al. found that 33% of the participants believed that the problem would get better by itself, whilst 21% reported that their drinking problem was not serious enough for them to seek treatment for it. Furthermore, in a study about gender, acculturation, and other barriers to alcohol treatment utilization among Latinos, Zemore et al. (39) found that most individuals, who avoided treatment, did so because they did not believe they had a problem. Here, the most commonly perceived barriers were that the treatment would not help or that the individual would not be understood.

The second reason, we found, was the fact that the participants wanted to deal with their alcohol overuse issue themselves (if they felt that it even was an issue) not involving professional help. This, again, is similar to findings from other studies. In the latent class analysis of perceived barriers to treatment for alcohol problems (38), Schuler et al. found the most frequently endorsed barrier to be the attitudinal belief among the participants, that they should deal with the alcohol issue themselves. 42% believed that they should be strong enough to handle it alone. In a study on barriers to help-seeking among American Indians with alcohol dependence, Venner et al. (40) found personal barriers to be the most commonly cited. Here, 64% of the participants reported a barrier in this category, primarily regarding lack of motivation to change and not believing that outside help was needed. In the study about reasons not to seek alcohol treatment, Probst et al. (33) found the most frequent reason for not seeking treatment to be lack of problem awareness, which 55.3 % of the participants responded. The participants did not consider their drinking a problem nor that help was needed, and 20.9% of them stated wanting to cope alone as reason for not seeking treatment.

This study indicates that some people, who suffer from AUD, may wish to moderate their alcohol use or stop altogether; however, none of them want professional help to do so. From a campaign perspective, it seems that information on subjects such as prevention, treatment-seeking, and stigma aimed at non-treatment-seekers may not always be targeting a non-treatment-seeking population. We had assumed to find structural reasons for not seeking treatment, such as lack of access to or knowledge about treatment offers, which would have been in concordance with findings from other studies (41). However, we did not recognize any such reasons in the stories told by the participants, who were all well-informed about public AUD treatment being a free offer. Also, we had assumed to find stigma and shame to be prominent reasons for not seeking AUD treatment. Such a finding would also have been in concordance with findings from other studies. According to a recent review (41), stigma is the most prevalent barrier to AUD treatment-seeking. However, in the present study, the participants did not feel that their alcohol use was serious enough to require treatment; thus, not feeling the need to hide it. Instead, it seemed that health and family-related issues may act as facilitators for habit change and could, therefore, be an area where information and feedback were relevant as well as needed.

For people suffering from AUD, who wish to maintain a moderate alcohol use, treatment offers not emphasizing abstinence per se, such as 'guided self-change' might be relevant (33). Such a brief cognitive-behavioral motivational intervention is designed to support patients in the process of becoming aware of and dealing with their alcohol use issues (42), comprising goal setting, self-monitoring of drinking behavior, analysis of drinking situations, and learning alternate coping skills (43).

Also, for people who suffer from a mild AUD and who are at increased risk but do not (yet) perceive a treatment need, primary sector continuous monitoring and assessment of alcohol use to prevent AUD and physical health consequences may be relevant (33). Tailored screening e.g. according to age (32), gender (40), and culture (39, 40) could also be considered. Rehm et al. (44) suggested a routine use of tools such as *SBIRT* as a means to identify non-treatment seeking individuals, who suffer from AUD and reduce the impact of lacking perception of treatment need as well as increase motivation for behavioral change. The

present study adds to the little insight into why *SBIRT* interventions at hospitals do not work as efficiently as hypothesized (9). We encourage future research in the field, to take into account the findings from the present and similar qualitative studies on patient-perceived barriers for treatment-seeking.

Strengths and limitations

It is a strength that we have recruited participants, who have never sought AUD treatment, from both somatic and psychiatric settings. However, it may be a limitation that only six respondents chose to participate in the study and that the participants from the general practitioner's office withdrew from the study prior to the interviews taking place. Despite the limitations stemming from the small sample size, it is our hope that the study is transferable and can serve as a basis for further research and discussion within the area.

Conclusions

This study has examined people who suffer from AUD and do not seek treatment's reasons for not doing so. The investigation indicated that the participants felt that alcohol added to their quality of life and that they enjoyed using it in social settings. Also, it seemed that there were two major groups of facilitating factors towards rehabilitation: 1) health-related issues; 2) relatives and relations. Finally, two major reasons for not seeking AUD treatment appeared: 1) that the participants neglected their problematic alcohol use and did not believe that alcohol treatment was a relevant offer for them, and 2) the fact that the participants wanted to deal with their alcohol overuse issue themselves and not involve professional help.

Declarations

List of abbreviations

AUD: Alcohol Use Disorder

SBIRT: Screening, Brief Intervention, and Referral to Treatment

HBM: Health Belief Model

AUDIT: Alcohol Use Disorder Identification Test

AA: Alcoholics Anonymous

Ethics approval and consent to participate

The study was conducted according to current ethical standards. The protocol was presented for and approved by the Scientific Research Ethics Committee of the Region of Southern Denmark. The Danish Data Protection Agency gave the permission to collect and store data, ID number 3499, record number 19/21386. The participants signed a consent form after receiving oral and written information about the study.

Consent for publication

Not applicable.

Availability of data and materials

The datasets generated and/or analyzed during the current study are not publicly available.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

ASN and SS designed the study. SS conducted the interviews. ASN and KT conducted the analysis. All authors contributed to writing the manuscript. All authors read and approved the final manuscript.

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Tables

Table 1. Interview guide

Information	<p>Thank you very much for participating in the study. I would like to ask you some questions. The interview will be audio-recorded and analyzed. The interview is about understanding reasons for deselecting alcohol treatment.</p>
Question 1	<p>Tell me something about yourself?</p> <ul style="list-style-type: none">- Age?- Education?- Employment?- Family?- Anything else relevant?
Question 2	<p>How do you use alcohol?</p> <ul style="list-style-type: none">- Which feelings does it bring out in you?- How is alcohol positive for you?- How is alcohol negative for you?- How do you experience it as a problem?
Question 3	<p>What are your thoughts on alcohol treatment?</p>
Question 4	<p>Will you try and explain to me why you have never attended alcohol treatment?</p> <ul style="list-style-type: none">- How did you decide on not wanting treatment?
Question 5	<p>Has anyone ever suggested you seek treatment?</p> <ul style="list-style-type: none">- Has anyone offered you help?- How?- Why do you think they feel you need help?
Question 6	<p>Do you know anyone who has attended alcohol treatment?</p> <ul style="list-style-type: none">- What was their experience with the treatment?- How do you perceive that they have experienced being in treatment?
Final remarks	<p>Thank you again for participating. Is it okay if I contact you again to clear up misunderstandings?</p>

Table 2. *Alcohol adds to the quality of my life story*

Alcohol tastes good and is a natural part of life → high and regular use → if the health consequences get too high, the individual may consider stopping drinking

<i>Explanation:</i>	Alcohol is enjoyable and part of life
<i>Cure:</i>	The individual's decision, in particular if health is affected
<i>Moral assessment:</i>	It is the individual's own choice
<i>Treatment:</i>	No need

Table 3. *Drinking with friends story*

Drinking is what you do with friends → high and regular use → if family responsibilities and health consequences get too high, the individual lowers his or her drinking

<i>Explanation:</i>	Drinking is what you do with friends and network
<i>Cure:</i>	The individual removes him or herself from the network (drinking buddies), and turn to family and <i>real</i> friends
<i>Moral assessment:</i>	It is the individual's own choice
<i>Treatment:</i>	Is associated with feeling limited

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [WitkiewitzMarlatt2011.pdf](#)