TITLE: Time to Get Help? Help-Seeking Process in Latin American Hospital Patients with Alcohol Use Disorder

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SUGGESTED RUNNING HEAD: Help-Seeking Process in Patients with Alcohol Use Disorder

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Abstract

Alcohol Use Disorder (AUD) is one of the most harmful conditions associated with consumption. Despite a high level of consumption and an elevated number of people living with an AUD, evidence from help-seeking processes in Latin America is scarce and absent in Argentina. This paper aims to describe reasons for delaying and starting help-seeking, the process of problem awareness, and the years elapsed between drinking initiation, problem awareness and help-seeking, as perceived by a clinical, non-random sample of people with AUD (n=51). The most frequent reason for delaying help-seeking was not believing there was a problem. The most frequent motivators for seeking help were having physical or psychological problems due to use and repeated attempts to reduce or stop use. The outcomes of this study can be useful for designing interventions to reduce help-seeking barriers and facilitate access to treatment.

Key Words: Alcohol Use Disorder; Treatment Barriers; Help-Seeking; Hospital Patients.

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Alcohol Use Disorder (AUD) is one of the most harmful diseases associated with consumption. Yet, AUD is one of the mental disorders with lower treatment-seeking rates. Evidence from high-income countries indicates that only around 10 percent of those diagnosed receive some kind of specialized help (Rehm, Manthey, Struzzo, Gual & Wojnar, 2015; Rehm, Dawson, Frick, Gmel, Roerecke, Shield & Grant, 2014). Even when alcohol-related problems may be acknowledged, often there is no help-seeking (Schuler, Puttaiah, Mojtabai & Crum, 2015), or the lag between the onset of substance-related problems and help-seeking is long (Chapman, Slade, Hunt & Teesson, 2015). Therefore, by the time people with AUD do find treatment, many aspects of the patient's life are impaired, hampering recovery (Rehm et al., 2015).

Consequently, the study of the reasons that delay the help-seeking process is of major importance. Studying a patient's reasons for not seeking treatment allows us to understand which actions can be taken to lift barriers in access to specialized help. Research in high-income countries shows that some of these barriers include: not seeing consumption as a problem, stigma, not acknowledging the risks of alcohol consumption, lack of readiness to change, as well as social barriers like marginalization, lack of service availability, cost of treatment, beliefs about abstinence as a requirement for being in treatment, and beliefs about the possibility of handling the problem on one's own (Browne et al., 2016; Haighton et al., 2016; Kalema, Vanderplasschen, Vindevogel, Baguma, & Derluyn, 2017; Mellinger et al., 2018; Probst, Manthey, Martinez, & Rehm, 2015; Wallhed Finn, Bakshi, & Andréasson, 2014).

On the other hand, there may be factors that facilitate a faster recognition of alcohol-related problems in AUD patients. Studies have found that the decision to seek treatment usually follows reasons such as comorbidity with other diseases, having a previous talk with a health professional, or reporting more negative consequences from substance abuse (Kaufmann, Chen, Crum, & Mojtabai, 2014; Watkins et al., 2018); these studies also point to disparities in perceived barriers by ethnic groups. In consequence, information regarding barriers and facilitators of the help-seeking process is not negligible but fundamental for the design of culturally appropriate fit interventions for this vulnerable population and their communities.

Despite a high level of consumption and a considerable number of people living with an AUD, little data regarding the help-seeking process has been found in Latin America and particularly in Argentina, where alcohol consumption is one of the highest worldwide (Poznyak & Rekve, 2018). Furthermore, drinking is greatly tolerated in several groups, including vulnerable populations such as women and youth (Observatorio Argentino de Drogas, 2017). Therefore, this paper aims to describe treatment-seeking barriers and motivators, as perceived by a clinical sample of people with AUD who sought help in one hospital's alcohol treatment unit in Argentina. Specifically, we will describe the reasons for delaying help-seeking, the main alcohol-related problem motivating help-seeking, the first alcohol-related problem acknowledged, and the years elapsed between drinking initiation and problem acknowledgment, and between problem acknowledgment and the actual help-seeking.

Method

Sample characteristics

Fifty-one patients with AUD who sought help in a specialized unit for hepatology and alcohol treatment were interviewed in 2014 and 2018. This unit is the only one of its kind in the city of Mar del Plata, Argentina, and depends upon a large regional public hospital. Participants were referred by the unit's physicians when they were seen as capable of giving informed consent and taking part in the interview. The sample was, thus, a clinical non-probabilistic sample. Six participants were females (12%), and 88% were males. Ages were between 31 and 74 (M=52.96, DS=9.98), and almost 40% were divorced or separated. The majority of patients were self-employed, underemployed, with precarious jobs (42%), or unemployed (35%), and only 3 (6%) were salaried workers. The rest of them (17%) were retired.

Study Design and Data Analyses

This study combines qualitative and quantitative (descriptive) methods. Once the patient received medical attention from the unit's physician, they were invited to participate in the study. Written informed consent was requested, and an information sheet about the study's characteristics, including the confidentiality of collected data and how to contact the researchers, was given to the patient. The project met the requirements of the Ethical Committee of the Regional Hospital Oscar E. Allende. Patients participated in a face-to-face interview in which a questionnaire with both fixed and open questions was administered. Two trained researchers (KC and TS) interviewed the patients and recorded the answers in written notes for open-ended questions. Each interview took about one hour to be completed. Along with information about their physical and mental health and AUD characteristics, we inquired about the following:

Alcohol-related problems: the first problem to be acknowledged and the main problem motivating help-seeking. After screening for AUD criteria with the Composite International Diagnostic Interview (CIDI), which yields diagnoses compatible with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases (ICD-10) (Rehm et al., 2015), we asked participants to remember which consequence of alcohol they had experienced first, and which had motivated help-seeking. The list comprised of: role impairment, craving, hazardous use, tolerance, larger or longer use than intended, not being able to stop drinking once started, repeated attempts or strong desire to reduce or stop use, time spent using, reducing activities in order to use, withdrawal, physical problems due to use, drinking despite an underlying illness, psychological problems due to use, interpersonal problems, and legal problems. We read the criteria once again, one by one, to aid the process. If they wished so, they could add an item not listed.

Reasons for delaying help-seeking. Following the former question, we asked: "Which is the main reason for not seeking help for alcohol-related problems until you had a particular problem?" Responses were first categorized into the three categories developed by Verissimo and Grella (2017): structural, attitudinal and readiness to change. They were then coded by two experienced researchers, yielding a very poor kappa value (*kappa*=.07, CI 95% 0-0.27). Hence, we created our categories derived from the data.

Years elapsed between drinking initiation and problem acknowledgment, and between problem acknowledgment and the actual help-seeking. We asked what their age was when they first initiated drinking, what their age was when they started to realize that there was an alcohol-related problem and their age when they finally sought help. Later, we computed the time difference between these events and performed descriptive statistics for the resulting variables.

We performed content and kappa analyses for the categories of reasons for delaying help-seeking. Two experienced researchers (RP and MC) rated the categories. Quantitative descriptive analyses of all the variables were also made.

Results

First Acknowledged Alcohol-Related Problem

The frequency with which each of the alcohol related problems was the first one to be acknowledged was: interpersonal problems (23%, CI 95% 10-35), not being able to stop drinking once started (10%, CI 95% 2-21), repeated attempts or strong desire to reduce or stop use (10%, CI 95% 2-19), withdrawal (10%, CI 95% 2-21), hazardous use (8%, CI 95% 2-17), larger or longer use than intended (8%, CI 95% 2-17), physical problems due to use (8%, CI 95% 2-17), tolerance (6%, CI 95% 0-15), reduction of activities in order to use (6%, CI 95% 0-15), time spent using (2%, CI 95% 0-6), drinking despite an underlying illness (2%, CI 95% 0-6), psychological problems due to use (2%, CI 95% 0-6), and legal problems (2%, CI 95% 0-8).

Alcohol-Related Problem that Motivated Help-Seeking

The patients indicated that the main alcohol-related problem that motivated help-seeking was: physical problems due to use (39%, CI 95% 25-53), interpersonal problems (23%, CI 95% 14-35) and drinking despite an underlying illness (12%, CI 95% 4-22), while a minority indicated: reducing activities in order to use (4%, CI 95% 0-10), tolerance (2%, CI 95% 0-6), use greater or longer than intended (2%, CI 95% 0-6), repeated attempts or strong desire to reduce or stop use (2%, CI 95% 0-6), withdrawal (2%, CI 95% 0-6), and legal problems (2%, CI 95% 0-6). Others (12%, CI 95% 4-22) reported religion, hitting bottom, work, having put a third party in

danger, friends, and family, and one participant who firmly disbelieved in the occurrence of any problems reported none.

Reasons for Help-Seeking Delay

Forty-six participants gave reasons for why they had delayed help-seeking. Content analyses yielded seven categories help-seek of these reasons: 1) lack of information on the problem or where to seek help; 2) lack of awareness of the problem or its seriousness; 3) not wanting to quit drinking; 4) lack of support; 5) distrust; 6) feeling that the problem could be managed on their own; and 7) being used to the problem. There was an adequate inter-rater agreement for these categories (*kappa*=.74, CI 95% .57-.90). The main reasons for delaying help-seeking were: lack of awareness about the problem or its seriousness (50%, CI 95% 36-65), not wanting to quit drinking (20%, CI 95% 9-33), and feeling that it could be managed on their own (17%, CI 95% 6-28); less frequently reported reasons were: lack of information about the problem or where to seek help (6%, CI 95% 0-15); lack of support from significant others (2%, CI 95% 0-6); distrust about professionals (2%, CI 95% 0-6); and being used to the problem (2%, CI 95% 0-6).

Time Gap between Drinking Initiation, Problem Acknowledgment, and Help-Seeking

The mean age and range (in years) of drinking initiation, awareness of problems, and help-seeking in AUD patients are presented in Figure 1.

The mean age at which drinking was initiated was M=14.44 (CI 95% 13.09-15.91), DS= 4.16, ranging from five to 25 years. When asked about the age in which they became aware of an alcohol-related problem, eleven patients (21%) stated they did not believe they had a drinking problem, despite the number of criteria met, having answered positively to the question about the main problem that motivated help-seeking, and the actual search for specialized treatment. For

the rest, awareness of problems first began at M=42.27 years (CI 95% 36.02-47.78), DS=14.78, ranging from 17 to 66 years. Help-seeking occurred at M=51.53 (CI 95% 48.39-54.89), DS=8.98, ranging from 34 to 66 years.

The mean number of years elapsed between drinking initiation and problem acknowledgment was M=27.62 (CI 95% 21.96-33.11), DS=14.43, with a minimum of 6 and a maximum of 49 years. Between problem acknowledgment and the actual help-seeking, an average of 9 years passed (M=9.08, CI 95% 4.74-13.63, DS=11.61), with a range of 0 to 42 years. Lastly, between drinking initiation and search for help, the mean number of years was M=36.70 (CI 95% 32.80-39.99), DS=9.42, with a range of 16 to 50 years.

Discussion

We discuss two aspects of these results: first, age of drinking initiation, first clinical manifestations, and help-seeking; second, help-seeking motivators and treatment barriers.

Our results indicate an early age of drinking initiation, agreeing with previous reports from Argentina (Pilatti, Fernández, Viola, García, & Pautassi, 2017), and a window of around 30 years between drinking initiation and the awareness of an alcohol-related problem. In agreement with our findings, other studies in the U.S. have also found long gaps between the onset of substance-related problems and help-seeking, using a similar methodology (Chapman et al., 2015). Therefore, adulthood seems to be the ideal time to study and intervene in denial, perhaps improving the self-recognition of alcohol-related problems (Glass, Grant, Yoon, & Bucholz, 2015). Besides, infancy, adolescence, and young adulthood may provide a window of opportunity to assess, avoid, or reduce alcohol intake (if started).

Linked to this finding, the awareness of problems came along with adulthood, almost 27 years after drinking initiation, when problems may have progressed to more severe expressions of

AUD. The awareness of, for instance, a physical problem related to drinking which prompted help-seeking, came almost a decade after the acknowledgment of alcohol-related problems.

Nearly one-fourth of the patients referred to interpersonal problems with family members as the first alcohol-related problem they acknowledged. Significant others are more aware of the consequences of drinking, and conflict may arise from confrontation with a family member with AUD. Additionally, family relations are highly valued among people of Latin American backgrounds, such as Argentineans (Lansford et al., 2016), likely making interpersonal problems arising from drinking more prominent than in other areas. Other problems among the first to be acknowledged were not being able to stop drinking once started, repeated attempts or strong desire to reduce or stop use, and withdrawal symptoms. These three problems may be part of the experience of losing control over drinking, or what has been called abnormal drinking behavior (Conde, Brandariz & Cremonte, 2016), which likely constitutes the core of alcohol dependence (Thombs & Osborn, 2019).

Regarding help-seeking and treatment barriers, the main alcohol-related problem motivating help-seeking was continued use despite health problems. This implies not only loss of control over drinking, but also the recognition of an inability to reverse it on their own, even when there is evidence of impairment to physical health. We also found a lack of awareness of the problem as the main barrier for help-seeking. Therefore, even though they could recognize some alcohol-related problems, the main reason for not seeking help was that they did not know or thought they had them. Such a phenomenon may be linked to cognitive distortions including self-deception (e.g. denial), which is in agreement with other studies that have also found denial as the main barrier for help-seeking (Owens, Chen, Simpson, Timko & Williams, 2018). Tackling denial may be a good way of shortening the time between the awareness of problems and help-seeking; however, denial is a complex construct, and evidence regarding interventions

to address it are sparse (Thombs & Osborn, 2019). Nonetheless, some authors have pointed out that denial and self-deception can be reduced with 12-step programs and/or abstention from alcohol (Martínez-González, López, Iglesias, & Verdejo-García, 2016).

An important limitation of our findings is the retrospective nature of the study. Researchers have advised caution in retrospective studies with patients in early recovery (e.g. Krenek, Lyons & Simpson, 2016) since memory and other cognitive functions might be affected. However, others (e.g. Ros-Cucurull et al., 2018) have noted an improvement in many mental processes within the first months of recovery, as was the case with many of the patients participating in our study. Another limitation to our findings is that other psychological comorbidities (either through additional axis I or axis II disorders) (American Psychiatric Association, 2013) were not explored, although they might play a role in the help-seeking process. Despite limitations, this is, to the best of our knowledge, the first description of help-seeking processes in Latin American people with an Alcohol Use Disorder.

Results presented here characterize AUD and examine treatment barriers as perceived by Latin American patients. Our findings highlight the need for regular AUD screening in primary health care settings, considering the variety of obstacles patients found for seeking treatment. The long gap in time between drinking initiation and awareness of problems evidences the need to implement public policies to change social norms regarding drinking and drinking problems among Argentineans.

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Conflict of interests. None to declare.

Informed Consent. All procedures followed were under the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.

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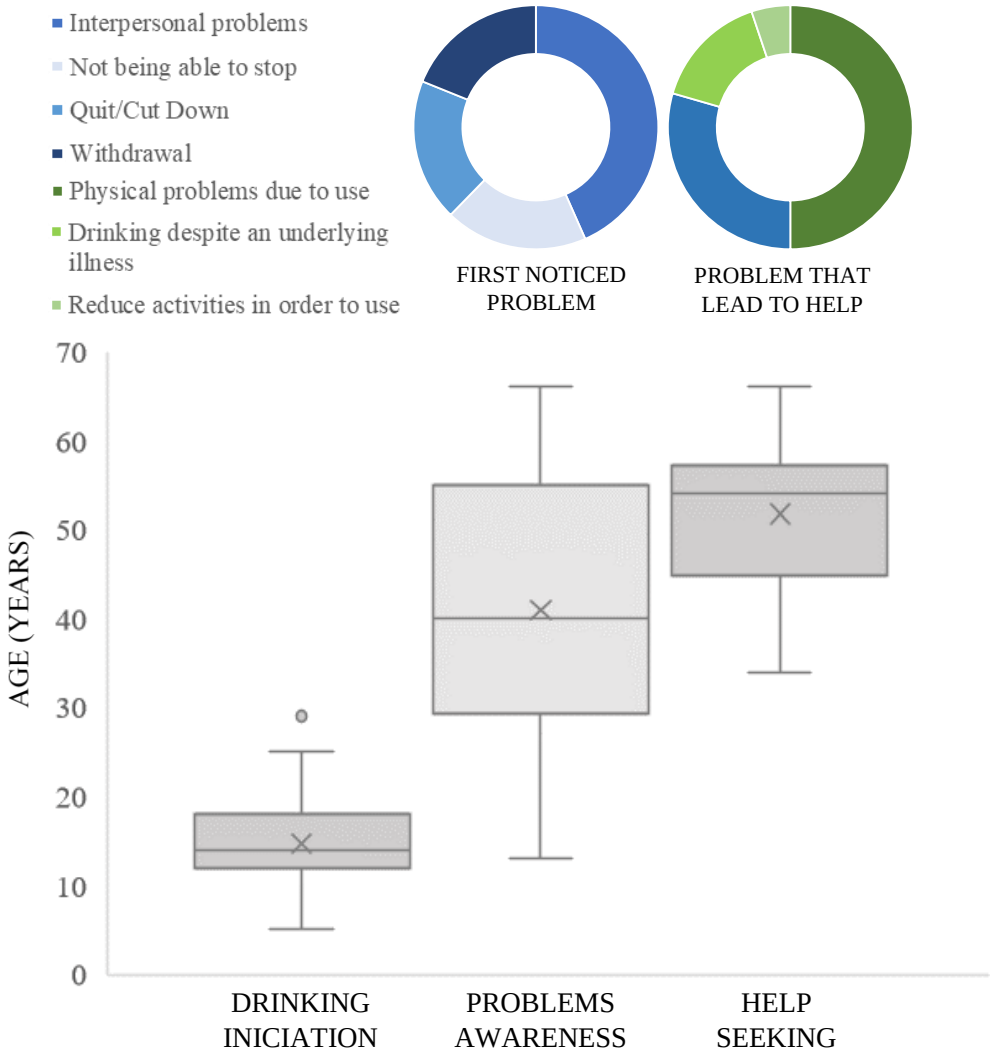

Figure 1. Mean age, CI 95%, SD, and range (in years) of drinking initiation, awareness of problems, and help seeking in AUD patients of an alcohol outpatient hospital unit (below). Percentage of drinking problems that were first acknowledged and percentage of problems that lead to help seeking (above).

CI: confidence interval; SD: standard deviation; AUD: alcohol use disorder.