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Characteristics and processes of treatment-seeking for alcohol problems

-findings from epidemiological and qualitative studies

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Picture on front page created by Christofer Olsson

In memory of my mother Britt Anna Maj 1929 – 2006 for her unconditional love and affection.

ABSTRACT

Background: Alcohol use and misuse are related to several physical, mental, and social harms in Sweden. Early identification and treatment of alcohol problems can lead to decreased alcohol consumption and a reduction of alcohol related harm. However, for many individuals, seeking help or treatment does not seem to become an option until the problems have become severe. Increased knowledge of characteristics and processes of treatment-seeking for alcohol problems is needed.

Aims: The overall objective of this thesis was to explore treatment-seeking behaviour in people with alcohol problems. Its specific aims were to investigate whether there were differences in women diagnosed with alcohol use disorders (AUD) between those who had or had not received treatment, to analyse the associations between personality and treatment-seeking in women, to explore the processes leading to treatment-seeking, and to analyse treatment-seeking for alcohol problems from a gender perspective.

Methods: The thesis was based on both quantitative and qualitative data. Quantitative data was taken from the multipurpose, longitudinal, general population-based project "Women and Alcohol in Göteborg" (WAG). A sample of women with a lifetime diagnosis of alcohol use disorders (n=52) was identified among 3130 women. Pooled cross-sectional data from three population samples and one clinical sample from the WAG project (n=1,342) formed the basis for the analysis of associations between treatment-seeking and personality traits using the Karolinska Scales of Personality (KSP). Qualitative data was gathered via interviews with 12 women and men who had sought treatment for the first time. The qualitative study was based on grounded theory. Content analysis was used to analyse the interviews from a gender perspective.

Results: Among women diagnosed with alcohol use disorders, the AUD was significantly more severe in those who had received treatment. Women with resolved AUD who had received treatment were more anxious, tense, irritable, and showed more guilt, than untreated women with resolved AUD. Untreated women with resolved AUD resembled women without AUD on most personality traits. Developing a willingness to change was found to be the basic psychosocial process leading to treatment-seeking for both women and men. The categories that constituted sub-processes and supported the development of willingness to change were: 1) actuating inner forces; 2) dealing with conflicting feelings and thoughts; and 3) hoping to turn the situation around. These processes were assisted by demanding and caring support from partners, friends, or professionals. The analysis of gendered conceptions in treatment-seeking showed that promoting factors for treatment-seeking in men were characterised by beliefs in their own capability, and future prospects. Women placed importance on pressure from someone significant, and sharing the problem with someone else. Hindrances for both women and men were feelings of shame and the significance of alcohol in their lives.

Conclusions: In motivating people to seek treatment, professionals and a woman's or man's social network can play a vital role by showing demanding and caring support. Gendered conceptions of alcohol problems and treatment-seeking should be considered both in planning prevention strategies and treatment. Future studies focusing on the significance of alcohol in people's lives and perceptions of gendered behavior could increase the understanding of what promotes and what hinders treatment-seeking in people with alcohol problems.

Key words: Alcohol problems, gender perspective, treatment-seeking, personality, severity, willingness. ISBN: 91-628-7043-2

SAMMANFATTNING

Bakgrund: I Sverige liksom i andra delar av världen är skadligt bruk av alkohol vanligt förekommande och bidrar till sjukdomar, dödsfall och sociala problem med ökade kostnader för individ, samhälle och näringsliv. Det finns idag väl beprövade behandlingsmetoder för alkoholproblem, men många människor med alkoholproblem avstår från att söka vård. Det finns behov av mer kunskap om vårdsökandets karaktäristiska och processer.

Syfte: Avhandlingens övergripande syfte var att studera vårdsökande vid alkoholproblem. Specifika syften var att: 1) undersöka skillnader och likheter mellan kvinnor diagnostiserade med alkoholberoende eller -missbruk (ABM) och som fått respektive inte fått vård, 2) analysera samband mellan personlighet och vårdsökande bland kvinnor, 3) utforska vägen till vård och behandling hos kvinnor och män med alkoholproblem, 4) samt att analysera vårdsökande utifrån ett genusperspektiv.

Metod: Avhandlingen baseras på kvantitativ och kvalitativ data, där kvantitativ data från en longitudinell befolkningsstudie, `Kvinnor och Alkohol i Göteborg´ (WAG), inkluderande ett kliniskt urval ingår. Kvinnor med diagnostiserat ABM (n=52), identifierade bland 3130 kvinnor, jämfördes avseende svårighetsgrad av ABM, samsjuklighet och sociodemografisk data. Sammanslagna tvärsnittsdata från tre kohorter ur populationsstudien samt det kliniska urvalet (n=1,342) utgjorde underlag för analys av samband mellan vårdsökande och personlighetsegenskaper enligt KSP (Karolinska Scales of Personality). Kvalitativa data omfattar intervjuer med 12 personer (7 män och 5 kvinnor), som för första gången sökt vård och behandling för alkoholproblem under den senaste månaden studerades med `grounded theory´ metod. Vidare genomfördes en innehållsanalys av kvinnornas respektive männens intervjuer för att studera uppfattningar om vårdsökande ur ett genusperspektiv.

Resultat: De kvinnor som hade sökt vård och behandling visade sig ha signifikant fler och långvarigare alkoholrelaterade problem jämfört med dem som inte sökt vård. De kvinnor med ABM som inte behandlats liknade kvinnor utan ABM avseende de flesta studerade personlighetsegenskaperna. De kvinnor som fått behandling och var återställda hade mer somatisk och psykisk ångest, spänning, irritabilitet och skuldkänslor än de kvinnor som blivit återställda utan behandling. De processer som föregick vårdsökande var komplexa och kunde sammanfattas i en central psykosocial process: `Utveckling av vilja till förändring´. Subprocesser som påverkade utvecklingen av viljan att förändra var: 1) aktualisering av inre krafter; 2) hantering av konfliktfyllda känslor och tankar; och 3) hopp om att förändra sin situation. Stöd som kännetecknades av både krav och omsorg från partners, vänner eller professionella, påverkade utvecklingen av viljan att förändra. Männen hyste tilltro till den egna förmågan och hade framtidsplaner, medan kvinnorna betonade att yttre påtryckningar, samt att dela sina problem med andra, påverkade deras val att söka vård. För både kvinnor och män utgjorde känslor av skam samt alkoholens positiva betydelse i livet hinder för att söka vård.

Slutsats: Lyhördhet för vilja till förändring kan vara av betydelse vid arbete med att motivera människor för vård och behandling. Genusrelaterade föreställningar om alkoholproblem och vårdsökande bör beaktas vid arbete med både alkohol prevention och behandling. Fortsatta studier om alkoholens betydelse i människors liv samt alkoholproblem och vårdsökande ur ett genusperspektiv kan öka förståelsen för vad som främjar och hindrar vårdsökande.

Nyckelord: Alkoholproblem, genusperspektiv, personlighet, process, vårdsökande.

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ORIGINAL PAPERS

The thesis is based on the following papers:

I. Jakobsson, A., Hensing, G. and Spak, F. Treatment-seeking in women with alcohol use disorders -a comparison of treated and untreated women in a population based study (submitted)

II. Östlund, A., Hensing, G., Jakobsson, A., Sundh, V. and Spak, F. A study of personality traits in women previously treated or untreated for alcohol use disorders (submitted).

III. Jakobsson, A., Hensing, G. and Spak, F. (2005) Developing a willingness to change: treatment-seeking processes for people with alcohol problems. Alcohol Alcohol 40, 118-23.

IV. Jakobsson, A., Hensing, G. and Spak, F. The role of gender conceptions in treatment seeking for alcohol problems (submitted).

CONTENTS

TERMINOLOGY AND ABBREVIATIONS

The following abbreviations and terms have been used in this work:

Abbreviations/Terms	Definitions
AUD	Alcohol Use Disorder
AUD severity index	The sum of all endorsed alcohol-related problems multiplied by the duration of each symptom in years.
Current AUD	AUD during the 12 months prior to the interview
Lifetime AUD	AUD at any time in life
Resolved AUD	AUD before, but not identified during 12 months prior to the interview
Brief intervention	Practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it (Babor &Higgins, 2001)
CIDI-SAM	Composite International Diagnostic Interview Substance Abuse Module. An instrument that assesses withdrawal symptoms: physical, social, and psychosocial effects; age at onset; course and severity; and impairment (Cottler, 1989)
DALY	Disability Adjusted Life Years The sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability.

KSP	Karolinska Scales of Personality.
Secondary prevention	Methods to detect and treat people at an early stage of a developing health problem.
WAG	The project Women and Alcohol in Göteborg

INTRODUCTION

The knowledge of how people with alcohol problems overcome their problem drinking is still not sufficiently mapped out. One reason may be the complexity of motives and the variety of ways used by different individuals to cope with their problems. Many people recover from alcohol use disorders (AUD) without formal treatment [1-3]. Various life events and intellectual appraisal concerning alcohol use and misuse have been found to precede the decision to seek treatment [1, 4, 5]. Even if self-solution of drinking problems occurs frequently, formal treatment will be needed for people with severe alcohol problems [1, 6], and also for people who for some reason cannot deal with their problems on their own. Further, early intervention/treatment may reduce the suffering and social problems caused by alcohol problems in both individuals and families.

The impact of alcohol is two-fold; while alcohol is one of the most addictive and harmful substances there is, drinking alcohol is also known to give pleasure and to stimulate relationships. Additionally, although harmful alcohol consumption is relatively common, and alcohol contributed to 9% of the burden of disease (measured in DALYs) in Europe in 2002 [7], most people in Sweden drink alcohol without it causing any problem [8]. Alcohol also plays a prominent role in many people's social lives, and can be regarded as a marker of gender, class, solidarity, and adulthood [9].

In Sweden, the consumption of alcohol has increased by 33% since the middle of the 1990s, and alcohol-related health problems can be expected to increase accordingly. Calculations have shown that approximately 5% of the population are alcohol dependent at a given point in time, and between 10% and 14% are dependent at some time in life, men more so than women [10, 11]. The social costs of alcohol dependence and abuse are difficult to calculate. In 2002, the total costs of lost life-years as productivity costs due to alcohol problems were estimated at 20.3 billion SKR. When the beneficial effects of alcohol were disregarded, the total costs increased to 29.4 billion SKR [12]. The most frequently occurring alcohol-related health problems are psychiatric disorders, injuries, and intoxication, but the social problems resulting from drinking and its effect on family life must also be taken into account when calculating the impact of alcohol in the global burden of disease [13].

Different strategies have been used for reducing alcohol-related harm to the community. To enhance public health and social well-being, regulation of alcohol prices and the accessibility of alcohol, along with drink-driving countermeasures, have been proven to be effective strategies to decrease alcohol-related harm, whereas the impact of school education and public service messages about drinking has been found to be low in both cost-effectiveness and cost-benefits [14]. Early detection of risky alcohol consumption, particularly in primary health care, combined with information and motivational support, can lead to decreased alcohol consumption and thus fewer alcohol problems [14].

The Swedish alcohol policy also includes facilitating the care and treatment of individuals with alcohol problems [15]. Today there are several treatment

methods available that have been found to be effective [16]. Awareness of the problems and obtaining the most suitable support is an advantage for both society and the individual.

My personal preconceptions

As a nurse I have worked in a number of different fields (orthopaedics; psychiatry; ear, nose, and throat; emergency wards), and everywhere I have met people with alcohol problems and seen the consequences of heavy drinking and AUD. I have also noticed that alcohol problems appear to be considered as secondary to the more immediate needs of the patients, and therefore less attention is paid to them. When teaching nursing I was surprised to find that students were reluctant to ask patients about their alcohol consumption because they did not want to risk the therapeutic relationship, and thought that asking about drinking habits might infringe personal integrity. In addition, my background includes studies in psychology, which arouse my interest in behavioural change and decision-making.

These experiences, together with a general interest in equality, equity, and women's health and living conditions, triggered my interest in treatment-seeking for alcohol problems in women. The interviews I have conducted with treatment-seeking women and men have only increased my interest in the relationships between alcohol problems and conceptions of femininity and masculinity, and I hope to be able to study the topic further.

"There is thus a strong justification for the health professions stepping up their heath advocacy with respect to policies to reduce rates of alcohol problems" (Room et al., 2005 p.523)

BACKGROUND

Alcohol – a public health issue

Alcohol use is related to several physical, mental, and social harms [7]. The social harms affect the behaviour of individuals and their interaction with partners, and can include both family and workplace problems; they have a major impact on wellbeing [17]. According to WHO, the globally predicted public health consequences of alcohol use and misuse are worrying. Particularly worrying is the trend of more harmful patterns of drinking among young people [7]. The alcohol-related burden of disease is influenced both by the average volume of alcohol consumption and by drinking patterns [18]; in order to reduce the burden of disease, these two aspects must be taken into consideration. Thus, the preventive strategy may be either to shift to a less harmful drinking pattern or to reduce the volume of alcohol consumed [7]. According to Skog [19], sensible prevention policies should be a mix of several strategies, with attention on both the general population and targeted groups. Strategies ought to be specifically aimed at decreasing consumption levels (intake/year), and changing drinking patterns (frequency of intoxication) and drinking contexts. Public health professionals working to promote population health can help in developing health surveillance, creating prevention strategies, increasing early treatment, and planning for health services [20].

The proportion of alcohol consumers that develop problems due to their drinking increases as the consumption in the whole population increases [14, 19-21]. The goal of Swedish alcohol policy is to reduce medical and social harms by allocating co-ordinated prevention recourses at a local level, including specific support at risky behaviours in individuals, care and treatment, and restricted access to alcoholic beverages[22]. In Sweden in 2002, there were approximately 2000 deaths with an alcohol-related diagnosis such as AUD, alcohol poisoning, liver cirrhosis, cardiomyopathy, gastritis, and alcohol induced psychosis; 20% of these deaths were among women. The real number of alcohol-related deaths is in fact higher, since for example, 11% of deaths among those under 70 years of age are regarded as alcohol-related [11].

Some beneficial health effects of alcohol consumption have also been reported. Even if caution is needed in making general drinking recommendations, there is epidemiological evidence showing that low to moderate average alcohol consumption protects against coronary heart disease [23, 24]. The biological mechanisms of how the protective effect is mediated have been mapped out, which strengthens the evidence [7].

Alcohol consumption in Sweden

Alcohol consumption in Sweden increased between the middle of the 1950s and the late 1970s. Consumption fluctuated during the 1980s and the beginning of the 1990s, but a considerable increase occurred between 1996 and 2005, somewhat more so in men than in women, and evidently more in young people

[25, 26] (Table 1). In 2002, the highest level of alcohol consumption in both adult women and men was found in the 20–24 age group, and the lowest in the 65–80 age group. The women in the latter age group contained the largest proportion of abstainers. The overall proportion of abstainers in the Swedish population was 28% in 1968 and 10% in 2000 (8% of men and 12% of women) [27].

Table 1. Litres 100% alcohol per inhabitant >15 years of age over 52 years.

Year	1953-1955*	1963-1965*	1973-1975*	1983-1985*	1996**	2005**
Alcohol consumption	5.4	5.6	7.7	6.4	8.0	10.2

*calculated from registered sales data [25]

**estimated from interviews and registered sales data [26]

Detection of risky alcohol consumption and brief intervention

Detection of incipient alcohol problems is of great importance for public health. Secondary prevention and adequate intervention can effectively limit the health consequences of AUD, and therefore it is important to identify risk factors and early signs of alcohol problems [14]. Risky alcohol consumption can be detected by different screening methods in connection with visits to primary care centres [16]. Several instruments for use in primary care are available as tools for routine screening for people at risk for AUD [28].

Brief intervention, including alcohol education, simple advice, and brief counselling, has proved to be effective once the problem is detected [29]. The intervention can be carried out by nurses or physicians in primary health care settings after some training [16]. Brief interventions are designed to motivate high-risk drinkers to moderate their drinking with the purpose of preventing alcohol problems from becoming established and then deteriorating. Several methods for brief intervention are available today. The methods usually demand some training, but are suitable for and have been proved effective in both primary care and emergency health care settings [11]. In Sweden, between 15 and 25% of people seeking treatment in emergency wards and approximately 15% of those in primary care settings are estimated to be high consumers of alcohol; however, these individuals are seldom asked about their drinking habits [30].

Although the benefits of brief intervention are well documented, there are difficulties involved in implementing the method as routine in primary care.

Good screening methods can be a way to increase detection of problem drinkers [31], but it is also known that GPs and nurses can be reluctant to screen for alcohol problems due to inadequate training and the conception that asking about alcohol can, particularly according to nurses, interfere with the nurse-patient relationship [32, 33].

Self-change

Most individuals who develop AUD do not seek treatment, but recover without professional assistance. The ratio of untreated to treated alcohol abusers has been estimated to lie between 3:1 and 13:1 [34], and recently in Canada it was found that only 36% of a group of people with a lifetime diagnosis of AUD had ever sought treatment for alcohol problems [2]. Recovery without formal treatment has been found to be related to environmental influences and to evolve as a process over time [35]. Different terms, such as spontaneous remission, natural recovery, and maturing out, have been used to explain the self-change process in people with alcohol problems. The common conception is that of an unwanted condition that is overcome without professional treatment or help [36]. Psychosocial resources play an important role in natural recovery from alcohol problems [37], as do significant life events and cognitive appraisal of the advantages and disadvantages of drinking and not drinking [1, 5]. The most important factor for maintaining recovery has been found to be spousal support. Other prominent factors were support from friends and family, and changes in social, recreational, and leisure activities [34].

Treatment versus no treatment

If self-change without formal or informal help or treatment is the most common way to recover from AUD, what are the incentives for promoting treatment-seeking? When studying one-year outcomes of treated and untreated individuals with alcohol dependence, Weisner et al. [38] found that a year after baseline, treated individuals had better outcomes concerning abstinence and unproblematic alcohol use compared to an untreated general population sample. Additionally, studies of long-term outcomes have shown that individuals who sought formal or informal treatment were better off in terms of abstinence, drinking-related problems, and intoxication than were those who chose to remain untreated [39]. Abstinence after six months of 12-step group treatment together with recovery-oriented social networks predicted long-term abstinence, while family or friends who encouraged alcohol use were negatively associated with abstinence [40]. A recent study by Dawson et al. [41] showed clear evidence of positive associations between help-seeking and abstinent recovery from alcohol dependence. On the other hand, findings from an outpatient psychosocial alcohol treatment trial in the USA suggest that the treatment was not particularly effective; a sample receiving treatment improved their percentage of abstinent days by 62% in the first week, but later improvements were only marginal, and to a great extent matched by an untreated dropout group [42].

Alcohol treatment

During the last 30 years, there has been considerable scientific development concerning the understanding of alcohol problems and treatment [13]. Once an alcohol problem has been discovered, a wide range of methods for treatment is available. No single "best" treatment for alcohol problems has yet been discovered [43]. A review, supported by controlled trials, of the efficacy of various treatment methods showed that a therapy providing behavioural skill training, combined with social support network, and pharmacotherapy (acamprosate and naltrexone) hitherto belong to the top ten of the most effective treatment methods [44]. In the USA, alcohol dependence treatment with Medical Management (9 sessions), Combined Behavioural Intervention (CBI), and medication (naltrexone) was found to be effective and suitable for primary and other health care settings [45].

Berglund et al. [31] reviewed treatment of alcohol problems and presented analyses of interventions/treatment in four areas: hazardous consumption of alcohol, alcohol withdrawal, psychosocial therapy, and pharmacological treatment. Their findings can be summarised as follows:

- Early detection and treatment of alcohol problems is of great importance and the treatment options are as effective as other common treatments for chronic conditions.
- Even if there is still insufficient knowledge of alcohol withdrawal treatment, there is strong evidence showing that symptom reduction can be achieved with benzodiazepines, carbamazepin calcium antagonists, beta-receptor antagonists, and clonidine.
- Psychosocial treatment was found to be effective, particularly when conducted by a trained therapist with a theoretical base and with systematic supervision (motivation enhancing, cognitive behavioural therapy, 12-step treatment, structured interactional therapy, and non-specific treatment; often supportive counselling and social support).
- Acamprosate, naltrexone, and disulfiram (if delivered under supervision) have a confirmed effect in short term treatment of alcohol addiction.

A combination of psychosocial treatment and medication (akamprosat and/or naltrexone) is recommended for treatment of AUD in Sweden [46].

Theories of behavioural change

Theoretical models of behavioural change are used both in research and as a basis on which to develop interventions. The models are used to increase the understanding of how people change, and to provide tailored strategies to correspond with the needs of people entering treatment [47]. Researchers have specifically been interested in refining the understanding of motivation and its implications for treatment assignment.

Motivation for change

When studying both the general population and those who had undergone treatment, Matzger, Kaskutas, and Weisner [48] found three main reasons for cutting down drinking: having a spiritual awakening, having experienced a negative/traumatic event, and hitting rock bottom. The latter concept is sometimes called "bottoming out", meaning that there is a point at which a person changes their status from unmotivated to motivated after having endured a sufficient amount of suffering to trigger a shift in their state of mind [49].

Motivation for behavioural change and motivation for help seeking do not always correspond, which can lead to a situation where the motivation to change exists but the motivation to seek help is lacking [47]. Hence, in treatment programs, both motivation for change and motivation for help-seeking should be taken into consideration in order not to over- or underestimate a client's motivation [47].

Motivational states are defined as a fluctuating state of balance between the pros and cons of behaviour. They vary along a continuum and are influenced by a variety of factors in the social environment [49]. Miller [50] has shown client motivation for change to be substantially influenced by therapist style and environmental characteristics. Prochaska and DiClemente [51] developed a trans-theoretical model used for assessing readiness to change. The model is often referred to as a tool for estimating readiness to change in people with alcohol problems [47]

The trans-theoretical model

To increase the understanding of behavioural change, DiClemente and Prochaska [52] studied how people gave up smoking on their own. Through retrospective, cross-sectional, and longitudinal studies they found evidence that the smokers passed though a series of stages of change, and they developed a model based on their findings. The stages were labelled as follows: precontemplation, contemplation, preparation, action, and maintenance. The first stage, precontemplation, is a period when the smoker does not think of stopping smoking, at least not in the next six months. Contemplation is a period when the smoker is seriously thinking of stopping smoking in the next six months. Preparation is a period when the smoker thinks about stopping within the next month, and has tried to stop smoking in the past year. Action is the period up to six months after the smoker has made a change and stopped smoking. Maintenance is the period that starts six months after action, and continues until smoking is terminated as a problem. The authors have attempted to demonstrate that the model can be generalised to all changes in health behaviour, but although they have found commonalities they have also discovered unique aspects of the specific behavioural change. Concerning behavioural change in

alcohol abuse, the authors stress that the complexity increases due to the associated cognitive impairment [53].

The process of role exit

The theory of the role-exit process is based on the assumption that behavioural expectations are associated with given social roles that are culturally prescribed and exist apart from any single individual in society. Fuchs Ebaugh [54], who studied the process in people exiting from a variety of roles, including alcoholism, describes the role-exit process as a social process that occurs over time, and one which focuses on getting out of an undesirable role and re-establishing one's identity in a new role that takes the old role into account. The process of disengaging from a role that is central to one's self-identity emphasises that role exiting is rarely a sudden decision. The social process taking place is unique, and is similar regardless of the role that is being departed from. A general pattern, containing four stages, characterises the process.

The first stage, labelled the first doubts, occurs after numerous events such as changes in relationships, or specific events leading to dissatisfaction with the situation. These doubts might lead to an evaluation of the costs and benefits of the current situation. The second stage of the exit process occurs when the person starts to seek alternatives. At this stage, negative reactions from others can interrupt or retard the process, whereas support from others can promote the seeking of alternatives. The experience of an emotional relief might occur at this stage as the person realises that choices are possible. The turning point is the third stage of the process, which occurs when the person realises that a change is desirable and possible. This turning point is sometimes triggered by a major event; however, often the event is insignificant in itself but is attributed a symbolic importance that can serve as the reduction of cognitive dissonance and the opportunity to announce the decision to others and to mobilise the resources needed to exit.

The fourth stage in the exit process is to create an ex-role. During the fourth stage there are several issues to handle; first, signalling the change to others, secondly, making changes in the social network, and thirdly, dealing with the identification with previous group members and roles. Making a successful transition through the exit process requires handling the challenges of the fourth stage in a successful way. One strategy frequently used is to identify with a group one is hoping to join, and to start becoming like the new group in values, orientation, and normative expectations. Fuchs Ebaugh also observed that role exits make individuals highly cognisant of the expectations of others, both as ex-members of previous roles and as novices in new ones [54].

Women's and men's drinking patterns

It is well known that in every society where alcohol consumption has been measured, men consume more alcohol than women. Consequently, alcohol

problems are more prevalent among men than among women, and social problems due to men's drinking are also more common [55]. This is also the case in Sweden [56].

In 1979, the ratio of male to female alcoholics was estimated as 5 to 1 [57]. A population study of women and alcohol in Göteborg showed that the lifetime prevalence of AUD in women, according to DSM-III-R, was 3.27% [58]. Lifetime prevalence rates of problem drinking (defined as heavy drinking or endorsing at least one dependence symptom) in 42-year old Malmö residents in 1992 were 4.6% in women and 15.5% in men [59].

Several reasons have been put forward as explanations for the gender difference concerning alcohol problems. Biological differences between women and men in response to alcohol are found in at least three areas; pharmacokinetics, the effect of toxicity, and the heredity of alcoholism [60-62]. It has been assumed that biological phenomena are used by societies in order to create rules for social behaviour and relationships [55]. Also, social and cultural beliefs and norms are known to influence gender patterns of alcohol use [63]; for example, it has been suggested that men may use alcohol as a way to gain social support from others [64, 65] .

Some factors that have been regarded as important for women's and men's different drinking patterns are parenthood, education, unemployment, and marital status. So far, no comprehensive theories have been presented that satisfactorily explain why women in general drink less alcohol than men, thus the gender difference is still not sufficiently explained [66].

Miller and Cervantes [67] observed more similarities than differences in problem-drinking women and men attending the same treatment clinic. The women drank more wine, reported more negative emotional effects of drinking, and had more spouses with alcohol problems than did men. Demographic measures, family history, and life problems showed few differences.

The convergence hypothesis

Due to the general social changes that have resulted from increased education, and the availability to women of professional options similar to those available to men, women now have the same opportunities and incentives to drink as men [55]. It would therefore not be unreasonable to expect that women would also adopt a lifestyle similar to that of men concerning alcohol consumption patterns [68]. The hypothesis that women's increased drinking should lead to a closing of the gender gap in alcohol consumption has been debated since the late 1970s [68]. This so-called convergence hypothesis has been tested several times, with diverging results from different parts of the world. Most findings reject the hypothesis, but gender convergence has been verified in Finland; this result was explained by the egalitarian position of women in Finland in addition to a long observation time [69]. A recent study from New Zealand also showed significant gender convergence, depending on women's increased alcohol consumption

[70]. Additional support for the theory that the drinking habits of women had become more like those of men was provided by York et al. [71], who studied age at first drink in a general population sample in the USA. Convergence can also occur due to decreased alcohol consumption in men and stable consumption in women [72]. However, even though there are studies showing that drinking behaviour in men and women is beginning to converge, considerable differences in alcohol use still remain [73].

Alcohol and conceptions of femininity – masculinity

Eriksen [74] discusses alcohol as a gendered symbol, by which individuals can express their identity. During the early 20th century, restrictive attitudes to alcohol and strict drinking habits in women were regarded as signs of feminine gender identity, and women were at this time held responsible for both men's drinking and their own. On the other hand, sobriety in men was seen as unmanly, and the use of alcohol was explicitly associated with the masculine world of urban life [74].

A Swedish study of associations between gender identity and alcohol consumption/AUD found increased odds for AUD among women who gained high scores on emotionality and low scores on leadership and self assertiveness on a masculinity/femininity scale [75]. Femininity has been found to relate to higher alcohol use among women in Toronto, and masculinity to higher alcohol use among women in Moscow [65]. For men in Moscow, on the other hand, masculinity was associated with lower levels of alcohol use [65]. This indicates that culture must be taken into consideration when studying alcohol consumption in relation to masculinity and femininity.

Treatment-seeking for alcohol problems

Promoting treatment-seeking

Stressful life events, such as severe health problems or serious social failings [76], the break-up of a marriage, or the loss of or threat of losing a child, have been shown to promote treatment-seeking in both women and men, but women were significantly more likely than men to point out pressure from others as the main reason for treatment entry [77]. Social pressure or support from a spouse or significant other was another important trigger for treatment-seeking [78]. Cunningham et al. [79] explored ten different motives for seeking treatment, and found that "weighing the pros and cons of drinking or drug use" and "warnings from spouse" were the most frequently cited reasons. Culmination of ongoing difficulties and problems have also been reasons for entering treatment [77]. Older adults with alcohol problems reporting negative life events, chronic stressors in the area of health, spouse and friend stressors, and having few friends who approved of drinking have been found to be likely to seek treatment for drinking or related problems [80].

Barriers to treatment-seeking

Negative emotional states, stigma, and insufficient social and financial resources have been found to interfere with treatment-seeking in both men and women [81]. Copeland [82] identified the following principal barriers to treatment-seeking: social stigma, labelling, costs, lack of awareness of treatment options, and concerns about confrontational models and stereotypical views of clients by treatment service providers. Tucker, Vuchinich & Gladsjo [83] found that "potential embarrassment" and "not wanting to share personal problems with others" hindered treatment-seeking.

Women and men have reported different barriers to treatment entry. Men reported having difficulties in asking for help, and reluctance to be seen as requiring psychiatric care, whereas women were concerned to avoid being labelled as alcoholics [84].

In Sweden in 1979, far more women than men were admitted to treatment in an acute condition. The women, at this time, often had dramatic complications and did not usually seek treatment spontaneously [57]. The reason for this was that women with early-stage alcohol problems regarded the abuse as part of a major life crisis, and hesitated to seek traditional treatment [85]. Women with AUD have been overrepresented in non-alcohol-specific health care settings, mainly mental health care, which might indicate barriers for women to seek traditional alcohol treatment [86]. Another reason could be that GPs had not paid attention to the alcohol problems.

Personality and treatment-seeking

The relationship between personality traits and the use of alcohol treatment services has previously not been sufficiently investigated, but personality is known to play a role in the development of AUD [87], as well as treatment outcome [88] and relapse [89]. Stability of personality traits have been confirmed in longitudinal studies [90], even if the stability has been questioned with regard to age [91]. Changes in personality have been reported in relation to treatment for depression [92] and after psycho-analytic psychotherapy [93].

Tomasson and Vaglum [94] found that a significant proportion of women and men seeking treatment for alcohol problems also suffered from anxiety or affective disorders. Dearing et al. [95] found evidence for a positive link between shame-proneness and problematic alcohol and drug use. Shame-proneness was found in samples with very low or very high levels of substance abuse problems, and the authors suggest that shame and guilt may have important implications for treatment-seeking for substance abuse problems.

Personality factors have also been found to influence treatment-seeking in mental health services. Among women, increased utility of such services was found to be associated with younger age, higher education, neuroticism, major

depression, and alcohol or substance use disorders, whereas conscientiousness and extraversion decreased the odds of using the mental health service [96].

Women, men and treatment-seeking

Women are known to utilise medical service in general to a greater extent than men [97]; but men are overrepresented in treatment for alcohol problems, although the gap has narrowed during the past several years [98]

Masculinity characterised by strength, independence, self-reliance, and being in control [99, 100], and masculine beliefs, have been found to influence men's reluctance to seek help when faced with illness [101]. When assessing the reasons for not seeking help for mental and physical health problems, Mansfield and Courtenay [102] found that a need for control and self-reliance was one of the most important factors. When men decide to seek help, the decision has been found to be supported by visible symptoms and the influence of others, and made easier when the aim was to preserve or restore a more valued masculinity [103]. The relation between help-seeking and masculine gender socialization is probably complex, and dependent on context including culture and type of health problem [104].

AIMS OF THE THESIS

The overall aim of this thesis was to explore treatment-seeking behaviour in people with alcohol problems. The specific aims were:

- to investigate the characteristics of women diagnosed with alcohol use disorder (AUD) who had and had not received treatment, focusing on treatment-seeking in relation to socioeconomic factors, co-morbidity, and severity of the alcohol problems;
- to analyse the association between personality and treatment-seeking in women, based on pooled data from three population samples and one clinical sample;
- to explore how women and men with recent experience of seeking treatment for alcohol problems experience the processes leading to treatment;
- to analyse promoting and hindering factors for treatment-seeking for alcohol problems in women and men respectively and to analyse if these factors reflect femininity or masculinity.

METHODS

This thesis is based on data from a multipurpose, longitudinal, population-based project entitled "Women and Alcohol in Göteborg" (WAG) and on data obtained from qualitative interviews with twelve women and men who had entered treatment within the last month.

Women and Alcohol in Göteborg

The overall aim of the study "Women and Alcohol in Göteborg" (WAG) was to increase the knowledge and understanding of women's drinking problems in order to form a basis for adequate treatment possibilities and prevention programs. More specifically, the aims were to study the occurrence, antecedents, adverse consequences, and natural courses of the disease, and ways out of AUD [105].

General population sample

The original study population comprised all women born in 1925, 1935, 1945, 1955, and 1965 and registered in District West in Göteborg on 31 December 1985. At the time, District West had 99 328 inhabitants, 51 132 of whom were women. The women were informed that the information they gave would be confidential, and that participation in the study was voluntary and could be terminated at any time.

Study design and screening

The study was conducted in two phases (Figure 1). In the first phase a 13-item questionnaire developed for screening of alcohol problems in women (Screening, Women and Alcohol in Göteborg, or SWAG) was sent, in 1986, to the selected women. The response rate was 77.7%. The screening questionnaire has been described in detail elsewhere [106]. The same procedure was followed in 1995 and 2000, with the addition of new birth cohorts (women born in 1970/1975 and 1980). The 1986 data also included a clinical sample, selected by screening and consisting of consecutive patients in all relevant public medical service units in the uptake area; these units included three mother care units, seven general practice centers, the three emergency wards for internal medicine, surgery and general psychiatry and two psychiatric outpatients units As the private health care sector was very small at the time of this investigation, the clinical sample is closely representative of the population seeking treatment in the uptake area. The sampling procedure was the same as for the general population sample, with the exception that the screening questionnaires were distributed during the visits.

Figure 1. Women and Alcohol in Göteborg (WAG) sample study design. Occurrence of alcohol use disorders (AUD).

Phase 1 **Questionnaire (SWAG)** **N**	**REPRESENTATIVE SAMPLE** **GENERAL POPULATION** **3130***				**TOTAL**
Score on questionnaire	0	1 - 3	≥ 4		
Respondents to questionnaire **n** **(%)**	1797	497	139	Did not respond 495	**2433** **(77.7)**
Phase 2 **Selected for interview**	Random 109	Random 118	All 139	Random 113	**479**
Conducted interviews **n** **(%)**	91 (83.5)	110 (93.2)	122 (88)	76 (67.3)	**399** **(83.2)**
AUD -diagnosis in interview **n**	**0**	**4**	**49**	**3**	**56**

***** n=202 women actively declined participation and have not been contacted since.

Interviews

In the second phase, a stratified random sample of 479 women was selected for interviewing and 399 (83%) agreed to participate. The stratification groups were made up of: respondents with a SWAG score of ≥4, respondents with a score of 1–3, respondents with a score of 0, and those who dropped out in the screening phase. Varying percentages of the latter three groups were chosen in order to form sample groups all of approximately the same size. The study design has been described in detail by Spak and Hällström [58].

The interviews were performed in 1990, 1995, and 2000 respectively. The semi-structured interviews contained approximately 1000 items and took from an hour and a half up to several hours to perform.

The interviewers had clinical experience, and were trained to make diagnoses according to the Diagnostic and Statistical Manual, 3rd revision (DSM-III-R) [107]. Face-to-face interviews were conducted in the interviewer's office or in the participant's home, and included a clinical psychiatric examination. The DSM-III-R criteria were used for diagnosis of AUD. In some cases, the clinical diagnoses were adjusted using information obtained with the Composite International Diagnostic Instrument-Substance Abuse Module (CIDI-SAM) [108] and/or information from medical files (2 diagnoses were added and 32 were removed). Somatic diagnoses were made according to the International Statistical Classification of Diseases and Related Health Problems, 9th revision (ICD-9).

The majority of the participants (90%) gave consent for a record file search to be conducted. This search included medical files of family practice centres and maternity units in the uptake area, departments of internal medicine and surgery at the university hospital, the two departments of obstetrics/gynaecology in Göteborg, and all departments of psychiatry in Göteborg.

The instruments

The interview protocol included questions about socio-demographic characteristics, social background, home conditions, drinking habits, health issues, sexual relations, and psychiatric diagnosis and experiences of treatment for AUD. Treatment was thus defined as seeking treatment specifically for alcohol problems, but could refer to any available kind of treatment. The following factors were selected for analysis in the present study:

- social factors: marital status, number and age of children, level of education of the participant and her spouse, occupation, and social status;
- health factors that were identified by scrutinising self-reported data on history of sickness, medication, and disease related to long spells of sick leave;
- experience of and attitudes towards alcohol treatment, and obstacles to and preferences of treatment.

As one part of the interviews, the respondents were asked to complete the Karolinska Scales of Personality (KSP) and the Masculinity/Femininity Questionnaire (M/F-Q). The KSP consists of 135 statements grouped into 15 different scales. Each statement has four response alternatives: "disagree completely", "partly disagree", "partly agree", and "agree completely"[1], with

[1]In Swedish, these response options are "stämmer inte alls", "stämmer inte särskilt bra", "stämmer ganska bra", and "stämmer precis".

scores of 1, 2, 3, and 4 points, respectively. The points for each scale are summed, and the raw scores are transformed into T-scores. The KSP is a personality test originally constructed to measure aspects of personality that are closely linked to the information processing and arousal systems in the individual [109, 110]. The scales included were designed to assess certain vulnerability traits in line with theories of biologically-based temperament dimensions underlying psychiatric disorders [111]. The stability and validity of the scales have been evaluated [109]. It was concluded that, with the exception of some of the aggression-related scales, the KSP scales demonstrate both stability and construct validity.

Women diagnosed with AUD who had and had not received treatment

A sample of 52 women, identified in interviews held in 1989 and 1990, each with a lifetime diagnosis of AUD, formed the basis for investigating characteristics in women who had and had not sought treatment. To study differences between the treated and the untreated women, the sample was divided into two groups. One contained 17 women who, according to self-reported data, had been treated for alcohol-related problems; the other consisted of 35 women who had not received any treatment for alcohol problems.

Personality and treatment-seeking

The study of personality and treatment-seeking was based on cross-sectional data from 1990 (general and clinical samples), 1995, and 2000. The clinical population differed from the general population sample in some respects. The women were older, had more children, and fewer were married or cohabiting. More women in the clinical population belonged to the lower social class, and fewer to the upper class, but there was no difference in educational level. The symptom severity among women with AUD was higher in the clinical sample. They also had higher scores on somatic anxiety and psychastenia, and lower scores on socialization measured with the KSP. Although we observed some differences between the samples we concluded that these differences would not interfere with the questions in the study in any important way, thus we pooled the samples in order to obtain sufficient sample size for statistical analysis.

The treatment-seeking process

Grounded theory was chosen as an appropriate qualitative method to study social and psychosocial processes such as the treatment-seeking process [112]. The aim of grounded theory is to develop concepts or a theory from empirical data [113]. The method is developed from symbolic interactionism; it sets each person in their own social context, and assumes that people act on the basis of the meaning that their experiences have for them. Grounded theory has been tested and found to be highly suitable both for studying new phenomena and for examining old

phenomena with a new approach. Furthermore, it is a commonly-used method within health care research [112]. By interviewing people who had sought treatment for alcohol problems, we attempted to discover the behavioural patterns underlying the processes preceding treatment entry [114]. The intention was to develop a hypothesis and create a theoretical model that could provide knowledge for clinical use [115].

Settings and informants

In Sweden, most people with alcohol problems apply for treatment from public medical services; thus, we recruited our informants from three such specialist outpatient treatment facilities in the city of Göteborg. The relevant staff at these facilities were informed of the study and the selection criteria. Two of the clinics specialised in substance dependence and abuse problems, and one clinic was a general psychiatric outpatient clinic. To gather as rich and substantial data as possible, we strove to select informants with varying backgrounds and experiences [116], using the following selection criteria: 1) The informant should be able to communicate their experiences in Swedish or English. 2) Alcohol problems should be the main reason for seeking treatment. 3) Treatment should have been sought freely by the informant. 4) Treatment should have been entered within the last month.

When a client who met the criteria for inclusion entered treatment, she/he was informed of the study by her/his counsellor. After obtaining informed consent, the interviewer (AJ) telephoned the potential informants to describe the research project and explain that participation in it was voluntary. At this point, two women and one man wanted to reconsider their participation, and offered to call back later; they never did, and no further contact was made with them.

Because the data collection was time-consuming and there was limited access to informants who fulfilled the requirements, we sampled on the basis of what was possible; but a balance was achieved concerning sex, age, and duration and severity of alcohol problems. Twelve informants — five women and seven men — were interviewed during their first month of treatment.

The interviews

Dates for the interviews were set according to the informants' preferences; seven interviews were carried out in a secluded room at the treatment unit, while five were conducted in an interview room at the Göteborg University. One man wanted his wife to be present during the interview, and one woman wanted her common-law husband to assist if language problems arose; these conditions were accepted. An interview guide covering the following themes was used: 1) the thought process leading to the decision to seek treatment; 2) factors promoting treatment-seeking; 3) factors hindering treatment-seeking; and 4) general perceptions of alcohol abuse treatment. The length of the interviews ranged from 50 minutes to two hours and the interviews were audio-taped and

transcribed verbatim in Swedish. The transcripts were analysed in Swedish, and translation into English was performed as the last stage of the study.

Analysis

The analysis was conducted by the interviewer (AJ) and started as soon as the first interview was transcribed. Following this, the interviews were analysed consecutively.

Data were analysed in four stages. Firstly, the transcribed material was scrutinised line by line in search of statements describing events, objects, happenings, actions, or interactions related to treatment-seeking. The statements were broken down into discrete parts and compared for similarities, differences, and meaning. Conceptualisation was carried out and written in the margin, mainly using the informant's own words. Secondly, the emerging concepts were listed and compared in order to identify situations in which the informant acted in a certain way and attributed a particular meaning. Concepts were then grouped into categories, and given labels that captured the phenomena. Five categories were identified at this stage. Thirdly, relations between the categories were explored, each being analysed in terms of context, conditions, and consequences. Three categories, each with 2–4 subcategories, were found to constitute steps of the process; one category was influencing the process continuously, while another category linked all the categories together and was identified as the basic psychosocial process. Fourthly, integration and refinement of the categories was pursued by listening to the interviews again, visualising patterns, and exposing the findings to scrutiny in seminars with co-researchers, academics, and professionals from different fields. The seminars were held after five and ten interviews, and added a variety of perspectives to the analysis, broadened the perceptions, and contributed to raising the level of abstraction in the emerging categories.

A content analysis of the interview protocols was then conducted [117] The analysis was made separately for men and women. Initially, the interviews were read through in order to obtain a sense of the whole. Next, the textual material was scrutinised line by line, and meaning units of the data were identified; the meaning units were then condensed, and overriding entities of meaning were listed. Finally, an interpretation of the sense of meaning was made, and categories were identified and given labels that described or captured the phenomenon. The categories found in the interviews with women and men respectively were compared, and differences and similarities were analysed.

Ethical approval and considerations

Approval for the studies was granted by the Research Committee for Ethics at the Faculty of Medicine of Göteborg University (Ö 591-99 and Ö128-00). Participation was based on informed consent. The scientific value of research should always be balanced against possible harm caused to the study subjects.

We regard the actions we have taken to be appropriate, and compliant with the Helsinki Declaration [118]. In order to enhance the data quality and to minimise the risk of harm, professional clinical interviewers were used. The interviews in the WAG-study were extensive, and contained questions that could be anxiety-evoking, but most women seemed to appreciate the opportunity to speak openly about themselves. The ethical issues were discussed among the interviewers, and women who seemed to need treatment were offered professional help. The interviewers had a list of different institutions and help organizations to offer women who seemed to need such contacts. Another ethical issue was the question of how to get in contact with the women selected for interview. In order to minimise attrition we used reminders by letter, telephone calls, and finally, when necessary, we went to look for the respondents in their homes. However, once we had made contact with the interviewees and given them information about the study, we respected any wish on their part to refrain from participation without making any effort to influence participation. Although it happened that women felt irritated with some questions, this was rare. When lack of time was given as a reason for not participating, we asked whether they would agree to participate in a short telephone interview instead, which many agreed to.

All of the qualitative interviews were performed by the same interviewer (AJ). Special attention was given to the integrity of the informants who shared their personal experiences with the interviewer. For that reason, demographic data about the informants had to be presented in order to avoid identification. This might decrease transparency, but in qualitative studies ethical considerations should be attached special values [119].

Figure 2. Overview of study design, main topics and data on which the four studies in this thesis is based.

STUDY	DESIGN	MAIN TOPICS	DATA
I **Treatment seeking in women**	Cross-sectional	Comparison of treated and untreated women with AUD.	Population based sample n=52
II **Personality and treatment seeking**	Cross-sectional	Associations between personality traits and treatment seeking for AUD in women.	Pooled data from three population samples and one clinical sample n= 217
III **Treatment seeking process**	Qualitative Grounded theory	Exploring the treatment-seeking process in women and men.	Open interviews n=12
IV **Treatment seeking from a gender perspective**	Qualitative Content analysis	Femininity and masculinity in treatment-seeking.	Open interviews n=12

RESULTS

Treatment-seeking in women with alcohol use disorders – a comparison of treated and untreated women in a population based study (Paper I).

Treated and untreated women

The age range of the 52 women was 25–65 years; the mean age of the treated women was 44.4 years and that of the untreated women 38.8 years. Mean age when entering treatment was 33.7 years.

Differences and similarities

A significant difference was found between the two groups concerning marital status (p=0.02); 82.% of the women who had received treatment were married or cohabiting, while the corresponding figure for the untreated women was 48.6%. A greater proportion (49%) of the untreated women than of the treated women (37%) worked full-time, and fewer untreated women (9%) than treated women (25%) received disability pension. Differences were also found between the two groups concerning occupation. Almost half of the women who had received treatment worked in the unskilled blue-collar sector (47%) compared with 27% of the untreated women. The severity of AUD differed significantly between the groups (p=0.008). The treated women had more alcohol-related symptoms and longer duration of AUD than did the untreated group. The significance remained even after adjusting for age.

Co-morbidity

Co-morbidity was high among the women who had received treatment for alcohol problems; 82% had at least one diagnosis other than AUD. Additionally, 59% had been on sick leave for more than three months due to a variety of diagnoses, with 65% being on medication and 76% perceiving different health problems. In the untreated group, 57% of the women had regular contact with health care providers due to either sick leave spells exceeding three months or continuous medication.

Conceptions of reasons for restricted alcohol consumption did not differ significantly between the groups. The two most common self-perceived obstacles to treatment entry were the same in both groups, namely “I do not believe treatment can help me” and “It is only I that can help myself”.

A study of personality traits in women previously treated or untreated for alcohol use disorders (Paper II)

Alcohol use disorders

In a logistic regression model, we controlled for age, education, social class, psychiatric co-morbidity, and severity. Personality did not predict treatment-seeking.

Women with lifetime AUD (n=217) had significantly higher scores on eleven KSP scales than a reference group without AUD. The KSP scales that differed were: somatic anxiety, psychic anxiety, muscular tension, psychastenia, impulsiveness, monotony avoidance, verbal aggression, indirect aggression, irritability, guilt, and suspicion. Women with lifetime AUD also had lower socialization scores. P-values ranged from 0.001 to 0.0016. Of all women with AUD, those who had been treated for AUD (n=42) had more deviating scores than did untreated women (n=175). The differences were significant for three scales: somatic anxiety, muscular tension, and guilt. The observed differences in the other scales went in the expected direction, that is, higher for most anxiety-related scales, some aggression-related scales, and social desirability; and lower for socialization. About 19% of the women with resolved AUD (n=123) had been treated for AUD. The treated women (n=23) were more anxious, more restless with autonomic disturbances, and had more guilt feelings than did the untreated women (n=100) with resolved AUD. Untreated women with resolved AUD scored more similarly to the reference group (n=1 122) than did treated women, however, they had significantly higher scores than the reference group on, somatic and psychic anxiety, irritability, monotony avoidance, impulsivity, psychasteni and lower scores on the socialization scale. There were no statistically significant differences between treated (n=19) and untreated (n=75) women with current AUD.

Anxiety in addition to alcohol use disorders

About 36% of the women with AUD had an additional diagnosis of anxiety (n=79). The women with resolved AUD had no increased risk of having any additional psychiatric disorder compared with women with current AUD, but the risk of having an additional lifetime anxiety disorder was higher for treated women with current AUD (OR=3.1, 95% CI 1.1–8.7) compared with untreated women with current AUD. Treated women with an additional diagnosis of lifetime anxiety (n=9) were more worried, tense, irritable, and restless, with autonomic disturbances, than were untreated women with an additional diagnosis of lifetime anxiety (n=36). The treated women had higher scores on somatic anxiety, psychic anxiety, muscular tension, and irritability.

Depression in addition to alcohol use disorders

About 21% of the women with AUD had an additional diagnosis of depression (n=45). There were no associations between treatment for AUD and the risk of having a depressive disorder (present or past). Compared with untreated women (n=20), the treated women with AUD and an additional diagnosis of depression (n=5) showed the same pattern as did women with AUD and anxiety, but in addition they had more guilt.

Developing a willingness to change: Treatment-seeking processes for people with alcohol problems (Paper III).

The path to treatment

The path to treatment for men and women with alcohol problems was an experience shared by the informants. A willingness to change their lives developed over time, and was identified as a complex and fragile process. The process was continuously influenced by support from somebody being both caring and demanding.

Demanding and caring support

Throughout the treatment-seeking process, support from others was a modifying or enhancing factor. A support-giver could be a relative, friend, spouse, or professional such as a social worker or physician. This support could be experienced as demanding, but when the supporting person was perceived as frank and genuinely wanting to help it was beneficial. When entering treatment, caring and supporting reception from the care deliverer was crucial for the informant's decision to continue the treatment.

Actuating inner forces

Both positive life events, such as becoming a father, and negative life experiences, such as observing friends or associates becoming social dropouts, initiated thoughts of lifestyle change. The directness of a physician explaining that one had a serious health condition was experienced as an existential threat, and led to an awakening. Experiencing existential threats led to reflections on life and meaning in general, as well as on missed opportunities for a better life.

Dealing with conflicting feelings and thoughts

Ambivalence, characterised by conflicting feelings and thoughts, also influenced the informants' decisions and actions. This conflict could begin at the time the

informants started thinking about changing their drinking habits, and remained even after they had sought treatment. Alcohol had a great impact on the informants' lives, and was used as medication in order to sleep, relax, kill pain, or temporarily escape other problems. Drinking was an important part of social life, and helped to create a festive atmosphere; it was also an excuse to behave in an uninhibited way. Internal conflict emerged as alcohol created an immediate feeling of well-being; the aftermath of drinking was, however, followed by anxiety and panic attacks. To abstain from alcohol implied losing an important source of comfort. The feeling of loss became obvious when the informants talked with grief about their future life without alcohol. The feeling of being in control hindered treatment-seeking, while experiencing blackouts and panic attacks promoted change. Managing work was important for social identity, and as long as a person could work, their alcohol problem was not regarded as serious. Whether an informant was influenced by social pressure appeared to depend on whether those exerting pressure were committed, caring, and played significant roles in the informant's life. The impact of such pressure also depended on timing, and to what extent it was in accordance with respondents' various life events or experiences of existential threats. The informants acknowledged that pressure could make a difference for treatment-seeking, as long as the decision was left to them.

Hoping to turn the situation around

Three subcategories underpinned hopes of turning one's life in another direction: anticipating a better future, seeking reconciliation, and enhancing well-being. Expectations for the future included retaining employment, regaining sound judgement, increasing self-respect, and finding other ways to experience meaning in life. Two of the informants' goals were to resume "normal life", and to be able to drink in a socially acceptable manner. Reconciliation seemed to bridge the gap between the past and the anticipated future. The informants hoped for increased physical, social, and above all, mental well-being. To feel well without alcohol and decrease the risk of future health problems were factors that strengthened the willingness to change. Seeking treatment was an attempt to avert unpleasant long-term consequences and increase one's everyday well-being — in contrast to the fleeting enjoyment of being drunk.

The role of gendered conceptions in treatment-seeking for alcohol problems (Paper IV)

Analyzing the interviews with women and men separately showed both similarities and differences regarding promoting and hindering factors for treatment-seeking. Two promoting and three hindering categories were identified in the women's narratives, and two promoting and two hindering in the men's narratives.

Factors promoting treatment-seeking

The promoting factors for seeking treatment in men were characterised by belief in their own capability and future orientation, whereas the women felt that the important factors were pressure from significant persons and sharing the problem. The women had friends, relatives, or boyfriends who had hinted that the informant's alcohol consumption was unhealthy. Even if it was possible to acknowledge heavy drinking to oneself, it was difficult to accept someone else's calling attention to the problem. When someone did so it was felt to be humiliating and created anger or obstinacy, and the concern was ignored. On the other hand, caring persons who showed both respect and authority, such as physicians, social workers, or friends, were able to put pressure on the women without being rejected. The men had also experienced pressure to seek treatment from people in their social network, but differed from the women in that they emphasised that their own willingness to change was more important for the decision to seek treatment. Some of the women had, more or less outspokenly, been given ultimatums to attend treatment or else their health would be at risk or they could lose their employment. Once a woman's attention had been called to her problem, she began to acknowledge that alcohol had a negative influence in her life, and chose to seek treatment. The first meeting with the therapist was crucial for signing up for a treatment program. The women found it a relief to be able to acknowledge the alcohol problems and still be regarded as a human being with dignity. The men stressed that they were not dependent on alcohol, but they had alcohol problems and these problems were not permanent. Prior to treatment-seeking they had believed that they could refrain from drinking if they decided to, but eventually they had realised that they needed professional treatment. The decision to seek help was influenced by the belief that one day it would be possible to drink "normally" again. The women talked about their life situation in terms of "here and now", whereas men talked about the future and the plans they had made. The men wanted help with their alcohol problems in order to prevent deterioration of their health and their life situation. However, they also expected improvements in their lives such as returning to the labour market, sorting out their finances, moving house, increasing their self-confidence, becoming "normal", changing their lifestyle, experiencing fatherhood, keeping their driver's licence, or increasing their day-to-day well-being. Another future-oriented hope expressed by some of the men was to be able once more to drink in a socially acceptable way.

Factors hindering treatment-seeking

Alcohol was experienced as an important factor in the men's lives, and this hindered treatment-seeking. Some examples of benefits attributed to alcohol were: increased well-being while drinking, reduced inhibitions, the provision of a basis for fellowship, and the potential for alcohol to act as a substitute for other activities. Talking about life without drinking was like talking about losing an old friend, and the subsequent sorrow was expressed in different ways. The men expressed shame over not being able to handle alcohol, and claimed that they

had thought that they were in control of their drinking. This conviction hindered treatment-seeking, until they discovered that they did not have control over their drinking and behaviours related to it. Loss of control created feelings of shame and embarrassment, which also hindered or delayed treatment-seeking as well as the opinion that seeking treatment implies weakness in men. For women, drinking with friends was relaxing, and getting drunk could be fun; it could make the woman feel bold, cocky, and cool and think "this is the real me". Alcohol was sometimes used as a medication against anxiety, or seen as a reward for a day of hard work.

Shame and guilt were hindrances to treatment-seeking in women. They described shame as a feeling that arose when they could not take care of themselves and their everyday duties, because according to the informants "a woman should not be careless or neglectful". Although all informants were asked to talk about their decision to seek treatment, the women began telling their stories by giving a thorough background to why they ended up with alcohol problems. Offering an acceptable explanation for their alcohol problems seemed to be aimed at providing credibility for the rest of the interview. The women were afraid of being perceived as "not good enough", and as being incapable members of society, and this made them avoid talking openly about their alcohol problems. Societal demands on women were in general considered to be very high.

Hindrances for both women and men were feelings of shame and the significance of alcohol in their lives. The findings indicate that treatment-seeking for alcohol problems was influenced by the informants' perception of femininity and masculinity.

DISCUSSION

Main findings

Factors influencing treatment-seeking behaviour

In the population sample of women diagnosed with AUD, severity of alcohol problems was found to be the single most important factor that differed between women who had received treatment for alcohol problems and those who had not. The findings are in line with previous studies pointing at severity of drinking problems as a strong predictor to treatment entry for women [120]. For both women and men, a personal willingness to change the current situation was found to be vitally important for treatment-seeking. The willingness to change developed during a process that was initiated by positive or negative life events or by existential thoughts or threats. Problematic events have already been shown to promote treatment-seeking [121, 122], we also found that positive life-transforming events, such as becoming a father for the first time, promoted treatment-seeking as well. Additionally, existential reflections created the incentive for a change of lifestyle. These reflections were characterised by thoughts of meaning, reconciliation, and present and future identity. As described in the "role exit process" [54], when creating an ex-role, often painful psychological and social processes involving thoughts of the past, present, and future identities take place. Also establishing congruity between the self-definition and social expectations can be difficult.

No evidence was found to support the theory that personality traits predict treatment seeking, but we did find that recovered women who had received treatment were more anxious, tense, irritable, and showed more guilt, than untreated women with resolved AUD. Untreated women with resolved AUD resembled women without AUD on most personality traits. These findings indicate that personality traits may be of importance for determining who is in most need of treatment, but further investigation is needed for exploring the causal directions more closely.

Demanding and caring support from significant others in the social network were crucial for developing willingness to change the current situation. That family and friends play an important role in influencing problem drinkers to do something about their problems has been concluded before, but the present study also points at social and health care professionals as being equally important. This indicates that treatment providers such as nurses, doctors, and social workers, when given the opportunity, can contribute to increased treatment-seeking for alcohol problems.

Contrary to previous findings [123] we found significant differences in treatment experiences between married/cohabiting and unmarried women; the married/cohabiting women had received treatment to a greater extent than their unmarried counterparts. It is possible that the married/cohabiting women were exposed to more pressure from significant others, and that this led to treatment-seeking.

Social pressure to enter treatment can vary, depending on both the person with alcohol problems and their social network [98]. Earlier studies have shown that pressure from the social network can trigger treatment-seeking [4], especially if employers or legal authorities are involved. [98]

Of the women diagnosed with AUD who had not sought treatment for alcohol problems in the population sample, 57% had been in regular contact with the health care system regarding health problems, previous to the interviews. This raises the question of whether the health care professionals failed to notice the women's alcohol problems, or if no obvious signs of alcohol problems existed. GPs in primary health care did not know how to identify problem drinkers who had no obvious symptoms of excessive consumption [32], which might explain why the women remained untreated.

Culturally influenced conceptions and norms regarding alcohol exist in society, and influence the decision to seek treatment for alcohol problems. We found that the decision to seek treatment was complicated by the great personal and social importance that the interviewees attached to alcohol. Alcohol was used as medication to aid sleep, to aid relaxation, to deaden pain, or in order to escape problems that needed to be solved. It was also used as a source of comfort, wellbeing, consolation, and catharsis after a day of heavy or dirty work. Drinking created a feeling of being oneself; it was fun, cosy, and something that was looked forward to. Combined with the preconception that treatment would necessarily include lifelong total abstinence, the expected loss was obvious [124], as were the expected social consequences.

We found that gendered conceptions of alcohol problems and treatment-seeking among women and men influenced the decision to seek treatment. Women in this study experienced that conceptions of femininity in society do not include the image that women have alcohol problems, which most likely delayed treatment entry. Men, on the other hand, considered both alcohol problems and seeking treatment as being inconsistent with masculinity. These findings are in line with Eriksson's [74] historical analysis, which describes alcohol as a gendered symbol during the 1900s.

Readiness and motivation for change

The trans-theoretical model [52] describes a series of stages leading to health behavioural change, mostly in smokers. The model is to a great extent based on the cognitive processes and behaviours of the individual, and is suitable as a tool for assessing readiness for treatment. We found that treatment-seeking is a complex phenomenon that is influenced by the social context, including the social care and health care systems, and societal phenomena such as gendered and culturally influenced conceptions and norms regarding alcohol. Thus, the behavioural change cannot solely be attributed to individual cognitive processes, but is also affected by social and societal influences. We perceive the process of treatment-seeking as a continuum proceeding forward, meaning that after treatment and possible relapse people do not return to the starting point, but in

line with the role-exit process develop other relationships to drinking, or new identities.

Methodological considerations

Strengths of the study

In this thesis, the phenomenon of treatment-seeking was studied using both quantitative and qualitative methods. The qualitative data sets forth the reasons for treatment-seeking given by people with recent experience of seeking treatment for the first time. The quantitative data is derived from face to face interviews and tests with women of several age cohorts recruited in a population sample. The interview protocols included around 1000 variables, which created a solid basis for both alcohol diagnosis and psychiatric diagnoses. Although the WAG study was accomplished with a two-stage sampling procedure in accordance with recommendations for health problems of low prevalence [125], only a relatively small number of women with AUD were identified. This was expected, since the prevalence of women with AUD in Sweden is low. Low prevalent disorders imply problems for reaching enough power for analysing statistical relations. Still, the prevalence of AUD estimated in this study is regarded as representative for Sweden [58]. Also, although the sample is small, the findings of Paper I are in accordance with those of other studies, which strengthens the view that the findings are valid.

Using both qualitative and quantitative methods gives a broad picture and the opportunity to explore a phenomenon from different angles, such as the cultural/societal, relational, and individual perspectives, which contributed to the development of a treatment-seeking model (Figure 3).

Limitations of the study

In Paper I and Paper II we could distinguish between women who had obtained treatment for AUD and those who had not, but we could not study the path that the treated women had taken to treatment.

In Paper II we used a pooled sample including data from both the general population and clinical samples; this was done in order to obtain sufficient sample size for statistical power. Although the samples differed in some respects, a comparison of the samples showed that there was sufficient similarity for the purpose of the analyses.

The qualitative study included interviews with twelve individuals, five women and seven men. The interviews took a year and a half to complete, because of the difficulties of recruiting individuals who had never previously sought treatment for alcohol problems in combination with the ambition to include people with as varying background as possible. As data collection and data analysis went on in parallel, it was possible to tell when sufficient quality of data had been achieved.

The findings of the qualitative studies are supported by earlier studies, enhancing the transferability of the created models [126].

Implications for research

Gender perspective in medicine implies raising new questions of significance in different contexts [127], which can be applied on questions regarding alcohol problems and treatment-seeking. New studies need to address gendered conceptions related to treatment-seeking on the organisational level and among professionals. Professional attitudes sometimes impact access to service [32, 33], a phenomenon which merits further study.

Another interesting question is also the future development of the role of alcohol in society from a gender perspective, and what implications this will have for treatment-seeking.

When studying treatment-seeking for alcohol problems, the need for treatment is a prominent factor to consider, as well as access to treatment [128]. The present study does not address the question of availability of treatment facilities related to the need for treatment; this is another option for future research. Related to that is the question why some women never seek treatment, which would be interesting to investigate further.

Assessing the meaning of alcohol in a person's life can increase understanding of hindrances to treatment entry, thus studying why women drink and how the effect of alcohol is experienced could give useful knowledge for prevention strategies.

Implications for practice

From this study some suggestions could be made in order to promote treatment-seeking. For example, by paying attention to the alcohol problems, and showing caring and demanding support, both the social network and health professionals can facilitate the treatment-seeking process. Also supporting reconciliation and encouraging a future orientation can make the thought of treatment easier. To some of the women merely talking about the problems was experienced as a relief, and the meeting with an understanding health care worker was unexpected but also affirmative. It might be useful to inform the public at large about alcohol treatment; the methods, goals and highly trained experts. Particularly important is to reduce the stigma associated with treatment for alcohol problems.

CONCLUSIONS

The findings indicated that severity of alcohol problems is an important reason for seeking treatment in women. Earlier identification of alcohol problems in women, for example by paying increased attention to women at risk, could

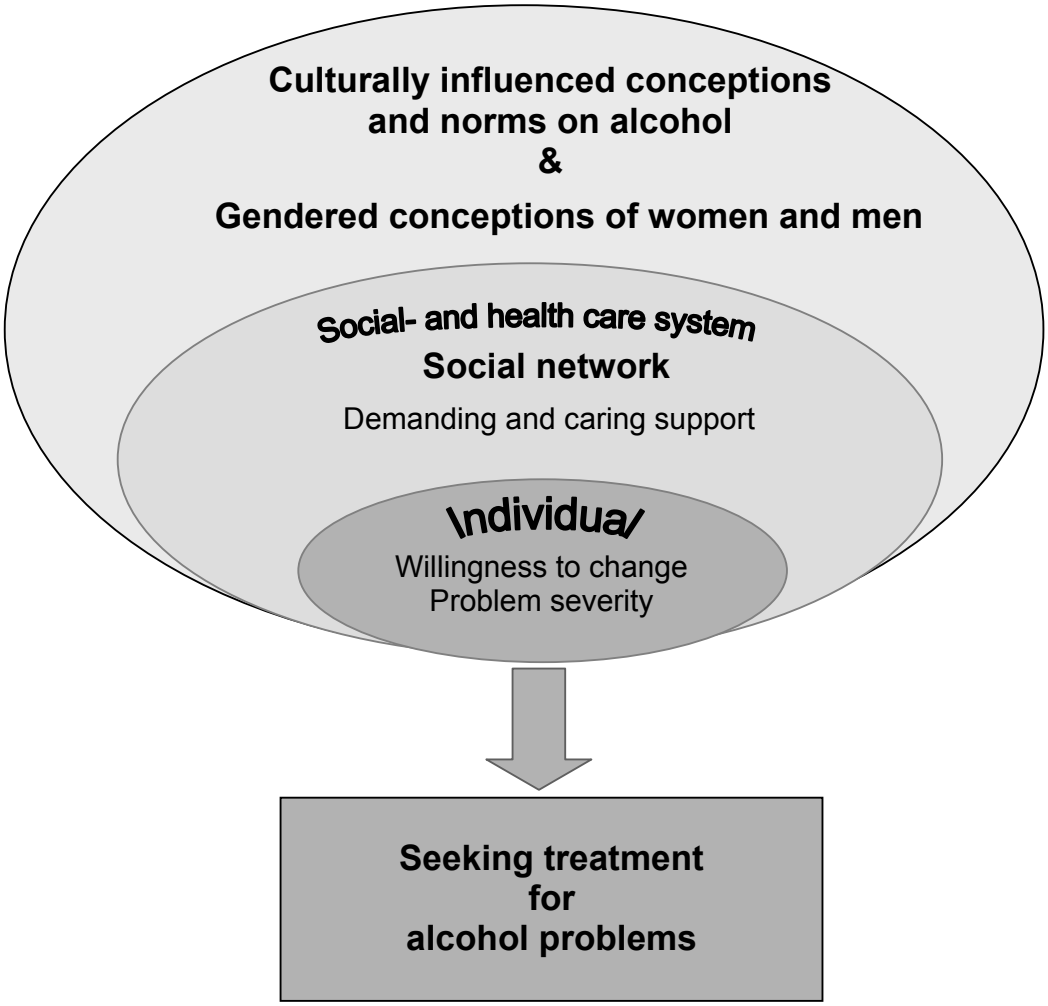
reduce both personal suffering and societal costs. The meanings of alcohol in people's lives had great influence on the willingness to change and need to be addressed when investigating or supporting treatment-seeking in people with alcohol problems.

Shame was found to delay or hinder treatment-seeking in both women and men. It can be assumed that if the stigma associated with alcohol problems and treatment was reduced, treatment entry might be considered before the problems have become severe.

The treatment-seeking processes were also influenced by external factors such as demanding and caring support from the social network and/or professionals in the social services or the healthcare system. Paying attention to the alcohol problems as soon as signs of the problems become perceptible and support help- or treatment-seeking can facilitate treatment entry in an early stage of the AUD.

Also culturally influenced conceptions and norms on alcohol influenced the decision to seek treatment. For both women and men, positive attributions to alcohol constituted strong hindering factors for treatment-seeking. Research of the attributed importance of alcohol in people's lives as well as the influence of alcohol in society in general, could be useful to increase the understanding of the conflicting feelings and thoughts concerning treatment-seeking. Both women and men also expressed gendered conceptions of alcohol problems and treatment-seeking which delayed or hindered their decision to seek treatment.The findings indicate that alcohol still is a gender symbol that need to be considered both in treatment practice and research. The health care system represents an important structural influence in the construction of gender and health, and this offers the possibility for health care staff to "do gender" differently, and to avoid reproducing social structures and gender stereotypes.

Figure 3. The multi level treatment-seeking model, describing a combination of internal and external factors influencing treatment-seeking for alcohol problems.



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