INTRODUCTION

Repeated investigations in different countries have found that only a minority of alcohol dependent individuals, around 20% in many studies, seek treatment (Grant, 1997; Cunningham et al, 2006; Blomqvist et al., 2007; Cohen et al., 2007).

One reason for avoiding treatment may be the recognition that treatment facilities primarily treat severely addicted people. Individuals in treatment are older and have more severe drinking problems, longer histories of drinking problems and more comorbid disorders compared with dependent non-treatment seekers in the general population (Fillmore and Midanik, 1984; Room, 1989; Schmidt and Weisner, 1993; Berglund et al., 2006). This observation has given rise to the notion of two worlds of alcohol problems (Storbjörck and Room, 2008). Drinking problems are usually resolved without formal treatment (Blomqvist et al., 2007; Grela et al., 2009). However, in a minority of cases problems become sufficiently severe for the barriers to treatment to be overcome. Severe problems among those in treatment probably reinforce the perception that alcohol dependence is a very severe disorder, and probably reinforces the reluctance to seek treatment in the majority with less severe problems.

Treatment increases the rates of recovery from alcohol dependence (Dawson et al., 2006; Cohen et al., 2007). From a public health perspective it is therefore important to understand why the majority with less severe problems do not seek treatment (Blomqvist et al., 2007; Cohen et al., 2007). This requires a better understanding of prevalent perceptions of alcohol consumption, dependence and treatment.

Important in this context is the stigma attached to substance use disorders (Livingston et al., 2012). Compared with other mental illnesses, people suffering from alcohol dependence are particularly stigmatized (Schoerus et al., 2011). Stigma reduces the likelihood of seeking treatment, because people fear being labelled as alcoholics and thereby losing status and facing discrimination (Room, 2005). Another barrier may be concerns about treatment content, e.g. abstinence as the only outcome goal, which many find neither feasible nor desirable (Copeland, 1997). Furthermore, individual attitudes against seeking treatment, i.e. thoughts about the problem getting better by itself, or doubts of the efficacy of treatment, are often found in surveys, and carry more weight compared with structural barriers related to treatment (Saunders et al., 2006; Sareen et al., 2007; Oleski et al., 2010).

Public perceptions of treatment for alcohol dependence

In a survey from Alabama, respondents preferred help that involved personal contact compared with computerized help or self-help, but were indifferent to whether help was dispensed by professional or lay providers (Tucker et al., 2009). Most respondents choose informal help for milder problems and formal treatment for serious problems. Respondents with family members who had used existing services were more dissatisfied with these than others. The authors conclude that consumer dissatisfaction with existing service, more than lack of availability, impedes utilization.

In Sweden in particular, where the primary responsibility for addiction treatment lies within the social services, mainly individuals with social problems are reached by treatment. Treatment for alcohol problems thereby has been associated with assistance for other social problems such as poverty and homelessness. Even if addiction treatment lies within mental health or other parts of the health system, as is the case in most countries, the focus has largely been on individuals with severe social problems and/or psychiatric comorbidity.

© The Author 2013. Medical Council on Alcohol and Oxford University Press. All rights reserved
The aim of this study is to investigate what type of treatment for alcohol problems, and delivered in what setting, that are preferred in the general population and also the reasons for not seeking treatment for alcohol problems. Furthermore, the impact of the level of alcohol consumption, education, employment status and income on these preferences will be studied.

MATERIAL AND METHODS

Participants
Data for this study come from a random, cross-sectional, interview survey of the Swedish general population, aged 16–80 years, (Ramstedt, 2010). Each month 1500 new, randomly selected Swedish-speaking respondents were interviewed, from April to September, in 2010. Response rates fluctuated slightly over the months, but were on average 62%. In total, 9005 persons (55.2% women and 44.8% men) aged 16–80 (mean age 51) were included in the analyses.

Measures
Alcohol consumption
Eighteen questions on volume and frequency of consumption (during the last 30 days) of six types of beverages: low strength beer (2.8–3.5% alcohol by volume); regular beer (4.5–5.5%); wine; fortified wine; spirits; cider and alcopops. The volume-frequency measure was transformed into estimated standard drinks (one drink containing 12 g of alcohol).

Standard drinks
Consumption was divided in three groups: 0–14 standard drinks per week for men or 0–9 for women; 15–28 standard drinks per week for men or 10–18 for women and >28 standard drinks per week for men or >18 for women.

Treatment questions
Throughout the survey, the respondents were asked treatment questions with regard to someone they know, a friend or relative, as opposed to preferences were they themselves to develop alcohol problems. The reason why this indirect form of questioning was chosen was that initial attempts to pose direct questions resulted in very few responses. Only 8 persons out of 1500 acknowledged that they during the last 12 months had experienced any form of problem with their drinking. An additional 23 persons indicated that they had had a problem earlier. Out of these 31 persons only a small minority responded to the questions regarding what type of treatment they would prefer, and reasons for not seeking treatment. Given this pattern of response, the decision was made after 1 month to switch to indirect questions, where respondents were asked what they would recommend to someone they knew, a friend or relative, who had developed a drinking problem.

Preferred treatment
Respondents could choose the following alternatives (one to five); help via the Internet; support group [e.g. alcoholics anonymous (AA)]; psychotherapy; pharmacotherapy and residential treatment.

Preferred source of treatment
Four alternatives; social services; psychiatry or addiction specialist treatment; primary health care and occupational health services.

Reasons for not seeking treatment
Respondents were given four alternatives; do not believe there is any effective treatment; concerns about confidentiality; would be ashamed to seek help for alcohol problems and do not know where to seek help.

Social background factors
Education
Respondents were categorized according to their highest education; elementary school, high school or university.

Employment
Respondents were asked about their present occupation or employment and categorized as either working/being employed (including students and conscripts) or not working/being employed (including people with retirement, early retirement or disability/sickness pension).

Income
Respondents were categorized, according to the median split, into two groups; people earning 0–19,000 SEK per month or 20,000 SEK or more per month.

Statistical analyses
Proportions of respondents, preferring a certain treatment; a certain source of treatment and giving reasons for why people do not seek treatment for alcohol dependence were calculated in relation to the number of standard drinks, employment, education and income. All analyses were done for men and women separately, and, in most cases, separately for the different age groups (16–29; 30–49; 50–64 and 65–80). Chi square analyses were used to examine possible gender and/or group differences. Bonferroni correction was used to test for spurious significances. All analyses were performed with SPSS version 20.

RESULTS

A majority of the men and women in the two lower consumption categories would recommend a support group for a friend or relative with alcohol problems, whereas men and women in the highest consumption group would instead recommend therapy (Table 1). Similar results were found in all age groups (age 16–29, 30–49, 50–64 and 65–80).

More than 50% of the men and 60% of the women would, irrespective of alcohol consumption, recommend psychiatric or addiction specialist treatment (Table 2). Around 10–11% would recommend primary health care and around 25% of men and 20% of women would recommend the occupational health services. About 5% would recommend the social services. Respondents with higher levels of alcohol consumption tended to recommend all treatment alternatives to a higher degree than respondents with low or moderate consumption. These results were similar for all age groups.
Respondents rated ‘feeling ashamed’ as the most important reason why people would not seek help for alcohol problems. Other reasons, ‘No effective treatment’, ‘Concerned about confidentiality’ and ‘Do not know where to find help’ were rated considerably lower. With increasing consumption levels among respondents all the alternatives for not seeking treatment were reported more frequently, with the exception of ‘Feeling ashamed’, where a higher proportion, 68%, among high consuming women and a lower proportion, 55%, among high consuming men were found.

Not shown here are outcomes in relation to patterns of consumption. These however were very similar to the results related to the volume of consumption. Frequency of heavy episodic drinking had the same low impact on the results as volume of drinking in Tables 1–3.

No significant differences were found regarding social background factors and what treatment one would recommend, except for psychotherapy, which both employed men and women, and men and women with high school and/or university education would recommend to a greater extent than unemployed men and women with elementary school education (not shown).

Table 4 shows the social background factors in relation to what source of treatment one would recommend; employed men and women with higher education and higher income were more likely to choose psychiatric or addiction specialist care than the other groups and less likely to choose primary health care. Men with high income and high education recommended the social services significantly less often than men with low income and low education; for women there were no significant differences in this regard (Table 4).

**DISCUSSION**

**Health care vs. social services**

The most important result in this study is that a large majority of the respondents would recommend treatment for alcohol problems within the health care system, primarily within psychiatry and specialized addiction services, but also within occupational health services and primary health care. Considerably fewer would recommend treatment in the social services. This suggests that a majority of respondents have greater confidence in the health care system in providing assistance for problem drinkers.

The present study does not provide the reasons for this preference. Clearly, there could be a number of reasons: viewing addictive disorders as health problems rather than social problems could be one. Another could be a general reluctance to seek assistance from the social services, tied to a reluctance to identify with the severe problem groups that presently make up the majority of the assistance seeking population in the social services.

Within the health services the majority would recommend psychiatry or addiction specialists, rather than the occupational health services or primary health care. This probably is
Reasons for not seeking treatment

When asked about reasons for not seeking treatment for alcohol problems the dominant response is that people would be ashamed to do so. Other reasons, such as concerns with confidentiality, not believing treatment to be effective or not knowing where to find help, are all much less acknowledged. Feeling ashamed illustrates the stigma attached to the addiction field. In the general population (and largely in the treatment community as well) alcohol problems are associated with social marginalization and treatment for alcohol problems is perceived to cater to people with severe problems. This likely is a major reason why so few alcohol dependent persons seek treatment, being reluctant to be associated with the severely afflicted group of people they expect to find there. This could also be a reason why so many would rather recommend a friend or relative treatment within the health care system, which has less stigma attached than the social services.

Another reason for not seeking treatment might be reluctance to accept abstinence as the only treatment goal. Controlled drinking as a goal has been found to be feasible for people with mild to moderate alcohol dependence (Witkiewitz, 2013). An example of an association between initial goal preference and successful treatment outcome has been reported by Adamson et al. (2010), emphasizing the importance of letting patients choose their treatment goal. Despite reports like these, treatment services often do not offer controlled drinking programmes. A recent Swiss study describes how abstinence-only programmes also can limit the content during treatment, with less focus from therapists on patient’s coping strategies during the actual drinking episodes (Klingemann et al., 2013). This study did not investigate the possible impact of abstinence as the only treatment goal on treatment seeking. However very few responders gave other answers than the suggested ones, and these answers were not analysed separately.

Social background factors

When the influence of three social background factors, employment, education and income, is examined, important patterns emerge. Respondents with favourable social background in all these three respects preferred specialist treatment in psychiatry or addiction services significantly more often than people with less favourable background. Fifty-four per cent of the employed men would recommend psychiatry or addiction specialists vs. 42.4% among unemployed men. Corresponding figures for women were 65.4% vs. 52.5%. Men with higher education would recommend this treatment alternative in 54.4%, vs. men with lower education, where 41.1% would do so; for women these figures were 65.7% vs. 49.5%. The same pattern was found for high vs. low income. Overall, the same patterns were found for occupational health care; this also was a more popular option among respondents with employment, high education and high income. For social services and primary health care the reverse pattern was seen however.

Table 3. Reasons for not seeking treatment. Percentages of respondents, suggesting different reasons why people with alcohol problems might not seek treatment, in relation to the respondents own alcohol consumption

<table>
<thead>
<tr>
<th>Reason for not seeking treatment</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0–14 (n = 2707)</td>
<td>15–28 (n = 393)</td>
</tr>
<tr>
<td>Do not believe treatment is effective</td>
<td>7.7</td>
<td>9.9</td>
</tr>
<tr>
<td>Worry about confidentiality</td>
<td>8.6</td>
<td>8.7</td>
</tr>
<tr>
<td>Would be ashamed</td>
<td>60.4</td>
<td>64.4</td>
</tr>
<tr>
<td>Do not know where to find help</td>
<td>7.6</td>
<td>8.1</td>
</tr>
</tbody>
</table>

*Respondents could choose several alternatives, and thus the sum exceeds 100%.
*Significant (P = 0.05) difference between 0–9 and 18+ standard drinks.

Reasons for not seeking treatment

Explained by a perception of alcohol problems as being difficult to manage, requiring specialist services. With more information about the actual prevalence of alcohol problems at different levels, where the majority have dependence with moderate severity (Andrénasson et al., 2012), it is possible that more people would prefer the general medical services, given that these would be less stigmatized than specialist services.

Treatment modality

This study indicates that level of alcohol consumption generally made little difference to treatment preferences. Arguably the group with the highest consumption level contained a larger proportion of people with alcohol problems of their own, even if there was no specific information on alcohol problems. Such personal experiences could be expected to influence these preferences. High consumers recommended all treatment alternatives to a higher degree than responders with low or moderate consumption, with no change in the ranking of the different alternatives however.

Respondents largely indicated a preference for traditional forms of treatment within the addiction field. Treatment alternatives preferred among both men and women were, in rank order, support groups, psychotherapy and residential treatment. Among high consumers however psychotherapy was slightly more popular than support groups. Fewer preferred pharmacotherapy and very few Internet-based treatment.

Possible explanations for both these results could be lower familiarity with these alternatives. Very few in the general population are aware of the existence of new medications for alcohol dependence such as naltrexone and acamprosate. Disulfiram (antabuse), being an old drug in this field, is more known, but also largely associated with severe alcoholism, which probably reduces its attractiveness to a broader audience. Internet-based treatment is still in its infancy, with little popular recognition yet. Again, with higher levels of alcohol consumption among the respondents, all the treatment options are recommended to a higher degree.

Table 3. Reasons for not seeking treatment. Percentages of respondents, suggesting different reasons why people with alcohol problems might not seek treatment, in relation to the respondents own alcohol consumption
These alternatives were more popular with respondents who had low incomes and little education. Regarding the social services, employed men and women reported a slightly higher preference for this alternative than the unemployed. While acknowledging these differences it should be emphasized that regardless of social background factors, the overall ranking of the four treatment alternatives remained the same.

**Strengths and limitations**

An important limitation of this study is its indirect questioning, where respondents are asked to state preferences with regard to someone they know, as opposed to preferences were they themselves to develop alcohol problems. While this may elicit information about public perceptions in this area, it does not necessarily reflect choices made by people who actually have alcohol problems. It is one thing to make a rational choice from a distance, another to face the stigma involved with that choice. This probably applies to the large proportion recommending psychiatric or specialized addiction treatment. While these alternatives carry less stigma than the social services option in Sweden, they still constitute a highly stigmatized treatment sector, compared with the occupational health services or primary health care.

Non-response to the survey was 38%. This is high, but of the same magnitude or better compared with other alcohol surveys. Non-response is a threat to the analyses to the extent that non-responders are different from responders. Earlier non-response analyses, of this data material, have found little support for this (Ramstedt, 2010). Variations in non-response rates from 40 to 55% have not had an impact on estimates of drinking. This does not preclude that changes among the hard-core non-responders, i.e. those 5–10% of the samples that cannot be reached by whatever methods, could have an impact.

An important feature of this study is that it is based on a representative population sample as opposed to a clinical sample. As observed in previous research, alcohol dependent people in treatment form a minority of all people with alcohol dependence and differ in important ways from non-treatment seekers (Storbjörk and Room, 2008; Grella et al., 2009). Reaching out with a survey to the general population provides a better understanding of perceptions of alcohol problems and treatment in the larger non-clinical group.

**CONCLUSIONS**

In this study of treatment preferences, based on a general population survey, large majorities of the respondents preferred treatment in the health care services and few, 5%, preferred treatment in the social services. Few respondents would recommend new forms of treatment such as Internet-based treatment or pharmacological treatment, the majority preferring more traditional forms of treatment such as self-help groups, psychotherapy and residential treatment. Alcohol treatment remains a stigmatized field, evidenced by shame being the most commonly reported reason for not seeking treatment. Possibly, shifting the responsibility for treatment of alcohol problems in Sweden from the social services to the health care services, in line with the majority preferences in this study, could reduce some of this stigma.

Table 4. Percentages of respondents, who would recommend a certain source of treatment for someone with alcohol problems, in relation to the respondent’s employment status, education and income per month

<table>
<thead>
<tr>
<th>Source of treatment</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social services or medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary school</td>
<td>5.4</td>
<td>6.9</td>
</tr>
<tr>
<td>High school/Univ</td>
<td>5.6</td>
<td>6.9</td>
</tr>
<tr>
<td>0–19,000 SEK/month</td>
<td>4.6</td>
<td>4.5</td>
</tr>
<tr>
<td>≥20,000 SEK/month</td>
<td>4.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Psychiatry or other addiction</td>
<td>4.2</td>
<td>5.1</td>
</tr>
<tr>
<td>0–19,000 SEK/month</td>
<td>4.2</td>
<td>5.1</td>
</tr>
<tr>
<td>≥20,000 SEK/month</td>
<td>4.2</td>
<td>5.1</td>
</tr>
<tr>
<td>Primary health care</td>
<td>14.0</td>
<td>15.4</td>
</tr>
<tr>
<td>Occupational health care</td>
<td>14.0</td>
<td>15.4</td>
</tr>
<tr>
<td>0–19,000 SEK/month</td>
<td>10.4</td>
<td>10.4</td>
</tr>
<tr>
<td>≥20,000 SEK/month</td>
<td>10.4</td>
<td>10.4</td>
</tr>
<tr>
<td>*Significant difference (P ≤ 0.05) between groups (employment, education, income).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

698 Andréasson et al.
REFERENCES

