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“I don’t feel like I have a problem because I can still go to work and function”: Problem recognition among persons with substance use disorders

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Abstract

Background.—Persons with substance use disorders (SUD) who do not recognize their substance use as problematic are less likely to perceive needing treatment and less motivated to seek help. Factors that contribute to problem recognition among persons with SUDs are poorly understood.

Objective.—To explore in-depth factors that may explain why those who meet diagnostic criteria for SUD do not perceive to have a substance abuse problem.

Methods.—We recruited 54 participants with recent (i.e., past-5-year) SUD for qualitative interviews. Interviews were coded to identify prominent themes that were linked to problem recognition.

Results.—We identified two prominent themes that contributed to problem recognition: modifying substance use behaviors to avoid adverse consequences and internalized stigma. Participants who reported adjusting their alcohol and drug use in ways that would not interfere with important life responsibilities, especially work-responsibilities; described those with alcohol and drug problems negatively; and associated treatment with personal defeat less likely to perceive having a substance use problem.

Conclusions/Importance.—These findings can be used to inform intervention strategies aimed at increasing problem recognition among substance using populations. Such strategies may

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facilitate motivation (i.e., desire for help and treatment readiness) to use and complete treatment, thereby reducing the unmet treatment gaps among persons with SUD.

Keywords

problem recognition; substance use disorder; treatment barriers; stigma; high-functioning

Introduction.

The landmark Affordable Care Act (ACA) has increased access to substance use treatment services in the US through provisions that expanded health insurance coverage among the uninsured and strengthened parity between behavioral health and general medical insurance benefits (1). However, these improvements have not significantly increased utilization of substance use treatment services among persons with substance use disorders (SUD; (1), suggesting that expanding access without addressing other barriers like negative beliefs and attitudes is insufficient to improving treatment behaviors. A significant barrier to alcohol and drug treatment for persons with SUD is coming to the realization that a problem exists. The majority of persons with SUD do not perceive their substance use as problematic, despite meeting diagnostic criteria for a substance abuse problem (2,3). Only about 6% of persons with SUD report needing treatment for their alcohol or drug problem (4). Problem recognition is an important predictor of treatment utilization, treatment completion, and sustained recovery post-treatment (5–8). Not surprising, those with low problem recognition are less likely to believe they need treatment or be motivated to seek professional help (9,10). However, why those meeting diagnostic criteria for SUD do not perceive to have a problem, while others do, is poorly understood.

The limited research on SUD problem recognition suggests that problem severity, greater number of dependence symptoms, higher levels of depression, and experiencing adverse social consequences (e.g., employment and legal problems) and severed relationships with family members, increases the likelihood that a person would recognize having a substance use problem (9,11–13). Conversely, positive perceived value of treatment and employment status, including having a trade and/or job skills have been found to be negatively associated with problem recognition (9), suggesting that persons with SUD who believe treatment is valuable or who have employment are less likely to perceive their substance use as problematic. This small body of research suggests that those experiencing severe consequences stemming from their alcohol and drug use may be more likely to recognize having a problem than those with greater functionality.

An important factor to consider within the context of problem recognition is the stigma associated with having a substance abuse problem. (14) broadly conceptualize stigma as consisting of four interrelated components: labeling, stereotypes, separation, and discrimination. Within the context of SUDs, their stigma framework suggests that differences between persons with and without substance use problems are distinguished and labeled. Negative stereotypes are then applied to labeled persons, thereby creating separation between labeled groups, which then lead labeled persons to experience negative social consequences like prejudice and discrimination. Substance abuse problems are highly

stigmatized and often regarded as a personal choice where the blame is placed on the individual (15). Studies have documented that persons struggling with addiction are well aware of negative perceptions associated with alcohol and drug abuse (16). Further, persons with SUD may also hide their substance abuse problems from others, such as only drinking or using drugs alone (16) to avoid being labeled as having a substance abuse problem and avoid being stigmatized. Relatedly, drawing on research on mental health, stigmatizing attitudes towards mental health prevents whether someone recognizes a mental illness (17,18). Thus, stigmatizing attitudes towards substance abuse may increase sentiments of denial among persons with SUD and contribute to low problem recognition.

Given the overall lack of research on factors that may influence problem recognition among persons with SUD, we undertook the present qualitative study to better understand why those who meet diagnostic criteria for SUD do not perceive to have a problem. To guide our study we draw on research on problem recognition within the field of mental health and health services, which provide a useful framework to examine problem recognition. Models of health and mental health services utilization often emphasize the importance of problem recognition in the treatment seeking process and conceptualize this construct as consisting of objective and subjective measures of need (19,20). Objective need reflects the presence of specific symptoms and is typically measured via clinical assessments or standardized symptom instruments. Subjective or perceived need is also closely related to perceptions surrounding the illness experience and whether the individual identifies with the sick/patient role. As such, the way in which an individual perceives their substance use, for example, may not always be aligned with the symptomology of their illness or disorder. For the current study, we conceptualized problem recognition as a subjective need for treatment because problem recognition is strongly linked to positive treatment behaviors. All participants in our study met DSM-5 diagnostic criteria for SUD in the past 5-years and therefore met an objective need for treatment. We use qualitative data from in-depth interviews with these participants to critically explore factors that may influence problem recognition.

Methods.

Study Design & Participants

Between 2017–2018, we recruited 54 participants with SUD to participate in qualitative study aimed at examining barriers to treatment (21). Participants were recruited via nationwide online ads for qualitative interviews. Ads included basic information about the purpose of the study, procedures, incentives, and a link to the study website where potential participants could complete the study's screening survey to determine eligibility. Eligible participants were: (1) 18 years old; (2) of White, Black, or Latino racial/ethnic descent; (3) and met diagnostic criteria for a recent (i.e., past-5-year) SUD. The screener questionnaire collected data on socio-demographic characteristics, past-5-year alcohol and drug use histories, and lifetime and past-5-year substance abuse treatment utilization. Twenty-two questions that assessed DSM-5 diagnostic criteria for an alcohol drug use disorder (AUD) and drug use disorder (DUD) were used to characterized participants as having an SUD. Those who met eligibility criteria for AUD, DUD, or both were characterized as having

SUD. Only those who were classified as having a recent SUD were prompted to provide contact information (i.e. first name, e-mail address, and/or telephone number), provided that they consented to be re-contacted if eligible and chosen to participate in the qualitative study. Participants were purposively sampled based on race/ethnicity, gender, past treatment history, primary disorder type, and substance use severity. Selected participants were contacted via e-mail to schedule a phone interview. Replacements were drawn after three failed attempts to contact and conduct the interview with a selected participant. Participant recruitment ended once data saturation was reached.

Interviews were conducted over the phone by a trained qualitative interviewer, were audio-recorded, and lasted approximately 40 minutes. Verbal informed consent was obtained before beginning the interview. The qualitative interviewer used a semi-structured interview guide. Open-ended questions focused on participants' alcohol and drug use behaviors, past treatment use experiences, and barriers/reasons for not using treatment. After completion of the phone interview, recordings were transcribed verbatim. Participants received a \$40 Amazon Gift Card for their participation. The Institutional Review Boards of the Public Health Institute and the University of Texas at Austin approved all study protocols prior to the start of the study.

Data Analyses

All interview transcriptions were uploaded into the qualitative data software NVivo (QSR International Pty Ltd. Version 11). An initial coding scheme was created based on the major themes in participants' narratives. We followed a general inductive, iterative approach where investigators focused on generating themes and identifying relationships among those themes (22). Emergent themes were discussed and a codebook was developed. The process was repeated until key themes were established and the codebook was finalized. To ensure that coders shared the same understanding of the coding scheme, two coders applied the coding scheme to the same 11 interviews independently. Coders met regularly with the first author to compare coded transcripts and discuss discrepancies. For the present analysis, we conducted a thematic analysis (23) of coded text segments to identify themes that may explain problem recognition. In particular, we focused on participants' responses to the open-ended questions: (1) Have you ever considered cutting down on your alcohol or drug use?; (2) How would you define an alcohol or drug problem?—This question was specifically asked to participants who stated that they did not have a problem or needed treatment.

Results.

Participant Characteristics

Table 1 summarizes participant characteristics. Participants were on average 39 years old, predominately female, and had at least a high school education (96%). In terms of substance abuse, the majority of participants reported co-occurring AUD-DUD (70%; n=38); only 5% (n=3) reported having DUD only, and 24% (n=13) reporting AUD only. Problem severity was high. On average participants reported 9 (out of 11) and 8 (out of 11) AUD and DUD symptoms, respectively. Less than two-thirds (n=33, 61%) of the sample reported using any

form of treatment in the past 5 years. The most common forms of treatment were mutual help groups, followed by hospital or clinic, and medical group or physician.

Qualitative Findings

Important themes emerged from participants' narratives that may help explain low problem recognition. Participants who described (1) modifying their substance use behavior to avoid adverse consequences and (1) internalized stigma stemming from substance abuse, were more likely to perceive not having a problem. Following, we discuss these findings in greater detail while providing representative text segments from participants' narratives.

Modifying substance use behaviors to avoid adverse consequences—Many participants explained not having a substance abuse problem because they were 'functional.' Participants frequently defined "being functional" as being able to meet important social and life responsibilities, such as attending to family and work obligations. This phrase was regularly used to justify not having a problem substance abuse problem. Notably, participants often described modifying their substance using behaviors in a way that would interfere with important responsibilities. Work-related responsibilities were particularly significant for many. For example, some participants described limiting their substance use to days when they did not work the following day, to assure that they would be able to attend to work-related duties. As one participant described:

Yeah, like my previous job earlier this year, I was still in the mentality of okay I'm getting money, okay I have a certain amount of free time... I'm gonna do these drugs. But then I would slack off at work or I wouldn't show up at work. Now, it's like when you lose two jobs back to back but you still got rent to pay and this is your first time moving out. You get a reality check though. I don't do drugs during the week. Like that's just it. I have to go to work. If my excuse for going to work... if I don't go to work, the drugs are not gonna be my excuse. I'm not gonna be homeless because you know I couldn't get up in the morning.

Similarly, another explained avoiding the use of cocaine on workdays and situations that would increase temptation to use. This participant explained:

If I have to do something the next day, [...] for example now that I have a job I almost always steer far away from temptations because if someone offers it [cocaine] to me, I can't say no. So, I purposively do not surround myself with people that I know will offer me [cocaine] or people that have [cocaine] or will say "let's go buy it [cocaine]" or something like that. There were a few days that I've said yes, and then I can't make it to work the next day. So that's what I try to avoid Monday through Friday, social gatherings where there are going to be people that are going to tempt me. But on the weekends, almost all weekends, I use cocaine.

Other participants described reducing their alcohol or drug use on working days, and engaging in heavier use on non-working days. This was commonly described as strategy to avoid adverse work-related consequences, while still using alcohol and drugs. For instance, in the following passage one participant justified not having a problem:

I don't feel like I have that much of a problem because I can still go to work and I still do things and function [...] I have a full-time job and stuff, so I try to limit like the amount I drink during the week. I have days that I drink too much and the next day I feel bad, but I still have to go to work. Monday through Thursday I generally don't drink maybe more than like five drinks a night and then on the weekend I probably do double that.

Thus, by adjusting their substance use behaviors to avoid experiencing any adverse consequences lead many to perceive their substance use as not being problematic.

Internalized stigma related to having a substance abuse problem—Internalized stigma (i.e., self-stigma) was also pervasive among participants' narratives and closely linked to problem recognition. Many participants used negative stereotypes to describe people with alcohol or drug problems, such as being “losers,” “homeless,” “terrible people,” “drug addicts,” and “people who have lost their jobs or families.” Many differentiated themselves from “those” people (i.e., people with alcohol and drug problems) and emphasized that these stereotypes were not applicable to them, thereby creating separation (sense of “us” vs. “them”) between labeled and unlabeled persons. For instance, one participant described treatment as:

“I just feel like it's... I don't know, I feel like that's the ultimate low, if I were to have to go there [to treatment]. I feel like that's for people who are homeless or don't have a job or have nothing going for them. So, I feel like if I were to go there, I would be categorizing myself as somebody... an awful person.”

For many, using treatment was akin to acknowledging having a problem. This in turn would mean also being ‘labeled’ as someone with a substance abuse problem, which many participants internalized negatively (e.g., “I would be categorizing myself as an awful person). Therefore, many emphasized that they were not like ‘them’ (i.e., people with SUD). Similarly, another participant described someone in treatment as:

“Somebody who makes big mistakes, like ruins things in their lives or relationships or [is] just constantly getting into some kind of trouble. That's not me. I'm not that person. And I mean, I guess there are different types, but I mean that's just how I associate it. When you see somebody who needs treatment and is like bad [...] they're like kind of crumbling or they're doing illegal things to get whatever they need [alcohol or drugs] and I mean I don't have, thankfully that's not me.”

For many, recognizing having a problem and needing help was also perceived as a personal defeat or failure—the ultimate low. Many perceived getting help as confirmation to themselves that they had a problem with alcohol or drugs. This hindered participant's ability to recognize having a problem to avoid having to deal with negative self-perceptions. As one participant explained:

“I have a lot of uncles that have died, have passed away at unusually young ages, like from their late 30s to their early 50s [due to substance abuse]. [...] So number one, I didn't want to end up like that, and I just associate treatment, which is a good

thing, I for some reason associated that with failure.... me needing help was like me saying: 'They're right, I am a loser.'"

Another participant expressed trepidation in acknowledging needing help:

"I feel like you are already going through emotions in regards to addressing the issue that you are having right now. You acknowledge [that you have a problem], which is the first step, that you have an issue, so how do we go about fixing the issue? But it is very scary to take that next step. I think that's one of the scariest things cause how do you move from point A to B without... like it's almost you don't want to lose your self-confidence or acknowledge like...it's almost like you would acknowledge that you let yourself down"

Avoiding negative self-perceptions associated with having a substance abuse problem contributed to participant's denial of not having a problem.

Discussion.

Results from our study expand on prior research investigating factors associated with problem recognition among persons with SUD. The in-depth qualitative interview approach to investigate reasons why those with SUD may not perceive having a problem is unique. We found that being able to engage in substance use without experiencing adverse consequences (despite heavy use) and internalized stigma were closely linked to problem recognition. Our findings can be used to inform strategies to increase problem recognition and utilization of treatment services among those struggling with substance abuse problems.

Participants in our sample who reported being able to meet important obligations, particularly work-related needs, were less likely to perceive having a substance abuse problem. This finding is aligned with past studies that have found that high-functioning individuals may be less likely to recognize having a problem (24,25). For example, one study among substance users who were not engaged in treatment found that having trade/job skills was negatively associated with problem recognition (9). Work may be an important marker of being a productive member of society, and as such, "being functional" does not conceptually align with having a substance use problem. However, building on these prior studies, our findings suggest that people with SUD may also be consciously adjusting their substance use behaviors as a strategy to circumvent negative consequences and therefore not perceive their alcohol and drug use as problematic, which is a novel finding that has not been previously documented (25–28). This is concerning because it suggests that a segment of people with SUD may delay treatment until it is too late or avoid it all together.

Innovative strategies to reach those not engaged in treatment are necessary. For example, Screening, Brief Interventions, and Referral to Treatment (SBIRT) services have been shown to be an effective approach to increase awareness of problematic alcohol and drug use, reduce substance use, and connect people to treatment services (29,30). Expanding these services beyond health care settings may be key in reaching those with SUD who do not perceive to have a problem, and could potentially increase problem recognition among this population.

Internalized stigma also influenced problem recognition. Participants were well aware of the stigma that plagues those struggling with addiction. Therefore, many did not want to be 'labeled' as having a substance abuse problem. Denial of having a problem may also be a strategy to avoid dealing with feelings of internalized stigma, or undesired self- or societal-identification as a substance abuser, for struggling with addiction. Internalized stigma often occurs when individuals are aware of stigmatizing attitudes, agree with those stereotypes, and respond with feelings of shame and blame, social distance, and failure to seek help (15, 16, 30–32). Overall, stigma may contribute to the concealment of substance abuse problems and reduce the likelihood of problem recognition and seeking help. Strategies to reduce stigma surrounding addiction are essential, such as communicating positive stories of people struggling with substance abuse (34). Encouraging those in treatment to be less anonymous and to share their recovery stories may have an important effect on how people with SUD are perceived and help combat stigma (35). In the field of mental health, public anti-stigma educational interventions, especially those that involve contact or interactions with the individual afflicted with a mental illness, have been found to be effective in improving attitudes towards individuals with mental illness (31). Such approaches can be adapted within the context of substance abuse and may be promising to deliver to people with and without SUDs.

The current findings should be interpreted with several considerations. Participants were recruited through online ads and interviewed by telephone. Therefore, findings may not be generalizable to all individuals with SUD and may be biased towards those with increased access to resources. Our study also dealt with sensitive topics; participants may have been more likely to underreport their substance use and negative experiences. However, interviewers were highly trained to ask questions in a non-judgmental manner and had extensive experience working with substance using populations. Despite these limitations, our study expands on the current evidence base regarding factors that may influence problem recognition.

Conclusions

Currently, about 19 million adults in the United States suffer from an alcohol or drug problem (36). However, despite the availability of effective treatments, only about 11% of those with SUD report ever using specialty treatment (37). Low problem recognition is a significant barrier to engage those with addiction problems in treatment (2,8). Increasing problem recognition among those with SUD represents a critical first step to increase motivations to seek treatment and reduce the burden of alcohol and drug problems in the United States. More research on problem recognition is also warranted. Results from our study can inform larger representative studies to confirm and extend our findings and emphasize subjective measures of problem recognition.

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Highlights

- Low problem recognition is a primary barrier to specialty treatment-seeking.
- Two themes that contribute to low problem recognition among this SUD population are being high-functioning and stigma.
- Findings may help inform strategies aimed at increasing motivation to use and complete treatment, especially among those with low problem recognition.

Table 1.

Socio-demographic and substance use characteristics among participants with past 5-year substance use disorders who have never sought specialty treatment, 2017–2018, N=54.

	Total Sample, N=54
	N (%) or Mean (SD)
Socio-demographic characteristics	
Mean age (SD)	39.44 (11.21)
Male gender	26 (48%)
Completed high school or higher	52 (96%)
Currently employed	43 (80%)
Substance use disorders	
Alcohol use disorder (AUD)	13 (24%)
Mean number of AUD symptoms	9.09 (0.43)
Drug use disorder (DUD)	3 (5%)
Mean number of DUD symptoms	8.17(0.63)
Co-occurring AUD and DUD	38 (70%)
Past-5 year treatment history	
Any treatment use	33 (61%)
Number of treatment services used	
1 type of treatment	36 (67%)
2 or more types of treatment	32 (59%)
Types of treatment services used	
Mutual help groups	18 (33%)
Specialty alcohol or drug treatment	9 (17%)
Hospital or clinic	15 (28%)
Social services program	9 (17%)
Medical group or physician	14 (26%)
Other agency/professional	2 (4%)