Factors influencing lack of adherence to mutual help groups in patients with alcohol use disorder in recovery: a study at the Hospital Universitario 12 de Octubre

Factores que influyen en la falta de adherencia a los grupos de ayuda mutua en pacientes con trastorno por uso de alcohol en recuperación: un estudio en el Hospital Universitario 12 de Octubre

Enrique Rubio-Escobar [1, 2], Laura Esteban Rodríguez[1], Ana Sión[1, 3], Victor Armada[1], Daniel Maldonado[1], Francisco Arias[1, 3] y Rosa Jurado-Barba[1, 4]

[1] Instituto de Investigación del Hospital Universitario 12 de Octubre, España
[2] In Recovery, España
[3] Universidad Complutense de Madrid, España
[4] Universidad Camilo José Cela, España
ORCID Enrique Rubio-Escobar: https://orcid.org/0009-0006-4708-4100
ORCID Laura Esteban Rodríguez: https://orcid.org/0000-0002-9092-3057
ORCID Ana Sión: https://orcid.org/0000-0002-1031-5124
ORCID ictor Armada: https://orcid.org/0009-0001-2112-9095
ORCID Daniel Maldonado: https://orcid.org/0000-0003-0046-115X
ORCID Francisco Arias: https://orcid.org/0000-0003-0740-9282
ORCID Rosa Jurado-Barba: https://orcid.org/0000-0002-1117-8387

Received: 09/09/2024 · Accepted: 20/09/2024

Cómo citar este artículo/citation: Rubio-Escobar, E., Esteban, L., Sion, A., Armada, V., Maldonado, D., Arias, F. & Jurado-Barba, R. (2024). Factors influencing lack of adherence to mutual help groups in patients with alcohol use disorder in recovery: a study at the Hospital Universitario 12 de Octubre. *Revista Española de Drogodependencias*, *49*(3), 159-176. https://doi.org/10.54108/10092

– Correspondence:
Enrique Rubio-Escobar
Email: quiquerubioo@gmail.com

Abstract

Background: One of the main challenges in the treatment of alcohol use disorder (AUD) is the lack of therapeutic adherence, being key the perception of the disease. Mutual aid group (MAG) attendance improves adherence and protects against relapse. Objectives: To identify the factors that influence the lack of adherence of patients attended in the program of the Hospital Universitario 12 de Octubre to attend the MAGs, as well as to identify which variables of the disease perception questionnaire are more relevant for not attending the MAGs. Methodology: The sample included 100 patients. The AUD diagnosis was made according to DSM-5 criteria, the reasons for not attending MAGs were collected by means of a semi-structured interview (ad hoc) and the perception of illness was assessed by means of the Revised Illness Perception Questionnaire (IPQ-R). Results: the study revealed that 72.3% of the reasons for non-attendance at MAGs were due to low awareness of treatment requirements. The main variables predicting non-attendance were: a) perception that the disease is not chronic and treatment is of little use, and b) belief that disease control depends on themselves. Conclusions: These findings suggest the importance of working on aspects related to disease awareness from the beginning of treatment in AUD patients, as well as highlighting the relevance of attending MAGs to complement the alcohol treatment program at Hospital 12 de Octubre.

Keywords

Illness perception; alcohol use disorder; therapeutic adherence.

Resumen

Antecedentes: Uno de los principales desafíos en el tratamiento del trastorno por uso de alcohol (TUA) es la falta de adherencia terapéutica, siendo clave la percepción de la enfermedad. La asistencia a grupos de ayuda mutua (GAM) mejora la adherencia y protege contra recaídas. Objetivos: Identificar los factores que influyen en la falta de adherencia de los pacientes atendidos en el programa del Hospital Universitario 12 de octubre para acudir a los GAM, así como, identificar qué variables del cuestionario de percepción de la enfermedad son más relevantes para no acudir a los GAM. Metodología: La muestra incluía 100 pacientes. El diagnostico TUA se realizó según criterios DSM-5, los motivos para no acudir a GAM se recogieron mediante una entrevista semiestructurada elaborada (ad hoc) y la percepción de enfermedad se evaluó mediante el Revised Illness Perception Questionnaire (IPQ-R). Resultados: el estudio reveló que el 72,3% de los motivos de inasistencia a los GAM se debía a una baja conciencia sobre los requerimientos del tratamiento. Las principales variables que predecían la inasistencia fueron: a) percepción de que la enfermedad no es crónica y el tratamiento es poco útil, y b) creencia de que el control de la enfermedad depende de ellos mismos. Conclusiones: Estos hallazgos sugieren la importancia de trabajar aspectos relacionados con la conciencia de enfermedad desde el inicio del tratamiento en pacientes TUA, así como poner de manifiesto la relevancia de acudir a los GAM para complementar el programa de tratamiento del alcohol del Hospital 12 de Octubre.

Palabras clave

Percepción de enfermedad; trastorno por uso de alcohol; adherencia terapéutica.

1. INTRODUCTION

Alcohol consumption is a serious public health problem in Europe, causing 138,000 deaths annually among people aged 15-64 (WHO, 2018). Spain is the sixth European country in alcohol-related costs (Wittchen et al., 2011). Alcohol use disorder (AUD) has important medical, family and social consequences, and being chronic (McKay et al. 2011), it requires programs that improve continuity of care to reduce relapses and future interventions (Lenaerts et al., 2014).

Therapeutic adherence is one of the main determinants of the effectiveness of medical treatments (Barroso et al., 2021). Non-adherence to treatment explains the differences observed between the efficacy and effectiveness of the therapeutic measures that users must adopt (WHO, 2004). The term therapeutic adherence can be described as the context in which the person's behavior should coincide with the health-related recommendations given by the professional; including: the person's ability to attend scheduled consultations; take the medications the way they are prescribed; make the recommended lifestyle changes and complete the complementary tests requested (Silva et al., 2005).

Lack of adherence is a common problem in mental health, especially among substance users (Ruiz, 2009). Addiction professionals face difficulties with inadequate compliance with the indications of patients, who often have problems such as modifying risky habits, inadequate medication intake, failure to attend check-ups and relapses or abandonment of treatment (Ladero, 2005). Non-compliance is therefore multifactorial, although one of the most determining elements is the lack of awareness of the disease (Cava et al. 2008).

One of the parameters to which therapists attribute the greatest predictive value for therapeutic adherence is awareness of the problem, or in other words, the perception of illness (Sirvent et al., 2010). At the beginning of treatment, few people with addiction are fully aware of their problem. This perception usually changes over time, but if the lack of awareness persists, the patient runs the risk of abandoning recovery (Sirvent et al., 2010). In the AUD setting, non-adherence, in addition to a lack of awareness of the disease, may be due to other reasons, such as relapse or the presence of certain barriers that impede the continuation of treatment (Rubio et al., 2020).

One of the problems in determining the lack or presence of disease awareness derives from its assessment. Among the instruments most commonly used in this type of studies is the Illnes Perception Questionnaire (IPQ-R) (Moss-Morris et al., 2002), which has been shown to have adequate psychometric properties when used in physical (Pacheco Huergo, 2012) and psychic (Baines & Wittkowski, 2013) illnesses.

With reference to the use of the IPQ-R in mental disorders, the most recent meta-analysis (Baines and Wittkowski, 2013) included 13 studies where patients had psychotic, bipolar, eating and mood disorders. More recently, other published works have included populations with addictive disorders: gambling use disorder (Dang et al., 2023), patients with eating disorders (Agüera et al., 2021) and a last one with AUD (Laranjeira et al., 2022). In all of them the IPQ-R was shown to be adequate for the assessment of illness awareness.

One way to promote disease awareness is through attendance at MAGs. Participation

in these groups provides a conducive context for individuals to address the challenges and limitations unique to their pathology. The peer support provided through the structured environment of these groups facilitates the development of new self-awareness, promotes coping, and facilitates the establishment of new skills. Participation in peer-led self-help groups can aid in the transfer of learning to new environments (Landstad,et al., 2022).

Mutual aid groups were introduced in our country in the middle of the last century and since then they have collaborated with public programs in the treatment of patients with AUD and their families (Rubio-Escobar and Rubio,2024).

These groups maintain different degrees of collaboration with therapeutic programs. Possibly the greatest degree of integration of these groups in a public treatment program has been achieved at the Hospital Universitario 12 de Octubre, called "Help Yourself, Help us" (Rubio et al., 2013, 2018, and Arias et al., 2021). This program was developed in collaboration with the Federation of Alcoholics Community of Madrid (FACOMA-Red CAPA) whose recovery program is also named Ayúdate, Ayúdanos (FACOMA, 2021). This collaboration improved family psychological health and reduced relapses, favoring therapeutic adherence both in the treatment of addiction and in other pathologies (Rubio et al., 2020; Bernal-Sobrino, 2019). In addition, patients who continued attending FACOMA had lower relapse rates and when they occurred they were detected earlier and referred back to the treatment program (Rubio et al., 2020).

The "Help Yourself, Help Us" program has based its efficacy and efficiency results on the integration of the MAGs into the treatment program. In other words, this program loses part of its effectiveness and meaning if the patient refuses to go to the MAGs. We cannot forget that, in this program, the fact of attending the groups was especially relevant to explain the results during the treatment period (Rubio et al., 2018) and during the continuity of care performed by the Primary Care teams (Rubio et al., 2020).

The act of attending or refusing to attend the MAGs is very important for the professionals in the program; therefore, the main objective of this study is to find out what difficulties patients encounter in following the recommendations of the professionals. Among the secondary objectives, we intend to identify which components of the perception of disease are most relevant to the lack of adherence to treatment.

2. MATERIALS & METHODS

The sample consisted of 100 subjects diagnosed with AUD who attended the alcoholism treatment program of the Hospital Universitario 12 de Octubre, Madrid, during the period December 2022-October 2023. The age range of the sample was 23-62 years, with a predominance of males with a medium-low educational level (see Table 1). Regarding the clinical variables (see table 2), the patients in the sample had begun to consume alcohol at the age of 14.63 years, all met criteria for alcohol addiction according to DSM-5 and the total number of standard drinking units per week at the start of treatment was 119.09. As can be seen in table 1, this was a population of patients with a long history of alcoholism.

Inclusion criteria: having been referred to the alcoholism treatment program of the Hospital Universitario 12 de Octubre, accepting to participate and not presenting psychotic disorders or bipolar disorder. Patients with cognitive impairment that made it difficult to understand the questions asked during the interview were excluded. All patients included signed the informed consent form. The study was approved by the Ethics Committee of the Hospital Universitario 12 de Octubre (CEIm No: 22/462).

All patients were detoxified and the interview for this study was conducted when they had been abstinent for 1-3 months.

2.1. Evaluation instruments

Semi-structured interview specifically designed for this study that included the following sections: a) sociodemographic data; b) verification of AUD diagnostic criteria; c) open-ended questions to determine the reasons why they had not attended FACOMA-CAPA network or Alcoholics Anonymous (AA) MAGs; d) interview at 3-month follow-up regarding attendance at MAGs and relapses during that time.

The severity of AUD was determined by the total number of addiction criteria included in the DSM-5 (APA, 2013). Relapse was understood as the consumption of more than five drinks or 40 g of ethanol per day (Rubio et al., 2001).

Illness perception was assessed using the Revised Illness Perception Questionnaire (IPQ-R), in its Spanish version adapted by Pacheco (2011). The IPQ-R consists of a general scale made up of seven dimensions that assesses people's beliefs about: timeline: acute/chronic (duration of the illness), consequences (impact of the illness on their life), personal control (influence they have over the illness), treatment control (susceptibility of the illness to medical intervention), illness coherence (how they understand the illness), timeline-cyclical (constant or cyclical illness trajectory) and emotional representations (the emotional impact of the illness). The IPQ-R has satisfactory psychometric properties in different languages and cultures (Ashley et al., 2013; Pacheco, 2011; Moos-Morris, et al., 2002; Giannousi et al., 2010) the internal consistency of the dimensions calculated with Cronbach's alpha is between 0.67 and 0.89 for its Spanish version (Pacheco, 2011).

2.2. Procedure

Recruitment included patients with a diagnosis of AUD who attended the alcohol program of the Hospital Universitario 12 de Octubre. They were informed about treatment and the importance of attending MAGs in the hospital area or elsewhere in Madrid. Participation was voluntary and recruitment took place between September 2023 and September 2024. The interviews were conducted face-to-face and individually in a hospital office, with a psychologist asking the questions, resolving doubts and recording the answers. Participants took between 15 and 20 minutes to complete them, and at the end they were collected together with the informed consent.

The categorization of the different responses explaining the reasons for not attending the MAG was carried out using the CQR (Consensual Qualitative Research) method. For this process, a group of judges or "primary group" formed by researchers from the

Hospital Universitario 12 de Octubre (ER, VA, DM & LE) was formed. Each researcher determined the responses of the participants in the categories they considered. Subsequently, a consensus was established among the judges regarding the meaning of the data. Finally, the data obtained by consensus of the "primary group" were presented to the figure of two auditors (RJ & AS) who were in charge of supervising the data proposed by the primary group. Finally, the construction (obtained by consensus) of all the patients' answers explaining the reasons for not attending the MAGs was represented in the following categories: (a) I do not attend MAGs because it is not necessary more treatment than I receive in the hospital; (b) I do not attend MAGs because I do not have time; (c) I do not attend MAGs because can manage on my own; (d) I do not attend MAGs because I feel uncomfortable in the meetings (those who made reference to negative emotions such as fear, anxiety, embarrassment) felt during the group sessions of the hospital program were included).

After three months, all patients were contacted in person (N=85) or by telephone (n=15) to find out whether or not they had attended the MAGs, as well as whether they were abstinent or relapsing.

Data analysis

This study proposes a mixed methodological design based on non-experimental methodology (Latorre et al., 2005), of the ex-post-facto type -after the fact (Buendía et al., 1998; Bernardo & Calderero, 2000; Latorre et al., 2005)-, and with a descriptive and improvement-seeking orientation. In research of this nature, the phenomenon has already occurred (Bisquerra, 2004) or is in development.

A descriptive analysis of the variables was performed, expressed as means and standard deviations for quantitative variables, and a description of percentages for qualitative variables. Subsequently, patients who reported not attending MAGs (n= 65) were compared with those who attended based on sociodemographic data, clinically relevant AUD characteristics, and IPQ-R scores. Chi-square test was used for comparisons of qualitative variables and Student's t test for quantitative variables.

To explore the qualitative data, a descriptive analysis of the motives expressed by the patients, expressed as means and percentages, was performed.

Finally, a binary logistic regression model was used to explain non-attendance at the MAGs, using as predictor variables those with statistical significance in the comparisons of the first analysis.

All analyses were performed with IBM SPSS Statistics 21.

RESULTS

Differences between patient groups according to whether or not they had attended MAGs.

As shown in Tables 1 and 2, patients who **did not attend** after their initial referral were younger than those who attended (45.9 years on average), belonging to the groups with lower sociocultural level, married, living with their family and predominantly active at work.

Regarding the course of alcoholism, those who **did not attend** the MAGs were those who had been consuming alcohol for the shortest time, had had fewer relapses and had started to consume alcohol on a daily basis later (27.26 years on average). These subjects had lower alcohol consumption per week. Those who **did not attend** MAGs had fewer treatment initiation attempts and had fewer relapses. They also had more problems with the use of tranquilizers and gambling.

In relation to the scores in the subscales of the IPQ-R, those who **did not attend** had lower scores in all the subscales of the questionnaire, but only in a statistically significant way in the subscales of "duration, consequences, control of treatment and coherence" (Table 3). That is, those who **did not attend** considered that **AUD was NOT a chronic disease**, that the **consequences of AUD were not excessive**, that the **treatment of the disease was not going to help them** much, and they **understood their disease worse** than those who attended the MAGs.

Reasons given by patients for non-attendance at MAGs

Of those who went to the MAGs (n=35), 91.5% went to FACOMA associations (Delicias: 48.57%; AARVIL: 11.42%; ARACYL: 31.42%) while 8.5% went to AA.

Table 4 shows the reasons for not attending the MAGs (N=65) and among those who attended (n=35), the reasons for stopping attending (n=25) or for continuing to attend (n=10).

In a first referral to the MAGs, 65% (n=65) of the patients decided **not to go to** the MAGs, the perception that there was no need for more treatment than that received in the hospital and lack of time were the most frequent explanations.

Of those who left the MAGs once they had attended (n=25), the reasons for leaving were: perceived lack of confidentiality (20%), lack of time (18%), conflicts with peers (16%), problems with schedules (8%), problems with the means of transportation to attend (12%), and feeling recovered (12%). On the other hand, the **reasons for continuing in the groups (n=10, 10% of the total)** were the perception that the MAGs were essential for their recovery and that they represented an important aid in the process of change.

Binary logistic regression analysis to explain non-attendance at MAGs

In the regression (step 9), the dependent variable considered was non-attendance at MAGs and the independent variables included: age, clinically relevant variables on the AUD that were statistically significant between those who attended MAGs and those who did not, as well as the subscales of the IPQ-R that were statistically significant between the groups. The final model included clinically relevant variables from the AUD: age of onset of alcohol consumption, habitual alcohol consumption, number of times treatment had been initiated to achieve abstinence; and corresponding variables from the IPQ-R: duration of illness, personal control and treatment control (Omnibus test: Chi-square=46.84; $p<0.001$), explaining 78.9% of the variance (R^2 *Nagelkerke*= .789). The model allowed us to correctly classify with 92% accuracy whether or not a subject attended the MAGs (see Table 5).

Table 1. Descriptive data on sociodemographic variables

Variable	Patients (n=100) M (±SD)	GAM Assistance (n=35) M (±SD)	Non-attendance GAM n=65 M (±SD)	*t Student (Gl)*	*p*
Age	47,27 (8.63)	49.77 (10.54)	45.92 (7.13)	2.165 (98)	**0.033**
	(n,%)	**(n,%)**	**(n,%)**	**x^2(Gl)**	***p***
Genre					
Male	67 (67%)	25	42	.478 (1)	ns
Female	33(33%)	10	23		
Level of education				20.834 (2)	**0.000**
Primary	36 (36%)	4	32		
Secondary/FP	42 (42%)	16	26		
University students	22 (22%)	15	7		
Employment Status				2.656 (2)	**0.009**
Active	36 (36%)	5	31		
Unemployed	46 (46%)	26	20		
Work leave	18 (18%)	4	14		
Marital Status				13.238 (2)	**0.004**
Single	32 (32%)	20	18		
Married/Couple	40 (40%)	5	29		
Separated/Divorced/Widowed	28 (28%)	10	18		
Coexistence				13.169 (5)	**0.022**
Only	26 (26%)	14	12		
Family	40 (40%)	9	31		
Couple	9 (9%)	1	8		
Children	6 (6%)	2	4		
Parents	7 (7%)	5	2		
Others	12 (12%)	4	8		
Economic level				30.976 (4)	**0.000**
Under	29 (29%)	12	17		
Medium-Low	38 (38%)	2	36		
Medium	28 (28%)	19	9		
Medium-High	3 (3%)	2	1		
High	2 (2%)	0	2		

M=mean, SD=standard deviation; t=student's t-index; x^2 = chi-square index; Gl=degrees of freedom; $p < .05$.

Table 2. Descriptive data on clinically relevant variables in the SUT

Variable	Patients (n=100) M (±SD)	GAM Assistance (n=35) M (±SD)	Non-attendance GAM n=65 M (±SD)	*t Student (Gl)*	*p*
Age of onset of alcohol consumption (years)	14,63 (2.82)	13.40 (2.26)	15.29 (2.89)	-3.354 (98)	**0.001**
Daily alcohol consumption (years)	25.81 (8.50)	23.11 (7.68)	27.26 (8.62)	-2.381 (98)	**0.019**
Weekly alcohol consumption (UBES)	119.03 (59.91)	141.25 (81.7)	107.15 (40.17)	2.807 (98)	**0.006**
Time of abstinence (months)	1.69 (1.32)	1.80 (1.94)	1.63 (.82)	.580 (98)	ns
Treatment initiation	2.04 (2.41)	3.54 (3.57)	1.23 (.55)	5.122 (98)	**0.00**
Number of relapses	2.54 (5.19)	5.85 (7.65)	.75 (1.15)	5.286 (98)	**0.000**
	(n,%)	**(n,%)**	**(n,%)**	**x^2(Gl)**	***p***
Family history of SUT (n,(%))	27 (27%)	13	14	4.809 (1)	ns
Cannabis use (n,(%))	50 (50%)	18	32	.044 (1)	ns
Cocaine use(n,(%))	38 (38%)	17	21	.424 (1)	ns
BZP consumption (n,(%))	10 (10%)	2	8	20.635 (1)	**0.000**
Gambling problems (n,(%))	17 (17%)	2	15	4.861 (1)	**0.022**

M=mean, SD=standard deviation; t=student's t-index; x^2 = chi-square index; Gl=degrees of freedom; $p < .05$.

Table 3. Comparison of the subgroups according to their scores on the IPQ-R subscales

	Patients (n=100) M (±SD)	GAM Assistance (n=35) M (±SD)	Non-attendance GAM n=65 M (±SD)	*t Student (Gl)*	*p*
Duration	21.68 (1.38)	24.42 (4.48)	20.20 (6.54)	3.411 (98)	**0.001**
Consequences	24.94 (5.59)	27.57 (4.64)	23.52 (5.58)	3.661 (98)	**0.000**
Personal Control	22.68 (5.08)	23.60 (5.28)	22.18 (4.93)	1.333 (98)	.185
Treatment control	20.50 (3.26)	21.42 (3.65)	20.00 (2.93)	2.126(98)	**0.036**
Consistency	17.00 (4.52)	18.88 (3.85)	15.98 (4.56)	3.196(98)	**0.002**
Cyclic duration	13.94 (3.66)	14.14 (3.60)	13.83 (3.71)	.405 (98)	.687
Emotional response	20.15 (5.17)	20.17 (4.32)	20.13 (5.61)	.030 (98)	.976

M=mean, SD=standard deviation; t=student's t-index; x^2 = chi-square index; Gl=degrees of freedom; $p < .05$.

Table 4. Reasons expressed by patients for not attending, leaving, or remaining in the GAMs

Patients not attending the GAMs (n=65)	***Patients attending GAMs (n=35)***	
Reasons for not attending GAMs (n= 65)	**Reasons for leaving the GAMs (n=25)**	**Reasons for continuing in the GAMs (n=10)**
No need for further treatment 36.9%	Low perception of confidentiality 20%	Indispensable for my recovery 40%
I don't have time 23.1%	Lack of time 18%	Helps the change process 40%
I can manage on my own 20%	Conflict with colleagues 16	Learning from other peers 20%
I do not consider my problem to be so serious 15.4%	No means of transportation to go 12%	
Going to groups generates negative emotions for me 4.6%	I felt recovered 12%	
	Coincides with working hours 8%	
	There are no professionals 8%	
	Unspecific subject 6%	

Final categories obtained through the CQR (Consensual Qualitative Research) method.

The variables that had the most weight in our model for classifying the GAM nonattendance group were age of onset of alcohol consumption (*Exp (B)*= 9.287), followed by personal control (*Exp (B)*= 2.426), habitual alcohol consumption(Exp (B)=.770), duration of illness (*Exp (B)*= .466), treatment control (*Exp (B)*= .348), and finally the number of treatment starts (*Exp (B)*= .015).

DISCUSSION AND CONCLUSIONS

Our study aimed to learn about the difficulties faced by patients in the alcoholism recovery program at the Hospital Universitario 12 de Octubre in following the recommendations to attend MAGs, given that the "Help Yourself, Help Us" program depends on the integration of MAGs for its effectiveness and efficiency.

The most relevant results of the study determined that the main variables predicting non-attendance at MAGs were of two types: clinically relevant AUD and related to the perception of the disease. The former included having started drinking at an older age, having a shorter course of dependence and fewer treatment attempts. Those related to the perception of the disease included not seeing the disease as chronic, considering treatment to be of little use, and believing that the evolution of the disease depends solely on them. In addition, the reasons why patients did not go to the MAGs were also noted.

Table 5. Binary Logistic Regression

		B	E.E	Wald	Gl.	Sig.	Exp (B)
Step 9	Age of onset of OH	2.229	.627	12.617	1	**.000**	9.287
	Usual consumption OH	-.261	.108	5.864	1	**.015**	.770
	Treatment Initiations	-4.196	1.116	14.125	1	**.000**	.015
	Acute/Chronic Duration	.764	.212	13.008	1	**.000**	.466
	Personal Control	,886	,232	14.552	1	**.000**	2.426
	Treatment Control	-1,055	,269	15.357	1	**.000**	.348
	Constant	,571	3.509	.026	1	.871	1.770

The following variables are shown in the table: Step 9 (refers to the number of steps required by the statistical method to achieve the best-fitting regression model). B = slope; S.E = standard error; Wald statistic= individual contribution of each predictor variable to the model; Gl =degrees of freedom; $p < 0.05$; Exponential of B (Exp (B)= odds ratio (OR) adjusted for the remaining variables in the model, indicating the effect size. If OR=1.68-3.47, the effect size is small; if OR=3.47-6.71, the effect size is moderate; if OR > 6.7, the effect size is large. 95% CI for Exp B (confidence interval).

Clinical variables related to nonattendance

People who did not attend MAGs had a less advanced addiction course, with a later onset of use and fewer treatment attempts. These findings, are consistent with other studies indicating that treatment seeking usually occurs when patients feel they have "hit rock bottom" (Barrio et al., 2016; Rubio, 2021). These studies show that patients seek treatment when they recognize that they have reached a critical point. The research by Jiménez-Henao and Ramírez-Jiménez (2023) found that having started using later was associated with fewer negative consequences, which influenced the refusal to attend treatment programs.

The findings of our study are hardly comparable to those of other studies, because in this case, the patients had requested help and were already undergoing treatment for AUD. Other studies analyzed which were the main obstacles delaying treatment initiation. Grant et al. (2015) note that the perceived lack of control over use generated feelings of helplessness, leading patients to doubt the effectiveness of treatment. Mojtabai et al. (2014) highlighted the lack of social support as a key factor, while Keyes et al. (2010) highlighted the stigma associated with alcoholism as a major barrier to seeking help. Other researchers have referred to the main reasons for dropping out of treatment in poly-consuming patients, such as the limits of the therapeutic program, the perception of having achieved goals, treatment group fatigue and the desire to return to use (López-Goñi et al., 2008). Calvo et al. (2018) pointed out factors that decrease adherence, such as lack of family accompaniment, being female, cocaine use, and young age. To increase adherence, they highlighted early detection of alcohol consumption and appropriate referral from health centers (Calvo et al., 2018). The differences with these studies, lies in that in our research we tried to determine how were the subjects who did not want to complement the treatment they were following with

another that they had to perform: outside the program circuit, in evening hours and where they are not directed by professionals.

We can posit that patients whose disease course is of shorter duration (have experienced fewer alcohol-related problems), are those who are less aware that the treatment of their addiction requires the added bonus of attending MAGs. This hypothesis can be explained in the context of theories of how illness awareness develops and the transtheoretical theory of stages of change (Prochaska and DiClemente, 1982).

Sickness perception and non-attendance

The results of our study show that the predictors of greater GAM nonattendance were: lower scores on the treatment duration and control subscales and higher scores on the personal control subscale.

"Duration'' refers to the belief that the disease will last for a long time, precisely because AUD is a chronic behavioral disorder (Horni, 2023), with characteristics typical of a chronic disease such as: the fact that the development of the disease is progressive in nature, generates changes in the brain that affect cognitive variables such as impulsivity, there is the possibility of relapse after a period of abstinence or the mere fact that the treatment of choice involves long-term interventions. In our study, those patients who considered that this disease was not chronic, but acute in nature, were the ones who showed the highest non-attendance at MAGs. These patients had an erroneous perception of the disease, as they did not consider it to be chronic. In our opinion, understanding that AUD is a chronic disease is at the basis of any patient's recovery, since, if this is not the case, he or she will return to use sooner or later, thus worsening the prognosis of his or her disease.

The "control of the treatment" (susceptibility of the disease to medical intervention), determines the belief that the treatment will be useful. Those patients who believed that the treatment would be ineffective had higher rates of non-attendance at MAGs. It is logical to think that if the patient has a low perception that the treatment will be effective, why would he or she pay attention to the recommendations of the professionals to go to the MAGs.

Several studies point out the difficulties reflected by patients with AUD in seeking treatment, including precisely the perception of treatment as ineffective, the lack of knowledge about where to go or their own fear of stopping alcohol consumption (Andréasson et al., 2013). Room (2005) noted that shame and stigma are the main reasons for not seeking treatment. In our study, although participants have already sought help and recognize consumption as problematic, 4.6% identify negative emotions (guilt, shame, fear, anxiety) as a reason for not attending MAGs.

Finally, "personal control'' refers to how much influence the sufferer has over the illness. Control of the disease refers to the feeling of empowerment regarding the effectiveness of coping behaviors (Hagger & Orbell, 2003). This variable, in other pathologies, acts as a protective factor and patients consider themselves experts of their disease (Quiceno & Vinaccia 2019). But AUD is a different pathology, since its essential symptom is the "difficulty to control alcohol consumption'', being therefore behavioral and non-bodily

cut (Serecigni, 2015). Therefore, it would seem paradoxical that a person with AUD, whose core symptomatology is the inability to control consumption, obtains high scores on the subscale that refers to personal control. This is because in the early stages of recovery, patients who manage to stop drinking, for a time, have the illusory perception of being completely "recovered", since they do not feel the "need" to drink and have found it easy to remain abstinent. This illusory perception is known as the "control fantasy" referring to the feeling that alcohol consumption can be controlled, despite having a problematic relationship with the substance. This belief often leads to relapse, as patients minimize negative consequences, such as legal, family or health problems (Serecigni, 2015).

Due to distorted beliefs, patients feel confident in controlling their alcohol consumption, which reduces their motivation to attend MAGs. This leads to relapses, showing a lack of real control. This illusion of control is maintained by the behaviors they engage in on a daily basis. According to motivational theory (Prochaska and DiClemente, 1982): people perform behaviors that generate more benefits than harm. In the case of AUD patients in these early stages, the behaviors they perform: going to the doctor and stopping drinking, are the ones that most optimize their abstinence. Hence, they do not feel the need to implement more behaviors, more efforts, to achieve what they are already achieving with these new habits.

Effective alcoholism treatment involves addressing these mistaken beliefs, generating new habits, providing education about the addictive nature of alcohol, and helping individuals develop realistic strategies for recovery, such as participation in mutual-help programs.

The acquisition of disease awareness in AUD is a long-term, individual and fluctuating process, as in other diseases that tend to be chronic. This awareness develops as a function of individual variables (those related to addiction: withdrawal syndrome, cravings, loss of control, medical complications), family and social variables (family dysfunction, fights, recriminations, legal sanctions) (Laranjeira et al., 2022). The conjunction of all of these determines that the subject accepts (or not) to ask for help, even if he/she does not understand the meaning of what it means to have an addiction to alcohol. Over time, people with severe addiction experience frequent relapses. This experience forces them to reconsider whether to make further lifestyle changes or expand coping strategies (Rubio-Valladolid, 2021). In our opinion, those subjects in our study with a shorter course (they started using later and had fewer treatment attempts) most likely developed the awareness that their disease needed help, but not to the point of complementing it by attending MAGs, because it was not considered necessary (the main reason they argued to justify their non-attendance).

According to the stages of change theory (Prochaska & DiClemente, 1982), a patient will perceive the need to make changes to improve his or her health if the decisional balance involved in the behavioral change brings more benefits than complications and if he or she does not encounter barriers to carrying them out. In this sense, our patients are in a precontemplation phase, in which they are not ready to make additional changes (such as attending MAGs), in addition to their current treatment. Therefore, recommending attending MAGs at this time seems to be inappropriate for their situation.

On the reasons for non-attendance

A large percentage (72.3%) of the reasons are related to a low awareness that the treatment they need requires the extra time required to attend the GAM, the fact of considering that they did not have time to attend (23.1%) (the meetings are held in the evening from 19 to 21 hours) may also be related to awareness of the disease, although we can think that if the meetings were held at other times some would have attended. The fourth and last reason was related to the negative emotions generated by attending the MAGs (fear, anxiety, shame and guilt) typical of diseases with greater social stigma such as AUD (Rubio, 2021).

Among the limitations of the study, although there were no significant differences between genders, the number of men 67% of our sample was greater than that of women 33%. On the other hand, it should be noted that only 33% of the patients followed the recommendations of the professionals and attended the MAGs. It is precisely this low attendance rate that prompts the study question.

Nor can we compare these findings with other published studies, since what has been published so far are the reasons given by patients for leaving the GAM (Rubio-Escobar & Rubio, 2024) and not so much the reasons for not attending.

In conclusion, more than 90% of the reasons for patients not attending MAGs are related to poor disease awareness. This information directly influences how we should adjust our clinical approach to treat these patients.

We highlight having included clinical variables characteristic of alcohol dependence, such as relapses, severity and time of abstinence, all of which were collected by expert professionals when the patients came for treatment.

This is the first research study carried out in our country on adherence to GAM in a sample of patients with AUD who have requested treatment and who have started a recovery program in the hospital.

REFERENCES

Agüera, Z., Riesco, N., Valenciano-Mendoza, E., Granero, R., Sánchez, I., Andreu, A., Jiménez-Murcia, S., & Fernández-Aranda, F. (2021). Illness perception in patients with eating disorders: clinical, personality, and food addiction correlates. Eating and weight disorders : EWD, 26(7), 2287–2300. https://doi.org/10.1007/s40519-020-01083-3

American Psychological Association [APA]. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Andréasson, S., Danielsson, A. K., & Wallhed-Finn, S. (2013). Preferences regarding treatment for alcohol problems. *Alcohol and Alcoholism*, *48*(6), 694-699. https://doi.org/10.1093/alcalc/agt067

Arias, F., Sion, A., Espinosa, R., Jurado-Barba, M.R., Marín, M., Martínez Maldonado, A., Rubio, G. (2021). Fases en la recuperación psicológica en pacientes del alcohol tras un tratamiento intensivo. Un seguimiento de 4 años. *Adicciones*, *13*(1). https://doi.org/10.20882/adicciones.1575

Ashley, L., Smith, A. B., Keding, A., Jones, H., Velikova, G., & Wright, P. (2013). Psychometric evaluation of the revised Illness Perception Questionnaire (IPQ-R) in cancer patients: confirmatory factor analysis and Rasch analysis. *Journal of psychosomatic research*, *75*(6), 556-562. https://doi.org/10.1016/j.jpsychores.2013.08.005

Baines, T., & Wittkowski, A. (2013). A systematic review of the literature exploring illness perceptions in mental health utilising the self-regulation model. *Journal of clinical psychology in medical settings*, 20, 263-274. https://doi.org/10.1007/s10880-012-9337-9

Barroso Morales M.L., Mora Sánchez I. y Sierra Hernández C.E. (2021). Adherencia terapéutica en los pacientes sometidos a intervencionismo coronario percutáneo primario. *Enfermería en Cardiología*, *28*(82), 46-51.

Barrio, P., & Gual, A. (2016). Patient-centered care interventions for the management of alcohol use disorders: a systematic review of randomized controlled trials. *Patient preference and adherence*, 1823-1845. https://doi.org/10.2147/PPA.S109641

Bernal Sobrino, J.L., Rubio Valladolid, G., Arias Horcajadas, F., Varela Rodríguez, C., Serrano Balazote, P. Ruiz López, P. (2019). Impacto sobre la mortalidad intrahospitalaria en un programa de tratamiento de los trastornos relacionados con el alcohol y otras sustancias. *I Congreso Nacional de hospitales y Gestión Sanitaria*. Santiago de Compostela, 8-10 de mayo, 2019.

Bernardo, J., & Calderero, J.F. (2000). *Aprendo a investigar en educación*. RIALP. https://bit.ly/2LFrXvU

Bisquerra, R. (2004). *Metodología de la investigación educativa. Manuales de metodología de investigación educativa*. La Muralla. https://bit.ly/349N6EC

Buendía, L., Colas, M.P., & Hernández, F. (1998). *Métodos de investigación en psicopedagogía*. McGraw-Hill. https://bit.ly/2LHlyQF

Cava, M.J., Murgui, S. y Musitu, G. (2008). Diferencias en factores de protección del con sumo de sustancias en la adolescencia temprana y media. *Psicothema, 20*(3), 389-395.

Calvo, F., Carbonell, X., Valero, R., Costa, J., Turró, O., Giralt, C., & Ramírez, M. (2018). Abandono precoz y retención en servicios ambulatorios de drogodependencias: análisis transversal comparativo de factores que aumentan o disminuyen la adherencia. *Atención primaria*, *50*(8), 477-485. https://doi.org/10.1016/j.aprim.2017.06.006

Dang, L., Zhang, M. X., Lau, J. T., Leong, K. K. H., & Wu, A. M. (2023). Applying the Revised Illness Perception Questionnaire (IPQ-R) to gambling disorder: Its psychometric properties in Chinese adults. *International Journal of Mental Health and Addiction*, *21*(6), 3971-3994. https://doi.org/10.1007/s11469-022-00837-7

FACOMA. Ayúdate-Ayúdanos: Programa para pacientes y familiares de personas con problemas por el alcohol u otras drogas. 2021. Disponible en: https://facoma.org/hacemos/.

Giannousi, Z., Manaras, I., Georgoulias, V., & Samonis, G. (2010). Illness perceptions in Greek patients with cancer: a validation of the Revised-Illness Perception Questionnaire. *Psycho-Oncology*, *19*(1), 85-92. https://doi.org/10.1002/pon.1538

Grant, B. F., Goldstein, R. B., Saha, T. D., Chou, S. P., Jung, J., Zhang, H., ... & Hasin, D. S. (2015). Epidemiology of DSM-5 alcohol use disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions III. *JAMA Psychiatry*, *72*(8), 757–766. https://doi.org/10.1001/jamapsychiatry.2015.0584

Hagger, M. S., & Orbell, S. (2003). A meta-analytic review of the common-sense model of illness representations. *Psychology and health*, *18*(2), 141-184. https://doi.org/10.1080/0887044031000813 21

Horni, J. (2023). *Somos lo que hacemos: La adicción, un trastorno de la conducta de uso o consumo*. Editorial Autores de Argentina.

Jiménez Henao, C. M., & Ramírez Jiménez, A. S. (2023). Consumo de alcohol y las posibles afectaciones a la vida emocional y/o a la salud mental en un grupo de alcohólicos anónimos en el año 2021.

Keyes, K. M., Hatzenbuehler, M. L., McLaughlin, K. A., Link, B., Olfson, M., Grant, B. F., & Hasin, D. (2010). Stigma and treatment for alcohol disorders in the United States. *American journal of epidemiology*, *172*(12), 1364-1372. https://doi.org/10.1093/aje/kwq304

Ladero, L., & Orejudo, S. C. JA (2005). Variables psicosociales en la adherencia al tratamiento antirretroviral en pacientes adscritos a un programa de mantenimiento con metadona. *Psicothema*, *17*, 573-79. https://doi.org/10.20882/adicciones.369

Landstad, B. J., Hedlund, M., & Kendall, E. (2022). Practicing in a person-centred environment - self-help groups in psychosocial rehabilitation. *Disability and rehabilitation*, *44*(7), 1067–1076. https://doi.org/10.1080/09638288.2020.1789897

Laranjeira, C., Querido, A. I., & Valentim, O. (2022). Psychometric properties of the revised illness perception questionnaire for people with alcohol use disorder in Portugal. *Journal of Substance Use*, *27*(2), 188-195. https://doi.org/10.1080/14659891.2021.1916848

Latorre, A., Del-Rincón, D., & Arnal, J. (2005). *Bases metodológicas de la investigación educativa*. Ediciones Experiencia.

Lenaerts E, Matheï C, Matthys F, Zeeuws D, Pas L, Anderson P. (2014). Continuing care for patients with alcohol use disorders: A systematic review. *Drug Alcohol Depend*, 135, 9-21, http://dx.doi.org/10.1016/j.drugalcdep.2013.10.030

López-Goñi; J. Fernández-Montalvo; C. Illescas; N. Landa; I. Lorea (2008). *Razones para el abandono del tratamiento en una comunidad terapéutica. Trastornos adictivos, 10(2), 104–111*. https://doi.org/10.1016/S1575-0973(08)74552-5

Mojtabai, R., Chen, L. Y., Kaufmann, C. N., & Crum, R. M. (2014). Comparing barriers to mental health treatment and substance use disorder treatment among individuals with comorbid major depression and substance use disorders. *Journal of Substance Abuse Treatment*, *46*(2), 268–273. https://doi.org/10.1016/j.jsat.2013.07.012

Moss-Morris, R., Weinman, J., Petrie, K., Horne, R., Cameron, L., & Buick, D. (2002). The revised illness perception questionnaire (IPQ-R). *Psychology and health*, *17*(1), 1-16. https://doi.org/10.1080/08870440290001494

McKay, J.R., Hiller-Sturmhöfel, S. (2011). Treating Alcoholism as a Chronic Disease: Approaches to Long-Term Continuing Care. *Alcohol Res Health*, 33, 356,70.

Organización Mundial de la Salud. (2004). *Global Status Report on Alcohol 2004*. Organización Mundial de la Salud.

Pacheco-Huergo, V., Viladrich, C., Pujol-Ribera, E., Cabezas-Pena, C., Nunez, M., Roura-Olmeda, P. Del Val, J. L. (2011). Perception in chronic illnesses: linguistic validation of the revised Illness Perception Questionnaire and the Brief Illness Perception Questionnaire for a Spanish population. *Atencion primaria*, *44*(5), 280-287. https://doi.org/10.1016/j.aprim.2010.11.022

Pacheco-Huergo, V. (2012). Medida de percepción en enfermedades crónicas: Adaptación cultural de los cuestionarios Illness Perception Questionnaire Revised (IPQ-R) y Brief Illness Perception Questionnaire (BIPQ) para la población española.

Prochaska, J.O. y DiClemente, C.C. (1982): Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research, and Practice*, 19, 276-288. https://doi.org/10.1037/h0088437

Quiceno, J. M., & Vinaccia, S. (2019). Percepción de enfermedad y características sociodemográficas en enfermos crónicos. *Psicología y Salud*, *29*(2), 159-166. https://doi.org/10.25009/pys.v29i2.2582

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and alcohol review*, *24*(2), 143-155. https://doi.org/10.1080/09595230500102434

Rubio, G., Jiménez-Arriero, M.A., Ponce, G., & Palomo, T. (2001). Naltrexone versus acamprosate: one year follow-up of alcohol dependence treatment. *Alcohol and alcoholism*, *36*(5), 419–425. https://doi.org/10.1093/alcalc/36.5.419

Rubio, G., Martínez-Gras, I., Ponce, G., Quinto, R., Jurado, R., & Jiménez-Arriero, M. Á. (2013). Integración de los grupos de autoayuda para familiares en un programa público de tratamiento del alcoholismo [Integration of self-guidance groups for relatives in a public program of alcoholism treatment]. *Adicciones*, *25*(1), 37–44.

Rubio, G., Marín, M., Arias, F., López-Trabada, J.R., Iribarren, M. & Alfonso, S. (2018). Inclusion of Alcoholic Associations Into a Public Treatment Programme for Alcoholism Impro ves Outcomes During the Treatment and Continuing Care Period: A 6-Year Experience. *Alcohol Alcohol*, 53, 78-88. https://doi.org/10.1093/alcalc/agx078

Rubio, G., Marín, M., López-Trabada, J. R., & Arias, F. (2020). Efectos de la integración de grupos de ayuda mutua sobre la adherencia al programa de continuidad en el cuidado a pacientes con dependencia del alcohol realizado en Atención Primaria. *Atención Primaria*, *52*(8),

555-562. https://doi.org/10.1016/j.aprim.2020.04.010

Rubio-Valladolid, G. (2021). *Del tratamiento del alcoholismo y de su recuperación: una guía para profesionales de la sanidad*. Editorial Circulo Rojo .

Rubio, G. (2021). *Alcohol, alcoholismo y emociones sociales*. Editorial Delta.

Rubio-Escobar, E. & Rubio, G. (2024). Los grupos de ayuda mutua en el alcoholismo y otras adicciones: presenta, pasado y futuro. En G. Rubio (Ed.), *La ayuda mutua en el siglo XXI: una necesidad imprescindible en el mundo sanitario*. Delta Publicaciones.

Ruiz, C. S. (2009). Fracaso, abandono y cumplimiento terapéutico. *Norte de Salud mental*, *8*(33), 51-58.

Serecigni, J. G. (2015). Los Antagonistas de los Receptores Opioides en el Tratamiento del Alcoholismo Opioid Receptor Antagonists in the Treatment of Alcoholism. *Adicciones*, *27*(3), 214-230. https://doi.org/10.20882/adicciones.708

Silva, G.E., Galeano, E. y Correa, J.O. (2005). Adherencia al tratamiento. Implicaciones de la no-adherencia. *Acta Médica Colombiana*, *30*(4), 268-273.

Sirvent, C., Villa Moral, MA., Blanco, P., Rivas, C., Linares, M., Quintana, L. (2010). Predicción del abandono (vs. Éxito) terapéutico en adicciones (presentación del cuestionario VPA-30 (Sirvent, C. 2009) de variables predictoras de abandono y adherencia al tratamiento en adicciones). *11º Congreso Virtual de Psiquiatría. Interpsiquis* 2010.

Wittchen, H. U., Jacobi, F., Rehm, J., Gustavsson, A., Svensson, M., Jönsson, B., ... & Steinhausen, H. C. (2011). The size and burden of mental disorders and other disorders of the brain in Europe 2010. *European neuropsychopharmacology*, *21*(9), 655-679. https://doi.org/10.1016/j.euroneuro.2011.07.018

World Health Organization (2018). Management of substance abuseWHO launches SAFER alcohol control initiative to prevent and reduce alcohol-related death and disability. Geneva, Switzerland: WHO; 2018.