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Acceptability of pharmacotherapy for hazardous alcohol use among men who have sex with men: Findings from a qualitative study

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ABSTRACT

Introduction: Men who have sex with men (MSM) experience high rates of binge drinking, alcohol use disorder (AUD), and alcohol-related health issues. Pharmacotherapy for AUD can reduce hazardous drinking, yet remains underutilized among MSM. This qualitative study examined knowledge and perceptions regarding AUD medications among MSM, with an emphasis on naltrexone.

Methods: Three focus group discussions (FGDs) with MSM who consumed alcohol in the past year were conducted in February 2015 (N = 39) in the San Francisco Bay Area. The FGD guide generated discussions about hazardous drinking, the social contexts of drinking, and alcohol reduction and cessation options, including pharmacotherapy. Interviews were analyzed via directed content analysis to codify themes.

Results: For participants, drinking at LGBTQ bars was an important social activity. Many expressed interest in reducing alcohol use, but few had heard of pharmacotherapy for AUD. Potential uptake was limited by perceptions of disulfiram as the prototype medication, side effects associated with disulfiram, and concerns that medications do not address alcohol-related stigma or social drivers of drinking. Participants were more receptive to pharmacotherapy when presented with medication options that did not require abstinence. Participants reported being more likely to try pharmacotherapy as part of a peer group or treatment program.

Conclusions: Efforts to increase the knowledge and availability of naltrexone and harm reduction approaches, while addressing addiction- and medication-related stigma, might improve pharmacotherapy uptake for AUD and decrease hazardous drinking among MSM for whom alcohol holds social significance.

1. Introduction

Rates of hazardous alcohol use, including binge drinking (five or more standard drinks for men), are disproportionately high for men who have sex with men (MSM) in the United States (US), with binge drinking rates among MSM approaching 51%, compared to 27% of the general US population (Hess et al., 2015; National Institute of Alcohol Abuse and Alcoholism, 2017; Substance Use and Mental Health Administration, 2015). Hazardous drinking is associated with the development of alcohol use disorder (AUD) (Gowin, Sloan, Stangl, Vatsalya, & Ramchandani, 2017; World Health Organization, 2014), and has been proposed to increase the risk of HIV seroconversion via condomless anal sex among MSM who do not use HIV pre-exposure prophylaxis (PrEP) (Kahler et al., 2015; Koblin et al., 2006; Mimiaga et al., 2011). Hazardous drinking has also been independently linked to co-morbid psychiatric conditions and decreased HIV antiretroviral medication adherence in MSM (Ferro et al., 2015; Reisner, Mimiaga, Safren, & Mayer, 2009; Woolf & Maisto, 2009). As MSM and people of color — and thus especially MSM of color — all experience a greater burden of new HIV infections in the US, it is important to address hazardous alcohol use as a risk factor for HIV (Brooks, Rotheram-Borus, Bing, Ayala, & Henry, 2003; Centers for Disease Control and Prevention, 2018; Maulsby et al., 2014; Shoptaw & Frosch, 2000).

Psychosocial interventions (e.g. Alcoholics Anonymous, behavioral

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therapy) are effective in treating AUD, but relapse rates are as high as 79% when used alone (Weiss, O'Malley, Hosking, LoCastro, & Swift, 2008). Pharmacotherapy may help with the management and treatment of hazardous drinking. Disulfiram (Antabuse) is a medication whose mechanism of action involves unpleasant, punitive physiological effects (e.g. facial flushing, chest pain, palpitations, nausea) should the user consume alcohol (Skinner, Lahmek, Pham, & Aubin, 2014). Naltrexone, an opioid receptor antagonist, is a newer medication available in oral and injectable depot forms that has been demonstrated to decrease alcohol cravings, heavy drinking days, and rates of relapse (Anton et al., 2006; Garbutt et al., 2005). Although the US Food and Drug Administration (FDA) has approved these and other medications for AUD, it is estimated that fewer than 10% of people with AUD in the US have ever received medications for alcohol use (Jonas et al., 2014).

While pharmacotherapy for AUD is considered underutilized in the US despite clinical guidelines for first-line use in those with moderate to severe AUD (Jonas et al., 2014; Mark, Kassed, Vandivort-Warren, Levit, & Kranzler, 2009; Reus et al., 2018), data specific to MSM remain scarce. In a cross-sectional study conducted by our research group, only 6.9% of MSM with hazardous alcohol use received medications for alcohol treatment (Santos et al., 2018). Several studies have documented health care provider barriers to medication-assisted treatment, including inadequate knowledge of medication options and concerns about adherence, cost, efficacy, and side effects (Lee, Kresina, Campopiano, Lubran, & Clark, 2015; Thomas, Wallack, Lee, McCarty, & Swift, 2003). However, few studies have looked at barriers to and facilitators of taking AUD medications among MSM. Limited data for MSM with AUD suggest low disulfiram acceptability among those who frequent lesbian, gay, bisexual, transgender, and queer (LGBTQ) bars, and lower acceptability of abstinence as a treatment goal when compared to the general population (Brown et al., 2017; Bux, 1996; Morgenstern et al., 2007). It is unclear whether acceptability among MSM differs for medications such as naltrexone, which can be initiated when the user is still drinking.

To expand the use of pharmacotherapy to reduce hazardous alcohol use and its health sequelae among MSM, this qualitative study was designed to assess knowledge, behaviors, and attitudes among MSM surrounding AUD pharmacotherapy, with an emphasis on naltrexone.

2. Methods

As part of a broader project to explore the knowledge and acceptability of current treatment options to reduce hazardous drinking (including pharmacotherapy) among MSM, three focus group discussions (FGDs) were conducted in February 2015 with a total of 39 participants at the San Francisco Department of Public Health (SFDPH). Focus groups are well-suited for research topics where group dynamics and interactive discussions may draw a wider range of ideas and experiences through “collective remembering” (Guest, Namey, Taylor, Eley, & McKenna, 2017; Kitzinger, 1994). Focus group methodology was especially appropriate for this study due to the social contexts of alcohol use within MSM communities. All focus group participants provided written informed consent. The Institutional Review Board at University of California, San Francisco reviewed and approved the study procedures.

2.1. Recruitment

Participants were recruited through community-based organizations that provide services for MSM, previous research participation at SFDPH, research staff members' MSM networks, internet posts on Craigslist.com, and flyers in MSM venues. Participants were eligible if they identified as male, reported having had sex with at least one male-identified partner, consumed alcohol in the past year, and lived in the San Francisco Bay Area.

Across the FGDs, participants had a mean age of 39.1 years (median = 34.5 years; range = 23–66) and were racially and ethnically diverse, with the majority (N = 29, 74.4%) identifying as a participant of color. Table 1 displays participant characteristics by FGD. HIV status and other demographics were not collected during these FGDs.

Table 1
Basic demographics of focus group participants (N = 39).

Focus group	Mean age (range)	Race/ethnicity N (%)				
		API	AA	Latino	Mixed	White
All	39.1 (23–66)	10 (25.6)	9 (23.1)	6 (15.4)	4 (10.3)	10 (25.6)
FGD1 (N = 17)	40.9 (25–62)	5	3	2	2	5
FGD2 (N = 10)	35.7 (27–58)	1	2	3	1	3
FGD3 (N = 12)	40.8 (23–66)	4	4	1	1	2

FGD, Focus Group Discussion. API, Asian and Pacific Islander. AA, Black or African-American.

2.2. Study procedures

A discussion guide was developed to assess patterns and motivators of hazardous drinking, consequences of alcohol consumption and intoxication, and perceived acceptability of treatment for hazardous drinking, focusing on pharmacologic interventions. Participants were asked to speak on behalf of themselves and MSM-identifying friends, and were not required to individually quantify their own alcohol intake. Two staff members of the research group conducted the FGDs. Each group lasted approximately 2 h and was audio-recorded in the presence of a scribe who documented additional nonverbal information (Kitzinger, 1994). Portions of the audio recordings specific to the study question were transcribed verbatim.

2.3. Analysis

Partial FGD transcriptions of the participants' responses were analyzed using directed content analysis (Hsieh & Shannon, 2005). In directed content analysis, theory and previous research guide the initial selection of key concepts and variables (Hsieh & Shannon, 2005; Mayring, 2000). This approach to content analysis was selected based on study goals to extend existing research on AUD pharmacotherapy acceptability among MSM, by relying on social constructionist frameworks of alcohol use to nuance discussions surrounding different AUD medications. Two members of the research team (EH and DJ) independently coded and analyzed the transcripts to create a formative matrix of key concepts influenced by those found in the literature. Using the FGD script and transcripts, the key concepts were grouped into themes, and reconciled with a third research member (GMS) to compare themes and resolve discrepancies. Illustrative anchor quotations were then selected to represent the themes and evaluated for inclusion of all participant perspectives using voice recognition (i.e. identification of a distinct number of voices commensurate with the FGD size) and facilitator observations. The authors conferred to discuss group dynamics not verbalized in the recordings, additional insights from a final working of the text, and the overall interpretation of the data.

3. Findings

Four overarching themes were identified across the FGDs: an interest in alcohol reduction, rather than elimination; limited knowledge of treatment options for AUD; barriers to uptake of pharmacotherapy; and facilitators of pharmacotherapy uptake. Since participants did not