Addictive Behaviors Reports 6 (2017) 76–82

Contents lists available at ScienceDirect

Addictive Behaviors Reports

journal homepage: www.elsevier.com/locate/abrep

A qualitative exploration of social support during treatment for severe alcohol use disorder and recovery

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ARTICLE INFO

Keywords:
Alcohol use disorder
Substance use
Social support
Social networks
Qualitative research
Rehabilitation treatment

ABSTRACT

Introduction: Severe alcohol use disorder (AUD) affects multiple aspects of an individual's life as well as their loved ones' lives. Perceived social support has the potential to help or hinder recovery efforts.

Methods: In this analysis we seek to understand the changes of social networks among individuals with severe AUD (n = 33) throughout their recovery process and the potential relationship between the quality and nature of those networks and sustained sobriety as they transition from an inpatient research facility providing rehabilitation treatment back to the community. Interviews were conducted in 2014 and 2015. We conducted in-depth thematic analysis of themes related to social support using an exploratory approach.

Results: The most common types of social support mentioned in both inpatient and outpatient settings were instrumental and emotional. Participants most frequently mentioned Alcoholics Anonymous (AA), an abstinence-based support system, as a source of support and often used the inpatient program as an exemplar when describing their ideal social networks.

Conclusion: These data provide insight into the complexity of the issues and barriers that individuals in recovery may be facing across "transition periods." From an intervention standpoint, it may be beneficial to focus on helping people choose environments and their accompanying social contexts and networks that are most conducive to recovery. Further elucidating the concept of social support and its role in recovery could provide information on unique needs of individuals and guide clinicians in engaging patients to develop new or sustain healthy existing social networks that result in continued sobriety.

1. Introduction

Excessive use of alcohol is the fourth leading preventable cause of death in the United States, making its prevention a public health priority (CDC, 2015). In 2014 alone, 16.3 million adults 18 years of age and older had an alcohol use disorder, only 8.9% of whom received treatment (NIAAA, 2016). Recently, the Diagnostic and Statistical Manual (DSM-5) reclassified substance use disorders, integrating what was formerly referred to as "alcohol abuse" or "alcohol dependence" into a single disorder called "alcohol use disorder" (AUD) with mild, moderate, and severe classifications (NIAAA, 2016). Severe AUD (often still referred to as "alcoholism" or "alcohol dependence") affects multiple aspects of an individual's life as well as their loved ones' lives. Two recent studies revealed that 59–70% of individuals who undergo inpatient treatment relapse after 30 days (Seo et al., 2013; Sinha et al., 2011). Perceived social support has the potential to help or hinder recovery efforts. This may be particularly true for individuals with severe AUD who receive intensive inpatient treatment over the period of detoxification and rehabilitation and are faced with the transition to becoming an outpatient in returning to "normalcy" (Brooks et al., 2016). This transition is associated with many challenges: accessing health services, maintaining motivation for sobriety, and ultimately learning how to re-integrate in their homes and communities as a sober individual.

1.1. Link between alcohol use and social support

The relationship between alcohol consumption and perceived social support is complex; perhaps even more so among those with severe AUD. Epidemiological data suggest that social network size and diversity is smaller among those with alcohol dependence (Mowbray, Quinn, & Cranford, 2014). Moreover, lower levels of perceived social

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http://dx.doi.org/10.1016/j.abrep.2017.08.002
Received 7 June 2017; Received in revised form 16 August 2017; Accepted 16 August 2017
Available online 18 August 2017

support can influence drinking rates, entry into treatment, and ultimately ongoing sobriety following treatment (Mericle, 2014). The relationship between perceived social support and maintaining sobriety is also demonstrated in Alcoholics Anonymous (AA), one of the most commonly-utilized abstinence-focused self-help groups for individuals with severe AUD. Stevens and colleagues demonstrated a positive relationship between social support and abstinence-specific self-efficacy, sense of community, and AA affiliation, as well as the role of sober living houses (environment) on perceptions of social support (Stevens, Jason, Ram, & Light, 2015). Individuals living in a structured sober living home reported gaining more from the sense of fellowship than the spirituality aspect of the AA meetings (Nealon-Woods, Ferrari, & Jason, 1995). Alcoholics Anonymous (AA) attendance may also simultaneously facilitate decreases in pro-drinking social ties and increased involvement with pro-abstinent social ties (Kelly, Stout, Magill, & Tonigan, 2010). Increasing sober social support while limiting the support of those who may have a "triggering" influence is supported by research suggesting that the drinking patterns of individuals in one's social networks are just as strong of a predictor of developing alcohol dependence as is having two parents with alcohol problems (McCutcheon, Lessov-Schlaggar, Steinley, & Bucholz, 2014).

Conversely, a lack of perceived social support can have detrimental effects on recovery. Among individuals who are alcohol-dependent who achieve abstinence, social exclusion may contribute to relapse (Zywiak, Longabaugh, & Wirtz, 2002). The importance of social networks in recovery has further been demonstrated in analyses that utilize dynamic social network modeling to understand relationships in sober living environments (Jason, Light, Stevens, & Beers, 2014). Convincing evidence suggests that social network composition is a causal predictor of alcohol outcomes, even for follow-up periods as long as three years (Stout, Kelly, Magill, & Pagano, 2012).

Finally, individuals with severe AUD often suffer a range of comorbid conditions (Boschloo et al., 2011; Gilpin & Weiner, 2016; Petrakis, Gonzalez, Rosenheck, & Krystal, 2002), and managing these conditions could potentially necessitate additional support in recovery. One relatively common example comorbidity is reflected among individuals who are alcohol-dependent with comorbid PTSD (Dutton, Adams, Bujarski, Badour, & Feldner, 2014).

1.2. Defining social support

Perceived social support is conceptualized as the "cognitive appraisal of being reliably connected to others" (Barrera, 1986, p. 416). Based on a conceptual analysis of theoretical and operational definitions of social support, four of the most frequently named types of social support are emotional, instrumental, informational, and appraisal support that individuals perceive to be meeting some type of need. Social support can be "tangible" or "intangible" and the outcomes of effective social support include but are not limited to health maintenance behaviors, effective coping behaviors, perceived control, and sense of stability (Langford, Bowsher, Maloney, & Lillis, 1997).

1.3. Purpose of study

Perceived social support and social networks are particularly variable for individuals with severe AUD who were recently discharged from inpatient facilities, based on two overarching factors: 1) their social networks in place prior to entering treatment and 2) what type of post-discharge environment the person is entering. An example of this is as follows: an individual who has a job and lives with their partner may be more likely to return to that environment and their level of support may depend solely on one person (their partner). An alternate example is a person who was single and jobless prior to entering inpatient treatment may be more inclined to enter a structured living facility such as an Oxford House. Oxford Houses are democratically-run, self-supporting sober living residences for people with a past history of substance abuse, with a main requirement for admission being the desire to abstain from drugs and alcohol (Oxford House, Inc., 2008). In these two examples, returning back home versus returning to structured living are two very different environments and have obvious implications for the type of support that the individual receives. Both of these examples represent unique situations and potential needs which may not be captured by traditional quantitative approaches to inquiry. In this analysis, we seek to understand the changes of social support networks among individuals with severe AUD throughout their recovery process and the potential relationship between the quality and nature of those networks and sustained sobriety as they transition from an inpatient research facility providing rehabilitation treatment back to the community. To our knowledge, changes in perceived social support have not yet been explored in a qualitative manner; these data may provide insight into the complexity of the issues and barriers that individuals in recovery may be facing. These results stem from a subanalysis of themes related to social support identified in transcripts from semi-structured interviews with 33 individuals from a larger research study (NCT #02181569).

2. Methods

2.1. Study overview/participants

This study was approved by the NIH Addictions Institutional Review Board (IRB) at the National Institutes of Health (NIH; NCT #02181659). All participants in this analysis (n = 33) were recruited from a clinical research facility providing abstinence-based rehabilitation treatment and enrolled onto a screening and assessment protocol for individuals with severe AUD. Table 1 outlines participant demographics and clinical variables. All participants received continued physical evaluations, medication management, inpatient treatment of alcohol withdrawal, psychosocial management, and an educational treatment program. Participants were offered twelve-step facilitation and motivational interviewing in the form of motivational enhancement therapy. Patients could receive up to six or more weeks of inpatient treatment followed by 16 weeks of optional outpatient treatment. Refer to Brooks et al., 2016 for a detailed description of study procedures.

2.2. Study timeline and procedures

Specific measures collected during the inpatient admission as part of the screening and assessment protocol were used to characterize patients who participated in this study. Interviews were conducted and questionnaires were administered within one week of participants' scheduled discharge date and again four to six weeks post-discharge when they returned for an outpatient follow-up visit or via phone. Most interview questions/prompts were based on the Social Cognitive Theory (Bandura, 1986).

This qualitative analysis was based on individual phenomenological semi-structured interviews focused on the "lived experiences" of individuals in recovery conducted in 2014 and 2015, which were audio-recorded with the interviewees' consent. The interview questions were reviewed and pilot-tested by clinicians and investigators with extensive experience working with individuals with severe AUD. A second interviewer was present at all interviews and introduced to the participants with an explanation that he or she would observe, take notes, and probe additional questions based on the participant's responses. This strategy was employed to decrease potential bias of only having one interviewer asking follow-up questions based on participant responses. We explained the role of the second interviewer to the participant to make them feel more comfortable and participants were assured that there were no "right" or "wrong" answers and that they could skip any questions or stop the interview at any time. Table 2 displays a selection of interview prompts employed specifically to gain a deeper