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Differences between abstinent and non-abstinent individuals in recovery from alcohol use disorders ☆

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HIGHLIGHTS

- Length of time in recovery and the probability of abstinence are positively related.
- Quality of life in abstinent recovery is better than in non-abstinent recovery.
- Time in recovery should be accounted for when examining correlates of recovery.

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ABSTRACT

Objective: Non-abstinent goals can improve quality of life (QOL) among individuals with alcohol use disorders (AUDs). However, prior studies have defined "recovery" based on DSM criteria, and thus may have excluded individuals using non-abstinent techniques that do not involve reduced drinking. Furthermore, no prior study has considered length of time in recovery when comparing QOL between abstinent and non-abstinent individuals. The current aims are to identify correlates of non-abstinent recovery and examine differences in QOL between abstainers and non-abstainers accounting for length of time in recovery.
Sample: A large (N = 5380) national sample of individuals who self-describe as "in recovery" from alcohol problems recruited in the context of the What Is Recovery? (WIR) study.
Method: Multivariate stepwise regressions estimating the probability of non-abstinent recovery and average quality of life.
Results: Younger age (OR = 0.72), no prior treatment (OR = 0.63) or AA (OR = 0.32), fewer dependence symptoms (OR = 0.17) and less time in recovery all significantly ($P < 0.05$) related to non-abstinent recovery. Abstainers reported significantly ($P < 0.05$) higher QOL than non-abstainers (B = 0.39 for abstinence vs. non-abstinence), and abstinence was one of the strongest correlates of QOL, even beyond sociodemographic variables like education.
Conclusions: Non-abstainers are younger with less time in recovery and less problem severity but worse QOL than abstainers. Clinically, individuals considering non-abstinent goals should be aware that abstinence may be best for optimal QOL in the long run. Furthermore, time in recovery should be accounted for when examining correlates of recovery.

1. Introduction

1.1. Non-abstinent recovery from alcohol use disorders

Traditional alcohol use disorder (AUD) treatment programs most often prescribe abstinence as clients' ultimate goal. "Harm reduction" strategies, on the other hand, set more flexible goals in line with patient motivation; these differ greatly from person to person, and range from total abstinence to reduced consumption and reduced alcohol-related problems without changes in actual use (e.g., no longer driving drunk after having received a DUI). In the broadest sense, harm reduction seeks to reduce problems related to drinking behaviors and supports any step in the right direction without requiring abstinence (Marlatt & Witkiewitz, 2010). Witkiewitz (2013) has suggested that abstinence may be less important than psychiatric, family, social, economic, and health outcomes, and that non-consumption measures like psychosocial functioning and quality of life should be goals for AUD research (Witkiewitz, 2013). These goals are highly consistent with the growing conceptualization of 'recovery' as a guiding vision of AUD services (The

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Betty Ford Institute Consensus Panel, 2007). Witkiewitz also argued that the commonly held belief that abstinence is the only solution may deter some individuals from seeking help.

Epidemiologic studies have demonstrated that non-abstinent goals like asymptomatic and low-risk drinking are plausible, viable recovery goals for individuals recovering from AUD. Results from the 2001–2002 National Epidemiologic Study on Alcohol and Related Conditions (NESARC) showed that of those with prior-to-past-year alcohol dependence (N = 4422), 11.8% drank asymptomatically and 17.7% were low-risk drinkers in the year prior to being interviewed (Dawson et al., 2005). In two Canadian general population surveys of more than 13,000 respondents combined, 38–63% of those are in recovery (i.e., free of alcohol-related problems in the past 12 months and drinking within national guidelines managed to continue drinking at low-risk levels; Sobell, Cunningham, & Sobell, 1996). In a large study of adults (N = 995) who had participated in randomized trials of outpatient treatment for AUD, 14% were low-risk drinkers (no days of 5+) six months post-treatment (Kline-Simon et al., 2013). Unlike epidemiologic studies that use lower severity general population samples (Dawson, Goldstein, & Grant, 2007), Kline-Simon and colleagues used higher severity treatment samples and still found that non-abstinent treatment outcomes are both attainable and beneficial. Furthermore, both low-risk drinking and abstinence six months after treatment were related to better 12-month psychiatric and family/social severity scores than was heavy drinking, though abstinence predicted the best scores (Kline-Simon et al., 2013).

1.2. Quality of life and recovery from AUD

The past decade has seen the AUD service field increasingly embrace the broader goal of 'recovery' as its guiding vision. Though research on recovery remains in its infancy and the term itself poorly defined, a handful of definitions of recovery have put forth the centrality of quality of life (QOL) as a key recovery component (Center for Substance Abuse Treatment, 2006; The Betty Ford Institute Consensus Panel, 2007). Furthermore, researchers have started to explore the prospective and dynamic association between QOL and substance use among persons in recovery from AUD and from drug dependence (Frischknecht, Sabo, & Mann, 2013; Laudet, 2011; Laudet, Becker, & White, 2009). Donovan et al. (2005) reviewed 36 studies involving various aspects of QOL in relation to AUD and concluded that heavy episodic drinkers had worse QOL than other drinkers, that reduced drinking was related to improved QOL among harmful drinkers, and that abstainers had improved QOL in treated samples (Donovan et al., 2005). The authors also stated that future research should examine how various recovery goals (e.g., abstinence, controlled drinking, harm reduction with continued drinking) affect QOL (Donovan et al., 2005). Similarly, results from the 2001–02 and 2004–05 NESARC studies showed that any remission (partial or full) from dependence, whether abstinent or not, was related to improvements in QOL as measured by the SF-12 (Dawson et al., 2009). However, the NESARC QOL analyses examined transitions across AUD statuses over a three-year period, and thus inherently excluded individuals with more than three years of recovery. In addition, previous QOL analyses have not accounted for length of time in recovery. Therefore, knowledge about whether and how QOL differs between non-abstinent vs. abstinent recovery remains limited.

1.3. Rationale for current study and study aims

The dearth of data regarding individuals in long-term recovery highlights the need to examine a sample that includes individuals with several years of recovery experience. Moreover, although previous studies have examined treated, non-treated and general population samples, none has focused on individuals *who identify themselves* as "in recovery" from alcohol problems. Instead, past studies have equated "recovery" with DSM-IV diagnostic criteria and national guidelines for low-risk drinking; these criteria may exclude people who consider themselves "in recovery." For example, individuals involved in harm reduction techniques that do not involve changed drinking may consider themselves in recovery. Importantly, the only published study that asked individuals in recovery (from crack or heroin dependence in this particular study) how they defined the term revealed that less than half responded in terms of substance use; the other definitions were more general, such as a process of working on oneself (Laudet, 2007). In addition, some might consider abstinence as a necessary part of the recovery process, while others might not.

In the context of "harm reduction," individuals may make positive changes in their lives that do not include reduced alcohol use and may consider themselves "in recovery" even though their AUD status remains unchanged (Denning & Little, 2012). For example, among the 2005 and 2010 National Alcohol Survey respondents, 18% of current drinkers who identified as "in recovery" from alcohol problems (who do not use drugs) are DSM-IV alcohol dependent, and 26% of current drinkers who also use drugs are DSM-IV alcohol dependent. Thus relying on DSM criteria to define a sample of individuals in recovery may unintentionally exclude individuals who are engaging in non-abstinent or harm reduction techniques and making positive changes in their lives.

We do not know what factors relate to non-abstinent vs. abstinent recovery among individuals *who define themselves as in recovery*. In addition, no prior study has examined whether quality of life differs among those in abstinent vs. non-abstinent recovery in a sample that includes individuals who have attained long periods of recovery. Here we discuss exploratory analyses of differences between abstinent and non-abstinent individuals who defined themselves as "in recovery" from AUDs. We used the What Is Recovery? study (WIR) dataset, one of the largest repositories of individuals in recovery available. A better understanding of the factors related to non-abstinent recovery will help clinicians advise patients regarding appropriate treatment goals.

Our first goal was to identify correlates of non-abstinent recovery by comparing the demographics (i.e., gender, age, race, ethnicity, education, employment) and recovery characteristics (i.e., length of recovery, help-seeking) of abstainers and non-abstainers within a large sample that includes individuals in long-term recovery (i.e., more than three years). Our second goal was to examine differences in quality of life between abstainers and non-abstainers controlling for length of time in recovery.

2. Material and methods

All procedures involving human subjects were reviewed and approved by the Public Health Institute's Institutional Review Board.

2.1. What Is Recovery? study

The study capitalizes on a large national sample of individuals who *self-describe* as "in recovery" from alcohol and/or drug problems recruited in the context of the What Is Recovery? (WIR) study. The only other inclusion criterion was to be 18 years or older. "*Recovery*" *was not defined in WIR recruitment materials* because the purpose of the WIR study was to develop a psychometrically sound recovery definition instrument that reflects the heterogeneity of experiences associated with different pathways to recovery (e.g., treatment, 12 step, pharmacotherapy, natural recovery, non-abstinent goals). To this end, extensive efforts were made to recruit a diverse group of individuals who consider themselves in recovery to take the 15-minute, confidential online WIR survey which included questions about specific facets of recovery. The WIR survey also asked about demographics, treatment/mutual aid history, substance use, and lifetime dependence. Participants were recruited from July 15, 2012 to October 31, 2012. The various recruitment methods included (but were not limited to) traditional newspaper ads,