Social Connection and Recovery from Alcohol Use Disorder during the COVID-19 Pandemic: Qualitative Findings from a U.S. National Sample

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PURPOSE: Social support is critically important to recovery from alcohol use disorder (AUD). Evidence shows that it can facilitate entry into treatment, promote abstinence, and protect against relapse [1-4]. Our previous study found that recovery capital—defined as the individual attributes (such as lived experiences or self-efficacy) and interpersonal resources (such as social relationships or recovery-oriented cultural contexts) that a person may draw upon to initiate and maintain recovery from a substance use disorder—served as a distinctly protective factor against relapse during the first year of the COVID-19 pandemic, whereas social support had no independent effect [5]. Although the disruption of social networks caused by pandemic restrictions may explain the lack of an observed association, there is a need to better understand the role of social support in recovery. In response, we analyzed qualitative data from a national U.S. survey for a deeper understanding of the ways people maintained recovery during the COVID-19 pandemic.

METHODS: We surveyed adults in recovery recruited from KnowledgePanel, a probability-based cohort of non-institutionalized adults maintained by Ipsos Public Affairs for internet-based research. In fall 2020, we obtained a general population sample of KnowledgePanel members and an oversample of racial and ethnic minority members for our survey about recovery from alcohol problems, which was available in English or Spanish. To be eligible to participate, individuals had to be age 18 or older and self-identify as a person in recovery or with a resolved alcohol problem. To generate qualitative data, a single open-ended question was asked of participants: "What has been most helpful in sustaining your recovery during the coronavirus/COVID-19 outbreak?" Of the full sample, 83% (n=1,236) of participants responded to the question; however, we excluded 18% (n=228) of responders because their statements did not address the question prompt, were ambiguous, or expressed no concern about the impact of the COVID pandemic on recovery. The final analytic sample consisted of 1,008 participants. We conducted an inductive thematic analysis of their text responses using Dedoose analytic software. The analysis was an iterative process that involved multiple rounds of reading, coding, and interpreting data by the authors. Questions and disagreements were resolved through discussion among research team members until consensus was reached.

RESULTS: The adjacent table shows select participant characteristics. The majority of the sample were age 45 years or older (75%), consisted of men (65%), and self-identified as White (65%). The sample was well educated, with notable proportions reporting some college (34%) or a college degree (26%).

In terms of alcohol problem characteristics, the majority of the sample met criteria for severe lifetime AUD (75%), reported being in recovery more than five years (72%), and was classified in the independent recovery group (i.e., having used neither specialty services nor mutual-help groups, 60%).

Select Participant Demographics		Alcohol Problem and Recovery Characteristics	
Age		Lifetime AUD severity	
18-29 years	59 (12%)	Sub-clinical (1 symptom)	23 (3%)
30-44 years	194 (25%)	Mild (2-3 symptoms)	84 (9%)
45-59 years	306 (29%)	Moderate (4-5 symptoms)	125 (13%)
≥60 years	449 (34%)	Severe (≥6 symptoms)	776 (75%)
Gender			
Men	683 (65%)	Recovery length	
Women	325 (35%)	<1 year	36 (6%)
Race/ethnicity		1-5 years	200 (23%)
White, non-Hispanic	660 (65%)	>5 years	767 (72%)
Black, non-Hispanic	116 (12%)		
Hispanic, any race	151 (15%)	Recovery group	
Multiple or other races	81 (8%)	Independent [a]	585 (60%)
Educational attainment		Assisted [b]	157 (14%)
Less than high school	65 (13%)	Treated [c]	266 (26%)
High school diploma	222 (27%)		
Some college	395 (34%)		
Bachelor's degree or higher	326 (26%)		

Note: Counts are unweighted; percentages are weighted.
[a] Independent recovery = no lifetime use of specialty treatment services and no lifetime use of mutual-help groups
[b] Assisted recovery = any lifetime use of mutual-help groups (e.g., Alcoholics Anonymous) and no lifetime use of specialty treatment services
[c] Treated recovery = any lifetime use of specialty treatment services (e.g., in-patient or out-patient rehabilitation)

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RESULTS (continued):
Staying connected was by far the most frequently invoked strategy among responses, characterized by statements about the importance of social ties for maintaining recovery. Family dominated the theme, accounting for the majority of excerpts (73%). Some comments referenced social interactions in general terms, for example "maintain[ing] communication with family and friends," or "spending more time with my family and playing with them." Participants also highlighted general support and encouragement from family, with one participant stating "[my family] sticks together and helps each other." However, there were also mentions of specific family members, such as "my wonderful husband, who listens and helps with my mental health," and "playing a daily game with my daughter." While both men and women referenced children, women mentioned children more often. "My kids keep me busy," said one female participant, while another woman endorsed "being there for my children" as a factor that helped her maintain recovery. These responses suggest that "staying connected" can bolster alcohol recovery by allowing participants to both receive family support and provide care to the family members.

Friends were also integral to staying connected, with participants highlighting support, care, and contact received from and given to others in their networks. Typical statements included "contact with friends with texting, e-mail or phone," "good conversations with friends," and "social interaction with friends." Some participants referred specifically to connections with friends who were also in recovery. For example, one participant said, "I have friends that are also in recovery, and we have weekly Zoom meetings when we do readings from recovery books." Indeed, many participants stated that they continued to attend in-person Alcoholics Anonymous meetings and other support groups; importantly, when in-person gatherings were not possible, some participants sustained social connections through various forms of telecommunication, such as video conferencing. One participant highlighted "modifying my recovery program to respect social distancing protocols by meeting online."

Unexpectedly, some participants characterized the lack of social interactions due to COVID-19 restrictions as beneficial to their continued recovery, as it removed opportunities and temptations to drink with others. "COVID-19 has actually helped keep me from dealing with social situations where I would be more likely to want to drink," said one participant. Another commented that "inaccessibility to social drinking has curbed lots of relapses."

CONCLUSIONS: This study extends our understanding of alcohol problem resolution by highlighting the important role and functions of social connections in maintaining recovery during the COVID-19 pandemic. Our findings may inform future work, such as research on the sources and types of support that are most beneficial for recovery, whether they vary across groups (e.g., by treatment history or recovery length), and novel interventions that may focus on family members and other close contacts as conduits of recovery support rather than focusing solely on the problem drinker.

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