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Perceived social support: Its impact on length of sobriety

Carol Richert Guy

PERCEIVED SOCIAL SUPPORT: ITS IMPACT ON LENGTH OF SOBRIETY

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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by

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Approved by:

[redacted]

Dr. Janet Chang, Faculty Supervisor
Social Work

6/5/01
Date

[redacted]

Helen Leahy, Program Director
ABC Recovery Center, Inc.

[redacted]

Dr. Rosemary McCaslin, MSW Research
Coordinator

ABSTRACT

This study examined the relationship between perceived social support and length of sobriety. In particular this study investigated whether higher reports of perceived social support had an effect on an individual's length of sobriety. Sixty-seven male and female residents of an inpatient alcohol and drug treatment center participated in this study. The participants filled out questionnaires that measured their perception and appraisal of social support in addition to answering demographic questions. A Pearson's r correlation test was used to examine the relationship between the primary independent and dependent variables, perceived social support and length of sobriety.

No significant relationship was found between perceived social support and length of sobriety.

Limitations included an underrepresented sample in terms of sample size, including ethnicity, and length of sobriety. Future research should focus on gathering data from a more diverse demographic sample in a wider variety of settings, such as Alcoholics Anonymous meetings or additional inpatient or outpatient treatment centers.

ACKNOWLEDGMENTS

I wish to extend a heartfelt thank you to Dr. Janet Chang for her enduring support and guidance in this endeavor. In addition I wish to thank her for her patience and sense of humor during those times of limitless meetings and questions in the process of refining this thesis.

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DEDICATION

I dedicate this thesis project to the two most important people in my life, my beautiful daughters, Poppy and Andrea who have always been an inspiration to me and whose love, patience and understanding I could not have done without while completing this project.

I also wish to thank all my other wonderful family members; Jim and JoAnn; Megan, Matt, and Morgan; Mike; and Patti and Tom, for their support and understanding while I was all consumed with this thesis project.

And finally I dedicate this thesis work to my beloved parents, who reside now in a higher place but I know are looking upon me with pride and love.

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CHAPTER ONE

INTRODUCTION

Problem Statement

The prevalence of, and damage derived from alcohol abuse in society today is alarming. Alcohol related deaths are the third leading preventable cause of death in the United States today (McGinnis & Foege, 1993). Current estimates put the number of problem drinkers who meet the diagnostic criteria for alcohol abuse and dependence at about 14 million individuals, 7.4 percent of the United States population (Grant, Harford, Dawson, Chou, Dufour, & Pickering, 1994).

The effects of alcoholism to the individual and those affected by the alcoholic are far-reaching and disconcerting. Alcohol related problems include illness, divorce, family strife, victimization, economic problems, and automobile accidents. As the social, economic, and individual costs of these problems increase, more lives will be affected and more people will attempt to stop drinking. With this in mind research continually looks for avenues for alcoholics to find ways to stop drinking and lead productive lives. It is at the core of this

study to investigate issues of alcoholism treatment and relapse that are associated with an individual's ability to cope with life stressors that may affect his/her ability to remain abstinent from alcohol. The importance of this study is multifarious. Not only does research in the field of alcoholism affect treatment approaches and the individual themselves, but society will benefit as a result because so many aspects of society are affected by alcohol related issues and problems.

As an individual comes to the realization that he must stop drinking, he may be able to stop without any outside help. But many individuals will decide on a treatment approach which involves either inpatient or outpatient treatment. Furthermore, various treatment approaches may use different modalities of treatment such as education, cognitive-behavioral coping skills training, social skills training, and peer-oriented motivational approaches such as 12 Step meetings in treating the alcoholic (Monti & Rohsenow, 1999; Kadden, Litt, Cooney & Busher, 1992).

In addition to these types of treatment strategies to help the individual to remain abstinent from alcohol, thus preventing relapse, is the individual's ability to

recognize and utilize outside resources for help such as his/her own social support system. Previous research points to the beneficial aspects of an individual's social support system in preventing or buffering against various life stressors such as illness and disease. (Cohen & Williamson, 1991; Cohen, 1988; Cohen & Wills, 1985). Furthermore, according to Cobb (1976) an individual's social support system may act as a moderator for stress in cases of illness, death, depression, and alcoholism.

Not only is an individual's social support system seen as helping them through rough periods but the perception of social support is also a contributing factor seen in preventing depression and the abuse of alcohol (Lepore, 1992; Maton & Zimmerman, 1992). In research conducted by Peirce, Frone, Russell, Cooper, and Mudar (2000,) a cyclical pattern of relationship between social contact, perceived social support, depression and alcohol use was hypothesized and supported. With issues such as the deleterious effects of alcoholism in mind one can understand the importance of having a capable social support system or at least the perception of a social

support system in helping the newly recovering alcoholic to manage the effects of life stressors in their lives.

The purpose of this study is to examine the effectiveness of perceived social support in conjunction with preventing relapse and increasing length of sobriety among recovering alcoholics.

Problem Focus

The issues I am addressing for this study are social support and alcoholism. In response to observing many alcoholics struggle with alcoholism and the various factors that contribute to achievement of sobriety or relapse, my interest in this issue is furthered. In order for alcoholics in recovery to maintain sobriety, their ability to handle a stressful situation may be an indicator as to whether or not that individual is able to remain sober. When a recovering person feels that they do not have the resources to draw upon in times of need or stressful situations, their abilities to cope are weakened and frustration mounts, thus increasing the odds of a relapse.

One aspect of alcoholism treatment of concern is the effect of stress on the recovering individual and it's

impact on whether the alcoholic can deal with it effectively in order to remain sober. Alcoholism treatment focuses on different aspects of environmental and social factors in helping the alcoholic to achieve and maintain sobriety. For example, social skills training, education, and the development of coping skills are considered important in aiding the newly sober individual to remain abstinent from alcohol. In addition the fostering of the development of and utilization of positive support systems to use as a coping strategy or response to life stressors is seen as an important component in relapse prevention (Marlatt & Gordon, 1985; Moos, Finney, & Cronkite, 1990).

In a continuation of Marlatt and Gordon's work (as cited in Sadava & Pak, 1993) which involves their model of stress related problem drinking, Sadava and Pak (1993) provided more evidence for an association between stress and drinking. Using a general population sample of college students to examine the determinants of vulnerability to drinking, their research found that an absence of social support, along with an external locus of control, depression, and the coping function of drinking did have an effect on predicting problem

drinking. Likewise research conducted by Brown, Vik, McQuaid, Patterson, Irwin, and Grant (1990) found that alcoholic men who relapsed during the first three months after alcohol treatment reported more severe stress than the men who were able to abstain from drinking during that time. The researchers also found a reciprocal effect of stress and alcohol use, that is, alcohol use can bring about stress also.

With such issues in mind as vulnerability to stress, coping strategies, social support resources or the perception of them in relationship to alcoholism, it is important to study this problem because of the impact it has on society, culture and the individual. In respect to treatment approaches, it is important to study the problem of alcoholism because it will serve to provide knowledge that will benefit the treatment that an individual receives while in an alcohol treatment facility.

This research will contribute to social work practice in three ways. First, it will generate information that will help social workers better understand the relationship between recovering alcoholics and their social support systems. Secondly, it will

extend the social workers knowledge base of relapse prevention theory enabling them to provide concrete intervention strategies to the alcoholic to empower the alcoholic with the tools to moderate stressful life events and maintain sobriety. Thirdly, it will provide information that can lead to new and effective treatment approaches in the field of alcoholism. In looking at an agency where the treatment of alcoholics takes place, their interests are twofold. They may have many clients who have few avenues for social support and who do not know how to develop such avenues. The present research will enable the agency to address this aspect of treatment and develop new methods of treatment to empower the client to find ways to develop effective social support systems for themselves. With this in mind the research question is posed: How does perceived social support affect the recovery process of the alcoholic and increase length of sobriety?

CHAPTER TWO

LITERATURE REVIEW

According to Cobb (1976), an individual's social support system may be defined as information from others that one is valued and part of a network of communication and mutual aid process. In addition, this support may come from close friends, relatives or other social and community persons who are connected to that person in some way to help them. Much research has been conducted on the effects of social support as a coping strategy in

ationship to stress (Cohen & Wills, 1985; Turner

f studies that looked at the

stress and social support, Cohen and

t social support might act as a buffer

of stressful events in various ways.

ducing the appraisal of the stressor,

g styles, or by affecting the

individual. Likewise, in research

four studies, Turner (1981) found that

cts as a buffer in instances of stress.

Their findings suggest a somewhat conservative

relationship between social support and an individual's

psychological well being but with social support having a direct effect in stressful situations.

For example, coping and one's social support system have been indicated in lessening some of the psychological effects of an individual losing his/her job. In fact, social support in particular was indicated as a component in reducing the elevation of depression in individuals who had experienced job loss by preventing the loss of self-esteem of the individual (Pearlin, Menaghan, Leiberman, & Mullan, 1981).

Thoits (1986) looked at social support as a coping mechanism in the form of coping assistance. She identified two important components in the individual's ability to ask for coping assistance. These are similarity and empathic understanding from the one sought for the coping assistance. In other words, the social support system that one is seeking assistance from must have an empathetic understanding towards the seeker of the assistance.

Along these same lines research conducted by Cutrona (1986) examined the social networks of 50 elderly adults and 71 mothers of 1 year-old children to determine an association with perceived availability of social

support. Perceived social support and social networks were measured using self-report questionnaires. Their findings suggested that for the elderly, the more kin and nonkin in the social network and contact with them demonstrated a stronger link between the social network and perceived social support than with the mothers. However the researchers did note that both populations in the study were not considered to be under any substantial stress at the time of the study. With this in mind the researchers further acknowledged that it is possible the findings could have been different if either of the two studied populations had been under a highly stressful situation at the time of the study.

Nevertheless other research has been conducted that demonstrates a link between alcoholism and social support. Utilizing a large sample (1,418) of elderly men and women from the general population, Jennison (1992) found that a significant relationship existed between individuals who experience highly stressful events and an increase in their consumption of alcohol. Conversely the researchers found that higher levels of social support, such as spouse, family, friends, and church might have a

buffering effect which may protect the individual from drinking too much during stressful times.

Beattie and Longabaugh (1997) conducted research to investigate relationships between interpersonal factors and their role in alcohol use post-treatment. They analyzed data from questionnaires filled out by 140 subjects, 12 months after alcohol treatment. In looking at associations between post-treatment indicators of social relationships and drinking behaviors, Beattie and Longabaugh found that perceived social support was related positively to the size of an individual's social network. In addition, the length of sobriety was positively related to the social relationships (social supports) of important others. Encouragement of non-drinking behaviors, average drinking status, and rootedness in an alcohol free life-style were interrelated with almost 80% alcohol abstinence of the alcoholics in the study. Thus a connection is seen between the social supports one has and abstinence from alcohol.

Other research into late-life drinking indicates that older adults have higher relapse rates (Atkinson, 1995). With this in mind, further research into late-life

drinking has been conducted by Brennan and Moos (1990) and Moos, Brennan, and Schutte (1998). Brennan and Moos (1990) investigated the relationships among stress, social resources and 501 middle-aged problem drinkers and 609 non-problem drinkers. Their findings indicated that the late-middle-aged adult drinkers experience more stressors and negative life events than the non-problem drinkers do. They also have fewer supports than do the non-problem drinkers. The researchers maintain that these findings indicate that these factors may play a role in maintaining late life drinking. In a similar longitudinal research study conducted by Moos, Brennan, and Schutte, risk factors such as being male, early onset, and having friends who approved of drinking were associated with more drinking problems. Also stressful relationships with friends and spouse were associated with drinking problems. Thus the lack of a positive social support system appears to be an important factor in problem drinking.

Further research by Peirce, Frone, Russell, Cooper, and Mudar (2000) was conducted using data obtained from a random sample of over 1000 adults. Longitudinal relations among an individual's social contacts, perceived social

support, depression, and alcohol use were investigated. Results found that being in contact with friends, family and participating in groups leads to perceived social supports. In addition, the researchers found that perceived social support was negatively related to depression. Furthermore, the findings demonstrated that depression was related to alcohol abuse and the alcohol abuse was indirectly positively related to depression. In other words, according to the researchers' findings, depression through alcohol abuse is indirectly associated with low social contact and perceived social support.

Barber and Crisp (1995) in Australia conducted additional research that examined post treatment factors in relapse. Thirty participants were randomly assigned to three different types of social support interventions as part of a process to refine the Community Reinforcement Approach (CRA), a relapse prevention strategy that creates artificial support systems for those who don't have adequate support available to them. The researcher's findings indicated that the artificially created support systems were not effective in preventing relapse but that the degree of support provided by one significant person in the social environment of the alcoholic was a better

predictor of reduced consumption. Previous research conducted by Havassy, Hall, and Wasserman, (1991) also found that specific types of social support in the form of general structural support, greater social integration, abstinence-specific support, and having a partner were linked to lower relapse risk among alcoholics and drug users. Therefore, the implications of social support as an intervention strategy in relapse prevention are important to consider.

Still other research conducted by Wills and Vaughan (1989) examined methods of coping that use support seeking from peers and adults as related to two types of substance abuse, alcohol use and cigarette smoking. Junior high school adolescents with a mean age of 12.2 years were the subjects for this research. The students filled out questionnaires that included items on psychosocial factors, coping responses, and alcohol and cigarette use. Results from this study found that in terms of peer and adult support, peer support increased the chances of adolescent use of smoking and alcohol. However adult support was inversely related to adolescents' usage of cigarettes and alcohol. In addition, support from peers increased the probability of

substance use when the adult support was low. The results from the research of Wills and Vaughan demonstrate the importance of evaluating support from different age cohorts. The issue of what kind of support is offered, such as emotional, financial, informational, or perceived social support also needs to be addressed.

Similarly, the results of an analysis of secondary data derived from the National Survey of Children, Wave III, 1987 (age 12 - 23 yrs.) produced mixed results in regards to the relationship between social support, certain demographic variables, and the use of alcohol and other drugs [AOD] (Christmon, 1994). Results indicated that age, gender, race and community involvement interacted with two other types of social support and AOD in producing various mixed results. For instance, high levels of social support satisfaction were related to the use of AOD. While a large social network of support and community participation was related to not having used AOD at all.

Because of the uniquely different environment that an alcoholic finds himself or herself in as a sober person their ability to regulate stress may be compromised. According to Marlatt and Gordon (1985),

stress-induced relapse is common in the recovery process and presents a challenge to all who are involved in the alcoholic's life. Similar research examined the associations between stress, vulnerability and relapse (Brown, Vik, Patterson, Grant, & Schuckit 1995). The research participants, 67 abstinent alcoholic men who were vulnerable to chronic stress, were followed as they entered treatment, at 3 months, and at 1 year. The results indicated that the men who were able to use more coping resources were less likely to relapse when under severe stressful situations than the men who had decreased coping resources to call upon. In addition, as the men's coping skills and self-efficacy changed with time, by reducing their vulnerability to stress, so did their ability to remain abstinent from alcohol after treatment.

Therefore, the present study will investigate how the alcoholic's perception of their social support system (i.e., perceived social support, social demographics, and gender) is related to the alcoholic's ability to cope with stressful situations and thus increase length of sobriety.

CHAPTER THREE

METHOD

Design

This research utilized a survey design using a self-administered questionnaire. This type of research method was chosen because of its convenience and practical approach. In addition this research method provided the study participants with a substantial amount of confidentiality.

This study examined the relationship between perceived social support and length of sobriety. The research question asked whether there was a relationship between an individuals' perceived availability of social support and their length of sobriety. The primary independent variable I examined was perceived availability of social support. Other independent variables examined in relationship to length of sobriety included the demographic variables such as age, gender, ethnicity, marital status, educational level, income, and two questions about importance of receiving help from others and who has been most helpful to the individual.

Sample

The study sample consisted of 67 participants who were selected on the basis of age and self-identification as an alcoholic in recovery. There were 30 females and 37 males. All participants were between the age of 18 and 72 years and were residents from an alcohol and drug treatment center in Indio, California. The original design of the study carried the option of gathering data from members of AA meetings in the area but because of the availability of the study participants from the treatment center it was decided for purposes of time constraints not to gather data from AA meetings.

The sample was drawn using a non-probability convenience sampling method because of its convenience and practicality. Because of the difficulty in identifying potential participants, the researcher endeavored to make all attempts to include a diverse sample of participants with respect to age, gender and ethnicity to increase the representativeness of the sample.

Data Collection

Written permission in the form of a letter was obtained from the director of the alcohol and drug treatment facility prior to conducting the research study there. Before handing out the questionnaires the study participants were asked if they would like to participate in a research study voluntarily. After permission was obtained, the questionnaires were handed out to the study participants to fill out in a group format before their treatment group began. An informed consent form, debriefing form, and a listing of a phone number to a local counseling center were attached to each questionnaire and handed out along with the questionnaire to the study participants. The participants were asked to sign the consent form before they began to fill out the questionnaire. The questionnaire was provided in English only.

The study participants were asked questions concerning their feelings about their perceived availability of social support from family and friends in addition to various demographic questions such as age, gender, income, and marital status and length of sobriety.

Instruments

Two quantifiable instruments (See Appendixes B, and C) and a demographic page (See Appendix A) were used in the data collection. The instrument that was used to measure perceived social support was the Multidimensional Scale of Perceived Social Support [MSPSS] (Zimet, Dahlem, Zimet, & Gordon, 1988) [See Appendix B]. The MSPSS is a 12-item instrument that measures perceived social support. The 12 items are set on a 7-point Likert-type scale ranging from 1, "very strongly disagree" to 7, "very strongly agree". It is divided into three subscales of items that pertain to family, friends, and significant other. Scoring is accomplished by summing up the individual item scores and then dividing them by the number of the items. Higher scores represent higher perceived social support. The MSPSS has good internal reliability with alphas of .91 for the entire scale and .90 and .95 for the subscales. Good construct validity is reported by the authors as well as good factorial validity when correlated with depression. It had a Chronbach's alpha of .87 for the study sample. In addition the MSPSS has been studied with various diverse populations. (Zimet et al, 1988).

In order to measure subjective appraisals of social support, the Social Support Appraisals Scale [SS-A] (Vaux, Phillips, Holley, Thompson, Williams, & Stewart, 1986) was used (See Appendix C). The SSA differs from the MSPSS in that it measures social support through the individuals' belief or affective appraisal that he/she is loved, esteemed, or involved with family rather than measuring the extent of perceived social support from others as the MSPSS does. The SSA is a 23-item scale based on the individuals' appraisal that social support is only social support when it is believed to be available. It examines the extent that individuals believe they are loved, esteemed, and involved with family and significant others in their lives. The scale is based on a 4-point Likert-type scale ranging from 1, "strongly agree" to 4, "strongly disagree". Scoring is accomplished by adding up the individual items after reverse scoring items 3, 10, 13, 21, and 22 to gain a total score. Lower scores indicate stronger levels of subjective appraisal of social support. The SSA reports good internal consistency with alpha coefficients ranging from .81 to .90. For this sample an alpha of .93 was obtained. The SSA also reports very good concurrent and

construct validity having strong correlation and predicted associations with various measures of social support and psychological well-being such as network satisfaction, perceived support, depression, and the SCL-90.

Procedure

Data was collected by means of handing out the questionnaires to the participants in a group setting and asking them to please fill them out. The researcher of this study handed out the questionnaires to the participants and removed herself from the room while they were completing them, thus reducing the Hawthorne effect of a bystander bias. A large manila envelope was set out for the participants to put the completed questionnaires in when they had finished filling them out. Total time to complete the questionnaire took approximately 10 minutes. After the study participants completed filling out the questionnaire and placing it in the envelope they were given a candy bar as a form of thank you for participating in the study.

The study participants were asked questions concerning their feelings about social support from

family and friends in addition to various demographic questions such as age, gender, income, and marital status and sobriety length. All data collection, coding, cleaning, and maintenance of data was done by the researcher. Data analysis and final work on the research project was completed during the Spring quarter, 2001.

Protection of Human Subjects

Maintaining the confidentiality and anonymity of the study participants was a primary concern of this researcher and all efforts were made on her part to accomplish this. For sake of protecting the participants' anonymity and inputting the data, a numbering system was utilized. No participant names were used. Study participants were asked to sign informed consents before they participated in the study and they were told that they could stop at any time during the study (See Appendix D). The participants were given debriefing statements with the names of the researcher and the advisor along with a phone number to contact the researchers if they had any questions concerning the study (See Appendix E).

Data Analysis

Univariate analysis using descriptive statistics such as frequency distribution, percentages, measures of central tendency, and measures of dispersion were used to examine the demographic variables including age, gender, education, marital status, and ethnicity along with the primary independent variable, perceived social support (nominal and ratio level data).

As stated previously the purpose of this quantitative study was to examine the relationship between perceived social support and length of sobriety. The primary independent variable is perceived availability of social support (ordinal/interval level data) measured by the two scales, the MSPSS and the SSA. The dependent variable is length of sobriety measured by self-reports of abstinence from alcohol (interval/ratio level data). In order to examine the relationship between the independent variables and the dependent variable, bivariate analysis of statistics, such as Student T test and Pearson's r were used. For example, an Independent Samples t-test was used to compare the mean scores between gender and length of sobriety. It was also used

to determine gender differences in length of sobriety and social support.

The research question was analyzed using the Pearson's r correlation test. This was used to test the strength and direction of the relationship between the independent variable, perceived availability of social support and the dependent variable, length of sobriety.

Lastly, an ANOVA was conducted to examine the relationship between marital status (nominal data), and perceived social support as measured by the two instruments, MSPSS and SSAS (interval data).

CHAPTER FOUR

RESULTS

Table 1 presents the demographic characteristics of the participants of this study. Of the 67 participants in the research study, 45% were female and 55% were male. The age range was 18 to 72 years with a mean of 36.6 years (SD = 12.17). The majority of the participants in this study were White (64.2%) while almost one-fourth were Hispanic (23.9%). All other ethnic groups were underrepresented in the study as indicated by a relatively small number of Native Americans (4.5%), African Americans (4%), and other ethnic backgrounds (3%). In regards to the education level of the research participants, about half (46.2%) were high school graduates and over one-fourth (26.2%) reported some college education. About one-fifth (21.5%) had less than a high school education. In addition, three participants reported having graduate degrees and one reported being a college graduate. Over one third (38%) of the participants were unmarried while 21% of the participants were married. About 28% were divorced or separated, 3.0%

were widowed and 7.5% were living with a significant other.

In regards to the participants reporting of their length of sobriety at the time they filled out the questionnaires, over 70% had two months or less of sobriety. Slightly over 11% had up to six months of sobriety and 7.8% had between 6 months and 11 months sober time. Three participants had between one year and two years of sobriety and three participants had over two years sobriety with one individual reporting 16 years of sobriety (See Table 1). The mean for length of sobriety was 6.86 months.

In response to the question, "How important is it to you to have someone to talk to when you have a problem", over 65% of the participants responded "very important" while about 28% responded "somewhat important" to the question. Three percent responded "a little important" and "not very important" respectively. In response to the question, "Who has been the most helpful to you when you need someone to talk to", almost 27% responded a friend, 13.4% responded parents, 11.9% responded spouse and other respectively, while 10% responded spouse, parents, friend, other/sponsor.

The means and standard deviations for the MSPSS scale are shown in Table 2. As can be seen, the range for the mean score of the items was from 3.78 to 5.58. Item seven, "I can count on my friends when things go wrong" yielded the lowest item score, while item ten "There is a special person in my life who cares about my feelings" yielded the highest item score.

Table three displays the frequencies for the SSAS scale. As can be seen a wide range of responses was given. For example, in response to the item, "My family cares for me very much" almost 90% of the respondents responded they either "strongly agree" or "agree". Similarly the respondents responded highly to another item about family relationships as 80% "strongly agreed" or "agreed" to the item, "I am loved dearly by my family." In contrast more than half of the respondents, 53%, either "disagreed" or "strongly disagreed" to the item, "I am held in high esteem". Furthermore, in responding to the item, "My family really respects me," the respondents were divided in their responses with slightly more than half, 56% responding they "strongly agreed" or "agreed". Taken together these analyses provide some support towards respondents' reporting

moderate levels of social support. However they do not feel respected by their families and they suffer from low self-esteem.

The results of the Pearson's r test failed to support what the research question was asking, "Does perceived social support have an effect on length of sobriety?" A nonsignificant relationship was found in the correlation test between length of sobriety and the MSPSS. In addition the results of the Pearson's r test between length of sobriety and the SSA was nonsignificant.

An independent samples t-test comparing gender differences in length of sobriety was conducted. It indicated females, mean = 9.77 having almost twice as much sobriety as males, mean = 4.29. However the results of an independent samples t-test were not statistically significant in determining gender differences between length of sobriety and social support.

A one-way ANOVA conducted on marital status and the MSPSS found a modest significant difference between groups, $F(1, 61) = 2.45$, $p = .04$. Respondents who were living with a significant other were found to report the highest level of support than those who are married,

divorced, separated, or widowed. Yet the unmarried group had only slightly less reports of support than the living with a significant other group. However an ANOVA conducted on marital status and the SSAS revealed no significant differences.

CHAPTER FIVE

DISCUSSION

The purpose of this research study was to investigate the relationship between perceived social support and alcoholics in recovery from alcoholism. Specifically this study examined whether there is an association between an individual's perception of social support and how long they have remained sober or their length of sobriety.

The results from this study demonstrated no relationship between perceived social support and length of sobriety. However, there are some methodological issues to consider in the findings.

The primary methodological concern of interest is the choice of the sample itself. Although the researcher made all attempts to obtain a diverse sample representative of any individual who suffers from alcoholism and is in recovery, the sample was too small with about 70% less than two months sober.

In addition, because the sample taken from the agency were newly sober alcoholics in the early stages of the recovery process, there was not enough variance in

length of sobriety to compare with perceived social support.

Still another issue to be considered with this study concerns itself with the sample also. As the participants of the study were residents at the inpatient facility, it is known that a majority of the inpatient clients there receive services paid for by the state. Thus they are not representative of alcoholics in recovery in general as we know that alcoholism can affect anyone regardless of their gender, ethnic background, or socioeconomic status. In addition, over 60% of the sample was white, thus limiting the generalizability of the results to various other ethnic groups.

Furthermore even though the female alcoholic participants were underrepresented in this study the female alcoholics reported longer lengths of sobriety than the males. This may indicate that females are more motivated in participating in their recovery process than males. The reasons for this may have to do with the fact that many female alcoholics need to care for children and are motivated to seek and participate in treatment so that they may return to their homes and children.

The marital status of the sample also had modest significant results in relationship to social support. Respondents, who reported living with a significant other reported higher levels of social support than the married or unmarried group. What does this tell us about a co-habitating population within the alcoholic population? Does living together help couples to adjust to outside pressures more easily than being married? Perhaps the co-habitating individuals feel less pressure to conform to the marital norms of society so there is less pressure on them. Much research does point to the high rate of divorce in marriages where one or both of the spouses have an alcohol problem. In this sample over one third of the study's respondents were unmarried, while another third of the respondents were divorced or separated. Thus a possible indication is that those in early sobriety are experiencing many difficulties when it comes to relationships.

This study produced a range of the means from 3.78 to 5.58 for the MSPSS scale indicating participants lower overall perception of social support. In contrast, the mean score for a college sample was from 5.38 to 6.01 in the initial study with the scale (Zimmet, Dahlem, Zimet,

& Farley, 1988). A possible reason for this could be related to the sample chosen for this study and the difficulties that continued use of alcohol can create within the alcoholic's social support systems.

However, the SSA did provide a few surprising patterns in some of the responses to the items on the scale. For instance in responding to the item, "I am not important to others" only three respondents answered "strongly agree" while half of the respondents answered "disagree and strongly disagree." This may indicate a trend towards friends or peers as being a source of support to an individual. In addition, the responses to items about family such as, "My family cares for me very much" and "I am loved dearly by my family" indicated higher levels of social support appraisal from family. However, the responses to the items about self-esteem and respect from the family were divided. This may signify that the alcoholic participants feel loved by their families but do not feel respected, and thus suffer from low self-esteem. Furthermore, in response to the item, I can't rely on my family for support," over half of the respondents responded "strongly agree or agree." This could also be indicative of the animosity from family and

friends that many alcoholics experience while in the midst of their active alcoholism. Thus a trend emerges that indicates the importance of others, friends, peers, or perhaps an AA sponsor as being important to an individual in the recovery process.

Implications for Theory, Research, and Practice

Implications for theory include applying the person in environment approach to the alcoholic in recovery. This is indicated because of the many different issues that individuals encounter in the recovery process. This would also include looking at gender differences in regards to how male and female alcoholics utilize social support systems in response to their diverse needs. As social workers discover new ways to help the alcoholic through the recovery process, treatment approaches could be modified to fit the individual and their support systems.

Limitations and Directions for Future Research

This study had several limitations. The central one is the issue of the majority of the participants' very short lengths of sobriety. Because of this there was no

way to measure an association between perceived social support and length of sobriety. Also the small size of the sample in addition to the participants being recruited from only one alcohol treatment center limits the validity of the findings from this study.

Although no association was found between perceived social support and length of sobriety, the agency where the participants were drawn from is a very peer oriented facility that emphasizes social support as a tenant of recovery. This could also have had an effect on the results of this study because the participants might have already been predisposed to the concept of social support regardless of length of sobriety.

While the findings were not what was expected, this research contributes to social work practice because it has generated information that can help social workers better understand the relationship between alcoholics in the early stages of recovery and their ability to utilize social supports. The findings from this study indicate social support is important even during the early stages of recovery. Social workers who work in the field of alcohol and drug treatment need to be aware of this and

create interventions that address this important phase of the recovery process.

Future research should examine the issue of gender differences in regards to how males and females cope or perceive their ability to cope when they are under stress while in the recovery process. With this in mind future research could focus more on examining which sources of social support are most effective in helping an alcoholic to cope with stressful situations and how they use their social support systems during stressful periods. Furthermore a wider range of settings such as Alcoholics Anonymous meeting is preferred to provide a more diverse study sample in regards to ethnicity and length of sobriety.

APPENDIX A

DEMOGRAPHICS

DEMOGRAPHICS

Now would you please tell us a little about yourself. Please mark your answer with an X.

1. What is your gender?
   ( ) 1. Female
   ( ) 2. Male

2. What is your ethnic or cultural background?
   ( ) 1. African American
   ( ) 2. Asian American/Pacific Islander
   ( ) 3. Hispanic/Latino(a)
   ( ) 4. Native American
   ( ) 5. White
   ( ) 6. Other, Specify

3. How old are you: _____

4. What is your marital status?
   ( ) 1. Married
   ( ) 2. Unmarried
   ( ) 3. Widowed
   ( ) 4. Living with a Significant Other
   ( ) 5. Divorced or Separated

5. What is your highest level of education completed?
   ( ) 1. Less than high school
   ( ) 2. High school graduate
   ( ) 3. Some college
   ( ) 4. College graduate
   ( ) 5. Graduate degree

6. How long have you been sober?
   _____ (months)

7. How important is it to you to have someone to talk to when you have a problem?
   ( ) 1. Very important
   ( ) 2. Somewhat important
   ( ) 3. A little important
   ( ) 4. Not very important
   ( ) 5. Not important at all

8. Who has been the most helpful to you when you need someone to talk to? Circle all that apply.
   1. Spouse 2. Siblings 3. Parents 4. Friend 5. Other

APPENDIX B

PERCEIVED SOCIAL SUPPORT

SCALE

Perceived Social Support Scale

The following statements are about your relationships with family and friends. Please read each statement carefully and indicate how you feel about each statement by circling the correct number on the number scale.

1 = Very strongly disagree

2 = Strongly disagree

3 = Mildly disagree

4 = Neutral

5 = Mildly agree

6 = Strongly agree

7 = Very strongly agree

1.	There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2.	There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3.	My family really tries to help me.	1	2	3	4	5	6	7
4.	I get the emotional help and support I need from my family.	1	2	3	4	5	6	7
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6.	My friends really try to help me.	1	2	3	4	5	6	7

7.	I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8.	I can talk about my problems with my family.	1	2	3	4	5	6	7
9.	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10.	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11.	My family is willing to help me make decisions.	1	2	3	4	5	6	7
12.	I can talk about my problems with my friends.	1	2	3	4	5	6	7

APPENDIX C

SOCIAL SUPPORT APPRAISALS

SCALE

Social Support Appraisals Scale

The following statements are about your relationships with family and friends. There are no right or wrong answers. Please read each statement carefully and circle the number on the scale that corresponds to if you strongly agree, agree, disagree, or strongly disagree with it.

		Strongly Agree	Agree	Disagree	Strongly Disagree
1.	My friends respect me.	1	2	3	4
2.	My family cares for me very much.	1	2	3	4
3.	I am not important to others.	1	2	3	4
4.	My family holds me in high esteem.	1	2	3	4
5.	I am well liked.	1	2	3	4
6.	I can rely on my friends.	1	2	3	4
7.	I am really admired by my family.	1	2	3	4
8.	I am respected by other people.	1	2	3	4
9.	I am loved dearly by my family.	1	2	3	4
10.	My friends don't care about my welfare.	1	2	3	4
11.	Members of my family rely on me.	1	2	3	4
12.	I am held in high esteem.	1	2	3	4
13.	I can't rely on my family for support.	1	2	3	4
14.	People admire me.	1	2	3	4

15.	I feel a strong bond with my friends.	1	2	3	4
16.	My friends look out for me.	1	2	3	4
17.	I feel valued by other people.	1	2	3	4
18.	My family really respects me.	1	2	3	4
19.	My friends and I are really important to each other.	1	2	3	4
20.	I feel like I belong.	1	2	3	4
21.	If I died tomorrow, very few people would miss me.	1	2	3	4
22.	I don't feel close to members of my family.	1	2	3	4
23.	My friends and I have done a lot for one another.	1	2	3	4

APPENDIX D

INFORMED CONSENT

Informed Consent

The study in which you are about to participate is designed to investigate recovering alcoholics and their social support system. This study is being conducted by Carol Guy, Graduate student under the supervision of Dr. Janet Chang, Professor of Social Work. This study has been approved by the Department of Social Work Sub-Committee of the Institutional Review Board at California State University, San Bernardino. The university requires that you give your consent before participating in this study.

In this study you will be asked to respond to statements about your relationships with family and friends. There are no right or wrong answers. Completion of this questionnaire should take approximately 10 minutes. All of your responses will be held in the strictest of confidence by the researcher. No names will be used in the questionnaire or in any part of this research study.

Your participation in this research study is completely voluntary. You are free to withdraw at any time. In order to ensure the validity of this study, the researcher asks that you not discuss this study with other participants.

If you are interested in the results of this study, copies will be available in the Phau Library at California State University, San Bernardino after June 2001. If you have any questions about the research at any time, you may contact Dr. Janet Chang at (909) 880-5184.

Please check the box below to indicate you have read this informed consent and freely consent to participate in this study.

Please place a check mark here ☐ Date: _____

APPENDIX E

DEBRIEFING STATEMENT

Debriefing Statement

Thank you for participating in this study.

The study in which you have just participated will explore an individual's perception of their social support system. In this study questions about relationships with families and friends were asked. This study is particularly interested in the ways that a person's social support system may be helping them to remain abstinent from alcohol or sober. All information collected will be kept anonymous and confidential. Thank you for not discussing the nature of this study with other participants. If you have any questions about this study, please feel free to contact Professor Janet Chang at (909) 880-5184. If you would like to obtain a copy of this study, please refer to the library at California State University, San Bernardino after June, 2001.

APPENDIX F

TABLE ONE

Demographic characteristics of the participants

Variable	Frequency (n)	Percentage (%)
Gender (N = 67)		
Female	30	48%
Male	37	55.2%
Age (N = 62)	(M = 36.6 years)	(SD = 12.17)
18-30	19	30.6%
31-40	22	31.2%
41-50	12	19.35%
51 & older	9	14.51%
Ethnicity (N = 67)		
African American	3	4.5%
Hispanic	16	23.9%
Native American	3	4.5%
White	43	64.2%
Other	2	3.0%
Education (N = 65)		
Less than high school	14	21.5%
High school graduate	30	46.2%
Some college	17	26.2%
College graduate	1	1.5%
Graduate degree	3	4.6%
Marital (N = 66)		
Married	14	20.9%
Unmarried	26	38.8%
Widowed	2	3.0%
Living w/ significant other	5	7.5%
Divorced or separated	19	28.4%
Length of Sobriety (N = 64)		
Less than 21 days	20	31.2%
1-2 Months	26	40.62%
3-6 Months	7	11.1%
7-11 Months	5	7.8%
12 Months - 24 Months	3	4.68%
24 Months - 192 Months	3	4.68%

Important to talk to someone about problems (N = 67)		
Very Important	44	65.7
Somewhat important	19	28.4
A Little important	2	3.0
Not very important	2	3.0
Who has been the most helpful? (N = 67)		
Spouse	8	11.9
Siblings	2	3.0
Parents	9	13.4
Friend	18	26.9
Other	8	11.9
Spouse, Parents,	3	4.5
Spouse, Friend, or Other	5	7.5
Spouse, Parents, Friend, Other, Sponsor	7	10.4
Various combinations of Spouse, Siblings, Parents, Friend, Other	7	10.4

APPENDIX G

TABLE TWO

Means and Standard Deviations for Multidimensional Scale of Perceived Social Support

MSPSS Items		M	SD
1.	There is a special person who is around when I am in need.	4.95	2.03
2.	There is a special person with whom I can share my joys and sorrows.	4.99	1.86
3.	My family really tries to help me.	5.37	2.04
4.	I get the emotional help and support I need from my family.	4.47	2.21
5.	I have a special person who is a real source of comfort to me.	5.07	2.00
6.	My friends really try to help me.	4.01	1.79
7.	I can count on my friends when things go wrong.	3.78	1.86
8.	I can talk about my problems with my family.	4.26	2.01
9.	I have friends with whom I can share my joys and sorrows.	4.56	1.68
10.	There is a special person in my life who cares about my feelings.	5.58	1.75
11.	My family is willing to help me make decisions.	4.94	1.95
12.	I can talk about my problems with my friends.	4.43	1.67

APPENDIX H

TABLE THREE

Frequencies for Social Support Appraisals Scale

SSAS Items	Frequency (N)	Percentage (%)
1.) My friends respect me.		
Strongly agree	13	19.7
Agree	39	59.1
Disagree	11	16.7
Strongly disagree	3	4.5
2.) My family cares for me very much.		
Strongly agree	40	61.5
Agree	18	27.7
Disagree	2	3.1
Strongly disagree	5	7.7
3.) I am not important to others.		
Strongly agree.	3	4.5
Agree	12	18.2
Disagree	31	47.0
Strongly disagree	20	30.3
4.) My family holds me in high esteem.		
Strongly agree	8	12.3
Agree	33	50.8
Disagree	16	24.6
Strongly disagree	8	12.3
5.) I am well liked.		
Strongly agree	12	18.5
Agree	41	63.1
Disagree	11	16.9
Strongly disagree	1	1.5
6.) I can rely on my friends.		
Strongly agree	8	12.1
Agree	29	43.9
Disagree	22	33.3
Strongly disagree	7	10.6

7.) I am really admired by my family.

Strongly agree	12	17.9
Agree	25	37.3
Disagree	20	29.9
Strongly disagree	10	14.9

8.) I am respected by other people.

Strongly agree	7	10.6
Agree	43	65.2
Disagree	13	19.7
Strongly disagree	3	4.5

9.) I am loved dearly by my family.

Strongly agree	34	52.3
Agree	18	27.7
Disagree	9	13.8
Strongly disagree	4	6.2

10.) My friends don't care about my welfare.

Strongly agree	8	12.1
Agree	14	21.2
Disagree	32	48.5
Strongly disagree	12	18.2

11.) Members of my family rely on me.

Strongly agree	11	16.4
Agree	31	46.3
Disagree	14	20.9
Strongly disagree	11	16.4

12.) I am held in high esteem.

Strongly agree	3	4.7
Agree	27	42.2
Disagree	25	39.1
Strongly disagree	9	14.1

13.) I can't rely on my family for support.

Strongly agree	13	19.7
Agree	23	34.8
Disagree	11	16.7
Strongly disagree	19	28.8

14.) People admire me.

Strongly agree	6	9.0
Agree	38	56.7
Disagree	19	28.4
Strongly disagree	4	6.0

15.) I feel a strong bond with my friends.

Strongly agree	9	13.4
Agree	31	49.3
Disagree	21	31.3
Strongly disagree	4	6.0

16.) My friends really respect me.

Strongly agree	8	11.9
Agree	28	41.8
Disagree	27	40.3
Strongly disagree	4	6.3

17.) I feel valued by other people.

Strongly agree	6	9.0
Agree	39	58.2
Disagree	20	29.2
Strongly disagree	2	3.0

18.) My family really respects me.

Strongly agree	11	16.7
Agree	26	39.4
Disagree	21	31.4
Strongly disagree	8	12.1

19.) My friends and I are really important to each other.

Strongly agree	6	9.1
Agree	33	50.0
Disagree	19	28.8
Strongly disagree	8	12.1

20.) I feel like I belong.

Strongly agree	11	16.7
Agree	30	45.5
Disagree	16	24.2
Strongly disagree	9	13.6

21.) If I died tomorrow, very few people would miss me.

Strongly agree	5	7.5
Agree	12	17.9
Disagree	31	46.3
Strongly disagree	18	26.7

22.) I don't feel close to members of my family.

Strongly agree	6	9.2
Agree	17	26.2
Disagree	23	35.4
Strongly disagree	19	29.2

23.) My friends and I have done a lot for one another.

Strongly agree	8	2.1
Agree	29	43.9
Disagree	20	30.3
Strongly disagree	9	13.6

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