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Significant Life Events and Their Impact on Alcohol and Drug Use: A Qualitative Study

Martha A. Jessup, R.N., Ph.D.^a, Thekla Brumder Ross, Psy.D.^b, Ashley L. Jones, Psy.D.^b, Derek D. Satre, Ph.D.^c, Constance Weisner, Dr.P.H., L.C.S.W.^d, Felicia Chi, M.P.H.^e, and Jennifer R. Mertens, Ph.D.^f

^aProfessor Emerita, Institute for Health & Aging, School of Nursing, University of California, San Francisco, CA; and Senior Research Consultant, Division of Research, Kaiser Permanente Northern California, Oakland, CA

^bResearch Behavioral Health Clinician, Division of Research, Kaiser Permanente Northern California, Oakland, CA

^cAdjunct Investigator, Division of Research, Kaiser Permanente Northern California, Oakland, CA; and Associate Professor, Department of Psychiatry, University of California San Francisco, San Francisco, CA

^dChief, Behavioral Health, Aging and Infectious Disease Research, Division of Research, Kaiser Permanente Northern California, Oakland, CA; and Professor, Department of Psychiatry, University of California San Francisco, San Francisco, CA

^eSenior Data Consultant, Division of Research, Kaiser Permanente Northern California, Oakland, CA

^fResearch Scientist, Division of Research, Kaiser Permanente Northern California, Oakland, CA

Abstract

This study used a life-course perspective to identify and understand life events related to long-term alcohol and other drug (AOD) use trajectories across the life span. Using a purposive sample, we conducted semi-structured telephone interviews with 48 participants (n=30 abstinent and 18 non-abstinent) from a longitudinal study of AOD outcomes 15 years following outpatient AOD treatment. A content analysis was conducted using ATLAS.ti software to identify events and salient themes. Caregiving for an ill or dependent family member was related to better AOD outcomes by reinforcing abstinence and reduced drinking, and contributing to alcohol cessation in most individuals who cited caregiving as a pivotal event. Grandparenting and parenting an adult child were motivational for sustaining abstinence and reduced drinking. Findings were mixed on death of a loved one which was related to abstinence in some and relapse in others. Redemption and mutual fulfillment as caregivers, reconciliations with adult children, and legacy-building as grandparents were themes associated with maintaining abstinence and reduced drinking. AOD treatment has the opportunity to employ motivational interventions for relapse prevention that

address the meaning and life-long reach of intimate relationships for individuals and their AOD use across the life span.

Keywords

life events; life course; substance use; qualitative; caregiving; relationships

INTRODUCTION

Life span theory (Erikson 1963) identifies life events, transitions, and role adaptation as critical influences on human development. A life course perspective for alcohol and other drug (AOD) research acknowledges changing patterns of AOD use over a lifetime and the importance of social context and life events in terms of their influence on shifts in AOD use and problem trajectories (Braveman & Barclay 2009; National Institute on Alcohol Abuse and Alcoholism 2008). For example, marriage among young adults protects against development of alcohol problems later in life (Gotham, Sher, & Wood 2003) based on a 7-year longitudinal study, and is also associated with reduced alcohol use (Neve, Lemmens, & Drop 2000; Curran, Muthén, & Harford 1998). However, in a community sample of older adults followed over a six-year period, marriage and divorce were associated with both increases and decreases in drinking (Perreira and Sloan, 2001). Among older adults, negative health events may motivate reduced drinking in both men and women (Satre, Gordon, & Weisner 2007). Retirement may be a risk factor for increased drinking among some late-middle-aged individuals (Ekerdt et al. 1989). In a study of blue-collar retirees, alcohol consumption increased with involuntary retirement (Bacharach et al. 2008), and among university retirees with particularly stressful pre-retirement work environments, drinking also increased after retiring (Richman et al. 2006). In a 3-year prospective study of adults who drank at least monthly prior to baseline, the perceived acceptability of drinking and social pressures to drink or abstain were consistent correlates of their drinking cessation (Dawson et al. 2012).

In clinical populations of individuals with AOD problems, developmental life events are associated with stable changes and produce both positive and negative outcomes (Krenek & Maisto 2013; Teruya & Hser 2010). At 5, 7 and 9 years after AOD treatment, losing a life partner and marrying are both associated with lower relapse rates (Satre et al. 2012). AOD-related medical conditions detected at baseline through 1 year after AOD treatment intake predict remission from AOD use at 5 years (Mertens et al. 2008). Research on gendered responses to life events among individuals with AOD problems suggests that males may be more prone to AOD use when faced with negative life events such as death of a significant other, problems in peer relationships, and worsening health (Nordfjaern, Hole, & Rundmo 2010). In a qualitative exploration of recovery in untreated drug-dependent men and women, the desire to maintain relationships caring for children and death of a father motivated decisions to end AOD use (Granfield & Cloud 2001). Comparing community and clinical samples, there may be similarities in type of life experiences (in particular having a medical condition) that are capable of exerting influence on AOD use. Yet we know of few studies

that have examined in either group the meaning of the event as it relates to the trajectory of use over time.

Here we report results on the qualitative portion of a longitudinal study that used a life span approach (Windle & Davies 1999; Windle & Searles 1990) to identify pivotal events in the lives of women and men many years after AOD treatment to discover how these events aided or challenged their recovery. We also explored participants' responses in light of their gender, age at treatment entry, AOD remission trajectory, and reports of current AOD use and health. AOD treatment (both formal and informal) is well-positioned to help patients identify and anticipate life events that could affect recovery. Therefore we were interested in understanding the impact and meaning of those events to inform motivational and relapse prevention strategies that could be employed in formal, informal (i.e. mutual help) AOD treatment, and in recovery support settings. Over time, even AOD clients who are not abstinent may have substantial reductions in harmful patterns of use, e.g. reduction in heavy drinking (Satre, Mertens, & Weisner 2004), and life events may contribute to these changes.

METHODS

Sample, Setting, and Recruitment

Participants in the current study were part of a sample of 1,204 adults in a randomized clinical trial (RCT) comparing effectiveness, medical services utilization, and cost outcomes of day hospital versus traditional outpatient AOD treatment (Weisner et al. 2000). The original study was conducted in 1994–96 in the Kaiser Permanente Northern California (KPNC) Chemical Dependency Recovery Program (CDRP) in Sacramento, California. KPNC is a nonprofit, integrated health care delivery system that provides health services and AOD treatment services to more than 3.4 million members in northern California. AOD treatment lasted 8 weeks and included supportive group therapy, education, relapse prevention, family therapy and individual counseling, all abstinence-oriented and requiring 12-step participation, with aftercare available for 10 months. Those declining random assignment self-selected a program and were included in the sample as a separate group (see Weisner et al., 2000 for more details). At recruitment, written informed consent was obtained for baseline, 6- and 12-month follow-up interviews, with permission obtained at 6 months for research staff to contact participants for future interviews. Subsequent interviews were conducted at years 5, 7, 9, 11, 13 and 15 with verbal consent obtained prior to each interview, and permission to be contacted for future interviews. Individuals in the current study continued as participants in this 15-year longitudinal research initiative, and quantitative findings from that research (Chi et al. 2011; Chi & Weisner 2008; Mertens et al. 2008; Ray, Weisner, & Mertens 2005; Satre et al. 2012; Satre et al. 2003; Weisner et al. 2000; Weisner et al. 2003; Mertens, Weisner, & Ray 2005) informed the present qualitative project.

The qualitative interviews reported here were conducted after completion of the 15-year quantitative interviews to prevent participant response bias in that interview. For exploration of patient experiences, a theoretical purposive sample of 48 participants was selected from among participants in the quantitative study to compose a sample stratified into groups by age at treatment entry (18–39 years; 40–54 years; and 55 years and older), gender, and AOD

use and problems trajectory. Three distinct AOD use and problems trajectory groups were identified by latent class growth analysis using quantitative data from baseline through the 13-year follow-up: The “early relapse” (high probability of relapse at 1 year and remaining low from 5 years on), the “declining” (remission probabilities declined over time), and the “stable remission” (remission probabilities remained high across time points) (Mertens et al. 2013). Individuals were then randomly selected from these three groups and within age group and gender. Participants were recruited via telephone. Study objectives were described, verbal consent procedures conducted and participants were reimbursed \$150 for the interview. The study was approved by the IRBs of the Kaiser Foundation Research Institute and the University of California, San Francisco.

Data Collection

One-time semi-structured audio-taped interviews were conducted over 9 months in 2012. Interviews were 60–90 minutes long, using a 16-question interview guide (available from first author) informed by a life span perspective. Information collected included current AOD use, use since treatment, and life events affecting use since treatment (probes included job and relationship changes, major losses, and change in responsibilities in life). We also asked about the impact of any use since treatment on other life events, on motivation and on role in the family; mental and physical health status; perspectives on past treatment experience(s), and recovery support tools and strategies. Questions on smoking and caregiver status were added early in the data collection phase as data on both emerged. Active listening, interpretive questioning, and reflexive objectivity informed the interview depth and direction (Kvale & Brinkmann 2009), in particular during participants’ attribution of significant events.

Data Analysis

Interviews were transcribed and read for completeness compared to the audiotapes. For content analysis, data coding was conducted using ATLAS.ti 6.2 qualitative analytic software.

A closed coding scheme based on a life span developmental perspective and using conceptually broad categories for coding was utilized (Bulmer 1979; Miles & Huberman 1994). The processes of data collection and analysis were conducted simultaneously in order to ensure validity, i.e. information provided by one informant is verified by asking other informants about the same content (Brink 1989). In the data collection and analysis phases, continual reflection on researcher beliefs and assumptions and the relationship to the research process (i.e. reflexivity of team members) was a source of data ensuring trustworthiness (Pope & Mays 2006). The data were compared by group membership (age at treatment entry, gender, remission trajectory) to determine group similarities and differences in content. As analysis proceeded, discussion of the data by team members allowed for explanation, further development and discussion of concepts and emerging themes. Respondent validation of the findings was not possible due to subject burden. As a check of credibility of the data, a group of expert AOD treatment staff stakeholders who did not know the respondents and who self-identified as “in recovery” reviewed the study results and concurred with the plausibility of the findings.

RESULTS

Demographics

Participants (N = 48) included 27 men and 21 women with a mean age of 62 years (SD = 13.9; range 39–88 years) at the time of interview, and mean age of 42 (SD = 13.1) years at the time of initial treatment entry. Ethnic composition was 78.7% white, 12.7% black, 4.2% Hispanic, and 4.2% other. Most participants (n=45) had health insurance, 4.2 % reported past military service in a war zone, and 39.5% were retirees.

Substance Use

Thirty (62.5%) participants reported abstinence from alcohol and other drugs at time of interview with periods ranging from 2 months to time since initial treatment. Of the 30, 17 reported abstinence since AOD treatment, and 13 reported one or more relapses since treatment. Twenty-eight cited alcohol and two cited stimulants as their primary drug of abuse at treatment entry, and three reported use of medicinal marijuana.

Eighteen (37.5%) participants reported some ongoing use of alcohol, but all said that compared to their pattern of use prior to treatment entry, the frequency and amount of their current alcohol use was significantly reduced and non-problematic. Each non-abstainer reported current use of alcohol, and two of those reported occasional use of marijuana; two non-abstainers reported drinking with their primary care physician's endorsement. Nine non-abstainers cited alcohol as their primary drug of abuse at treatment entry, seven cited stimulants and two cited both.

Health Conditions

At time of interview, 20 (41.6%) participants reported a medical condition; 13 (27.0%) both a medical and a psychiatric condition; nine (18.8%) a psychiatric condition; and six (12.5%) no current medical or psychiatric health conditions. Participants reporting a psychiatric condition (n=22; 45.8%) described it as "depression," including one-quarter of the men and almost three-quarters of the women. Of the 22 with depression, 18 were currently taking antidepressants, and five reported past suicide attempts. Twenty-one (43.7%) had a history of tobacco dependence: 15 (31.2%) were current smokers and six of those reported a depression diagnosis.

Life Events

Content analysis identified four life events that challenged or aided recovery in abstinent and non-abstinent individuals: caregiving of a dependent adult, parenting and grandparenting, and death/near-death of a loved one. Thirty-three participants cited at least one event, and the events cited are dispersed throughout the sample groups (see Table 1). Most participants described their designated event as a positive experience that reinforced abstinence, helped to maintain reduced use, or initiated abstinence.

Respondent group differences are noted, and after each quotation the participant's age and self-reported current AOD use pattern is included, e.g. *Ab since treatment* (Abstinent since treatment), *Ab* (Abstinent at time of interview with reported past relapse[s]) and *Non-ab*

(Non-problem use of a substance at time of interview). All names are pseudonyms and quotations were edited for clarity only.

Caregiving—Providing physical and emotional care for a close adult family member who was ill, disabled, or dying was cited by almost half of the study participants as having a significant impact on their recovery. Of those reporting caregiving experiences, half were currently serving as family caregivers when interviewed, and the rest reported prior caregiving between AOD treatment and the time of the interview. Caregiving included provision and management of activities of daily living, including physical care, emotional support, and maintaining the family member's well-being. The respondent provided care during an acute health crisis or over time for a chronic disease or major accident, and often anticipated providing it for the foreseeable future (e.g., caring for an aging partner in deteriorating health or for an adult child with a physical or developmental disability). In most cases, these responsibilities were associated with a fatal illness and/or the eventual death of the family member. Three-quarters of current caregivers were abstinent.

Redemption: Respondents described caregiving as a form of redemption, and participants expressed gratitude that their abstinence/reduced use allowed them to “pay back” a family member for causing them emotional suffering during their past drinking and drug-using. The majority described caregiving as a life-altering opportunity and “a blessing” they could provide, as a result of no longer actively drinking and using. However, some recounted that caregiving experiences resulted in increased drinking and relapse. Several men described caring for ill and aging wives with chronic and fatal illnesses, and described the opportunity for caregiving while acknowledging their past behavior. Respondents described how their wives' illnesses led to abstinence for the first speaker and reduced drinking by the second:

... Shortly after I returned [from relapse-related AOD treatment] it was discovered that she had cancer...that was a definitely life-changing event for us both... and I was able to be there for her and provide her with all the support she needed. Without my having stopped drinking, that wouldn't have happened...if I started drinking, all would be lost.

Will, age 74, Ab

[13 years ago] my wife got cancer, she's been with me since we were 17 years old. I just felt really guilty about the life that I'd given her for the last ten years of doing drugs in my life. I wanted to pay her back by being a more responsible husband, giving her more joy in life rather than heartache.

Isaac, age 59, Non-Ab

Reciprocal fulfillment: Other caregiving experiences were part of respondents' daily responsibilities, intentional, welcomed, and mutually gratifying. A woman, caring for her 31-year-old adult son diagnosed with autism and schizophrenia at the time she entered AOD treatment, spoke about her drinking during pregnancy. Her son had recently opted to leave an adult care facility to return home and be with her. Caring for him was motivating for maintenance of significantly reduced drinking:

I still blame myself for the problems he had after he was born...at one point it [did make me drink more]...I'm glad he moved back. I am.

Janeen, 62, Non-Ab

This long-term resident of a mental health facility called his mother every day and spoke about his caregiving in the form of emotional support:

I feel really responsible for [her]...I care for my mom a lot and she's kind of ill...

Simon, 43, Ab since treatment

Caregiving was at the center of other post-treatment experiences that altered participants' use trajectories. Although occurring amidst differing life contexts, each caregiver located caregiving as the stimulus for change in their use trajectory. In this case, caring for dying parents was related to escalation and extension of drinking in the time since treatment.

I was [caring for my father]. He was dying of cancer in the hospital... I brought him home and he died within a week. I was there 24-7. I never slept or anything... after that, I decided to go [drinking] for about five years.

Wallace, 58, Non-Ab

For this woman, caring for a dying parent led to a crossroads when faced with a decision to leave her alcohol-dependent abusive mother. She spoke about her affirmation toward continued sobriety shortly after her discharge from AOD treatment:

My mother was very ill. She had cirrhosis of the liver and it was very difficult to live with her...I had to get out of that ...I didn't want to go that way; I almost wanted to go...and drink...but I said "No! It's terrible!" ...nothing will make me go back to that way of life...

Winnie, 64, Ab since treatment

Parenting—Parental responsibilities in the period since the participants' treatment experience had reinforced abstinence and reduced drinking. Parenting was an aid to recovery in caring for young children, relating to adult children, and working to be a positive role model. Half of the men and three-quarters of the women who reported parenting as a life event affecting their substance use were abstinent. Men focused on their perceived role-bound responsibilities of fathering, including maintenance of family unity and being a role model for their children. Their enthusiasm for fathering was located in parenting activities and in pride for what they were doing as effective fathers:

...the example that I set before my children and the rest of my family is going to speak a lot louder than whatever words I have...Who I am and what I do with my life. Not just what I say, but what I do.

Raphael, 61, Ab

Women's descriptions of their mothering were attuned to feelings of shame and guilt, needing to continue to prove their ability to be dependable mothers, and being worthy of their children's trust and praise. In their stories about current parenting, women often dwelled on the past, referenced AOD behaviors that made them unavailable to their children,

and expressed regret about not having lived up to an image of what a good mother should be like.

I have a really close relationship with my kids now. I look at my kids and I think... I'm going to prove to them and my mother that I'm not really as bad as I was and I'm not a real bad person and that I can succeed and I will succeed. I'm determined.

Cecilia, 43, Non-Ab

How do I stay abstinent today? ... I remember the faces of my children when they came to see me in the hospital and I remember the stories they would tell me about how I acted when I was drinking... That's what I work on this for. And I don't want to see those faces... or hear what they had to say. I feel very good about myself... and I don't ever want to lose that.

Aileen, 65, Ab since treatment

Rocky reconciliations—Both older men and older women spoke about fragile relationships with their adult children, and expressed the hope that their current positive parenting efforts would eventually restore faith and trust into their children's feelings about them as parents. This man spoke about his children's past suspicions and worry about him, feelings he believes they still harbor and reflect on in the present:

...I had a two-year-old, she kind of understood...she knew dad was out of the picture for about a year and a half...and my twins?... it does give them a void to where their dad wasn't around and subconsciously and spiritually, they're not as close to dad as they would be... [my kids say] "You weren't here!"...they're 22 and 19 now. But see, here's the key: that's still in reflection, even to this day.

Rich, 54, Non-ab

...[my daughter had] never been able to sit down and have an honest talk about all the stuff that she's gone through...I made my amends to her...I have a lot of hope today that we can... It may not happen...But I tell ya, when she learned that my husband had cancer... she and her family came out to visit and it was just like nothing had ever happened between us...

Vikki, 66, Ab

Grandparenting—The experience of grandparenting was viewed as an opportunity to gain positive standing in the family and like parenting, provided motivation for continued sobriety and reduced drinking. Respondents noted that they wanted to "stay sober" in order to carry out childcare responsibilities for their grandchildren, and took pride in being able to do so.

Legacy building: Respondents hoped they would be remembered well, and concerns about their legacy were related to the opinions of both their children and their grandchildren. Most of the grandparents were non-abstainers, and there were no detectable differences in their responses by gender. Most respondents expressed the belief that their grandchildren were unaware of their past problems with alcohol.

I didn't want to be remembered as being a drug user... I wanted to be remembered as a grandfather and a father that loved his wife and granddaughters. I'm going to be 60 and am glad I made that choice because I do have the respect of my granddaughters. They don't know anything about this...

Nolan, 59, Non-Ab

...I have a bunch of grandchildren now and I just want to be a good example...I wouldn't want them to ever, ever see me like I used to be... I did it for me but I did it for my children and my grandchildren. I didn't want to pass that on.

Helen, 43, Ab

Hopes for a positive legacy as a grandparent included acknowledging that substance use had a negative impact on their children, but that being a devoted grandparent might heal that loss:

I realized that I'd missed my daughter's younger events and I couldn't make up that time. That's time that was lost. And the only way that I can really kind of live through those times is through my grandkids so I guess that's why I'm kind of [devoted to] seeing things good for them.

Paulo, 61, Ab since treatment

Death and near-death—Death and near-death experiences were defining events that led to conscious decisions for abstinence and reduced AOD use, and in other cases led to relapse. For those who stopped drinking and using drugs in response to a death, these memories were readily accessed. Abstinent participants' memories about the death served as an on-going deterrent from drinking and drug use, and among those reporting reduced drinking, the death served as a reminder to keep alcohol consumption low. Most of the respondents who cited death experiences were abstinent, and no other group differences were detected. In most all of the recalled death experiences the deceased were close family members, and in some cases the deceased person was alcohol dependent:

...we lost my sister...she died an alcoholic death, so you ask what keeps me sober is, I know that would have been my eventuality, too. She had esophageal varices... not a pretty way to go. This is a sweet girl, too...

Ronny, 52, Ab since treatment

Death of a loved one also influenced changes in the use trajectory of participants causing relapse:

Around the time my dad was dying, I started using meth really heavily...I ended up not being able to say goodbye and I think it was because of me being on the meth and that affects me still...I think that's what caused me to start using and using heavily...

Arita, 46, Ab

The near-death of this respondent's mother prompted her to become abstinent again after a lengthy post-treatment relapse:

... My mom had a stroke last July so that's kind of what started the not-smoking anymore, because I'd been an over 30-year marijuana smoker and she made me promise I'd quit smoking...so that's why I've abstained now from everything... my mom's stroke is what caused me to stop.

Addy, 50, Ab

We also include this respondent who experienced his own near-death event. His survival after acute esophageal and gastric hemorrhage caused him to re-commit to abstinence after multiple relapses involving extensive family, legal, and health consequences. He described his near-death two years before the interview:

I basically started bleeding out...17 units of blood later, they ran out...and it didn't stop... The doctor came out and told [my partner] that he lost me... I was definitely gone for four to seven minutes, depending on who you talk to. But everybody agrees, I was dead [laughs]... And then the bleeding stopped. It just stopped. You can call it whatever you want. Divine intervention or whatever, but it just stopped. Dying and getting another shot was definitely a big deal...I really feel like I shouldn't be here so whatever I'm here for, I'm going to try to do something good.

Jerry, 64, Ab

DISCUSSION

Among these participants, significant life events both negatively and positively influenced the course of their AOD use and problem trajectories in the years since treatment. Each event cited by the respondents occurred in the context of an intimate relationship, and the dynamic forces at work prompting abstinence, relapse, or escalated substance use in this sample were explained. Lived experiences occurring at the time of the interview as caregivers, parents and grandparents were identified as the influential event affecting substance use. Most of the caregivers and all of the parents and grandparents described assumed roles in the context of a relationship that aided their recovery, supporting the conjecture that individuals choose reinforcers for behavior change on the basis of reinforcers' value to them (Rachlin et al. 1976). For these respondents, the reinforcement was their desire to be the competent caregiver, parent, and grandparent, and to maintain connection to a loved one. For respondents who cited the significance of a death event, the loss of the loved one was so momentous and the memory of it so preserved as to alter the course of their AOD use.

Parenting is an event that stimulates treatment-seeking and maintains recovery in women and men of child-bearing age (Berkowitz, Brindis, & Peterson 1998; Sword, Niccols, & Fan 2004; West et al. 2013). However, in the current study those who cited parenting as the significant event had older adult children, and the experience supported abstinence and reduced drinking. Likewise, the grandparents reported that wishes for a positive legacy sustained their abstinence and was a factor in reduced drinking. With expected increases in the rate of treatment need among older Americans (Han et al. 2009), these age-related role changes could be useful topics in educational treatment group discussions to support challenges related to family, and for building intimacy in recovery.

Death events reported by respondents supported recovery for some, and challenged recovery for others; similar findings have been reported elsewhere (Cloud & Granfield 2008; Nordfjaern, Hole, & Rundmo 2010; Perreira & Sloan 2001). As noted, some deaths were the result of AOD use by a family member. Given the familial and lethal nature of AOD dependence, death events are likely a shared experience among recovering individuals. Twelve-step groups and other social supports, psychological services, and learning positive coping skills for grief may be important in relapse prevention related to this universal life event. Further, specific groups and education for dealing with loss of a loved one may be helpful in online recovery communities (e.g. www.intherooms.com).

The caregiver experiences of almost half the participants in the current study speak to the reality of family caregiving as the “backbone of the long-term care system in the US today” (Coleman & Pandya 2002). The satisfaction and meaning in life finding is similar to others in community samples involving cancer care (Awadalla et al. 2007; Rhee et al. 2008), AIDS (Mitchell & Knowlton 2012) and dementia (Donaldson, Tarrier, & Burns 1998). Likewise, in community samples caregiver stress is associated with increased health problems, including depression (Couper et al. 2006), panic disorder and PTSD (Vanderwerker et al. 2005), AOD use (Kershaw et al. 2004), and increased risk for suicide in older adults (Office of the Surgeon General & National Action Alliance for Suicide Prevention 2012).

The findings on caregiver stress versus satisfaction have added significance for caregivers in clinical populations. In this study, self-reported medical and psychiatric conditions presented a health burden to recovering individuals already encumbered with care responsibilities. Most individuals with AOD dependence are likely to have a comorbid condition (Mertens et al. 2003) which may confer added stress-induced health problems. Conversely, most caregivers associated their caregiving with their ability and desire to maintain abstinence and reduced drinking, suggesting that for them caregiving shielded them from relapse. Caring for others or “doing service” is a mediator for alcohol abstinence following 12-step participation (Subbaraman, Kaskutas, & Zemore 2011), and caring for a chronically ill family member is associated with caregiver personal growth, peace and a sense of accomplishment (Kim, Schulz, & Carver 2007; Hudson 2006). We know of no studies however, in which family caregiving by persons with AOD dependence has been examined for its risk or protective effect, and caregiver stress would be important to address in further research. Support groups, online resources, hotlines, and inclusion in health treatment planning for the ill family member (Administration on Aging 2012; Miller, Allen, & Mor 2009; Levine et al. 2010) would seem especially relevant for recovery management and relapse prevention for AOD-dependent caregivers.

In caregiving, death, and near-death events, the differences in meaning that respondents gave to an event deserve exploration. For some, a family member’s death from AOD use disorders served as a warning against continued use; in others, grief overwhelmed and led to extended relapse. These divergent outcomes are consistent with research on stressful life experiences in which the individual cannot exert personal control (Keyes, Hatzenbuehler, & Hasin 2011; Rutter 1996). In future research on how events affect AOD trajectories, the multiple meanings derived from those events should be of interest (Teruya & Hser 2010).

Relationships have risk and protective effects in the lives of individuals with AOD dependence (Bond et al. 2005; Administration on Aging 2013), and assisting patients to assess them is a fundamental task of treatment. Motivational enhancement approaches that explore and resolve ambivalence about AOD use (Rollnick & Miller 1995) have led to improved treatment outcomes (Barrowclough et al. 2001; Satre et al. 2013), and may be especially useful to examine and regain valued family roles and intimate connections. Finally, committed intimate relationships are sometimes simplistically viewed as forms of excessive “over-involvement” that pull the recovering person away from their own needs and self-care. Distinguishing engaged intimacy from conventional notions of co-dependency is critical in initial treatment assessments of the potential motivational power of the client’s relationships. The caregiver’s dilemma of total focus on their loved one may be especially vulnerable to misinterpretation.

We expected to find retirement, divorce, and health events as factors affecting participants’ substance use. However, retirees in this study either retired before treatment entry or made no mention of retirement as a factor in their AOD use since treatment. No women mentioned divorce as an event altering their substance use since treatment, and of the five men who cited divorce as a significant event, three relapsed and divorce ensued, and two sought divorce to preserve their abstinence and recovery efforts. Health events that respondents mentioned also occurred before treatment entry. These mixed findings regarding divorce are contrary to our quantitative findings that losing a partner (through separation, divorce or widowhood) was detrimental to abstinence and remission (Satre et al. 2012), and highlights the importance of examining divorce separately from widowhood.

A limitation of this work is the threats to the accuracy of memory. First, the participants were older and many had a diagnosis of depression. Second, desirability dynamics and the possible tendency to focus on the positive may have influenced participants’ responses. Third, we did not include questions on specific traumatic events (e.g., sexual assault, active duty war experience), and inclusion of these may have identified other life events affecting participants’ substance use trajectories. To reduce recall bias, continued probing and follow-up on meaningful response phrasing were employed in the interview process (Kvale & Brinkmann 2009).

In analyses of response differences per AOD use and problem trajectory and age-at-treatment entry, the small number of participants in each sample strata limited detection of group-based themes associated with significant events. The ethnic homogeneity of the sample and lack of information on participant sexual orientation also limited the data’s scope. Finally, causality cannot be attributed to the significant events as the findings cannot be empirically tested, and the results are not generalizable to other settings. However, the life occurrences related to AOD relapse and recovery in this group of respondents suggest that these particular developmental events—caregiving, parenting and grandparenting, and death of a loved one—may influence AOD use and problem trajectories of AOD-dependent individuals.

CONCLUSION

This study identified significant life events and explored how and why those events influenced participants' AOD trajectories. It complements our prior quantitative longitudinal research on life events as predictors of remission and abstinence by identifying events such as caregiving not commonly examined. In the findings, we glimpse individual life circumstances, the quality of connections to others, and the timing of events in the life span that influenced shifts toward recovery or relapse.

We acknowledge that in this study one side of the relational story was shared, leaving the parallel experience of partners and family members unknown. In the future, naturalistic observation and engagement with research participants in the context of their lives over time, and interviews with their partners, parents or other family members may expand our understanding of the dynamics of long term recovery. Our findings suggest that the power of a relational event to influence both relapse and recovery, possibly in the same person at different points in time, is intriguing and suggests a need for research focused on the life-long reach of intimate relationships and their meaning to individuals.

For AOD treatment, addressing the potential for intimate relationships to influence outcomes many years after the treatment experience may be especially important for relapse prevention and recovery across the lifespan.

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TABLE 1**Events and Their Effects on Alcohol Consumption**

	Caregiving (n=20)	Parenting (n=18)	Grandparenting (n=7)	Death Experience (n=9)
Age at treatment entry				
18–39	6	8	1	5
40–54	8	10	5	4
55>	6	0	1	0
Gender				
Female	8	9	4	6
Male	12	9	3	3
Abstinent	13	10	2	7
Non-Abstinent *	7	8	5	2
Effect of event on AOD use				
Positive outcome **	(17)	(18)	(7)	(6)
Negative outcome ***	(3)	(0)	(0)	(3)

* All non-abstainers reported current alcohol use significantly reduced compared to use at treatment entry.

** Positive outcome = The event aided recovery in that it was an active reinforcer for abstinence, or it reduced drinking, or it was a factor in alcohol or drug use cessation after a relapse.

*** Negative outcome = The event challenged recovery in that it was a factor in relapse or increased drinking.