CASE STUDY

Adaptation to virtual congregational peer recovery groups during COVID-19

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Abstract:

Complex humanitarian disasters and emergencies like COVID-19 can disrupt needed mental health services such as substance use recovery programs. Physical distancing requirements can further exacerbate existing mental health disorders or initiate additional ones. Individuals benefiting from congregational peer recovery programs can find themselves in a state of extreme stress and be at an increased risk of relapse. Transitioning to virtual platforms can help congregational peer recovery groups maintain a connection with group participants, share spiritual and physical encouragement, and mitigate potential relapse. This case study identifies the concerns and benefits of virtual recovery groups and the potential for hybrid groups moving forward.

Key words: congregational peer recovery, COVID-19, virtual, alcohol use disorder

Introduction

According to the World Health Organization, three million deaths annually are associated with alcohol misuse.[1] Increased alcohol misuse is associated with times of severe stress due to neuroadaptations in the stress/reward pathway feeding back to even greater cravings for alcohol.[2,3] The coronavirus disease 2019 (COVID-19) pandemic is a time of unknown, severe, chronic stress for individuals that may initiate or exacerbate existing alcohol misuse or increase the risk of relapse among those in recovery. As high stress levels continue during and after the peak of the pandemic related to experiencing severe illness, death, or unemployment, many individuals will likely progress further into harmful substance use as a coping strategy.[3] In addition, humanitarian disasters like COVID-19 can disrupt needed mental health services such as substance use recovery programs.

Religiosity, religious service attendance, and faith-based peer recovery programs are important protective factors against alcohol or other drug misuse.[4-6] A congregational peer recovery program is defined as a program facilitated through a faith community mobilizing the resources of the congregation including religious beliefs and values to guide participants through their recovery. A peer-based model is used to create trust and acceptability from the beginning. Evidence-based practices, from psychology and sociology, are incorporated that

support the congregation's beliefs. This short report will briefly review the empirical evidence for these protective factors, describe a faith-based peer recovery model that leverages these protective factors, discuss acceptability of a virtual meeting adaptation due to COVID-19, and share implications for future research.

Religiosity and Recovery

The study of religion has resulted in a strong evidence base for the salutary effects of religiosity and religious participation on health and well-being.[5,7] In a recent study, Chen and colleagues found that women who attended religious services at least once per week had a 68 percent lower hazard of death from suicide, unintentional alcohol or other drug overdose, and chronic liver disease and cirrhosis and 33 percent lower hazard among men.[7] Studies have found religiosity to be important for individuals in recovery as a pathway to social support, connection to a higher power, feelings of gratitude, and engagement with grace and forgiveness.[5,8] In fact, a systematic review of studies on religiosity and substance abuse found significant reductions in substance use along one or more dimensions of religiosity.[9] Religion is an important source of coping and professional support. In some contexts, clergy are contacted at higher proportions than mental health professionals and psychiatrists among individuals seeking help for behavioral and mental health conditions.[10] Leveraging religiosity, religious service attendance, and participation with congregational groups are important aspects to protect against stress-induced increases in alcohol and other mental health disorders. Given the desire to seek assistance from clergy, minimal evidence and literature is available on congregational peer recovery programs.

Twelve Step Facilitation (TSF) groups, the model for Alcohol Anonymous, has been the focus of most studies in this space. A recent Cochrane review found that a manualized TSF program resulted in 42 percent abstinence the year following treatment compared with 35 percent in a Cognitive Behavioral Therapy (CBT) program.[11] The authors suggest that most of the difference is due to the manualized TSF emphasis on attending associated programs following treatment.[11] However, other faith-based or congregational peer recovery programs such as Celebrate Recovery and Resilient Recovery have not been studied systematically. Initial studies of the Living Grace Groups (now called Transform Groups) support the use of congregation-based recovery services in reducing psychiatric symptoms alongside improvements in recovery and spirituality (based on the Theistic Spiritual Outcome Survey).[12] Such congregation-based peer recovery groups offer individuals in recovery with a culturally appropriate peer group, consistent engagement with grace through the group, and connections for subsequent referrals and resources for additional services such as food and health screenings.[12]

Resilient Recovery Groups

Resilient Recovery is a faith-based, peer-led, weekly, support group model designed by a professional counselor and a pastor from CrossWalk Ministries in Arizona. Resilient Recovery started in 2012 and currently includes three groups in three states in the United States of America. Since 2012, approximately 300 individuals have interacted with Resilient Recovery through local groups or the national retreat. The groups are guided by a publicly available workbook called "The Ultimate Guide to Resilient Recovery." The workbook includes 18 lessons that focus on grace, forgiveness, and healthy reliance on God, rather than putting pressure on individuals with addictions to change things outside of their control. Even though Resilient Recovery used faith-based content, groups are open to individuals of all faiths as well as the non-religious. Partnerships are established with local residential treatment centers, which refer individuals to the group based on individual interest. Each lesson is introduced through a passage from the Bible, a main point related to recovery, meditation on biblical law and gospel, pronouncement of the gospel, and tips

and traps to consider for the week. The balance and integration of a Christian law-gospel approach is a unique aspect of Resilient Recovery compared with other twelve step facilitation models. This short report highlights one example of a Resilient Recovery group from Maricopa County transitioning from face-to-face to a virtual format as an adaptation strategy associated with COVID-19 physical distancing guidelines.

Methods

In reaction to the physical distancing guidelines to prevent the spread of COVID-19, a Resilient Recovery group of 15 members stopped meeting for a period of three weeks. Following the three-week hiatus, virtual meetings commenced over a premium Zoom video conferencing account. The premium account offered fewer restrictions regarding time limits and number of attendees while being available through desktop, laptop, or mobile platforms. Thirteen of the 15 members continued to attend the virtual group. A qualitative research strategy was used to assess the feasibility and acceptability of transitioning to a virtual platform. Over the initial three weeks, the peer facilitator used an observational and unstructured focus group approach to gather information regarding the feasibility and acceptability of the virtual meetings. The facilitator conducted a thematic analysis to identify common benefits and concerns generated from the focus group. The information used for this report was collected anonymously as part of an informal evaluation of the group transitioning from a face-to-face to a virtual platform. An IRB review was not required since individual-level outcomes or behaviors were not collected as part of this process evaluation.

Results

Concerns

Initial concerns included limited access to the internet and limited proficiency with technology. Privacy issues were also voiced by some participants given the sensitivity and legal nature of issues related to discussing topics of recovery and relapse. Some members lamented the loss of physical proximity and the ability to see everyone, hug one another, or sing together. One participant commented, “I keep hearing that the group sang in person. Why can’t we still do that? We could sing with a YouTube video you share on your screen for all of us.” Another commented, “I’d like to see the person speaking when the question is open to the group.” Those calling into the group may not have video capacity resulting in the loss of visual connection for those individuals. These concerns suggest that virtual groups fill some needs but may require face-to-face components to allow participants to experience actions of acceptance and forgiveness in addition to words of acceptance and forgiveness. Individuals with past physical or emotional abuse may distrust individuals in their social network, and such physical acts become important to start building trust-based relationships to support recovery efforts.

Benefits

Most of the group affirmed the effectiveness of virtual meetings. Even those who could only attend by phone because they lacked internet access expressed that the groups were helpful. All members supported the continued use of virtual meetings as an adjunct to in-person meetings when physical distancing restrictions are lifted. Participants reported that without the virtual meetings, they would not have access to a recovery group syntonic to their religious convictions. A virtual participant commented, “We can meet with people who need Resilient but don’t live in the Phoenix metro area. It is a safe gathering for sharing. Most of all, it is a group grounded in the Savior.” Perceived benefits of the virtual groups were 1) inclusion and participation by individuals from diverse parts of the city and from other states, 2) reduced driving time for individuals living more than 30 minutes from the group’s physical location, 3) the return of individuals who had moved away from the location where the physical group was being held, and 4) the ability to

form a virtual community around the Resilient Recovery program's core philosophy for ongoing support in between meetings.

Discussion

The stated concerns suggest the importance of ensuring privacy, which was being addressed by and included some aspect of face-to-face, physical interaction alongside virtual group meetings. Having complementary access to a known and supportive group when physical attendance is a barrier may increase the effectiveness of faith-based recovery groups and should be studied further. Individuals going through recovery may experience frequent moves and disruption in care and support. Remote access to virtual or hybrid congregational peer support groups could increase the continuity, compliance, and long-term effectiveness of a participant's recovery as the individual is already known by the members of the group with established trust and congruence in religious beliefs. Physical attendance may prove to be necessary for sustainability and greater effectiveness given the needs to experience actions associated with forgiveness, acceptance, and grace, critical components of the recovery pathway. Behavioral outcomes associated with this transition were not collected for this short report, and additional research is needed to evaluate the comparative effectiveness of virtual groups relative to traditional face-to-face groups and hybrid peer recovery groups.

Conclusion

The COVID-19 pandemic has forced peer recovery groups to consider alternative options in order to continue providing support. The Resilient Recovery program explored the option of virtual group meetings through an unstructured focus group, which proved to be an acceptable and feasible model for facilitating congregational peer recovery groups. The concerns included privacy and connectivity issues. The benefits included greater accessibility and inclusion, especially among those that move away from their known group, reduced drive time, and the opportunity to maintain social connection in between group meetings for ongoing support. The information in this short report suggests that a hybrid congregational peer recovery model may be as or more effective than traditional face-to-face peer groups and deserves greater study.

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Peer Reviewed: Submitted 3 Aug 2020, accepted 24 Aug 2020, published 9 Nov 2020

Competing Interests: None declared.

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Cite this article as: Paltzer J, Jonker J. Adaptation to virtual congregational peer recovery groups during COVID-19. Christ J Glob Health. November 2020; 7(4):28-32
https://doi.org/10.15566/cjgh.v7i4.431