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Research Article

Influence of Social Support on Self-Efficacy and Readiness to Change among Alcohol Users

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- Alcohol Use Disorder; Social Support; Self-Efficacy; Readiness to Change; Rehabilitation

Abstract

The purpose of the study is to understand the perceived social support, self-efficacy level, and readiness to change alcohol use behavior among alcohol users in rehabilitation centers versus those not in treatment. The study also aims to examine the relationship between social support and self-efficacy, and assess the relationship between social support and readiness to change. The data for the study was collected from 60 participants (30 participants in rehabilitation centers and 30 participants who are not receiving treatment). The data for the study was collected using the Multidimensional Scale of Perceived Social Support (MSPSS), the Alcohol Abstinence Self-Efficacy Scale (AASES), and the Readiness to Change Questionnaire (RCQ). The data analysis was done by using jamovi software. The results indicated no significant correlation between social support and self-efficacy ($p = 0.455$), or social support and readiness to change ($p = 0.815$). However, alcohol users in rehabilitation exhibited significantly higher self-efficacy ($p < .001$), and readiness to change ($p < .001$), compared to those not in treatment. The findings suggest that structured rehabilitation programs enhance self-efficacy and readiness to change. This emphasizes the need to include self-efficacy-building techniques and motivational interventions in recovery programs.

INTRODUCTION

Alcohol Use Disorder (AUD) is a pervasive global health concern, leading to approximately 3 million annual deaths and contributing to 5.1% of the global burden of disease [1]. AUD is associated with a wide range of adverse outcomes, including physical and mental health problems, impaired social relationships, and reduced productivity. In India, the prevalence of alcohol consumption is rising, with 14.6% of the population consuming alcohol and 5.7% suffering from alcohol dependence [2]. These statistics indicates an urgency towards effective interventions to address AUD and support recovery. Alcohol Use Disorder (AUD), is a significant global public health issue, contributing to millions of deaths annually and imposing a substantial burden on healthcare systems. Self-efficacy and social support are widely recognized as critical factors in the recovery process, yet their interplay remains poorly understood. This study aims to explore the relationship between social support, self-efficacy, and readiness to change among alcohol users, amongst alcohol users those in rehabilitation centers with those not receiving formal treatment.

Self-efficacy

Self-efficacy refers to an individual's belief in their capacity to plan, organize, and execute actions to achieve specific goals [3]. According to the American Psychological Association (APA), it involves a person's perception of their capability to succeed in particular situations or attain desired outcomes, commonly referred to as perceived self-efficacy [4]. In the context of alcohol use, Alcohol Abstinence Self-Efficacy (AASE) describes a person's confidence in their ability to resist alcohol consumption in different scenarios [5]. Mastery experiences, Vicarious experiences, Verbal persuasion and physiological and emotional states are the different self efficacy. In the context of alcohol abstinence self-efficacy, these components influence how individuals cope with cravings, social pressure, and emotional distress, making them essential factors in addiction recovery interventions such as Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), and peer support programs determining the individual's chance of maintaining abstinence or relapse.

Studies on self-efficacy in alcohol use and recovery have shown its impact on regulating drinking behavior and treatment outcomes. A meta-analysis study revealed an inverse relationship refusal self-efficacy and different alcohol-related behaviors, suggesting that individuals with high self-efficacy avoid problematic drinking. Studies also find the association between motivation and self-efficacy concerning the maintenance of long-term abstinence, and greater Self-efficacy in maintaining abstinence and motivation focused on taking action predict lesser alcohol

consumption [6]. In another study, the authors found that drinking refusal self-efficacy (DRSE) was a major predictor of problem drinking among adolescents over a 12-month period. Specifically, higher DRSE was connected with lower levels of problem drinking. Additionally, DRSE mediated the relationship between alcohol expectancies and problem drinking, suggesting that interventions aimed at enhancing adolescents' willpower towards their alcohol resistance ability may be effective in preventing underage drinking [7].

Readiness to change

Readiness for change is the degree to which a person or group of people are cognitively predisposed to accept, embrace, and implement a specific plan to consciously alter the status quo [8]. Readiness to change can also be defined as the willingness or psychological preparedness to change alcohol consumption [9]. The key components of readiness to change are Stages of Change, Ambivalence, Motivation, Self-Efficacy, Decisional Balance, Relapse, and Processes of Change [10]. Research has extensively explored the association between readiness to change and alcohol consumption, emphasising its importance in predicting and enabling behavioural changes. A research established that higher levels of readiness to change were substantially connected with less heavy drinking days and average drinks taken per day over a 12-month period [11]. Another study discovered that among alcohol-dependent inpatients, greater willingness to change was associated with better treatment results and higher self-efficacy at a three-month follow-up [12]. Furthermore, another study found that baseline readiness to change, as well as perceived importance and confidence in modifying drinking behaviours, predicted decreased alcohol use six months later [13].

Social support

APA defines social support as offering help or comfort to others, usually to assist them in managing biological, psychological, and social stressors. This support can come from various interpersonal relationships including family, friends, neighbours, religious communities, colleagues, caregivers, and support groups [14]. It is a psychological phrase describing the mind related and bodily comfort that comes from our relationships with others. It is critical for maintaining both psychological and physical health and might take the form of advice, guidance, understanding, or practical aid. Four recognized constructs of social support are emotional, instrumental, informational, and appraisal.

Extensive research has explored the connection between social support and alcohol consumption, emphasizing its critical role in influencing drinking behaviors and recovery outcomes. Studies have shown that higher levels of social support can buffer the association between a family history of alcohol use disorders and the manifestation of alcohol-related problems, suggesting that strong social networks may mitigate genetic or familial risk factors [15]. Additionally, social support has been found to be particularly beneficial for individuals with mental health conditions, as it can reduce alcohol consumption among this population [16]. These findings highlight the importance of fostering strong, positive social connections as a protective factor against alcohol misuse and a crucial component in recovery interventions.

OBJECTIVES AND HYPOTHESIS

The study aimed to investigate the relationship between social support and self-efficacy, as well as the relationship between social support and readiness to change among individuals in rehabilitation centers for alcohol use disorders and those who consume alcohol without receiving any treatment. Additionally, the study sought to examine the differences in social support, self-efficacy, and readiness to change in both groups.

Hypothesis

1. To assess the differences in social support perceived amongst alcohol users in residential centres and alcohol users who are not receiving treatment.
2. To measure the differences in self-efficacy amongst alcohol users in residential centres and alcohol users who are not receiving treatment.
3. To understand the differences in readiness to change alcohol use behaviour amongst alcohol users in residential centres and alcohol users who are not receiving treatment.
4. To assess the relationship between social support and self-efficacy amongst alcohol users in residential centres and alcohol users who are not receiving treatment.
5. To assess the relationship between social support and readiness to change amongst alcohol users in residential centres and alcohol users who are not receiving treatment.

Methodology

The study was conducted to access the correlation between alcohol users and their social support, self-efficacy, and readiness to change. The population under the research comprised 200 participants: 100 were rehabilitated clients in rehabilitation centers and 100 people who drink but are

not going for any kind of treatment. Purposive sampling was used to select participants, who were at least 18 years of age and either in treatment at a rehabilitation center for AUD or had a score of 2 or greater on the CAGE screening test.

The MSPSS was used as the measuring tool for collecting data. It is a 12-item scale developed by Gregory Zimet in 1988, which ranges from perceived support from family to friends and significant others. The scale had good reliability, with Cronbach's α at 0.95. The Alcohol Abstinence Self-Efficacy Scale (AASES), developed by Mark S. DiClemente in 1994, is a 20-item tool measuring confidence in maintaining alcohol abstinence, with a reliability of Cronbach's α = 0.98. The Readiness to Change Questionnaire (RCQ), created by Nick Heather and Stephen Rollnick, is a 12-item scale assessing individuals' readiness to change their drinking behavior, with internal consistencies of 0.73, 0.80, and 0.83 across its three subscales. Screening for alcohol use disorder was done using the CAGE questionnaire, a widely used four-item screening tool for problematic drinking.

RESULTS

The data collected were analysed using jamovi software. Table 1 shows spearman's Correlation between Social Support and Self-Efficacy among Alcohol Users.

Correlation between social support and self-efficacy among alcohol users in rehabilitation centers and those not receiving any treatment. Spearman's correlation coefficient between social support and self-efficacy among alcohol users in rehabilitation centers was 0.060, suggesting a very weak positive correlation between the two variables. Since, the p-value was 0.753, suggesting that the correlation was not statistically significant. Similarly, for alcohol users not receiving treatment, Spearman's correlation coefficient was -0.182, indicating a weak negative correlation. The p-value was 0.335, showing that this correlation was also not statistically significant.

Table 2 shows the correlation between social support and readiness to change among alcohol users in rehabilitation centers and those not receiving any treatment. Spearman's correlation coefficient between social support and readiness to change for alcohol users in rehabilitation centers was 0.028, suggesting a very weak positive correlation between social support and readiness to change. Since, the p-value was 0.882, meaning that the correlation was not statistically significant. Similarly, for alcohol users not receiving treatment, Spearman's correlation coefficient was 0.059, also indicating a weak positive correlation, with a p-value of 0.759, which was not statistically significant as well.

Table 1: Result of spearman's correlation between social support and self-efficacy among alcohol users

Group	Spearman's rho	df	p-value
Rehabilitation Center Users	0.060	28	0.753
Non-Treatment Users	-0.182	28	0.335

Table 2: Result of spearman's correlation between social support and readiness to change among alcohol users

Group	Spearman's rho	df	p-value
Rehabilitation Center Users	0.028	28	0.882
Non-Treatment Users	0.059	28	0.759

Table 3: Results of the independent t test done on social support, self-efficacy, and readiness to change among alcohol users

Variable	*t*	*df*	*p*-value	Mean Difference	SE Difference
Social Support	-0.76	58	0.45	-2.83	3.72
Self-Efficacy	-5.61	58	< .001	-20.1	3.58
Readiness to Change	-3.87	58	< .001	-5.90	1.52

Table 3 shows the results of an independent sample *t*-test comparing social support, self-efficacy, and readiness to change between alcohol users in rehabilitation centers and those not receiving treatment. The difference in social support between the two groups was not statistically significant ($t(58) = -0.762$, $p = 0.449$), with a mean difference of -2.83, indicating that levels of social support were similar between groups. The difference in self-efficacy was statistically significant ($t(58) = -5.61$, $p < .001$), with a mean difference of -20.1, suggesting that alcohol users in rehabilitation centers had significantly higher self-efficacy than those not in treatment. The readiness to change was also statistically significant ($t(58) = -3.87$, $p < .001$), with a mean difference of -5.90, indicating that those in rehabilitation were significantly more motivated to change compared to those not receiving treatment.

DISCUSSION

The findings of this emphasize the critical role of self-efficacy in alcohol recovery, as individuals in rehabilitation centers demonstrated significantly higher self-efficacy and readiness to change compared to those not receiving treatment. This aligns with Bandura's (1977), Social Cognitive Theory, which highlights self-efficacy as a key determinant of behavioral change. The significant positive correlation between self-efficacy and readiness to change ($r = 0.470$, $p < .001$), supports previous research indicating that individuals with greater belief in their capability to stop drinking increases the likelihood of taking proactive measures toward recovery [17,18]. Moreover, research indicates that structured interventions, including cognitive-behavioral therapy (CBT), and motivational interviewing (MI), effectively enhance self-efficacy and

reduce the risk of relapse [19,20]. The results indicate that addiction treatment programs should focus on strategies that enhance self-efficacy, including goal setting, coping skills development, and relapse prevention methods, to improve recovery outcomes.

Interestingly, social support did not significantly correlate with self-efficacy or readiness to change, challenging the widespread assumption that external support networks are always beneficial in addiction recovery. While previous research has suggested that social support can serve as a protective factor in maintaining sobriety [21,22], this study suggests that in early-stage recovery, personal motivation and self-efficacy may be more influential than external support. One possible explanation is that not all social support is constructive—some forms may even reinforce substance use through co-dependency, peer pressure, or enabling behaviors [23,24]. Future research should explore how different types of social support (e.g., family vs. peer vs. professional support), influence recovery at various stages, as well as whether social support becomes more significant in long-term relapse prevention rather than initial behavior change. Overall, these findings underscore the importance of structured rehabilitation programs in fostering recovery by focusing on individual psychological resilience rather than external social influences.

LIMITATIONS

1. The limited sample size (30 in rehabilitation centers and 30 not receiving treatment), limits the generalizability of the findings. A larger sample could provide more robust results.

2. The study may not have accounted for demographic diversity (e.g., gender, socioeconomic status, cultural background), which could impact the perception of social support and motivation for change.

3. The study did not control for potential confounders, such as Severity of alcohol dependence, Duration of alcohol use, previous attempts at quitting, Mental health conditions (e.g., depression, anxiety) etc.

IMPLICATIONS

1. Clinical Interventions: Rehabilitation programs should incorporate self-efficacy-building techniques, such as cognitive-behavioral therapy and motivational interviewing, to enhance recovery outcomes.

2. Policy Recommendations: Support systems should focus on fostering individual motivation and resilience rather than relying solely on external social support.

3. Future Research: Longitudinal studies are needed to explore whether social support becomes more influential over time and to identify other factors that may mediate the relationship between social support and recovery outcomes.

CONCLUSION

This study explored the influence of social support on self-efficacy and readiness to change among alcohol users, comparing individuals in rehabilitation centers with those not receiving treatment. The results indicated that whereas self-efficacy and readiness to change were significantly higher for individuals in structured rehabilitation programs, social support showed no significant association with either self-efficacy or readiness to change in both groups. These findings contradict the widespread belief that social support is a critical determinant of recovery motivation, and individual psychological factors, such as self-efficacy, are more crucial in bringing about behavioral change.

The study has several clinical, policy, and research implications. Rehabilitation programs should focus on enhancing self-efficacy through targeted interventions, such as cognitive-behavioral therapy, motivational enhancement techniques, and relapse prevention training. Policymakers should expand access to rehabilitation services and incorporate training in self-efficacy in their public health campaigns for alcohol recovery. Future research should continue to explore the long-term role of social support in maintaining recovery, consider other psychological factors that drive behavior change, and consider various forms of social support, such as family, peer, or professional social support.

Overall, the study points to the need for not only the structured environments of treatment but also relevant recovery interventions that focus on the psychological resilience and motivation of alcohol users, rather than just social support.

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