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Perceptions of Chronicity and Recovery among Youth in Treatment for Substance Use Problems

Rachel Gonzales, Ph.D. M.P.H.[a], **M. Douglas Anglin, Ph.D.**[a], **Rebecca Beattie, M.P.H.**[a], **Chris Angelo Ong, M.P.H.**[a], and **Deborah C. Glik, Sc.D.**[b]

[a]Integrated Substance Abuse Programs, University of California, Los Angeles

[b]School of Public Health, University of California, Los Angeles

Abstract

Purpose—To explore how youth contextualize substance use problems and recovery, in general and for themselves, in relation to the commonly accepted chronicity framework.

Methods—Fourteen focus groups were conducted with 118 youth in substance abuse treatment settings (aged 12-24; 78.3% male; 66.1% Latino) located throughout diverse areas of Los Angeles County. Transcribed qualitative focus group data were analyzed for major substance use and recovery themes.

Results—Most (80%) youth do not accept a chronicity framework that conceptualizes substance use problems as recurring and constituting a life-long illness. Most (65%) view substance use problems as a function of poor behavioral choices or a developmental/social lifestyle phase. Youth perceptions of recovery tend to parallel this view, as most define recovery to mean having an improved or changed lifestyle that is achieved through making better behavioral choices (67%) and exerting personal control over one's behavior (57%) through willpower, confidence, or discipline. Other recovery themes identified by youth were substance use related (47%), wellness or well-being related (43%) and therapeutic or treatment related (14%).

Conclusions—Findings highlight the importance of considering youth perceptions about substance use chronicity and recovery in making improvements and promoting new developments in clinical and recovery support approaches to better meet the needs of youth with substance use problems. Findings are discussed under a theoretical context of behavior change to provide insights for the treatment and recovery communities.

Keywords

Treatment-involved Youth; Substance Use; Chronicity and Recovery

Substance use among young people is a long-standing public health concern in the United States. Approximately 10.1% of youth under 17 have used illicit drugs in the past year, among whom 7.3% meet criteria for substance abuse/dependence. Rates increase in older youth 18-24: 21.5% have used illicit drugs and 19.8% meet criteria for substance abuse/

Address Correspondence to: Rachel Gonzales, UCLA ISAP, 1640 S. Sepulveda Blvd, Suite 320, Los Angeles, CA 90025. rachelmg@ucla.edu.

dependence [1]. Examining the public treatment landscape in California, 30% of past year admissions (210,846) were under 25 (12% 12-17; 18% 18-24) [2].

Treatment outcome studies with youth demonstrate that treatment produces positive changes in substance use and other psychosocial outcomes [3]; however despite "effective" treatment exposure, such benefits tend to diminish over time. Studies show that 60-70% youth relapse during the first 90 days after treatment [4-5] and two-thirds move in and out of recovery during the subsequent year [6, 7]. Trends appear similar to clinical adult populations: repeated cycles of remission-resumption of use and treatment re-entry as relapse risk continues 4 to 5 years after initial abstinence [8-10]. To date, considerable agreement exists throughout the substance abuse treatment community that substance abuse/dependence is best characterized as a chronic, relapsing disorder [11,12] with increasing support given to a "chronic health/illness" contextualization of it [13] similar to psychiatric and other long-term illnesses [14-16]. Despite increasing support for a chronicity/illness framework [16, 17], the applicability of such a model to youth populations is less studied and findings are still emerging.

The chronic illness contextualization of substance use disorders has had major implications in the field around the area of recovery [18, 19] given the need to promote and sustain benefits gained during substance treatment [20-23]. Although still evolving, most of what is known about recovery is based on outcome studies with adults; commonly defined in reference to abstinence, quality of life, and citizenship [24] and characterized as a process (rather than a discrete outcome) linked to 12-step involvement [25].

Substance use "recovery" has been a largely understudied area among youth populations, as most attention tends to focus on understanding initiation/maintenance processes [18, 19], identifying effective treatment models [26], and evaluating treatment via outcomes analysis [27]. Although research has attempted to understand the developmental pathology of dependence and recovery [28-30], findings remain unclear and are often contradictory, as some research rejects a pathological process altogether and supports a "natural recovery" process where youth outgrow such problems [31-34]. This complexity is supported by substance use etiological and maintenance research that characterizes youth substance abuse/dependence patterns based on a diverse array of cognitive, attitudinal, social, personality, pharmacological, and developmental risk factors constantly in flux [28] that are different from adult substance abuse clinical pathology [26-27]. In efforts to better understand youth substance abuse/dependence and recovery, this study utilizes a qualitative approach to explore youth perceptions about substance use chronicity and recovery.

Methods

Participants

The average age of the 118 youth was 17.4 ± 2.9 years (range 12-24). Most were under 18 (79.1%), male (78.3%) and Latino (66.1%). Other racial/ethnic groups included: White (25.2%), Black (3.5%), Native American (1.7%), Asian (0.9%), and Other (2.6%). Youth were asked about their "primary substance of abuse" that they were receiving treatment for; results indicate that the majority were in treatment for marijuana (40.9%) and methamphetamine (30.4%), followed by heroin (7.8%) and prescription opiates (6.1%), alcohol (6.1%), ecstasy (4.3%), cocaine (2.6%), and polydrug use (1.7%). Many were treatment first-timers (67.8%) and in outpatient (69.5%) programs. Characteristics are representative of the youth from the California system [2]: average age of youth admissions is 17, 68% male, and 59% Latino.

Procedures

A convenience sample of youth (aged 12-24) enrolled in participating substance abuse treatment programs in diverse Los Angeles areas (San Gabriel Valley, North Hollywood, West Los Angeles, San Fernando Valley, and Antelope Valley) were recruited to participate in the qualitative study by the study research assistant using research procedures approved by the Institutional Review Board of the University of California Los Angeles. Treatment-involved youth who voluntarily agreed to be part of the qualitative study participated in a 90-minute focus group that was conducted at respective substance abuse treatment programs. Each participant received a $10 gift card for their time. All focus groups were digitally audio-recorded, moderated by the Principle Investigator (PI) of the study with assistance from the study (RA) using a structured focus group script [35].

The scripted questions covered “youth” perceptions and attitudes around reasons for substance use behaviors (etiology and maintenance), attitudes around the concept of addiction and dependence, opinions about the applicability of a chronic illness model to young people in treatment for substance use, reasons for substance use relapse and risk factors, perceptions about dominant treatment models (including 12 step approach), and views about the concept of recovery, including definitions, goals and types of approaches that would be useful to young people (as opposed to older people with substance use problems). Additionally, youth participants anonymously completed a brief demographic questionnaire for descriptive purposes.

Data Analysis

Focus group audio recordings were transcribed verbatim by two study Research Assistants (RAs) and edited and re-reviewed by the research team for accuracy and fidelity [35]. Transcripts were coded using a systematic set of procedures based on grounded theory [35] to inductively develop general themes around youth perceptions of substance use chronicity, treatment, and recovery. For analysis purposes, a codebook was developed using ATLAS.Ti qualitative software, where the PI and RAs separately assigned frequency counts to responses to determine reliability of emergent themes using a majority response pattern and ranking scheme of the codes [36]. Divergent coding was resolved by internal reconciliation. Descriptive analysis of demographic characteristics was conducted using Statistical Program for Social Sciences v 18. Because of the assured anonymity, demographic data could not be linked to focus group responses; hence results are presented descriptively.

Results

Results below are emergent themes based on the 14 focus groups (N=118) illustrated with select quotations. Note, direct quotes from youth were edited for more consistent and cleaner sentence structure whereby awkward terms of “umm,” “ugh,” and suchlike were removed.

Perceptions of Substance Use Chronicity

Four domains emerged from qualitative responses given to the questions “how would you define substance use problems in your own words and do you view substance use among treatment-involved youth a long-term chronic illness?”

The dominant theme characterizing substance use problems among youth is lifestyle behavioral choice (65%):

> “*It's a bad habit...and poor choice of behavior.*”

> “I wouldn't agree that substance abuse for youth is a chronic issue or illness because I used for years and now I don't. I mean I don't feel stuck or like sick...and

> really don't think it's the same for adults because, if you really want to stop, you'll stop. It's just about focusing on changing your life or doing something with your life."
>
> "I don't think you should categorize everybody (young or old) as chronic or sick because people have a will and a choice, so if they think they can stop, then they can and shouldn't be categorized as if they can't."
>
> "For me, even though the cycle of addiction has been going on for generations in my family, I believe I can break this cycle because I'm still young and can have a life without drugs if I choose to (mind over matter). I don't think young people have a chronic problem like older people probably, because young people still have a chance to stop [the addiction] before getting there."

A majority (75%) holding this lifestyle view indicated that substance use is a matter of personal control and stopping depends on individual willingness:

> "I don't agree with the chronic illness view because you can get the desire to change or just get bored with what you're doing [using] and just stop. If the person themselves don't want to change, they won't change...and if they are willing to stop, they will."
>
> "Any young person can stop no matter how much they are using, they just have to really want to achieve something else. If you have goals in life and you want to reach them, then that'll be a good reason to stop."

Among those that held a lifestyle view, 25% expressed "*they can stop their use without formal treatment*," and 75% indicated "*they didn't see a need for continued treatment.*" Rather, they believe that once they finish, it's up to them not to use again, reinforcing personal choice and control:

> "Substance use is a self-decision. So when they get out of treatment – they can choose to go straight or decide to go back to using. Everyone has a choice."
>
> "Many here are forced to come by probation officers, parents or teachers...they got caught and not here by choice. So they'll stop using when they are ready to."
>
> "There are many success stories of youth that don't do aftercare (12-step program) but just found something else to keep them busy and clean...because the steps are nothing but busy work. They are not something magical you need for the rest of your life. I think treatment helps you set the path and open your mind to what you could be like, but it's mainly yourself and decision to do it."

Many (45%) of those that held a lifestyle view expressed frustration with receiving chronicity-type information about substance use from programs:

> "It's frustrating that one of the main things they teach us here is that addiction is a chronic disease that we will have for the rest of our lives. They don't understand that we are constantly challenged in a society with being normal young people. This is especially hard to do when we got counselors telling us we are sick and will be in recovery for the rest of our lives."
>
> "Some of the information they sell us here about being a lifelong disease just doesn't apply. It doesn't account for the fact that we can control our behaviors. We are not 50 or 60 who may at that point have a chronic problem...we are still young (18, 21, or 23) and still have a chance to get out of this mess."
>
> "The treatment people here do not really get or understand youth and how substance use is really just a big part of growing up. So telling us that we need to

continue with treatment for a long time after or be part of the 12-steps is not necessary or what we plan to do."

The second theme generated for substance use problems is psychological (45%):

"It's psychological - using to deal with stress like being in a social situation or a work situation or trying to face your chaotic day."

"Substance abuse is really a matter of looking at the reasons for use in the first place. From all the information I hear about why people get prescribed certain antipsychotic or any sort of medication for any ailment, it makes me think that people are really just self medicating for something they might have an underlying problem for."

"When I crave drugs and relapse, it's because of emotional pain, like loneliness or anger - not because I'm physically sick like a diabetic or cancer patient."

"It seems like the larger problem is always your mental state. Most people here have a lot of self hatred, depression, anxiety, and fear. Yes, you can talk about all the external things, like triggers, but until you can do anything for yourself internally, nothing of what they tell us here is gonna matter."

The third theme generated related to how youth substance use problems is loss of control (35%). These youth endorse the chronicity framework:

"I agree with the chronic disease view because I've been through it many times and I use because I need it. I will run over you, I will run through you, I'll steal from you. I'll do whatever it takes to get it...whatever it takes."

"Yes, it's an illness because it's not like you just want it anymore, you need it. You can't go on without it."

"I agree with the chronicity view because I think the desire for me will never leave. Thinking about it, using was such a comfort to me...even though it was negative for me (consequences), it still brings those feelings for me that are out of my control."

Many (25%) of these that support this view base this assumption on drug severity:

"I think chronicity depends on what drug it is...some drugs are more addictive than others...like marijuana is not as addictive as heroin or meth, you know."

"I would agree with substance use disorders being chronic for those who are on meth because they experience addiction symptoms, like withdrawals, urges to use more, and all of that."

"The chronicity factor depends on what you use...the type of drug, like meth or heroin, because weed doesn't do that. I haven't met a person who got the shakes from not smoking weed."

"I think this chronicity view holds up for people on meth because...I think that is always in the back of your head that comes. I've heard people in meetings talk about it...they have 50 years clean and they still have that voice...and I know what they're talking about because I get it and it's like fuck it tells you to do shit...it's not like I'm hearing voices, it's just a powerful addictive drug."

The last theme identified for youth substance use problems was related to social development (25%):

"It's just like a little thing young people go through, like a phase...it's just a time in their life because they are young."

"Substance use is really just a big part of growing up."

"Using is a pastime and is what we do to connect [with peers], and exist in our social surroundings."

Recovery Perceptions

Five recovery domains were generated from responses to the question "how would you define recovery in your own words or what does recovery mean to you?"

The dominant recovery theme identified (67%) related to lifestyle improvement:

"Starting a new life, having a fresh start at life, or changing your life."

"*A second chance on life, regaining what you lost.*"

"Being successful (education or career, keeping on track with life goals."

"Doing something else with your life, like finding a better high, and doing whatever brings you joy."

The second recovery theme related to personal control (57%):

"Having confidence in yourself because change is a challenge."

"Being disciplined or having will power to change and refusing to lose."

"It's maturing and changing your personal thoughts about using."

The third recovery theme was substance use-related (47%):

"If you want to hear what they tell us here...sober comes to mind or learning how to be sober - live without mind-altering substances."

"*Staying clean...not using any drugs.*"

Many of these (25%) indicated that "sobriety" or "getting clean" is typically how they hear recovery referenced to in treatment settings. Although there was no reference to abstinence given in definitions, these youth were asked to comment on the extent to which their definition included "*total abstinence.*" Few (10%) endorsed total abstinence and supported "just not using their drug of choice and being able to still use (on occasion) any other drug, like caffeine, tobacco, or alcohol."

The fourth recovery theme had to do with wellness or well-being (43%) as reflected by the following statements:

"*Getting better.*"

"*Being healed.*"

"Improving your brain and body, physically and mentally."

"*Having a positive mentality, being happy again.*"

"Coping with life, dealing with stress and anger in a better way."

"Getting fit or in better shape, like playing sports, skating, dancing, working out, exercising."

The last recovery theme was therapeutic-related (14%) and had to do with receiving treatment or recovery-based self-help models:

"*To be in treatment to fix your problem.*"

"*Getting the right amount of help to stop using.*"

> "Something that treatment can give, like that motivation you wouldn't necessarily get from your own sense of motivation."

> "Going to NA/AA...because it gives a second chance to get to do what you want to do. Now I have confidence, different beliefs...friends who have gone through the same experience that pushed me along when I didn't want to do anything."

When questioned about the utility of 12-step as a viable method of recovery support for youth, the majority (90%) dislike and 25% express frustration with the 12 step recovery rhetoric they hear commonly promulgated in treatment:

> "Oh I hate those... they are stupid...and a waste of time...they are boring and for older people...nobody wants to hang out at AA/NA meetings."

> "It doesn't matter if you're older or younger...they don't work."

> "They just tell you the stories about using that make you want to do some more or learn different ways to use."

> "One thing that I wish was different in here [treatment] is the recovery rhetoric. There's a lot of like, yea there's stuff from research but I mean a lot of it is about self-control. Yeah I go to meetings, yeah I believe in a higher power, yeah surrender yourself to addiction...but it's just different for us."

> "I just wish there was a group that wasn't like NA/AA but rather met our [young people's] recovery needs...and was just about moderation. Not in treatment joints...they don't tell us about places we could go to that had a moderate understanding of our use."

For about a fifth, recovery was difficult to define: "I don't know." "That's hard for me to define." "Too difficult, pass." "If we knew what it is or what we're supposed to be doing, then we probably wouldn't be here."

Discussion

Although several treatment-specific approaches that have shown promise in producing positive outcomes for youth including family therapy, cognitive-behavioral therapy (CBT), and motivational enhancement therapy/with CBT [28, 37], relapse is still a prominent issue for youth [4-8]. Despite considerable efforts that attempt to understand the chronicity and recovery of substance use disorders, little attention has been given to these concepts within the youth treatment system.

This study utilized a qualitative, inductive inquiry approach to explore youth perceptions about substance use chronicity and recovery. Results suggest that the chronicity-illness rhetoric does not readily resonate with treatment-involved youth. For most youth, substance use problems are considered to be more of a behavioral lifestyle (individual choice) rather than a life-long chronic illness (i.e., they don't view it as serious; they feel they can stop at anytime without relapse concern; and they don't think they're at risk for negative outcomes. This dominant perception, however, is well ensconced in the Health Belief Model (HBM) [38], which assumes that a critical factor involved with continued risk-taking behavior (e.g., substance use) is the optimistic bias youth carry about personal risk. Results highlight that most youth misperceive the true risk of their substance use behaviors as they have difficulty understanding the effects of cumulative risk (chronicity/illness) of continued use over time. Although having optimistic beliefs about health can positively affect personal health behavior [39]; it is important to question, from a youth standpoint, such optimism in substance abuse settings as it may serve to hinder one's willingness to accept treatment or recovery support models and constituent behaviors.

Youth perceptions of recovery parallel how they view substance use problems as well. Most define recovery as “changing or improving one's behavioral lifestyle,” as well as asserting personal control, like confidence, maturity, discipline, and will power” over their lives. Although the theme of wellness (or well-being) was tied to recovery, reflecting on youth definitions of “healing, getting better, fitness, or coping” can also fit with the lifestyle improvement theme. Using the HBM premises, cessation has a greater chance of occurring when the substance use behavior is replaced with a “new behavior” that is of value to them and provides outcome(s) that they expect will be positive or give the same (or better) benefits of those associated with the substance use behavior. Based on the treatment effectiveness literature, the “new behaviors” typically promoted to youth in treatment settings are “substance related-abstinence” and “continued participation in 12-step” [3, 37]. Our findings question the value youth place on such acquired behaviors, since most downplay the importance of these as recovery components.

Results highlight the potential utility of using intervention-based models of behavior change (such as the HBM) as they tend to focus on “tertiary prevention/education” as opposed to commonly used “clinical” models that focus on the clinical aspects of the addiction-relapse cycle. Our data question whether or not youth can be readily placed under theoretically-defined clinical stages, such as pre-contemplation of the commonly applied transtheoretical model [38]. Using premises from the HBM (i.e., educational and persuasive strategies that target misperceptions about risk) can be useful for providers working with youth as it does not approach them from a “disordered, chronic” state with a serious clinical problem, especially among youth who are resistant to clinical treatment (i.e., there because they were “caught” or “coerced”). This approach moves away from telling youth they have a clinical problem to “teaching” them about their increased vulnerability and risks to biological addiction, even though they may not initially “see or feel” it, thereby raising their awareness for why they should start viewing their substance use as “irrational behavior.”

Our findings suggest that programs should have greater sensitivity in too quickly applying the currently endorsed recovery rhetoric (abstinence and 12-step participation) to youth. Providers should emphasize the need for recovery support after treatment, but in so doing avoid giving the impression that recovery support needs to be life-long. Even though the 12-step model seems an ideal candidate for supporting recovery, we found it is not readily accepted by most youth. As supported by our findings, there are competing messages worth exploring between what is conveyed in 12-step venues and how youth perceive notions of behavioral control. A major premise underlying the 12-step model is that substance abuse is a progressive physiological disease that can only be successfully addressed through “relinquishing personal control” to a higher power and maintaining a “life-long commitment to total abstinence” [40], messages that are resisted by most youth.

Overall, findings suggest that more efforts are needed to develop age-appropriate recovery support models for youth. Foremost, the data point to the need to re-evaluate the treatment system orientation towards youth as a whole given that “youth-specific treatment” has been largely based on adult treatment model historical artifacts [37]. Given that most youth rated lifestyle improvement as a top recovery priority, treatment programs should advocate such activities. Further, because recovery support is vetted upon delivering/receiving “social support” from embedded social networks, future research should identify which among the theoretically grounded types of social support [38] are most appropriate to youth as sources of recovery support: (1) emotional (empathy/caring), (2) instrumental (aid/services), (3) informational (advice/information), or (4) appraisal (constructive feedback/affirmation). More work is needed to understand how to develop recovery support models that provide equal benefits of youth “social networks” and minimize the costs of “changing/losing peer networks,” considered to be a major clinical challenge in achieving behavior change.

Limitations

This study has several limitations. The participants represent a narrow selection of young people with substance use problems as they are treatment involved and results may not generalize to youth with substance use problems outside of treatment. Additionally, although the treatment sites used to conduct the qualitative work include a homogeneous treatment population of youth, the results cannot be over-generalized to treatment-involved youth in other treatment settings. However, we did find that sample characteristics matched those obtained for all California treatment admissions to public programs during the same period. Furthermore, because the data are based on focus group methodology, a limitation that is worth noting is that youth responses may be an artifact of emergent group norms, i.e., they may reflect more of a "shaped normative response" rather than unique personal responses. Additionally, results presented are descriptive in nature and could not be examined by unique demographic characteristics due to confidentiality limitations associated with anonymous focus group data collection. Nor were they analyzed by type of setting. Further research should find procedures to remedy such deficiencies.

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