Published in final edited form as:
Am J Health Behav. 2012 September ; 36(5): 602–614. doi:10.5993/AJHB.36.5.3.

Understanding Recovery Barriers: Youth Perceptions About Substance Use Relapse

Rachel Gonzales, PhD, MPH [Research Psychologist],
Integrated Substance Abuse Programs, University of California, Los Angeles, CA, Semel Institute for Neuroscience and Human Behavior, David Geffen School of Medicine at UCLA, Los Angeles, CA

M. Douglas Anglin, PhD [Professor in Residence, Associate Director],
Integrated Substance Abuse Programs, University of California, Los Angeles, CA, Semel Institute for Neuroscience and Human Behavior, David Geffen School of Medicine at UCLA, Los Angeles, CA

Rebecca Beattie, MPH [Staff Research Associate],
Integrated Substance Abuse Programs, University of California, Los Angeles, CA, Semel Institute for Neuroscience and Human Behavior, David Geffen School of Medicine at UCLA, Los Angeles, CA

Chris Angelo Ong, MPH [Staff Research Associate], and
Integrated Substance Abuse Programs, University of California, Los Angeles, CA, Semel Institute for Neuroscience and Human Behavior, David Geffen School of Medicine at UCLA, Los Angeles, CA

Deborah C. Glik, ScD [Professor]
School of Public Health, University of California, Los Angeles, CA

Abstract

Objective—To qualitatively explore how treatment-involved youth retrospectively contextualize relapse from substance use.

Methods—Fourteen focus groups were conducted with 118 youth (78.3% male; 66.1% Latino) enrolled in participating substance abuse treatment programs (4 young adult and 10 adolescent) throughout Los Angeles County. Transcripts were analyzed for relapse perception themes.

Results—Dominant relapse themes include emotional reasons (90%), life stressors (85%), cognitive factors (75%), socialization processes (65%), and environmental issues (55%).

Conclusions—Youth perceptions about relapse during treatment should be used to better inform clinical approaches and shape early-intervention recovery agendas for substance-abusing youth.

Keywords

substance abuse treatment; relapse; youth perceptions; adolescents; young adults

Contact Dr Gonzales; rachelmg@ucla.edu.

Substance use problems among youth under 25 represent one of the major prevention and treatment issues in the United States: nearly 70% of all youth mortality (ages 15–24) has been attributed to unintended injuries, homicide, and suicide,[1] all of which are highly correlated with substance use behaviors.[2,3] Moreover, statistics from general population US-based prevalence surveys, national treatment admission data, and juvenile justice drug offense cases support the extent of problem. National (US) survey studies show that illicit substance use and binge drinking trends for youth are up from previous years: 10.0% of 12- to 17-year-olds and 21.2% of 18- to 25- year-olds report past-month use of illicit substances, and past-month binge drinking rates were 8.8% and 41.7% for 12- to 17-and 18-to-25-year-olds, respectively.[4] Publicly funded treatment admissions are also high: 7.6% of admissions are under 18 and increase to 21.6% for those 18 to 25.[5] Substance use-related juvenile/criminal court cases are common as well: 44.2% of all cases ages 10–24 were for drug offenses, 15.1% for juveniles 10–17 years of age.[6]

Given such public health complexities, much of the attention regarding addressing substance use issues among youth has been directed at interrupting drug use through treatment settings, where the main goals are to “effectively reduce substance use behaviors and improve critical areas of life functioning that are expected to be positively influenced by treatment.”[7] Large-scale treatment outcome studies with youth demonstrate that treatment (in general) produces positive changes in substance use and other psychosocial outcomes;[8–11] however, treatment benefits tend to diminish over time.[12] Substance use “relapse” is of primary concern, which is typically about 65% in the first 90 days after treatment and increases to rates of about 85% during the post-year follow-up period.[11,13–20]

Relapse has been contextualized both as a “discrete outcome” or “a process.” [21] Definitions of relapse also differ and typically have been either operationalized as “a return to any use” or “a return to original problematic use” before treatment.[22,23] There have been several attempts to establish specific conceptual models for relapse among adult populations.[23–33]

To date, conceptual models tend to categorize relapse using 4 major precursors/antecedents,[34,35] including the specific drug (agent), characteristics of the user (personal), characteristics of the user’s social relationships/setting (interpersonal), and environmental (situational) factors. Relapse precursors that have received the most support include negative affective emotional states,[34,36,37] cognitive-behavioral factors including self-efficacy/confidence,[38] outcome expectancies,[39] urges/temptations,[40] coping,[41,42] and motivation/readiness to change.[34,44,45]

Interpersonal determinants include relationship conflict,[46–48] social pressures,[49] social support, and life stressors.[50–53] Environmental determinants include cue-situational exposures and geographic disadvantage, ie, high availability of drugs, crime and poverty.[27,54–57] Despite these findings, many studies conclude that relapse is often random, complex, and dynamic,[58–60] determined by an interaction of diverse physiological, individual, and situational factors,[32,61] and cannot be solely captured by a single process model.[62]

Research on substance use relapse among youth is less extensive. Existing youth-based studies have identified similar relapse determinants as are found among adult samples[63–66]; however, it is considered to be particularly more complex for several reasons: adolescents are still undergoing brain maturation and are in the midst of greater cognitive and social-emotional development processes;[67–69] have higher co-occurring mental health and psychosocial dysfunctions within family, school, and legal settings;[70–73] have greater influence from social agents/events;[74–76] have different clinical courses of substance use severity/diagnosis[77–80] and lower levels of treatment motivation.[80,81]

Although the literature is growing in the area of substance use relapse among youth populations, retrospective accounts of the relapse process are limited, and many substantive questions remain. This study employed a qualitative approach to examine the following research questions: (1) How do youth in treatment perceive their risk for substance use after treatment? (2) What are some major factors that are associated with relapse risk among treatment-involved youth? This study seeks to address these questions to identify some of the early warning signals indicating potential relapse for youth 24 years and younger to better inform clinical approaches to better meet the needs of substance-abusing youth as well as shape early-intervention recovery agendas.

METHODS

A convenience sample of youth aged 12–24 was drawn from participating substance abuse treatment programs (10 adolescent specific and 4 adult) in diverse Los Angeles areas (San Gabriel Valley, North Hollywood, West Los Angeles, San Fernando Valley, and Antelope Valley). Unlike the adolescent-specific programs used, this sample does not include young adult-specific programs, but rather a select set of participating adult programs that had designated young adult groups to capture youth 18–24. Hence, due to the participating treatment sites availability of young adults, there are fewer young adults groups available. Research procedures were approved by the Institutional Review Board of the University of California Los Angeles.

Participants

One-hundred eighteen youth between 12 and 24 constitute the study sample: average age was 17.4 ± 2.9 years; 78.3% male; 66.1% Latino and 25.2% white (25.2%); 69.5% were in outpatient treatment; and most reported marijuana (40.9%) or methamphetamine (30.4%) as their primary substances of abuse. Sample characteristics are representative of youth based on wide-scale California treatment evalautions: average age of youth admissions is 17, 68% male, and 59% Latino.[84]

Procedure

A total of 14 focus groups were conducted with 118 youth in participating substance abuse treatment programs between September 2010 and December 2010. Focus groups were 90 minutes in length and digitally audio-recorded. Each participant received a $10 gift card for incentive. The principal investigator (PI) moderated each group using scripted questions.[34]

A research assistant (RA) trained in focus group procedures assisted with moderating the focus groups.

The scripted questions covered youth perceptions and attitudes around substance use behaviors, substance use relapse, and substance use recovery. The focus group leader (PI) used a standardized script to discuss the relapse concept and provide a common level of understanding of relapse. For this, participants were asked to think about life after treatment and consider the most common situations or reasons that caused them to relapse (defined as both (1) using any alcohol or drugs again and (2) reverting back to their pretreatment pattern of drug use). Using the following scenario: "Jane/John went through treatment for substance use problems. After treatment (within the next 3 months), he/she relapsed. Finish my statement: 'He/she relapsed because…?' " After general responses to the relapse scenario were noted (ie, stress), specific reasons related to each response were assessed (ie, family, school, legal, etc). In addition to participating in the focus group discussion, all participants anonymously completed a demographic questionnaire collecting age, gender, race/ethnicity, primary substances used, and treatment history information for descriptive purposes.

Data Analysis

Audio recordings for 14 focus groups were transcribed by 2 research assistants and edited and re-reviewed by the research team for accuracy and fidelity. Transcripts were coded using a systematic set of procedures based on grounded theory[84] to inductively develop themes around relapse perceptions among youth. To ensure completeness and accuracy, 2 reviewers coded each transcript, and a third coder was used to resolve any discrepant coding by a consensus approach with the research team.[85] Using ATLAS.Ti, a qualitative statistical software program for content and text analysis,[86] focus group responses from all youth participants (N=118; 92 adolescents and 24 young adults) were assessed to obtain overall percentages for each theme identified and unique responses per theme by age-group. Responses to the brief demographic questionnaire were quantitatively analyzed using SPSS, version 18; however, because of the assured anonymity, demographic questionnaire data could not be linked to focus group responses; hence, these results are presented descriptively. Overall, themes reported in results are based on analysis of open-ended responses to focus group scripted questions. Where appropriate, focus group (age) differences (ie, adolescent versus young adult) are reported.

RESULTS

Table 1 provides 5 major themes that emerged in response to qualitative youth responses to the relapse scenario "He/She Relapsed Because…" This table is followed by examples of youth statements supporting each theme. It is important to note that some youth (from 10 adolescent focus groups, n=92) did not even know what *relapse* meant (10%). For these youth, they were asked to consider responding to the questions based on the definitions of relapse used in the field [defined as (1) using any alcohol or drugs again or (2) reverting back to their pretreatment pattern of drug use].

Emotional Reasons

The dominant relapse theme for youth, including both adolescents (ages 12 through 17) and young adults (ages 18 through 24) was emotional reasons (90%), feeling unable to cope with negative emotions without drugs. Table 2 displays combined statements from youth supporting this theme.

Life Stressors

The second theme identified was life stressors (85%) for both adolescent and young adults as supported by statements such as “To take the stress away,” “To get away from life stressors,” “Because life and everything that comes with it – sucks.” However, when questioned more deeply about the reasons for stress, responses greatly differed for adolescent and young adult participants worth noting. For adolescents (12–17), stress was referred to more so because of parents (criticizing, nagging, mistrust, conflict, put-downs, no faith/confidence in us, not being around), school (failing classes, getting in trouble), and peer pressure (fitting in); whereas older-aged youth (18–24) were more likely express stress in terms of realities of life that had to do with intimate relationships (commitment), financial responsibility (debt, employment issues) and housing stress (rent and bills). Table 3 displays statements from both youth groups supporting this theme.

Cognitive Factors

The third theme in response to “He/She Relapsed Because…” was cognitive (75%), with the dominant reasons for both adolescents and young adults alike being poor motivation, craving/urges, and low confidence. Table 4 displays combined statements from youth supporting this theme.

Socialization Processes

The fourth theme had to do with socialization processes (65%); however, responses regarding the type of social processes differed between adolescents and young adults. Specifically, adolescents were more likely to note peer pressure and media influence whereas young adults discussed issues related to social networks and social norms. Table 5 displays statements from both youth groups supporting this theme.

Environmental Issues

The final theme identified among both youth groups was environmental issues (55%), which included responses about access/availability and cues/triggers (55%). Table 6 displays statements from both youth groups supporting this theme.

Discussion

Considering the relapse ecology of youth, our data highlight 5 major reasons for youth relapse: negative emotions, stress, cognitive factors, socialization processes, and environmental issues. Although this study contributes a qualitative assessment of the relapse process among treatment-involved youth, there is still significant complexity in understanding the developmental pathways to relapse.

As supported by our results, such pathways are best conceptualized as multifactorial,[87,88] which fall into 3 general theoretical streams of influences: individual-level factors, socialization influences, and broader environmental influences. Specifically, individual-level influences included negative emotions, stress, and cognitive factors; socialization influences included peer pressure, social network/social norms, and media influence; and broader environmental influences included access/availability and cues/triggers, which merit separate discussions for each. It is important to note that, as discussed in the introduction, these relapse determinants are fairly similar to relapse factors observed among adult samples;[63–66] however, such relapse processes have more emphasis around social-emotional and environmental development processes, rather than personal clinical orientations around substance use severity.

Negative emotions—Research supports that the majority of youth with substance use problems also have one or more co-occurring problems such as depression, anxiety, traumatic stress, self-mutilation or suicidal thoughts, hyperactivity and conduct disorder, criminal or violent tendencies, etc. Prevailing beliefs under the psychoanalytic framework is that drug use is a symptom of an underlying psychological disorder.[89] Accordingly, substance use is a secondary condition caused by underlying mental disturbances, known as the self-medication model, whereby individuals use drugs to self-medicate or relieve symptoms of psychological distress.[90] Because relapse is likely to occur if these symptoms are not adequately addressed during treatment, a major goal of treatment programs is to include care and services (counseling interventions) that uncover and treat the underlying psychopathology feeding drug abuse behaviors.[91,92] Although treatment programs are working to effectively address such multiple problems simultaneously (eg, standardized assessment for other problems and provision/coordination of case management services),[16] extending these efforts beyond formal treatment is not a common practice.[95] It is possible that the positive outcomes observed in treatment could be better sustained if posttreatment recovery maintenance services (ie, continuing care models) included emotion regulation and coping skills for dealing with negative emotions.

Stress—Stress has been well established as a significant risk factor for relapse.[96–101] We found developmental differences in relapse-associated stress that support the conceptualization of stress “as a relationship between an individual and his/her environment.”[102] For adolescents, parental issues, peer pressure, and school problems were dominant stressors, whereas for young adults, stress was described more in terms of life circumstances, emerging adult responsibilities, and interpersonal romantic relationships that coincide with their current developmental period: “gaining greater independence” and “leaving the parent nest or family environment.”[103] Many studies consistently show that parents, peers, and school serve as major socialization factors in predicting the initiation, maintenance, and exacerbation of substance abuse in adolescents; and the stress-related findings specific to young adults are similar to what is typically found with older adults in treatment, which is linked to pretreatment problems of legal issues, relationships, job loss, and financial debt.[104,105] From a clinical and recovery support perspective, these results highlight the importance of integrating stress management efforts into programs rather than

simply focusing on parental, school, or employment problems specifically as is done in most programs.[76,106,107]

Cognitive factors—Three important cognitive factors warrant further consideration in terms of understanding relapse among youth: motivation, cravings/urges, and confidence, ie, self-efficacy. As other studies have found, relapse or continued use of alcohol and drugs, is related to the fact that few youth with substance use problems are motivated to be in treatment as they rarely express desires to quit or any strong commitments to maintain abstinence.[81,108,109] Further, most youth presenting for treatment are not self-referred. Instead, they are coerced by a parent, juvenile justice system official (judge, probation or parole officer), school official, child welfare worker, or representative of some other community institution.[8,10] These findings highlight the need for relapse prevention models in both clinical and recovery support settings to take into account the extent to which youth are motivated or ready to change their substance use behaviors.[44,110] Future research on youth relapse needs to consider the potential differences in perceptions among youth mandated to treatment versus youth voluntarily in treatment. By ignoring motivation at treatment admission, assessments of outcomes become complicated and often limit interpretation of relapse prevention models.

Confidence (self-efficacy) was also cited as an important cognitive factor related to relapse as has been found in other studies.[111] However, the confidence expressed by youth had more to do with one's ability to abstain from drugs in the face of life stressors or internal/social cues/triggers, such as the stress of fitting in, rather than on peer pressure associated with being "forced" to use drugs. This result highlights the importance of integrating stress management skills (in addition to peer resistance skills) into youth relapse-prevention models. Lastly, an interesting area of research worthy of further inquiry has to do with continued substance use after treatment that is not related to one's primary drug of choice, particularly tobacco use. As others have noted, a major issue facing individuals in treatment (in general) is a drug-use recovery environment that far too often facilitates tobacco use.[112]

Socialization processes—All youth support the view that relapse is a byproduct or function of socialization processes that influence developmental vulnerability for relapse. Although we observed differences in socialization processes between adolescent and young adults, the circumstances and extent to which relapse occurs is largely regulated by peer/social norms, customs, traditions, and standards.[113] In general, adolescents reported friendships and peer pressure along with media influence as important relapse triggers; whereas young adults tended to highlight social networks and social norms as dominant features of their social surrounding that influenced relapse.

Numerous studies have established that peer-group and social norm processes are strong influencers of drug use behaviors,[86,115,116] as they foster positive expectancies about drug use and create prosocial norms, and both serve to encourage drug use behavior.[117,118] It is important to point out that for most adolescents, cliques or friendship bonds are an important and a common feature during social/emotional development contributing to substance use risk behaviors.[114,115,120,121] However, as our data indicate, the peer/friendship clique might not be as important for young adults as they have "developed and matured" over time into a

web of social relationships and social networks more associated with larger social processes operating.[122]

Moreover, although not as apparent for older youth, media depictions of drugs were noted as important determinants of relapse by many adolescents. Other research supports this view, such that the tobacco and alcohol industries alone spend billions of dollars each year aggressively marketing their products to adolescents through depicting images of glamour, success, and independence – all highly esteemed social values within American society.[123] Such marketing strategies have paid off as noted by several studies showing a positive impact on youth decisions to smoke or drink.[124,125] Overall, such socialization processes that youth experience are complex issues that create obstacles for those attempting to develop a drug-free recovery lifestyle (ie, break free from peer pressure and extant social norms that promote and normalize substance use).

Environmental issues—As reflected by our data, environmental factors of access/availability and cues/triggers also play a critical role in facilitating relapse for youth. According to most, drugs are readily available and accessible to them. National survey data from Monitoring the Future highlight the importance of the positive relationship between perceived availability of drugs and trends in use among adolescent youth.[126]

To date, most attention on relapse determinants has been directed at individual-level factors, promoting the view that the responsibility for one's relapse ultimately falls on oneself and shifting attention away from larger environmental forces that also may be influencing relapse behavior. However, such environmental influences on relapse are important to consider as "the individual cannot be conceptualized as an autonomous actor making self-governing decisions in a social vacuum."[129] For clinical and recovery support programs to be effective, they must also address such structural influences.

Limitations

The present study must be considered in light of its limitations. The accuracy of relapse descriptions or circumstances among this clinical sample must be questioned as they are retrospectively providing aggregate perceptions of relapse rather than any specific experiences. Also, the data were from a single time point, thereby limiting conclusions regarding the process of posttreatment relapse. Additionally, the results cannot be overgeneralized to treatment-involved youth in other treatment settings given the variability between the treatment sites used to conduct the qualitative work as well as the nature of the sample used (convenience). Finally, focus group thematic results are only presented descriptively. Although it may be that the general risk for substance use relapse among youth as a whole may be similar, with some general differences noted among age-groups, there may be important gender or other differences in relapse risk factors among treatment-involved youth that this study did not consider due to confidentiality limitations associated with anonymous data collection. Further research should find procedures to remedy such deficiencies.

Conclusion

This study contributes to the extant literature on relapse specific to youth populations. Results add clarity to the dynamic process of relapse in youth as they explicate the actual experiences and perceptions of treatment-involved youth. Overall, there is no single variable sufficient to predict relapse among youth alone. Although individual (personal)-level factors have been shown to account for much of the variance explaining proneness to youth initiation and maintenance of substance use,[84,108] there is still a wide array of social and environmental forces that contribute to the progression of substance use behavior.[128,129] Hence, the interrelations among key individual, socialization, and broader environmental variables are likely to be of increasing importance for understanding the developmental relapse trajectories of treatment-involved youth.

Furthermore, because treatment for substance use and related problems tends to be treated acutely and for a relatively short period (less than 3 months),[130] a systems issue to consider is the need for ongoing interventions (continuing care) to promote the necessary skills acquired during treatment, as they may not carry over or be sustainable posttreatment. It needs to be recognized that most treatment-involved youth are in a structured clinical environment and when it is removed they struggle with the loss of structure as they transition into a less unstructured world. In the transition they continue to experience co-occurring issues that can hijack emotions, be exposed to drug using friends, encounter repeated life stressors, face competing social norms that reinforce drug use, enter into a broader environment where drugs and alcohol are frequently available, and continue to be triggered or cued to drug use. To minimize adverse effects, continuing care models must be developed addressing such complex, interrelated issues.

Acknowledgments

The authors would like to thank the administrative and treatment staff at the participating treatment programs for their support. This study was supported by a grant provided by the National Institute on Drug Abuse (NIDA), grant number DA027754-01A1.

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Table 1

General Themes of Substance Use Relapse Among Youth 12–24 (N=118)

	% Overall Group Response
Emotional Reasons	90%
Life Stressors	85%
Cognitive Factors	75%
Socialization Processes	65%
Environmental Issues	55%

Table 2

Combined Qualitative Youth (12–24) Statements of "Emotional Reasons"

"To cope or take the edge off of problems"
"To feel better about all the drama in our life"
"To cope with negative feelings, anger, sadness, loneliness, guilt, fear, pain, and anxiety"
"To escape or just to get away from reality"
"They don't want to face their fears"
"They know there is a better feeling than being sober where life sucks"
"Because it helps you break those internal barriers"

Table 3

Qualitative Statements of Life Stressors by Youth Group

Adolescents (12–17)

"Still, after treatment, parents continue to just criticize us all the time and put us down…we're no good, failures. They constantly complain and nag about how we do everything wrong. They don't trust us, where we go, who we talk to. Basically they have no faith or confidence in us."

"School is hard, all the homework, tests, and class things you have to keep up with…it never ends."

"Relapsing has to do with the stress of hanging out with your friends and fitting in." "Using starts as a social thing, and then after a while, it becomes all you do with your friends…You wouldn't know what else to do."

Young Adults (18–24)

"Well coming out of treatment you're on a pink cloud, telling everyone you're gonna do hella f'ing well…. And then life kicks in … just reality is a bitch… the stress is overwhelming and makes me, feel like stuck. Cuz I've gotten myself in a hole and that makes me want to use you know."

"Relapse happens because relationships go bad, break-ups and being lonely, sex becomes an issue, or just commitment issues."

"Drugs and alcohol become an easy solution for fears about your financial and life stressors…having a job or a place to live."

Table 4

Combined Qualitative Youth (12–24) Statements of Cognitive Factors

Poor Motivation
"They weren't ready or willing to do what it takes to stay clean."
"There are some who choose to be here, but most are here because of parents or court-ordered, so they're gonna relapse because they have to want to stop on their own"
"Because motivation is the biggest issue for most of us – and it's not there…everything told to us in treatment just comes in one ear and out the other"
"No more testing, they're finally out of treatment"
Cravings/Urges
"Having positive feelings that make you want to celebrate - have a drink or use"
"They had cravings because you are either in the presence of drugs or alcohol, drug or alcohol users, or at places where you used or bought drugs before"
"Because that's what typically happens after treatment – we all go back to craving or chasing that first high"
Low Confidence (Self-efficacy)
"Because they were scared to take on the challenge of quitting… they didn't have the strength to not use again"
"Not having confidence to manage their life on their own"

Table 5

Qualitative Statements of Socialization Processes by Youth Group

Adolescents (12–17)

PeerPressure

"Because my friends are negative influences…they keep asking – you want to get high"

"For me, it's not really about the place or situation - like a party, but about the people there – friends have a strong influence on what we do – they can turn any place into a bad place"

Media Influence

"Because they saw it glorified on TV or heard about how fun it is on the radio, so it reminds them of how it feels and how it's good, and how happy they will feel"

"I think because of the media influence. All types, TV, radio, film, internet, video games show alcohol, cigarettes, marijuana, prescription pills, other drugs, in a positive light and make using/drinking normal. So we start to believe it and think it's normal part of life"

Young Adults (12–24)

Social Networks

"They continued to want to party and connect with old drug use networks"

Social Norms

"Like seriously? Like if you've never tried pot. Like, I mean, you don't have to be a black tar heroin user, but I mean it's just what's in our social culture and expected"

"Because of the social standards or whatever you want to call them about using alcohol and drugs in our age group – young people just use a lot of drugs…and they think it's normal and being sober is not normal"

Table 6

Combined Qualitative Youth (12–24) Statements of Environmental Issues

Access/Availability
"We just have to walk down the street in our neighborhood…dope dealers and drugs are everywhere"
"We just have to walk down the street in our neighborhood…dope dealers and drugs are everywhere"
Cues/Triggers
"Just triggers – the day-to-day things we hear, see, do,"
"It's always around – in your face…and when you see it or smell it you're like damn, pass that - you might contemplate it little bit, but in the end, you just say, ok"