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## **Adolescent Recovery: What We Need to Know**

### **A Commentary**

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Student assistance professionals have long been on the front lines of responding to alcohol and other drug (AOD) problems among young people but have lacked service models derived specifically from studies of the long-term solutions to these problems. As a country, we have a commanding knowledge of the pharmacology of psychoactive drugs, adolescent drug use trends, and the factors that contribute to youthful drug experimentation. We know a great deal about the etiology, patterns, course, and consequences of adolescent substance use disorders, and we are beginning to build an impressive body of knowledge from studies evaluating prevention, early intervention, and treatment programs. Studies of AOD problems and interventions to resolve them have advanced our responses to these problems, but there are growing calls for extending the existing research agenda to embrace a resilience and recovery paradigm (White, 2005).

The resilience and recovery paradigm posits that solutions to AOD problems already exist in the lives of individuals, families, neighborhoods, and communities and that our focus of study should be extended to learn from these successes. The assumption is that studying “at-risk” individuals who have resisted development of AOD problems or who have experienced but then resolved these problems will reveal principles and practices that can lead to more effective prevention and treatment strategies. This article hopes to spark interest in this emerging paradigm by posing questions about the resolution of severe AOD problems among adolescents that have received limited scientific inquiry. These missing links stand as potential catalysts for system transformation in the prevention and treatment arenas.

### **Defining Recovery**

A factor inhibiting adolescent recovery research is the lack of scientific consensus on a definition of recovery. There is general agreement among adolescents who have resolved AOD problems and those who have

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assisted in that process that recovery is more than the removal or radical deceleration of alcohol and drug use from an otherwise unchanged life. Adolescent alcohol and other drug problems are often closely bundled with other personal or family problems. Recovery connotes the broader resolution of these problems and the movement toward greater physical, emotional, and relational health. Recovery also frequently involves improved educational and vocational performance, the formulation of and movement toward life goals, and acts of service to the community. We need a recovery definition that is marked by precision (offers clarity and measurability), inclusiveness (embraces varieties of AOD resolution pathways and styles), and exclusiveness (withholds recovery status from those lacking essential recovery ingredients, e.g., those who shift from alcohol dependence to cannabis dependence) (White, in press). Achieving such a consensus definition is a considerable challenge that must be met.

### **Degrees of Recovery**

White and Kurtz (2006) have described three depths of recovery based on the degree of change involved in the recovery process. These include full recovery (complete resolution of AOD problems and movement towards global health), partial recovery (reduced frequency, intensity, and consequences of AOD use and related problems), and transcendent recovery (full recovery followed by an extraordinary level of personal achievement and social contribution). What is the point-in-time prevalence of these different patterns of recovery among young people? What is the course of these patterns over time? Is partial recovery a permanent state or a precursor to re-addiction or full recovery? What factors predict depth of recovery? Are there particular types of services associated with the movement from partial to full recovery?

### **Recovery Prevalence**

We know from clinical follow-up and community surveys of adults that recovery rates for substance use disorders approach or exceed 50% across all ages (Dawson, et al., 2005; Vaillant, 2003), but we have no comparable studies that isolate long-term recovery rates for adolescents. We meticulously and repeatedly measure the incidence and prevalence of adolescent AOD use as well as changes in perceptions and attitudes toward such use, but we do not know the prevalence of adolescent recovery. Is the prevalence of recovery among young people increasing or decreasing in

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your school, in your community, and in the country as a whole? Do adolescent recovery rates differ by gender, ethnicity, drug choice, or other important variables? We need long-term National Institutes of Health studies that track the course of adolescent AOD problems and their resolution patterns into adulthood to help us answer such questions.

### **Age of Onset**

We know that lowered age of onset of regular alcohol and other drug use increases risk for the development of AOD problems and is linked to more severe AOD problems and related behaviors (White, Godley, & Dennis, 2003). We do not know how age of onset of regular AOD use affects later recovery prospects and processes. Nor do we know how age of onset of recovery influences styles and stages of recovery, or whether there are particular windows of opportunity for recovery initiation that, if not capitalized upon early, will not open again until a much later point in one's addiction career.

### **Recovery Effects on Risk**

We know that a family history of AOD-related problems increases an adolescent's risks for developing such problems, but we do not have answers to questions like the following. Does a family history of recovery ameliorate the risk for AOD problems in the generations that follow? Does the recovery of an adolescent affect the problem vulnerability or course of such problems among his or her siblings? Does recovery of a young person affect the recovery prognosis of siblings who subsequently develop such problems? Answers to such questions could have great import to prevention, early intervention, and treatment strategies.

### **“Recovery Capital”**

Nearly every adolescent screening and assessment instrument generates recommendations related to service needs based on an evaluation of problem severity data. Only a few of these instruments illuminate how a level of service intensity could be similarly influenced by *recovery capital*—a concept reflected in the recent emphasis on “strengths-based” approaches. Recovery capital is the total quantity of internal and external assets that an adolescent can draw upon to resolve AOD problems (Granfield & Cloud, 1999). Those of us who have had extensive contact with adolescents and

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young adults know individuals who develop transient AOD problems and then go on to resolve these problems without involvement in professional treatment or recovery support groups. The answer to why some youth mature out of AOD problems while others spiral into chronic drug dependence may well lie within this dimension of recovery capital. We need to know more about how problem severity and recovery capital interact to shape the course and outcomes of adolescent substance use disorders.

### **Pathways and Styles of Recovery**

There is growing interest in the religious, spiritual, and secular frameworks that aid recovery initiation and how these frameworks can evolve throughout the years of recovery maintenance. There is similar interest in the diversity of ways people achieve recovery (e.g., natural recovery, treatment-assisted, peer-assisted) and the changes in personal identity and interpersonal relationships throughout the recovery process (White & Kurtz, 2006). Little of this work has examined recovery across the life cycle or examined how recovery initiation and maintenance differs for adolescents and adults.

We know more about the adolescent treatment process than we know about the processes involved in long-term adolescent recovery. Knowledge of recovery could well serve as a foundation for dramatic enhancements in the quality and effectiveness of adolescent treatment. The goal is to move adolescent treatment from serial episodes of acute biopsychosocial stabilization to a process of sustained recovery support. That shift in focus could be guided by a new science of addiction recovery.

### **The Stages of Adolescent Recovery**

There are anecdotal reports of youth with severe substance use problems who experience a profound breakthrough of self-perception that suddenly and permanently alters their prior pattern of substance use. Yet recent studies of transformational change experiences have focused exclusively on adults (Miller & C'de Baca, 2001). A pattern of recovery more commonly seen by student assistance and treatment professionals occurs when young people move through substance use problems toward the achievement of stable recovery in incremental steps. The Transtheoretical (Stages of Change) Model (Prochaska, Norcross, & DiClemente, 1994) has been a popular framework to explain how people who are drug dependent move from problem denial/minimization through increased awareness to

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problem resolution and solution maintenance, but this model is being scientifically challenged (West, 2005) and has not been tested in well-designed studies for its applicability to the adolescent recovery process. We need to map the course of long-term adolescent recovery and the support strategies that are most helpful at particular stages in this process.

## **Recovery and Family Environment**

There are numerous studies on the effects of family environment on the development of AOD problems in adolescents, but we know very little about how the family environment and longer-term family relationships influence the course of long-term recovery. Godley and colleagues (Godley, Kahn, Dennis, Godley, & Funk, 2005) provide an example of a study that uses data over a 12-month follow-up period to examine the relationship of recovery environment (including family measures) and social risk (including peer measures) to outcomes. Important questions in this area are: Do adolescents who are enmeshed in heavy AOD-using family subcultures need to completely sever family ties to sustain their recoveries? To what extent do recovery support groups serve as surrogate family structures for recovering adolescents? We do not have complete answers to the most important question of all: How can parents and other family members best help a young person initiate and sustain his or her recovery over a lifetime?

## **Treatment and Recovery**

The picture we have of the treatment of adolescent substance use disorders is a complicated one. On the one hand, treatment outcome studies consistently confirm potential positive effects of treatment of varied modalities and theoretical orientations—including Twelve Step approaches, cognitive-behavioral therapies, family-based approaches, and therapeutic communities. On the other hand, no one adolescent treatment approach has been found to be consistently superior to the others. Studies across these approaches confirm low rates of voluntary attraction to treatment, low rates of sustained sobriety following treatment, and high treatment re-admission rates. What is left unanswered in all of this, based on the short follow-up windows of existing studies, is the relationship between adolescent treatment and the prospects of long-term recovery.

We need replicated studies that answer such questions as: 1) Does treatment of a substance use disorder in adolescence increase the prospects of long-term recovery even if that recovery is not immediate? 2) Does an

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earlier stage of treatment initiation (measured by age and the time from first problem development to treatment entry) shorten addiction and treatment careers? 3) What are the effects of post-treatment monitoring, recovery coaching, assertive linkage to communities of recovery, and early re-intervention on long-term recovery outcomes for adolescents? 4) What effects do efforts to shape the post-treatment family and social environment have on long-term recovery outcomes? We have already learned that treatment-imposed respites in addiction careers do not in themselves constitute sustainable recovery. We need to know the specific treatment and post-treatment recovery support services delivered at age 15 that predict recovery status at age 25, 35, and older. We need a research-guided bridge between treatment and long-term recovery.

### **Role of Recovery Support Groups**

Most everything we know about groups like Alcoholics Anonymous, Narcotics Anonymous, other Twelve Step groups, and their religious and secular alternatives is based on studies of adult members of these groups. While John Kelly, Mark Myers, Sandra Brown (2000), and others have begun to chart the patterns of adolescent involvement in these groups and their effects on short- and long-term recovery rates, research in this area remains in its infancy. We need studies with replicated findings across geographical and cultural contexts and across key demographic, personality, and problem severity variables that illuminate adolescent recovery support group affiliation rates, obstacles to participation, the differential effects of mainstream versus young people's meetings, the active ingredients of participation most linked to long-term recovery outcomes, and any negative side-effects resulting from such participation. There is a growing pool of young people in long-term recovery within these support groups. They have much to teach us.

### **Peer-based Recovery Support Services**

There is growing interest in the role of peer-based recovery support services provided by volunteer or paid specialists (recovery coaches, personal recovery assistants) and delivered through local treatment agencies, recovery advocacy and support organizations, or faith-based recovery ministries. The Center for Substance Abuse Treatment's Recovery Community Support Program is designed specifically to fund and support such projects. The emerging models for delivering peer-based recovery

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support services are based exclusively on adult populations and have yet to be rigorously evaluated. There is a need to pilot school-based and community-based peer-based recovery support services for adolescents and evaluate the effects of such services on long-term recovery rates and processes.

### **Wired Recovery**

There are two technologies that are currently at the core of adolescent culture in the United States that also constitute underutilized mechanisms of post-treatment recovery support: the cell phone and the Internet. Recent research is holding out great promise for telephone-based continuing care following treatment (Kaminer & Napolitano, 2004), and there are growing numbers of people who are using Online support groups as alternatives or adjuncts to traditional face-to-face recovery support meetings (Hall & Tidwell, 2003; White & Kurtz, 2006). There is enormous potential in these technologies to enhance long-term recovery outcomes, just as there are potentially harmful side-effects of such technologies. We need research studies that map these potentials and pitfalls.

### **Recovery and School Performance**

Many studies have noted the detrimental effects of AOD-involvement on school performance, but we know very little about how recovery affects such performance or if there are special recovery support services that are specifically linked to increased school performance. We need to identify the extent to which innovations such as recovery schools, SAP-sponsored recovery support groups, school-based peer mentor programs, and other school-based recovery support services enhance academic performance and graduation rates (White & Finch, 2006).

### **Toward a Recovery Research Agenda**

As a country, we have focused attention on adolescent AOD problems for more than 200 years and have admitted and studied adolescents within American treatment institutions since the 1860s. We know a lot about the pathology of addiction and the mechanics of intervention. It is time we studied the lived solutions to AOD problems among young people and their families and the lessons these solutions hold for the redesign of community-based treatment and school-based recovery support services. We invite

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student assistance professionals and others concerned about substance-involved youth to join us in advocating for this revolution in perspective.

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## References

- Dawson, S. A., Grant, B. F., Stinson, F. S., Chou, P. S., Huang, B., & Ruan, W. J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction, 100*(3), 281-292.
- Godley, M. D., Kahn, J. H., Dennis, M. L., Godley, S. H., & Funk, R. R. (2005). The stability and impact of environmental factors on substance use and problems after adolescent outpatient treatment for cannabis abuse and dependence. *Psychology of Addictive Behaviors, 19*(1), 62-70.
- Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.
- Hall, M. J., & Tidwell, W. C. (2003). Internet recovery for substance abuse and alcoholism: An exploratory study of service users. *Journal of Substance Abuse Treatment, 24*(2), 161-167.
- Kaminer, Y., & Napolitano, C. (2004). Dial for therapy: Aftercare for adolescent substance use disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(9), 1171-1174.
- Kelly, J. F., Myers, M. G., & Brown, S. (2000). A multivariate process model of 12-step attendance and substance use outcome following inpatient treatment. *Psychology of Addictive Behaviors, 14*(4), 376-389.
- Miller, W., & C' de Baca, J. (2001). *Quantum change: When epiphanies and sudden insights transform ordinary lives*. New York: Guilford Press.
- Prochaska, J. O., Norcross, J. C., & DiClemente, C. O. (1994). *Changing for good*. New York: Avon Books.
- Vaillant, G. (2003). 60-year follow-up of alcoholic men. *Addiction, 98*(8), 1043-1051.
- West, R. (2005). Time for a change: Putting the Transtheoretical (Stages of Change) Model to rest. *Addiction, 100*(8), 1036-1039.

- White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, 23(1), 3-15.
- White, W. (in press). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment, Special Issue*.
- White, W., & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor*, 7(2), 54-58.
- White, W., Godley, M., & Dennis, M. (2003). Early age of substance experimentation: Implications for student assistance programs. *Student Assistance Journal*, 16(1), 22-25.
- White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61.