

# Recovery processes among young adults treated for alcohol and other drug problems: A five-year follow-up

Nordic Studies on Alcohol and Drugs

2020, Vol. 37(4) 338–351

© The Author(s) 2020

Article reuse guidelines:

[sagepub.com/journals-permissions](https://sagepub.com/journals-permissions)

DOI: 10.1177/1455072520936814

[journals.sagepub.com/home/nad](https://journals.sagepub.com/home/nad)



Lisa Skogens 

Stockholms Universitet, Sweden

Ninive von Greiff

Stockholms Universitet, Sweden

## Abstract

**Aim:** Studies on recovery from alcohol and other drugs (AOD) among young adults are scarce. In the present study, young adults, previously interviewed with a focus on their recovery process shortly after they completed treatment, were re-interviewed five years later focusing on their recovery process during the last five years in relation to their former AOD problems, other problems and processes of change. **Methods:** Twenty-one young adults were interviewed: 16 women and five men aged between 25 and 33 years. After transcribing the interviews, the material was analysed thematically. **Results:** Three overall themes emerged: previous problems, mental illness and the search for identity. The results were discussed in relation to recovery capital, primarily focusing on human and social capital. The results indicate that the group in focus often needs professional support for mental health issues in order to reach a stable recovery. **Conclusions:** Since the problems described were heterogeneous, this client group might benefit from individual treatment and extended support after treatment. Further, the results indicate that the established period of five years for a stable recovery might need to be extended for young adults.

Submitted: 13 December 2019; accepted: 23 April 2020

## Corresponding author:

Lisa Skogens, Stockholms Universitet, Institutionen för socialt arbete, Sveavägen 160, Stockholm, 106 91, Sweden.

Email: [lisa.skogens@socarb.su.se](mailto:lisa.skogens@socarb.su.se)



Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (<https://creativecommons.org/licenses/by-nc/4.0/>) which permits non-commercial use, reproduction and distribution of the work without further permission

provided the original work is attributed as specified on the SAGE and Open Access pages (<https://us.sagepub.com/en-us/nam/open-access-at-sage>).

## Keywords

alcohol, AOD problems, recovery capital, recovery process, stable recovery, treatment, young adults

The concept of “recovery” is an established term used to describe positive processes of change concerning problems related to alcohol and other drugs (AOD) (Witbrodt, Kaskutas, & Grella, 2015). The recovery process stretches over a long period of time and it is suggested that stable recovery is achieved after five years at the earliest (Hibbert & Best, 2011). There are many pathways to recovery (White & Kurtz, 2006) and variations of important factors have been found between different timespans during the recovery process (Laudet & White, 2010; Litt, Kadden, Kabela-Cormier, & Petry, 2009; Best et al., 2012; Best, Groshkova, Sadler, Day, & White, 2011) and between groups (Ammon, Bond, Matzger, & Weisner, 2008; Orford et al., 2006; Skogens & von Greiff, 2014; Timko, Finney, & Moos, 2005; von Greiff & Skogens, 2017). However, studies on the recovery process in adolescents and young adults are scarce (Hennessy, 2017; Hennessy, Cristello, & Kelly, 2019).

In the present study, young adults, previously interviewed in Swedish studies (Skogens, von Greiff, & Esch Ekström, 2017; von Greiff & Skogens, 2017) focusing on recovery processes shortly after they completed treatment for AOD problems, were re-interviewed five years later. The research questions for the present article were on how their recovery process during the last five years was related to their former AOD problems, to other problems and to processes of change.<sup>1</sup> How their specific problems relate to other areas and challenges that characterise this age group in general has been an issue of specific interest.

## Recovery and recovery capital

In research on treatment for AOD problems, the concept of recovery is well established and it

has been defined by Betty Ford Institute as “voluntary maintained lifestyle characterized by sobriety, personal health, and citizenship” (The Betty Ford Institute Consensus Panel, 2007, p. 222). Although there are no empirically established timeframes for describing stability of recovery from AOD problems, three phases are identified: *early sobriety* (1–12 months), *sustained recovery* (1–5 years) and *stable recovery* (more than five years) (The Betty Ford Consensus Panel and Consultants, 2010; see also Hibbert & Best, 2011). Related to this, the concept of recovery capital (RC) has been used to provide professionals with in-depth knowledge to assist individuals in their process of change (Best et al., 2010; Davidson & White, 2007). RC was introduced by Cloud and Granfield (1999, 2008) inspired by theories in social science on certain preconditions relating to resources and social structures (cf. Bourdieu & Wacquant, 1992; Coleman, 1990; Teachman, Paasch, & Carver, 1997). Along with the exploration of recovery capital in research on recovery from AOD problems, variations of this original model have been developed (Hennessy, 2017) albeit with consistent main properties and domains but varying in labelling and fine-tuning. RC, according to Cloud and Granfield’s model, consists of social capital (such as a stable social network offering support and trust as well as demands), physical capital (financial and material resources), human capital (knowledge and skills, education, physical and mental health) and cultural capital (norms and values). A central premise for the use of recovery capital is that it is not static but constitutes a changeable description of a person’s ability to initiate and maintain a recovery process which implies that individuals are able to change their recovery capital (with or without professional assistance). Since RC

includes personal as well as contextual resources, it is considered useful for the analysis of preconditions and possibilities for positive change.

Factors that have been suggested as strengthening RC during a change process are related to an improved and deepened quality of life and include, for example, a sober social network (Litt et al., 2009), engagement in meaningful activities that reduce the risk of relapse (Best et al., 2012) and the development of a healthy and productive life (White, 2007). Stable social relationships are important for improving mental health and quality of life (Best et al., 2011). Studies on clients treated for AOD problems suggest that those with a marginalised social position need more time for recovery and the strengthening of RC in order to maintain recovery compared to people with a more integrated social position (Skogens & von Greiff, 2014; von Greiff & Skogens, 2017). Further, research on clients with co-occurring AOD and mental health problems concludes that important factors for the recovery process are leaving the identity of being institutionalised behind, and gaining agency in life (Skogens, von Greiff, & Topor, 2018).

### **Adulthood and young adults with psychosocial problems**

For young adults recovering from AOD problems, the process of change often also concerns the process of moving from adolescence to adulthood. This “youth transition” may offer a time of hope and positive change, but may also create exclusion and marginalisation (Giddens, 1997; Masten et al., 2004), and in a more individual-based and untraditional society, the paths for transition to adulthood are less linear and more fragmented. Some examples of this are more years spent in education systems, more flexible and changing working conditions, later parenthood and marriage. Arnett (2005) uses the term *emerging adulthood* to describe the development period characterised by identity uncertainty and exploration. However, the

term has been criticised for ignoring variations, for example, related to social class (cf. Côté, 2014). Recently, another concept – *young adults*, based on studies on people well into their thirties – has been launched to describe the phase between adolescence and adulthood that is characterised by social ambiguity and oscillation between dependence and independence (Magaraggia & Benasso, 2019).

A strong body of research shows that, in relation to other young adults, those leaving care have limited possibilities for this oscillation between dependence and independence (Furlong, Cartmel, Biggart, Sweeting, & West, 2003; Höjer & Sjöblom, 2009; Osgood, Foster, & Courtney, 2010) which leads to a shorter and more compressed transition compared to their peers (Höjer & Sjöblom, 2014; Stein, 2012). Also, it has been reported that this group tends to have complex problems and that they struggle with problems such as poor mental health, poor school performance and crime more often than their peers (cf. Berlin, Vinnerljung, & Hjern, 2011; Courtney & Dworsky, 2006; Vinnerljung & Sallnäs, 2008).

Research on RC has primarily focused on recovery among adults. However, studies focusing on young adults imply that RC might have a somewhat different meaning and implications for them (Elswick, 2017; Hennessy et al., 2019; Hennessy, Glaude, & Finch 2017; Mawson, Best, Dingle, & Lubman, 2015). An Australian study stresses that low social and human capital (for example, level of education and health) among young adults with AOD problems reduces the possibilities for recovery (Mawson et al., 2015). However, it has also been suggested that high social capital, such as sober networks, may reduce the negative effects of low human capital and, further, that the social network can be supportive or work as an incentive for change (to encourage the young adult to leave or disassociate him or herself from an old social network). During adolescence, social capital tends to be focused on peers (Bassani, 2007) and this is accentuated for those with problematic upbringing

conditions. However, in line with RC for adults, employment and/or education (Laudet & White, 2010) are also highlighted as being important (Skogens et al., 2017).

## Methods

In two Swedish projects on recovery from AOD problems, 32 young adults were interviewed approximately six months after finishing treatment (Skogens et al., 2017; von Greiff & Skogens, 2017). The inclusion criteria were that the interviewees should: (a) have undergone a treatment intervention; (b) be at the end of or have recently completed a post-treatment intervention; and (c) be judged by a professional to be in a positive process of change regarding the AOD problems they had received treatment for. The intention was to recruit interviewees with some distance from the treatment in order to be able to reflect on their process of change. The focus of the first interview was what the clients themselves highlighted as important for initiating and maintaining positive change, and overall themes in the different phases were the importance of internal, social and treatment-related factors. The recruitment of interviewees was conducted through contact with treatment units (outpatient and inpatient) in seven Swedish city areas.

In the present study, the young adults were contacted again for a new interview five years later. When designing the study, one of the worries were that we would not get data from the interview persons (IPs), even if we had written consents to contact them again. Thus, in order to increase the IPs' possibilities to take part in the study, it was decided to keep the interviews limited in time and, further, to offer interviews by telephone. This turned out to be important since many IPs were busy, for example, with work and/or small children. The IPs were approached via telephone and asked if they were willing to be interviewed again. Thus, when the actual interview took place, the IP was prepared for the subject of the interview (i.e., how their recovery process had proceeded

during the last five years). Twenty-one clients were re-interviewed with the overall aim to study the stable recovery of young adults. Of those not interviewed, nine were impossible to reach via the contact information available (the five-year old telephone number did not work and no new number was found in internet searches) and two individuals declined to participate. The majority of the interviews in the follow-up study were conducted by telephone and lasted about 30 minutes. The interviews were recorded and transcribed verbatim within 48 hours. Both authors were responsible for the complete process of collecting and analysing data at the initial and the follow-up study. In order to follow individuals between the first and second interviews, the interview guide was thematised in the same way, i.e., internal, social and treatment-related factors. The interviews began with the interviewer giving a brief summary of how the IP had described his/her process of change the last time. With this as a starting point, the IP was asked to describe the last five years in terms of both possible so-called relapses and the retention and/or resumption of positive change. The interview guide also dealt with questions on treatment contacts during the follow-up period (frequency, extent and type), the view of one's own and others' alcohol consumption, and factors that were important to continuing or resuming a positive change.

## Analysis

After transcribing the interviews, the material was analysed thematically (Braun & Clarke, 2006) by coding the interview passages according to what was brought up. After re-listening to the interviews and scrutinising transcripts, the material was categorised and summarised by selecting relevant parts from each transcript. By iteratively analysing and compiling these in an increasingly condensed form, themes were created at an aggregated level, following a process of going back and forth between transcripts and the emerging themes as described by

**Table 1.** Mental health problems, living situation and occupation at first interview and at follow-up ( $N = 21$ ).

	First interview	Follow-up interview
Mental health problems	16	13
Living situation		
<i>Living alone</i>	11	8
<i>Living with children and/or partner</i>	10	13
Occupation*		
<i>Work/studies</i>	14	17
<i>Unemployed/sick leave</i>	4	3
<i>Parental leave</i>	2	0

\*Missing information for one respondent,  $n = 20$ .

Braun and Clarke (2006). NVivo, a software package for qualitative data analysis, was used to validate the condensed descriptions and thematisations made manually by returning to the transcripts and comparing highlighted sentences at the level of the individual with general aggregated descriptions.

Quotations are followed by numbers referring to a specific interviewee.

## Results

### *Description of the IP $n = 21$*

Sixteen women and five men were interviewed five years after the first interview. The majority described their former AOD problems in terms of polydrug use (12 IPs), a third reported drugs as the main problem (7 IPs) while two IPs reported alcohol abuse as their main problem.<sup>2</sup> Thirteen IPs had undergone individual treatment, while eight had undergone group treatment (strictly following or based on the 12-step philosophy). Although all the clients had undergone treatment for AOD problems, most of them reported several and often complex problems including, for example, crime and destructive relations. As shown in Table 1, below, all IPs brought up mental health problems, but most often only in passing. However, these problems can be described as rather severe: diagnosed ADHD/ADD/PTSD (9), suicide attempts (6), psychosis (3), anxiety (6), and an eating disorder (1).

At follow-up, the IPs were aged between 25 and 33 years (mean age 29). A majority (13 IPs) described that they used alcohol in a controlled way and just under a third (6 IPs) were sober (half of whom had been so throughout the whole follow-up period). One IP described ongoing drug abuse and another described recurring periods of overconsumption of alcohol but did not define it as a problem since it did not affect the rest of his life (such as work). While the majority of the women (12/16) reported living with partners and/or children at follow-up, four out of five men were single. The majority of the IPs did not bring up contact with parents or siblings. In general, the IPs described their social network, including friends, as limited.

### *How IPs relate to previous problems*

When asked to describe the past five years in relation to their recovery process, not everyone shared the perception that they used to have AOD problems – although all the IPs had met the inclusion criteria to have undergone treatment for AOD problems. Some said that there were others who had expressed concerns about their “abuse”. Other IPs admitted that they had used drugs but that their alcohol use had never been a problem (thus making a clear distinction between alcohol and drugs) and therefore did not see their current use of alcohol as an issue. However, apart from the one IP who described recurring bouts of overconsumption, it was

generally a matter of small amounts of alcohol and only on a few occasions.

I use alcohol but to a very limited extent. I was very careful to begin with because you don't know whether it will trigger something. But for me alcohol doesn't have that effect so I can have a glass now and then. But that happens maybe twice a year, I don't get drunk. (IP9)

One IP described smoking cannabis in a similar way as the descriptions above of alcohol consumption.

I might smoke on occasion, but then I do it as an alternative to going to the pub, [I] stay at home with a friend, we smoke and chat and bake a chocolate cake. (IP10)

Some reasoned or expressed concerns about relapse, abstinence and alcohol consumption. This was generally about relating to abstinence as the only alternative, which was conveyed in the context of the treatment they had undergone. However, during the follow-up period, these IPs had begun to question this and had started to listen more to their "gut feeling" and based on that they had begun to use alcohol. For some, this gave rise to feelings of ambivalence.

A part of me says that this is the first step in a relapse process, but my gut feeling says that it's ok, because I trust myself. I don't think it's as clearly black and white as it was ingrained in me during the 12-step programme. (IP1)

For other IPs, staying sober and drug free was not an issue, they described that they basically had no alternative and that they had not considered re-evaluating that decision at all.

I did my treatment, which was my first, and since then I've stayed sober and drug free. (IP3, who used to inject drugs)

There were IPs who described themselves as having an "addictive behaviour" and that

this "disease" could take on different expressions, i.e., different addictions. One IP described a relapse after several years of sobriety and explained that this was related to receiving psychiatric help (ADHD diagnosis), which resulted in her forgetting her "addiction disease". Another example was IP 12, who stopped using drugs but started to drink alcohol instead.

When I stopped using what was classified as drugs, I was over 20 and was allowed to drink alcohol. Since I didn't view this [alcohol] as a drug, I drank during the first few months of my sober phase. But I stopped doing that because I realised that the so-called addictive behaviour follows every substance that comes my way. (IP12)

Some IPs described themselves as having an "addictive personality". This was expressed as thoughts about and experiences of different addictions, where they put one type of abuse behind them and replaced it with another. This can be linked to the AOD problem as one of several complex problems and/or as an expression of other problems. If these problems were not dealt with, there was a potential risk of replacing one type of abuse with another:

I used to have problems with food and stuff...// for me there really isn't that big a difference between an eating disorder and an addiction and...these are different types of self-harming behaviour.// I've had a lot of treatment. It started with the 12 steps, followed by a form of eating disorder treatment. // Then I started another course of treatment that was crucial to me, a kind of family therapy in a group. (IP4)

In addition to IP12 (above), IP18 described the experience of having a relapse period. Unlike IP12, who received psychiatric help, IP18 resumed the recovery process without external professional support. Two IPs described a shorter period of what could be interpreted as

a relapse, even if they themselves did not use that term.

I had a lot of anxiety so after a couple of days I felt that this was no good, I had to get sober and take control of everything, this really was no good. (IP18)

One IP described an ongoing abuse of amphetamine. However, that person pointed at crime as the primary problem and that the amphetamine abuse was a consequence of that.

I survive by committing crimes, and the addiction helps me get through the day. (IP17)

### *Mental health problems*

More than half (13/21) stated that they had suffered from mental health problems during the follow-up period. There were major variations in severity from “common” concerns and stress (in particular associated with the process of transition to adulthood) to various psychiatric diagnoses (depression, ADHD, PTSD and eating disorders). While ADHD was relatively common, other diagnoses were mentioned by individual IPs. Some had had continuous contact with psychiatrists and/or had undergone therapy with a psychologist, while others had had occasional or sporadic contact. The problems for which IPs sought professional help were not described in relation to their previous AOD problems (i.e., not caused by the AOD problems) but were described as something separate or an underlying factor.

Then I also got psychiatric care, after having dealt with what was the addictive disease in the programme, other problems were discovered. (IP11)

... they [professionals in AOD treatment] didn't take into account the effects of how you felt when you became drug free and sober. You often have other problems; most people who do drugs have some form of disability. You didn't really get any help for that. There was no one you could talk to about it. That's why I have contacted professional psychotherapists and experts in

psychiatry. // ... [I have] childhood trauma, there's quite a lot of grief. (IP6)

In line with the descriptions of former problems (as being complex and sometimes unclear), the problems that needed to be addressed during the follow-up were heterogeneous. Generally, different kinds of professional support were considered important:

... I've been given a lot of tools to handle my everyday life and stress and to not put so much pressure on myself. (IP7)

Throughout my journey I've had a lot of support from therapists and psychologists, until a year ago. It's been a huge..., a support in this process. There have been different people who have helped me with different things. That they have been outside the community has helped me in that process... (IP5)

IP5, above, described the importance of having a professional contact outside the “community” (the 12-step movement) and linked this to the perception of his/her identity as an “addict” no longer being relevant but rather something he/she had left behind. The IP had also started to drink alcohol in a controlled way.

Professional contacts were also mentioned when ADHD was being diagnosed, with regard to medication for cravings and as examples of shorter outpatient contacts during the follow-up period.

### *Searching for identity and the process of becoming an adult*

Identity seeking ran as a silver thread through several descriptions – what was mainly emphasised was that IPs did not want to identify themselves as drug addicts and/or as something negative. Professional contacts and the context conveyed in treatment became central for some IPs in this process. It was not just about the view of abuse conveyed during treatment, but rather that this view influenced their entire identity.

[I] was lost then – the programme and the treatment had given me that, my life was like a blank slate, I knew nothing about how to behave, thought everything was thanks to the 12-step programme, but now I feel it was thanks to me, that I struggled so hard. (IP1)

...you identify yourself so much, all the behaviours are because you're an alcoholic, for example, and it's something negative and I don't want to identify myself with something negative. (IP2)

Initiating a process of becoming an adult became for some IPs a clean break with the identity of being a former substance abuser. This was expressed by IP5 in terms of starting to question the 12-step movement:

[There] are other ways than the dogmatism that exists within NA and it was a process in itself because five years ago my social contacts were mostly within NA. It was like losing a large part of your family when you chose to leave. //... I started to feel that I wasn't able to say that I was addicted, I had been addicted but today I'm just not that. //... a long process since I stopped [going to NA meetings] and when I started drinking again. [Authors' note: drinking in a controlled and limited way] (IP5)

The results showed that for most IPs the last five years had involved clear steps into adulthood, such as parenting (highlighted only by young women), education, entry into the labour market, cohabitation, etc. During this process, some described the importance of professional support for managing ordinary life.

I've now got a lot of tools so I can handle my everyday life and stress and not put so much pressure on myself. (IP7)

For some, these steps into adulthood appeared to have been taken without explicit problems, but for many IPs the follow-up period was characterised by stress related to exclusion and a feeling of "lagging behind" others of a similar age. In addition to, for example, not completing

upper secondary school, some IPs reported functional impairments and mental illness as additional stressors.

Sure, I can provide for myself now, but the future is very uncertain. How can I enter the labour market? I'm almost thirty, have never had a permanent job, have no education after upper secondary school. I feel quite a lot of stress about how I will manage in society because I have the difficulties I have. (IP6)

... it's a bit more stressful, existential angst and so on; others [peers] are having children, they are studying and so on. What should I do? But compared to five years ago, I feel better within myself, my basic outlook on life is better. (IP10)

It feels like I haven't accomplished as much as I wanted, or want. It's probably one of the reasons why I have started to get organised and to study. I don't even have upper secondary school qualifications, I have to start there. It's really things like these, it makes you feel fairly... that you're lagging behind, that you've missed out on a lot. You should finish upper secondary school when you're 18–19 years old, I'm over 30 now. It feels a bit stressful, that I have to achieve all the time. (IP14)

The quotations show that the IPs managed to make major changes during the five years studied. Their descriptions show an inherent strength, an agency, to leave what was for many a comprehensive and complex set of problems (i.e., many different problems – both their own and in relation to their environment, such as growing up, destructive relationships, etc.).

## Discussion

To start with, it is important to mention that there are always exceptions to the general patterns that will be described and discussed below. For example, there were individual IPs who described their lives very much in the same way as they had in the interview five years ago, as a quiet life without any particular obstacles or shifts. However, in line with previous research describing recovery as a long process



(Best et al., 2011, 2012; Laudet & White, 2010), the dominant pattern was an ongoing process of both recovery and change throughout the last five years.

The IPs' descriptions of how and in which areas they had worked with strengthening their RC during the follow-up period can be linked to the complex problems that often characterise the client group in focus (Berlin et al., 2011; Courtney & Dworsky, 2006; Vinnerljung & Sallnäs, 2008). This implies that the initial treatment for AOD problems was mainly the start of a recovery process and that the strengthening of RC needed to continue in order to maintain positive changes and reach a stable recovery. As in previous research on young adults with AOD problems (Mawson et al., 2015), the IPs mainly described that they needed to strengthen their human capital, and most often this concerned their mental health but also their education. Strengthening their social capital was also crucial; this was, for example, evident in the importance they placed in establishing a family of their own at an early age. This does not imply that other areas were less important, rather that other areas had been relatively stable for the vast majority of the IPs. During the interview five years ago, the IPs reported a relatively stable – although sometimes fragile – base concerning employment or other financial aspects and housing. In most cases, these needs were attended to by their treatment facility or social service unit. The importance of having these basic needs met as a prerequisite for being able to deal with other issues was identified more than half a century ago in Maslow's hierarchy of needs (Maslow, 1954), and has also been described in particular for marginalised groups with AOD problems (Skogens & von Greiff, 2014; Skogens et al., 2018).

It seems that the results are in line with previous research stressing that compared with young people in general, the moving out process, i.e., moving into your own home, is short and occurs at a younger age for young adults leaving care (Höjer & Sjöblom, 2014; Stein, 2012). On the other hand, the need to strengthen

human capital, such as mental health and education, as actualised during the follow-up period, can be interpreted as a somewhat delayed transition to adulthood.

As mentioned above, a central theme for the IPs during the follow-up period was strengthening their mental health, and the majority had done that with support from mental health professionals such as psychiatrists and therapists (cf. White, 2007). This strengthening was not predominantly described as leaving mental health problems behind them but, rather, that the IPs had got to know themselves better, learnt to handle issues in this area and thus become more accepting of themselves. It is worth noting that the mental health problems that the IPs sought professional help for were not described in relation to their AOD problems but as problems separated from these and/or underlying the AOD problems. When the need for professional support was described, this did not only concern severe mental health problems. Although a majority of the IPs described a history of severe mental health problems in the first interview, what was often stressed was a need for ordinary support in life in terms of guidance and support in decisions and about worries. Thus, this can be related to the kind of support that is often fulfilled through social capital, i.e., family and friends. During the follow-up, IPs referred to social capital in relation to establishing a family of their own. However, even though a majority had a partner and/or children, this did not provide sufficient support to strengthen their human capital. This might be related to the general descriptions of IPs regarding the lack of a stable relationship with their birth family. This implies that the importance of professionals empowering individuals as a prerequisite for recovery generally highlighted in research on recovery (cf. Best et al., 2010; Davidson & White, 2007) seems to be even more significant in this group and, moreover, crucial over a long period of time (cf. Bengtsson, Sjöblom, & Öberg, 2018; Wade & Dixon, 2006).

All those who did not define themselves as abstinent, but at the same time stated that they

definitely did not have any problems with alcohol, emphasised that their consumption was limited. They rather emphasised the *possibility* of having a glass of wine, not having to take a completely sober attitude in contexts where alcohol was used, and not having to identify themselves as abstainers. In turn, this meant that the social capital of family and friends did not need to be completely abstinent but, rather, needed not to consist of people who did have AOD problems. This relates to the suggestions made by Hennessy et al. (2017) that successful recovery among adolescents does not necessarily require lifelong abstinence. However, Hennessy et al. highlight that initial abstinence seem to be important. The IPs in the present study followed this suggested pattern: they were abstinent when they initiated a “successful recovery process” five years ago and all but one of them continued this process at the follow-up but with mixed attitudes towards abstinence. Many of the young adults in the study described drinking alcohol in a controlled and unproblematic way after a period of sobriety. This was not only linked to the severity of the problem but also to the image they had of themselves, i.e., there were those who did not see themselves as “former addicts”.

This can be compared with adults recovering from AOD problems where the identity of “former addict” is often used as a tool to stay abstinent. For young adults, this identity might instead be perceived as a barrier in the process of developing an adult identity. In fact, there were IPs who did not share the perception that they used to have AOD problems, although they had undergone treatment for AOD problems. The often complex problems of young adults reported in previous research (Berlin et al., 2011; Courtney & Dworsky, 2006) together with the fact that young adults have often had AOD problems for a shorter period of time than other adults, might be linked to having less of a need to identify as abstainers.

This might add a nuance to the proposed model of recovery capital for adolescents made by Hennessy et al. (2019). In the model, social

capital consisting of sober and supportive relationships with family and friends is emphasised as important. Based on the assumption that total abstinence is more crucial for the young adults at the beginning of the recovery process but can be, at least for some, abandoned later during recovery, it might accordingly be suggested that a sober networks (in terms of total abstinence) are less central over time. However, more research is needed to confirm this.

Some IPs described that they had an “addictive behaviour”, which included other addictions as well as the addiction to substances. This underlines the individual variations in how the nature of the AOD problems in the group investigated can be defined. However, also for these IPs, the AOD problems themselves were not described as the main problem. Rather, the IPs defining themselves in this way described that they, after getting help with their AOD problems, were able to get to know themselves better and identify ways of dealing with themselves. Another result that differs from previous research on adults is the experience of an extra stigma related to the transition into adulthood, expressed as the feeling of lagging behind peers of a similar age and resulting in internal and external pressure. Professional contacts during the follow-up period can be interpreted as a way of mentally and practically dealing with this, in terms of, for example, guidance when choosing education and/or profession.

## Conclusions

The young adults in the study did receive treatment for AOD problems and at the first interview this seemed to be sufficient for continuing their recovery. However, the results from the follow-up interviews indicate that this group often also needs professional support for mental health issues in order to reach a stable recovery. Since the problems described were heterogeneous, it is suggested that this client group could benefit from individual treatment and extended support after treatment. Further, the

results indicate that the period of five years in order to reach a stable recovery might need to be extended for young adults.

### Limitations and strengths

Previous research on different phases of recovery has mainly focused on adults and knowledge about whether these phases also are suitable for young adults is therefore limited. Thus, the article can contribute to the research field on recovery processes with a recovery capital perspective. However, the follow-up interviews were rather short and do not allow for in-depth analysis.

The IPs consisted predominantly of women, which may have had an impact on the results. There were gender differences; several women described becoming a parent as central, while only one of the men had children and he described this as important at the first interview but not during the follow-up process.

The group investigated in the study were between 25 and 33 years old when interviewed. As pointed out in the introduction, previous research highlights that young adulthood is characterised by specific issues but, at the same time, is difficult to limit to a specific timespan. This complicates the study of this group in general, and especially when comparisons are made with other adults. Thus, the results discussed, for example, on identity-seeking cannot be interpreted as applying to a clearly identified age group. However, the results may help to shed light on factors that might be of more importance in younger age groups that are establishing their adult lives during their recovery process.

### Ethics

This research project was scrutinised and approved by the Ethical Review Board in Stockholm, Sweden (2018/1770-32; 2018/1973-32)

### Notes

1. The terms recovery, process of change and positive change, are used in the article. While a

process of change can have a negative or positive direction, the term recovery implies a positive direction. Also, recovery is related to former problems while positive change is a wider concept including many areas in life. Thus, positive change refers to the interview persons' own perceptions of what this means and what had been important to achieve this.

2. Of those not interviewed ( $n = 11$ ), five were women and six men, and their main problem at the first interview was polydrug (4 IPs) and drug (7 IPs) use. The age distribution in the dropout group was 24 to 32 years (mean age 29). Just over half (6 IPs) reported mental health problems. Five IPs lived alone, two with their parents and four with a partner and/or with children. All IPs except one were working or studying (information is missing on one IP). Six had been in individual treatment and five in group treatment.


### Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Swedish Research Council for Health, Working Life and Welfare [Grant # 2018-00743].

### ORCID iD

Lisa Skogens  <https://orcid.org/0000-0001-9345-8667>

### References

- Ammon, L., Bond, J., Matzger, H., & Weisner, C. (2008). Gender differences in the relationship of community services and informal support to seven-year drinking trajectories of alcohol-dependent and problem drinkers. *Journal of Studies on Alcohol and Drugs*, 69(1), 140–150.
- Arnett, J. J. (2005). The developmental context of substance use in emerging adulthood. *Journal of Drug Issues*, 32(2), 236–253.

- Bassani, C. (2007). Five dimensions of social capital theory as they pertain to youth studies. *Journal of Youth Studies, 10*(1), 17–34.
- Bengtsson, M., Sjöblom, Y., & Öberg, P. (2018). “Well, it’s up to me now”: Young care leavers’ strategies for handling adversities when leaving out-of-home care in Sweden. *Nordic Social Work Research, 8*(1), 8–18.
- Berlin, M., Vinnerljung, B., & Hjern, A. (2011). School performance in primary school and psychosocial problems in young adulthood among care leavers from long term foster care. *Children and Youth Services Review, 33*(12), 2489–2497.
- Best, D., Bamber, S., Battersby, A., Gilman, M., Groshkova, T., Honor, S., . . . White, W. (2010). Recovery and straw men: an analysis of the objections raised to the transition to a recovery model in UK addiction services. *Journal of Groups in Addiction & Recovery, 5*(3), 264–288.
- Best, D., Gow, J., Knox, T., Taylor, A., Groshkova, T., & White, W. (2012). Mapping the recovery stories of drinkers and drug users in Glasgow: Quality of life and its associations with measures of recovery capital. *Drug and Alcohol Review, 31*(3), 334–341.
- Best, D., Groshkova, T., Sadler, J., Day, E., & White, W. (2011). What is recovery? Functioning and recovery stories of self-identified people in recovery in a services user group and their peer networks in Birmingham England. *Alcoholism Treatment Quarterly, 29*(3), 293–313.
- Bourdieu, P., & Wacquant, L. (1992). *An invitation to reflexive sociology*. Chicago, IL: University of Chicago Press.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.
- Cloud, W., & Granfield, R. (1999). *Coming clean: Overcoming addiction without treatment*. New York, NY: NYU Press.
- Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use & Misuse, 43*(12–13), 1971–1986.
- Coleman, J. (1990). *Foundations of social theory*. Cambridge, MA: Harvard University Press.
- Côté, J. (2014). The dangerous myth of emerging adulthood: An evidence-based critique of a flawed developmental theory. *Applied Developmental Science, 18*(4), 177–188.
- Courtney, M. E., & Dworsky, A. (2006). Early outcomes for young adults transitioning from out-of-home care in the USA. *Child & Family Social Work, 11*(3), 209–219.
- Davidsson, L., & White, W. (2007). The concept of recovery as an organizing principle for integrating mental health and addiction services. *Journal of Behavioral Health Services and Research, 34*(2), 1094–3412.
- Elswick, A. (2017). *Emerging adults and recovery capital: Barriers and facilitators to recovery*. Theses and Dissertations—Family Sciences, 51. Lexington: University of Kentucky.
- Furlong, A., Cartmel, F., Biggart, A., Sweeting, H., & West, P. (2003). *Youth transitions: Patterns of vulnerability and processes of social inclusion*. Research Findings, no 8. Enterprise and Lifelong Learning Research Programme. Edinburgh: Scottish Executive.
- Giddens, A. (1997). *Modernitet och självidentitet. Självet och samhället i den senmoderna epoken* (Sten Andersson övers) [Modernity and self-identity: Self and society in the late modern age]. Göteborg, Sweden: Daidalos (Ersätts med: (Original work published 1991).
- Hennessy, E. (2017). Recovery capital: A systematic review of the literature. *Addiction Research & Theory, 25*(5), 349–360.
- Hennessy, E., Cristello, J., & Kelly, J. (2019). RCAM: A proposed model of recovery capital for adolescents. *Addiction Research & Theory, 27*(5), 429–436.
- Hennessy, E., Glaude, M. W., & Finch, A. J. (2017). “Pickle or a cucumber?” Administrator and practitioner views of successful adolescent recovery. *Addiction Research & Theory, 25*(3), 208–215.
- Hibbert, L., & Best, D. (2011). Assessing recovery and functioning in former problem drinkers at different stages in their recovery journeys. *Drugs & Alcohol Review, 30*(1), 12–20.
- Höjer, I., & Sjöblom, Y. (2014). Voices of 65 young people leaving care in Sweden: “There is so much

- I need to know". *Australian Social Work*, 67(1), 71–87.
- Höjer, I., & Sjöblom, Y. (2009). Ungdomar i utsatta livssituationer och deras väg till självständighet [Youths in vulnerable life-situations and their way to independence]. I: *SOU 2009:68. Bilaga till betänkandet Lag om stöd och skydd för barn och unga (LBU)*. Betänkande av Barnskyddsutredningen (pp. 41–76). Stockholm, Sweden: Fritzes.
- Laudet, A., & White, W. (2010). What are your priorities right now? Identifying service needs across recovery stages to inform service development. *Journal of Substance Abuse Treatment*, 38(1), 51–59.
- Litt, M., Kadden, R., Kabela-Cormier, E., & Petry, N. (2009). Changing network support for drinking: Network support project 2-year follow-up. *Journal of Consulting and Clinical Psychology*, 77(2), 229–242.
- Magaraggia, S., & Benasso, S. (2019). In transition . . . Where to? Rethinking life stages and intergenerational relations of Italian youth. *Societies*, 9(7), 1–15.
- Maslow, A. H. (1954). *Motivation and personality*. New York, NY: Harper and Row.
- Masten, A., Burt, K., Roisman, G., Obradovic, J., Long, J., & Tellegren, A. (2004). Resources and resilience in the transition to adulthood: Continuity and change. *Development and Psychopathology*, 16(4), 1071–1094.
- Mawson, E., Best, D., Dingle, G., & Lubman, D. (2015). Social identity, social networks and recovery capital in emerging adulthood: A pilot study. *Substance Abuse Treatment, Prevention, and Policy*, 10(45), 1–11.
- Orford, J., Hodgson, R., Copello, A., John, B., Smith, M., Black, R., . . . UKATT Research Team. (2006). The client's perspective on change during treatment for an alcohol problem: Qualitative analysis of follow-up interviews in the UK alcohol treatment trial. *Addiction*, 101, 60–68.
- Osgood, D., Foster, E., & Courtney, M. (2010). Vulnerable populations and the transition to adulthood. *The Future of Children*, 20(1), 209–229.
- Skogens, L., & von Greiff, N. (2014). Recovery capital in the process of change: Differences and similarities between groups of clients treated for alcohol and drug problems. *European Journal of Social Work*, 17(1), 58–73.
- Skogens, L., von Greiff, N., & Esch Ekström, J. (2017). Positiva förändringsprocesser bland unga vuxna i öppenvård [Positive change processes in young adults in outpatient care]. *Socialvetenskaplig tidskrift*, 1(24), 39–57.
- Skogens, L., von Greiff, N., & Topor, A. (2018). Initiating and maintaining a recovery process: Experiences of persons with dual diagnosis. *Advances in Dual Diagnosis*, 11(3), 101–113.
- Stein, M. (2012). *Young people leaving care, supporting pathways to adulthood*. London, UK: Jessica Kingsley.
- Teachman, J., Paasch, K., & Carver, K. (1997). Social capital and the generation of human capital. *Social Forces*, 75(4), 1343–1359.
- The Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, 33(3), 221–228.
- The Betty Ford Consensus Panel and Consultants. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *Journal of Groups in Addiction & Recovery*, 5(1), 89–93.
- Timko, C., Finney, J., & Moos, R. (2005). The 8-year course of alcohol abuse: Gender differences in social context and coping. *Alcoholism: Clinical and Experimental Research*, 29(4), 612–621.
- Vinnerljung, B., & Sallnäs, M. (2008). Into adulthood: A follow-up study of 718 young people who were placed in out-of-home care during their teens. *Child and Family Social Work*, 13(2), 144–155.
- von Greiff, N., & Skogens, L. (2014). Mechanisms of treatment: Client and treatment staff perspectives on change during treatment for alcohol problems. *Nordic Social Work Research*, 4(2), 129–143.
- von Greiff, N., & Skogens, L. (2017). Positive processes of change among male and female clients treated for alcohol and/or drug problems. *Journal of Social Work*, 17(2), 186–206.

- Wade, J., & Dixon, J. (2006). Making a home, finding a job: Investigating early housing and employment outcomes for young people leaving care. *Child and Family Social Work, 11*, 199–208.
- White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1–2), 21–61.
- White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment, 33*, 229–241.
- Witbrodt, J., Kaskutas, L. A., & Grella, C. E. (2015). How do recovery definitions distinguish recovering individuals? *Drug and Alcohol Dependence, 148*, 109–117.