The Good, the Bad, and Recovery: Adolescents Describe the Advantages and Disadvantages of Alternative Peer Groups

Substance Abuse: Research and Treatment
Volume 14: 1–9
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DOI: 10.1177/1178221820909354
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ABSTRACT: In 2017, approximately 1.5 million American adolescents had a substance use disorder (SUD). Adolescents with SUD risk hindering their neurological development, which can result in problems with memory and self-regulation, and in turn disrupt their education, relationships, and life opportunities. Treating adolescents with SUD is challenging. Thus, effective models that help adolescents engage in long-term recovery are needed. The Alternative Peer Group (APG) is an adolescent recovery support model that incorporates pro-recovery peers and sober social activities into standard continuing care practices. In this qualitative study thematic content analysis methods were used to explore transcripts from in-depth interviews with adolescent APG participants collected in a prior study. The aim of this secondary analysis was to get a clear understanding of adolescents' perceptions of the advantages and disadvantages of APGs for supporting SUD recovery. Findings suggest that pro-recovery peer and adult role models, structured activities and a positive social climate that promotes fun, a sense of belonging, and accountability are continuing care elements that are likely to help adolescents resolve their ambivalence about SUD recovery and increase their motivation to engage in the hard work of recovery. These findings can inform the design of effective recovery support model services that promote long-term recovery for adolescents with SUD.

KEYWORDS: adolescent, alternative peer group, substance use disorder, recovery, recovery support model, qualitative research

RECEIVED: January 27, 2020. **ACCEPTED:** January 30, 2020.

TYPE: Original Research

FUNDING: The author(s) received no financial support for the research, authorship, and/or publication of this article.

DECLARATION OF CONFLICTING INTEREST: The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Introduction

The Alternative Peer Group (APG) is a family-centered recovery support model that integrates a positive social environment and a pro-recovery peer group with professional counseling and case management to support the recovery and positive development of adolescents with substance use disorders (SUD).[1] Though originating in Texas, APGs have been rapidly proliferating across the United States; in 2019 there were 24 established APGs in 16 states and 20 more in development.[2] Previous studies have explored adolescents' experience of recovery in APGs, and how participation in APGs increased their capacity to sustain recovery.[3,4] In the current study, adolescent APG participants identified the advantages and disadvantages of APGs for supporting their recovery from SUDs. A better understanding of the benefits and drawbacks of the APG will identify best practices and can inform the development of new programs and the enhancement of existing APGs.

The National Institute on Drug Abuse defines SUD as the continued use of alcohol or other drugs despite harmful consequences.[5] A national survey estimated that one in 27 adolescents met the criteria for SUD in 2018.[6] Adolescents are particularly vulnerable to developing SUDs because neurobiologically, they typically desire risky and pleasurable new experiences; and those who choose to drink or use substances tend to use heavily. Adolescents' brains are undergoing rapid remodeling and heavy substance use during this time increases their risk for developing SUDs.[7] Having SUD during adolescence can harm affected individuals' neurological development, resulting in problems with memory and self-regulation.[8] In turn, this can disrupt their education, relationships, and life opportunities. Most adults with SUD started using alcohol or other drugs in adolescence and young adulthood.[9] Furthermore, early substance use (before the age of 18) results in excess risk of addiction in adulthood.[10] Preventing chronic adult addiction and all the associated personal and societal costs requires that attention be given to effectively treating and supporting the recovery of adolescents with alcohol or other drug use problems.[11]

Adults in stable recovery from SUD benefit from maintaining positive relationships and avoiding negative ones.[12] This dynamic is even more critical among adolescents. For adolescents, peer groups are of paramount importance, and their effect on self-esteem and behavior must be considered to effectively treat adolescent SUD.[13] Negative peer influence is strong enough to cause adolescents to engage in self-destructive behaviors and behaviors that harm others.[14] Alternatively, positive peer influence can promote prosocial beliefs, values and behaviors, leading adolescents to make healthy lifestyle choices.[15] Social identity and the sense of "belonging" to a positive peer group promote resilience, well-being and healthy behaviors.[16,17] Strong connections with pro-recovery peers increase adolescents' personal motivation to pursue and

maintain stable recovery; this commitment and the associated changes in beliefs and behaviors, are critical to recovery maintenance.[18–20]

In addition to personal resilience and a supportive family and peer group, adolescent recovery is aided by a supportive community (eg, school, community recovery support models) and adequate financial resources (eg, health insurance, transportation, etc.). Personal, social, financial, and community resources that support the hard work of recovery have been called "recovery capital".[4,21,22] Another critical element for adolescent treatment and recovery is involvement in structured activities. Rorie et al found that higher levels of structure resulted in decreased levels of antisocial and violent behavior in students participating in after-school programs designed to reduce problem behaviors.[23] Structure that includes therapy, positive adult-youth interactions, social skills training, role modeling, and the expectation of care and concern for others, are all elements of an effective youth misconduct management programs.[24]

As a recovery support model, APGs provide structure and wrap-around support for adolescents to help them build recovery capital and encourage them to find recovery more attractive than substance use.[3,25-27] APGs, along with recovery high schools and youth-focused SUD support groups, are components of the adolescent recovery-oriented system of care, which is a coordinated continuum of professional and community services to address substance use, and its consequences and comorbidities, through all phases of the recovery process, and support recovery maintenance.[28] The APG is designed to provide long-term recovery support for adolescents by integrating fun social activities and pro-recovery peers into typical continuing care practices.[2] APGs seek to generate trust in reluctant adolescents by providing reinforcing experiences that teach them how to have fun without drugs or alcohol.[9,29,30] In a climate of warmth, acceptance, and strong accountability APGs provide adolescent-friendly environments and fun activities along with structured services for youth and their families. These services may include case management, group and individual counseling, family support, psychosocial education, recovery coaching, and 12-step or general SUD support groups. APGs vary in provision of clinical services; some provide them in-house, some integrate intensive outpatient program services in their program, and others collaborate with outside providers. The expected frequency/duration of attendance also varies based on the needs of the communities they serve. Some APGs are stand-alone programs, others are co-located in recovery schools and others are provided in public school settings. All APGs aim to build affected adolescents' recovery skills and facilitate their establishment of new pro-recovery peer networks. Accountability from professional counselors, young adult recovery coaches, peer role models, and/or recovery sponsors is a key component of APG culture. Most APGs encourage sustained participation (12-18 months) in the APG activities because time spent in the APG leads adolescents to bond with pro-recovery peers. If adolescents remain in the APG for at least three to six months they typically develop strong personal relationships with pro-recovery peer and adult role models. This leads participants to begin valuing recovery over substance use, reduces their risk for relapse and promotes voluntary sustained participation. As adolescents progress through the APG program, they are expected to take on leadership and serve as role models to adolescents who are new to the program. Adolescent leaders are encouraged to establish and nurture pro-recovery social ties outside the APG as well.[1,13,31] Many alumni continue to serve as sponsors for new members after they leave the APG.[3]

This paper describes a secondary analysis of interviews with APG participants to answer the following research question: What do adolescent APG participants perceive to be the advantages and disadvantages of APGs for supporting their recovery from SUD?

Methods

Interview data

The interview transcripts utilized for this analysis came from a prior mixed-methods study that was conducted with adolescents who were participating or had participated in an APG. Twelve of the 36 study participants volunteered to participate in face-to-face semi-structured interviews designed to explore factors that promote or hinder adolescents' recovery. All interviews were conducted by the original study's principal investigator (PI). The interview guide solicited participants' narratives in these areas of interest: (1) their SUD and recovery journey; (2) the recovery advantages and disadvantages of participating in an APG; (3) their perceptions of the 12-steps; and (4) their suggestions for improving recruitment and retention in future studies. A full description of the methods and findings of the original study were described in a previous paper.[32]

Secondary analysis

The secondary analysis reported in this paper was conducted by four doctoral student-researchers in a qualitative data analysis research elective in which the original study's PI served as one of the course faculty. The course faculty provided didactic content on qualitative data analysis methods in a variety of formats throughout the course (readings, media, video, and lecture). Then the PI served as content and methodological consultant to the student-researchers as they practiced the steps of thematic content analysis.[29,30] After completing the required human subjects protection training, students were given access to the professionally transcribed transcripts of the original 12 interviews and blinded demographic information of the interviewees. Analysis occurred over the 15-weeks allotted to the course. See Figure 1 for details of the analytic process, which involved extensive debriefing among the student-researchers

through postings within the university's online learning management system and weekly instructor-facilitated in-class group meetings to achieve consensus on emerging themes.

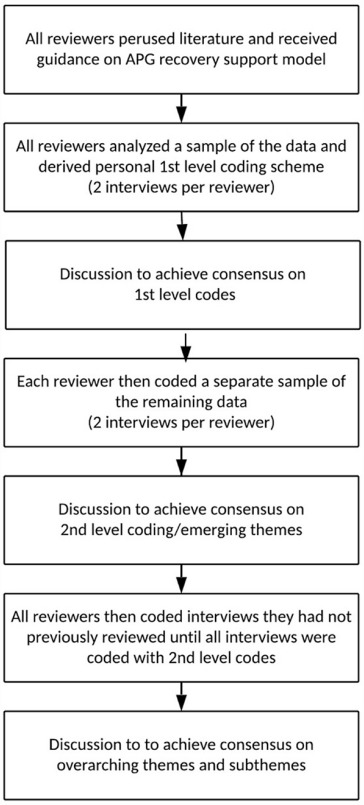

Figure 1. Analytic process.

Discussions of the interpretive and iterative process of identifying and validating emerging themes served as a foundation to pivot the student-researchers into the process of defining a first-level coding scheme with definitions. As clear themes and subthemes emerged, consensus was achieved on a robust second-level coding scheme which was subsequently applied to all the interviews (Figure 2). The student-researchers then identified overarching themes and subthemes and selected exemplars to illustrate them.[29] Peer review was accomplished by presenting these findings to the full class and other course faculty. Finally, the PI supervised the students in comparing the findings with the literature and composing a report of the findings and a discussion, using O'Brien's Standards for Reporting Qualitative Research as a guide.[33] Two students (the first and second authors) worked to develop the final report for publication with the faculty providing guidance and editing.

Results

The student-researchers reviewed 455 pages of transcripts for analysis. Interviews ranged from 30 minutes to 120 minutes in duration. Participants (Table 1) were mostly male, white, and ranged in age from fourteen to nineteen (M = 17 years). Most participants had only been involved with one APG, two had experience with two different APG's and one participant had experience with three APG's. The average time from enrolling in the APG to interview partic ranged from 160 days to 1,073 days (Mdn = 448 days). Eight of the interviewees were actively participating in the APG, two had graduated but were still participating as alumni, and two had left the program dissatisfied or were actively using substances. Eight of the interviewees self-identified as being in recovery and four did not identify as being

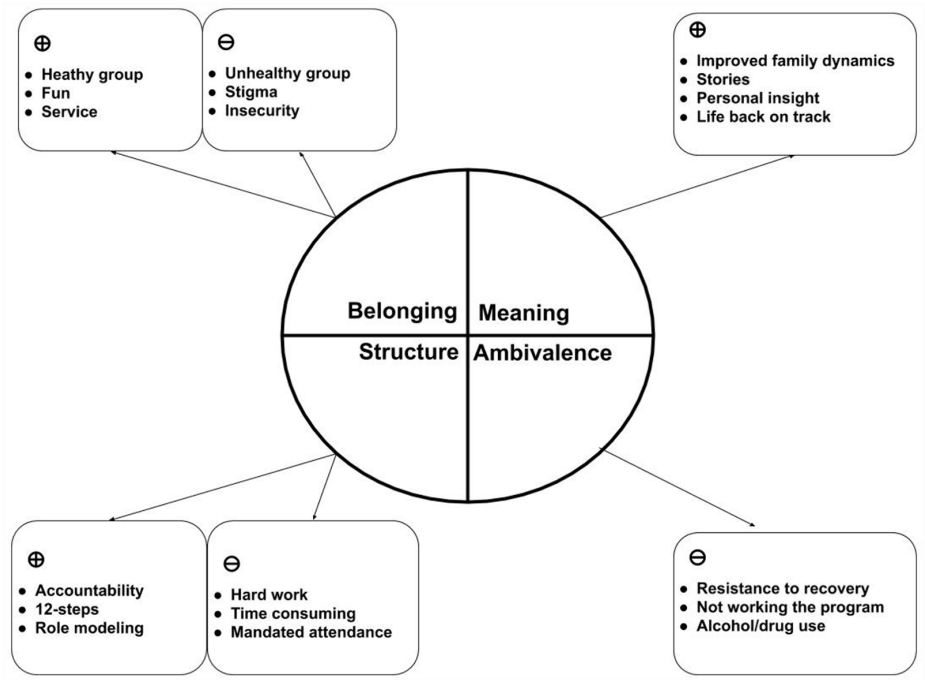

Figure 2. Thematic display: advantages and disadvantages of alternative peer groups.

Table 1. Participant characteristics.

#	GENDER IDENTITY	AGE	RACE	RECOVERY IDENTITY[a]	APG STATUS[b]	# APGS ATTENDED	APG DAYS UNTIL INTERVIEW[c]
1	Male	15	Hispanic	Yes	Active	1	539
2	Male	17	White	No	Active	1	481
3	Male	17	Black	Yes	Active	3	160
4	Male	17	Hispanic	No	Left	2	229 (NA)
5	Female	19	White	No	Left	2	458 (NA)
6	Male	15	White	Yes	Active	1	347
7	Male	16	White	Yes	Active	1	620
8	Female	14	White	No	Active	1	643
9	Female	16	White	Yes	Active	1	416
10	Male	17	Mixed	Yes	Alumnus	1	359
11	Male	18	Mixed	Yes	Alumnus	1	1073
12	Male	18	White	Yes	Active	1	325

[a]Participant self-identifies as being in recovery.
[b]Denotes whether participant is actively being treated, is an APG alumnus who still actively participates, or left APG dissatisfied/is actively using substances.
[c]Days from APG admission to interview (NA = Participant not included in calculation of mean duration because participant left APG).

in recovery. Most of the participants were polysubstance users (alcohol, marijuana, opioids, benzodiazepines, hallucinogens, cocaine, heroin, LSD, inhalants, and/or amphetamines); only three used marijuana and/or alcohol exclusively.

The following main themes emerged from the secondary analysis: Belonging, Meaning, Structure, and Ambivalence (see Figure 2). The following section defines the themes and subthemes with exemplars from the data. Quotes are labeled with participant identification (ID) numbers. Refer to Table 1 to match ID numbers with associated participant characteristics.

Belonging

One of the most consistently identified advantages of the APG that participants expressed was the feeling that they belonged to the group. Belonging was characterized in various ways, such as feeling welcomed, socially accepted, connected, understood, loved, and supported. Participants asserted that belonging was the natural result of "fellowship" in a "healthy group". Over time this sense of belonging led to the development of close personal relationships or bonds with other APG participants. This was identified as an advantage even by those who self-identified as not being in recovery.

> Showing me that much love not even knowing my name. . . It's like, the staff, they're great. They love us, every single one of us to bits,. . . the fellowship helps me get my mind off of all the demons and BS in my head— (#1)

> The strongest thing in like an APG. . .the top one is fellowship because, like, we have, like – we can relate much more of – we, like meet kids our age that, like, have the same problem. (#2)

> like giving me a second family pretty much. (#9)

> the whole recovery has revolved around, uh, community and fellowship and, and unconditional love. (#10)

Several subthemes under belonging were identified. One was "fun". Belonging was facilitated through fun activities such as retreats, campouts, and social activities. Some participants said that before the APG activities, they did not believe they could have fun while being sober.

> . . . the retreats, like the campouts, all those things, I think—those are usually really fun and they're like really beneficial for your program because it makes like a—like when you go camping with someone, it like, makes a stronger bond between you. (#6)

> . . . like just having fun and messing around. And like having fun with kids who don't have to get high to have fun" (#12)

Another subtheme was "service." A critical component of the APG model was the expectation that participants in the APG serve and give back to the APG community. Participants who had graduated from the APG typically continued to participate in APG activities as sponsors or recovery role models.[1,3] By serving, APG participants and alumni received satisfaction and support for their own recovery while contributing to the supportive and sober community - a "healthy group" - that supported others' recovery.

> . . . For me, like I love sponsoring people. I don't know, it gives me a purpose. . .. And like helping other people, like it's the best feeling for me." (#9)

". . . And then like I have the opportunity to sponsor kids. Like right now I have four sponsees. And it really, like helps me a lot to be able to help other people that are struggling also, like, it's just a sense of like service that I have. . .. That I really enjoy. . . And that helps my recovery. (#12)

Not "belonging" to a recovery-oriented, healthy group was a clear barrier to recovery. Even though APG leadership strove to create a culture of welcome and acceptance within the group,[1] a few participants reported feeling excluded, stigmatized and/or disconnected from the recovery-seeking APG community. This lack of belonging to the healthy group was cited as a reason for choosing to be around peers who still misused substances, engaging in unhealthy behavior, and struggling with recovery.

And then I relapsed like six months in. . . it was just kind of because I was hanging with the wrong person at [*APG*]. . .. that person, in particular, should have been like I guess kicked out a long time ago because they had relapsed a lot. Not just like relapsing on their own, but like with other people in [*APG*]. And then he relapsed with me and that was when they finally like kicked him out. Because he had been trying to get me to like - I was hanging out with him and he was trying to get me to like use for a while. And I finally like gave in. (#2)

Because like, I don't want my whole life to be surrounded by sobriety. . .. I want to like with my old friends and stuff too . . .sometimes the staff. Like, if you're having a bad day they can be assholes. (#8)

Some APG participants learned additional unhealthy behaviors from other APG participants. These unhealthy groups of APG participants displayed toxic behaviors and at times even promoted the use of alcohol or drugs. These participants who left the APG asserted

I'd say maybe two out of five or three out of six of those kids are going to get with each other and say, hey, let's get high. . .. I think for people who don't want it, it's very, very, very dangerous. Because, you know, not only can they get drugs that they want, they can get new drugs that they haven't done. (#4)

as I got in there I was having personal problems. . .. I feel like I didn't build a relationship with everyone in [*name of APG*]. But I know damn well half my fucking group went to my school. . .. Yeah, there were also some shitty people that, you know, got me involved in a lot of different things I've never have before. Yeah, I don't necessarily think it

[APG] even works. (#5)

Participants asserted the importance of ongoing peer to peer accountability and staff monitoring to prevent "unhealthy groups"

(In response to the question, "how does the group stay healthy?") It's a mix of kids start to leave, or kids get kicked out, the staff starts to crack down, because they get a whiff of what's going on. Um, a couple of the kids have, you know, like, they're, they're done with all that BS of the unhealthiness so they step up. (#1)

Meaning

Most of the participants said their APG experience was meaningful, helpful and significant in providing the tools needed for successful recovery.

I think it saved so many lives [. . .] I think APG's are awesome [. . .] can prevent suicide, can prevent homicide. (#4)

I've really gotten what I needed out of [the APG]. Not only have I gotten recovery, I've also like, gotten real-life skills. I know how to get a job. I know how to like, have a relationship with people. (#9)

Subthemes under "meaning" included "improved family dynamics" and "stories." Most participants described the APG experience as meaningful for their family because it improved their family communication and relationships and reduced feelings of shame.

Like my family dynamic has gotten like, a lot better. Like, there's a better attitude at home. (#3)

. . .my mom has like opened herself up to understanding it. I don't think she feels as much shame about me being a drug addict as she did before. Yeah, they've just become a lot more accepting, and they really like, care about me. (#9)

. . .making financial amends to my dad and telling him how much money I had taken from him. Um, I, like, expected really bad reactions from everyone. Um, but I didn't get those reactions. I knew, if I thought rationally, that's not how it would go. People wouldn't get mad at me for apologizing. Uh, but it was definitely really nerve-racking, but after I did that, I felt like a weight lifted off my shoulders. I felt, like, less guilty and less shameful, um, and that helped a lot with that. (#10)

The subtheme of stories refers to the APG practice of participants sharing their personal recovery narratives. Participants found these narratives helpful because they provoked insight into their own behavior and served as a form of informal psychoeducation.

Those that come in that are open-minded who don't think that they're addicts, they'll listen to what you have to say. They'll listen to other people's stories, and then, they can make connections and learn a little bit, and, um, then be like, 'Oh, I blacked out on Xanax, too. I might have some things that have to do with addiction.' (#10)

I'd listen to what other people talked about [. . .] I was picking up what they were saying and, like, what they'd learned. (#11)

Another subtheme was "personal growth and insight."

Whenever it came to my inventory, I was very like fearful doing my inventory. I put it off for a really long time. However, whenever I did do my inventory, I grew a lot from it. I like quit having anger

> towards people. I was able to recognize like my part in what I was doing, and like my behavior, and like my patterns. That's where I really grew a lot, also working on my character defects. And recognizing that made me grow a lot too. (#9)

> I was really happy with everything that was going on in my life. . .. I just needed to work on myself and, um, be more self-aware and grow and become more healthy, and that's helped a lot for me. But, yeah, at that point, and still today, um, I'm really happy. I mean, life will hit me, hit me sometimes, and that's just how life is. . .. Um, but when that happens, I know it's okay for me to feel sad. . .. And, um, it's okay for me to feel those emotions, um, but I don't allow myself to get sucked into it. I just kind of keep on putting one foot on another and keep on doing, uh, what I'm doing. And, I don't know, I have a lot more energy now, and just, like, optimism toward everything. (#10)

Participants frequently described changes in their goals, attitudes, and behaviors that they credited to participation in APG; the term they used to describe this was "life back on track."

> For the advantages of an APG, I mean, like, you can get your life back on track. Like, you can realize what you were doing wrong the whole time. (#6)

> It was just, like, the energy that I knew that I - like I said, I knew I had a lot of talents, and I had a lot of personality and purpose, um, but I wasn't living up to, uh, the expectations I had for myself, and I saw it as, like, a baby step towards reaching those— (#10)

Structure

Participants repeatedly cited structure as an important advantage of the APG. This refers to the APG climate of accountability as well as to the weekly routines, schedules, and expectations required by the APG, including participation in the 12-steps. Deemed the agency for recovery, the 12-steps included such concepts as accepting personal responsibility for behaviors, self-examination, surrendering to a power greater than oneself, personal integrity and service to others.[34]

> For me the advantages of [the APG] is giving me a, a very. . .. giving me a lot of structure, and giving me a lot of accountability. It was really what I needed when I first joined. (#9)

> . . . at that point, I had so much structure, and, although I wanted to get high, I would talk about it, and as soon as I expressed it, um, that craving would kind of decrease. . .. The accountability helped me a lot. (#10)

> Like the 12 Steps has like, corrected my behavior, made me recognize like my patterns. And then like, in the end it's like, given me a purpose. (#9)

Another important component of APG structure was the presence of recovery role models. These were APG staff or peers who were farther along in recovery who intentionally modeled the values, attitudes, and behaviors of recovery

> They showed me how to stay sober and they, like, guided me. My sponsor, like, sat me down and he, like, told me a bunch of shit to, like, keep me on track, keep my head up, and, like, boom, I just, like, took off like that, and I stayed sober for nine months. (#3)

> I wouldn't have been able to get sober if I didn't have someone that was healthier than me, um, supporting me. . .. peer role models. . .. that are supportive. (#10)

> It kind of gives me people to look up to, like my staff. Like, I really look up to them. I think it's important if you're trying to accomplish something in any aspect of your life to be able to have someone to look towards that is kind of an example. . .. A role model. . .. And I find a lot of those in my APG. (#12)

Even though the APGs' structured approach to encouraging positive changes was considered an advantage by many participants, the effort to get one's life back on track through accountability, personal insight and growth, and heeding role models was "hard work." Some participants also considered the time commitment required by the APG's structure to be a disadvantage. The majority of new APG participants did not attend willingly, but were mandated by parents, the schools or legal system (thus the need for welcome and fun).[31] Participants who persistently resisted the structure were considered to be hazardous to others' recovery. This was especially the case for participants who felt compelled to participate in an APG and despite time in the positive social environment never became willing to pursue recovery. One interviewee described these participants as those who ". . . need a paper signed or, you know, they're just there because their mom or something." (#4) Another interviewee explained:

> Teens in recovery, and teens, in general, um, don't want to do what they're told or follow a certain rule because they disagree with it. Um, and a lot of structure can—because a lot of people are forced to come it, and they're not ready to get sober, or they're not willing to do it, and I've seen that that structure can push them away a little bit, and then, that kind of draws a line almost. . .. I remember, at one point, we had, like, people—there was no in-betweens. Either you're extremely healthy, and you're doing great, or you're struggling. And, um, and, for a little bit, it was almost like, uh, there was the people that were doing really good and following the rules, and people that weren't following the rules and were doing bad. (#10)

One of the interviewees, who did not identify as being in recovery, "got caught and. . . got sent to [*name of APG*]" (#8) and thought that an APG disadvantage was "that it takes a lot of time." Another said a parent deceived them by promising to seek SUD care at the same time as the participant, but backed out of the commitment. This interviewee went into more detail about the APG time commitment:

> Do you know how hard that was to juggle all of that? To go to school, to go to [the APG] nearly five days a week, and then go to meetings in between that and not have a car. It was like, so hard to juggle. . .. and I had no car and I had to be there for so long and do

this so I don't get kicked out. But like, do this, and. . . the 18-year old that was still in high school trying to do everything. [My sober house] were more like, give her a break. (#5)

Ambivalence

Ambivalence (the presence of conflicting or mixed feelings towards sobriety or recovery) was a common theme that emerged in several participants' narratives.

I thought it was dumb for the pure and simple fact that I did not want to be called an "addict". I did not want to be—I did not want to have my name tainted with the same name as a crackhead, you know, smoking crack under a bridge. (#4)

That's on my part because like, just like I told you, I never really wanted to be sober, truly, for myself. I wanted to do it for other people. (#5)

. . . but for some reason I wanted the benefit of like the program wanted to provide me, but I also wanted the benefit of getting high. . . I would have like my good days and bad days. I would have days where I really wanted to get high. I would have days that I was like I really like wanting sobriety (#9)

I was going to a lot of AA meetings by my own choice and stuff. I was loving the, like, life skills part of it, but, like, not doing the sober part of it, and I just felt really guilty. . . (#11)

Having access to alcohol and other drugs via other APG members or becoming careless about working a program of recovery were other reasons for resisting recovery or for return to use.

And it was because I wasn't working my program fully. I like wasn't calling my sponsor. I wasn't working the steps at the time. I wasn't finding positive female fellowship. Yeah, I just wasn't doing what I was really supposed to be doing. There was a lot more I could've been doing. (#9)

Participation in the APG was time-consuming and "working the 12-steps" was considered hard work. Both of these were cited as initial barriers to APG participation. Listening to the personal recovery narratives of peer or adult recovery role models within the APG social climate of welcome, fun, and accountability led to bonding with a healthy pro-recovery group. Over time belonging to this healthy group resulted in a gradual resolution of ambivalence and meaningful change in their motivation for engaging in the hard work of recovery. "Working the 12-steps" with a sponsor was reported to lead to changes in their values, beliefs, and behaviors ("getting my life back on track"). Then they began to perceive the time commitment and "work of recovery" as benefits rather than barriers.

I immediately started working my steps. And like this time I wasn't like half-assing my steps. I was really working my steps to the best of my ability. I was calling my sponsor like every day of the week. I was going to AA meetings like three or four times a week too with my sponsor. And that like helped me build a really strong foundation. And I also like—I started opening up. . . more. And I got a lot of support. . .. And I started like working my program. . .. it made me realize like what I really want in life, the person I really want to be. And it wasn't easy. Like it, it's not. I don't think anyone would like say it's easy. (#9)

Discussion

The aim of this secondary analysis was to understand more clearly the recovery advantages and disadvantages of APGs as perceived by adolescent APG participants. Having a sense of belonging and APG structure were clear advantages that emerged from the data. Ambivalence, the time commitment, and "hard work" of recovery were primary disadvantages noted by participants. Ambivalence is considered to be normal for any individual, regardless of age, who is charged with changing habitual unhealthy behaviors, as people engage in these behaviors because they are so rewarding. Ambivalence is particularly pronounced in adolescents because of their neurobiological penchant for risky and pleasurable new experiences, and incomplete development of their ability to self-regulate.[7,8,35] Another source of ambivalence in adolescents, is the belief that their substance use is developmentally normal and any "problems" experienced will resolve in adulthood.[35] Because of the paramount influence of peer groups in adolescents, it is logical that ambivalence was magnified if participants felt excluded or did not experience a sense of belonging. The associated shame, stigma and insecurity of exclusion frequently led to resistance to APG participation, the feeling that the APG was "meaningless," and led to an affiliation with unhealthy groups (peers who resisted recovery and were engaging in risky behaviors and substance use). Affiliation with an unhealthy group always hindered recovery. Participants reported that encouragement from their peers led them to engage in the "work of recovery." As they began to experience the benefits of recovery, their ambivalence resolved and they began to perceive the time commitment and "work of recovery" as advantages rather than disadvantages.

These themes align with previous research on APGs and adolescent recovery. Nash et al studied the process of recovery and keys to success in APGs, as seen through the eyes of a different group of APG alumni.[3] In that study, participants noted the importance of recovery narratives, pro-recovery relationships, and wholehearted dedication to "working the steps." Maintaining recovery was attributed to cultivating close relationships with pro-recovery peers, a commitment to structured activities (such as 12-step meetings), personal growth, and engaging in acts of service (such as serving as sponsors for other adolescents in recovery.[3] Hennessy et al reported administrators' and practitioners' perceptions of the vital components of successful adolescents' recovery. They cited the importance of teaching affected adolescents to apply skills to improve their emotional health; encouraging them to "stick with winners" (invest in pro-recovery peer relationships) and emphasized the vital need for family involvement.[26]

The findings of this study concur with the Adolescent Recovery Model (Figure 3).[32] This model depicts adolescent

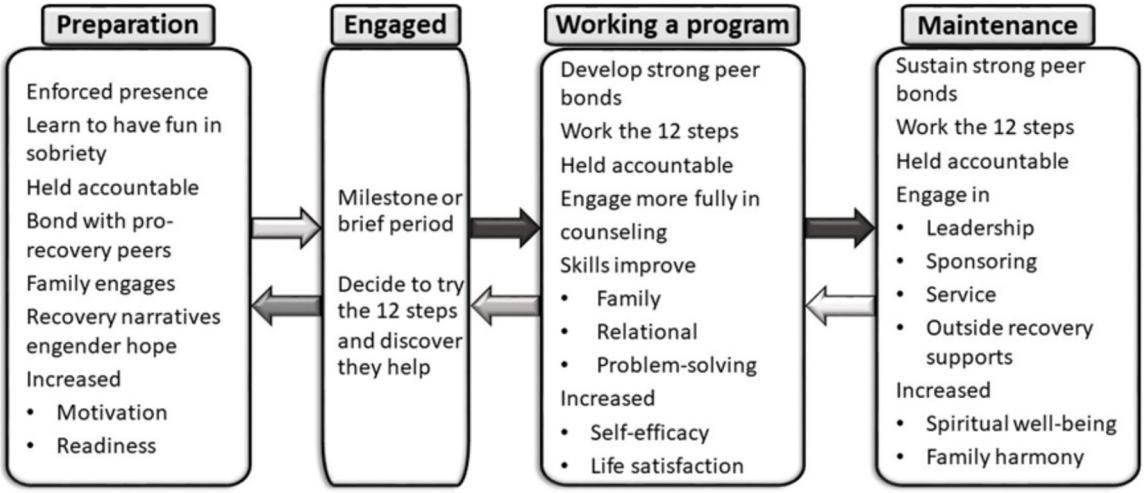

Figure 3. Model of adolescent recovery process in an alternative peer group.
The shaded arrows represent forward (right) or backward (left) movement, and variation of shading within the arrows represents potential for movement (lighter shades = less potential; darker shades = more potential).
Used with permission from Sage. First published in Nash A, Collier C, Engebretson J, Cron S. Testing the Feasibility of Measuring Recovery in Adolescent Participants of an Alternative Peer Group: Lessons Learned and Next Steps. Journal of Adolescent Research. 2019:1-28.

recovery as a protracted process consisting of four distinct but iterative stages that may or may not involve relapse. Elements such as sober fun, relationships with recovering role models, and time emerged as critical to the initiation, progression, and maintenance of recovery.[3,32] A mainstay of SUD treatment across all age ranges involves helping affected individuals resolve their ambivalence and thus, increase their motivation to pursue recovery.[36] It is not surprising that the advantages and disadvantages of APG elements reported by participants of this study seemed to emerge as a continuum that changed over time as their ambivalence resolved.

Findings of this study concur with positive youth development theory that posits that positive peer cultures can overcome negative peer influence in groups of high-risk youth.[37] The concept of "peer deviancy training" (the mutually reinforcing negative effect that peers who engage in high-risk behaviors can have on one another) has been used to question the wisdom of promoting strong relationships among youth who engage in deviant behaviors.[14] Positive youth development asserts that the antidote to peer deviancy training is cultivating positive group cultures among groups of high-risk youth that encourage love, respect, personal responsibility, and peer-helping with strong accountability. This results in groups that reinforce prosocial attitudes and behaviors.[23,24] APG leadership strove to create positive social climates that promote fun, warmth, acceptance as well as strong accountability from positive adult and peer role models. Though peer deviancy training was reported to occur periodically ("unhealthy groups"), the majority of adolescents in this study reported that the positive climate and accountability led to a quick reversal of this process and restored the health of the group.

An in-depth exploration of the narratives of active adolescent APG participants is a strength of this study. It allows readers to hear the advantages and disadvantages of APGs directly from the adolescents themselves, which increases the trustworthiness of findings. The small sample size is a potential weakness of the study. However, saturation on the reported themes was clear. Genders were not equally represented. Had the study been able to recruit more females themes may have varied from those reported. The secondary analysis limited the researchers' ability to return to participants to explore concepts further. Data were collected from only one APG in a large city in the Southwest, so findings may not translate to all adolescent populations. However, the resonance of the findings with positive youth development theory suggests findings may be applicable to other groups. Larger studies that solicit narratives from diverse groups of APG participants are warranted to see if similar themes emerge across populations. Nevertheless, this study provides clues to promising continuing care strategies for promoting long-term recovery from SUD in adolescents.

Treating adolescent SUD is difficult; relapse rates within a year of treatment often surpass 60%.[38] Given this challenge, it is imperative that clinicians and peer recovery support specialists who work with adolescents have a clear understanding of which program elements are perceived as helpful to recovery, and those that may be barriers to recovery. This study suggests that pro-recovery role models, structured activities and a positive social climate that promotes fun, a sense of belonging, and accountability are continuing care elements that are likely to help adolescents resolve their ambivalence about SUD recovery and increase their motivation to engage in the hard work of recovery. These findings can inform the design of effective recovery service model services that promote long-term recovery for adolescents with SUD. The availability of effective services that promote long-term sustained recovery for adolescents is critical to prevent the high personal and social costs of chronic SUD.[39-41]

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REFERENCES

1. Nash A, Collier C. The alternative peer group: a developmentally appropriate recovery support model for adolescents. *J Addict Nurs*. 2016;27(2):109–119.
2. Association of Alternative Peer Groups. Home Page. http://www.aapg-recovery.com. Accessed January 15, 2019.
3. Nash A, Marcus M, Engebretson J, Bukstein O. Recovery from adolescent substance use disorder: young people in recovery describe the process and keys to success in an alternative peer group. *J Groups Addict Recover*. 2015;10(4):290–312.
4. Nash AJ, Hennessy EA, Collier C. Exploring recovery capital among adolescents in an alternative peer group. *Drug Alcohol Depend*. 2019;199:136–143.
5. National Institute on Drug Abuse. The science of drug use and addiction: the basics. https://www.drugabuse.gov/publications/media-guide. Published July 2, 2018. Accessed December 13, 2019.
6. Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*. Rockville, MD: Center for Behavioral Health Statistics and Quality, SAMHSA; 2019.
7. Squeglia LM, Gray KM. Alcohol and drug use and the developing brain. *Curr Psychiatry Rep*. 2016;18(5):46.
8. National Institute on Drug Abuse. The science of drug use and addiction: the basics. https://www.drugabuse.gov/publications/media-guide/science-drug-use-addiction-basics. Published 2018. Accessed April 12, 2019.
9. National Center on Addiction and Substance Abuse, Columbia University. Adolescent Substance Use: America's# 1 Public Health Problem. https://eric.ed.gov/?id=ED521379. Published 2011. Accessed April 16, 2019.
10. Chen C-Y, Storr CL, Anthony JC. Early-onset drug use and risk for drug dependence problems. *Addict Behav*. 2009;34(3):319–322.
11. Peiper NC, Ridenour TA, Hochwalt B, Coyne-Beasley T. Overview on prevalence and recent trends in adolescent substance use and abuse. *Child Adolesc Psychiatr Clin N Am*. 2016;25(3):349–365.
12. Pettersen H, Landheim A, Skeie I, et al. How social relationships influence substance use disorder recovery: a collaborative narrative study. *Subst Abuse*. 2019;13:1178221819833379.
13. Collier C, Simpson S, Najera J, Weiner L. Peer influence and recovery. *Prev Res*. 2012;19(5):6–8.
14. Dishion TJ, Tipsord JM. Peer contagion in child and adolescent social and emotional development. *Annu Rev Psychol*. 2011;62:189–214.
15. Hawkins JD, Weis JG. The social development model: an integrated approach to delinquency prevention. *J Prim Prev*. 1985;6(2):73–97.
16. Kim BKE, Oesterle S, Catalano RF, Hawkins JD. Change in protective factors across adolescent development. *J Appl Dev Psychol*. 2015;40:26–37.
17. Scarf D, Moradi S, McGaw K, et al. Somewhere I belong: long-term increases in adolescents' resilience are predicted by perceived belonging to the in-group. *Br J Soc Psychol*. 2016;55(3):588–599.
18. Best DW, Lubman DI. The recovery paradigm - a model of hope and change for alcohol and drug addiction. *Aust Fam Physician*. 2012;41(8):593–597.
19. Finch AJ, Tanner-Smith E, Hennessy E, Moberg DP. Recovery high schools: effect of schools supporting recovery from substance use disorders. *Am J Drug Alcohol Abuse*. 2018;44(2):175–184.
20. Joe GW, Knight DK, Becan JE, Flynn PM. Recovery among adolescents: models for post-treatment gains in drug abuse treatments. *J Subst Abuse Treat*. 2014;46(3):362–373.
21. Hennessy EA, Cristello JV, Kelly JF. RCAM: a proposed model of recovery capital for adolescents. *Addict Res Theory*. 2019;27(5):429–436.
22. Laudet AB, Humphreys K. Promoting recovery in an evolving policy context: what do we know and what do we need to know about recovery support services? *J Subst Abuse Treat*. 2013;45(1):126–133.
23. Rorie M, Gottfredson DC, Cross A, Wilson D, Connell NM. Structure and deviancy training in after-school programs. *J Adolesc*. 2011;34(1):105–117.
24. Laursen EK. The evidence base for positive peer culture. *Reclaiming Children & Youth*. 2010;19(2):37–42.
25. Gumbley SJ. Recovery in the 21st century: from shame to strength. *J Addict Nurs*. 2016;27(2):143–147.
26. Hennessy EA, Glaude MW, Finch AJ. "Pickle or a cucumber?" administrator and practitioner views of successful adolescent recovery. *Addict Res Theory*. 2017;25(3):208–215.
27. McKay JR. Making the hard work of recovery more attractive for those with substance use disorders. *Addiction*. 2017;112(5):751–757.
28. DiClemente CC, Norwood AEQ, Gregory WH, Travaglini L, Graydon MM, Corno CM. Consumer-centered, collaborative, and comprehensive care: the core essentials of recovery-oriented system of care. *J Addict Nurs*. 2016;27(2):94–100.
29. Green J, Thorogood N. *Qualitative Methods for Health Research*. London: Sage; 2018.
30. Miles MB, Huberman AM, Saldaña J. *Qualitative Data Analysis: A Methods Sourcebook*. 3rd ed. Thousand Oaks, CA: Sage; 2014.
31. Collier C, Hilliker R, Onwuegbuzie A. Alternative peer group: a model for youth recovery. *J Groups Addict Recover*. 2014;9(1):40–53.
32. Nash A, Collier C, Engebretson J, Cron S. Testing the feasibility of measuring recovery in adolescent participants of an alternative peer group: lessons learned and next steps. *J Adolesc Res*. 2019;34(6):655–682.
33. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245–1251.
34. Alcoholics Anonymous World Services. *Twelve Steps and Twelve Traditions*. 77th ed. New York, NY: Alcoholics Anonymous Publishing;2012.
35. Shaffer HJ, Simoneau G. Reducing resistance and denial by exercising ambivalence during the treatment of addiction. *J Subst Abuse Treat*. 2001;20(1):99–105.
36. Miller WR. *Treatment Improvement Protocol (TIP) 35: Enhancing Motivation for Change in Substance Abuse Treatment; Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment*. 1999.
37. Brendtro LK, Mitchell ML. Positive peer culture: antidote to "peer deviance training." *Reclaiming Children Youth*. 2007;15(4):200–206.
38. Passetti LL, Godley MD, Kaminer Y. Continuing care for adolescents in treatment for substance use disorders. *Child Adolesc Psychiatr Clin N Am*. 2016;25(4):669–684.
39. American Academy of Pediatrics. Substance use screening and intervention implementation guide. https://www.aap.org/en-us/Documents/substance_use_screening_implementation.pdf. Published 2016. Accessed October 4, 2019.
40. National Institute on Drug Abuse. Principles of adolescent substance use disorder treatment: a research-based guide. https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/introduction. Published 2014. Accessed April 10, 2019.
41. Center for Behavioral Health Statistics and Quality. *Results from the 2017 National Survey on Drug Use and Health: Detailed Tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2018.