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Anne Thompson Heller

University of Connecticut, anne.heller@uconn.edu

Beth S. Russell

University of Connecticut

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The Impact of Social Influence, Gender, and Non-Parental Guardianship on Adolescents in Substance Use Recovery

Anne Thompson Heller

Beth S. Russell

University of Connecticut

This study explored potential barriers to sustaining recovery from substance use disorders (SUD) in adolescence, particularly for youth enrolled in school-based recovery programs, or recovery schools. Participants (N = 28) enrolled full-time in a Massachusetts recovery high school completed a survey of demographic information and scales assessing social desirability, parent and peer influence, and stigma. Results indicated that peers have slightly higher influence than parents, particularly among girls and adolescents with non-parental guardians. Participants living with parents who use substances reported being sober an average of 28.7 months, versus 40.9 months for those living with non-using parents. Participants with parental guardians also reported experiencing significantly greater social desirability when there is no family history of substance abuse.

Keywords: adolescent substance use, internalized stigma, substance use recovery, social influence

Introduction

Adolescents are entering substance use recovery programs at younger ages. In 2009, approximately 1,438,000 adolescents between the ages of 15 and 17 met criteria for substance dependence (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Despite the widespread scope of the problem, little is known about factors that relate to recovery success, yet understanding these factors is vital to promoting effective intervention practice.

Adolescents entering treatment for substance use disorders (SUD) are influenced during their recovery by multiple factors, including stigma and their relationships with peers and parents (Laitman & Lederman, 2007; Passetti & White, 2007). Internalized stigma results from an individual's internalized negative feelings based on perceptions of negative judgments by others (Livingston & Boyd, 2010). How stigma influences adolescent substance use recovery is not well documented, though the literature on perceived stigma suggests that it creates a barrier to recovery for adolescents (Passetti & White, 2007). One example of how stigma may act as a barrier to adolescents' recovery is found in studies of 12-step fellowship programs, one of the

Direct correspondence to Anne Thompson Heller at anne.heller@uconn.edu

most commonly available recovery supports, where adolescents are in the minority. In this setting, where youth are potentially marginalized by dint of their age, adolescents can feel isolated, disconnected, and further stigmatized, often resulting in disengagement from fellowship groups (Harris, Baker, Kimball, & Shumway, 2008; Passeti & White, 2007).

Stigma felt as a result of changing substance-using behavior may also present a barrier to recovery because efforts toward recovery may violate norms within the adolescent's social context, both among parents and peers. According to Moberg and Finch (2008), changing social contexts—either by challenging group-accepted group norms or by leaving one social group behind to find another—is more difficult for adolescents than adults. If social environments are not supportive to substance use recovery, adolescents may be at a higher risk of relapse than adults (Moberg & Finch, 2008).

Parents influence adolescents' beliefs, attitudes, and behaviors around substance use, including those relevant to recovery (Richter, Brown, & Mott, 1991). Without parental support for an adolescent's substance use recovery, the home environment may be a high-risk context for the adolescent. If the home environment is one where substance use is common or accepted, recovering adolescents are placed at higher risk (Richter et al., 1991). The power of a teen's home environment is not limited to shared biological or genetic factors. Even youth living with non-parental guardians face potential threats to their reductions in substance use as contextual factors—such as conflict, parent or guardian substance use, or those unsupportive of reduction in substance use—can pose a threat to an adolescent's recovery (Moberg & Finch, 2008; Richter et al., 1991). Although the circumstances that lead to non-parental guardianship vary, negative life experiences, such as displacement from parents, increases an adolescent's substance use, particularly when the protective factor of others' recovery support is absent (Wills, Vaccaro, & McNamara, 1992).

Peer relationships are also a crucial part of adolescent development as efforts to gain approval and social acceptance can hinder or promote high-risk behavior among adolescent peers. Social desirability indicates how individuals view the acceptability of their behavior in relation to others (McElhaney, Antonishak, & Allen, 2008). The stress to be accepted has tremendous influence on adolescent behavior and decision-making but can vary by gender. According to Rose and Rudolph (2006), adolescent girls may look for closeness in peers and seek approval, while worrying about being abandoned by friends and feeling lonely; for adolescent boys, the focus may be on social image and popularity. These different social goals often create stress as adolescents seek to achieve their goals of closeness, approval, social status, and popularity (Rose & Rudolph, 2006). In recovery, a peer support network of friends is particularly important for helping adolescents achieve and sustain their recovery (Richter et al., 1991). The current study sought to explore linear relationships between stigma and social influences in adolescents enrolled in an SUD recovery high school.

Methods

Participants

A total of 28 participants were selected from a public recovery high school in New England. Participants were invited to take part in the study by the school's principal via recruitment letters sent home with each student. The study saw a 100% recruitment rate, as all 28 students enrolled at the school volunteered to participate. The recovery high school setting is designed to support the unique needs of students along a recovery continuum while also providing educational supports to advance students' academic progress. Specifically, this recovery high school uses a harm reduction model, which identifies an adolescent's motivation for change and helps reduce substance use to reduce risk, while working toward a goal of abstinence (Association of Recovery Schools, 2013; Prochaska & DiClemente, 1983).

Participants ranged in age from 15 to 18 ($M = 16.90$; $SD = 0.90$) years, with ethnicity reported as 35% Caucasian/non-Hispanic; 9% African American; 54% Hispanic; and 2% multi-racial. Of this sample, 64% reported legal guardianship by one or both parents; 36% reported non-parental guardianship, including kin-care and foster care; 87% received free or reduced lunch; 13% spoke English as a second language; and 50% were considered to have exceptional education needs, such as a current Individualized Education Program (IEP) or similar intervention documentation. Results indicate 16 participants (57%) were polysubstance users, identifying more than one substance as their preferred drug of choice. Further details are presented in Table 1.

Table 1. Sample Demographics

	<i>N</i> (%)	<i>M</i> (<i>SD</i>)		<i>N</i> (%)
Age		16.93 (.90)	Drug of Choice	
Male	13 (46.4)		Smoke Cigarettes	16 (57.1)
Female	15 (53.6)		Alcohol	15 (53.6)
Length of Sobriety (In months)		3.25 (6.74)	Marijuana	23 (82.1)
Legal Guardian			Prescription Drug	6 (21.4)
Mother	12 (42.9)		Cocaine or Crack Cocaine	4 (14.3)
Father	2 (7.1)		Hallucinogens	2 (7.1)
Mother & Father	4 (14.3)		Heroin	1 (3.6)
Grandparent(s)	2 (7.1)		Family History of SUD	
Foster Parent(s)	7 (25)		Yes	16 (57.1)
Other Relative	1 (3.6)		No	12 (42.9)
Number of Siblings		4.04 (2.87)		

Measures

Three measures were administered. Perceived stigma was measured using Ritsher, Otilingam, and Grajales's (2003) Internalized Stigma of Substance Abuse (ISSA) survey, containing 29 Likert items using a 4-point rating scale. These 29 items make up five subscales: alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance. Higher total scores indicate greater level of internalized stigma, and average scale scores between 1-2 indicate minimal to no internalized stigma, between 2-2.5 indicate mild internalized stigma, between 2.5-3 indicate moderate internalized stigma, and between 3.5-4 indicate severe internalized stigma (Ritsher et al., 2003). The measure has acceptable test-retest reliability of .80 and a reported alpha of .90 (.92 in this sample).

The Parent and Peer Influence Scale (PPI; Werner-Wilson & Arbel, 2000) is a 17-item scale that measures the degree to which an adolescent is influenced by his/her parents versus peers. Items are designed to measure adolescent parent/peer alignment across general values, basic beliefs, dating, sexuality, alcohol and substance use, and political beliefs (i.e., *My parents and I have the same value system* and *My friends influence my beliefs about sexuality*) using a 7-point Likert rating scale. Lower scores indicate a higher degree of parental influence based on a median split cutoff. Scores below the cutoff indicate a higher degree of peer alignment, and higher scores indicate a greater degree of parental alignment. The measure has acceptable internal consistency, with a reported alpha coefficient of .75 (.66 in this sample).

The Social Desirability Scale (SDS; Crowne & Marlowe, 1960) is a 33-item measure of participants' tendency to endorse socially desirable activities using a nominal *true-false* format. Example items include *I like to gossip at times* and *I always try to practice what I preach* (Crowne & Marlowe, 1960). Higher scores indicate greater levels of agreement with socially desirable behaviors. This scale has acceptable internal consistency with a reported test-retest reliability of .89 and an alpha coefficient of .88 (.63 in this sample).

Procedures

Approval from the University of Connecticut's Institutional Review Board (IRB) was granted prior to recruitment. Information forms notifying the student's legal guardians of the study were sent home, including an "opt-out" option for guardians to complete and return if they did not want their students to participate; no forms were returned to the school. Students were recruited to participate in the single-time point, anonymous study by the school principal. Surveys took students approximately 15-20 minutes to complete before each student received a ten-dollar gift card. Students' anonymity was maintained throughout data collection and during the distribution of the gift card incentives as no identifiable information (e.g., names, contact information) was

collected. Participants completed the survey using Qualtrics, an online survey program which enables anonymous data collection, on computers in the school's computer lab.

Results

Due to the small sample size of this pilot study, it was reasonable to expect the results to be underpowered; therefore, we adjusted significance for all results presented here to $p < .10$ (Suresh & Chandrashekar, 2012). This adjustment is recommended for small, exploratory studies (Cohen, 1992), where trends that are significant at an alpha level of .10 will likely become significant at an alpha level of .05 in a larger sample (Cohen, 1988).

Descriptive results for the PPI, SDS, and ISSA are presented in Table 2. For the entire sample, scores for the PPI ranged from 52 to 105 out of 119, with a mean score of 66.76 and a median score of 65. The median score of 65 is higher than 59.50, the median score for the measure (Werner-Wilson & Arbel, 2000), indicating a slightly greater influence by peers. Scores for the SDS ranged from 36 to 59, with an average score of 48.83 ($SD = 4.54$). More socially desirable responses were rated a two versus a one for less socially desirable responses yielding a possible range for total scores from 33 to 66 (Crowne & Marlowe, 1960). These results indicate participants may be concerned about social approval and have a bias toward social desirability, as the average score falls in the high range for the measure (40-66; Crowne & Marlowe, 1960). Scores for the ISSA ranged from 1.45 to 3.48, with an average score of 2.32 ($SD = 0.52$). These results indicate mild levels of internalized stigma, as they are within the range of 2.01 to 2.50 (Ritsher et al., 2003).

Group Differences

Table 2 presents descriptive data for the PPI, SDS, and ISSA by gender of respondents, as well as t -test results. Results suggest there are no significant group differences based on age or family history of substance use disorders. Results indicate a significant difference between gender and PPI ($t = -2.03$; $p = .05$), suggesting that, compared to their male counterparts, female participants are more influenced by peers than by their parents.

Table 2. Descriptive Statistics and t -Test Comparisons Among Respondents

	Males ($n = 13$)		Females ($n = 15$)		t
	M	SD	M	SD	
ISSA	2.20	0.39	2.42	0.59	-1.06
PPI	61.72	7.18	70.71	13.18	-2.03*
SD	48.58	3.15	49.09	5.86	-0.26
Months Sober	3.00	4.49	3.47	8.37	-0.18

* $p < .05$

Additional *t*-tests compared the four key variables on the basis of parental versus non-parental guardianship (See Table 3). Results indicated a significant relationship between parental guardianship and the PPI ($t = -1.59$; $p < .10$) and the SDS ($t = -1.57$; $p < .10$), such that adolescents living with parental guardians align less strongly with their parents/guardians. There were no significant differences between parental guardianship and the ISSA or between parental guardianship and length of sobriety in months. However, there were significant differences in length of sobriety when comparing youth living with parental guardians to those with non-parental guardians. Participants who reported living with their parents averaged 1.89 months of sobriety, and those with non-parental guardians averaged 5.70 months of sobriety. An independent *t*-test indicated this is a significant difference ($t = -1.47$, $p = .033$) with a moderate effect size (Cohen's $d = .55$; Cohen, 1988).

Table 3. Group Differences by Parental and Non-Parental Guardianship

	Parental Guardianship		Non-Parental Guardianship		<i>t</i>
	<i>N</i> = 18		<i>N</i> = 10		
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
ISSA	2.25	0.10	2.45	0.22	-0.93
PPI	64.29	1.96	72.00	5.83	-1.59*
SDS	47.88	1.15	51.00	1.43	-1.57*
Months Sober	1.89	4.04	5.70	9.74	-1.47**
Guardian Drug of Choice	<i>N</i> (%)		<i>N</i> (%)		
Tobacco	8 (44)		2 (20)		
Alcohol	4 (22)		3 (30)		
Marijuana	2 (11)		0 (0)		
Prescription Medication	0 (0)		0 (0)		
Meth	0 (0)		0 (00)		
Does not know	9 (50)		6 (60)		

* $p < .10$; ** $p < .05$

A crosstab analysis of participants living with parental guardians revealed that 11 respondents reported living in non-substance-using homes, and 7 reported living in substance-using homes. Results indicate a remarkable difference in adolescent sobriety between those living with guardians who used substances and those living with guardians who did not use substances; participants in substance-using homes reported an average of .86 months versus 4.05 months in non-substance-using homes ($t = -1.47$; $p < .05$).

Discussion

The most noteworthy result from this work is that significant differences were found in students' length of sobriety based on parental guardianship, such that adolescents with non-parental

guardians report longer sobriety on average than those with parental guardians. Few would dispute that a 4-month difference is both clinically meaningful and statistically significant. This trend contradicts much of the existing literature on risk with adolescents with non-parental guardians. An explanation for this may be found in family systems theory (Broderick, 1993). If an adolescent is part of a system that promotes substance use, a change in guardianship may provide a more supportive environment for the adolescent's goals for recovery should the new guardians model values that endorse sobriety more so than the previous guardians. Our comparison of sobriety duration among adolescents who lived with substance-using versus non-substance-using guardians lends credence to this perspective.

The relationships between parental guardianship and the PPI and SDS suggest that participants with parental guardians are less influenced by their peers than those with non-parental guardians. These results also suggest participants living with parents show lower levels of agreement with socially desirable behaviors; this may be due to parental behaviors creating a norm for behaviors deemed socially desirable as discussed above. Children experience a number of social, emotional, and behavioral problems as a result of disrupted or insecure attachment with their parents (O'Connor & Zeanah, 2003).

The lack of research on recovery high school students highlights the importance of conducting research with this population. Results presented here demonstrated greater female alignment with peer influence, which is consistent with the literature indicating that compared to their male counterparts, females have a greater investment in and focus on their peer relationships (Rose & Rudolph, 2006). This gender difference in investment in peer relationships likely remains an influence for those in recovery, particularly as adolescents entering recovery are at risk of being placed in an "out-group" by former social groups that may have endorsed their substance use. This may further their desire for a sense of belonging in a peer group (Harris, Baker, & Cleveland, 2010).

Limitations

While small sample size can limit the power and generalizability of results, small samples can be advantageous in describing trends of disease (i.e., sentinel sampling methods; Schrag, Zell, Schuchat, & Whitney, 2002). Further, it is noteworthy that the number of participants included here represents the full enrollment of an entire recovery high school. Exploratory studies with hard-to-reach populations are often small by dint of the social stigma, criminal status, or similar constraints on access to participation. Such investigations, however, can play a vital role in representing the experiences of often-unavailable populations.

Due to the sensitive nature of the investigation, ensuring participant anonymity was important but also prevented the collection of additional demographic information. As a result of these

concerns, some of the above demographic information was provided by the school's principal. For example, learning that nearly half of the students had IEPs and 13% of the students spoke English as a second language was not discovered until after data collection was complete. Careful examination of the data and reports from the research team indicate there were no comprehension or language-related barriers to survey completion. Although the school's full enrollment participated in the study, results are not necessarily representative of all recovery schools; further research across a range of recovery schools is needed, as schools may vary in their recovery philosophy, services provision models, and student demographics.

Implications

Given that so little research is done with this population, further work is needed to better understand the needs of adolescents in school-based recovery programs. Services can be better tailored to maximize impacts when we better understand the development of this population, the barriers and challenges students face, as well as supports to achieve recovery. This small study yielded valuable and interesting findings pertaining to parental guardianship. More work is needed to explore the impact of both parents and non-parental guardians on adolescent recovery, specifically looking at the protective factors that support recovery and the risk factors for relapse, such as guardian substance use. As trends were also observed with respect to the influential role of peers among recovering adolescents, particularly in females, peer influence needs to be further explored among this population, as well. One promising area of future work would be to explore how peers assist in the development of personal identity—how youth in recovery think about themselves and their behavior.

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Anne Thompson Heller, M.A., M.F.T., has earned one Master's in Educational Leadership, Higher Education, and Student Affairs and a second Master's in Marriage and Family Therapy from the University of Connecticut (UCONN). She is currently a Ph.D. student in Human Development and Family Studies at UCONN.

Beth S. Russell, Ph.D., is an Assistant Professor of Human Development at the University of Connecticut (UCONN) where she studies the development of self-regulation. Her research program examines individual differences and contextual influences in self-regulation from birth through adolescence in normative and high-risk populations. As an affiliate of UCONN's Center for Health, Intervention, and Prevention and of the Center for Applied Research in Human Development, her work is translational in nature and emphasizes implications for prevention and intervention practice. Dr. Russell's work with adolescents focuses on the self-regulatory mechanisms believed to underlay several mental and behavioral health issues for this age group—specifically, self-control and impulsivity.