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INVESTIGATING INDIVIDUAL PATHWAYS TO RECOVERY

by

MACKENZIE MCBRIDE

(Under the Direction of Bryan Miller)

ABSTRACT

Drug use is most prevalent among young adults between ages 18 and 24; this is just one factor that contributes to the high rates of substance use on college campuses. Collegiate recovery programs (CRPs) have been growing in number, awakening the “youth in recovery” movement. This paper presents literature on various tools and elements of recovery, with a focus on CRPs and their significance. This study aims to fill the knowledge gap by examining individual pathways to recovery and learning about the characteristics of students participating in CRPs, including their life events and decisions to seek treatment. Semi-structured interviews were conducted with 15 students in a CRP at a large university located in the southeastern region of the United States. The results describe the participants’ personal experiences and reasons for using alcohol and other drugs such as peer pressure and family adversity, in addition to reasons for seeking treatment. Many participants reported spirituality/religion, hobbies, and involvement in the recovery community as important tools for sustaining recovery. Participants also discussed the challenges of living in recovery including fear of stigma and time management. Overall, college students in recovery describe CRPs are beneficial as they offer a sense of community, support, and motivation. Implications are discussed with hopes to help guide decisions about whether these programs should be expanded to other institutions.

INDEX WORDS: Collegiate Recovery Programs, CRPs, Recovery, Social Learning Theory, Substance use, SUDs, Treatment

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MACKENZIE MCBRIDE

B.S., Georgia Southern University, 2015

A Thesis Submitted to the Graduate Faculty of Georgia Southern University in Partial
Fulfillment of the Requirements for the Degree

MASTER OF ARTS

STATESBORO, GEORGIA

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May 2017

ACKNOWLEDGEMENTS

I would like to express my gratitude to those who contributed to the work presented in this thesis. First, I would like to thank Dr. Bryan Miller, my committee chair, for guiding me through this process, offering continuous feedback and encouragement, and dedicating so much of his time. I would also like to individually thank each of my committee members for their time, patience, and support. Dr. Posick, thank you for providing me with my first research opportunity and inspiring me to enter graduate school. Dr. Brent, thank you for always taking the time to explain things, for the pep talks when I was feeling overwhelmed, and for encouraging me to step outside my comfort zone and guest lecture.

I am beyond appreciative for those who agreed to participate in my study. Thank you for trusting me and for taking the time to share your stories. I thoroughly enjoyed meeting each of you and learned more from you than I could ever explain. Your kindness will always be remembered. Additionally, I would like to thank Ms. Emily Eisenhart for supporting my research idea. Without your trust, assistance, and approval this project would not have been possible.

I am extremely fortunate to have had the opportunity to work with the wonderful people within the Department of Criminal Justice and Criminology. I wish I had more space to thank each person individually, but thank you all for your support, guidance, and fellowship. Special thanks to Mrs. Laurie Hartlett for her administrative help and patience when dealing with paperwork. I thank my family for their endless encouragement and emotional support throughout my years of school and the process of developing this thesis. Last, but not least, I would like to thank my friends; I am lucky to have met some of the best friends during my time in this program. We have laughed, cried, and sometimes did not think we would survive, but I am so thankful I had each of you by my side throughout this journey.

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CHAPTER 1

INTRODUCTION

Substance use is a significant public health problem in the United States costing the nation over 700 billion dollars annually (National Institute on Drug Abuse [NIH], 2015). Moreover, each year, alcohol and other drug use disorders contribute to more than 90,000 deaths in the United States (Centers for Disease Control and Prevention, 2015). The Substance Abuse and Mental Health Administration reported in 2015, nearly 22 million people needed substance use treatment in the previous year. Young adults (ages 18 to 25) had the highest percentage (15.5 percent) with 5.4 million reports of needing treatment. Additionally, 1.3 million adolescents (ages 12 to 17) and 15 million adults (ages 26 and older) reported needing substance use treatment. However, an overwhelming majority (93.7% of adolescents; 92.3% of young adults; and 87.7% of adults) of those who reported needing substance use treatment did not receive care (Lipari, Park-Lee, & Van Horn, 2016). There is evidence youth drug use is declining in certain aspects such as alcohol, tobacco, and prescription misuse; however, it remains important to continue prevention efforts, educate youth about the risks associated with substance use, and work to provide treatment to those who develop substance use disorders (SUDs; NIH, 2016).

The term “recovery” has a long history of definitions, generally meaning a process of change leading to improved health and functioning among individuals and in terms of those with SUDs; this process would include abstinence (SAMHSA, 2011; White, 1998). Lately, “recovery” has been used to replace stigmatizing terms like “disease/disorder”, igniting a “recovery movement” (SAMHSA, 2011; White, 2007). Recently, recovery programs on college and university campuses have also been growing in number, awakening the “youth in recovery” movement (Watson, 2014). For the purpose of this study, I focus on the large growth in the implementation of Collegiate Recovery Programs (CRPs), which utilize a campus-based peer

support model for students recovering from SUDs (Laudet, Harris, Kimball, Winter, & Moberg, 2016). However, there is still much to be studied when it comes to these programs and the individual characteristics of the students who choose to participate. Also, many institutions are not aware that campus-based recovery support resources are available. Additional research is needed to identify the contextual, psychosocial elements that foster seeking treatment and recovery in early adulthood. For example, literature lacks empirical evidence on students' socioeconomic background and the circumstances surrounding seeking treatment (e.g. family intervention, criminal justice involvement). To contextualize these issues, I first examine the literature on various tools and elements of recovery, with special focus on CRPs and their significance. Through rich qualitative data, this study seeks to fill the knowledge gap by examining individuals' pathways to recovery and learning about the individual characteristics of students' in CRPs with a focus on their life events and decision to seek treatment. Additionally, findings from this research will explore the impact of CRPs for participants and may inform decisions about whether these programs should be expanded to other institutions.

CHAPTER 2

LITERATURE REVIEW

Recovery and Recovery Tools

The term “recovery” has been used in various ways to generally define improved health and functioning among those with substance use disorders (SUDs) following abstinence (White, 1998). SAMHSA (2011) developed guiding principles of recovery that includes four dimensions: (1) Health: overcoming one’s disease(s) and making healthy decisions to achieve physical and emotional wellness; (2) Home: living in a stable and safe place; (3) Purpose: partaking in meaningful daily activities; and (4) Community: forming relationships and social networks that offer support, friendship, love, and hope. Similarly, Maslow’s (1954) hierarchy of needs relates these dimensions to his process of reaching self-actualization. Maslow (1954) posited that humans are motivated by achieving each level of needs beginning with basic needs such as biological and physiological needs (e.g., food, water, oxygen) and safety needs (security, protection). Then, one must reach psychological needs such as belongingness and love (e.g., affection, friendship) and esteem needs (achievement, self-respect). Once these needs are satisfied, one can finally reach self-actualization or realize personal potential, seek personal growth, and self-fulfillment (Maslow, 1954). Not only are Maslow’s needs related to SAMHSA’s dimensions of recovery, but these factors play a significant role in the goals of CRPs and successful recovery. Kelly and Hoepfner (2015) conceptualized and defined recovery in a biaxial formulation. They explained recovery as a “dynamic process characterized by increasingly stable remission resulting in and supported by recovery capital and enhanced quality of life” (p. 9). This model suggests, individuals with less recovery capital (i.e., fewer recovery resources) are more likely to experience stress and distress and have less success of remission.

There are both informal and formal tools for recovery used with college students, which are usually located off campus in the community instead of on campus. Formal tools include inpatient rehabilitation, intensive outpatient care, and outpatient care, while informal tools include peer-based supports such as Alcoholics Anonymous (AA), Self-Management and Recovery Training (SMART Recovery), and other 12-step groups (Watson, 2014). Recovery houses are important tools in the recovery community, which provide people in recovery a place to live together in a family-like environment while also receiving professional support (White, Kelly, & Roth, 2012). Recovery houses could be a successful tool implemented into CRPs as they offer peer support and active involvement (e.g., meetings with house members and counselors, household chores, community service, and encouraging others' sobriety; Watson, 2014).

Collegiate Recovery Programs

Collegiate Recovery Programs (CRPs) are campus-based recovery programs, often based on mutual aid and self-help groups (such as 12-step programs), are peer-driven, and provide support groups and sober events to assist students in their recovery (Laudet, Harris, Winters, Moberg, & Kimball, 2013). These programs first appeared at a few universities in the 1980s after being created by interested university faculty and staff. They developed informational seminars about addiction and established sober housing and a safe environment for recovery (Laudet, 2016). In the early 2000s, there was an increase in the demand for CRPs as academic institutions and federal agencies increased their recognition of youth substance use (Laudet, Harris, Kimball, Winters, & Moberg, 2015). The number of CRPs grew from four in 2000 to fifty in 2010 (Laudet, Harris, Winters, Moberg, & Kimball, 2014). Currently, there are over 50 CRPs in the

nation, with an average of three to five programs starting each year (Association of Recovery in Higher Education, 2016; Laudet, 2016).

As mentioned above, one element that is significant in recovery success is social support. Recovery can create feelings of isolation, especially among college students who refrain from general leisure activities (e.g., parties, drinking games, tailgating) that can trigger thoughts of substance use and put their recovery at risk (Depue & Hagedorn, 2015). Also, people tend to adopt the roles and behaviors of the people they are most often around and those whose opinions matter most to them (e.g., peer pressure; Laudet, 2006). Thus, CRPs strive to create a supportive social community for students through drug-free housing and non-drug-related leisure activities (Laudet et al., 2015). Research shows individuals in recovery find it helpful to interact with peers who also have a history of addiction and learn coping mechanisms from their peers in recovery (Laudet et al., 2006; Palmer & Daniluk, 2007). Students involved in CRPs are provided individual and group counseling to discuss recovery and academic issues to enhance students' emotional growth and educational opportunities (Laudet, 2016). Further, CRPs often offer weekly seminars, which can include discussions ranging from health and spirituality to academics and personal achievement (Center for Addiction Recovery, 2016). Spirituality is important to some individuals as it gives them a greater purpose in life, enhances coping skills, and increase their sense of control and stability (Laudet et al., 2006). Lastly, family is an important form of support for recovery. Parents and caretakers are often the ones to recognize substance abuse and initiate an intervention or treatment (Gifford, 2013; Rickwood, Deane, Wilson, & Ciarrochi, 2005). Thus, when young adults get to college and are no longer surrounded by family, many students may fall off the recovery track or simply fail to recognize their SUD symptoms (Rickwood et al., 2005). Overall, it is clear there are many elements that

are important for recovery, including social and emotional support from peers, spirituality or religion, and family. However, these elements differ among individuals and not all forms are equally important for everyone, thus, there is more to be discovered in terms of what methods and elements are most successful when it comes to recovery services such as CRPs.

Social Learning Theory

Building on the works of Sutherland (1947) and Skinner (1953), Aker's (1985, 1998) explains social learning theory (SLT) with four main concepts: differential association, definitions, differential reinforcement, and imitation. Differential association refers to the people an individual comes in contact with such as family members, peers, teachers, coaches, neighbors, and authority figures. The process of differential association has been shown to have the strongest influence on behavior compared to the other social learning measures (Akers, 1998; Schaefer, Vito, Marcum, Higgins, & Ricketts, 2015; Young & Weerman, 2013). Learning behavior is influenced by how soon the person is exposed (i.e., priority), how long they have been exposed (i.e., duration), how often they are exposed (i.e., frequency), and how salient the exposure is (i.e., intensity; Akers, 1985). Early in life family primarily influences people, but as they reach adolescence peers become greater influences. Therefore, adolescents with friends who engage in substance use are more likely to have favorable definitions of substance use and are also more likely to engage in substance use than adolescents who do not have peers that use alcohol or other drugs (Norman & Ford, 2015). Definitions include orientations, attitudes, and rationalizations that label a behavior as right or wrong, acceptable or unacceptable (Kubrin, Stucky, & Krohn, 2009). When an individual defines substance use as acceptable or advantageous they will be more likely to engage in drug use. According to Sutherland (1947), definitions can vary over four dimensions: (1) frequency (i.e., how often one is exposed to a

definition); (2) duration (i.e., amount of time a person is exposed to a definition); priority (early definitions are more influential than later ones); and (4) intensity (i.e., definitions are more intense when attached to a significant person in one's life). Thus, a person with positive definitions of substance use is more likely to drink alcohol and use drugs, and those definitions will be more influential when that individual is frequently exposed to the definitions by a significant person, at an early age, and over a long period of time (Sutherland, 1947). Differential reinforcement is the balance of expected or actual rewards and punishments that are consequences of behavior. Positive reinforcements include obtaining the approval of others, money, and positive feelings (Kubrin et al., 2009). In contrast, a negative reinforcement increases the likelihood of a particular behavior by removing an unpleasant stimulus or decreases the likelihood of reoccurrence by punishing a behavior. Reinforcements and punishments are more likely to influence behavior if they are large, frequent, or probable (Sutherland, 1947). In sum, an individual is more likely to engage in alcohol or other drug use if they receive or expect to receive positive outcomes. Social learning theory uses observation, modeling, and imitation to explain why one's behavior is often similar to that of family and friends. Akers (1998) stated imitation is more important for the initiation of a behavior rather than its persistence declare. Adolescent alcohol and other drug use initiation have been linked to peer influence through modeling of use and reinforcement (Trucco, Colder, & Wieczorek, 2011). An individual is more likely to imitate behavior that is rewarded and less likely to model the behavior they see being punished (Akers, 1985). For example, a parent drinking alcohol to relieve stress would provide a behavior that could be modeled by the child.

Akers (1998) proposed SLT should consider the elements of social structure (i.e., class, gender, age, marital status, race, and ethnicity) on a person's general learning context. For

example, an adolescent of a low socioeconomic status, living in the inner-city will be more likely to be exposed to and model delinquent behavior that could include alcohol and other drug use and distribution than an adolescent from an upper-class family that lives in a rural community. Also, there are non-social components of SLT, such as non-social reinforcements, which include psychological and physiological rewards and do not require contact with others. For example, drugs may create physiological changes within the body leading one to need more drugs to satisfy their biological needs (Akers, 1998; Higgins, Mahoney, & Ricketts, 2009). Bandura (1971) argues SUDs are “the result of complex learning from an interaction of the person with his or her environment” (Maisto, Galizio, & Connors, 2004, p. 358). Just as social learning often plays a role in why people SUDs, there are several aspects of the recovery community that can provide support for SLT. For example, CRPs and the general recovery community provide “models” such as sponsors and older people in the program seeing peers in CRP focus on school and do volunteer work would provide a behavior that could be modeled.

College and Addiction

It is no surprise that the “college culture” exposed students to various environments that foster binge drinking and substance use (e.g., fraternity and sorority parties, bars and clubs located near campus, and tailgating). Yet today’s college students are at particular risk of developing SUDs as a result of binge drinking, exposure to drugs and alcohol, peer pressure, and sensation seeking (Depue & Hagedorn, 2015; National Center on Addiction and Substance Abuse [CASA], 2007). The rate of alcohol use and binge drinking is higher among full-time students compared to part-time students or non-college individuals and illicit drug use remains highest between the ages of 18 and 20 years (SAMHSA, 2008, 2009). In fact, full-time college students construct the largest group of individuals to meet the criteria for SUDs; however, they

are the least likely to seek treatment (Wu, Pilowsky, Schlenger, & Hasin, 2007). One reason students often avoid treatment is fear of social stigma; for example, in a nationally representative study of 2,000 college students, 88 percent of students recognized alcohol and drug programs were available, yet 37 percent reported fear of social stigma as a deterrent to seeking help. Additionally, the study concluded students felt unmotivated to seek help and lacked support and guidance from college administrators and advisors (CASA, 2007).

Collegiate recovery programs are very important due to the high rates of substance use and abuse on college campuses and onset of SUDs in early adulthood (SAMHSA, 2011). CRPs aim to provide a campus-based, recovery friendly environment that supports and enhances educational opportunities while supporting students' recovery and emotional growth. In addition to feeling welcomed and supported by other students, faculty, and staff, CRPs help decrease the stigma attached to behavioral addictions, making it more likely that students will seek treatment and address their substance use disorder (DePue & Hagedorn, 2015; Laudet et al., 2015). Relapse rates are high among individuals with substance use disorders (SUD); therefore, some individuals in recovery are discouraged from pursuing a college education due to the high rates of substance use on campus, which can jeopardize their recovery (Finch, 2010; Laudet et al., 2015). However, students enrolled at schools that offer CRPs often maintain their sobriety while earning their degree.

Students Participating in CRPs

To date, there is little information about students who join CRPs and young people who are in stable recovery. The only national study was descriptive in nature and gave a snapshot of the CRP field at one point in time. In 2012, Laudet found students in these programs are older than the traditional college age. Additionally, reports show the students' mean grade point

average as 3.2/4.0, they participate in their CRP for an average of seven semesters, consider themselves in good physical health, yet engage in several unhealthy behaviors (e.g., smoking, unhealthy eating) and often report mental health problems (e.g., depression, anxiety, bipolar disorder) at a high rate (Laudet, 2016; Laudet et al., 2015). However, researchers did not collect information on students' socioeconomic background (although found 91 percent are Caucasian) or the circumstances surrounding seeking treatment (e.g. family intervention, criminal justice involvement). Although CRPs are all dedicated to the same goal of creating a safe haven for students in recovery, some CRPs vary in terms of admission and requirements. For example, minimum duration of recovery or abstinence, cost to students, level of supervision, participation requirements, and types of services offered (seminars, tutoring, counseling, academic advising). However, prior research shows overall, CRPs often include sober/drug-free housing options, sober activities, teaching life skills to prevent relapse, and individual or group counseling to discuss recovery and academic issues (Laudet et al, 2014).

The purpose of the current study is to fill this knowledge gap by examining individual pathways to recovery and learning about (1) the individual characteristics of students in CRPs; (2) the events leading to the participants' decision to seek treatment, or their "moment of clarity", (3) tools utilized to sustain recovery; and (4) personal experiences of living in recovery, with special focus on the challenges of being a college student in recovery. This study will add to the literature on CRPs and disseminating the findings may provide institutions with information as they explore the possibility of hosting a CRP. Also, I hope to gain insight about the individuals who participate in these programs. Participants will be asked about their life events that may have influenced them to seek treatment and also their experiences with stressful events

that could have led to self-medication or certain coping mechanisms. Therefore, it will help address what factors may influence an individual to seek treatment and join the road to recovery.

CHAPTER 3

METHODOLOGY

This study is guided by methods of both Interpretive Phenomenological Analysis (IPA) and Template Analysis (TA) as both aim to explore meaning of experience (Bachman, Schutt, & Plass, 2017). The main objectives of this study are to learn about the events leading to the participants' decision to seek treatment, or their "moment of clarity"; the individual characteristics of students' participating in CRPs; the tools students used to sustain recovery; and the challenges of being a college student living in recovery. Participants were asked about their life events that influenced them to seek treatment and also their experiences with stressful events that may have led to self-medication or certain coping mechanisms. Accomplishing this helped address what factors may influence an individual to seek treatment and join the road to recovery. Specifically, the purpose of this study is to address the following research questions: (1) What events influence a person's decision to seek treatment for a substance use disorder?, (2) What are the individual characteristics of students participating in CRPs?, (3) What are the most important tools to sustain recovery?, and (4) What are the challenges of being a college student who is in recovery?

Population/Sample

The current study relies on in-depth, semi-structured interviews with students participating in a CRP at a large, public university in the southeastern region of the United States. According to university's website (2016), total enrollment is just over 20,000 students, and approximately 88 percent of those are undergraduates. In the fall of 2016, approximately 53 percent of the student population was female and 47 percent male. The university has a predominately White student body with 62 percent of students self-identifying as White, 26

percent as Black/African-American, and 12 percent “Other” (i.e., American Indian/Alaska Native, Asian, Hispanic, Native Hawaiian/Other Pacific Island, Two or More Races, and Unknown). Specifically, the university’s CRP is comprised of 40 students with an average age of 25 years and an average of 2.4 years sober. In 2016, the CRP had approximately 39 percent female and 61 percent male. Over the past nine years, the CRP has consisted of 97 percent White students and 3 percent “Other” which includes Black/African American, Latino, and mixed races. The average student is enrolled in 12 credit hours per semester and works 18 hours at an on- or off- campus job (Center for Addiction Recovery, 2015b). This particular CRP only serves students whose primary diagnosis was a substance-use disorder prior to entering recovery, though students can be in recovery from other addictive or behavioral disorders (Center for Addiction Recovery, 2015a).

The sample for the present study consists of 15 students enrolled in the CRP program. Table 1 presents information about their background, current status, and length of recovery. Closely resembling the makeup of the program, the majority of the sample was male (3 females, 12 males). All participants identified themselves as White/Caucasian. Duration of recovery at the time of the interviews ranged from 9 months to 4.5 years ($\bar{x} = 2.5$ years). The participants’ ages ranged from 21 to 32 ($\bar{x} = 26.33$). One student was a freshman, 3 were sophomores, 5 were juniors, 4 were seniors, and 2 were in graduate school. Two participants did not work, 4 worked on-campus, 8 worked off-campus, and 1 worked both on- and off-campus. Five participants indicated they identified as being “Spiritual”, 7 indicated they were Christian, and 2 indicated that they were “Not Religious.” All of the participants with the exception of one went through long-term treatment.

Table 1 Demographics

Name *	Age	Gender	Class Year	Months Sober	Work	Religious/Spiritual Identity	Addiction in Family
Stephen	24	Male	Freshman	17	Off-Campus	Christian-Protestant	None
Justin	21	Male	Sophomore	9	None	Not religious	Extended
Kyle	22	Male	Junior	11	Off-Campus	Christian-Methodist	Extended
Thomas	32	Male	Graduate School	17	Off-Campus	Christian-Catholic	Nuclear
Brooke	22	Female	Sophomore	17	Off-Campus	Spiritual	None
Sarah	28	Female	Sophomore	48	Off-Campus	Spiritual	Extended
Tyler	22	Male	Junior	36	None	Christian-Jesus	Nuclear
Wes	27	Male	Senior	36	On-Campus	Spiritual	Extended
Adam	28	Male	Senior	30	Off-Campus	Christian-Catholic/Spiritual	Nuclear / Extended
Brian	31	Male	Junior	48	Off-Campus	Not religious	Nuclear
Matt	25	Male	Junior	14	On-Campus	Christian-Catholic	N/A **
Carter	26	Male	Junior	30	On & Off	Not religious	Nuclear
Scott	34	Male	Graduate School	24	On-Campus	Christian-Protestant	Extended
Rachael	28	Female	Senior	54	Off-Campus	Spiritual	Nuclear
Keith	25	Male	Senior	48	On-Campus	Spiritual	None

* Pseudonym

** Participant adopted; family history unknown

Data Collection

After being reviewed and approved by the Institutional Review Board (#H17024), participants were primarily recruited through convenience sampling. However, snowball sampling was also utilized when participants offered to tell other students in recovery about the benefits of the study. Although it was unlikely the participants directly benefited from participating in this study, some respondents seemed to enjoy telling their stories and this can be therapeutic in the recovery process. Snowball sampling was useful for this study because people in recovery are often hesitant to disclose their history for various reasons, such as fear of judgment and negative stereotypes (Bachman, Schutt, & Plass, 2017). With the permission of the program director, I conducted four recruitment sessions in person at the CRP's weekly seminars. At the seminar, I introduced myself to the students and explained the purpose of the project. The students had the opportunity to ask any questions. I provided my contact information to the coordinator and encouraged the students to email me if they had any questions or wanted to participate in the study. Also, I left a sign-up sheet at the recovery center so students who wanted to participate could write down their contact information. I left the sign-up sheet so the students

did not feel pressured to participate or feel guilty if they did not write down their information as I was standing before them. Thus, following each recruitment session, the coordinator emailed me the contact information of students who were interested in participating, and then I emailed the students to set up a time and date for the interview.

In total, interviews were conducted with 15 participants (38 percent of the program). Interviews were held in private settings. Interviews lasted between 24 minutes and 68 minutes (\bar{x} = 49 minutes) and took place between September 2016 and February 2017. Before beginning each interview, I explained the project to the participants and reassured them that their participation is voluntarily and they will not face any consequences for declining to participate. Additionally, I ensured them they could withdraw from the study at any time. Due to the sensitive nature of some the questions, I provided information about the counseling services on campus. Participants were reminded that their answers would not be linked to their identity in any way. I allowed the participants to ask any questions before providing them the consent form to sign (see Appendix A). Once informed consent was provided, participants were asked to complete a brief questionnaire sheet that focused on demographic information (see Appendix B).

This study employed semi-structured interviews. Interviews with open-ended questions often result in broad transcripts that make it difficult to code and obtain themes; however, for the same reasons they are considered one of the best methods to use to avoid researcher bias (Creswell, 2007; Bachman, Schutt, & Plass, 2017). The interview protocol was organized by topic with open-ended questions and probe questions to gain more detail of their experiences. The interviews consisted of open-ended questions which explored the following themes: (1) personal experiences with substance use and opinions of drug use, (2) life events leading to decision to seek treatment, (3) sources of stress and support as a college student, (4) barriers to

treatment, and (5) experiences with their CRP. An example of an open-ended question included in the interview protocol is “Have you ever experienced a moment of clarity?” (See Appendix C for full interview protocol). Open-ended questions are useful to facilitate discussion, especially when asking questions about sensitive information since they allow the participants to express their feelings and thoughts without feeling restricted (Bachman, Schutt, & Plass, 2017). All participants were asked the same general questions from the interview protocol, but the order in which the questions were asked varied depending on the flow of the interview. For example, some participants answered questions before they were asked. Additionally, it was important for me to be able to ask additional questions that were relevant to the participant in order to build rapport (Bailey, 2007).

Data Analysis

Data analysis began by transcribing each interview verbatim using the qualitative software Express Scribe. The process of transcribing interviews verbatim was beneficial because it established familiarity with the data. Due to interviews being open-ended, using an inductive approach ensured the themes within the data were thoroughly assessed to include all of the experiences and perceptions that were evident in the raw data (Thomas, 2006). I found reading and re-reading the transcripts in full before starting the coding process allowed me to familiarize myself with the data and pick up on things I did not recall from the interview. First, I used open line-by-line coding to find key words and phrases, making sure to note points relevant to the research questions addressed in this study, such as, personal experiences with drugs and alcohol, seeking treatment, participating in a CRP, and living in recovery. However, I left room for emerging themes. Each theme that emerged from the data was coded in a different colored highlight using the computer program Microsoft Word. Also using Microsoft Word, I created a

separate document for each interview transcript where I listed the themes and copy and pasted supporting quotes from the participant's story. After completing the thorough initial coding process, I used focused coding to condense the data into larger categories that included multiple codes (Bailey, 2007). For example, I took items labeled "having a safe environment," "sense of belonging," and "fellowship" during initial coding and combined them to make a category called "recovery community."

Once the codes were finalized, I created a table containing each major theme and its corresponding subthemes (see Table 2). In addition to highlighting key words and quotes, I wrote down notes or "memos" while reading the transcripts. Memos included, but were not limited to topics such as, emerging areas of interest, and any reflections, thoughts, or feelings that came to mind (Birks, Chapman, & Francis, 2005). The notes were particularly helpful when distinguishing between commonalities and contradictions between participants. For example, originally one theme was "motivators" but it became evident that the participants' descriptions reflected opposite ends of the same spectrum since some participants were motivated to get better after losing relationships with their family or failing in school, while others were motivated to maintain their recovery when they started regaining things such as, trust from their family members and success in school. Thus, I felt it was important to separate "motivators" into two categories: (1) motivators to seek treatment and (2) motivators to maintain recovery. As stated above, the analysis of interview transcripts was guided by IPA and TA; since the main goal of these methods is to uncover meaning behind experiences, it is important to note the codes were determined *in vivo* (i.e., directly from the words of the participants) to fully capture the participants' characteristics, experiences, and perspectives. Codes ranged from simply descriptive to more interpretive concepts. Examples of descriptive codes are narratives

describing his or her first time using a substance, first arrest, or length of sobriety. Interpretive concepts were more complex and included experiences such as what happened that led them to seek treatment, moments of clarity, how their relationships were affected by their substance use, and where they view themselves in recovery.

Table 2 Outline of Chapters and Themes

Chapters	Themes	Topics/Codes
Individual Experiences Leading up to Treatment	The Beginning and Escalation	Peer pressure; Tragedy; Divorce; Fasination; Freedom; Tragedy; Legal Consequences; Enjoyment
	Barriers to Seeking Treatment	Family; Friends; Denial; Pride
Motivators and Tools	Motioventions to Seek Treatment	Moments of Clarity: Legal Consequences; Loss; Death,
	Motivations to Maintain Recovery	Getting Things Back: Relationships; Health; Success
	Tools for Maintaining Recovery	Spirituality/Religion; Helping Others; Recovery Community; Staying Busy
Living in Recovery	Challenges	Finding Balance; Going Back to School; Socialization
	Stigma	Fear of Judgement; Labels; Telling People

Ethical Considerations

As a researcher, it is my responsibility to ensure my study is ethical. Thus, I made sure my project incorporated the fundamental research ethics principles originally articulated in the

Belmont Report: respect for persons, beneficence, and justice (National Institute of Health, 1979), which I will discuss in detail in the following paragraphs.

Before recruiting participants, this project was reviewed and approved by the Institutional Review Board (H17024). After receiving approval, I conducted four recruitment sessions in person at the collegiate recovery program's weekly seminars. At the seminar, I introduced myself to the students and explained the purpose of the project. The students had the opportunity to ask any questions and were not coerced in any way. I provided my contact information to the coordinator of the recovery center and encouraged the students to email me if they had any questions or wanted to participate in the study. Also, I left a sign-up sheet at the recovery center so students who wanted to participate could write down their contact information. I felt leaving the sign-up sheet there without being present would let the students freely decide whether they wanted to participate without feeling pressured by my presence. Following each recruitment session, the coordinator sent me the contact information of students who were interested in participating, and then I emailed the students to set up a time and date for the interview. All of the participants' information used for scheduling was held confidentially.

Before beginning each interview, I introduced the consent form and explained the project to the participants. I reassured them that their participation was voluntarily and they would not face any consequences for declining to participate. Additionally, participants were reminded that they could terminate the interview or ask for the tape recorder to be stopped at any point. I also reassured them of their confidentiality, making it clear that their answers would not be linked to their identity in any way. I informed the participants if there was anything they did not wish to have quoted, they may tell me at any point or after the interview that they wish to have it kept "off the record," and it would not be quoted. I allowed the participants to ask any questions

before providing them the consent form to sign (see Appendix B). Once consent was received, participants were asked to complete a brief questionnaire that focused on demographic information (see Appendix C). Since some questions may present possible emotional stress or discomfort, I provided contact information to the university's counseling center should any form of distress be apparent or reported during the interview. Although this did not occur at any point during the interviews, I was prepared to escort the participant to the university's counseling center and/or counseling center in the event that a student expressed that they may wish to harm themselves or others, or if they reveal any suicidal ideation. I also reminded students that they could terminate the interview or ask for the tape recorder to be stopped at any point. Interviews were conducted on campus in an empty office located away from the main faculty offices and classrooms in the Carroll building.

To ensure the participants identity remained confidential the audio recordings were deleted from recorders and hard-drives after the interviews were transcribed. Any personal identifiers (e.g., names, contact information, locations, and/or occupations) were removed from transcripts and all subjects, locations, and identifiers were referred to by pseudonyms. Additionally, participants were not discussed using any other identifying attributes such as nicknames or distinguishing personal features in the transcription documents. In other words, all data was deidentified. All physical data was stored and kept secure in a locked and secured location and all data saved on computers were encrypted and only accessible via password, which is only known by myself. Further, the participants' consent forms were secured in a separate locked file cabinet. Lastly, collected data and consent forms will be retained for a minimum of three years as required by federal regulations.

Results

A total of 15 participants completed semi-structured interviews in which they were asked questions pertaining to their road to recovery. Each interview started with the same question: “Where do you view yourself in recovery?” and the proceeding questions were primarily guided by their individual answers. Other questions include, but are not limited to, topics such as life events before entering treatment, barriers to treatment, personal moments of clarity, tools utilized in recovery, and challenges of being in recovery. The results of the analysis will be presented in the following three chapters. Each of these chapters and the corresponding themes seeks to offer insight into the participants’ experiences before seeking treatment including drug use and barriers they had to overcome, as well as their experiences along their road to recovery. Chapter four presents themes that capture the beginning of the road to recovery for the participants including events that escalated their substance use and certain barriers they overcame to seek treatment. Chapter five presents themes that explain specific motivators and tools that are important to their recovery. Lastly, chapter six offers the participants’ perspectives on what it is like to live in recovery, including stigmatization and other challenges they face as a person who is in recovery.

CHAPTER 4

INDIVIDUAL EXPERIENCES LEADING UP TO TREATMENT

This chapter focuses on the events leading up to treatment as well as the individual experiences for why the participants sought treatment. The responses from the participants were geared to address research questions such as: “When did you realize your substance use was problematic?” and “Did you experience any barriers to seeking treatment?” Two themes emerged from the analysis: (1) the beginning and escalation of substance use, and (2) barriers to treatment.

Theme 1: The Beginning and Escalation of Substance Use

Several of the participants explained they first used drugs or alcohol after being pressured by their peers. Interestingly, both Carter and Rachael said they were “late bloomers” and did not start drinking until their later years of high school. They both explained how they committed to extracurricular activities and their school work, thus partying did not appeal to them. However, they both eventually succumbed to peer pressure. Carter explains his experience, “But, then I was peer pressured by some girls that I thought were cute (laughs) and I ended up drinking and I loved it. I was like, I don’t understand why I didn’t before!” Rachael’s story of when she finally caved is a little bit different. She explains after her parents separated her junior year her mom “went a little crazy.”

She [her mom] started having like parties at my house and she was like always like the “teen mom” for everything I did. She was like the mom from Mean Girls. You know, like “I’m not like a regular mom. I’m a cool mom!” and “You want a drink? Just give me your keys.” And so, she was like that with all of my friends. Meanwhile, I don’t do any of that crap...but, all these people wanted to come over and hang out because my mom was the “cool mom” who’d buy them alcohol and I’d just sit upstairs and do my homework. But, when my parents separated and she would have them over without me knowing... it was the weirdest thing... I don’t know, but everyone just started trying to get me to do it with them. Saying like “Just have fun with us... you’re so lame... c’mon, c’mon!” and for a

long time I was just able to do my stuff and not be a part of it... but one day, and I don't know why, but I just decided you know what, yeah, I mean it looks like fun... Let me try!

Like Carter, she explains she loved her first experience of being under the influence and remembers wondering why she had not done it before.

The first thing I ever did - any chemical or anything I ever put into my body was (laughs) ecstasy...of all things. But, this girl said she had one and I was like "What is it gonna do to me?" and she was like, "Nothing, it'll feel really good!" (...) It was really...I remember talking a lot and then I remember thinking my hands felt cool. Like they were tingling a lot and I felt like I belonged with everybody. Cause you know - or maybe you don't know - but when you're rolling, everybody is just SO nice to everybody and you're feeling good and you just kind of feel like you know everybody and you just talk a lot and you really do get to know these people over the next twelve hours...and I just felt like I belonged and I was cool and none of this was as bad as everybody was making it out to be and like why hadn't I been doing this all along?!

Divorce and peer pressure also played a role in Kyle's beginning of substance use. He explains how his parent's divorce led to his mom not being home in the afternoons.

(...) so, me and my brother spending a lot of time by ourselves, you know that's not a good place for a high school boy to be, especially in the fall when I wasn't playing sports. So yeah, I think the divorce kinda brought out a lot in me and made me like, I don't know, I think it kind of led me down to like "I wanna try some things" or more inclined to fall into peer pressure.

Kyle adds his substance use escalated when after the death of his father, "Once my dad died it was like, I'm gonna smoke pot till the day I die and I don't care what anybody says." Similar to Kyle's experience with lack of supervision, Brooke recalls her substance use escalating when she went off to college: "You know I went off to [college] and absolutely just, oh my God, that was a disaster. I was away from my parents. I was away from this ex-boyfriend. I had all this freedom. (...) There was so much space between us. They couldn't get to me easily. And so, I just drank like a fish for the longest time up there and I failed all my classes and you know all that...the whole spiel that we all do." Two participants describe being fascinated by drugs and alcohol at

an early age. Keith recalls, “growing up I was always - like even as young as five years old - I always remember being attracted towards like alcohol and people partying and like movies, like I always wanted to be a part of that.”

Most of the participants were able to recall significant events or situations that accelerated their substance use, which eventually led them to the realization that their behavior was problematic. Several of the participants discussed their substance use increased when facing difficult times with their family. Carter said he distinctly remembers when his substance use escalated:

I was a sophomore in college. It was post my grandfather dying and I decided that I did not care anymore and I just started to sell a whole bunch of drugs...do a lot of - I was never a guy who liked to go down, so I did a lot of ecstasy and cocaine. So, I did like - for six months it was that...just like riddled. And I remember after like three months into it I was like, “this is a problem” and I tried stopping, but it would be like stop for a little while, and then it’d be like a binge...then stop and a binge...then stop and that went on for like three or four years. So, I kinda realized it at that time, but I just couldn’t stop.

He goes on to explain how it was difficult to be at home during that time because his family was going through a “transition phase” due to his parent’s divorce. Additionally, his relationship with his family was “tumultuous” because his parents were “trying to handle his brother’s addiction” and Carter had just been kicked out of his first school.

Other reasons for the escalation of substance use stem from legal consequences. For example, after getting several charges for driving under the influence, Matt was getting drug tested and had to wear an ankle bracelet so he could not do drugs or drink. So, he started doing “weird drugs,” which ultimately played a role in his suicide attempt and led to his first treatment.

Theme 2: Barriers to Treatment

Several participants felt being in denial was a barrier for them to overcome to commit to treatment. Carter explains he was in denial even though his family said he was an alcoholic and

despite his dad, brother, and sister all being in some type of recovery. He goes on to say, “I think that’s like the biggest hurdle that anyone has to overcome is figuring out what they are or are not... and then you realize it and can’t stop. That’s one thing that I was faced with.” Similarly, Brooke explains her family was “so beyond done” but she did not think she had a problem.

I did not want any help. I did not want to be sober. Because I had done it before and it didn’t work – but really that’s not the case. And so, I didn’t wanna get sober, I just wanted to continue doing what I was doing and so you know at first there was no initial commitment to doing this thing and wanting to do it. I came up to [city] and basically did whatever I wanted still, so like disrespectful and rude.

Stephen grew up in a community where it was novel for people to talk about substance abuse or seek treatment. Therefore, the biggest barrier for him was finally accepting and admitting he had the problem and that he could not control it on his own. He states he also struggled with believing in a Higher Power or God. However, he eventually overcame those two barriers after realizing how bad his life had become: “Like I went from living on the beach, not having to work, like just going fishing every day, to like six months later I was homeless. Um, I didn’t really talk to anyone at all, like nothing I just really wanted to die.

One participant, Scott, described an extreme case of denial. He explains how he was a barrier to himself as he used his medical knowledge in attempts to find a reason to justify his drug abuse.

I had gotten to a point where I was just so mentally out of it, you know, after I had withdrawn from the curriculum in 2010, I knew there had to be some explanation for it. So, I used my medical knowledge sort of against myself and tried to find a reason for why this was going on...cause accepting the fact that I was just a drug addict was just too much for me. There had to be a reason why I was doing these things, not just because I was a drug addict. There had to be another reason. And so, I got a bunch of hormone testing done and come to find out that my pituitary gland was really messed up. My hormones were all messed up and to the point where they could not explain it other than a brain tumor. And so, they did a scan on my brain and they found a small - what they thought was a tumor on my pituitary gland.

Scott experienced a sense of relief when he was told he had a brain tumor because it meant he had an understanding of what caused his use of drugs ultimately making him feel like it was not his fault.

And this is just how far I was in my addiction... I was happy, because there was an explanation as to why I was doing what I was doing. I needed to have an explanation for it. It couldn't just be me. And so, I went to a specialist down in [city] and they did a special type of MRI that really is able to look at the pituitary gland and she's like "No... that's just an artifact from the old MRI. That's not a tumor." And so, I was actually sort of - I was prepared to have surgery on my brain in order to fix myself... something outside of me had to fix me.

Similarly, Keith explains the biggest barrier he faced, and still faces today, is himself:

(...) the biggest barrier for me and what I believe with anyone and anything in life - and you know since we're talking about addiction - the biggest barrier I had, always will have, and presently have, is myself. And that's the only barrier I had. Like these preset ideas of like - the preset limitations that I set on myself of like "this is the best I can ever be" or "I can't take this many classes" or "I don't deserve to have this profession" or "I don't deserve to have this girl" or whatever... those are all preset barriers that are already within me. And those will always be my biggest - I've always been my own worst enemy and I will always continue to be if I don't keep that in check. (...) So, it's like being willing to like be vulnerable and being willing to realize that I don't have all the answers and that I need other people's help... that was like the biggest barrier in getting into recovery. Just like me getting the fuck out of my own way.

Pride and self-involvement were both barriers for Thomas to overcome in order to seek treatment. Despite realizing his body was unhealthy and he was in toxic relationships, he felt he had his life and drug use under control. Thomas explains he was so self-involved that he was blind to effect that his addiction had on his family. He recalls thinking "I'm only hurting myself, so what does it matter?" or in other words, why seek treatment?

So, for me the biggest one was – how do I say this – self-ignorance, like I was so naïve to how bad, but I knew my body was a mess and that I was overweight and I was in these toxic relationships with these girls who - we were together because she didn't judge. So, that was all negative. But, it was also pride – like I don't need that, like I got this under

control and then you try to hide it from like everyone and you think you're doing this wonderful job and you're just not (laughs). Like everybody knows. Like you stink of booze and your eyes are red and your nose is running. Like "you're high man, c'mon." So, coming to the fact that it was no big secret was a hurdle like ya know and then yeah I didn't learn this until seven months into my journey and I was still relapsing, but like pride.

For some participants, family members were also considered barriers to treatment. Tyler states his fear of hurting his grandma hindered him from seeking treatment.

(...) my Dad was addicted growing up, and he passed away from it when I was like 14. So, like my grandma – that just like – my dad's mom – that just like tore her to pieces. So, like that was the biggest thing that hindered me. And I told my Papa one time, like when I was 18 that I had tried to get sober and he was like, "Yeah we can't tell your Gran, because that would literally put her in the grave." So, that's the one thing was holding me back from actually seeking help when I went down here.

Additionally, Tyler has calls his relationship with his mother "tricky" and feels she may have been a hindrance to him seeking treatment because they would do drugs together. Adam also feels his mother acted as a barrier:

Ok, so my mother will love unconditionally to the point of harming me and not knowing she's harming me. She enabled me through everything and this was before I got sober. Um, she enabled through everything, she had caught me numbers and numbers of times and like in my family, growing up, it was like smoking weed, like drinking, going out and partying, that's normal. Ya know, when you're starting to do heroin and shoot heroin into your arm – completely different story. So, when she found out I was doing those things she still kinda like gave me the benefit of the doubt.

A few participants mentioned certain friendships made it more difficult to reach recovery. Carter explains he and his close friends at college were selling drugs and "going nuts" together. Moreover, it was difficult for him to accept that he could not balance the party lifestyle and schoolwork like his friends, even though they were all doing approximately the same amount of drugs. He describes this experience:

I was like why can you do drugs and continue doing life and like everything seems to be fine and I like do drugs and everything else shuts down and I can't do anything else besides those things. Initially that was - I wanted to understand that. And I was just comparing apples to oranges, because they're not an alcoholic and I am. So, that initially - but I didn't talk to them, so the separation for a year and a half was good but once I had like a basis of my recovery, it was much easier for me to speak with them, cause all I wanted to do was be like "Well, I can be like them. So, keep trying! Keep trying!" but I learned that I couldn't (Carter).

Summary

The reasons for first using drugs and alcohol were centered on peer pressure and family issues. The process of differential association is evident as participants describe first using drugs due to peer influence. Additionally, many of the participants also felt their substance use escalated due to some of the same reasons such as, deaths in the family, parent's divorce, and freedom at college. The most common reason for delaying treatment was denial that they had a problem. Many participants felt their family and friends were significant barriers when it came to entering and committing to treatment. Based on differential reinforcement, one may avoid changing drug use behavior because fears the unpleasant consequences that are attached to quitting drugs such as losing friends or disappointing family members. Also, a person may not commit to sobriety because removing substance use also impedes the pleasant feelings drugs produce.

CHAPTER 5

MOTIVATORS AND TOOLS

This chapter focuses on the reasons for why the participants sought treatment and motives for sustaining recovery. Similarly, it provides information about the tools they consider most important for their recovery. The three themes presented in this chapter are: (1) motivations to seek treatment, (2) motivations to maintain recovery, and (3) important tools for sustaining recovery.

Theme 1: Motivations to Seek Treatment

No two people experience the same “rock bottom” or “moments of clarity”. However, alcohol and drug users often seek treatment after experiencing negative consequences related to their use and desiring an enhanced quality of life (Laudet, Morgen, & White, 2006). The participants suggested various reasons for why they sought treatment ranging from trying to get their family “off their back” to more serious consequences such as going to jail, homelessness, deteriorated health, and fear of death.

Many of the participants state they have had several moments of clarity, however many times they were ignored. For example, Justin had multiple moments of clarity but he chose to ignore them until he finally realized he needed to seek treatment after withdrawing from a second semester of school. Tyler states he continuously tried to get sober, but it never seemed to “click”. He describes his struggle, “One second I was like, ‘Yeah! I need to stay. I’m really messed up in the head’...and then the next moment I was like, ‘No I gotta get outta here. I gotta get high. I gotta figure out something.’” Tyler explains during his most recent stint in treatment, God granted him a brief, but meaningful moment of clarity:

[after leaving treatment] I ended up calling my girlfriend’s dad, at the time, and like we started talking and they were like fed up with me at this point. They were like, “We’ve

got nothing to say to you.” But, he was kind enough to pray for me over the phone and I feel like at that point God had granted me a very short moment of clarity. And that guy who ran the house kinda explained a moment of clarity – it’s a short moment of time where God allows to see the truth of the situation. And that’s kinda what I was allowed and he gave me just enough to get me into treatment, and stay committed and come clean.

Scott recalls hitting an emotional and spiritual bottom, which led him to reach out to people from church and start going to recovery meetings, ultimately saving his life,

(...) then I really had a desire to go to long-term treatment and try to change my life because, ya know, it was at that point that I knew was about to die and I really didn't want to live anymore.

Similarly, Keith struggled emotionally and explains feeling hopeless and isolated before seeking treatment, “It was like constant moments of I'm gonna die...like, I'm so miserable and I want to die and no one wants anything to do with me...and it was like I would live through those moments and then be like okay, but then it would dissipate. But then, the last like six months of my using it was like that every day.” He goes on to explain that eventually it was clear he needed to find a new solution, “Eventually, I was like it’s not going away and no amount of drugs you take is gonna numb that feeling.” Now that Keith is in recovery, he explains he still has moments of clarity but they are different in their meaning. Keith gives an example of a moment of clarity that he experiences today, “(...) like I study really hard for a test or I work really hard for a few weeks and the payoff of doing well on those tests like that’s the moment of clarity - the relief, the euphoria of like accomplishing goals - to me we call those a spiritual experience.”

One participant explains he did not “wake up” and realize his substance abuse was no longer a “game” until people he knew started to die:

Unfortunately, for me... people started to die, and when people started dying, like people close to me started dying, either from overdose or from suicide that was depression related due to addiction. And when like it was no longer a game and like children lost parents and I lost friends and husbands and wives and all that kinda stuff, it was just a big

time slap in the face. (...) But, when friends started to actually die, like people that I ran with, it got real, real fast. And that's when I was able to be like "alright, something's gotta change" and then I checked myself in for the first time. So, it was unfortunately loss of life that woke me up. (...) like I woke up and I looked at the girl I was with and I was like "I gotta go" and she was like "I know" and I got into my car the next day and I drove back down to [state] and I did it all like on my own. And it didn't click right away but I went into it with an open mind and I wasn't so combative and I wasn't just dismissing everything these people said. And eventually it started to make sense (Thomas).

Matt's big moment of clarity came to him during month three or four in jail. His significant other was struggling financially without his help, his mom was immobile due to injuries, and his dad suffered a stroke, thus leading him to feel guilty for not being there to provide support for his loved ones. He explains:

So it was kind of like ok how do I not keep going to jail? It was never like, how do I not use? It was like, how do I quit coming back to jail? (...) So, like trickling down these lists of effects I eventually came to the conclusion of alright, for a little while I should not use drugs. Not forever. Just for a little while. And so, eventually I decided ok I'll come here [treatment] I won't go to prison. So I did, I came here [treatment].

One participant was in denial and did not want to be sober, but after seven or eight months, she began to accept that a problem did exist and started to take steps towards recovery.

And then, like it started to happen to where I started to care about the people I lived with. I started to gain genuine interest in their life. I started wanting to be better, not only for myself, but for them too. You know? People were starting to rely on me and that made me feel good. Like you know doing stuff like that and learning these little everyday skills – like doing my laundry and changing an A.C. vent filter. (...) And you know before I couldn't even brush my teeth, or like shower, you know, like live like a normal person. And you know it was not until like seven or eight months that I could see like how unmanageable my life truly was and how much better it was since I had gotten to [city] and gotten sober and had the women in my life that I did have (Brooke).

Similarly, Kyle explains he entered treatment to get his mom off his back and minimize the negative consequences he was facing. He describes how "the rooms" [recovery meetings] always proclaimed "don't leave until a miracle happens" and that his "miracle" was when he actually

wanted to get clean and sober. After getting a sponsor and starting to work the 12-steps, he started to see his life in a different perspective and realized if he continued to make the same mistakes he had been making then he would eventually squander away all of his opportunities.

I'd say my moment of clarity was (A), I am the problem, ya know, with my way of the thinking and my decisions... ya know, it's no one else's fault but my own. So, I started taking responsibility for myself. And then, (B) I realized that if I could stay clean I would do much better in school. I would have much better personal relationships. I would, ya know, feel more at peace and ya know, feel spiritually connected. (...) It's just like a combination of all those...it's kinda like the perfect storm of things that happened to make me realize that staying sober is the best way for me to live.

Theme 2: Motivations to Maintain Recovery

Several of the participants proclaim being successful is a huge motivation for maintaining sobriety. For example, Rachael explains what keeps her sober: "I like being successful and I think people thinking I'm smart, and cool and whatever...talented and that I'm capable of living life and doing these things." However, her biggest motivator for staying sober is being a mom.

When I was in active addiction, I was surrounded by a few women who did have children and were using and I saw kind of you know what they had to go through and I just...God I can't imagine doing that to him [her son]. So, I really - I gotta stay sober. And his Dad is actually still in active addiction, in and out of jail, and we don't talk and he doesn't ever see him and so you know, I guess I feel like I gotta be the one who does it, cause clearly he's not.

All of the participants mentioned their relationships with their families and how they were affected by their addiction. For most participants, rebuilding their relationships with their families and making amends is a huge gift of sobriety. Scott says he has great relationships with his family and friends today, "It's taken a long time to build my trust back with them, but the way that I can engage in a relationship today is different than how I could engage in a relationship before." He realizes he is now able to have meaningful relationships with his friends and family because he is no longer self-centered. Similarly, Thomas is motivated by the things he now has

that he thought were a “pipe dream” or unattainable, such as being able to help his family (rather than being a liability), doing well in school, and being in a healthy relationship. He recognizes his ability to achieve these things is directly correlated to his sobriety.

Among the participants there was a collective belief that people in recovery are playing a game of “catch-up.” Carter explains this phenomenon, “We lost so many years, like we were wasted and we wasted them (laughs). So, we’re playing catch-up.” Similarly, Brian explains people in recovery are often motivated by the desire to make up for lost time and by their appreciation for the things they have regained.

I think what it is, is you’ve got a person who has spent so much time wasting their life and they feel like they’ve missed out on what life’s really about, cause you see how much you wasted and how many people you’ve hurt. And when you – the greatest struggles in life, create the greatest change. I mean that’s just a psychological fact. And I think when you take someone who’s really been bottomed out by addiction and they’ve gone through that whole ordeal... it makes you appreciate the opportunities that are there in life a lot more. You stop taking so many things for granted. So, I think that is fuel for the fire.

In contrast, Scott tries not to worry about “catching up” or let himself become consumed by the things he has yet to regain. Instead, his most motivated by his relationship with God and realizing he is not in control.

Overall, every participant who spoke about his or her physical, emotional, or mental health said it has gotten better since being in recovery. Brooke declares her physical health has increased in several ways while being in recovery, “I was always getting sick when I was out there, ALWAYS. I mean like, every weekend like physically sick. I’d go out and I’d get these horrible, just like upper respiratory infections and then I’d be going out and you know still doing the same thing and I just wasn’t sleeping and I was working full time at a restaurant.” She also suffers from guttate psoriasis, which is an autoimmune disease, so her body would “flare in this horrible looking rash all over.” However, since she has been in treatment and sober she has not

had an outbreak or been sick. Similarly, one participant describes how his health had declined before getting into treatment:

When I started smoking meth and then eventually shooting meth, my health just fucking deteriorated. Like it was within about six months I went from how you see me today like 6 feet tall, 200 pounds, I'll say athletic build or whatever you wanna say – relatively healthy, color in my skin, healthy hair, beards not falling out... within six months, I was down to about 120 pounds, my skin was flaking, my hair was falling out...didn't look good. (Matt)

Additionally, he explains his liver started to fail because he was taking “research chemicals” (i.e., synthetic drugs) and drinking around a handle of vodka every day – which he attributes to being in a fraternity. Today, Matt says his health is fine and he switched from smoking cigarettes to “vaping.”

In addition to physical health, several participants feel they are much stronger emotionally and mentally now that they are sober and have a solid support group. Sarah describes the emotional strength she gets from the women she met in her recovery house:

I have my women that I can talk to today and before I felt alone like nobody got me. And so, with that it's like there's an extent to the A.A., but then there's like your women who relate to me so much. And so, emotionally that's where I get that.

Several of the participants stated recovery has taught them healthy coping mechanisms, which in turn increase their emotional well-being. Brooke says, “Sobriety has taught me how to handle life appropriately and react appropriately to daily life situations. Because life is pretty daily and you know I don't have to fall apart at the seams.” Carter explains his mental health has been one of his biggest changes since entering recovery. He describes how he lacked coping skills and had a very distorted view of himself:

I thought that I was God's gift to Earth and everyone owed me something and I took real - not a lot of ownership for my actions. Basically, I was just a little boy in a man's body and it took some hardships for me to realize that. But, I think I have a lot more self-

esteem than I did before. Like I'm much more confident in a good way, I guess is a way of putting it.

Theme 3: Tools Used to Maintain Recovery

Although spirituality and religiousness are generally thought to be interchangeable there are some main differences when it comes to the overall concepts. Spirituality can encompass the traditions and behaviors that religion involves, such as prayer, church, and a belief in God. However, not all practices of spirituality involve religion. Several of the participants explain that religiosity and spirituality mean different things to them.

So, ya know I think recovery has taught me there is a difference from spirituality and religion. And, for me spirituality is ya know, my conversations with God throughout the day, my decision to continue doing the right thing, my relationships with other people, how I treat other people, my motives behind how I treat other people, ya know... I participate in religion and I'm still involved in church and stuff like that. But, I would consider spirituality the way that you know, I communicate with God through my words and actions. Whereas religion is just the social setting kinda of, where I ya know, go to church and get involved with certain groups there. But, I think recovery has taught me there is a huge difference between spirituality and religion. Spirituality is sorta putting it into action (Kyle).

Some of the participants describe their sense of spirituality comes from meditation and being mindful. Justin defines spirituality as "internal peace" and he uses meditation to achieve that each day.

I have this little like meditation book that I'll read every day and I'll just like read one section and ya know, sit outside on the back porch and for like thirty minutes or so just kind of just not think about anything except for what I just read. Ya know, just focus on that, try to take something out of it, and apply it to my day.

When describing what spirituality means to him, Brian used the word "altruism" as in acting in a selfless manner and focusing on the welfare of others. He explains, "If I can go through a day putting more into it with somebody or a situation than what I got out of it that's my idea of spirituality. If I can get through a day and accomplish that at least once then I've had a spiritual

day.” When asked if spirituality plays a role in her recovery, Brooke gave a powerful description of how she believes her Higher Power got her through the challenges she faced and is the reason for her success today.

I don't know how I could've done this without some sort of spiritual connection keeping me here cause like I went through some pretty hard stuff in the [halfway] house – stuff where like I wanted to leave. I wanted to run. I wanted to forget it all. And so, I can think of no other reason why I stayed other than the fact that you know my higher power keeping my feet planted there when they needed to be. I believe that my higher power showed me a lot of mercy, a lot of grace, and a lot of love during the past 17 months and even before that. You know, I wanted nothing to do with God (...) I'm just so grateful that my higher power kept me safe longer enough to help me get sober.

In contrast, a few participants seemed to struggle with their views on spirituality due to being raised in an overly restrictive religious regulation. For example, Adam went to a catholic elementary school which he describes as: “this was not like your typical southern [church] – this was like Roman Catholic, like very, very devout, so it was like beat into us like “you do this, or you go to Hell” type of thing. Even though he felt resentment, during recovery he has kept an open mind to what God represents and finally found what God means to him, which is “Good Orderly Direction.” He says, “For me, now my God that I believe in is different than the God that you believe in or anyone else because it's special to me.” His relationship with God is “more of a friendship now than it is a devout, have to do these things type of thing.” In the same manner, Sarah believes as long as she is doing good for others and not being a “maniac” or “menace” to the community then she is following the pathway of “G.O.D.”

Similar to Adam's experiences, Sarah struggles with spirituality today because she comes from a background of “this is the way you have to live and if you're not living this way then you're very sinful and you're not pure in God's eyes.” However, like many of the other participants she finds her spirituality in nature.

But, the biggest thing what and how I see my spirituality is I fish a lot offshore, so I see it in the horizon. I see it in the water. I see like all of His creations that He's made and the beauty. Over the years of traveling - you know before my addiction - when my mom took us to Montana and to all of the national parks – I see it in all of that. How He has been able to like – like it just makes you want to say like “awe” or “wow” or you're in awe (Sarah).

Thomas was raised Catholic, but when he was old enough to make his own decisions he completely turned his back on it. Since getting sober, it has been difficult for him to find God and now he realizes he only needs a Higher Power of his own understanding, which is nature. He states, “I use nature, like I use [the fact that] it's a beautiful day outside, like it's 90 degrees in the middle of October – like somebody did that and it wasn't me. So, like I use the Higher Power more so than I do religion. Adam explains there are several different dynamics to his spirituality, but like Thomas being outside and experiencing nature is spiritual to him. He details this process, “(...) one part of it is like settling of the mind, just like calming down and not having so much crap going on that I can't handle it. So, just settling down and realizing being in the moment that I'm here and enjoying what I'm doing.”

Helping Others and Giving Back

A common saying in Alcoholics Anonymous is, “You have to give it away to get it.” Several participants mentioned a significant tool to their recovery is volunteering and helping other people in their “recovery community.” Tyler says:

A.A. keeps me sober and keeps me grounded, but so does the treatment facility I went through, like going over there and keeping it fresh and helping guys out and kinda like, ya know, like I guess giving away what was given to me, like giving back.

Similarly, Carter explains his most important tool to maintaining his sobriety is volunteer work:

I volunteer a lot. I call it volunteer work, but it's more like just being a part of recovery. Like I help out a lot at the halfway house I was at, cause if I don't do those things I'll forget where I came from. And one thing I was taught for a while is you can't squeeze the source out, and the source in my life comes from A.A. and being an alcoholic. Like the

life I have today is because I'm an alcoholic and the only way I can continue not actively drinking is by volunteering and giving myself away and not thinking about myself so much.

In addition to wanting to prove himself to those who have seen him at his lowest, Kyle wants to be a role model to younger people entering recovery. He explains, "I want to be there for the kids who come in next and be that guy who was there for me. Like you can do this – you can get to where I'm at – here I am a year later, I've got good grades, I'm gonna get into the college of education next semester hopefully... I wanna be that way for somebody else."

Similarly, several participants mentioned they use their experiences and knowledge on addiction to educate kids, teenagers, and young adults about the negative consequences that can come from abusing drugs and alcohol. Both Sarah and Carter are involved in programs that attempt to prevent substance abuse by sharing their stories with young kids in hopes of helping them better understand the risks of substance use. Sarah goes on to explain they have recently switched their focus from high school students to middle school students because they are "using and sex is happening." Some participants find it most useful to share their experiences of addiction with students in college. Kyle explains why this is important to him:

I feel like that it's my responsibility to do what I can to not sit on the sidelines and tell people this isn't normal, this binge drinking is not productive, it hurts, it's destroying – I've seen lots of kids – we [his fraternity] finished pledging with eighteen kids and there are seven active now from my pledge class. I've seen so many kids fail out or leave [college] and they had the same habits that I did.

The general concept of "staying busy" was frequently noted as an important tool for maintaining recovery. Stephen offers a good explanation for why being busy helps:

I kinda feel like I thrive more when I have more stuff to do. When I like only have one thing to do in a day, I tend to put it off, but like if I have a bunch of stuff I have to do - kinda like today, I have, I had to wake up, hit a meeting, came to the library, studied for

my test, then took my test, then came and met with you, then gotta go to work. So, I tend to get more stuff done.

Participants discussed certain hobbies they engage in such as hunting, fishing, working out, playing music, and cooking. Exercise was one of the most popular activities among the participants (N = 5). Thomas explains he used exercise as a distraction when he was feeling vulnerable in his early recovery:

For a long time like my mind raced so bad that like I would need to go and like exhaust myself so that I could then just go like sit on the couch, or go to bed, or whatever and like make it through one more day, type of thing. Like that's how I got through each day. Like when I would be wanting to go get a bag or go get a bottle, like I would just go for a run or a bike ride or go to the gym until like I was exhausted and I'd come home and go to bed. And then I'd be ok.

Just as nature plays an important role in some participants' spirituality, it is also significant in many (N = 9) of the participants' favorite hobbies. When asked about coping mechanisms, Brian answers he handles a tough day by going hunting or fishing. With humor Brian says, "My girlfriend jokes because she gets worried on a weekend where I'm not out fishing or I'm not out hunting. So, as long as I get to go kill something, I'm probably fine."

The majority of the participants assert that fellowship and the sense of belonging that their recovery community offers is one of the most important tools for maintaining their recovery.

When asked what his most important tool to recovery is, Brian without hesitation answers:

Fellowship. A.A.'s structure is really smart on a psychological basis. If you've got at least one person - it really only takes one - that's got just a little more experience than you do in the beginning and you can talk to them every day and the further you get down in recovery and you've got someone you can call when you need to... that to me is one of the greatest tools I've had trying to get sober. I mean it is the number one tool for me.

Brooke also finds strength in her recovery community through the fact she has people she can relate to and not worry about being judged by her past mistakes:

(...) what I've come to find is the spiritual piece of it, the fellowship, you know having people that relate. You know, being able to go to a meeting and say just whatever crazy thinking that we may have and then people are sitting there saying like, "Yeah, I get it. Yeah, I get it." and there's just something so cathartic and something so spiritual about sitting in a room, where not only can people identify with the happiness and joy you feel in sobriety, but the loneliness and pain and the suffering that we felt before we got sober. There's just something so incredibly powerful about that.

Brooke continues to explain how she thinks her Higher Power uses fellowship in a way to get through to her. She recalls a particular day that she felt uneasy after sharing her experiences during a meeting and afterwards a girl came up to her and said, "It's okay, I did this, this, and this" helping Brooke realize "okay I'm not this horrible person."

For the participants in this study, the CRP at their college is an especially important tool to their recovery. Participants explain that being involved in the CRP made their transition from treatment to the college environment manageable by offering them a safe place to meet other students in recovery and rebuild their social network. For example, Kyle explains how it helped him:

And one thing that really helped me out when I first got back in was I met guys that were about my age, that had been clean for two or three years, that were serious about school, but they also weren't squares. They were cool guys and they were – like I wanted to be like them. And so, I had a group of friends who were taking school seriously, that weren't getting fucked up, and that's one thing that really helped me out.

Just as a sense of belonging is often found in A.A. and N.A., several participants feel that within their CRP. Thomas describes what he feels is the most attractive thing about the CRP:

I think the most attractive thing about it is that so many young people, in college, in recovery, being brought together. That is powerful. A sense of family, a sense of like, "I'm not doing this alone". There are lots of other people at this school, in recovery, that are going to meetings, that are going to the same shit as me, that have been through the same shit as me. So, that was one thing that really attracted me to want to get involved.

All of the participants agree that the CRP offers students a safe place to hang out with like-minded people. However, they also mention the helpfulness of other benefits it offers such as the private study room/computer lab, scholarships, and early registration. Even though Thomas was a little bit older than the other students in the CRP he says, “It was still a safe place where if I was having a shitty day I could just go play Wii and ya know, like hang out and eat some popcorn and like be around like-minded people and they’ve got that little study room there.”

Summary

Motivation to seek treatment had an overarching theme consisting of “moments of clarity.” The moments of clarity the participants experienced included: loss of relationships, opportunities, health, life and physical possessions, legal consequences, and hitting a spiritual and emotional “rock bottom.” Reasons for maintaining recovery include: getting things back such as, relationships, health, success and trust, and fear of losing everything again by using. Research suggests both spirituality and religiosity often provide strength and motivation for an individual on his or her road to recovery (DiClemente, 2013; Mustain & Helminiak, 2015). Participants reported finding his or her spirituality or Higher Power through various ways, such as, God, nature, meditation, helping people, humility, and altruism. Other tools that help sustain recovery are hobbies such as: hunting, fishing, exercising, playing music, and sleeping. Helping others and volunteer work, especially in the recovery community, were indicated as beneficial in maintaining sobriety among the participants. Last, but definitely not least, all the participants mentioned an aspect of their recovery community when discussing important tools.

CHAPTER 6

LIVING IN RECOVERY

This chapter focuses the participants' experiences of living in recovery with special emphasis on the challenges of being a college student in recovery. The two major themes presented in this chapter are: (1) challenges and (2) stigma.

Theme 1: Challenges

Several participants note it is hard to find time for everything they do to maintain their recovery as well as other things like school, work, sleep, relationships, and socializing.

Last semester I took 18 hours. I have a girlfriend – we've been together 2.5 years and I have my friendships that I have to keep up with. I have sponsees that I have to keep up with. I have my homework and all that aside from the in-class stuff. I have career prep stuff. So, I mean I have a full plate of everything going on...probably more than a full plate. So, making meetings and that's like primary source of recovery is like going to A.A. and going to meetings – it's been very limited for the last 4 or 5 months. And I try to make up for it in other areas like I said working with my sponsee, talking to my sponsor, hanging out with people in recovery and like talking to them about stuff that might be going on with me and so like that. But, I mean it's very difficult to find time to slip in a meeting because I can rationalize in my mind that a meeting is not as important as me doing my homework that's due at midnight and then like finding some sleep in the night (Matt).

Thomas discusses an interesting point on how his addictive personality creates a struggle for him even when it pertains to a positive coping mechanism such as working out:

I would go [exercise] every single day, seven days a week, and that's like not healthy either. So like, I have an addictive personality, so like I need to address that in positive and in negative things. So like, I need to be aware that like it's Saturday, you're busy, you don't have to get up early and go to the gym or go for a run. I need to watch that because – I mean I look back on the little fit tracker thing and it would be like 37 days straight and like that's obsessive. Ya know? So, the obsessive tendencies are definitely still there.

Loneliness is another challenge of living in recovery. While not all participants mentioned feeling isolated or lonely, the few that did gave powerful descriptions. Since being in recovery

Thomas's physical health is the best it has ever been; however, it has been very difficult for him mentally and emotionally:

Because recovery is lonely, at least for me at my age it is. Like, I have two groups of friends, either they're married with kids or kids on the way or whatnot, or they're still out there running. So, I'm like where do I fit? Like I can only go to so many date nights where I'm the fifth wheel type of thing. And I did not anticipate how difficult it would be to start dating again sober. (...) But, like I've met every girlfriend I've ever had at a bar or a concert. So, like how do I meet a girl? And this age is super weird, like either they're married or they're running. And like, I don't wanna go to the bar and I don't really wanna date a divorced chick so like (laughs). It was super hard and like I spent a lot of time by myself. And that was mentally tough because like the loneliness hurts and then the "oh well if I just got sober to make dinner by myself on a Saturday night – I can do this high" so I had to fight that for like a long time. Um, but that all goes back to just being patient, like its not gonna happen tomorrow, or maybe it will, but it might not. So like just cool out, like you'll meet someone when it's time. So loneliness was the biggest mental hurdle that I had to deal with.

Keith explains he limits himself socially from most people in general, which has nothing to do with drugs or alcohol, but is because he does not want people around him that do not have the same goals as him.

Being in the "college environment" can be difficult if you are in recovery, but especially in early recovery. For one participant it was also difficult because he was still living in his hometown where he was active.

At first it was really difficult. Um, like I said, I'm from here. I've been to every [university] football game since I can remember. Um, all my pledge brothers are here, my old fraternity is here. I know just about everywhere I go, I know somebody...and it at first was extremely, extremely hard because I could not put myself in the situation where pot or alcohol would be in front of me, unless I had somebody there with me (Kyle).

A few participants felt being in recovery and in a college environment was difficult in some ways, but helpful in others. For example, Thomas explained, "Um, I mean like I think being in recovery makes it easier for me to go through school because I can actually focus on that more. I mean there, like when I gone to a few football games, like seeing the environment brings about

thoughts of using... but, as long as it's not like something, like that I can't get outta my head then I kinda think it's healthy for me to experience those things, cause life is still gonna happen."

Several of the participants discuss feeling thankful for where they are today, especially when hearing other students talk about the "debauchery" that took place over the weekend.

I'll hear kids talking about whatever they did over the weekend, whatever debauchery that took place over the weekend, and it honestly, I'm just glad I'm not doing that stuff anymore cause like I'll hear people talking about uh ya know, "this cop came to my room like five times last night" or whatever and I'm like umm that doesn't sound fun... (Justin).

Similarly, Brooke thinks living in a college environment is "interesting." She explains how in the beginning of her recovery it was difficult to be at work with people who were talking about things she was no longer able to be involved in, for example the party lifestyle, boyfriends, and Snapchat. However, since growing in her recovery her perspectives have changed and she is now grateful that she does not have those stressors in her life and that she can "wake up and feel good about her life."

Re-entering college after taking years off can be intimidating and stressful, especially if you are just getting out of treatment and feel you may be vulnerable to the temptations that run rampant on college campuses. Thomas describes his fears when going back to school:

(...) coming back to school after almost eight years was intimidating and I was still full of a lot of self-doubt. Like, I wasn't sure if I was smart enough, or if I was capable, ya know, or how I was gonna transition, too. Cause my old college was WILD. Like it was, ya know, I guess not really normal but it was not school focused whatsoever and like I was the party kid. So ya know coming back in, I was a little scared as to like how am I gonna transition and make sure I'm staying on my track and ya know going to meetings and just basically the things that I need to do to stay sober.

Several of the participants explain they are older than the average college student and also are not interested in the "party lifestyle" anymore, thus they do not struggle with temptations of

being on a college campus. Even though Carter specified his substance use escalated in college, it is not difficult for him to be back in the “college environment.”

I mean I'm 26. Everyone here is 18 to 22... it's a LOT different. I listen to people talk and I'm like, “I'm sorry, I wish you could just go and live in the real world for a couple years and then come back.

However, Carter totally understands how being out of the guidance of parents can lead to experimentation and a desire to have “fun”. However, he explains his mindset has changed since being in recovery: “But, after going through what I have been through, you come back to school and your perspective is much different. This is a job. This is something I have to do in order for me to move on.”

Theme 2: Stigma

Several participants expressed pride in their recovery and stated they had no issue talking about it except in professional settings. For example, most of the participants felt reluctant to tell their professors, employers, and colleagues about being in recovery due to the fear they will be stigmatized and seen in a negative light.

Now, when it comes to like my profession – you gotta be careful about all that. I definitely don't want co-workers or professors or whatever, I don't want them to know because that's a liability (Kyle).

Adam asserts he does not care what other people think of him and he expects people to judge him by his present actions, not his past. Similar to Kyle, Adam is very careful about who he discloses his past to when it comes to moving forward professionally.

But, I will say when it comes to getting a job or like moving forward in this world a lot is networking you know a lot of it has to do with “it's not what you know, it's who you know” – so like when you present yourself with a resume and going into a job interview and stuff and you're like “sober” and they're like “Oh, well this person had a substance use problem.” That could be a serious detriment to a company. So, that's where I was saying about the resume it's like it depends – you pick and choose who you're open to

about it. But, like one-on-one, you and I, I would tell you all day any day. Like it doesn't matter to me what you think I am.

Scott also limits what he discloses about his recovery in order to keep his professional and personal life separate. He expresses frustration when describing certain instances when faculty members and other professionals have told him that he is at “way too high of a risk to be a doctor.” Even though he acknowledges they are right when it comes to statistics, he still has a hard time accepting the fact that people may think he is limited when it comes to a professional level. In addition, he also explains how he struggled with self-stigmatization after getting out of treatment and returning to his medical school classes. Scott explains:

But, I remember when I went to treatment the first time and then I came back to medical school and it was pretty obvious that I disappeared for a couple months, you know cause you're very close-knit with your colleagues each year like you have one class you do all four years together with them and I was not able to graduate with my class. And you know, everyone knew and I knew that. And so, can I speak for the stigma that they felt? No. But, in my head I felt like they felt that I, you know, I thought that they were stigmatizing against me and I did not feel comfortable in my classes anymore or in my rotations. But, again, I think that had a lot to do with my perception.

Nevertheless, a few participants stated they feel no fear or shame when it comes to their recovery. In fact, participants express pride in their recovery due to how hard they have worked.

Rachael brags about her recovery and thinks it is a “badge of honor.”

I don't know, I just feel like it kind of sets me apart and almost above some of the other students who maybe haven't been through that kind of thing and can still not seem to do well in school.

Several participants assert they do not care what anyone else thinks of them. For example, Wes declares, “Like back in the day people probably didn't like me because I was using drugs and now people that used to like me back in the day won't like me because I'm sober.”

Keith does not feel there is a stigma attached to being in recovery. Instead, he believes the stigma is against people who do illegal drugs and who are addicted to illegal drugs. Furthermore, he goes on to explain that when he was in middle school and high school he embraced the rebel label that was attached to using drugs and even used it as an isolation technique.

But, like there's a huge stigma - there's a stigma against people that do illegal drugs, but there's an even bigger stigma against people who are addicted to illegal drugs. And, when I was growing up in like middle school, high school, and I started getting into that - I was more so the type that like embraced that. It like kinda helped build my rebelliousness. So, it was like a certain joy of like realizing... it was like an isolation technique. (Keith)

Summary

Balancing academic work and recovery can be extremely difficult for some people, while for others it is not a problem. Compulsive busyness is a term used to draw the line between being in control and staying busy with healthy activities and keeping busy out of compulsive need (Mooney, Eisenberg, & Eisenberg, 1992). Although the participants are thankful and proud to be in recovery, it can be frustrating to hear people talk about their reckless behavior as if it is "cool". Additionally, it can make it very difficult for people in recovery to relate to those who are still living an active "party lifestyle" (Bell et al., 2009). Many of the participants discussed fear of being judged or seen as lesser due to being in recovery. Thus, the majority of the participants are careful who they disclose their recovery status, especially when it comes to professional settings. Almost all of the participants agreed the best way to fight stigma is through talking about it and it is the responsibility of the people in recovery to share their experiences and educate society about the process and elements of recovery.

CHAPTER 7

DISCUSSION

This qualitative study explored college students' experiences on their road to recovery, including events that lead them to seek treatment, motivators and tools utilized in recovery, and their perceptions of living in recovery as a college student. The data collected and analyzed for this study answered several research questions:

1. What events influence a person's decision to seek treatment for a SUD?
2. What are the individual characteristics of students in CRPs?
3. What are the most important tools to sustain recovery?
4. What are the challenges of being in recovery as a college student?

Through conducting qualitative analysis of fifteen participants involved in a CRP at a university in the southeastern region of the United States, the questions were answered and themes emerged. In the following sections, the findings will be discussed as well as the limitations of this study and the opportunities for future research.

The Beginning

In line with SLT, the majority of the participants recalled first using drugs or alcohol due to peer pressure or as a coping mechanism during stressful and difficult times. Pressure from peers ranged from simply seeing friends having fun and using alcohol and other drugs to the extent of being offered drugs and alcohol and encouraged to try it. According to SLT's concept of differential association, an individual who is exposed to normative definitions favorable to drinking alcohol or using drugs is more likely to engage in the same behavior. Differential association has been noted as the strongest link of all the social learning measures to behaviors (Akers, 1998; Schaefer et al., 2015). Participants relied on alcohol and other drugs to cope with

stress related to school, anxiety in social situations, tragic family events such as the death of family members and parent's divorce, and other difficult situations. Often times people use alcohol or other drugs as a coping mechanism when dealing with stressful events because the relief comes faster compared to other, healthier ways of coping (See, 2013). However, participants were similar to those in Rivaux, Armour, and Bell's (2008) study since they also mentioned eventually coming to realize the negative effects outweighed the positive effects.

Unlike much of the extant literature on drug treatment that often focuses on individuals with substance use disorders from low socio-economic backgrounds, and are educationally and vocationally disadvantaged, this research centered around affluent students seeking undergraduate and graduate education. Collegiate recovery programs may be beneficial for disadvantaged students from minority and lower socio-economic status backgrounds, but, unfortunately, very few of these types of students participate in the programs. Students in CRPs are predominantly white, come from upper-middle class families, and have either a high school diploma or GED (Laudet et al., 2015). When creating goals for treatment, it is important to consider the person's use of alcohol or other drugs as well as other aspects of the person's life (Maisto et al., 2004). Considering the stories of the participants it seems the goals and aims of their treatment followed those of SLT which includes, building a new social network that includes people also in recovery or "models," learning and adopting healthy coping mechanisms, reinforcing abstinence and not reinforcing/punishing substance use, and learning about the negative effects of alcohol and drugs (Maisto et al., 2004).

Motivations

Participants reported various reasons for entering treatment and motives to sustain recovery. Loss and regaining things are at opposite sides of a spectrum but intertwined when

considering many of the participants' roads to recovery. Social learning theory's concept of differential reinforcement was apparent in individual reasons for using drugs and for stopping drug use. For some participants, substance use behavior was reinforced physically (i.e., made them feel good and confident, relieves stress) and socially (i.e., acceptance from peers, fun, bonding). In contrast, participants discussed their feelings of loss in several contexts such as, loss of relationships, loss of identity, and loss of opportunities. Many participants explained how their negative experiences were necessary for them to get to where they are today and be successful in their recovery. This concept could be linked to Cox and Klinger's (2004) theory of current concerns which explains one is motivated to change their substance use behavior after experiencing both the negative consequences of substance use and the advantages of being in recovery. Additionally, suffering negative consequences due to their behavior resulted in changing their definitions about substance use, which is an example of SLT's concept of differential reinforcement. Two frequently reported reasons for seeking treatment and sustaining abstinence include relationships and health. Respondents described the negative effects their substance use had on their relationships with family and friends, including but not limited to: feelings of disappointment, stress, shame, and anger. However, every participant mentioned their relationships were strengthened by recovery, and many reported them being better than ever. Similarly, every participant noted some type of negative effect their substance use had on their physical, mental or emotional health; yet, now that they are sober their health has improved in at least one way.

Tools

For the participants in this study, the recovery community (i.e., halfway house, sponsor, CRP) is a fundamental tool for maintaining sobriety. In line with SLT's concept of differential

association, participants changed their peer groups to include other individuals in recovery, which changed their perceptions or definitions of alcohol and other drug use. Once participants fully accepted a problem exists and committed to recovery, they began engaging with others in the program and experienced positive reinforcers such as compassion, support, acceptance, and belongingness, which are important feelings for building self-efficacy (Laudet, Morgen, & White, 2006). A few participants discussed frustrating aspects of the recovery community such as competition between people who are trying to one-up each other when it comes reasons for being there.

Several of the most valued aspects of the CRP in the present study were also reported in Bell and his colleagues (2009) study about a CRP in Texas. However, the present study added to literature by exploring how students learned about the CRP and how they got involved. All of the participants explained they found out about the CRP from someone in the recovery community (e.g., sponsors, peers, treatment center staff) and most got involved through contacting the director or coordinator of the program. The aspects most important to the participants in this study were sense of belonging, network of peers also in recovery, and having a safe place to go. Several participants enjoy being able to hang out, play games, and socialize in the gathering room that CAR provided. They also have access to a computer lab that several of the students use to study and do school work. Since the students in CAR get early registration, they often sign up for classes together, therefore having a private room to get together and study is extremely beneficial and also further builds their sense of community.

Research shows spirituality, religiousness, and senses of purpose often increase as a person advanced through the recovery process. Often times substance users enter recovery feeling isolated, hopeless, and abandoned by his or her Higher Power (Laudet, Morgen, & White,

2006; The National Center on Addiction and Substance Abuse, 2001). However, finding a “Higher Power” is a key element in *Alcoholics Anonymous* and is mentioned in six of the twelve steps (Mooney et al., 1992). The purpose of using the term “Higher Power” is to keep it open for individuals to decide what power they believe in that is greater than themselves. The majority of the participants explained their sense of spirituality has become stronger and taken on a new meaning since being in recovery. Whether it be a Higher Power such as God, meditation, nature, or simply helping others, every participant described at least one thing that gives them a sense of purpose and support in their recovery.

It is important to tell people outside of your recovery community about your sobriety in order to minimize the risks of temptation (Mooney et al., 1992). Moreover, being open about your recovery can be beneficial for others who may be contemplating sobriety, but are afraid and need encouragement or a sense of support. Teaching people in recovery about the negative effects that alcohol and other drugs have on a quality of life is often used in treatment (Maisto et al., 2004). Some participants in this study take it a step further and use their experiences and knowledge on addiction to educate kids, teenagers, and young adults about the negative consequences that can come from abusing drugs and alcohol. It is important to take a proactive approach and educate middle- and high-school students on topics such as triggers to substance use, healthy coping skills, and the negative consequences alcohol and other drugs can have on people’s health, relationships and opportunities (Maisto et al., 2004).

Living in Recovery

Recovery is a life-long process and it can take some people several years to get to a point where they are “comfortable” in their recovery (Laudet et al., 2003; Mooney et al., 1992). In contrast to prior research, the majority of the participants in this study said they do not feel

tempted by the parties, bars, and other alcohol and other drug-fueled aspects of the “college environment” (Bell et al., 2009). The other few participants mentioned it being difficult at first, but it no longer phases them for reasons such as, having a new social network, using healthy coping mechanisms, and fear of losing all they have regained. For most of the participants, it is difficult to relate to and socialize with college students who are not in recovery due to differing perspectives and goals. Also, an “age gap” may exist because the person withdrew from school while using or in treatment.

For the participants in this study, one of the greatest challenges of living in recovery is facing and battling stigma. Fear of stigma attached to addiction and being labeled a “drug addict” may explain why the majority of the participants denied having a problem in the beginning and avoided treatment. Similar to prior research, participants reported feeling isolated in active addiction, treatment, and recovery (Larkin & Griffiths, 2002). While in active addiction some participants isolated themselves and abandoned relationships with family and friends. Substance users often isolate themselves to avoid feeling hurt, rejected, and unloved (Hecht, 2016). Then, in treatment people deny a problem exists and refuse to engage with others, and in recovery a sense of loneliness exists for some because they must avoid those who are still using or in active addiction, but they also fear judgment from those who are not in recovery and those they may have hurt before seeking treatment. Another challenge is deciding who they should and should not disclose their history of substance abuse. A popular rule of thumb was to not share it in a professional setting or when it could prohibit professional development. In contrast, one student wanted to tell people as she feels being in recovery sets her apart from the other students. Generally, participants seemed to agree they have become more comfortable talking about their recovery and history as time passes.

Limitations

This study is not without limitations. First, interviews were conducted with students in only one CRP at one university. Future research is needed at other colleges in various geographical locations to compare findings and evaluate generalizability. Second, those who are most passionate about their recovery or their CRP may have been the most likely to volunteer to participate. Third, although I did not get the impression that any of the participants felt ashamed or embarrassed to tell their story, there is always the risk that participants hold back certain details when self-reporting. Fourth, as previous research has found, participants in the sample were not diverse with 80 percent males and all the participants identifying as White/Caucasian. Future research should attempt to find out about the experiences of people in minority groups. Findings would be especially interesting and useful since minority groups often have different family backgrounds, cultures, and face different challenges. For example, the majority of participants in this study come from middle- and upper-class families and graduated from high school. Given the general demographics of emerging adults with SUDs, this may signify a problem with CRPs that they are less available to lower social-economic, minority, and female students (Laudet et al., 2003). It is important to consider barriers to treatment such as cost, education level, and lack of knowledge about treatment options that would hinder one from being able to participate in CRPs. Due to the scholarships, support, fellowship, and various other aspects CRPs offer, these programs may be especially useful for disadvantaged students from minority or lower SES backgrounds. CRPs may have predominately White students from middle- and upper-class backgrounds because treatment can be very expensive, making it inaccessible for a person from a low-SES background. Many times a person learned about the CRP from people in their treatment facility and recovery community, so students who do not

have the resources to seek treatment are not given an equal chance to join a CRP. Fifth, data analysis utilized a single coder. In order to maximize validity, future research should implement “member checking” which gives each participant an opportunity to check his or her interview transcript for accuracy. Also, it allows the researcher and participant to exchange comments, ask questions, and provide feedback (Creswell, 2009). Last, it would be beneficial to conduct a longitudinal study of this sort to see how students’ perceptions of CRPs change over time. For example, students could be interviewed each year starting with their first year in the CRP and ending with their last to see if the challenges they face and the tools they use change throughout their recovery process.

Implications

Aside from filling a sizeable gap in the literature, this study uncovered the individual characteristics of students’ in CRPs and the events leading the students to seek treatment. Findings may help policymakers and education officials better understand the effects of CRPs on students in recovery. It is clear the sense of belonging, fellowship, and support that CRPs offer students are significant tools for sustain recovery. Though CRPs may not be able to provide psychotherapy to treat mental health problems, they do provide students with a safe place with relatable peers where they can discuss uncomfortable feelings like depression, anxiety, stress, and loneliness that could threaten their recovery. Also, being able to openly discuss these feelings and other factors pertaining to their SUD may decrease one’s fear of judgment and help one to feel more confident in their recovery. Factors that influence substance use behavior such as demographics, family life, spirituality, life events, peer networks, and stressors, also play a key role in one’s initiation and continuation of sobriety. Thus, clinicians and other specialists within treatment programs should acknowledge these factors when creating goals for treatment

and guiding them through the recovery process. It is important to recognize people from disadvantaged social, economic, and educational backgrounds are less likely to overcome barriers to treatment such as cost, accessibility, and lack of knowledge about treatment options. CRPs may want to consider specifically targeting and reaching out to individuals from minority or lower-SES backgrounds. Informing local hospital emergency rooms about the CRP is one way to expand referral sources. For example, if a student is treated in the ER for an overdose or another substance use related issue, the hospital staff could inform the student about the CRP and provide them with the program's contact information. Additionally, with a better understanding of what motivates students to seek treatment or maintain sobriety, college administrators and advisors can hopefully increase the number of students who decide to seek treatment and enter recovery. Further, the findings will hopefully increase awareness of the needs among college students in terms of SUDs and recovery support, thus, prompting college administrators to develop CRPs at their school.

Conclusions

The purpose of this research was to investigate individual roads to recovery. In sum, participants discussed their experiences before committing to treatment, during treatment, and living in recovery, with emphasis on being a college student and involved in a CRP. An in-depth look at each participant's road to recovery was made possible as they shared their experiences about the first time they used substances, including timeframes of when their substance use became problematic, and reasons for seeking treatment. Additionally, they detailed certain relationships that benefited and hindered their journey to recovery. The participants reflected on many aspects of their journey of recovery such as overcoming feelings such as denial and shame, accepting a problem exists and committing to treatment, experiencing loss, and making amends.

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APPENDIX A

COLLEGE OF LIBERAL ARTS AND SCIENCES

DEPARTMENT OF CRIMINAL JUSTICE AND CRIMINOLOGY

INVESTIGATING INDIVIDUALS' PATHWAYS TO RECOVERY

Purpose of the research study: As a Master of Arts in Social Sciences student I am conducting research to fulfill my thesis requirements. The purpose of the current study is to fill a knowledge gap through examining individuals' pathways to recovery by learning about the events leading to the participants' decision to seek treatment, and/or their "moment of clarity". This study will also examine individual characteristics of students in Collegiate Recovery Programs, and gain insight on the positive effects of these programs on individuals. This project has been reviewed and approved by the Georgia Southern University Institutional Review Board under tracking number H17024.

What you will be asked to do in the study: You will be asked to answer a series of open-ended questions about your life events that may have influenced you to seek treatment and past substance use. Additionally, you will be asked about the barriers to treatment and recovery, including general student body drug use. Moreover, you will be asked about your experiences with the Collegiate Recovery Program, including your sources of support and pathway to recovery. An electronic audio recording device will record the interview. The electronic recording will be destroyed following the transcription of the interview. You are under no obligation to be interviewed if you do not wish to do so. You are not obligated to answer any of the questions. You may decline to answer any or all of the questions, and you may terminate the interview at any point.

Time required: 30-90 minutes

Benefits: Respondents are unlikely to benefit directly from participating in this study, although some respondents enjoy telling their stories and this can be therapeutic in the recovery process.

Confidentiality: The researchers will not disclose information that may reveal your identity unless threats of self-harm or harm to others are made. Otherwise, your identity will be kept confidential to the extent provided by law. If there is anything you do not wish to have quoted, you may say at any point or after the interview that you wish to have it kept "off the record," and it will not be quoted. If quoted, your name will not be used and all names and places will be changed along with any identifiable characteristics. Collected data and consent forms will be retained for a minimum of three years as required by federal regulations. All data that has been de-identified (see above) will be retained indefinitely to use for future research by the PI using the protocol above to maintain its security.

Voluntary Participation: Your participation in this study is completely voluntary. There is no penalty for not participating from either the researcher or your employer. Agreeing or

disagreeing to participate in the interview will not affect participant's relationship with GSU or the Center for Addiction Recovery.

Potential Risk: This study carries minimal risk due to talking about events in the past associated with substance use. Some of the topics covered in this interview may be sensitive in nature. If at any time during the interview you experience any emotional distress please stop the interview. If this discussion triggers the need to speak with someone, the student coordinator, Nathan Walker's, office number is (912) 478-4840. The number for the Georgia Southern Counseling Center is (912) 478-5541. You have the right to stop the interview at ANY time. Any suicidal ideation will result in referral to a 24/7 counseling service and potential accompaniment to the service location.

Right to withdraw from the study: You have the right to withdraw from the study at ANY time without consequence.

Whom to contact if you have questions about the study:

Ms. Mackenzie McBride; P.O. Box 8105, Georgia Southern University, Statesboro, GA, 30460, Phone 912-478-5210

Dr. Bryan Miller; P.O. Box 8105, Georgia Southern University, Statesboro, GA, 30460, Phone 912-478-5213, Fax 912-478-4999

Agreement: I have read the procedure written above. I voluntarily agree to participate in this procedure and I have received a copy of this document.

Participant Signature

Date

I, the undersigned, verify that the above informed consent procedure has been followed.

Investigator Signature

Date

APPENDIX B

Investigating Individual Pathways to Recovery

Directions: Please fill in the blank or mark the box with an “x” that is appropriate for you or complete the short answer sections to the best of your ability. Thank you.

1. Age _____

2. Which gender do you identify with? Male Female Other _____

3. How would you describe your race and ethnicity? Please be detailed:

4. GPA _____

5. What is your class year? Freshman Sophomore Junior Senior

6. What do you identify as? Straight Gay Lesbian Bisexual
 Transgender Other _____

7. What was the approximate annual income of your household during last year?

<input type="checkbox"/> Under \$10,000	<input type="checkbox"/> \$50,000-\$74,999	<input type="checkbox"/> \$125,000-\$149,999
<input type="checkbox"/> \$10,000-\$24,999	<input type="checkbox"/> \$75,000-\$99,999	<input type="checkbox"/> \$150,000-\$174,999
<input type="checkbox"/> \$25,000-\$49,999	<input type="checkbox"/> \$100,000-\$124,999	<input type="checkbox"/> \$175,000 and over

8. Do you identify as a member of any of the following religions?

Christian-Protestant Christian-Catholic Jewish Muslim
 Spiritual Not Religious Other (please specify) _____

9. Do you live on or off campus?

10. Do you work? If yes, is it on or off campus?

11. Are you a member of any student organizations or associations on campus? If yes, please circle all that apply: Greek Athletic Other type of student organization

APPENDIX C

Interview Instrument

Recovery

1. Where do you view yourself in recovery?
 - a. How long have you been in recovery?
2. What does recovery mean to you? OR how do you define recovery?
3. How do you define treatment?
 - a. How is recovery different from treatment?
4. How long have you been in recovery?
 - a. Have you had any relapses?
5. Have you been involved in any other types of recovery resources or treatment programs?
 - a. If so, which one(s)? *e.g., wilderness program, A.A., rehabilitation facility, prescription*
 - i. Which were most beneficial?
 - ii. Which were not beneficial?
6. Can you tell me about your health? (*i.e., physical and emotional wellness*)
 - a. How has it changed since you have been in recovery?
 - b. Are there any behaviors you engage in that you feel are unhealthy?
 - c. How about your mental health?
 - i. Have you ever been diagnosed with a mental health problem?

Elements of Recovery

1. Can you tell me about your living situation?
 - d. How has it changed since you have been in recovery?
2. Can you tell me about any hobbies or daily activities you engage in that helps with your recovery?
 - a. Why are these beneficial to your recovery?
3. Can you tell me about any relationships you have (e.g., family, friends, mentors) that help you with your recovery?
 - a. Are there any relationships that make recovery more difficult?
4. Does spirituality play a role in your recovery?
 - a. If so, can you explain how your spirituality is important to your recovery?
5. Overall, can you tell me the most important tool or element of your recovery?
 - a. Why is this so important for your success in recovery?

Personal Experiences

6. When did you first use a substance?
 - a. At what age was that?
 - b. Can you tell me about that experience?
 - c. What substances were you using?
7. Can you tell me about your family?
 - a. Do you have any family members that struggle with substance use?

8. When did you realize your substance use was problematic?
 - a. Can you tell me about what happened?
9. What happened to lead you to seek treatment?
 - a. Do you view this as a “moment of clarity”?

Challenges/Stressors

10. What challenges or stressors do you face as someone who is in recovery and living in a college/university environment?
11. What are your perceptions of general student body drug and alcohol use on college campuses?
 - a. What about our campus in particular?
 - b. Do you feel like you have limited opportunities in the “social world” of college?
12. Is it difficult to balance recovery and your academic/school work?
 - c. Does the recovery program help with this? If so, how?
13. Do you have any specific coping mechanisms to deal with these challenges and stressors?

Recovery Program at GSU

1. How did you find out about the recovery program here at Georgia Southern?
 - a. Did you know about it before you came to school? Or after?
 - b. Would you have come to Georgia Southern if it did not have the recovery program?
2. How has the program at Georgia Southern influenced and/or aided in your recovery?
 - a. What are the most helpful aspects of the recovery program? And why?
e.g., having a recovery community, on-campus meetings, support from program staff, academic support
 - b. How does it offer you support for your recovery?
 - i. What about academic support?
 - c. Are there any things about the program that you would like to see changed?
 - i. What about things you would add to the program?

Barriers to Treatment

3. Can you tell me about any barriers you faced when seeking and/or receiving treatment?
e.g., cost, access, lack of information, stigma
 - a. Has the recovery program helped you overcome these barriers?
 - i. If so, in what ways?

Concluding Questions

4. Is there anything else you would like to add?
5. Do you have any questions for me?