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The Lived Experience of Recovery Home Residents: An Interpretative Phenomenological Analysis

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The Lived Experience of Recovery Home Residents: An Interpretative Phenomenological Analysis

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Biography

The author was born in El Paso, Texas, October 9, 1981. She graduated from Montwood High School in El Paso, Texas and earned her Bachelor of Science degree in Biology and Bachelor of Arts degree in Psychology from The University of Texas at San Antonio in 2006. She later went on to earn her Master of Arts degree in Clinical Psychology from DePaul University in 2014.

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Abstract

Substance use disorders have had an enormous impact on individuals, families, and communities in the United States. The societal cost of substance abuse in terms of health care, crime, and lost wages is over $700 billion annually. Despite advances in evidence-based treatments, the chronicity of substance use disorders underscores the need to explore and expand long-term aftercare options to prevent relapse after acute residential treatment. Oxford Houses offer an affordable alternative to more costly and limited forms of transitional housing. These self-sustaining, democratically-run recovery homes provide a safe and sober living environment with peer support and no professional staff. Provided residents remain abstinent, pay their rent, help with household chores, and are not disruptive, they can stay as long as they want. In addition to the demonstrated effectiveness of Oxford House across populations, research has also identified the minimum dosage required to attain the maximal benefits and has found support for some of the therapeutic components associated with recovery. However, less is known about what the experience of living in an Oxford House is like from the perspective of the residents or how their attitudes regarding expectations and needs influence the impact of the therapeutic components.

The current study employed a qualitative design using the Interpretative Phenomenological Analysis approach to explore the subjective experiences of Oxford House residents to gain understanding of how they assign meaning to their experience within the context of their recovery. Ten first-time Oxford House residents who had lived in an Oxford House at least two months were recruited to

participate in semi-structured, open-ended interviews related to their experience in the house. Findings indicated that Oxford House was perceived as a positive experience, likely due to the following factors: low expectations, limited resources, and the perception that Oxford House was responsible for providing any resources gained during their tenure (e.g. employment). In line with existing research, participants tended to prioritize basic needs before higher order needs but also highly valued resources they lacked prior to Oxford House entry. Together the governing structure and recovery-oriented communal living in Oxford House created an environment that promoted self-sufficiency, self-regulation, and social support. Additionally, residents tended to help one another to learn coping skills to manage recovery and interpersonal challenges. The adoption of recovery-oriented goals that went beyond abstinence (e.g., becoming a better person) was associated with increasing their length of tenancy. These findings call attention to the importance of expectation management and need fulfillment in the subjective experience of Oxford House residents while emphasizing the importance of personal investment via goal orientation and new relationships to increase the length of stay. Most importantly, this study gave a much needed voice to Oxford House residents and provided insight into the complex interaction of the multiple factors impacting their recovery process.

Introduction

Prevalence and Societal Impact of Substance Abuse in the United States

Substance abuse problems have a tremendous impact on individuals, families, and communities in the United States. A national survey conducted in 2013 revealed approximately 17.3 million individuals 21 years of age and older were dependent on or abused alcohol, 6.9 million people aged 12 or older were dependent on or abused illicit substances, and 22.7 million people needed treatment for an illicit drug or alcohol use problem (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Substance abuse has been associated with many health and social problems, including teenage pregnancy, HIV/AIDS and other sexually transmitted infections, domestic violence, child abuse, homicide, and suicide (HSS, 2010). This has resulted in an annual cost of over $700 billion in health care, crime, and lost work productivity (Centers for Disease Control and Prevention, 2014; National Drug Intelligence Center, 2011; U.S. Department of Health and Human Services [HSS], 2014).

Although advances toward the prevention and treatment of substance use disorders have helped many in recent years, disparities in attitudes toward drug and alcohol use and access to treatment persist (HSS, 2014). In 2013, over 95 percent of the 22.7 million people in the US who were classified as needing treatment for drug or alcohol problems did not perceive that they needed it; approximately 316,000 people perceived a need for treatment but were unable to receive it, with the most common reason being a lack of health insurance or an inability to afford the cost of treatment (SAMHSA, 2015). For the small fraction

of people who are able to receive treatment, many resume substance use upon discharge due to the relapse-remit nature of substance use disorders. The combined impact of the neurobiological structural and functional changes associated with long-term substance use and environmental stressors, such as interpersonal strain or financial problems, challenge sobriety long after substance use has ceased.

Preventing Relapse: Models of Aftercare

The chronicity of substance use disorders underscores the importance of affordable, long-term treatment options to prevent relapse after short-term detoxification and inpatient treatment. The risk of relapse escalates when people return to high risk environments (e.g., living in neighborhoods where they used or obtained drugs, having to live with people who are users) without any supportive networks in place. Aftercare programs are intended to minimize relapse risk by providing ongoing services and a support system when people encounter circumstances in their day to day lives that challenge their sobriety. People in recovery who utilize aftercare services typically engage in one or more modalities, including outpatient treatment, support groups, 12-step self-help groups, and transitional housing. Transitional housing, also known as halfway houses, is a comprehensive type of residential aftercare program that provides sober housing in addition to professional therapeutic services and peer support. Transitional housing is particularly beneficial for those who lack substance-free housing options, as continuing to live with people who engage in substance use increases the risk of relapse (Jason, Olson, & Foli, 2008). Research has

demonstrated the positive impact of halfway houses in a variety of areas (Milby, Schumacher, Wallace, Freedman & Vuchinich, 2005; Schinka, Francis, Hughes, LaLone, & Flynn, 1998).

Despite the utility of transitional housing, it has plenty of limitations including restrictions on length of stay, financing that is usually dependent on the availability of government subsidies, and many rules and regulations that can hinder efforts to increase independence (Polcin & Henderson, 2008; Polcin, Korcha, Bond, & Galloway, 2010). Recovery homes, in contrast, offer a more flexible, affordable sober-living alternative to transitional housing. Oxford House is one type of self-run, sober-living recovery home offering peer support and independent living. The majority of Oxford Houses are single-family homes comprised of a moderately sized group of single-sex individuals (Oxford House Inc, 2014). There is no professional staff and house rules are kept to a minimum, which include running the houses in a democratic manner (e.g., voting to make decisions with each member having one vote including the addition of new rules), abstinence, paying a share of rent and household expenses, helping with household responsibilities, and no disruptive behavior (Oxford House Inc, 2014). The basic rules allow residents to retain many liberties compared to other types of recovery or transitionally living homes (e.g., relatively flexible curfew, allowed to have guests), including whether they engage in ongoing substance abuse treatment or involvement with 12-step organizations. There are also no restrictions on length of stay provided residents abide by household rules. A majority rules with the exception of acceptance of a new member when 80% of

the vote is required (Oxford House, 2014). Residents who relapse are required to obtain some form of treatment before consideration will be given to allow them to return.

Oxford House

Outcome studies. Over twenty years of research has demonstrated the effectiveness of the Oxford House model on substance use outcomes and other measures of well-being. A longitudinal study of nearly 900 Oxford House residents found that only 18.5% of participants who left Oxford House during the course of the 1-year study reported any substance use (Jason, Davis, Ferrari, & Anderson, 2007). The investigators also examined the impact of length of stay in Oxford House in accordance to the process of change theory (Prochaska & DiClemente, 1992) that asserts six months of abstinence is necessary to stabilize self-efficacy expectations, which is a precipitating factor of addictive behavior change (DiClemente, Fairhurst, & Piotrowski, 1995). Study findings showed staying in an Oxford House for at least six months was associated with increased self-efficacy and maintaining abstinence, underscoring the necessity of being in the Oxford House environment for a minimum amount of time to obtain the maximal treatment effects (Jason et al., 2007).

Another longitudinal study randomly assigned 150 people to either an Oxford House or a usual aftercare condition (i.e., what occurs naturally after completing treatment) (Jason, Olson, Ferrari, & Lo Sasso, 2006). Results revealed those in the Oxford House condition were less likely to use substances (31% versus 65%) and be incarcerated (3% versus 9%) and more likely to have a higher

monthly income ($989.40 versus $440.00) compared to the usual aftercare group at the 24-month follow up. Additionally, staying in an Oxford House six months or more was associated with less substance use (16%) than staying in an Oxford House less than six months (46%) or usual aftercare (65%). The impact of dosage was particularly salient for younger participants: those who stayed in Oxford House less than six months had similar substance use, employment, and self-regulation outcomes to the usual aftercare group at the 24-month assessment (63% versus 65% substance use; 57% versus 49% employment; 2.8 versus 2.7 self-regulation scores, respectively). Of note, only 7% of younger participants who lived in an Oxford House for at least six months reported substance use at the follow-up. Older residents, however, appeared to benefit from Oxford House regardless of whether they stayed for more or less than six months, suggesting they may be in more advanced stages of their recovery lending a greater awareness of the consequences of relapse (Jason et al., 2007). The same study also demonstrated the potential of Oxford House to enhance abstinence in conjunction with other types of mutual-help programs (Groh, Jason, Ferrari, & Davis, 2009). Of those with high 12-step involvement, the addition of Oxford House residence significantly increased the likelihood of abstinence (88% versus 53%); however, the abstinence rates were similar for those with low 12-step involvement across conditions (31% versus 21%).

The effectiveness of Oxford House on abstinence has also been demonstrated across diverse populations including European Americans, African Americans, and Latino/as (Alvarez, Jason, Davis, Ferrari, & Olson, 2004; Flynn

et al., 2006), men and women (Davis & Jason, 2005; Olson et al., 2003), deaf individuals (Alvarez, Adebanjo, Davidson, Jason, & Davis, 2006), veterans (Millar, Aase, & Jason, & Ferarri, 2011), and those with co-occurring mental disorders including anxiety, posttraumatic stress disorder, and eating disorders (Aase et al., 2005-2006; Curtis, Jason, Olson, & Ferrari, 2006; Jason, Mileviciute, & Aase, 2011; Jason et al., 2007; Majer et al., 2008). A recent longitudinal study conducted by Jason and colleagues (2015) provided evidence for the effectiveness of Oxford House on criminal justice-involved populations. Two hundred and seventy participants who had been released from correctional facilities within the past two years were randomly assigned to one of three conditions: Oxford House, therapeutic community (TC), or usual aftercare (UA). Participants were recruited from inpatient substance abuse treatment facilities (98%) or case management programs (2%). At the 24-month follow-up, participants in the Oxford House condition had achieved significantly higher continuous sobriety rates (66%) compared to TC (40%) and UA (49%). The Oxford House condition also had more favorable economic outcomes including more money earned, more days worked, and better cost-benefit ratios (net benefits per person $12,738 versus $7,510 for TC and $3,804 for UC).

The strong empirical support for the Oxford House model has resulted in the network of recovery homes being listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices (2011). Despite the many benefits associated with Oxford House residency, attaining the minimum dosage for maximum effects remains a

challenge; over 50% of people leave Oxford House before the six month mark (Jason et al., 2008). Although most people who leave Oxford House do so on good terms (i.e., following house rules, no relapse; Bishop, Jason, Ferrari, & Huang, 1998; Majer, Jason, Ferrari, & North, 2002), certain characteristics and circumstances likely play a role in how long people decide to stay. Research has identified characteristics associated with longer lengths of stay, including older age (Bishop et al., 1998), lower pessimism (Bishop et al., 1998; Jason et al., 1997), and lower anxiety (Aase, Jason, Ferrari, Li, & Scott, 2013); however, little is known about how these or other factors interact in the decision-making process. Understanding how residents weigh their options when deciding residency tenancy is critical to preventing premature attrition through improved selection processes or the provision of additional supportive services.

Therapeutic mechanisms. ***Theory.*** Various theories have been applied to the Oxford House model to understand the mechanisms facilitating recovery. Moos (2008) proposed therapeutic mechanisms by which self-help groups facilitate recovery using four theoretical frameworks: social control theory, social learning theory, behavioral economics, and stress and coping theory. The role of social structures and relationships in which people are embedded are common elements among the theories that impact the development and maintenance of substance use disorders. Consistent with these interrelated theories, self-help groups such as Oxford House provide many of the essential ingredients to promote recovery along three dimensions: interpersonal relationships, goal orientation, and system maintenance (Moos, 2008). According to social learning

and stress and coping theories, the formation of new friendships and mentorships provides opportunities to observe people modeling abstinence-oriented attitudes and behavior, encourages the formation of new norms, and promotes self-efficacy and coping skills (Moos, 2008). Social control, stress and coping, and behavioral economics theories would predict that encouraging a pro-social goal orientation would result in the adoption of abstinence-oriented activities and personal growth (Moos, 2008). Finally social control theory would predict that system maintenance (i.e., structure and monitoring) would result in stronger ties to conventional social structures that would decrease the likelihood of abusing substances (Moos, 2008). This last dimension is a particularly salient for Oxford House, as affordable and safe housing is one of the central tenets of the organization.

***Empirical Evidence*.** Research examining the Oxford House model has found evidence that the social support supplied by the house is critical to the recovery process of residents. A quantitative study of 52 Oxford House residents indicated that peer social support (34.6%), having nowhere to go (30.7%), and seeking a drug-free environment (25%) were the most common reasons they entered an Oxford House and having a drug-free environment and respect for others were the most helpful aspects of the Oxford House experience (Majer et al., 2002). Another study revealed that the formation of a single Oxford House relation reduced the probability of relapse in the first six months by a factor of six (Jason et al., 2012). Mueller and Jason (2014) found that people who stayed in an Oxford House for at least six months experienced significant changes in the size

and homogeneity of their social networks; their networks evolved from a mix of drinkers and non-drinkers to mostly non-drinkers.

Alvarez and colleagues (2009) captured the importance of the social and functional components of Oxford House in a grounded theory qualitative study. A model of the therapeutic components of Oxford House was developed based on the perspectives of 12 Latino/as obtained through semi-structured interviews. Study results revealed past experiences (e.g., growing weary of the consequences of substance use, history of substance abuse treatment) impacted readiness to change, therapeutic change agents included the functional components of the Oxford House structure (i.e., absence of professionals, living in a sober environment, affordability, accountability, freedom of choice) and interpersonal features (e.g., emotional support, modeling, trust, respect), and recovery was associated with abstinence, new skills, and sense of purpose.

Resident Attitudes and Resources: Differential Treatment Effects?

The literature base associated with the active therapeutic components of Oxford House is growing; however, we know very little about what impacts the effectiveness of the therapeutic components in an Oxford House. Although people within an Oxford House share the struggle of addiction and the various hardships that come along with it, they are a heterogeneous group who likely interpret their experience of Oxford House in different ways (Jason, Ferrari, Dvorchak, Groessl, & Malloy, 1997). Among the many dispositional and circumstantial characteristics that can impact the perception of an experience, the expectations and needs of Oxford House residents may encompass the most basic and

pervasive factors that influence their experience in the house. Thus, it is critical to explore how attitudes and resources influence the experience within an Oxford House to gain an understanding of how to maximize treatment effects.

Expectations. Expectations are beliefs and assumptions that are centered on the future. Many factors can influence expectations, including past experiences, positive or negative information received about the object or experience, and hopes for the future (John, 1992; Quintana et al., 2006). Although the addictions literature has not examined the influence of expectations on treatment engagement or recovery outcomes, it has been demonstrated in numerous studies examining placebo effects. A placebo response is a psychological or physiological response that follows the administration of active or inactive substances in addition to contextual factors, such as affirmations of treatment efficacy (Bystad, Bystad, & Wynn, 2015). Placebo effects have been observed in many medical and psychiatric conditions, including pain (Wager et al., 2004), depression (Dworkin, Katz, & Gitlin, 2005), and sleep disorders (Huedo-Medina, Kirsch, Middlemass, Klonizakis, & Siriwardena, 2012). Expectations are a central mechanism through which placebo effects occur (Benedetti, 2009; Kirsch, 1999; Price et al., 1999). There is evidence to suggest the degree of expectation influences the strength of the placebo response (Kirsch, 1999; Bjørkedal & Flaten, 2011) and that changing negative expectations or promoting positive expectations can influence treatment response (Benedetti, et al., 2003; Rabkin, McGrath, Quitkin, & Tricamo, 1990). In certain circumstances, the expectations regarding what a pharmacological substance will do can override

the actual effects of the substance (Colloca & Finniss, 2012; Flaten, Simonsen, & Olsen, 1999).

Research in the area of consumer behavior has extensively examined the influence of expectations on subjective experience. The influence of product information on evaluation via expectation manipulation has been demonstrated, including the impact of flour origin on liking of bread (Kihlberg, Johannson, Langsrud, & Risvik, 2005) and the influence of wine origin on wine ratings (Wansink, Payne, & North, 2007). A study examining the influence of information on wine ratings demonstrated that timing of information could not only influence the overall assessment of wine after the sensory experience but also the experience itself (Siegrist & Cousin, 2009). Researchers randomly assigned 136 participants to 1 of 5 conditions: two groups received either positive or negative information about the wine prior to the wine tasting, two groups received either positive or negative information about the wine after the wine tasting but before evaluating the wine, and the control group received no information. Information given included the name of the wine critic, his experience, and the point rating scale for the wines (e.g., 80-89 points: above average to very good), with the positive and negative conditions differing only on the rating given by the critic for the wine (positive: 92 out of 100; negative: 72 out of 100). Participants who were given the information prior to the tasting significantly differed on how much they liked the wine, whereas no significant difference between the positive and negative conditions was observed when the participants were given the information after the tasting. These results suggest that

the positive or negative expectations formed based on the critique before tasting the wine altered their experience rather than influencing their appraisal of the wine. This experiment was modeled after a study examining the liking of beer with added balsamic vinegar that demonstrated similar results (Lee, Frederick, & Ariely, 2006).

Despite evidence demonstrating the ability of raised expectations to improve treatment response and subjective experience, having positive expectations that are not met can also result in dissatisfaction. This idea is the basis of the disconfirmation of expectations paradigm (Cadotte, Woodruff, & Jenkins, 1987) commonly used in consumer behavior research to study consumer satisfaction (York & McCarthy, 2011). In order to determine satisfaction or dissatisfaction, a comparison must be made between expectations and the perception of the experience (Oliver, 1996). Findings from an exploratory, longitudinal study of 132 male Oxford House residents examining the differences between those who departed prior to the six month follow-up and those who were still living in the Oxford House (Jason, Ferrari, Smith et al., 1997) appear to support this model. Continuing residents reported experiencing more positive aspects (e.g., house safety, fellowship among peers) and less negative aspects (e.g., cramped living space, personality conflicts) than they had initially expected compared to those who departed. These results suggest longer stays may be predicated on satisfaction from having positive expectations exceeded and negative experiences minimized.

It has been suggested that the disconfirmation of expectations paradigm may not translate well to health-related issues due to differences in how expectations are formed (York & McCarthy, 2011). Unlike service consumers, health consumers may rely on limited indirect information obtained from friend and family recommendations as opposed to direct information about intervention quality, which results in less prior expectations when making provider or service choices (York & McCarthy, 2011). Furthermore, the expectations formed using indirect information are likely influenced by existing schemata and source characteristics rather than careful consideration of issue-relevant information due to heuristic processing (Cacioppo & Petty, 1984; York & McCarthy, 2011). Because Oxford House residents can vary greatly regarding who provides information about the Oxford House (e.g., referral from social worker versus referral from a friend) and what type of information they receive prior to taking up residency (e.g., factual information versus subjective experience), it is critical to investigate whether source and content information impacts their expectations about the experience.

Given the evidence demonstrating the impact of prior experiences and information on expectations, it is important to explore how expectations may impact the subjective experience of residents. What remains unknown is how Oxford House residents form expectations and how positive and negative factors that occurred were weighed when making an appraisal of the overall experience.

Need fulfillment. Needs theorists have explored the role of need fulfillment on motivation, satisfaction, and well-being for several decades.

Maslow's motivational theory (1954), one of the most well-known and widely applied theories of human motivation, proposes that people have universal needs they strive to meet in a specific order to enhance their well-being; basic needs for survival (e.g., physiological, safety) are essential to attain before higher-order social and psychological needs (e.g., love, esteem, self-actualization) are considered. Maslow acknowledged that people often have multiple competing needs at the same time; however, he believed people maintain a dominant need that drives their behavior (Maslow, 1954). Although this framework is still used in various settings due to its intuitive appeal, research has found little empirical support for the ordering scheme (Goebel & Brown, 1981) and cross-cultural validity has been criticized (Gambrel & Cianci, 2003).

A recent study examining the relation between subjective well-being and universal need fulfillment across a sample of 60,865 people in 123 countries provided support for the presence of universal needs (Tay & Diener, 2011). Information was gathered on the cognitive and affective components of subjective well-being (global life evaluation and the presence of positive and negative feelings) consistent with subjective well-being research (see Kahneman, 1999; Lucas, Diener, & Suh, 1996) in addition to the fulfillment (or deprivation) of six needs within the past year (basic needs, safety and security, social support and love, feeling respected and pride in activities, mastery, and self-direction/autonomy) based on the needs theories of Maslow (1954), Deci and Ryan (2000), Ryff and Keys (1995), and Csikszentmihalyi (1988) and the study measures. Need fulfillment was strongly associated with more positive feelings

and less negative feelings but insufficient for high life evaluations (i.e., additional factors are relevant). Furthermore, differential patterns of association between needs and well-being were consistent across the world regions: basic needs were strongly associated with life evaluation and negative feelings; the social and respect needs were associated with positive feelings; respect and autonomy needs were associated with negative feelings. Despite providing evidence for Maslow's (1954) hierarchy (people tended to attain lower-order needs before others), the fulfillment of specific needs was associated with subjective well-being regardless of whether other needs were fulfilled. Taken together, these findings suggest that the deprivation or fulfillment of certain types of needs has different effects on affect and cognition and having excess fulfillment of a certain need does not make up for the deprivation of others. A study of psychological needs also found evidence for the importance of balanced need satisfaction for well-being (Sheldon & Niemiec, 2006).

Although people may share many universal needs, individuals differ in the relative desire of those needs (Tay & Diener, 2011). Socialization processes likely influence the value judgments and relative importance placed on desires (Holmes & Warelow, 1997; Tay & Diener, 2011). For example, it has been suggested that the basic need for collectivistic cultures is belonging, as they place a higher premium on group rather than individual interests (Gambrel & Cianci, 2003). The impact of context and cultural factors on needs and subsequent treatment impact has been demonstrated in Oxford Houses. A recent study examining the effects of culturally modified Oxford Houses assigned 135 Latino/a participants to

culturally modified or traditional Oxford Houses (Jason, Luna, Alvarez, & Stevens, 2015). Traditional houses were ethnically diverse and English-speaking; culturally modified houses had only Latino residents, allowed the option to speak English, Spanish, or a mixture of both languages, facilitated the sharing of experiences specific to Latino culture, and provided an environment conducive to culturally congruent communication styles (Jason et al., 2013). Findings confirmed previous research and also provided unexpected results. Similar to other studies (e.g., Jason et al., 2007), length of stay was negatively associated with substance use. The relation between collectivism and length of stay, however, appeared paradoxical; those participants high on collectivism had a lower length of stay in culturally modified houses compared to traditional houses. Taken together, this would suggest that participants high on collectivism in culturally modified houses: 1) leave sooner because their needs are not being adequately met and are also 2) at higher risk of relapse compared to those in traditional houses due to having received a lower treatment dosage. However, results indicated participants high on collectivism were found to be less likely to relapse in culturally modified houses compared to traditional houses, suggesting the cultural modifications met their needs in such a way that a lower dosage was required to obtain positive treatment effects (Jason et al., 2015).

In addition to the influence of values, resource availability also has a profound impact on individual differences of need desires (Goebel & Brown, 1981). A study examining cross-cultural differences in predictors of life satisfaction among 39 nations provided evidence for the needs and values-as-

moderators model of subjective well-being (Oishi, Diener, Lucas, & Suh, 1999). Satisfaction with esteem needs was more predictive of global life satisfaction in individualistic nations than collectivistic nations. Additionally, financial satisfaction was more predictive of life satisfaction in poorer nations, whereas home life satisfaction was more predictive of life satisfaction in wealthy nations.

Research findings suggest the values and the material, social, and emotional resources residents have prior to arriving at the Oxford Houses will influence the types of needs they desire. Oxford House residents who lack specific resources, such as abstinent social support or material resources, may value and desire them more than those who do not have that specific deficiency. Thus, two people living in the same Oxford House may experience it differently depending on the constellation of needs they desire and the ability of the house to fulfill them, which may ultimately impact their perception of the experience and length of tenancy. For example, a study examining resource loss in sample of mostly under-resourced women with a history of substance use problems conducted a factor analysis of a measure of resource loss (Conservation of Resources-Evaluation, 1989) to examine which aspects of resource loss were most prevalent in this type of population (Siegel, Ram, Pope, Landreth, Jason, 2015). Two hundred women between the ages of 18 and 59 were recruited from substance abuse treatment centers and the county jail. Contrary to the prediction that participants would primarily endorse the loss of economic resources, results indicated that psychological factors (hope, sense of optimism, feeling that life has purpose/meaning, and positive feelings about oneself) were the resources that

were most salient to this group. The findings suggest that these internal factors were the most valued for this population or, alternatively, these women may have never had many of the other resources to begin with, so they did not experience a loss per se (Siegel et al., 2015). It is also possible that those with more overall need deficiencies may affiliate and benefit more from the support and structure of Oxford House compared to higher-resourced or higher-functioning residents (Moos, 2008). More research is needed to understand how need deficiency relates to the various components of the Oxford House model residents find most meaningful, how the fulfillment of needs relates to the perception of Oxford House, and how this perception relates to continued tenancy in Oxford House.

Rationale

Although theory and empirical evidence have given insight into which components of the Oxford House model effect therapeutic change, we know very little about how the complex interaction of multiple factors influence the recovery process from the perspective of the residents. Living in an Oxford House entails a substantial change to the physical, social, and emotional dimensions of an individual's life (Jason et al., 2008). Understanding the lived experience of residents can give us insight into these dynamic, complex processes and the relative importance of the components of the Oxford House model. Exploring resident experiences can also help us understand why certain people thrive in this setting and what influences how long they decide to stay. Specifically, exploring the lived experience of residents may provide clues about why many residents do

not stay long enough to receive the minimum dosage despite leaving Oxford House on good terms.

When attempting to understand the subjective experience of an individual in Oxford House, it is important to consider the factors that influence the way people perceive events. Two people within the same house may have a completely different appraisal and reaction to it based on their previous experiences. The life experiences a resident has had prior to Oxford House residency can influence what their expectations will be, and in turn, these expectations likely influence the overall appraisal of the experience. For example, someone who has been in numerous residential substance abuse treatment facilities may have different expectations of an Oxford House than someone who has never had professional treatment. Personal history and dispositional characteristics also impact what people need while in the house. Within an Oxford House, someone who is financially stable may be more interested in the social support within the house, whereas someone who has financial difficulties may be more drawn to the functional structure. Thus, if a particular house does not supply a heavy dose of social support, the person whose needs are more central to social support may be more dissatisfied with the experience compared to the person whose primary needs are related to housing affordability. Expectations and need fulfillment are important factors to be considered when attempting to understand how events are experienced.

The current study employed a qualitative design to address the gaps in the literature by exploring the experiences of Oxford House residents. The objectives

guiding the study were threefold: 1) to empower Oxford House residents by allowing their voices to be heard; 2) to understand how people assign meaning to their experience of Oxford House in the context of their recovery; 3) to explore the decision-making process of residency tenure. The current study answered research questions regarding the subjective experience of residents in Oxford House while taking into account the unique life circumstances that influence their perception. Qualitative research is uniquely suited to the exploration of subjective experience due to its philosophical and epistemological underpinnings that encourage the examination of complex processes through the preservation of the individual among the data; quantitative approaches necessarily lose the individual in the aggregation of data resulting in the representation of people who may not actually exist in the sample (Datan, Rodeheaver, & Hughes, 1987 as cited in Smith, Flowers, & Larkin, 2009). While quantitative approaches allow researchers to identify significant associations at the group level (e.g. the what), qualitative approaches contextualize the data and helps us understand the nature of the associations (e.g., the how and the why) (Guest, Namey, & Mitchell, 2012). In-depth interviews were conducted due to the flexibility and versatility this method lends, which enables the exploration of multiple research aims and provides the ability to gather a rich description of individual-level knowledge including the attitudes, beliefs, thoughts, and feelings about a particular phenomenon (Guest et al., 2012).

Statement of Research Questions

Research Question I. How do people in recovery perceive their experience in Oxford House as it pertains to their recovery and meaning-making?

Research Question II. What are the needs of Oxford House residents?

Research Question III. How does Oxford House fulfill resident needs?

Research Question IV. How do people form their expectations of Oxford House?

Research Question V. How do expectations impact the subjective experience of Oxford House residents?

Research Question VI. How do residents decide when to leave the house?

Method

Sample

Participants were purposively sampled from a larger panel study examining the association between dynamic social networks and various aspects of adjustment and recovery in 40 Oxford Houses across three regions of the United States. Purposive sampling allows for the recruitment of a homogenous sample across key variables to examine differences and similarities of a phenomenon within a particular group, which is consistent with the theoretical approach of IPA (Pietkiewicz & Smith, 2014). The homogeneity of the group generally depends on two factors: interpretative concerns and pragmatic considerations (Pietkiewicz & Smith, 2014). The research team discussed the impact of variability across potentially salient demographic variables, including gender, race/ethnicity, and age. Based on the existing literature and the aims of the current study, we did not expect major differences to emerge along these characteristics and concluded that constraining the sample along any of these

demographic variables would be arbitrary. The resultant inclusion criteria included the following: (a) first-time Oxford House residents, (b) 18 years of age or older, (c) had resided in an Oxford House for over two months and (d) ability to communicate in English. Although repeat residents would have certainly provided valuable insight into what it would be like to have multiple experiences with Oxford House, it was beyond the scope of the current study. The two-month residency criterion was included to capture the participants' experience beyond the initial adjustment period. The research team also discussed the most appropriate size for the current study. Various guidelines exist on qualitative study sample size (e.g., Dukes, 1984, suggests 3-10 and Polkinghorne, 1989, suggests 5-25); however, Smith et al. (2009) and other IPA researchers (e.g., Larkin, Watts, & Clifton, 2006) suggest a small number of participants to allow for the highly detailed and comprehensive examination of particular cases in IPA. Thus, a sample size of 10 was selected, as it was small enough for a sufficiently detailed examination of each individual case while providing enough cases for a thorough cross-case thematic analysis.

The study sample consisted of six men and four women with a mean age of 35.5 years (*SD* = 12.61; range: 21-57 years old). Eight participants identified as non-Hispanic White and the two identified as Hispanic. The geographic representation included two participants from the Northwest region, three participants from the East Coast region, and five participants from the Southern region. The mean length of sobriety was 25.8 months (*SD* = 31.70; range: 3-96 months). The distribution of time sober was as follows: 20% were sober six

months or less; 40% were sober seven to 12 months; 20% were sober 13 to 24 months; and 20% were sober 25 months and beyond. The mean length of residency in Oxford house was 18.4 months (*SD* = 25.73; range: 2-84 months). The distribution of time spent in Oxford House was as follows: 60% had resided six months or less; 10% had resided seven to 12 months; 10% had resided 13 to 24 months; and 20% had resided 25 months and beyond. Most participants (50%) endorsed methamphetamine as their preferred drug, followed by heroin (20%), alcohol (10%), methamphetamine/heroin (10%), and alcohol/opiates (10%). Only one participant did not endorse a history of homelessness or housing instability. Regarding substance use treatment and self-help involvement, all participants reported 12-step involvement, most endorsed residential (90%) treatment, and less than half (40%) endorsed outpatient treatment and mandatory court-ordered treatment. At least 50% were incarcerated prior to living in Oxford House.

Procedure

Panel Study. The parent study will recruit a total of 560 participants residing in 40 Oxford Houses in three regions of the US (Northwest, South, East Coast) over a two year period. Over the course of the study, new residents will be recruited and participants who leave will continue to be followed; as such, the baseline sample size is expected to grow exponentially over the course of the study. Due to the study's research objectives (i.e., examination of house and external dynamic social networks), houses with more than one nonparticipant in the baseline assessment will not be included in the study. Three field interviewers representing each region have been overseeing recruitment and conducting survey

interviews over the telephone or in person if requested by the participant. Prior to data collection, individual informed consent will have been obtained, taking care to emphasize the voluntary nature of participation and the right to decline participation without penalty. Participant compensation is $20 for each interview.

Qualitative substudy. Approval from the DePaul University institutional review board (IRB) was obtained prior to recruitment and data collection for the current qualitative substudy. Field interviewers from the panel study were briefed on the inclusion criteria of the substudy and were responsible for identifying eligible participants during baseline and follow-up interviews. Field interviewers then provided eligible participants with brief information about the current study to gauge interest and obtained permission from those interested for the principle investigator (PI) to contact via the telephone. During the initial call, the PI provided detailed information about the study (purpose, risks and benefits, procedure), determined eligibility, and obtained verbal informed consent. The informed consent process emphasized the voluntary nature of participation, including the option to refrain from answering any question for any reason or discontinue the interview at any time Permission to audio record interviews for transcription was also obtained. If the participant agreed to participate but was unable to complete the interview during the initial call, a mutually convenient time to conduct the interview in the future was arranged. The PI conducted an in-depth interview with each of the participants lasting approximately 25 to 60 minutes. Sociodemographic information obtained from the panel study was verified during the interview. Participants were compensated with $15 Starbucks

gift cards for their participation. Collected data was kept and analyzed in a password-protected computer by the PI.

Instruments

A semi-structured interview guide with open-ended questions developed by the PI was used to explore the subjective experience of living in an Oxford House. Questions were broad and unstructured in the beginning of the interview to elicit views most relevant to the participants' experience free from researcher bias. Subsequent questions were more structured to permit the exploration of secondary research question (e.g., assess expectations of Oxford House prior to residency and need fulfillment). Throughout the interview, inductive probing (e.g., "Tell me more about that") and clarifying questions (e.g., "What did you mean by that?") were employed to ensure the participants' views were expressed as accurately as possible.

The interview protocol was tested by the PI and reviewed by the research staff of the panel study to ensure appropriateness of content and clarity of language. The final instrument was approved by the DePaul University IRB prior to usage. See Appendix A for the complete protocol.

Analytical Approach

There are many different approaches for qualitative research that have their own philosophical assumptions that guide the inquiry process, such as phenomenology, grounded theory, and narrative studies. The current study analyzed data using the Interpretative Phenomenological Analysis (IPA) approach, which aims to examine how people make sense of their significant life

experiences (Smith et al., 2009). This approach is distinguished from other qualitative approaches such as grounded theory in its epistemological flexibility; the inquiry process and subsequent analyses may be informed by existing theory or directed toward answering a preformed research question (Larkin et al., 2006). IPA draws from phenomenology in its focus on the in-depth examination of the subjective reality of a situation (i.e., perception, thoughts, and feelings) rather than the objective reality (i.e., aspects devoid of human influence) and hermeneutics to interpret how people make sense of their experience (Larkin et al., 2006; Smith et al., 2009). Because the researcher is trying to make sense of the participant's sense-making, the researcher is engaged in a two-stage interpretative process known as a double hermeneutic. The double hermeneutic captures the dual role of the researcher who uses the same mental faculties as the participant to sense-make but differs from the participant due to the second-order sense-making of someone else's experience (Lyons & Coyle, 2007). The primary focus of IPA is to allow the voice of the participant to be expressed to understand their lived experience, with other epistemological approaches and research questions being secondary (Larkin et al., 2006; Smith et al., 2009). Thus, in addition to providing a first-person, in-depth, descriptive account of the participant's experience, the researcher also offers an interpretative account of what it means for the participant to have their thoughts and feelings within their particular context (Larkin et al., 2006).

Data were transcribed verbatim and subsequent coding and analyses were conducted in several stages as suggested by Smith and colleagues (2009). The PI

and undergraduate research assistants trained by the PI transcribed the interviews in Microsoft Word 2010. Each transcript was reviewed two to three times to ensure accuracy of the content and interpretation, with the PI performing the final review. The document was then converted into a table to separate each speaker entry into numbered rows and allow for the insertion of columns for initial noting and emergent themes. The PI performed the coding and analysis, debriefing with the research team frequently to reduce bias or misinterpretation. The first two steps of IPA analysis occurred simultaneously and consisted of reading the transcript its entirety several times and making initial exploratory notes, which included descriptive, linguistic, and conceptual commentary, to facilitate immersion in the data. Emergent themes that reflected both the participant's original text and the analyst's interpretation were then developed. Next, themes were spatially clustered in Excel 2010 by using a macro that created movable text boxes labeled with each theme. This cycle was repeated on each of the remaining transcripts, taking care to treat each case individually. The final step identified patterns across the cases to highlight unique features while also identifying shared qualities. The cross-case commonalities were then modified as needed to create superordinate themes and subthemes representative of the sample. Next, a hierarchical diagram was created to gain a thorough understanding of how these concepts related to one another (see Figure 1). Finally, the study research questions were used with the diagram to guide the development of a cohesive narrative of the study findings.

The study design, data collection, and analyses reflected Yardley's (2000) four principle criteria outlined in Smith et al. (2009) to ensure the quality of the research. The first principle is sensitivity to context, which was demonstrated throughout the various stages of the research process through the selection of IPA as a methodology given its focus on the particulars of one's experience, awareness of the existing literature, having awareness of interpersonal dynamics and empathy during the interview process, and maintaining immersion during the analytic process. The second principle is commitment and rigour. Commitment was demonstrated through close attention given to the participant during data collection and to the data analytic process. Rigour, which refers to the thoroughness of the study, was demonstrated through careful selection of the sample, skillful and in-depth interviewing, and systematic, comprehensive analysis of the data going beyond a description of the data to offer an interpretation of what the data mean. The third principle of transparency and coherence was attained through the clarity and coherence of the research process description in the final written product. The final principle, impact and importance, was reflected in the topic and significance of the study.

Additional measures were taken to enhance credibility and reliability of the data. Available research staff from the panel study and members of the dissertation committee provided debriefing and auditing of the themes and interpretation. This process included the examination of data to assess the accuracy of the emergent themes on the individual level and feedback regarding the relevance of emergent themes to study aims on the group level. Although

member-checking is an often employed validation strategy in qualitative studies, the combined effects of amalgamation of accounts and researcher interpretation can make this strategy counter-productive (Larkin & Thompson, 2012). Other forms of validation, such as sample validation (i.e., people eligible to participate but who did not), are preferable (see Larkin & Thompson, 2012). Due to unforeseen recruitment constraints, sample validation was not employed as originally proposed. A research diary was also kept to record impressions of the data and descriptions of how the analytic process unfolded to maintain consistency of analyses between cases.

Results

The findings are organized into three major sections corresponding to the superordinate themes that emerged from the analysis: Needs, The Role of Oxford House on Recovery, and Addiction and the Changing Self. The superordinate themes Needs and The Role of Oxford House on Recovery also contain subthemes and the research questions they addressed. The third subordinate theme, Addiction and the Changing Self, was unexpected and unrelated to the research questions but emerged from the participant accounts. Figure 1 displays a visual depiction of the emergent themes and their relation to one another, including the factors that influence the subjective experience of Oxford House.

Superordinate theme 1: Needs

Research questions addressed:

IV. How do people form their expectations of Oxford House?

II. What are the needs of Oxford House residents?

VI. How do residents decide when to leave the house?

V. How do expectations impact the subjective experience of Oxford House residents?

This section provides an overview of the needs and resources of the participants. Most participants exhibited several forms of resource deficiency prior to moving into Oxford House, including a lack of tangible resources (e.g., housing instability, financial instability, transportation problems), insufficient social support, and unemployment. Additional needs that all participants endorsed were accountability (i.e., answerability), structure (e.g., household rules and responsibilities, routine), and abstinence social support. Although participants shared many of the same needs, their relative importance was largely influenced by how long they had been in the house and the unique circumstances of their situations. The themes below describe participant similarities in relation to changing needs and resource acquisition over time (i.e., before living in the house, during their tenure, and when considering leaving the house).

Need salience and resource acquisition. This subtheme describes participant similarities in relation to changing needs and resource acquisition over time (i.e., before living in the house, during their tenure, and when considering leaving the house). Participants considered Oxford House because they had heard it was safe, affordable, self-governed, substance-free housing during residential treatment from recovery peers, treatment staff or during Oxford House outreach presentations.

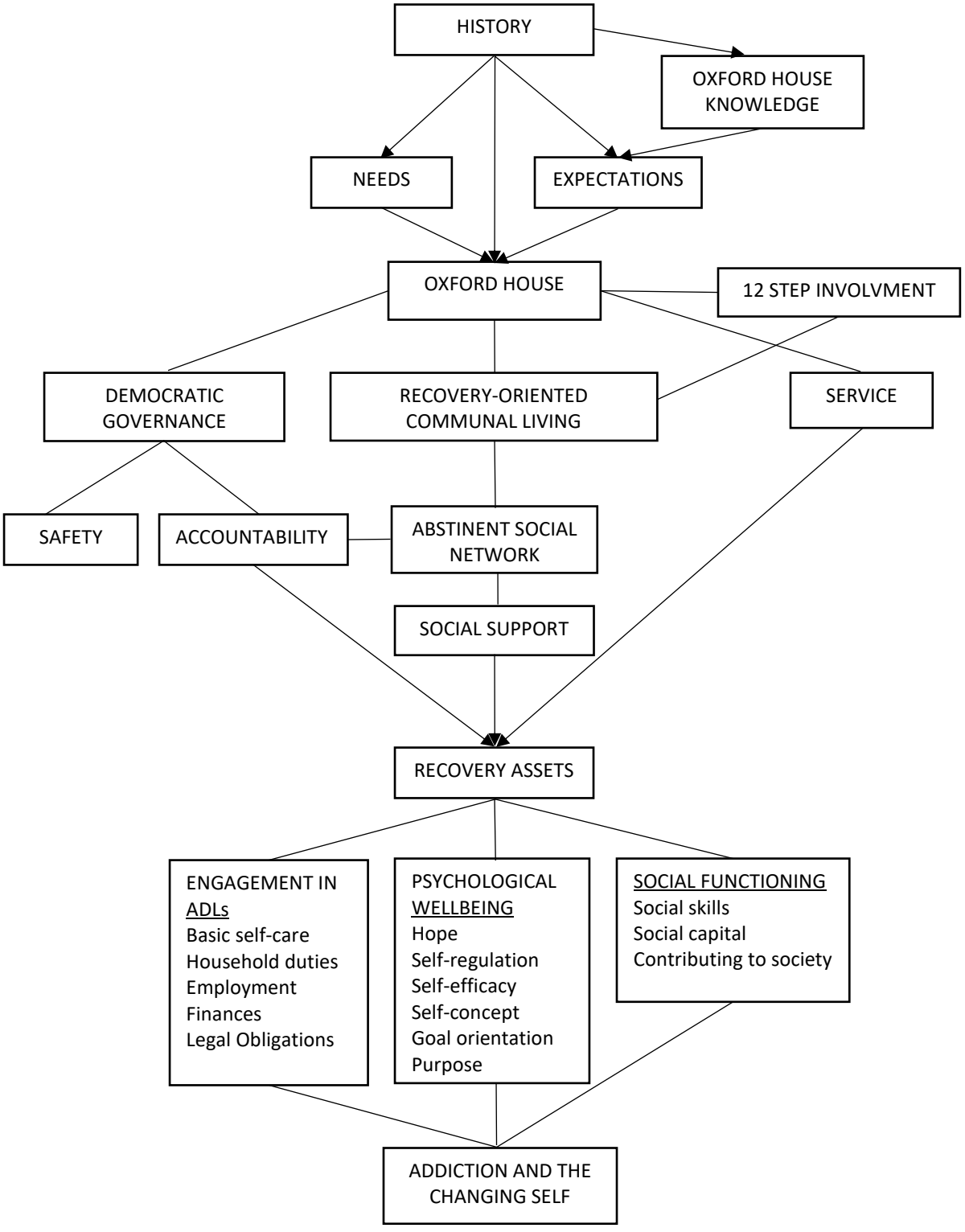

Figure 1. Factors affecting the subjective experience of Oxford House as it relates to recovery, functioning, and well-being. ADLs = activities of daily living.

Housing was the most pressing concern prior to Oxford House entry for all of the participants due to their limited housing options: three had been or were about to be kicked out of where they were living, three lacked stable housing following treatment, and one was issued an ultimatum by her parents to get treatment or they would cut off support (she "compromised with Oxford House"). The other three participants cited getting out of work release and wanting to live in a new environment (not wanting to live with mother/in neighborhood where he abused substances; desire for structured environment with accountability) as the reasons they decided to live in Oxford House. Many of the participants had longstanding problems with housing instability, with six endorsing a history of literal homelessness. Below Luis describes his experience of housing instability and uncertainty prior to living in Oxford House:

> Interviewer: Okay, and what influenced your decision to live in an Oxford House?
>
> Luis: Um, to be honest um, I really didn't have anywhere to go. Um my father uh, where he stayed, he didn't want me to go back there because um well, [pause] there, there was a kid there that was actually selling drugs, and me being on probation and trying to do right um… my dad just was looking for another o- option for me. And um, so basically I had nowhere to go [laughs].
>
> I: Okay, and [interrupted by background noise]... okay and um, you said that there was a kid selling drugs, w- I'm sorry I didn't catch… wh- where was that kid?

L: Uh, yes that's where my dad was staying at the house. He was staying with his uh, his co-worker, and his co-worker's nephew lived there, and he was selling. He was selling drugs out of the house.

I: Oh, okay I see. [pause] I see...

L: [interrupts] So there was nothing I could do [inaudible] to go on to that environment.

I: Okay, makes sense. Um, and um, [pause] can you tell about, um, if, if there was um, a sense of readiness that went into your decision to live in an Oxford House?

L: You know at first I wasn't. I was, you know, I was a little upset cuz I wanted to stay with my father um, and it's something new. You know coming straight out of treatment er, and just being, you know, having, you know half of year clean in a controlled environment. Uh, um [pause] I kind of honestly didn't, didn't know, you know, I didn't know that that's what I wanted to do um but I knew that I had… I needed to do something else from what I was doing, and uh, you know from what I heard that was a, a safe place for me to go. So um, you know, I became willing to stay, stay there you know. Um, more or less, or here I mean.

The above extract demonstrates Luis' struggle to find suitable housing that would not jeopardize his legal status or sobriety. It is clear that Luis' father was concerned about Luis' sobriety and wanted to limit his exposure to drugs; however, his father had a limited capacity to assist him with basic resources. Discussing his resource deficiencies and lack of social support may have been

uncomfortable for Luis; his pause before disclosing the reason he could not stay with his father and the laughter following the admission he had nowhere to go suggest he may have felt embarrassed to disclose that. Another notable feature of this extract is Luis' preference to stay with his father in a risky environment. Despite the potential consequences, experiencing familiarity may have been more important coming out of rehab than contending with the discomfort of a new setting. Moreover, Luis was uncertain of the best course of action to take. Thus, the transition into the community following residential treatment marked a period of vulnerability for Luis where the avoidance of negative emotions and uncertainty influenced his behavior. James described the period following rehab as a time particularly vulnerable for relapse:

> That is like my downfall. Before I would, I would get out of rehab, then go back to my... I would go to my mom's house or go back to my friend's house or someone else that was still using because I didn't know anyone else. And umm, or if I went back to my mom's house, I didn't, I didn't know anybody. I'd get lonely. I would think that maybe oh, I can go just hang over at a friend's house and, and not get high, and it only a matter of time before I would wind up using again. So having, having a whole new environment to come to with the new people, you know is, is fundamental.

Limited housing options and loneliness following rehab contributed to James associating with old friends who were still abusing substances. Even if he had the intention to remain clean, repeated exposure to substance-using friends would

eventually wear down his resolve. For James, having a drug-free environment following treatment was vital for his sobriety.

The affordability of Oxford House and the pooling of resources across the residents increased the standard of living for many of the participants and allowed them to allocate money to other pressing needs, such as legal fees. Ben stated the following regarding his standard of living in Oxford House:

> Well, I mean I always lived in okay houses growing up. You know I've never ri- poor or nothing like that, but I've never lived in any, any, nice house like that, like a four bedrooms, two story house. I've never lived in nothing like that you know. I've lived [pause] it's always one bedroom houses you know, shared a room with either my brothers or somebody or little apartments like one bedroom, two bedroom apartments you know [pause] never anything like a yard or you know big kitchen, got a big living room, with a big screen tv, couches and everything. I've never had really nice stuff.

James indicated that being able to "catch a ride" with someone to a 12-step meeting helped him stay engaged in recovery. Lucy was able to rely on her roommates to help her move into the home:

> I didn't have my car that weekend, so one of the other roommates, one of my other roommates she had her car so sh…umm before I moved in here, I lived in a hotel for a week because like I said I got kicked out of where I was staying. A- and I was staying in a hotel, and I had no one else to come help me move all my stuff. And she came and picked me up and you know

> packed all my stuff up in the truck and moved on in, helped me carry it in. I mean i- i- it was nice.

Once participants became stabilized, their focus appeared to shift to higher-order needs such as building life skills, resource stabilization, and long-term recovery. This progression of salient needs was most striking when comparing the reasons participants entered Oxford House with the conditions that had to be satisfied before leaving the house. Participant goals tended to become more ambitious over time, and as a result, many extended their original residency plans. Although Melanie had initially planned to stay in Oxford House just long enough to get back on her feet, her involvement in service motivated her to advance within the organization and extend her stay:

> Uh at first I just really wanted to move there just to, you know, gather up all the money I needed and just kinda leave, but living here and, you know, taking service positions in the house and also for uh, for uh, you know, I mean uh, [omitted digression] so, uh you know I'm now chapter X secretary um, and I just want to keep advancing. I want to keep going, not only for my chapter, but I also want to go up to state, and uh, and you know offer my service to them.

Together with her roommate's suggestion to stay at least six months, Melanie goes on to say that being elected to a service position "[showed] me that, you know what, maybe this is the place for me. Maybe I do need to just stick this out, and um and just stay where I need to stay." Melanie's election to this position seems to have promoted a sense of belongingness and purpose. With the help of a

sponsor and active involvement in Alcoholics Anonymous (AA), Camille's goal orientation similarly broadened:

> [w]hen I first came in, umm my attitude was just to get my stuff... my shit together [giggles] and then move on. Whereas, through actually working a program of recovery with a sponsor, working steps and looking at myself, myself, my priorities, and my goal became much larger. It became to work on myself as a person, become stable and become a better person and understand myself and get... you know there… it's just so much bigger than just getting my shit together now. And since there is no time limit on your stay here, I haven't even really thought about it. Right now, for me financially, it is the perfect situation. Locationally it's perfect because I found my job near here, I'm walking distance to school, and I have a great roommate and it's, it's been the accountability I need right now, and there's no reason to change something that's helped me so much to this point right now, because like I said, my focus is is no longer just getting my crap together, it's bettering myself as a person around other people who are doing the same thing.

Earlier in the interview Camille had stated that she was not entirely ready for recovery when she moved into the Oxford House; she indicated that her legal situation, health, and relationships were in "such a bad state that my [housing] choices were very slim." Despite her initial desire to stabilize and leave, working through the recovery program while living in an Oxford House afforded Camille the opportunity for self-reflection, which ultimately led her to reevaluate her life.

Because there is no time limit and Camille's current needs were being met, she was content and not focused on leaving.

Nearly all participants related that they wanted more stability regarding tangible resources and recovery progress before moving out of Oxford House, with most endorsing multiple considerations including (in order of frequency) financial stability/higher income, confidence in recovery (i.e., abstinence self-efficacy), and the desire to live with a romantic partner. Nonetheless, most of the participants reported varying degrees of uncertainty, mostly regarding emotional or recovery readiness, about when they would know they were ready to leave. For example, Camille stated in the previous excerpt that she was focused on self-improvement, which she later defined as "just about becoming a well-rounded person, with not just the good intentions but actually living those good intentions and feeling good about myself and feeling like I'm being honest and loving." When asked when she would know she achieved that, she responded with the following:

> Umm, honestly I, I don't know for a fact since I'm not there yet. Umm, I assume that I'll know it when I feel it, but I believe it'll be when [pause] even in my weak moments I feel strong. Like now I still have weak moments, I, I mean not weak enough to pick up or use or drink, but I have weak moments where this house really saves my butt, where I, when I need to come home and talk to somebody about it and deal, and deal with my emotions and be in a safe environment. So when I am more stable in

> my weak moments, I would imagine that that's when I would be willing to take the next step.

The other participants who expressed uncertainty indicated that they did not know how or when they would be ready or that they would just know it when it happens. The process of recovery is complex, and identifying concrete, external markers of progress is easier than defining and recognizing abstract, internal markers of change. Some participants expressed discomfort with the question ("that's a hard question to answer"), as they had not thought too much about it or there was a reluctance to project too far into the future ("don't know what every, what tomorrow's gonna bring"). Given that this was their first Oxford House experience, it is likely they have not had the opportunity to stay in a recovery-oriented residence until they felt ready to leave. Despite the ambiguity regarding Oxford House departure for many, participants generally related they would leave when they believed they could thrive on their own and wanted more independence (e.g., to live with a romantic partner). The four longer-term residents in the group (20+ months) did not express uncertainty regarding Oxford House departure; their decision to leave was dependent on financial considerations or a desire to change living arrangements rather than recovery progress.

Fulfillment of unique needs. Although the participants shared many of the same needs, the relative importance of the needs tended to vary depending upon their unique circumstances, including their recovery progress. This variation was most apparent when comparing their most meaningful experiences within Oxford House. Nearly all participants emphasized the importance of the

relationships they had built in the house and the social support they received; however, only the participants who had been in recovery for one year or less also stressed the structure within the house as remaining significant (e.g., rules, responsibilities, accountability). Lucy (8 months sober), who identified the structure as being particularly meaningful for her, describes why the curfew was integral to helping her stay clean:

> And i- it keeps you... okay I gotta be home at this time. I've already stayed out this late, and I gotta go home okay. Or I have to be home at a certain time. I don't, you know like, that... it does help, you know knowing that you know being home at a certain time, that I'm not just driving around in the middle of the night because I can't sleep, and then I see some drug dealer in the corner, and I got money in my pocket, and for some reason I'm in a bad mood or whatever, and I want to get high. It keeps me in the house. I don't see that stuff you know.

The curfew limits unnecessary exposure to environmental risks (i.e., drug dealers) that may lead Lucy to relapse during moments of weakness. Earlier in the interview, Lucy also indicated that the curfew "forces me to go to bed early, so I can wake up on time and keep the job that I have" but provides enough flexibility that "it gives me that option [to stay out three nights per week), but I have to like plan." She also stated that the curfew is not overly restrictive because it can be amended based on house approval. The flexibility of the curfew is important to Lucy because she found the curfews in halfway houses overly restrictive, which "caused me to move out before I was ready," and relapse one or two months

later. In contrast, James, who has been sober for nearly two years and in the house for six months, discusses why curfews were not as essential to him as someone early in their recovery:

> James: Umm, at first there was a curfew at ten o'clock in the evening and on the weekdays and at midnight on the weekends for the first thirty days, and then after that it's two o'clock in the morning across the board, across, throughout the whole week. And then only being allowed to stay out three nights a week, three nights a week uh [pause], I guess that's about it.
>
> Interviewer: How has that, for instance that umm, that rule how has that helped you?
>
> J: Which one the nights out?
>
> I: Mhm. You said it's better so...
>
> J: Umm, at first umm, well I don't know. I kinda believe I can see in other people that that rule, they, they have the opportunity to stay out a few nights or more than two nights in a row, they would probably use that opportunity to go use, to go get high, and then come back to the house and nobody would even know the difference. And so those rules hold people accountable you know. Anybody been given the opportunity to go try to do something like that.
>
> I: Mmh. And so has that been something that you've gone through?
>
> J: Umm, it I mean it, it helps me I guess. It helps me out a little bit uh [pause]... I was fortunate enough to just be ready to, to not want to go out

and use anymore. But for other people who, who are struggling with that, I could see it help with them a lot more.

I: Okay, so, so for you it hasn't been too much... it's been helpful but it hasn't been like necessarily instrumental because you haven't necessarily had the desire to do that?

J: Correct. Yeah that's exactly right.

Given that James had been further along his recovery when he entered Oxford House, the rules restricting his activities did not have as much of an impact on him at any point compared to someone coming into the house early in their recovery like Lucy. Service and mentorship were especially meaningful to the two participants who had been in the house the longest (over 3 years). As residents become increasingly stabilized and confident in their recovery, activities that foster esteem and a sense of mastery may be most salient. Of note, 12-step programs generally promote service and tout the benefits of helping others on one's own sobriety.

The other notable pattern regarding unique need fulfillment is that previously unmet needs tended to be most valued for all participants. When asked to elaborate why a certain element was so meaningful to them, half specifically stated that it was due to the absence or scarcity of that element in their life prior to Oxford House entry.

Expectations and Perception of Oxford House. Although most participants denied having had any expectations when asked explicitly at the beginning of the interview (e.g., "I didn't know what to expect."), they indicated

that their expectations had been met or exceeded when asked later in the interview. It is possible that the word “expectation” was initially interpreted narrowly, referring specifically to abstinence expectations. The term may also have a negative connotation in the recovery community, as AA’s primary text, the Big Book (Alcoholics Anonymous, 2001) discusses the risks associated with placing expectations on others. Lucy reflected this in the excerpt below:

> Umm, actually my expectations, I had no... I had no expectations of it because one thing I’ve learned... I’ve been trying to get clean since... for 11 years now, and one thing I’ve learned about that I haven't lost is having expectations because they always say an expectation is a pre-determined resentment because people are going to let you down. And you know I can't expect anyone to do anything because I'm powerless over that person. What they do, how they act, what they say, how they think. So like I had no expectations be- besides the fact that I knew it would be a safe, clean, structured environment that I could live in, and it would be good for me.

Lucy disclosed her expectations only after providing what sounds to be a disclaimer explaining the reasons why she tries to avoid having expectations of other people. The circumvention from the original question to her script-like response in addition to the referral to what others have said (i.e., “they always say…”) suggests the word expectation has a strong association with her recovery vernacular, specifically factors that may lead to relapse. The other participants may have similar associations with the word “expectation.”

Despite being unable to extract that information by directly asking the participants, expectations were expressed during other parts of the interview. As discussed in the previous section, all participants endorsed knowledge (positive or neutral) about Oxford House prior to entry. At the very least, participants expected a safe and structured environment. Although it might stand to reason that positive information would raise participant expectations, it is also possible that previous recovery experiences and/or feelings of hopelessness may have lowered expectations for some. All of the participants endorsed previous residential substance abuse treatment, including residential treatment programs, the Salvation Army, and halfway houses, which were described as more restrictive, more costly, and provided less privacy. For example, one of the only participants who identified specific expectations- a "temporary" stay long enough to get her financial and legal situation stabilized- also indicated that her expectations were related to her previous experience in a halfway house, which was negative. Additionally, the subpar living conditions in which participants were living prior to Oxford House entry (unstable housing, homelessness, incarceration) may have lowered expectations.

All participants expressed satisfaction and stated that their expectations were exceeded. The low expectations appeared to have a positive effect on their experience. Although low expectations could have resulted in decreased motivation or compliance, the low expectations may have worked in the participants' favor due to their limited options that made it more difficult to leave prematurely. Nearly all participants indicated that Oxford House provided

everything they needed in their treatment, suggesting that resources and opportunities that were obtained while they were in Oxford House were more broadly associated with the Oxford House experience. In contrast, Camille perceived Oxford House to be distinct from the other skills and resources that she needed in recovery:

> Interviewer: Mhm, mhm, yeah that, that makes complete sense. Umm so given all of these things that, that Oxford House has, has um provided, is there anything that you've needed in your recovery that you felt that Oxford House has not been able to provide?
>
> Camille: Umm, [pause] no. I, I feel like there were other things that were needed in my recovery such as getting a sponsor and attending meetings and um learning how to navigate relationships with people. But like the house is… all it needed to do for that at the beginning you know, when we have a meeting amount that you have to get per week, you have to get five meetings at first, then three and then you have to... you're supposed to get a sponsor, all that. S-, so we suggest that you do that in the house, but it's not really the house's job to shape you. It's my job to do that. So the house has done everything that it could.

The other participants may have perceived Oxford House to provide more comprehensive resources than it actually does because it provided the means; thus, they may believe none of it would have been attained without the support the house provided.

Superordinate theme 2: The Role of Oxford House on Recovery

Research questions addressed:

III. How does Oxford House fulfill resident needs?

I. How do people in recovery perceive their experience in Oxford House as it pertains to their recovery and meaning-making?

This superordinate theme includes the different components of Oxford House and their influence on the recovery process. Participants reported on their experience within the household, including the living accommodations, rules, and relationships, and how their recovery was strengthened as a result. The subthemes within this section correspond to the major active components of Oxford House, including Democratic Governance and Recovery-Oriented Living.

Democratic governance. Oxford House fulfills the need for structure (e.g., household rules, activities of daily living, routine, and accountability) through its democratic governance. Since the house has no professional staff, it is up to the residents to work together and monitor one another to make sure the house runs smoothly. This can be a challenging but ultimately welcoming adjustment for newcomers; most participants stated that structure was among the most important factors in recovery due to the chaotic lifestyle associated with addiction. Below Doug describes his observation regarding the lack of structure that often accompanies addiction:

> Where a lot of your addicts you know, we are all addicts, and we are coming off you know, long term usage and addiction that we've lost the structure in our lives that we need you know. Umm, how to have a bank account, you know, umm clean up like you did in the past umm, and

> making amends, stuff like that. Here you're held t- to being accountable to um, [pause] continue to make forward progress, you know?

The content of the excerpt suggests that people in the midst of addiction begin abandoning the mundane responsibilities that encompass the daily routine of peoples' lives. In the beginning of the excerpt, Doug speaks on behalf of the entire group rather than specifically to his own experience. This use of inclusive language ("we") was present in most of the interviews, which may reflect an inclination toward group affiliation. Indeed, many of the participants spoke very generally about their experiences and had to be prompted to confirm whether their own personal experience fit their more generalized narratives. When Doug goes on to describe what the structure entails, he switches to distancing language (i.e., "you"), perhaps to avoid being associated with the specific perceived deficits in functioning he is describing.

Burt echoed a similar sentiment when he remarked that "there was so much chaos and there wasn't here, but then there was the, this structure to be able to h-, gradually help you, you know, move back in-into basically life on life's terms." AA's Big Book (Alcoholics Anonymous, 2001) coined the phrase "life on life's terms," indicating "unless I accept life completely on life's terms, I cannot be happy. I need to concentrate not so much on what needs to be changed in the world as on what needs to be changed in me and in my attitudes." (p. 417). Burt used this AA saying to demonstrate how the structure of the house helped him to become more functional in his environment rather than focusing on changing external factors in which he has less control. It appears that Burt is connecting the

principles of recovery he has learned in AA to one of the fundamental features in the house. This connection may lead Burt to perceive the rules as being beneficial for his recovery. References to 12-step jargon were rather common for the participants, with about half mentioning 12-step jargon in their interviews.

The self-run governance of the house necessitates that residents re-engage in activities of daily living they had been neglecting, including basic self-care, household chores, employment, management of finances, and legal obligations. Having a daily routine also helped a few participants adjust to living in Oxford House ("when you wake up in the morning you have a routine of getting coffee, and getting in the shower, listening to music or whatever it may be, you started getting in a routine in your environment, and you start being happy with it and feeling comfortable with it," Camille). In addition to practicing neglected activities, some participants like Ben reported learning new skills:

> Uh you know it's taught me how to [pause] basically manage life with all hold of like officer positions in the house, like president, treasurer you know, I'm a check signer, and you know before, I'd never sign any checks, you know. I never even really know how to, how to do a bank account you know?

Luis further elaborated on this process of structuring time and activities, which promoted skill acquisition, trust, and a sense of becoming reconnected to society:

> It, it helps you build uh structure and you have responsibilities and you're accountable for your... you have to do chores around the house, and if you don't you, you, you know and you got to follow certain rules, be in at

> certain times and not stay out for, you know, so many days at a time, and you have to check with the house and, and kinda let everybody know what's going on. Um, so you know it helps you build that, that, that trust amongst people. Um you're getting… being honest. Um something you, you get back into [pause] to um to society and being a responsible adult.

In the extract above, it appears that the transparency within the house fostered honesty, which in turn lead to trust. Regaining the capacity to care for oneself and others led some participants to increase their self-efficacy, and in turn their self-worth.

Several participants stated that only their recovery peers could provide the accountability they needed. Melanie indicated that her parents "were so naive to drugs and alcohol they would never know whenever I was on it, so I was, you know, I was always able to just kind of do what I please and just, uh, a-, and not worry about getting caught." Ben also captured the limits of his family support when he remarked, "my family loves me you know, they do, but they're going to love me whether I do bad or whether I do good." Camille, on the other hand, stated that "I needed accountability and not necessarily in the form of an authority figure, but in the form of people that I could get close to and care about and not want to disappoint and not want to hurt." This and other remarks made by the participants suggest residents are able to hold each other accountable because they are able to recognize signs of intoxication and relapse risk behaviors. Moreover, with accountability comes conditional positive regard; the household relationships are contingent upon conformity to house rules and prosocial conduct.

In addition to learning and practicing conflict resolution skills, understanding the rationale underlying house rules appears to facilitate enforcement despite the discomfort that can accompany confrontation. All the participants mentioned the rules were fair and reasonable (e.g., rationale for the rules was clear, majority rule to amend rules, rules were graded in restrictiveness) and served many purposes (e.g., ensures the sustainability of the house and suitable living conditions, physical and emotional safety, substance-free environment). The extract below reflects Doug's perception of why rule adherence is necessary specifically as it relates to employment:

> Interviewer: Okay so it's, it sound like the gray area can include like trying to find loopholes to some of these rules. [Doug: Correct, correct, correct.] Okay, got it. And so he was able to support himself but he wasn't working umm. So, so the working piece it sounds like isn't just about financial stability. It sounds like there's another reason why it's important to have employment.
>
> Doug: [Doug interrupts] Yeah if, if, if you don't wanna work, go find a volunteer job you know, or something like that. Give something. Don't just sit here at the house all day. Cuz when you're just sitting, when you're just sitting here doing basically nothing except watching TV or, or reading or something like that, there's a very good chance to slip back into old behaviors, which is isolation, which can lead to you know...

The participants also indicated the rules provided adequate structure while also supporting autonomy, which was a difficult balance to achieve elsewhere. In the

extract below, Melanie contrasts the structure/autonomy within Oxford House versus other half-way houses in which she had lived:

> Uh I mean in [halfway house] it was very strict, like they would have to take you to your work to your job, they would have to pick you up, um they wo-, uh would even set any sort of curfews. Um, it was just where you're either at home or at work or you're at school. Uh so being able to be in an Oxford home, I'm still able to spend uh nights out with family or friends. I'm still able to uh not have to worry uh about being kicked out because I'm working, you know, a little later than what I was supposed to, and um, and just, and just being able to still go out and experience what life has to offer you know, whether it's in a new city, uh which is uh my situation, uh where I moved from [omitted] to [omitted]. And um, and just being able to, to go out and just have free reign of, of how we do things and making sure that, you know, you learn ways to stay sober in the real world.

Despite the advantages of close supervision in early recovery, the extract above demonstrates that overly restrictive rules can interfere with social engagement and employment, which are crucial components to long-term stabilization and recovery. Increased autonomy allows for residents to learn and practice new abstinence skills in the external settings where they will be needed most. Fairness also extended beyond rules of conduct to the distribution of power within the house. For example, Kurt remarked of the elected positions:

> Uh, everybody in the house holds the position. You don't got... even if, if it went to a newcomer, or you're, you still hold position for six months. I mean, being even president, I have no more power than anybody else in the house. We're all equal here. We all have the same say so.

Recovery-oriented communal living.

Social support. Oxford House fulfills the need for abstinence social support by providing an environment that is conducive to the development of supportive relationships: sober living with recovery peers. Providing social support is not an Oxford House requirement; however, all participants indicated they received social support during their tenure. As one resident remarked: "It, you're not, it's not demanded of you, but uh I know that my brothers in this house back me up in my recovery you know, and uh, and I'd do the same for them."

The relationships the participants had with their roommates shared characteristics with those that occur in support groups: shared experience (i.e., addiction history) and goal orientation (i.e., recovery). Indeed, a few participants explicitly stated that their roommates were another support group for them; one participant went even further and remarked he "was gaining eight more other sponsors because I have eight roommates, which is a comfort of itself. You can ping pong ideas off of... to gain a stronger recovery." What distinguishes Oxford House relationships from those in outside support groups is the high degree of contact they have through shared housing and the increased opportunity for dyadic interactions, which appear to facilitate accelerated bonding and deep friendships. For example Anna, who had only been in the house two months,

stated that she felt like she had known her roommates "forever, even though I hasn't [sic]." One participant stated that she and her roommates were "all good friends" who knew what was going on in each other's lives and their typical behavior, which made it easier to detect idiosyncratic behavioral deviations that may be indicative of relapse risk. Thus, the reciprocal self-disclosure that occurs in friendships can benefit recovery through transparency.

Many participants indicated that they felt understood, cared for, and accepted by their roommates, which may have made it easier for them to reach out for support during difficult times. One participant related that he found it easier to "open up" to recovery peers than his family when he had thoughts about "getting high or using dope" because his family might think something is wrong with him because they do not understand that "these thoughts do come up" and have to be worked through. The experiential knowledge his roommates possess regarding the recovery process can facilitate self-disclosure of maladaptive thoughts and negative emotions that may ultimately aid in preventing relapse. In addition to helping with more general thoughts and emotions regarding substance use, some participants reported that their roommates supported them during major life stressors that threatened their sobriety. In the following extract, Lucy describes an instance when one of her roommates provided support after finding out that her partner had cheated. She then goes on to discuss how her roommates have more generally helped her in times of need:

> Lucy: Umm, w- when I was in need? Umm, well recently, couple months ago umm, my partner cheated on me, and I broke up with 'em. And you

know I was an emotional wreck, and I wanted to go get high, and I wanted to do a lot of stuff. I was, I was just seriously fucked up in my head. Excuse my mouth. [Interviewer: it's okay] Umm, and I just [pause] came home, and my roommate you know, one of my roommates was was here, and she just gave me a hug and talked to me and asked me what was wrong, and you know helped me through it.

Interviewer: [pause] Wow. And so [Lucy interrupts: you know...] no go on, go on.

L: Sh- sh- she helped me from… she helped me keep me from leaving and going to go get drugs or go find drugs. So you know I really um had to [inaudible], and I wanted to get high.

I: Mhm [pause] Wow. So, so that really, that really helped you. Th- that helped you prevent relapse is what it sounds like.

L: Yeah, [pause] because the one thing about, one thing about th- this Oxford House, I know that at, at any time [pause], it doesn't matter what time of the day, I can go in one of my… you know go up to one of my roommates and tell them hey I wanna get high, and they'll help me through my feelings.

I: [pause] And how do they help you through that? How do they… like what kinds of things do they tell you?

L: I mean they can it- I mean they don't... they don't just have to talk to me they can be like, hey let's go, let's go do something, let's go get some food, let's go for a walk you know. They're there for me…

Given Lucy's strong desire to use drugs, she would have likely relapsed without someone being there to help her get through the pain and prevent her from leaving before the urge subsided. When asked to elaborate on what roommates have told her to get through tough times, Lucy was quick to point out that they also help her in other ways that does not involve talking (e.g., activities to distract). This statement, followed by her saying "they're there for me" was perhaps meant to clarify that the most important aspect of the support was someone being there, regardless of the specific activity. The importance of mere presence underscores another important feature of living with a support group mentioned by many participants: availability. Not only does the close proximity facilitate access, but several people within a house increases the likelihood that someone will be able and willing to support someone at any given time.

The built-in abstinence social network also provides residents with companionship that does not interfere with their recovery goals. As mentioned in the previous section, Needs, loneliness and boredom can lead people in recovery to hang around others who continue to use because they lack companions, increasing their risk of relapse. Once they move into Oxford House, they have several people who can join them in pro-recovery activities, such as accompanying them to meetings or doing sober activities. Along with structure and responsibility, it is important for people in recovery to learn how to spend their free time in ways that will not compromise their recovery. As one participant stated: "It's, it's a blast to know that you can have fun in recovery. And it doesn't take the drugs and the alcohol to like have fun." Participants described many

shared leisure activities including watching television, cooking, and going to restaurants.

Although similarity regarding addiction history and recovery orientation help the residents bond, the unique experiences they have had allow them to learn coping skills from one another. Most participants endorsed that they received this instructional type of social support, with many indicating it was particularly useful in their recovery. The coping skills that they acquired shared many qualities of cognitive-behavioral approaches, including shifting perspective (i.e., cognitive restructuring) and learning to manage negative emotions (i.e., emotion regulation). One notable example comes from Burt who detailed how one of his roommates helped him grieve the loss of his father:

> Burt: That's what helped me… kept me [inaudible]. You have to understand that umm, when I was 14, it's just part of my story, my dad went over a 50 foot cliff with a snowmobile and got his head squished between a snowmobile and a tree and was in a coma for six months, and then came out of it but yet, it was like he was like a child and an infant. Even though I got to have him 30 years later, but then when he did pass, it was like I lost him twice. And through those 30 years that I had him, I didn't know how to grieve because I held on to guilt, shame, and remorse because he was supposed to have taken my helmet, and he came back twice and didn't take it. So, I felt that shame that it was my fault and all this, and it had nothing to do with me. But it had to do with my perceptions. It helped me look at those perceptions and change those

> perceptions to where, you know I can grieve to where, okay well he is gone now, but he's in a better place. The neat thing is, is and the flip of all of it, is how this grief, it turned it into gratitude, to where I was able to have him for thir-thirty years that I wouldn't've had before. So that was a healthy flip of learning to grieve in that positive manner.
>
> Interviewer: And what would have been an unhealthy way that you typically would have grieved?
>
> B: Oh I would have went out and got f'ing loaded. No, no doubt about it. You know, because that's how I dealt with everything. That was a natural state for me, numb, so I didn't have to feel. It helped me grasp a hold and be able to watch the feelings that I was uncomfortable with and didn't have before and help me walk through those feelings. And that's what this is all about, helping each other walk through things that we haven't gone through before and be able to assist each other.

With his roommate's help, Burt was able to adopt a more balanced and realistic perspective regarding his father's accident, which helped minimize the guilt and shame he had been carrying for over 30 years. He was able to grieve his father's death and gain closure by focusing on the positive aspects of the tragedy (i.e., despite his father's disability, he was able to spend several years with him before he died) and learning to process the difficult emotions he had been avoiding. Without the newly acquired coping skills, it is likely he would have dealt with the difficult emotions using his typical coping style: avoidance through intoxication.

Overall, the social support the participants received in the house appeared to foster self-regulation, social capital, belongingness, and hope. Depending on the household composition, the social support can mimic a combination of qualities from both support groups and individual therapy conducive to recovery including emotional support, tangible support (e.g., rides to meetings), companionship, and advice/building of coping skills.

Service. Similar to relationship-building and social support, participation in service activities is available and encouraged, though not required. Some participants indicated that the opportunity to be of service to the organization gave them a sense of accomplishment and purpose beyond themselves. Additionally, participating in service activities appeared to increase investment in the organization and extended the length of stay for a few participants.

Superordinate theme 3: Addiction and The Changing Self

This final superordinate theme represents a narrative unrelated to the study's research questions that emerged across nearly all participants regarding a change in their self-concept. Although the narratives varied in some ways (e.g., prominence of past versus current self, a return to the self prior to addiction), they consistently described their current self-concept as distinct from their past self-concept during addiction. As they described how their lives changed during the recovery process, they also integrated details of how they have changed as people. The description of their self-concept had a dynamic, evolving quality working toward an idealized, "normal" or "responsible" self. The narrative was one of redemption, reminiscent of the mythological story of the phoenix; acknowledging,

atoning, and shedding the person of the past to become a stronger version of themselves.

The splitting of the self-concept associated with addiction may promote recovery through the minimization of negative emotions and the promotion of positive emotions. The shame and guilt associated with certain behaviors during their addiction (e.g., deception, theft, irresponsibility) might be reduced when the behaviors are associated with a past self rather than the current self, thereby facilitating the development of a positive self-concept. Moreover, the maintenance of these negative emotions may make it more difficult to instill the hope that helps the participants persist in recovery.

Discussion

The overall aims of this study were to empower Oxford House residents and gain a better understanding of their subjective experience and meaning-making as it relates to their recovery and tenure in the house, with a close examination of expectations and need fulfillment. The findings demonstrated that Oxford House was perceived as overwhelmingly positive, which is likely due to all or a combination of the following: initial limited resources; low expectations; resource gains made in the house perceived as being provided by Oxford House although they were not. Despite all participants having some knowledge of Oxford House prior to entry, participants were reluctant to admit that they had any expectations, possibly due to the negative association of expectations in self-help circles, avoidance of disappointment, or lack of insight. Treatment history, including previous halfway house experiences, also informed expectations such

that Oxford House was anticipated to be more restrictive. The expectations that were indirectly extracted were generally related to tangible resources (i.e., safe and drug-free housing) and the possibility of recovery.

Other findings in relation to research questions that emerged include the dynamic nature of need salience, with basic needs (e.g., housing, safety) of most importance during house entry and social and esteem needs prioritized after stabilization. Of note, tangible resource acquisition was consistently present, with people wanting to continuously improve their financial stability. Aside from the salience of needs progressing over time, variation in need constellation and valuation of resources were demonstrated and influenced by the participants' resource availability; specifically, the absence of resources appeared to increase their value and meaningfulness. Oxford House was able to fulfill many of the participants' needs through democratic self-governance and recovery-oriented communal living. Of the needs Oxford House could not directly fulfill, linkages were often provided to direct forms of support (e.g., help finding an AA sponsor or leads on employment opportunities). The democratic self-governance provided enough regulation to structure participants' lives while simultaneously promoting autonomy through self-regulation of household rule adherence in order to maintain the independent functioning of the house. The recovery-oriented communal living provided participants with an easily accessible social support system that fostered a sense of belongingness and assistance with the recovery process. Regarding the decision-making process of Oxford House departure, several notable features emerged. Participants considered multiple factors during

their decision making process, particularly tangible resource stability and confidence in recovery. Most participants were uncertain when they would leave due to the difficulty they had predicting when emotional or recovery readiness would be attained. In fact, discussing plans too far into the future proved to be distressing to many, which may be reflective of the one-day-at-a-time attitude in recovery-circles. Despite ambiguity regarding departure, many had extended their residency tenure to accommodate new goals that would be more easily achieved with the financial and social support received in Oxford House.

The study findings complement and expand upon the existing Oxford House literature examining precipitants of Oxford House entry and mechanisms of change. Regarding Oxford House entry, my findings align with those of Majer et al. (2002) in that having nowhere to go and a desire for a drug-free environment were strong motivating factors for Oxford House entry. Differences emerged regarding the proportion of the participants that endorsed housing instability at time of entry (30.7% vs. 70% in current study); current study participants also included other functional attributes of the house (e.g., the safety and affordability) and excluded peer social support when describing reasons for choosing Oxford House. There are many reasons that may explain the observed differences. The current study had a much smaller sample size (N of 10 vs 53), a potentially different population (comorbidity of psychiatric conditions in the Majer et al., 2000 study), and a different methodological approach that allowed participants to give more elaborate and unrestricted responses (current study). Although both studies had a similar proportion of participants with a history of homelessness, it

is unknown what proportion of participants from the Majer et al. (2002) study had lived in only one Oxford House. It may be possible that Oxford House residents with multiple stays have the experience of the social support in the house to inform their decision to return, whereas first-timers may only consider Oxford House as a last resort when tangible resources have become scarce. This suggests that limited housing options may promote Oxford House entry and recovery for a few reasons: it would provide exposure to the Oxford House model for people who would choose other accommodations if given the chance; exposure to the Oxford House model may facilitate recovery readiness; because they have nowhere else to go, it might increase the likelihood residents would stay despite the discomfort associated with the adjustment period and negative aspects of the experience (e.g., cramped living space). The findings in relation to therapeutic change agents support the theoretical mechanisms outlined by Moos (2008). The structure and social support mimic what would be obtained from a support group and halfway house; however, the combination of self-governance and emersion with recovery peers (i.e., living with them) appears to provide benefits that exceed both. Similar to the findings of the Alvarez et al. (2006) study, recovery was associated with the acquisition of new skills, abstinence, and a sense of purpose. The current study findings found additional associations with recovery, namely that it was associated with lifestyle changes (e.g., new sober activities, sober social network) and a new self-concept.

The changing self-concept was an unexpected theme that emerged from the data. The phenomenon of multiple selves has been a longstanding topic of

philosophical (e.g., the *I,* "self as knower" and *me* "self as known," James (1890/1950)) and scientific inquiry. It has been suggested that the experience of a having a past self is predicated upon past actions that are at odds with current standards of behavior (Libby & Eibach, 2002). The emergence of identity transformation has been demonstrated in addiction and recovery research as well as the 12-step literature. As was found in Shinebourne and Smith (2011), participants in the current study often contrasted their current selves with who they were in the past during their addiction, which was portrayed as dark and chaotic. This narrative of the changing self may be reflecting a process of disidentification with a past self that is associated with undesirable behavior inconsistent with who they are now or how they would react today (Libby & Eibach, 2002). It may be possible that changing one's environment and life circumstances, such as living in an Oxford House, may promote the development of a new recovery self-concept.

The findings regarding need fulfillment supported Maslow's (1954) hierarchy of universal needs, with basic needs given priority before attempting to address higher-order needs. The study participants, who were generally underresourced and unstably housed or homeless, were most concerned with the attainment of safe and stable housing prior to Oxford House entry. Over time as they stabilized, social and psychological needs became the dominating motivator to their behavior. Despite this evidence for a hierarchy of needs, participants were able to experience fulfillment of higher order needs even if basic needs had not been satisfied, which is consistent with the findings of the Tay & Diener (2011)

study. For example, some participants expressed satisfaction from social support received prior to resource stabilization. The variability in resource valuation found in the current study supports research demonstrating the impact of context and resource availability on the relative desire of needs (see Goebel & Brown, 1981). Several participants attributed finding certain resources more meaningful than others due to the lack of the resources in their life. The high value placed on sober friendships across participants was likely due to both the lack of an abstinent social network as well as the positive emotions that Tay & Diener (2011) found to be associated with the fulfillment of social needs.

Previous research demonstrated that high levels of 12-step involvement (e.g., Narcotics Anonymous (NA), Alcoholics Anonymous (AA)) coupled with Oxford House residency was associated with significantly better abstinence outcomes than involvement with either alone (Groh, Jason, Ferrari, & Davis, 2009). The authors speculated that this was due to shared guiding principles, namely social support, structure, abstinence, and self-direction. The current study also found evidence regarding this overlap of principles and/or values. One potential mechanism through which shared principles lead to significantly better abstinence outcomes is that they allow residents to practice translating them into action. One participant had remarked that there were many people who went to 12-step meetings and related that they were working their steps and following the 12-step traditions; however, there was no way to be certain whether they were being truthful because they were not being monitored outside of the meetings. Oxford House, on the other hand, provides the opportunity for people to observe

one another in their home environment on a consistent basis, which increases the likelihood that inconsistencies between word and action will be uncovered. It is also possible that the common principles indirectly promote recovery though alterations in length of stay in Oxford House. All of the participants in the current study were actively involved in AA or NA, although their level of involvement was unknown, and half of the participants referenced 12-step sayings during their interviews when discussing their recovery. For some, it appeared that these mantras were used to help overcome challenges encountered in Oxford House (e.g., personality conflicts, compromising with others) and served as conduct guidelines that went beyond the basic rules laid out by Oxford House. The values emphasized in AA of letting go of resentments, not allowing others to affect your recovery, making amends, and being of service (Alcoholics Anonymous, 2001) contribute to prosocial behavior that promotes harmony through tolerance, patience, generosity, and respect for others. It may be that higher involvement in AA is associated with more prosocial behavior, which leads to better conflict resolution and prosocial behaviors and less instances of premature Oxford House departure. Future research should examine these associations to better understand the relation among high 12-step involvement, conduct, and Oxford House length of stay.

The study should be interpreted in light of several limitations. Sampling was not completed as proposed because the parent study did not obtain permission to contact participants for future research opportunities. As a result, potential participants could only be told about the study during the course of a regularly

scheduled follow-up interview in the parent study. This resulted in convenience and snowball recruitment, which limited the pool of potential participants. Additionally, the limitations on participant contact in the parent study proved to be a barrier in the identification of a participant for member-checking. Nonetheless, the themes were consistent across participants in geographically distinct areas, suggesting that modification in sampling would not have considerably impacted the findings. Despite the inability to engage in member-checking, quality was addressed by the other methods outlined (e.g., debriefing, adherence to Yardley (2000) guidelines). Furthermore, rather than using qualitative statistical software to facilitate data analyses, analyses were instead conducted similarly to the manner recommended by Smith et al. (2009) to facilitate data immersion and ensure the emergent themes reflected the participants' original text. Another study limitation was the large sample size and scope of the study for the IPA framework. IPA is suited for smaller sample sizes due to its emphasis on in-depth analysis. Having a large sample size, coupled with several research questions, limited the ability to allow the particulars of the participants' experience to surface. Considerable time was spent attempting to find the best balance of depth and generalities while attempting to answer the research questions. Despite the objectives of the study being broadly achieved, much of the analysis was focused on a more descriptive level rather than the linguistic or conceptual levels due to limited resources and time. Given the richness of the data collected in this study, future research should isolate and examine each of the major components of this study in more detail with a smaller

number of participants. This would likely yield more robust findings regarding the particularities of the subjective experience within Oxford House within the context of participant history and current circumstances. Future studies should also examine the impact of need fulfillment, resource deficiency, and expectation management on resident tenancy in larger samples to investigate whether the observed relationships are generalizable. Finally, the findings in relation to the recovery-oriented communal living should be interpreted with caution. As was previously mentioned, the social networking and support within the house is not a requirement of Oxford House and is also limited by the characteristics, skills, and temperament of the cohort in the house. Given the small sample size of the current study, it is possible that the social support and peer skill acquisition varies in quality across houses.

The findings of the study have several practical implications for improving the subjective experience of Oxford House and increasing the likelihood they will stay long enough to receive the therapeutic dose. This study demonstrated that many aspects of the governing structure and abstinence social support are perceived to be associated with recovery. It is likely that underresourced people might have a more positive experience due to the increased value placed on aspects that were absent in their life prior to Oxford House entry. Given that Oxford House was associated with most of the unrelated resources acquired while in the home (e.g., securing employment, getting a car), it stands to reason that those who had more to gain would perceive Oxford House more favorably and become more invested. Thus, people with more resources or less to gain may not

be as satisfied with Oxford House or may be less motivated to deal with the negative aspects of the experience. Increasing their investment in Oxford House may increase the value they place on the experience. Based on study results, encouraging involvement in the house governance (i.e., holding a position such as secretary in the house) and chapter service may help to incentivize these people to stay engaged long enough to achieve the therapeutic dose. For example, the only participant who related that she was not entirely ready to get clean at Oxford House entry indicated that being elected into a service position one month into her stay showed "… me that, you know what, maybe this is the place for me. Maybe I do need to just stick this out, and um and just stay where I need to stay." Taken together with past research demonstrating favorable outcomes when residents have at least once friend in the house (Jason et al., 2012), finding ways to promote the development of friendships would also likely increase investment and duration of stay in the house. Promoting group engagement in pleasant activities on a consistent basis (e.g., cooking, watching movies, going bowling) may facilitate and deepen bonds by fostering a sense of community and increasing positive interactions among one another. Future research should explore the activities that promote the development and deepening of bonds to increase the satisfaction and duration of stay within Oxford House. Educating people about the therapeutic dosage may be another factor that can keep people engaged and motivated to increase their length of stay. Several participants stated that they set length of stay goals based in part on the recommended dosage. Future research should examine the duration of stay for those who are higher resourced and explore what may

increase their desire to stay at least six months. Improving the subjective experience of Oxford House through expectation management may also be a feasible strategy for increasing length of stay. Providing general information regarding the functional aspects and minimal information on the non-mandatory but generally present social support may help instill hope without promising experiences that may not materialize (e.g., gaining close friendships, household harmony). Moreover, it may be prudent to include information regarding the adjustment process to prepare them for the inevitable temporary discomfort that will subside with persistence and effort. Otherwise, people may be surprised and discouraged with the difficult aspects of the process. Finally, the study findings suggest that those who attend 12-step groups may have a better experience managing their behavior and emotions in the house via adoption of values consistent with prosocial behavior. However, there is a segment of those in recovery who have an aversion to 12-step group participation. It is possible that these individuals may reap the benefits of value-driven behavior with evidence-based individual or group therapy (e.g., cognitive behavioral approaches). Future research should examine whether those receiving professional treatment in lieu of 12-step involvement demonstrate similar improvements in self-regulation and conflict resolution skills that allow them to better manage the difficult aspects of the house.

Previous research and the current study provide compelling evidence that Oxford House has the potential to fill the gap in affordable aftercare options for those in recovery. This self-sustaining model is a feasible alternative to costlier

traditional transitional housing options that have limited availability and time limits often resulting in discharge before sufficient stabilization is achieved. Oxford House can serve as a foundation that allows residents to build the social and economic capital necessary for independent functioning in the community in addition to paving the way for upward mobility. Given the many health and social problems linked to substance abuse, the importance of identifying viable evidence-based approaches to relapse prevention cannot be overstated.

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Appendix A

Interview Protocol

Hello, my name is [Interviewer]. Thank you for helping us with our research at DePaul University. The purpose of this interview is to learn what it is like to live in an Oxford House from the perspective of the residents.

I am going to record this interview so I can remember what you have said. Once I have transcribed the interview, I will destroy the recording. I want to remind that your participation in this study is voluntary. You can stop the interview at any time, or you can choose to not answer any question. If you do not understand a question and want me to say it another way, please let me know.

[*Ask clarifying and probing questions throughout the interview as needed, such as, "tell me more," "what do you mean by that" and "is there anything else you would like to add that we have not talked about."*]

[*Note. Use guide flexibly and allow for the participant to move through topics naturally. Just be sure to ask Questions 1-3 in order to limit priming and make sure the following topics are discussed:*
__Expectations
__Need fulfillment
__Decision-making process related to length of stay]

1. People find out about Oxford House in a lot of different ways. Can you tell me how you found out about Oxford House? [*What kinds of things did you hear about Oxford House? Who told you those things?*]

2. What influenced your decision to live in an Oxford House? [*Probe for influence of family, friends, stage of recovery*]

3. Tell me what it's been like for you to live in an Oxford House. [*Probe for thoughts and feelings associated with shared housing, house rules, house relational dynamics, impact on recovery.*]

4. What were you expecting to get from the Oxford House experience? [*What was the source of those expectations- previous experiences in recovery settings, family, friends*]

5. To what extent has Oxford House been what you expected it to be?

6. Tell me which aspects of the Oxford House experience have been most important for you. [*Why? Probe for functional aspects such as affordable, safe housing and psychosocial aspects such as social support, independence, etc.*]

7. Is there anything that you have needed in your recovery that Oxford House does not provide?

8. How long did you originally plan to stay in the Oxford House?

9. What kinds of things have you considered when deciding how long to stay? [*Probe for how they weigh these aspect, e.g., Tell me about what is most important when considering this decision.*]

10. Would you recommend Oxford House to a friend? [*Why or why not? What kind of person do you think would do well in an Oxford House?*]

11. Is there anything else important about your Oxford House experience that we have not talked about yet? [*Please tell me about that.*]