

MAINTAINING LASTING RECOVERY  
AFTER GRADUATING FROM A  
COLLEGIATE RECOVERY  
COMMUNITY

by

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## ABSTRACT

This phenomenological study sought to identify best practices employed by Collegiate Recovery Community (CRC) members who successfully stayed in recovery after graduating and leaving said community. Research was conducted through semi-structured interviews with CRC graduates that self-reported uninterrupted sobriety for at least one year post-graduation. Twelve interviews were conducted and nine tertiary themes were identified through content analysis. Two independent reviewers were utilized to eliminate potential bias, consciously or unconsciously from the researcher. The independent reviewers confirmed six of the nine originally identified themes. The six tertiary themes that were identified and confirmed were: *Maintaining Recovery Routines, Social Support, Personal/Peer Accountability, Motivating Emotions, Recovery/Life Balance, and Spirituality*. The results of this research provide insights into the best practices utilized by successful CRC alumni and inform the growing literature surrounding CRCs.

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## CONTENTS

ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	iii
LIST OF TABLES.....	vii
LIST OF FIGURES.....	viii
CHAPTER	
1 INTRODUCTION.....	1
Purpose of Study.....	3
Organization of Remainder of Thesis.....	5
2 REVIEW OF LITERATURE.....	6
Substance Use Disorders and Addiction.....	6
Treatment.....	8
Post-Treatment Recovery.....	10
Barriers to Recovery for College Students.....	14
Collegiate Recovery Communities.....	15
Example of Current CRC Model.....	16
CRC Success.....	17
3 METHODOLOGY AND PROCEDURES.....	19
Research Plan.....	19
Sample Selection and Interview Procedures.....	20
Data Coding and Analysis.....	23

4	RESULTS .....	26
	Interview Themes.....	26
	Conclusions.....	40
5	DISCUSSION.....	42
	Interview Themes.....	42
	Implications.....	48
	Limitations .....	49
	Future Research .....	50
	Conclusion .....	51
	REFERENCES .....	53
	APPENDICES	
	A Consent Form.....	58
	B Study Summary.....	62
	C Survey Instrument.....	64
	D Interview Script.....	66
	E Sample of Coding Spreadsheet.....	68
	F IRB Approval.....	71

## LIST OF TABLES

Table 1: Treatment Options for Substance Abuse .....	9
Table 2: The Twelve Steps of Alcoholics Anonymous .....	12
Table 3: Themes Identified by Researcher .....	27

LIST OF FIGURES

Figure 1: Web of Themes: Maintaining Recovery Routines ..... 28

Figure 2: Web of Themes: Social Support..... 31

## CHAPTER 1

### INTRODUCTION

Substance use disorders are an ever-increasing public health concern in the United States. Data from the 2013 National Survey on Drug Use and Health show that 21.6 million Americans - age 12 and older - met the criteria for substance abuse or dependence; 2.6 million for both alcohol and illicit drugs, 4.3 million for illicit drugs, 14.7 million for alcohol (SAMHSA, 2014a). In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), substance abuse and substance dependence were combined into a single disorder – substance use disorder – to be measured on a scale from mild to severe. This revision allows for each individual substance use disorder to be addressed more specifically based on severity. Alcohol Use Disorder, Opiate Use Disorder, and Stimulant Use Disorder are a few examples of substance use disorders (American Psychiatric Association, 2013).

Substance use disorders are steadily growing among college students. From 2002 to 2012, the number of college-aged individuals (18-29 year olds) receiving treatment for substance use disorders rose six percentage points from 28% in 2002 to 34% in 2012 (SAHMSA, 2014b). In a sampling of 18 to 24 year olds who admitted to treatment for a substance use disorder, over 3% (12,000 of 374,000) of those were college or postsecondary students (CBHSQ, 2012). American culture is growing increasingly more comfortable with substance use, thanks in part to movements like the legalization of Marijuana in some states (“Marijuana Resource Center,” n.d.). Over the past decade, the general public considers consuming alcohol a normal part of everyday life, especially during one’s time at college (NIAAA, 2006).

College campuses are environments where parental influence on individual students decreases while the influence of peers increases (Borsari & Carey, 2001). Further, many students enter college with a propagandized view of the college experience, one based upon the “college experience” they have seen portrayed by popular culture. Many try to play this role, which is merely their attempt to fit in. According to psychologists Baumeister and Leary, “human beings are fundamentally and pervasively motivated by a need to belong” (Baumeister & Leary, 1995, p. 522). The confluence of these factors – increased substance use, decreased public concern, increased availability to alcohol and other substances, and the basic human desire to belong - creates an environment where substance use inevitably breeds substance use disorders (Clifford, Edmundson, Koch, & Dodd, 2009; Moberg & Finch, 2008).

A primary role of a college administration is to ensure the health and safety of their students. Ultimately administration is faced with the need to offer safe, fun alternates for students that desire to forego the pop culture college experience of TV and movies. One group of students with the greatest need for this safe haven is those in recovery from substance use disorders. A 2012 study reported that approximately 12,000 of the 374,000 individuals aged 18 to 24 that received treatment for a substance use disorder were college or postsecondary school students (CBHSQ, 2012). These post-treatment, college students enter the collegiate atmosphere with the same trials of students not in recovery but with the additional challenge of avoiding relapse - “falling back into addiction” (Marlatt, 1984, p. 263).

In 1977, Brown University created the first Collegiate Recovery Community (CRC) to assist students in recovery during their time in college (White & Finch, 2006). Following the lead of Brown University, Rutgers University and Texas Tech University created their own recovery communities in the 1980’s, forever altering the collegiate landscape for students in

recovery (Greenagel, 2011; Harris, Baker, & Cleveland, 2010; White & Finch, 2006). A CRC is a community “of support and relapse prevention for college students recovering from addictive behaviors—primarily alcohol/drug addiction...in the college/university setting” (Harris, Baker, Kimball, & Shumway, 2008, p. 221).

Recent years have produced quality information and research investigating CRCs – including their structure, programming, relapse prevention, and academic performance (Cleveland, Harris, Baker, Herbert, & Dean, 2007; Harris et al., 2008; Harris et al., 2010; Laudet, Harris, Kimball, Winters, & Moberg, 2014). The results of these studies show that these programs are successful – assuming success is measured by the ability to prevent relapse during their tenure as a member of a CRC. For example, Texas Tech’s Center for the Study of Addiction and Recovery (CSAR) reported a low (4.4%) relapse rate as recent as 2007 (Harris et al., 2008).

Once a CRC student transitions out of college or university life, presumably after completing their degree, they suddenly find themselves alone in recovery. They have left the safety net, accountability, and peer-support of their CRC. There is currently no research on the post-graduation experiences of CRC students (e.g., relapse rates, coping skills). This study attempts to gain a better understanding of the behaviors and strategies CRC graduates use/used, which has enabled them to maintain their recovery long-term after graduation.

#### Purpose of Study

The collegiate environment has proven to be one of the more challenging environments for young people, but even more so for those in recovery. College campuses have long been difficult environments, and prior to Brown University in 1977, there were few resources available to support students with prior struggles with substance use disorders and to assist in

maintaining their recovery (Greenagel, 2011; White & Finch, 2006). At the time of this study, there are currently more than thirty-five CRC programs at universities around the country that are members of the Association of Recovery in Higher Education (“Recovery Programs”, 2015). These programs have a proven track record of relapse prevention for college students, while allowing students in recovery to have a normal college experience, within an extremely challenging environment (Cleveland et al., 2007; Harris et al., 2008). Upon graduation from college – and leaving their CRC – students’ recovery holds two distinct possibilities: maintain long-term recovery or relapse.

The purpose of this phenomenological study was to uncover the common strategies, techniques, and/or approaches employed by CRC graduates who have maintained lasting recovery after graduation. Methods of inquiry included phenomenological reflection on data produced via one-on-one interviews. Although this study gathered the individual experience of many CRC graduates, the focus was on the common themes that arose from the sample population.

The goal of this project was to collect experiences of people living lives of long-term, post-graduation recovery, in order to shed light on the subject of post-CRC life, ultimately offering faculty and students of CRCs a research-based resource to turn to when faced with the uncertainty of life after graduation.

#### Research Question

The body of research surrounding the post-graduation lives of student members of CRC programs is scant. Accordingly, statistics such as post-graduation relapse of CRC students are unknown. Such information could prove difficult to obtain due to the negative connotations associated with relapse and a student’s unwillingness to report this status. However, this research

focused on members of CRCs that have maintained continued sobriety for at least one year post-graduation. The following research question was posed: What best practices do Collegiate Recovery Community members utilize on an on-going basis to maintain their recovery, long-term, post-graduation?

#### Organization of Remainder of Thesis

The remainder of this thesis is presented in four chapters. Chapter 2 presents a literature review, examining previous research regarding substance abuse, substance abuse treatment, barriers to collegiate recovery, and CRCs. Chapter 3 explains the research methodology used to for this study. Chapter 4 presents the themes extracted from qualitative interviews and the findings from the quantitative survey. Together, Chapter 4 and Chapter 5 offer a discussion of the results, implications for research and practice, limitations of this study, and recommendations for future research.

## CHAPTER 2

### REVIEW OF LITERATURE

The primary goal of this study is to add to literature in the field of substance use treatment and recovery, with a special emphasis on Collegiate Recovery Community (CRC) graduates and their recovery maintenance techniques. In the absence of literature on post-CRC life, literature regarding substance use disorders, treatment, and CRCs is outlined below. These topics will create a better understanding of the community of those in active addiction and/or recovery, barriers presented by the collegiate environment, and a detailed look into CRCs, their structure, and success.

#### Substance Use Disorders and Addiction

In 2013, approximately 4.1 million American men and women sought treatment for a substance use disorder, which constituted roughly 1.3% of the U.S. population at the time (“Annual Population Estimates”, 2013; SAMHSA, 2014a). As described earlier, the term “substance use disorder” replaced the terms “substance abuse and substance dependence” in the DSM-5 and encompasses a variety of specific sub-sets of use disorders such as Alcohol Use Disorder. Some of the key criteria of a substance use disorder according to the DSM-5 are: failure to perform responsibilities due to substance use, a physiological tolerance to the substance, cravings for the substance, and failing to stop use despite multiple attempts to quit (American Psychiatric Association, 2013).

As an example, Alcohol Use Disorder can be diagnosed as mild, moderate, or severe. The number of symptoms present determines the distinction between mild, moderate, or severe for

the individual. The DSM-5 lists 11 possible symptoms of Alcohol Use Disorder, and for an individual to be diagnosed with mild Alcohol Use disorder they must possess two to three of the 11 symptoms. For an individual to be diagnosed with moderate Alcohol Use disorder they must possess four to five of the 11 symptoms. For an individual to be diagnosed with severe Alcohol Use disorder they must possess six or more of the 11 symptoms (American Psychiatric Association, 2013).

The change also allows health care professionals a more precise approach for the individual treatment of each use disorder instead of looking for general characteristics of overarching substance abuse or dependence. Prior to the consolidation of terms into substance use disorder, substance dependence was also commonly referred to as addiction, expanding on the definition of substance abuse to include previous definition in that, the user continues to use in light of negative life consequences *and* is both mentally and physically dependent on the substance (Keen, 2012). The National Institute on Drug Abuse defines addiction as “a chronic, relapsing disease characterized by compulsive drug seeking and use despite harmful consequences as well as neurochemical and molecular changes in the brain” (“The Science of Drug Abuse and Addiction: The Basics,” 2014).

It also is important to note the distinction of addiction as a disease (Center for Substance Abuse Treatment, 2004). This disease is influenced by a combination of genetic and environmental factors, that – when coupled with the effects of abused substances – can lead from occasional use to full-blown addiction (Kreek, Nielsen, Butelman, & LaForge, 2005). The opinion currently held by researchers in the field of medicine is that dependence on drugs or alcohol is a long-term illness, no different than illnesses such as asthma or diabetes (“The Science of Drug Abuse and Addiction: The Basics,” 2014). Further, like other brain diseases,

behavioral and social factors complicate this disease and its treatment (Leshner, 1997).

Therefore, the disease of addiction must be treated using a variety of methods.

## Treatment

The complex, multifaceted disease of addiction affects a person physically, behaviorally, and socially; therefore, treatment must be tailored to each person affected (“The Science of Drug Abuse and Addiction: The Basics,” 2014). There are many ways an individual can recover from addiction. Some individuals are able to stop use on their own and maintain a lifetime of recovery. However, the data show that many require more involved forms of treatment to overcome their addiction. While the forms of substance use disorder treatment vary greatly, there are three common categories of treatment that are most commonly recognized and utilized: ambulatory, detoxification, and rehabilitation/residential (SAMHSA, 2014b). These three categories are described in Table 1.

Historically, the conceptual model of addiction treatment believed to be sufficient involved one treatment episode: evaluation, treatment, and discharge (Dennis & Scott, 2007). However, more than 50% of individuals involved in one treatment episode will require multiple experiences with treatment before they are able to sustain long-term recovery on their own (Dennis, Foss, & Scott, 2007). Majority of Americans in recovery will relapse (i.e., fall back into a former state of compulsive behavior or misuse of alcohol and/or drugs) within one year of leaving treatment (Bond, Kaskutas, & Weisner, 2003). “The progress of many patients is marked by cycles of recovery, relapse, and repeated treatments, often spanning many years...” (Dennis & Scott, 2007, p. 45).

Table 1.

*Treatment Options for Substance Abuse (SAHMSA, 2014b, p. 39)*

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Category 1: Ambulatory	
Outpatient	Ambulatory treatment services including individual, family, and/or group services; these may include pharmacological therapies.
Intensive outpatient	As a minimum, the client must receive treatment lasting two or more hours per day for three or more days per week.

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Category 2: Detoxification	
Free-standing residential	24-hour per day services in a hospital setting for safe withdrawal and transition to ongoing treatment.
Hospital inpatient	24-hour per day medical acute care services in a hospital setting for detoxification of persons with severe medical complications associated with withdrawal.
Ambulatory	Outpatient treatment services providing for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological).

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Category 3: Rehabilitation/Residential	
Short-term	Typically, 30 days or less of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency.
Long-term	Typically, more than 30 days of non-acute care in a setting without treatment services for alcohol and other drug abuse and dependency; this may include transitional living arrangement such as halfway houses.

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Falling back into active addiction, post-treatment, is a burden to both the individual and society in terms of public health and safety risks. Therefore, the literature suggests it is critical to continue to build on an individual's initial recovery and implement sustainable methods of post-treatment recovery (Bond et al., 2003; Ferri, Amato, & Davoli, 2006; Moos and Moos, 2006a; Pagano, Friend, Tonigan, & Stout, 2004; Tonigan, Miller, & Connors, 2000).

## Post-Treatment Recovery

In 2007 the Betty Ford Institute defined recovery as “Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship.” (Betty Ford Institute, 2007, p. 221). Various forms of substance use disorder treatments strive to provide an environment where individuals with newly found recovery may strive to attain *sobriety, personal health, and citizenship* (Betty Ford Institute, 2007), in a safe, structured environment. This assisted recovery is an important phase in the transition from addiction to long-term recovery. However, once an individual completes his or her chosen treatment, they are faced with post-treatment recovery. Post-treatment recovery is arguably the most critical component of any substance use disorder treatment plan.

Previous research concludes that substance use disorder treatment alone does not effectively yield long-term abstinence from addiction (Bond et al., 2003; Harris et al., 2010). However, there is increasing evidence to show the combination of substance use disorder treatment in combination with active participation in a mutual-help group (e.g., Alcoholics Anonymous or SMART Recovery) increases an individual's likelihood to remain abstinent in the long-term (Alcoholics Anonymous, 2001; Ferri et al., 2006; Kelly, Stout, Zywiak, & Schneider, 2006; Moos & Moos, 2006a; Steinberger, 2004; Tonigan et al., 2000). These aforementioned mutual-help groups allow individuals in the early stages of recovery to join a group of like-minded individuals, with the common goal of maintaining recovery (Ferri et al., 2006; Kelly et al., 2006; Moos & Moos, 2006a; Tonigan et al., 2000). Mutual-help groups have some “treatment-like” features, as well as similarities to other social groups (Humphreys & Noke, 1997).

Post-treatment support such as mutual-help groups are advantageous for individuals in recovery as the groups provide a focus on recovery, are widely available, cost free, and have no pre-requisites to join other than a desire to get better (Alcoholics Anonymous, 2001; Kelly et al., 2006; Steinberger, 2004). There is evidence of the effectiveness of changing social networks and embracing a mutual-help group for those in recovery (Bond et al., 2003; Ferri et al., 2006; Litt, Kadden, Kabela-Cormier, & Petry, 2007; Pagano et al., 2004; Tonigan et al., 2000). Additionally, those who actively participate in helping others in recovery via a mutual-help group increase their own likelihood of sustaining long-term abstinence (i.e., staying in recovery) (Pagano et al., 2004). Two popular mutual-help groups are 12-step programs (e.g. Alcoholics Anonymous) and SMART Recovery programs.

#### 12-step Programs (Fellowships)

A 12-step program is a set of guiding principles, which establishes a framework for confronting a plethora of specific problems including alcoholism, drug addiction, and other compulsive behaviors (VandenBos, 2007). In 1935, two self-identified alcoholics established the seminal 12-step program, Alcoholics Anonymous (AA). AA was the first mutual-help group to propose the Twelve Steps (Table 2) as a method of recovering from alcoholism (Alcoholics Anonymous, 2001; VandenBos, 2007). The original Twelve Steps were published in the book *Alcoholics Anonymous: The Story of How More Than One Hundred Men Have Recovered from Alcoholism*; commonly referred to as “the Big Book of Alcoholics Anonymous” or simply “the Big Book” (Alcoholics Anonymous, 2001). AA and its literature paved the way for numerous other “Anonymous” 12-step groups – known as fellowships – to be patterned after AA.

Table 2.

The Twelve Steps of Alcoholic Anonymous (Alcoholics Anonymous, 2001, p. 59-60)

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- Step One: We admitted we were powerless over alcohol—that our lives had become unmanageable.
- Step Two: Came to believe that a Power greater than ourselves could restore us to sanity.
- Step Three: Made a decision to turn our will and our lives over to the care of God as we understood Him.
- Step Four: Made a searching and fearless moral inventory of ourselves.
- Step Five: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
- Step Six: Were entirely ready to have God remove all these defects of character.
- Step Seven: Humbly asked Him to remove our shortcomings.
- Step Eight: Made a list of all persons we had harmed, and became willing to make amends to them all.
- Step Nine: Made direct amends to such people wherever possible, except when to do so would injure them or others.
- Step Ten: Continued to take personal inventory, and when we were wrong, promptly admitted it.
- Step Eleven: Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
- Step Twelve: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.
- 

In 1953, the first derivative 12-step program, Narcotics Anonymous (NA), was established. NA was granted permission to use the framework of AA to create a mutual-help group, tailored specifically to drug addicts (Narcotics Anonymous (Ed.), 2008). The following is excerpt from NA fellowship-approved literature, “Staying Clean on the Outside,” summarizes the key principles and practices of 12-step programs.

It is never too early to establish a personal program of daily action. Taking daily action is our way of taking responsibility for our recovery. Instead of picking up that first drug, we do the following:

- Don't use, no matter what
- Go to an NA meeting
- Ask your Higher Power to keep you clean today
- Call your sponsor
- Read NA literature
- Talk to other recovering addicts
- Work the Twelve Steps of Narcotics Anonymous

(Narcotics Anonymous (Ed.), 2007, p. 40)

#### SMART Recovery

SMART Recovery (Self Management and Recovery Training), organized in 1994, is another mutual-help group framework. SMART Recovery uses a secular, scientifically based approach utilizing the techniques of Motivational Enhancement Therapy (MET) (Miller, 1995), Cognitive Behavioral Therapy (CBT), and Rational Emotive Behavior Therapy (REBT) (Steinberger, 2004). SMART Recovery boasts the scientific validation of its treatment methods (Steinberger, 2004).

Like 12-step programs, SMART Recovery meetings are free of charge. Meetings are led by volunteer facilitators and are intended to be informational as well as supportive. Online resources are also available for volunteer facilitators and participants; including daily online meetings (Steinberger, 2004).

The SMART Recovery program emphasizes “the 4-Point Program:” Building Motivation; Coping with Urges, Problem Solving, and Lifestyle Balance (Shaw, Ritvo, & Irvine, 2011). SMART Recovery is often referred to as an alternative to 12-step groups. However, it does not exclude or dismiss 12-step programs. SMART Recovery believes that each individual’s journey to recovery is unique; which could include attending 12-step meetings. In such cases, SMART Recovery suggests using *The SMART Recovery Handbook* to supplement the individual’s 12-step program (Miller, 1994; Steinberger, 2004; Volpicelli & Szalavitz, 2000).

### Barriers to Recovery for College Students

The increasing population of post-treatment young people (SAHMSA, 2014b) coupled with the “pro-drug culture” (Bell et al., 2009) of college campuses today presents an issue for these students entering college (Cleveland et al., 2007). College students in recovery face the same daunting obstacles entering college that normal students (students not in recovery) face, along with the added pressure of avoiding relapse into their addiction (Harris et al., 2010). These students must learn to live on their own, create and maintain educational goals, develop healthy relationships with their peers, and find a group for social support all while trying to maintain abstinence in a hostile environment (Borsari & Carey, 2006; Laudet et al., 2014). Previous research suggests that there is something about the collegiate environment that increases the prevalence of the misuse of alcohol and illicit drugs (Harris et al., 2008).

The National Survey on Drug Use and Health reported that the rate of illicit drug use for full-time college students was 21.6% in 2013 (SAMHSA, 2014a). For the same population 40% were binge drinkers (i.e., having 5 or more drinks on the same occasion on at least 1 day in the 30 days) and 14% were heavy drinkers (i.e., consumed 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days) (SAMHSA, 2014a). The prevalence of such alcohol

and drug use within the college environment not only presents problems for students academically, but also presents many unwanted physical dangers (e.g., injury, physical assault, unsafe sex) (Hingson, Heeren, Zakocs, Kopstein, & Wechsler, 2002).

### Collegiate Recovery Communities

The convergence of both drug and alcohol abuse statistics continuing to trend upward (SAMHSA, 2014a) and negative academic and physical effects of these behaviors to students, colleges are being forced to look into ways to support students in addiction and recovery (Harris et al., 2008). While focus may be initially placed on students' inpatient or outpatient treatment, the research community has given little to no attention to students' lives after treatment (Harris et al., 2008). In response, colleges across the country implemented Collegiate Recovery Communities (CRCs) since the 1980s ("ARHE," 2015; Greenagel, 2011; Harris et al., 2010).

CRCs are sustained communities of peer support that promote abstinence from alcohol and other drugs for students in recovery (Harris et al., 2008). These communities allow students to interact with other students in recovery on both the micro (interpersonal relationships) and macro level (community involvement) (Harris et al., 2010) to attain educational, personal, and professional goals (Harris et al., 2008). On the surface, CRCs across the U.S. (e.g., Center for the Study of Addiction and Recovery, Alcohol & Other Drug Assistance Program, StepUP) may appear different from one another based on the organization they are affiliated with (Harris et al., 2010), but the main goal of a CRC remains generally the same: to provide a safe place of support for students in recovery, within the collegiate environment (Cleveland et al., 2007; Greenagel, 2011; Harris et al., 2008; Harris et al., 2010; Laudet et al., 2014).

## Example of Current CRC Model

One such CRC was established at Texas Tech University in 1986 and is housed within the Center for the Study of Addiction and Recovery (CSAR) (Harris et al., 2008). In order to support their students, the staff of the CSAR requires CRC members to fulfill six components of the CSAR program. These six components are seminar, participation in a mutual-help group, participation in CRC self-governance, weekly “Celebration” meetings, maintaining academics, and minoring in Addictive Disorders and Recovery Studies. This basic structure holds the community together and links the CRC to the CSAR (Harris et al., 2008).

The first of the six components requires CRC members to sign up for one hour of “seminar” per semester. Seminar (formally known as Community Service Seminar) is a time where students can interact in a staff-supervised atmosphere. Here students are able to discuss issues with their recovery, academic struggles, or anything else pertinent to their life (Harris et al., 2008).

The second component requires students to participate in the mutual-help support groups of their choosing. The staff does not dictate which of the various groups students must attend, but they do make space available for these meetings to occur within the CSAR if needed. It is also important to note that CSAR staff does not facilitate these meetings, but rather the CSAR students themselves lead each meeting (Harris et al., 2008).

The third component requires that the CRC is a self-governing student organization. The name of the governing body for the Texas Tech CRC is the Association of Students About Service (ASAS). ASAS is recognized within the Student Government Association at the university and along with governing the CRC, one of their main goals is to give back via community support (Harris et al., 2008).

The fourth component of the Texas Tech CRC is attendance to the weekly “Celebration of Recovery” meeting. This is a meeting held each Thursday that follows a 12-step format. This meeting is an open meeting and allows members of the CRC and members of the community to celebrate individual student recovery milestones together (Harris et al., 2008).

The fifth component focuses on the CSAR’s stance on academic success. If a student has one full year of abstinence from their addiction, three letters of recommendation, and has met the requirements to be a student in good standing of Texas Tech University, they become eligible to receive financial assistance from the CSAR in the form of a scholarship. All students initially receive \$500, but may earn more each semester based on academic success measured by grade point average (GPA) (Harris et al., 2008).

The final of the six components requires that students must at least minor in Addictive Disorders and Recovery Studies. For this 18-hour minor, CSAR developed curriculum, which allows the student to be certified as a Licensed Chemical Dependency Counselor in the State of Texas upon graduation. It also provides important education on addiction that most students do not experience (Harris et al., 2008).

#### CRC Success

Data to support the success of the aforementioned CRC model above appear promising. Academically, students in the CRC at Texas Tech had an average GPA of 3.18, which is noticeably higher than the GPA of the overall undergrad population (2.93) at the university (Cleveland et al., 2007; Harris et al., 2008). Further, they reported a relapse (“any use”) rate per semester between 4.4% and 8% (Cleveland et al., 2007). With a mean relapse rate of around 6%, this demonstrates that the CRC at Texas Tech has provided successful support to 94% of their students in recovery. This statistic is even more powerful when you compare it to the relapse

rates in standard (non-CRC) recovery situations. One study showed a relapse rate estimated between 20-80% (Moos & Moos, 2006b) while another cited a 25-50% relapse rate (Fiorentine, 1999); there is no follow-up data published.

In summary, this review of the literature was able to determine that the U.S. has a problem with substance abuse in the general population, and it is increasingly affecting the college student population. Further, the college student population is especially vulnerable due to the high-risk environment in which they intend to remain in recovery. CRCs are on the forefront of this battle, giving students in recovery a safe place to thrive. CRCs have proven their ability to support students in recovery with extremely low relapse rates (Cleveland et al., 2007; Harris et al., 2008). However, there is no literature that describes what happens to students once they graduate and leave the safety net of their CRC and enter the real world. This thesis contributes to the literature by focusing on what strategies CRC graduates are using in the real world to maintain their recovery.

## CHAPTER 3

### METHODOLOGY AND PROCEDURES

The purpose of this study was to find best practices employed by Collegiate Recovery Community (CRC) members who successfully stayed in recovery after graduating and leaving said community. CRCs create a community of support for students in recovery where they can feel safe and supported *in a college environment*. This affords CRC students the opportunity to maintain their recovery in a safe, structured environment, while achieving a college degree (Harris et al., 2010).

However, a student's daily, personal relationship with their CRC is often severed upon graduation from their university. Further, at the time of this study, no data was available regarding CRC students post-graduation. Due to this lack of literature, this study investigated successful (at least one year of uninterrupted recovery, post-graduation) CRC graduates. Their post-graduation experiences were analyzed to identify a common set of "best practices" CRC alumni use/used to maintain long-term recovery. The University of Alabama Institutional Review Board (IRB) approved this study; all procedures for conducting research with human subjects were followed for this study.

#### Research Plan

This qualitative study utilized a phenomenological research approach. The phenomenological approach best suited this study due to the ability to utilize a small number of subjects (Moustakas, 1994), focus on individual experiences and how those experiences were experienced (Patton, 2005), and extract the "essence" of those experiences concerning a

phenomenon (Creswell, 2002). This afforded the opportunity to gain insight from a smaller group of CRC graduates.

The sample size for this study was 12. Each participant self-identified as a CRC graduate with at least one year of uninterrupted recovery, post-graduation. The experiences of this specific population are critical to the literature surrounding CRCs. Literature regarding CRCs, their structure, and their success has been established (Harris et al., 2010). However, the literature and research on CRCs and CRC student success stopped at graduation. This led to the question: What best practices do Collegiate Recovery Community students utilize on an on-going basis to maintain their recovery, long-term, post-graduation? This study provided an opportunity to produce a research-based answer to the literature, based on the analysis of the proven, personal practices of CRC students with at least a year of uninterrupted recovery, post-graduation.

#### Sample Selection and Interview Procedures

The initial pool of perspective participants was identified for recruitment via the faculty at various CRCs from around the United States. In order to qualify, participants must have been over the age of 19 years, graduated from a CRC, and had at least one year of uninterrupted recovery (i.e., sobriety without relapse into their addiction) since graduation. Recruitment started through the researcher's established network of faculty working at CRC programs throughout the United States. Email messages were used to contact faculty members at CRC programs. The researcher emailed each faculty member a summary of the study (Appendix B), which included criteria for participants, asking for referrals of successful alumni from their program.

The faculty members then reached out to their CRC alumni to garner interest from potential qualifying participants. Any interested participants were instructed to contact the researcher directly via email. Additionally, the researcher encouraged qualified participants that

consented to this study to refer other qualifying contacts that may be willing to participate; this method of referral is known as the snowball method (Creswell, 2002). The snowball method of sampling was advantageous for this study due to its ability to locate individuals of a niche population (CRC graduates) and posed no monetary cost to the researcher (Voicu & Babonea, 2011).

All potential participants that expressed interest in participating in this study made contact with the researcher via email. The researcher replied to each email with a consent form (Appendix A) to be read, signed, and returned. Consent was obtained before any other research procedures were conducted to ensure each participant understood the details of the study, what would be required of them, and their ability to discontinue participation at any time. Once the completed consent form was returned and checked for completeness, two methods of data collection (survey and interview) were utilized. In tandem, these methods allowed the researcher to analyze individual participant experiences and extract best practices based on the shared experiences of the group (sample population) (Creswell, 2002).

After consent was obtained, each participant was emailed a survey (Appendix C). The survey established a demographic profile of the sample; collecting information on participants' age, gender, race, marital status, number of children, employment, income, and highest level of education. All survey questions were closed-ended, multiple-choice questions. Participants completed the survey electronically and emailed it back to the researcher. Once each of these documents (consent form and survey) were signed and returned, a random number was assigned to that participant and all identifying information was struck from the documentation. A temporary key of participant names and assigned numbers was constructed to ensure any data collected could be de-identified and the correct number ascribed.

Once all paperwork was signed, returned, and de-identified, the researcher coordinated with each participant to establish a time to conduct an interview. The interviews were conducted via Skype – Internet-based video call software. This method of data collection was selected because it permits participants to answer open-ended questions from an interview script (Appendix D), ultimately allowing for deeper insight into the essence of their experiences (Creswell, 2002).

Prior to each interview, the researcher established a secure Internet connection in a secure, confidential location. The researcher then ensured all software was functioning properly before establishing a connection with the participant. Once a connection was established with a participant, the researcher introduced himself, briefly summarized the study, made sure the participant was comfortable being recorded, and reiterated that their participation was voluntary and may be ended at any time for any reason. Once the researcher felt confident that the participant was informed and willing, the researcher would initiate the recording and begin the interview.

The researcher utilized an interview script (Appendix D) to give consistent structure to the interview process. Though the interview structure was the same for all participants, the interviews varied in length from ten minutes to one hour, potentially due to the broad, open-ended nature of the questions and the received responses. For example, some participants confidently answered each question with longer, detailed examples, while others appeared to answer each question as quickly and succinctly as possible. It was during interviews with the latter that the researcher would slightly deviate from the script to prompt for clarification if he felt a question was not understood or answered fully. Once the participant answered the last question, the researcher stopped the recording.

Following the recording, the researcher thanked each participant for his or her participation and ended the call. The interview recordings were automatically saved at the end of each call. The researcher then converted each video recording into an mp3 audio file to be transcribed. Once all interviews were transcribed and de-identified by the researcher, all interview recordings and the temporary key of names was securely deleted. As a final measure of security, the files were securely deleted via 7-pass erase. 7-Pass Erase meets the US Department of Defense 5220-22 M standard (Frields, 1995).

### Sample Demographics

The sample consisted of eight Caucasian males, one Caucasian female, one Hispanic male, one Asian or Pacific Islander female, and one mixed race male. Eight of the twelve had no children and half were single. Their ages ranged from 19-24 year to 40 years and above category. All participants were employed and only two of the twelve worked part-time. Five of the twelve reported an annual income of \$40,000 - \$59,000, with three participants earning over \$100,000. All participants graduated from college and half of those went on to complete an advanced degree (i.e., Master's, Ph.D., etc.).

### Data Coding and Analysis

Data coding and analysis began following the completion of all surveys, interviews, and interview transcriptions. The researcher initially coded each interview and constructed a set of preliminarily identified themes. Following the researcher's preliminary coding, two blind reviewers followed the same coding process as the researcher, coding each interview into a set of themes. The primary researcher's themes were developed as the outline for the results of this study. The blind reviewers' themes were then utilized to eliminate any potential bias the researcher may consciously or unconsciously have had having conducted the interviews and

transcribed the interviews. Both blind reviewers were undergraduate students and neither had any prior connection to the research or researcher. The coding and analysis process is detailed in the upcoming paragraphs.

To begin the data coding process, the researcher and both blind reviewers coded (identified themes) each interview transcript following the method outlined by Bryman (2012). Once the researcher and the reviewers were finished coding, the researcher amassed all of the themes and generated a spreadsheet. The headings of the spreadsheet were: primary theme, two blank columns for possible secondary or tertiary themes, the participant's number, the reviewer's name, and the direct quote from the text which the primary theme was derived. This spreadsheet, once complete, allowed the researcher to sort the data by reviewer, participant, theme, or a variation of all three; Appendix E contains a sample from the aforementioned spreadsheet.

A method of qualitative analysis known as "thematic networks analysis" was utilized as the framework for organizing and condensing the primary theme data. Attride-Stirling (2001) described the process including basic themes, organizing themes, and global themes. The researcher deviated from the descriptive terminology utilized by Attride-Stirling (2001) in favor of his own terminology; Basic Themes became Primary Themes, Organizing Themes became Secondary Themes, and Global Themes became Tertiary Themes for the purpose of this study. As described by Attride-Stirling (2001),

A thematic network is developed starting from the Basic Themes and working inwards toward a Global Theme. Once a collection of Basic Themes has been derived, they are then classified according to the underlying story they are telling and these become the Organizing Themes. Organizing Themes are then reinterpreted in light of their Basic Themes, and are brought together to illustrate a single conclusion or super-ordinate theme

that becomes the Global Theme. Thematic networks are presented graphically as web-like nets to remove any notion of hierarchy, giving fluidity to the themes and emphasizing the interconnectivity throughout the network. Importantly, however, the networks are only a tool in analysis, not the analysis itself. Once a thematic network has been constructed, it will then serve as an organizing principle and an illustrative tool in the interpretation. (Attride-Stirling, 2001, pp. 389-390).

Once all primary themes were listed, verbatim, the researcher then grouped these primary themes into broader secondary themes. Once secondary themes were identified, the researcher was able to further condense the themes into a set of tertiary themes; Figures 1 and 2 visually represent this process (Attride-Stirling, 2001).

The tertiary themes were then sorted to include only those found by the researcher. These themes were analyzed to include the frequency with which they appeared across all interviews, the number of participants that identified each specific theme, and the number of blind reviewers that confirmed each specific theme. The most prominent themes were then analyzed, based on the research question, and conclusions and implications were drawn.

## CHAPTER 4

### RESULTS

The purpose of this study was to find best practices employed by Collegiate Recovery Community (CRC) members who successfully stayed in recovery after graduating and leaving said community. The following research question informed this study: What best practices do Collegiate Recovery Community alumni utilize on an on-going basis to maintain their recovery, long-term, post-graduation? During semi-structured interviews, the participants of this study described their experiences maintaining their recovery, post-graduation. Key themes emerged following the analysis of the interview transcripts. This chapter reports the research findings obtained from the participants' descriptions of their experiences maintaining long-term recovery.

#### Interview Themes

At the conclusion of this study, a total of 12 interviews were conducted with CRC alumni from various U.S. universities. Though the sample size was small, it was determined to be sufficient for the researcher to clearly decipher the rise of common themes. In qualitative research, this is known as “theoretical saturation” or the point in a study where the interviewer is no longer learning any new information from the interviewees (Strauss, 1994).

During the interviews, each participant articulated between 2 – 6 primary themes. Following the interview process, the researcher and two blind reviewers each identified their own set of primary themes. Each set of the primary themes was entered, verbatim, for each individual reviewer. These primary themes were condensed twice before arriving at a final set of

tertiary themes. Figure 1 and Figure 2 illustrate the researcher’s process of condensing primary themes to secondary themes and ultimately to tertiary themes.

Nine tertiary themes (Table 3) were discovered in all, however only six of the nine were confirmed by both blind reviewers. The tertiary themes that were identified and confirmed were: *Maintaining Recovery Routines, Social Support, Personal/Peer Accountability, Motivating Emotions, Recovery/Life Balance, and Spirituality*. The following sections will detail each of these themes.

Table 3.  
*Themes Identified by Researcher*

Theme	Frequency	Number of Participants Reporting	Number of Blind Reviewers Confirming
Maintaining Recovery Routines	48	12 of 12	2 of 2
Social Support	33	9 of 12	2 of 2
Personal/Peer Accountability	20	6 of 12	2 of 2
Motivating Emotions	16	6 of 12	2 of 2
Recovery/Life Balance	14	6 of 12	2 of 2
Spirituality	10	8 of 12	2 of 2
Service Work	9	6 of 12	1 of 2
Geographic Location	3	2 of 12	0 of 2
Counseling/Therapy	1	1 of 12	1 of 2

### Maintaining Recovery Routines

*Maintaining Recovery Routines* was the most frequently identified key component of recovery maintenance. Each of the 12 participants referred to *Maintaining Recovery Routines* at some point during their interview for a collective total of 48 times across all interviews; an average of four times per interview. This tertiary theme was formed from such primary themes as “making recovery a priority,” “utilize lessons learned in CRC,” and “continuity/routine.”

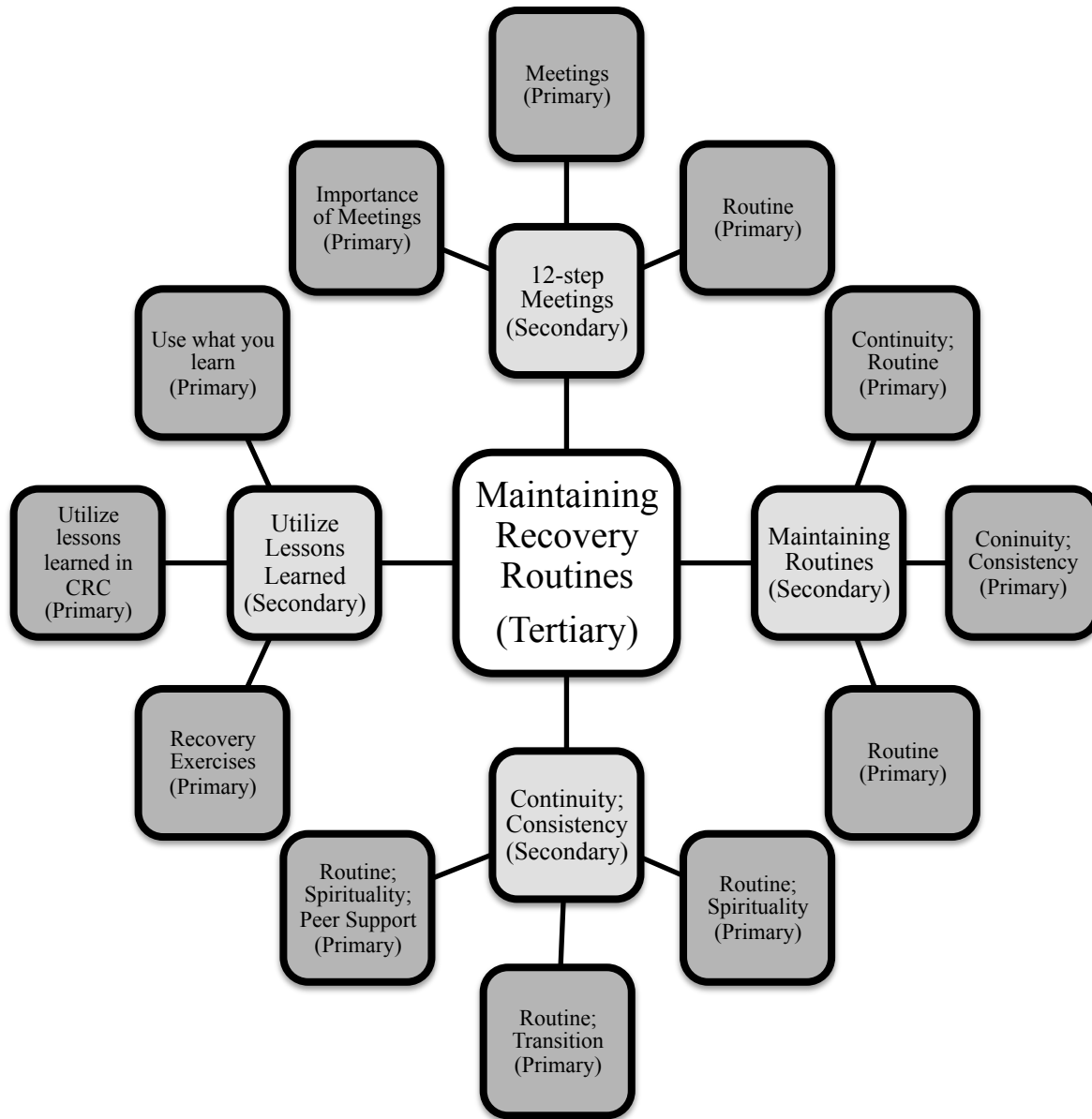


Figure 1. *Web of Themes: Maintaining Recovery Routines*

*Note.* The primary and secondary themes in Figure 1 are not an exhaustive list. They are a sampling of the data set to give a visual representation of how the themes were condensed.

The aforementioned primary themes, in context, were used to convey the importance of a routine, habit, or some form of lifestyle continuity that proved key to their recovery maintenance. Some participants specifically stated the importance of Maintaining Recovery Routines, habits, or “fluid continuity” as a key to long-term recovery maintenance. Participant 11 suggests staying in the same city as the CRC he graduated from in order to alter his life and routines as little as possible post-graduation.

Participant 11 is a 25-30 year old Caucasian male.

*But if circumstances allow, maybe stay in that city or college town where your CRC was just for a little, not forever, but just to keep things going to the same meetings, the same people, that kind of thing. Stay in touch with people. Do what you do. Do your meetings, meeting with your sponsor, service work, all of that stuff, any kind of spiritual practice. I think that was the big thing. I think my big worry was what am I going to do when I am not in a situation, I was in a situation where people are watching me and I have to go to meetings or I might risk getting kicked out. Things like that. What am I going to do. And by the time I left I was in a place where (a) it was just part of the routine and (b) there were things I wanted to do. So I think just keeping that kind of fluid continuity throughout is pretty helpful.*

However, other participants described specific routines that were either maintained or important to maintain. During the analysis of the primary themes, the researcher determined these examples fit into the larger heading of *Maintaining Recovery Routines*. A good example of a primary theme that appeared multiple times was “12-step Meetings.” Though participants talked specifically about meeting attendance, they described a routine that was developed in

early recovery and maintained throughout their recovery. Participants 9, 1, and 3 provide examples of such statements.

Participant 9 is a 30-35 year old mixed race male.

*Just continue doing the things I was doing while I was in there. Continue going to meetings, continue participating and really for me it was, like I said, it was kind of starting to do those things more so.*

Participant 1 is a 25-30 year old Caucasian male.

*I still sponsor guys. I still go through the book. I try to make at least three meetings a week. I have a home group. I sponsor newcomers. I spend time with newcomers. I hang out with people who are early in sobriety because it's good for me, it's good for them. I pray and I meditate and I have to take my recovery away from my work.*

Participant 3 is a 19-24 year old Caucasian female.

*So I graduated and three weeks later I moved to (City 1), (State 1) by myself. I did not know anybody down here, literally nobody. And the first thing I did was I went to a meeting because I was taught that that's what you do. So I went to meetings. I connected with people.*

Finally, some participants referred to *Maintaining Recovery Routines* that were mental, not physical. These participants discussed the importance of routinely utilizing various mental roadmaps, games, or lessons learned as a member of their CRC. Participant 6 describes a mental routine she maintained that proved important to her recovery.

Participant 6 is a 19-24 year old Caucasian female.

*I kind of have kept everything I learned and gained at (CRC program) in my undergraduate years; and I kind of live by those rules now.*

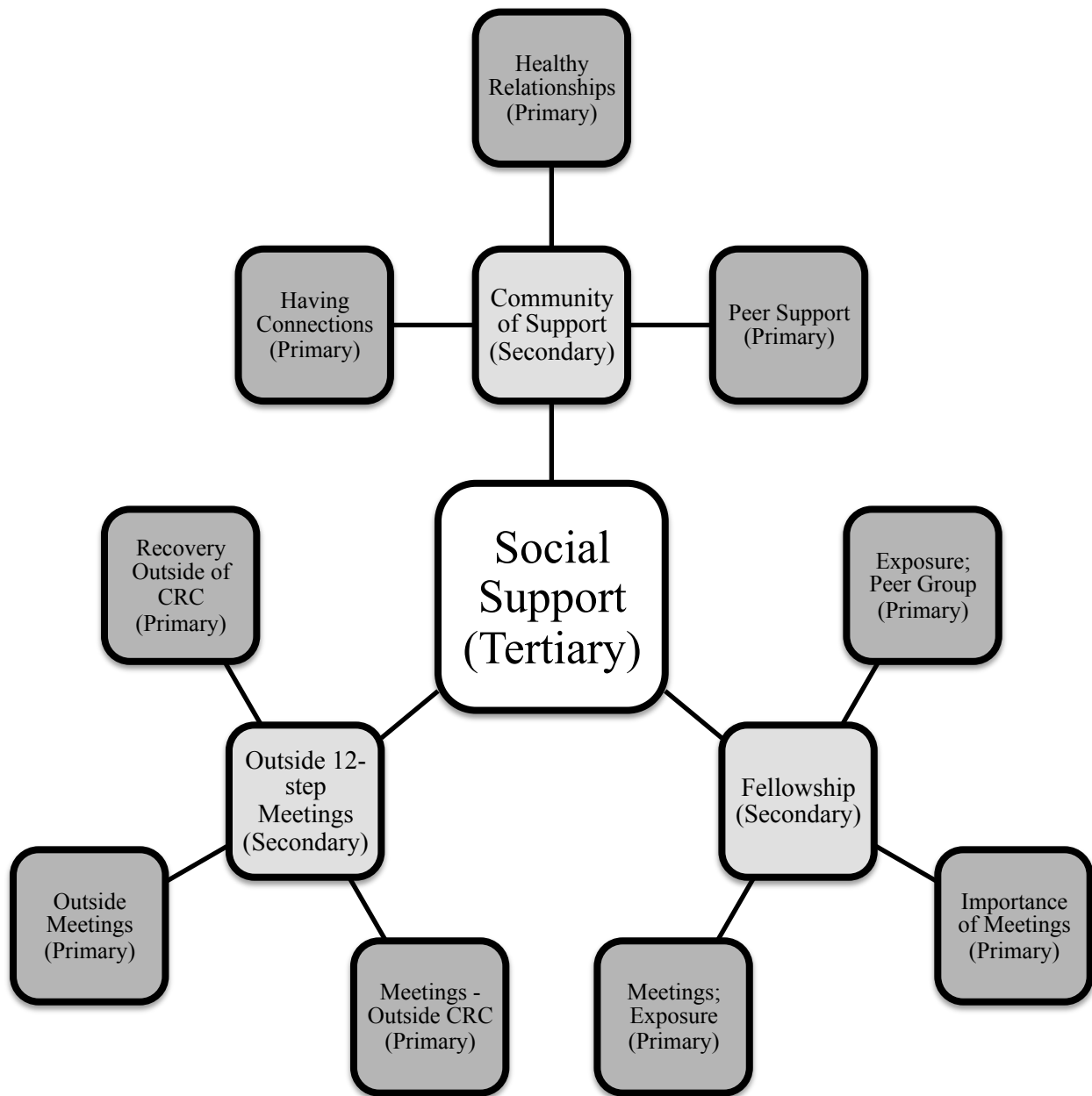


Figure 2. *Web of Themes: Social Support*

*Note.* The primary and secondary themes in Figure 2 are not an exhaustive list. They are a sampling of the data set to give a visual representation of how the themes were condensed.

## Social Support

*Social Support* was the second most frequently identified, key component of recovery maintenance. Nine of the 12 participants described the important role *Social Support* played/plays in their recovery. Identified a total of 33 times, this tertiary theme encompasses such primary themes as “healthy relationships,” “having connections,” “peer support,” “peer support - outside CRC,” and “fellowship.” Again, each of these primary themes, in context, demonstrated the key role that *Social Support* had on the participant’s long-term recovery maintenance.

The need for *Social Support* was described with varying levels of specificity and complexity among the nine participants identified. However, a commonality between all examples of *Social Support* was the idea this being social is not just going to fall into your lap. The participants describe the importance of actively seeking out opportunities to engage socially with those in recovery, as well as healthy people in general. Participants 10, and 7 discussed the important role that *Social Support* from other “addicts” or individuals in recovery play in their own recovery maintenance.

Participant 10 is a 25-30 year old Caucasian male.

*Reaching out, continuing to build relationships with addicts when you leave because most of the time people leave that town and go somewhere different. And so it is just about creating that fellowship and continuing to do the same things that we did in early sobriety, on a daily basis.*

Participant 7 is a 30-35 year old Caucasian male.

*You know, to be honest with you, I'm still in the process of building that network of people. It's a lot of the same as it always is - the same work I did when I first got in recovery. Its meetings, working with another alcoholic, and sponsor contact.*

Of the interviews identifying *Social Support* as a key component to recovery, Participant 4 was the most specific. He gave a very detailed actionable process, not limited to any specific type of person. The excerpt below was one of a few that the researcher and both reviewers highlighted and noted as very important. This passage was so specifically noted by the three reviewers that the researcher seriously considered making “Fab Five” a stand-alone theme.

Participant 4 is a 30-35 year old Caucasian male.

*I tell people all the time “Find your ‘Fab Five’”. Find the five people in your life that can hold you...and I don't care if they're in recovery or not...that can hold you accountable and can push you to be better, to be better every day. It's about keeping that core hub with your recovery because that comes first. If I use, I lose everything. Keeping those people in my life-the program, the sponsors, the steps, all that kind of stuff-but also bringing in people that can push me in other ways. People that can push me in being a better academic, people that can push me in being a better father, people that can push me into be better and stronger in my faith...that's what is important. As I branch out, its learning to...it's anchoring myself in the recovery community.*

#### Personal/Peer Accountability

The researcher identified *Personal/Peer Accountability* as a key component of recovery maintenance in six of the twelve participant interviews. This tertiary theme encompasses such primary themes as “sponsorship” and “accountability.” The related interview responses

conveyed the importance of being held accountable for your actions either by another individual in a mentor-type relationship or by holding oneself to a higher standard.

“Sponsorship” was the most referenced primary theme within the tertiary theme of *Personal/Peer Accountability*. The researcher considered leaving “Sponsorship” as its own individual theme due to the high frequency of times it was specifically referenced. However, the researcher determined that there were other primary themes that alluded to the same idea of internal or peer accountability.

Participant 7 is a 30-35 year old Caucasian male.

*Constant contact with a sponsor. I... something I heard early on that I've kind of stuck by, or live by, is “Are you telling somebody what you're thinking?” Not just anybody, somebody who is in recovery...and it doesn't always have to be somebody but...somebody who's in recovery that knows this way of life that you're trying to live-are you telling them what you're thinking? Because without that accountability - call it a sponsor, call it whatever-without that one person that I stay accountable to at least weekly.... My ideas sound awesome...until I run them by someone and they're like “Woah”. Like the “I'm lonely. I'm not making any friends” and hes like “What are you doing?”, ya know? So, I mean, definitely it would be accountability within sponsorship.*

Participant 8 is a 35-40 year old Hispanic male.

*You know, it's pretty easy I think. It's sponsorship outside the facility-sponsorship back home-where ever it is that you are going. It's almost like discharging from treatment. You want to have a discharge plan, a graduation plan, when you go home to stay sober because you're right-it is a safety net. I think going home, wherever it is you're going,*

*have a sponsor before you go home. That's it... because to me, sponsorship is the best thing that happened to me-it still is. In one word - sponsorship.*

### Motivating Emotions

*Motivating Emotions* was identified as a key component of recovery maintenance in six of twelve participants. The term “Motivating Emotions” was created by the researcher to describe the collection of emotions presented in the individual interviews that were credited with recovery maintenance. Identified a total of 16 times, this tertiary theme encompasses such primary themes as “gratitude,” “healthy pride,” “courage,” and “fear of disappointing others.” Over half of the participants stated a deeply held emotion that drove them to either maintain their recovery or avoid relapse. *Motivating Emotions* proved to be an effective tool to be used for day-to-day progress, as described by Participants 3 and 12 for examples of positive, *Motivating Emotions*, while Participant 8 describes how the fear of disappointment was a key factor for him. Participant 3 is a 19-24 year old Caucasian female.

*Be proud. Absolutely, 100%. Be proud, let the shame go, let the feelings that people aren't going to understand you, go. Because my experience when I left was that people are very understanding. People, even people who aren't in recovery. And by living in recovery and pride and not shame, it's much easier to get by day by day without the thoughts of using. It's much easier to function in anything that you do without constantly thinking I'm a drug addict and that's what's going to stop me from doing this. So, it is healthy pride about the fact that achieving recovery at a young age is an extraordinary fete because of the types of situations that we come from. And it's something that is valued and the lessons that we have from program and from recovery communities are actually extremely successful life skills.*

Participant 12 is a 25-30 year old Caucasian male.

*It has got to be an attitude of gratitude, man. It's just got to be an attitude of gratitude that you were sober through school and you got yourself a degree because you were sober and you had a place like that. I mean I just can't believe those kind of places exist in the first place. It's pretty weird and it's awesome. So to remain an attitude of gratitude about where you have come from, where you are going, and be grateful for the tools that were given to you to say you know what I have enough self worth, enough self confidence, enough mental faculties, and enough spiritual fitness because I went through kind of like a training program at one of these centers, like an "I'm getting ready for life" training centers. Attitude of gratitude, man. If I ever forget that I came from the center or if I don't show up... I just got a card in the mail today for their holiday dinner, scholarship dinner. They invited me back every year. I don't know why they do that. I'm not even in the center, but if I go every time I go I just get really immense amounts of gratitude for what they've done for me. And I'm just looking at them. I'm like, wow, this is crazy because all these people just keep coming through and they keep treating them all the same and just changing lives. It's a trip. I mean that's it – attitude of gratitude. Because there ain't a lot of people who went through school and had that kind of opportunity.*

Participant 8 is a 35-40 year old Hispanic male.

*I think I'm back. For me, it was my...I didn't want to disappoint anybody. I think it all started with (Sponsor's Name) when I didn't want to disappoint him...and then I didn't want to disappoint (CRC Director's Name)...and then I didn't want to disappoint the (CRC Program). They gave me a free education and someone like me is not supposed to graduate from college-much less high school. It wasn't so much that I was motivated to*

*do better - I was just scared to fail and fail them. I felt like if I failed I would lose that connection with the (CRC Program) and all of its members. That's one of the key components.*

#### Recovery/Life Balance

The researcher identified *Recovery/Life Balance* as a key component of recovery maintenance for six of the twelve participants. The researcher developed the phrase “*Recovery/Life Balance*” to describe the crucial practice of balancing an individual’s personal recovery outside of their work and life responsibilities. This tertiary theme referenced 14 times across all participants and was one of the few themes that remained unaltered from its primary theme. This theme was one of two themes that were not grouped or condensed into a tertiary theme.

Through the interview process, the researcher noted that many of the participants either currently or previously worked in the addiction/recovery-based field as counselors, CRC directors, etc. This produced many responses that stressed the utter importance of maintaining your recovery while taking care of family responsibilities. Participants 12 and 1 captured the essence of this theme in their interviews.

Participant 12 is a 25-30 year old Caucasian male.

*Well I tell you what, I don't know if this is a positive or a negative, but I went in to counseling. The center actually got me a job at a treatment center they are connected to outside of town, so I am always inundated with recovery lingo, meetings, sponsors, 12-step work, spiritual exercises, etc. etc. etc. The only problem with that is and I agree with this speaker I heard the other day said that I have a better chance of being a drug dealer and staying sober than I do being a person in recovery being an alcohol and drug*

*counselor. Because what happens is I can become unteachable or unsponsorable because all day long I am talking about this stuff, I am Mr. Know-It-All, blah, blah, blah and I go home and I'm like well that's what I did all day, I don't need to go do anymore of that. And see that's where the problem lies. So what I have had to do is, I've had to take serious service positions in my home group, like president of the club, so I have to be accountable and I have to show up even if I do not want to some times. And I have to do things like absolutely have these sponsees meet at these certain days. I don't care if we are going to have steaks or if my wife is feeling frisky, I have to go and do what I have to do. And that is because those kids count on me. Because my sponsor says my real job is not at the (Treatment Center), it's really when I clock off and that's my real job. My job at (Treatment Center) is just to pay the bills to be able to operate in the matrix. But off the clock, that's the important job. So meeting up with cats and going and doing HNIs and going on spiritual retreats to (City 1), (State 1), and stuff like that. That's what I really have to do. Because if I don't lose those I am just going to lose this other paid for job anyway.*

Participant 1 is a 25-30 year old Caucasian male.

*I worked for a treatment center so all day long I talked about treatment, I talked about recovery, and for a couple of months I was getting miserable inside because I wasn't going to as many meetings. I was slacking on many of the things that I was doing because I kind of looked at my job as like "Oh this is recovery work, blah, blah, blah". I started feeling like crap on the inside and really had to start making more time for me and for my meetings and setting boundaries and know that my job is a job. Very clearly – I get paid for the work that I do and then I have my own recovery. It was good that I experienced*

*that because I see a lot of people burn out in the position that I do. It was definitely an obstacle at first, but for me.... You know, I've been sober a little over eight and a half years. I still sponsor guys. I still go through the book. I try to make at least three meetings a week. I have a home group. I sponsor newcomers. I spend time with newcomers. I hang out with people who are early in sobriety because its good for me, its good for them. I pray and I meditate and I have to take my recovery away from my work. I also....I see people relapsing constantly just because of what I do. I do interventions also for a living so I see...I see all of this. So addiction is so...you become numb to it sometimes. For me, like, I become kind of numb to it, unfortunately. If I don't work my own solid program I can't...I can't relate. Since I do work my own program, I am very passionate about what I do but it took a long time for me to balance. Figuring out how to make a schedule and know what nights I can go to a meeting because it's all about having a schedule and when I am going to meet with my sponsees. Because I've got my work time, I've got my recovery, and I need some down time.*

### **Spirituality**

The researcher identified *Spirituality* as a key component of recovery maintenance for eight of the twelve participants. *Spirituality* was mentioned 10 times overall and was one of two themes that remained unaltered from its primary theme. Though it was not mentioned at the high frequency of the previous themes, *Spirituality* was referenced in over 60% of the interviews. The participants did not go into detail regarding *Spirituality* like some of the other themes. However, it was faithfully mentioned as a key to their success as seen in interviews with Participant 8, 1, and 5.

Participant 8 is a 35-40 year old Hispanic male.

*...and the other part was spirituality. I had a good connection with my Higher Power.*

Participant 1 is a 25-30 year old Caucasian male.

*I pray and I meditate...*

Participant 5 is a 35-40 year old Caucasian male.

*I had to stay in touch with my spiritual program.*

## Conclusions

The interviews conducted with CRC graduates with at least one year of uninterrupted recovery, post-graduation resulted in six tertiary themes: *Maintaining Recovery Routines*, *Social Support*, *Personal/Peer Accountability*, *Motivating Emotions*, *Recovery/Life Balance*, and *Spirituality*. The purpose of this study was to find best practices employed by CRC members who successfully stayed in recovery after graduating. The interview findings suggest that the best practices used by CRC graduates are not new or unheard of. The findings suggest that CRC students are being taught most of these practices in 12-step literature.

For example, practices such as *Social Support*, *Personal/Peer Accountability*, utilizing *Motivating Emotions*, and *Spirituality* are principles taught in 12-step literature. Further, though the importance of *Maintaining Recovery Routines* was never stated directly, this tertiary theme referred routine practices like “90 meetings in 90 days” or common phrases such as “keep coming back it – it works if you work it.” The interviews go on to establish the importance of establishing any individual best practices as a part of a routine.

The only practice that is not directly referred to in 12-step literature was the practice of finding *Recovery/Life Balance*. This practice was the only practice that was specific to life after graduation. While *Recovery/Life Balance* could potentially be a component of CRC life, the

participants of this study referred to this practice as something discovered post-graduation. This was the only “new” theme (not previously identified in the recovery literature) that arose from these interviews and gave insight into the importance of making recovery a priority in post-graduation life.

## CHAPTER 5

### DISCUSSION

The purpose of this study was to identify best practices employed by Collegiate Recovery Community (CRC) members who successfully stayed in recovery after graduating and leaving said community. Research was conducted through semi-structured interviews with CRC graduates that self-reported uninterrupted sobriety for at least one year post-graduation. This chapter reviews, analyzes, and discusses the findings of this study. This chapter also outlines implications of the findings for CRC staff and students and illustrates the potential impact for CRC students on the cusp of graduation. Following the discussion of the implications, the limitations of this study are discussed. Finally, suggestions for future research are offered.

#### Interview Themes

At the conclusion of this study, a total of 12 interviews were conducted with CRC graduates from various U.S. universities. Though the sample size was small, it was determined to be sufficient for the researcher to clearly decipher the rise of common themes. In qualitative research, this is known as theoretical saturation or the point in a study where the interviewer is no longer learning any new information from the interviewees (Strauss, 1994).

During the interviews, each participant articulated between 2 – 6 primary themes. The primary themes identified were entered verbatim from each individual reviewer. These primary themes were recorded and condensed into secondary, then tertiary themes. Figure 1 and Figure 2 illustrate how themes were condensed from primary to secondary to tertiary themes.

It was not the intent of the researcher to match the theme names with the literature. The researcher described the themes that emerged from the data and named them without consulting any literature. However, upon review of the literature, the researcher must acknowledge that some of the tertiary themes match or closely resemble terms in the literature. It was not the intent of the researcher to match these themes with any specific literature or prior research.

Nine tertiary themes (Table 3) were discovered in all, however only six of these themes were confirmed by both blind reviewers. The tertiary themes that were identified and confirmed were: *Maintaining Recovery Routines*, *Social Support*, *Personal/Peer Accountability*, *Motivating Emotions*, *Recovery/Life Balance*, and *Spirituality*. The following sections will discuss each of these tertiary themes individually.

#### Maintaining Recovery Routines

*Maintaining Recovery Routines* was the only theme that was identified by all 12 participants, the researcher, and both blind reviewers. This theme was identified 48 times in 12 interviews. Participants in all 12 interviews referred to consistently maintained routines they attributed to aiding in their long-term recovery maintenance. Both the interviews and literature indicate that *Maintaining Recovery Routines* is a crucial practice in recovery maintenance.

CRCs (Harris et al., 2008) and treatment centers (Kelly et al., 2006) alike utilize routines as a means of establishing an easily adopted pattern of recovery maintenance. This approach is effective due to its lack of expense (Kelly et al., 2006) and proven success if implemented (Litt et al., 2007). Positive recovery routines that are built into 12-step programs like Narcotics Anonymous are established in routines such as “Go to an NA Meeting,” “Call Your Sponsor,” and “Work the Twelve Steps of Narcotics Anonymous” (Narcotics Anonymous

(Ed.), 2007, p. 40). Participant 11 reiterated this point when he said, “*Do your meetings, meeting with your sponsor, service work, all of that stuff, any kind of spiritual practice.*”

The “Big Book” of AA and NA contain enough information on routines and *Maintaining Recovery Routines* to fill this section with quotes. However, the researcher believes that one of the most simple, recurrent, 12-step saying represents this theme best - “Keep coming back” (Alcoholics Anonymous, 2001, p. 334; Narcotics Anonymous (Ed.), 2008, p. 125). This sentiment was echoed throughout the interviews. Simply showing up on a consistent basis, making recovery a part of your lifestyle, was an easily implemented, universal key for all participants.

### Social Support

*Social Support* was identified by nine of the twelve participants, the researcher, and both blind reviewers. This theme was identified 33 times in 12 interviews. Participants referred to the need for fellowship and/or social interaction in any setting as a critical best practice for their long-term recovery maintenance. The literature and participant interviews also confirm *Social Support* as a vital component of recovery maintenance.

The need for *Social Support* was highlighted as one of the components of a 12-step program, which states the need to “talk to other recovering addicts” on a daily basis (Narcotics Anonymous (Ed.), 2007, p. 40). *Social Support* is also supported by both 12-step and SMART recovery literature regarding mutual-help groups and their ability to provide new, healthy social connections for individuals in recovery (Alcoholics Anonymous, 2001; Ferri et al., 2006; Kelly et al., 2006; Moos & Moos, 2006a; Steinberger, 2004; Tonigan et al., 2000). Research has shown that mutual-help participation, changing social networks (Bond et al., 2003; Ferri et al., 2006;

Litt et al., 2007; Pagano et al., 2004; Tonigan et al., 2000), and maintaining healthy social relationships with peers are proven recovery maintenance practices (Harris et al., 2008).

The interview participants repeatedly referred to “*creating that fellowship*” or “*continuing to build relationships*”. The researcher hypothesizes that, though it was not specifically stated, a major reason for the emphasis on *Social Support* was a positive way to say, “avoid isolation.” Individuals new to recovery can become isolated. Cutting out drinking or using drugs likely means cutting out a significant portion of an individual’s established social circle. Building these new, “healthy” relationships may seem miniscule, but the wisdom of those in long-term recovery recognized this near the top for a reason.

#### Personal/Peer Accountability

*Personal/Peer Accountability* was identified by six of the twelve participants, the researcher, and both blind reviewers. This theme was identified 20 times in 12 interviews. Participants primarily referred to participation in a sponsor/sponsee relationship as their form of *Personal/Peer Accountability*.

The 12-step literature and participant interviews also confirm the importance of *Personal/Peer Accountability* to individuals in recovery. As discussed earlier, “Sponsorship” was the most referenced primary theme within the tertiary theme of *Personal/Peer Accountability* (Alcoholics Anonymous, 2001; Narcotics Anonymous (Ed.), 2007). The researcher debated including the primary theme “sponsorship” under the heading of *Social Support*; however, the researcher determined a key difference between the two themes.

*Social Support* differs from *Personal/Peer Accountability* in the intention of the relationship. *Social Support* described a relationship with no real goal or motive – simply spending time with others individuals. A *Personal/Peer Accountability* relationship is defined by

intention and intensity. While a sponsorship relationship can be friendly and fun at times, their main purpose is to be a guiding, challenging, force of accountability for an individual.

### Motivating Emotions

*Motivating Emotions* was identified by six of the twelve participants, the researcher, and both blind reviewers. This theme was identified 16 times in 12 interviews. Participants discussed a range of emotions as both positively and negatively motivating factors.

The literature of Alcoholics Anonymous (2001) and SMART Recovery (Miller, 1995; Shaw et al., 2011) mention motivation or motivating emotions as positively supporting ones recover. For example, the foreword of the first edition of AA's Big Book states, "The only requirement for membership is an honest desire to stop drinking" (Alcoholics Anonymous, 2001). They do not require that you stop, but simply you possess the motivating emotion of desire. Gratitude was also another strong emotion that played a part in a few participants' recovery story. SMART Recovery utilized Motivational Enhancement Therapy (MET) in its programming and also contains "building motivation" as one of the keys to the 4-Point Program (Miller, 1995; Shaw et al., 2011).

Of the various motivating emotions referenced in the participant interviews, "fear of disappointing others" was most interesting to the researcher. The researcher hypothesized, prior to the study, that a newfound set of positive emotions would be identified as critical to recovery maintenance. While this was not identified, the negative *Motivating Emotions* of fear of failure or the potential for shame were equally as effective. Though it may not be discussed in as much detail, the positive effect of avoiding negative emotions such as fear can have just an equally important place in one's recovery maintenance.

## Recovery/Life Balance

*Recovery/Life Balance* was identified by six of the twelve participants, the researcher, and both blind reviewers. This theme was identified 14 times in 12 interviews. This theme was not altered from its original definition and title as a primary theme.

This theme, though not mentioned at the frequency of the other tertiary themes, stood out to the researcher as the most important. This is another theme that could have been included under the larger heading of *Maintaining Recovery Routines*. However, due to the number of specific examples that arose, it was determined that this theme was important enough to stand on its own.

The difference in this theme and the others is that it is not a main or commonly talked about principle in any 12-step fellowship. However, the SMART Recovery literature does support this theme. “Lifestyle Balance” is one of the components comprising the 4-Point Program (Shaw et al., 2011). The researcher also believes that this theme is really the only “new” information discovered in this study. The rest of the themes are simply restating the importance of things that are already established as important.

The researcher created this theme to describe the importance of balancing and prioritizing your recovery and your life responsibilities, especially for individuals working in the field of addiction and recovery. Anecdotally, the researcher notes that the CRC graduates gravitate toward jobs related to substance abuse, substance abuse treatment, etc. The interview participants shed an interesting light on the slow, but deadly trap of believing that you did not need to go to a meeting or call your sponsor because you work in the field. As Participant 12 stated, “*That’s what I really have to do. Because if I don’t lose those I am just going to lose this other paid for job anyway.*”

## Spirituality

*Spirituality* was identified 10 times by eight of the twelve participants, the researcher, and both blind reviewers. This theme was another theme that was too specific to group into another later theme. Though it was not discussed at length, over half of the participants mentioned prayer, meditation, or some Higher Power.

One of the defining characteristics of 12-step fellowships is the acknowledgement and reliance on some form of a Higher Power (Emotions Anonymous, 1994). The helpful concepts section of Emotions Anonymous (EA) explains, “The steps suggest a belief in a Power greater than ourselves. This can be human love, a force for good, the group, nature, the universe, God, or any entity a member chooses as a personal Higher Power” (Emotions Anonymous, 1994, p. 232).

SMART Recovery, on the other hand, boasts a secular, scientific foundation and does not consider spirituality to be a contributing, measurable factor for recovery. Further, SMART Recovery is still in its infancy, compared to 12-step programs like AA. While currently identified as a theme, *Spirituality* may grow increasingly less significant as more and more CRC students adopt SMART Recovery over 12-step.

## Implications

This study presents potentially valuable perspectives for CRC staff and students, though these results should not be generalized beyond this study’s participants. This research was conducted following conversations with CRC faculty members about their need for research-based approaches for post-graduate maintenance of recovery. The results of this study add to the literature at the disposal of CRC faculty whose goal it is to best equip their graduates to succeed outside of the safety and structure of their program.

The results of this study could be integrated into a mandatory course for students in their final semester as CRC students. This senior seminar would focus on the key components, as reported by successful graduates, to maintain their recovery long-term, post graduation. During the semester, students should spend time identifying currently utilized routines in order to understand which ones are worth carrying forward into the next chapter of their life. Students should also be required to join a social group outside of their comfort zone. This group could be an outside 12-step meeting, sports team, or social club. Any social interaction outside of their current CRC system will help establish confidence in their ability to assimilate into their post-graduation environment.

#### Limitations

This study contains limitations that should be noted prior to drawing any conclusions about the validity or efficacy of the research contained herein. One such limitation identified early in the process was the decision to use Skype video conferencing software. Due to the widespread locations of the participants, the researcher assumed that Skype would be the most well-known, easily implemented method to interview for this study. Skype was mentioned numerous times to each participant prior to the study, from the initial study summary to the consent form to email conversations.

No participants questioned what Skype was or showed any level of discomfort with their ability to use it for the interview. However, when it came time to conduct the interviews, some participants realized they had underestimated the level of computer savvy it would take to install Skype on their computer, create a username, and log in correctly. Future work may benefit from a step-by-step handout of installing and using Skype or including as part of the criteria that the

participant had Skype installed on their computer and knew how to use it. This process caused three potential interviews to be cancelled.

Another limitation was the researcher's lack of personal experience with addiction and/or recovery. While the researcher is involved with the recovery community in his town, has experiences with those in active addiction, and is more familiar with addiction and recovery than the average person, he still lacks the deep personal understanding that comes from experiencing it first hand. This may have limited the researcher's ability to interpret the interview responses as deeply or in the same way as someone in recovery may have.

Lastly, a limitation of this study was its lack of diversity in CRC programming approaches. All alumni interviewed for this study graduated from a CRC based around a 12-step model. This means that the CRC required or heavily suggested some level of involvement with a 12-step fellowship. Though there are an ever-increasing number of substance-specific 12-step fellowships (i.e., Alcoholic Anonymous, Narcotics Anonymous, Cocaine Anonymous, etc.) there are a common set of principles and practices that unify each of these to operate similarly.

This researcher acknowledges the possibility that this programming similarity may have limited the results of this study. For example, the language in 12-step literature mandates some interaction with the "Higher Power" of your choosing, where SMART Recovery does not require participants to even acknowledge a "Higher Power" in order to work their program. This is an important distinction that could have caused different themes to arise – especially the 7<sup>th</sup> theme that was discovered – *Spirituality*.

#### Future Research

Future research may benefit from continuing to explore best practices utilized by successful graduates as well as graduates who experienced a relapse post-graduation. The

experiences of successful alumni provide a proven method of recovery maintenance and will likely be most cooperative due to the pride associated with maintaining recovery long-term. However, the researcher believes the stories of alumni who experienced a relapse post-graduation, if attainable, may hold an incredibly useful set of applications and implications for CRC programs.

A similar study interviewing CRC graduates who experienced a relapse post-graduation may also expand the body of literature. At the time of this study, no research has been conducted on the post-graduate CRC population to identify what small, seemingly insignificant, actions expose a graduate to potential relapse. Equipped with both best practices and pitfalls, CRC graduates would have a set of practices to strive for as well as a set of things to avoid.

The collection of information on these practices could be obtained if CRCs would work to establish and maintain cohorts of graduates. Though this could never guarantee all graduates would respond or participate, the likelihood of obtaining responses from graduates who experienced a relapse post-graduation would be more likely using this method of follow-up. The graduates who experienced a relapse post-graduation may feel more comfortable being open about their failures with staff they are familiar and through a familiar process (one that was in place before relapse), rather than an unfamiliar process with a researcher from another state.

## Conclusions

The purpose of this phenomenological study was to uncover the common strategies, techniques, and/or approaches employed by CRC graduates who have maintained lasting recovery after graduation. Methods of inquiry included phenomenological reflection on data produced via one-on-one interviews. Although this study gathered the individual experience of

12 CRC graduates, the focus was on the common themes that arose from the sample to apply to the larger CRC graduate population.

Key themes emerged following the analysis of the interview transcripts. Nine tertiary themes were discovered in all, however only six of the nine were confirmed by both blind reviewers. The tertiary themes that were identified and confirmed were: *Maintaining Recovery Routines*, *Social Support*, *Personal/Peer Accountability*, *Motivating Emotions*, *Recovery/Life Balance*, and *Spirituality*.

Five of the six themes above fit within or follow 12-step teaching and principles. Many of the primary themes were 12-step specific practices such as “12-step meetings,” “Sponsorship,” “Spirituality,” etc. This could be attributed to the requirements of some CRCs. For example, the CSAR at Texas Tech does not specify the mutual-help group you must affiliate with, but they do require you affiliate and participate regularly (Harris et al., 2008). This requirement, possibly unconsciously for some, may have provided a set of routines, habits, and skills that are ingrained over time. It is incredibly satisfying to discover the skills needed to maintain recovery, post-graduation, are largely already practiced and possessed.

This study has shed light on the attainability of long-term recovery, post-graduation from a CRC. Many students involved in 12-step fellowships are already practicing the principles needed to be successful. However, they must remember to consistently maintain those practices after graduation and not slip into the trap of thinking your work can double as your recovery. It is the hope of the researcher that this information is utilized and expounded to increase the availability of information for individuals seeking a life of recovery.

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## APPENDIX A

### Consent Form

#### THE UNIVERSITY OF ALABAMA HUMAN RESEARCH PROTECTION PROGRAM

#### UNIVERSITY OF ALABAMA INSTITUTIONAL REVIEW BOARD

Title of Research: How to Maintain Lasting Recovery After Graduating from a CRC (Collegiate Recovery Community)

Investigator(s): John Lovett

IRB Approval #:

OSP #:

You are being asked to participate in a research study.

\*At times the term Collegiate Recovery Community may be abbreviated to CRC.

The name of this study is How to Maintain Lasting Recovery After Graduating from a CRC (Collegiate Recovery Community).

This study is being done by John Lovett, who is a Master's Student in the Department of Consumer Sciences at the University of Alabama. The study is supervised by faculty in the Department of Consumer Sciences.

What is the purpose of this study—what is it trying to learn?

A CRC is a university learning community where students share the common bond of being in recovery from their addiction. This environment allows these students to have a normal college experience while having a "safety net" of friends and faculty to help them stay in recovery, in such a hostile environment. Upon graduation from college, leaving a CRC, and going into the real world, some of these students relapse into their old addiction while some flourish and lead successful, sober lives. The purpose of this study is to learn from those who have successfully stayed in recovery after leaving their CRC. The detailed knowledge of best practices would benefit faculty and students of CRC's across the nation.

Why is this study important—what good will the results do?

The findings from this study will constitute a resource that recovery communities can utilize in their efforts to prepare students, on the cusp of graduation, for a life of successful, long-term recovery. The number one concern of graduating CRC students, and staff responsible for their education, is whether or not they are sufficiently prepared to stay in recovery after leaving the safety, structure, and support of their CRC. The experiences of former CRC graduates, who have successfully managed to stay in recovery after graduation, could serve as guidelines for current CRC students, and those responsible for their education.

Page 1 of 4

Prospect Initials \_\_\_\_\_

Why have I been asked to be in this study?

This study is focused on former CRC students, who graduated from their respective program, and have maintained uninterrupted recovery. You have indicated an interest in this study by responding to a call or email sent to you, based on referral.

How many other people will be in this study?

We are collecting data from between 12 – 18 former CRC students, who graduated from their respective program, and have maintained uninterrupted recovery.

What will I be asked to do in this study?

You will be asked to sign and return this informed consent form.

After signing and returning the informed consent form, you will be asked to complete a pre-study questionnaire that will collect relevant demographic information.

Next, the principal investigator (John Lovett) will set up a time to meet with you via Skype (a video chat service).

At the agreed upon meeting time, you will be interviewed, via Skype, regarding your journey to addiction, from addiction to recovery, and your personal methods of maintaining lasting recovery. This interview will be recorded. To ensure the maximum amount of security and anonymity, the principal investigator (John Lovett) will be in a secured, University location and all recordings will be stored on an encrypted drive.

Next, the surveys and interviews will be reviewed and their information will be coded and given an identifier to ensure your anonymity. In order to verify the correctness of reasoning and conclusions drawn from the interview, you may be contacted again for verification purposes. Once all data is coded from the surveys and interviews, the files will be securely deleted via 7-pass erase.

How much time will I spend being in this study?

The consent form should take you approximately 5-10 minutes to complete.

The pre-study survey should take you roughly 20-30 minutes to complete.

The interview process will be the most time consuming portion of this study. Since the interview questions are all open-ended, the time it takes to answer each will vary with each participant. Interviews are expected to last between 50 – 90 minutes, but may be shorter or longer depending on the person being interviewed.

The total estimated time you will be involved and have data collected about you will be no longer than 3 hours.

Page 2 of 4

Prospect Initials \_\_\_\_\_

Will being in this study cost us anything?

There is no cost to you aside from the time you will provide in completing the consent form, survey, and interview.

What are the benefits of being in this study?

By participating in this study, you will have the ability to help others further their recovery by sharing the experiences of your own personal journey. Otherwise, there are no further direct benefits from participation.

What are the risks (dangers or harms) to me if I am in this study?

Personal experiences of addiction and recovery can be sensitive issues for some. It is possible that some of the questions during the interview process may make you uneasy, feel stress, or discomfort. However, you are free to discontinue participation at any time or simply skip questions that cause discomfort.

How will my confidentiality be protected?

We will protect your information by giving each participant in this study an identification number. Your names will not appear on any study document besides this consent form. Any identifiable information will be kept strictly confidential and will be used solely for research purposes. Data will be stored in secure computers with password protection accessible only to the principal investigator and faculty advisor. The data file linking an individual's name to their assessment identification number will be kept in a locked filing cabinet in the principal investigator's office on the UA campus. At the end of the study, all information identifying a participant will be destroyed.

How will my privacy be protected?

We will protect by restricting access to participants and their information to the principal investigator (John Lovett) and his advisor. All records containing information that could be used to contact or identify a participant will only be accessible by the principal investigator and his

advisor. Furthermore, the Skype interview will be held in a secured University location and will not be heard or viewed by anyone but the principal investigator.

Do we have to be in this study?

No. Participation is strictly voluntary. You can refuse to be in the study. You can also start the study and decide to stop at any time.

If we don't want to be in the study, are there other choices?

If you do not want to be in this study, the other choice is to refuse. We will thank you for your time and you are free to leave.

Page 3 of 4

Prospect Initials \_\_\_\_\_

What if we have questions, suggestions, concerns, or complaints?

You may also ask questions, make a suggestion, or file complaints and concerns through the IRB Outreach Website at [http://osp.ua.edu/site/PRCO\\_Welcome.html](http://osp.ua.edu/site/PRCO_Welcome.html). After you participate, you are encouraged to complete the survey for research participants that is online there or you may ask Mr. Lovett for a copy of it. You may also e-mail us at [participantoutreach@bama.ua.edu](mailto:participantoutreach@bama.ua.edu).

What else do we need to know?

You do not give up any of your legal rights by signing this consent form. You will be given a copy of this consent form to keep. Save it in case you want to review it later or you decide to contact the investigator or the university about the study.

The University of Alabama Institutional Review Board (IRB) is the committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that people in research studies are being treated fairly and the study is being carried out as planned.

I have read this consent form. I have had a chance to ask questions. My questions have been answered. I understand what I will be asked to do. I freely agree that I will take part in it.

I certify that I am at least 19 years of age or older.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Research Participant

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Investigator

Do you agree to have your Skype interview recorded? Circle one. YES / NO

Page 4 of 4

Prospect Initials \_\_\_\_\_

## APPENDIX B

### Study Summary

This study aims to pin point the key strategies of staying sober in the “real world” after graduating from a collegiate recovery program. Participants meeting the qualifications detailed below will first be asked to read and fill out a consent form. Participants will then be asked to fill out a questionnaire containing basic demographic data such as ethnic background, age, income, etc. As the final and main component of this study, the participants will be interviewed and video-recorded, via Skype, regarding their journey from addiction to recovery and their personal methods of maintaining their recovery in the “real world”.

These testimonies of experiences and methods will be analyzed in order to identify a few key components to successfully stay in recovery after leaving a collegiate recovery program. This data will then be used to write and disseminate a master’s thesis (and a scholarly paper) on how to successfully remain in recovery after leaving a collegiate recovery community. For security purposes, each participant will be given a randomized identity number in order to ensure complete anonymity of their identity. Once this data is coded, all survey instruments and videos will be securely deleted.

The ultimate goal of this study is to be a resource that recovery communities can utilize in their efforts to prepare students, on the cusp on graduation, for a life of successful, long-term recovery.

#### Study Participant Qualifications

- Participants must have been a member of and graduated from a collegiate recovery community or program during their college career.
- Participants must have uninterrupted recovery since graduating from their collegiate program.
  - No relapses
- Participants must have the ability to fill out and return forms or questionnaires related to this study (email or snail mail).
  - Study consent forms
  - Questionnaire

- Participants must be willing to participate in an interview, via Skype, about their journey from addiction to continued recovery.
  - Must have access to a computer with a webcam and Skype
  - Interviews will be recorded
    - Skype is a free video-chat software available online
- Participants should have a willingness to help others find lasting recovery by sharing their personal experience.

### Time Requirement

Estimated time for each participant to complete and return the consent forms and survey is 45 minutes.

Estimated time for each participant to complete the interview is 1.5 hours. The total estimated time each participant will be involved and have data collected about them will be no longer than 3 hours.

### Info Needed for Qualified Participants

1. First and last name
2. Phone number
  - a. Times available to receive calls
3. Email address

## APPENDIX C

### Survey Instrument

How to Maintain Lasting Recovery After Graduating from a CRC (Collegiate Recovery Community)

(Please check one box for those that apply)

1) Age:

- 19 - 24
- 25 - 30
- 30 - 35
- 35 - 40
- 40 - above

2) Gender:

- Male
- Female

3) Race:

- Caucasian, non-Hispanic
- Black, non-Hispanic
- Asian or Pacific Islander
- Hispanic
- Native American
- Other (please specify) \_\_\_\_\_

4) Marital Status:

- Single (never married)
- Married
- Separated
- Divorced
- Widowed

5) How many children do you have?

- 0
- 1
- 2
- 3
- 4 or more

6) Do you currently have a job?

- Yes, full time
- Yes, part time
- No

7) What is your annual income (approximate)? Please include all earnings from work as well as income you might receive from family members or accounts/trusts.

- Less than \$20000
- \$20000-\$39999
- \$40000-\$59999
- \$60000-\$79999
- \$80000-\$99999
- \$100000-\$149999
- \$150000 or more

8) What is the highest level of schooling you have completed?

- Completed high school or equivalent
- Some college
- College graduate
- Completed advanced degree (graduate or professional)
- Don't know

9) What is the highest level of schooling your father or mother completed?

- Neither parent completed high school
- Completed high school or equivalent
- Some college
- College graduate
- Completed advanced degree (graduate or professional)
- Don't know

## APPENDIX D

### Interview Script

1. Begin Study (call participant)
  - a. Introduce myself and briefly explain the purpose for the study.
  - b. Make sure participant is comfortable with me recording our conversation.
  - c. Reiterate that their participation is completely voluntary and all personal and/or identifying information will be kept secure and anonymous.

---
2. Begin Recording
3. Question 1:
  - a. Tell me about becoming an addict. How does the story of your journey to recovery begin?
    - i. Events that lead to addiction
    - ii. Length of addiction
    - iii. Peer Influence
    - iv. Etc.
4. Question 2:
  - a. Tell me about your experience getting sober. What were the contributing factors to recovery?
    - i. Cold turkey
    - ii. Rehab
    - iii. How many times in rehab?
    - iv. Any relapses?
5. Question 3:
  - a. In order to be eligible for this study, you had to have graduated from a Collegiate Recovery Community. In your opinion, what were the pros and cons of your program?
    - i. Any negatives?
    - ii. Meetings, sponsor, accountability, spirituality

6. Question 4:
  - a. After graduation and leaving the “safety net” provided by your Collegiate Recovery Community, what would you say have been the key components to remaining in recovery in the “real world”?
    - i. Meetings?
    - ii. Sponsor?
    - iii. Sponsee?
    - iv. Spirituality?
  
7. Question 5:
  - a. Finally, if you were able to give one KEY piece of advice to a new graduate of a Collegiate Recovery Community on staying in recovery in the “real world”, and it was guaranteed that they would take your advice, would it be?
  
8. Stop Recording. Thank them for being a part of the study and again reiterate the fact that all personal and/or identifying information will be kept secure and anonymous.

APPENDIX E

Sample of Coding Spreadsheet

Primary Theme	Secondary Theme	Tertiary Theme	Participant Number	Reviewer	Direct Quote
Importance of Meetings	12-step Meetings	Maintaining Recovery Routines	9	Blind #1	"...continuing doing what I was doing. Going to meetings..."
Meetings	12-step Meetings	Maintaining Recovery Routines	6	Principal	"...continuing going to meetings..."
Meetings	12-step Meetings	Maintaining Recovery Routines	7	Principal	"...I found a meeting and instantly made it my home group and I, at the least, go to that meeting twice..."
Routine	12-step Meetings	Maintaining Recovery Routines	2	Blind #2	"...going to meetings."
Continuity; Consistency	Continuity; Consistency	Maintaining Recovery Routines	11	Blind #1	"So I think just keeping that kind of fluid continuity throughout is pretty helpful."
Continuity; Consistency	Continuity; Consistency	Maintaining Recovery Routines	11	Blind #1	"I mean to be very broad I think just continuity - keep things as consistent as you can."
Routine	Continuity; Consistency	Maintaining Recovery Routines	1	Blind #2	And once you graduate, to like, you know, stay balanced, make your meetings.
Routine; Spirituality	Continuity; Consistency	Maintaining Recovery Routines	10	Blind #2	"I also attend 12-step meetings regularly, prayer and meditation."

Routine; Spirituality; Peer Support	Continuity; Consistency	Maintaining Recovery Routines	10	Blind #2	"Just staying plugged in to your spirituality and the 12-step program. Reaching out, continuing to build relationships with addicts when you leave because most of the time people leave that town and go somewhere different." "I think it was mostly a continuation of things I had been doing and it that transition was definitely on my mind and I had some worries."
Routine; Transition	Continuity; Consistency	Maintaining Recovery Routines	11	Blind #2	"...continuity - keep things as consistent as you can."
Continuity; Routine	Maintaining Routines	Maintaining Recovery Routines	11	Principal	"...it was mostly a continuation..."
Continuity; Consistency	Maintaining Routines	Maintaining Recovery Routines	11	Principal	"...continuing to do the same things that we did in early sobriety, on a daily basis."
Routine	Maintaining Routines	Maintaining Recovery Routines	10	Principal	"There was this thing called "Roses and Thorns" where you talk about a good thing that's happening in your life, a bad thing that's happening in your life, and then how your recovery's going, then people ask how they can help you."
Recovery Exercises	Utilize Lessons Learned	Maintaining Recovery Routines	6	Principal	

Use what you learn	Utilize Lessons Learned	Maintaining Recovery Routines	6	Blind #2	"There was this thing called "Roses and Thorns" where you talk about a good thing that's happening in your life, a bad thing that's happening in your life, and then how your recovery's going, then people ask how they can help you."
Use what you learn in CRC	Utilize Lessons Learned	Maintaining Recovery Routines	6	Blind #1	"I kind of have kept everything I learned and gained at ( <i>CRC program</i> )...and I kind of live by those rules now."

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## APPENDIX F

### IRB Approval

Office for Research  
Institutional Review Board for the  
Protection of Human Subjects

June 15, 2015

John Lovett

THE UNIVERSITY OF  
**ALABAMA**  
R E S E A R C H

Re: IRB # 13-OR-190-R1 "How to Maintain Lasting Recovery After Graduating from a CRC (Collegiate Recovery Community)?"

Dear Mr. Lovett:

The University of Alabama Institutional Review Board has granted approval for your renewal application.

Your renewal application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

*(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.*

Your application will expire on June 14, 2016. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Study Closure Form.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,



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