Students' Perceptions of Social Support and Recovery: The Social Support Model used in Replicating Collegiate Recovery Communities

by

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TABLE OF CONTENTS

APPENDICES

ABSTRACT

The purpose of this thesis was to investigate the Social Support Model used in the replication of Texas Tech University's Collegiate Recovery Community. Secondary data was drawn from a larger study, with four universities participating in the quantitative cross sectional study. Examined was the relationship between recovering college students' perception of functional social support and their perception of their own quality of recovery. The results showed, when viewed separately, none of the four types of perceived social support were significantly related to students' perceptions of quality of recovery. However, the relationship between the combined social support components and recovery revealed a statistically significant relationship. This finding suggests a holistic approach to social support, one that offers the array of the four types may benefit recovering students. Additionally, the study found that younger students perceived greater amounts of recovery.

LIST OF TABLES

CHAPTER I

INTRODUCTION

Lost in Transition: The Dark Side of Emerging Adulthood (Smith, Christoffersen, Davidson, & Herzog, 2011) exposes the more vulnerable areas of the population between the ages of 18-23. This national longitudinal sample reveals risky areas that young adults face in everyday life, including substance use. The book identifies and labels groups that encompass the wide array of substance use from zero to excessive amounts. The terms used and the percentages revealed in this research are: nonusers (22%), occasional substance users (25%), partiers (22%), recovering partiers (21% - those who have substantially cut down through maturity), addicts (8%) and recovered addicts (4%). This research supports the belief that the majority of young adults tend to engage in the use of substances at various levels. The current inquiry studies the smallest and, perhaps, the most unique of these developmentally specific populations, recovered addicts. A better term for this study would be recovering addicts. More specifically, I will investigate *recovering college students*.

The term, recovering college students, is used to define the group that consists of young adults (age 18-26) who are living substance-free lives while seeking college educations. The completion of a college education is one path chosen by recovering young adults as they leave behind drug and alcohol habits and former social environments to begin newly realized clean and sober lives. What makes this group of young adults unique is they have begun the substance

abuse recovery process at a relatively young age compared to the general recovery population who, as a result of the progressive nature of addiction, tend to enter recovery later in life.

Compared to young recovering adults, individuals who enter recovery later in life have typically experienced more severe consequences from their substance abuse. The costs of addiction for older adults can include employment problems, marital problems, loss of children and medical problems. Likewise, older persons entering recovery tend to face greater losses should they fail to maintain their recovery. Specifically, they may face loss of employment, divorce, increased medical problems and even death. Although recovering college students may not yet have encountered the more severe consequences of their addictions, the goal is to prevent them from doing so. The unpredictable nature of addiction progression from one individual to the next leaves recovering students at risk for relapse and the potential harmful events that could follow. For these reasons, it is essential for colleges and universities to recognize the significance of doing their part in supporting this population in their recovery journey. According to Doyle (2001), although decision-making in this stage of life creates risk for all college students, recovering students' choices pose threats above and beyond those of students not in recovery.

> For recovering college students, the decision of whether or not to consume substances could be one of life or death. Relatively innocuous situations such as social gatherings, fraternity or sorority events,

> intercollegiate athletic competitions, and dormitory living can become literally life-threatening situations for students in recovery; simple decisions such as identifying a potential roommate, choosing one's social group, or making leisure plans become vitally important (p.1).

Statement of the Problem

The problem is, at every turn on university campuses, recovering students encounter developmental and contextual barriers to recovery. The recovery lifestyle that is characterized by sobriety and personal growth contrasts greatly with the widespread use of alcohol and drugs found at most colleges and universities (Presley, Meilman, & Leichliter, 2002). Additionally, the risks take place not only in social settings, but also, as a means to cope with the stressors of college life (Schulenberg & Maggs, 2002). Furthermore, the effects of substance abuse on healthy development during the earlier formative years, including those on the development of effective social skills, leave this population vulnerable to peer pressure (Weibe, Cleveland, & Harris, 2010).

Attempting to meet the special needs of recovering students, several universities in the United States have developed programs, from here forward referred to as Centers. These Centers are designed to assist recovering college students to remain in recovery while they obtain a college degree despite their emersion in an abstinence-hostile collegiate environment (Bell et al., 2009; Smock, Baker, Harris, & D'Suaza, 2011). Although not considered aftercare, per se, these developmentally driven Centers extend the continuum of care following

the decision to remain abstinent from alcohol and/or drugs, either through substance abuse treatment or the adoption of a recovery centered way of life (Bell et al., 2009).

The Center for the Study of Addiction and Recovery (CSAR), a comprehensive program for recovering students established in 1986, at Texas Tech University (TTU) in Lubbock, Texas represents a well-known and highly regarded Center in the United States. Its longstanding history, its ability to obtain private funding for operational expenses and student scholarship endowments and its replication and research endeavors funded through federal grants and private endowments have set it apart from other university programs that provide similar services. At the heart of the CSAR is a Collegiate Recovery Community made up of recovering college students, CSAR faculty and staff, and Lubbock community members, some of whom are also in recovery (Cleveland, Harris, Baker, Herbert, & Dean, 2007).

Over the past few years, the CSAR has undertaken a project that aims to replicate versions of its program adapted to fit within other colleges and universities in the United States (Smock, Baker, Harris, & D'Suaza, 2011). Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Education, the curriculum used for replication of the CSAR, *Making an Opportunity on Your Campus: A Comprehensive Curriculum for Designing a Collegiate Recovery Community* (Harris, Baker, & Thompson, 2005), has been distributed to over 500 colleges and universities throughout the United

States. Based largely on social cognitive theory, the replication curriculum uses a Social Support Model (Harris, Baker, & Thompson, 2005). The five types of social support described by Salzer (2002) are (a) Instrumental support (tangible); (b) Emotional support (appraisal); (c) Companionship (belonging); (d) Validation (self-esteem); (e) Informational support. The Centers use a combination of the social support types through peer interactions, social comparisons, relationships, and modeling by peers, faculty and staff to provide a safe place for the recovering population on college campuses that is designed to embolden, encourage, and embrace change in students' behaviors during the course of their time of participation at the Centers while enrolled in school.

Once Centers are established, the replication curriculum encourages staff to promote peer support as much as possible, inspiring students to take charge of facilitating 12-step meetings, mentoring new students through the orientation process and taking leadership roles in Center student organizations, activities, and service projects. However, paid staff members remain available and involved in day-to-day operations that are normally associated with college/university tasks such as academic advising, teaching instruction and purchasing of supplies and materials. Throughout students' processes at the Centers, social support components are designed to strengthen their recovery as they complete their college educations, paving the way for the formation of a new identity in recovery.

Like Salzer's Model (2002), in the replication curriculum, students take in knowledge primarily through experiential learning rather than book learning. As a rule, admission to the various Centers is based on an application process that differs from Center to Center. Campus cultures, geographical characteristics, financial resources, support from campus administrators and local communities determine how each replication site is designed. The two areas that have shown the greatest promise at these Centers are the low relapse rates experienced by students and the high grade point averages achieved while students are enrolled (Smock, Baker, Harris, & D'Suaza, 2011). However, more research that includes a larger sample size and multiple campus sites is needed to assess the effectiveness of the Social Support Model for recovering college students.

The underlying assumption of these Centers is that a quality college education combined with strengthened recovery increases students' likelihood for long-term, continued recovery (Harris, Baker, Kimball & Shumway, 2008). Whereas some individuals find success in recovery through abstinence and learning to cope with life stressors by applying psycho-educational strategies or association with Twelve Step recovery communities, others may benefit from, or perhaps even require, a more profound reformation of identity that could be achieved or enhanced through higher education (Koski-Jännes, 2002). Higher education is believed to be associated with financial security, marital satisfaction, and overall physical and mental health. Moreover, paid employment could be an instrumental factor of successful recovery (McIntosh & McKeganey, 2001). A

college education may well improve chances for gainful employment and, subsequently, sustained recovery. Success in the areas of maintaining recovery and achieving higher education could feasibly contribute substantially to an individual's recovery, impacting not only surrounding friends but also the immediate community and society as a whole. Perhaps, most importantly, in addition to the improved quality of life for the recovering students, the resocialization process that takes place when individuals enter and remain in recovery potentially breaks the familial cycle of addictive disorders that tends to be passed down generationally.

Because previous research has indicated that students who participate at these Centers tend to remain in recovery and are inclined to have higher grade point averages than non-recovering students at these schools outside the Centers (Smock, Baker, Harris, & D'Suaza, 2011), this inquiry set out to determine one aspect of the effectiveness of the Social Support Model. The aim of the study was to examine whether or not and to what extent there is an association between recovering college students' perceptions of social support and their self-evaluated level of recovery.

Purpose of the Study

Despite the scarcity of literature on recovering college students, it is known that recovering college students exist as a hidden and unique population with special needs who will seek and use on-campus recovery supportive services when they are available (Doyle, 1999; Woodford, 2001). It has also been

suggested that recovering students possess strengths that can positively influence the collegiate environment (Bratter & Parker, 1994; Bratter, Parker, & Pierson, 1995; Woodford, 2001) and this resilient group of individuals is capable of making constructive contributions to society at large (Woodford, 2001). Like other unique populations, the fundamental nature of recovering individuals is complex and multifaceted (McIntosh & McKeganey, 2001). Recovering young adults may be especially complicated to explore because of their developmental stage that is often a time of exploration with substance use, particularly among peers and peers groups.

The data for this study were collected through a larger project conducted by the CSAR. Four universities in the United States participated in the study. This quantitative cross sectional study provides preliminary answers to the question of whether or not, and to what extent, overall perceived social support is related with quality of recovery in recovering students from the perspective of recovering students. The study explores the usefulness of the Social Support Model. It predicted that students who report higher amounts of perceived social support would rate themselves with a greater degree of recovery.

Research Questions

This thesis evaluates the Social Support Model used in the replication of Texas Tech University's Collegiate Recovery Community. Specifically, the research questions in this study are:

RQ1: What types of functional social support (tangible, appraisal, self-esteem, belonging) are most strongly correlated with self-assessed quality of recovery in recovering college students?

RQ2: Is perceived functional social support correlated with self-assessed quality of recovery in recovering college students?

CHAPTER II

LITERATURE REVIEW

This chapter provides a review of the literature, beginning with a brief definition of addiction followed by an outline of the contextual and developmental aspects in the dilemma of recovering students progressing through the college years. Next, social cognitive theory that provides the foundation for this inquiry is described as it relates to the recovering population. The chapter concludes with explanations of the social support and recovery constructs that serve as the independent and dependent variables, respectively, in this study.

Substance Abuse in Young Adults

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), 4th Edition (1994), substance abuse is the repetitive pattern of continuing substance use in spite of experiencing undesirable outcomes as a result of use. Undesirable outcomes associated with substance abuse include (a) the inability of the individual to successfully perform in roles at home, at school, or at work; (b) substance use when physical harm can result such as when driving; (c) recurring legal problems associated with substance use; (d) the continued use of substances in the face of experiencing problems associated with substance use. To be categorized as a substance abuser as specified in the DSM-IV (1994), one or more of these events must have occurred during the previous twelve months. In addition to the behavioral characteristics of substance abuser,

substance dependent individuals frequently have physical symptoms such as tolerance and withdrawal (DSM-IV, 1994), characteristics that are more frequently found in older people with substance abuse problems. Woodford (2001) suggests that the term substance abuse most accurately portrays traditional college-aged students, even though some of them may be categorized as substance dependent.

Although alcohol is the most common substance associated with college life (Prendergast, 1994; Woodford, 2001), research on recovering students indicates other substances (marijuana, cocaine, methamphetamine, and hallucinogens) are more often used, making the term substance abuse more appropriate than alcohol abuse (Cleveland, Baker & Dean, 2010). Other characteristics believed to be present in substance abusers are loss of control over use, failing to stop use after setting clear limits for use, feeling guilty or sorry following use, and the inability to see or to admit that use is a problem (Roper, 1999), a circumstance that substance abuse professionals often refer to as denial.

Progressing through the College Years

Contextual Aspects. It is well documented that excessive amounts of substance use occurs on college campuses due to developmental factors (Schulenberg & Maggs, 2002) and contextual factors (Presley, Meilman, & Leichliter, 2002). Substance use on college campuses has been associated with harmful events, including "sexual assaults, campus violence, personal injury, and deaths" (Presley, Meilman, & Leichliter, 2002, p. 82). Additionally, health issues

such as unprotected sexual activity that result in the spread of sexually transmitted diseases such as AIDS are also connected to substance use in the collegiate environment (Feilgelman, Gorman, & Lee, 1998). Despite a downward trend in binge drinking among young men in the general population, young women's binge drinking has remained unchanged (Grucza, Norgerg, & Bierut, 2009). Minority women report an increase of this behavior, and binge drinking among college students continues to be problematic, supporting the notion of contextual influences (Grucza, Norgerg, & Bierut, 2009).

Virtually all higher education institutions have implemented prevention and intervention programs to address substance use (Toomey & Wagenaar, 2002; Wechsler et al., 2002). Strategies include a ban of all on-campus alcohol, provision of alcohol free residence halls, restriction of alcohol at campus events, and alcohol education to specific populations such as freshmen, sororities, fraternities, and athletes (Wechsler et al., 2002). Additionally, colleges and universities use "social norms" marketing campaigns to curtail use of alcohol (Perkins, 2002). These campaigns normalize the perception that most students drink in limited quantities rather than excessively (Wechsler et al., 2003). Harm reduction models, such as needle exchanging and nicotine substitution methods, have also been implemented with the focus on lessening rather than prohibiting substance use (Marlatt, 1996).

Although these various approaches are widely used, substance use in the collegiate environment remains widespread, as reported by local and national

media. Unfortunately, destructive behaviors associated with substance use at and around colleges and universities continue to result in destruction of property, assaults, and student deaths (Toomey & Wagenaar, 2002). Furthermore, the services available to address substance abuse tend to neglect students who are already in substance abuse recovery, overlooking a group that could conceivably be open to, or even searching for, services that provide relapse prevention, otherwise called "backdoor" prevention or recovery support (Baker, 2006).

Developmental Aspects. In addition to the contextual problems this population encounters with college life are the developmental factors associated with this age group. The stage of development that occurs between adolescence and adulthood, *emerging adulthood* (Arnett, 1998), is a time when "… the young person is distinctly in transition, having moved out of one stage but not yet having entered the next" (p. 313). The salient features of emerging adulthood are formation of identity, exploration of vocational options, consideration of worldviews, and reflection of significant relationship selections (Berry, 2004). Additionally, Arnett (1998) ascertains that central to emerging adulthood are the processes of individuation and building of character, qualities that enable the person to "stand alone" (p. 302).

The developmental transition that occurs at this point in life represents an ecological transition (Bronfenbrenner, 1979). Ecological transitions take place "whenever a person's position in the ecological environment is altered as a result

of a change in role, setting, or both" (p. 26). When individuals move away from their families to a college or university, changes occur at the individual level as well as the levels of family, school, and community. Consequently, young adults moving off to college experience not only geographical change, but also changes in roles and responsibilities. This life transition, like others, is characterized by gains and losses (Baltes, 1987; Cantor & Langston, 1989; Schulenberg & Maggs, 2002).

The progression of moving into adulthood is essential to identity development and personal growth; nevertheless, this transformation creates stressors not yet encountered in life. From a developmental perspective, the association between transitions that occur during the college years and alcohol use vary from person to person. Generally, alcohol use in college tends to revolve around biological, emotional, and social factors that include dealing with anxiety or stress and fitting in with peers and/or peer groups (Schulenberg & Maggs, 2002). From this perspective, recovering students appear to come into university life as outsiders on campus, not having the option of using alcohol as a mechanism to deal with stress or to safely engage in social activities where even acceptable amounts of substance use may occur.

Recovering college students, like their non-recovering counterparts, experience normal developmental quandaries of young adulthood and the transition to college life that includes substance use in social settings and as a means by which to cope with stressors (Schulemburg & Maggs, 2002). However,

recovering students face the added challenge of maintaining sobriety while in the midst of a population prone to substance use (Bratter & Parker, 1994; Bratter, Parker, & Pierson, 1995; Doyle, 1999; Doyle, 2001). In addition to avoiding social situations that involve substance use, they may find it difficult to construct recovery-supportive social systems (Weibe, Cleveland, & Harris, 2010). For recovering students, the pervasive use of alcohol and drugs in the collegiate setting (with or without a recovery support system in place) unquestionably increases the susceptibility of relapse, creating risk for this population during a vital stage of life (Harris, Baker, Kimball & Shumway, 2008; Bell et al, 2009). Hypothetically, recovering students could be compelled to choose between a recovery supportive environment and their college degrees. Forfeiting college educations may well inhibit these young adults' personal and professional growth (Harris, Baker, Kimball, & Shumway, 2008).

From recovering college students' perspectives, college life reveals school-related factors that support or inhibit their recovery process. Although Woodford's sample size is small (2001; N = 3), the results underscore the idea that recovering students face developmental and academic dilemmas similar to non-recovering students while, simultaneously, facing predicaments that accompany recovery lifestyles. According to Woodford (2001), themes relating to the experience of recovering students include (a) administrative response; (b) adapting to college life; (c) social support network; (d) campus recovery meetings; (e) sponsorship influence; (f) balancing academics and recovery; (g)

recovery influences academics; (h) attitude toward learning has changed in recovery; (i) service work; (j) self-disclosure; (k) spiritual aspects. Research findings by Baker (2006) and Bell et al. (2009) support these preliminary outcomes, reiterating the special needs of recovering students as well as further research into how collegiate recovery communities can meet those needs.

Perhaps as a result of having the opportunity of a second chance at education, recovery seems to positively impact the area of academics as evidenced by recovering students' tendencies to take education seriously (Doyle, 1999). Also, students' utilization of recovery-related services offered by higher education entities suggest recovering students employ and presumably benefit from recovery-related services (Woodford, 2001). According to university officials, as many as 125 recovering students on one campus actively access recovery-related services (Doyle, 1999). Services include individual counseling (64%), a treatment/referral list (50.6%), on-campus twelve-step meetings (30.1%), and substance-free housing (18.9%). Other recovery-related services include on-campus recovery support groups and peer-to-peer counseling.

Social Cognitive Theory

Even though the recovery process is an individual journey, relationships with other people play a critical role in the initial decision to enter into recovery and the creation of the social environment believed by most addiction professionals to be conducive or perhaps even essential to maintaining recovery. Specifically, successful recovery is thought to occur when individuals can be

assimilated to healthy interpersonal relationships as well as community involvement (Harris, Baker, & Cleveland, 2010). Accordingly, social cognitive theory, with its reflection on individuals as they exist within larger social groups, provides the theoretical framework for the current investigation. Social cognitive theory recognizes a bi-directional relationship between personal attributes and environmental determinants such that "people are both producers and products of their life condition" (Bandura, p. 214). Three fundamental aspects of social cognitive theory that coincide with the typical recovery process are human agency, self-efficacy, and social structures.

Human agency refers to the personal choice and decision-making aspects of human behavior, highlighting the idea that people are not predestined to a lesser quality of life because of disadvantages such as social background or poor decision-making at some point in life. Human agency plays perhaps the most significant role in the recovery process because of its tie to intent in behavior, consideration of goal-direction in decision-making, self-reactiveness that is embedded in motivation and self-regulation, and self-reflectiveness that connects behavior with thought (Bandura, 2001). Human agency allows individuals to make decisions in life that potentially decrease or, as in the case of recovering individuals, increase quality of life.

Self-efficacy recognizes individuals' beliefs regarding their ability. According to Bandura (1999), "Unless people believe that they can produce desired effects by their actions; they have little incentive to act or to persevere in

the face of difficulties" (p. 214). Relating to recovering individuals, Bandura (1999) suggests, "Perceived self-efficacy affects every phase of change in substance abuse – the initiation of changes, their achievement, recovery from relapse, and long-term maintenance of abstinence" (p. 215). Bandura's assertion of the positive relationship between self-efficacy and the recovery process underscores the notion of resiliency in recovering individuals.

Finally, social cognitive theory views social structures or social environments as greatly influencing human behavior. Recovering people who possess self-efficacy are capable of creating social structures or environments that assist them in maintaining recovery (Bandura, 1999). Additionally, Bandura (1999) acknowledges "…personal changes require an enabling sub-community that promotes the diverse competencies needed to turn one's life around" (p. 216). Along these same lines, Gecas and Schwalbe (1983) suggest, "social-structural conditions enable and constrain efficacious action" (p. 86). The formation of strength-based, structured social support networks of recovery-oriented populations like Oxford Houses have proven to be helpful to older populations who may have experienced greater consequences as a result of their addictions (Majer, Jason, Ferrari, Venable, & Olsen, 2002). Social structures, such as the Centers explored in this study, are believed to provide social environments that facilitate the recovery process through the provision of social support, providing opportunities for these young recovering adults to remain on the path of recovery.

Social Support

Within the realm of social structures recognized by social cognitive theory is the complex construct of social support. Social support is believed to impact physical and mental health directly and indirectly. Cohen, Gottlieb, and Underwood (2000) identify two types of support under the umbrella of social support that are structural support and functional support. Structural support, often called social integration, is defined as "health benefits that accrue from participation in one or more distinct social groups" (p.4) , assuming that "others can influence cognitions, emotions, behaviors, and biological responses in manners beneficial to health and well-being through interactions that are not explicitly intended to exchange help or support" (p. 4). Healthy familial relationships and friendships developed through this involvement with others are believed to build self-esteem and self-worth, positively influencing physical and mental health.

Newly recovering individuals are encouraged to leave behind social networks that are associated with substance use and move toward substance free social environments. The newly formed social environments have been found to support recovery, reducing the risk of relapse and promoting recovery (Mohr, Averna, & Kenny, 2001; Smock, Baker, Harris, & D'Sauza, 2011). According to Beattie and Longabaugh (1999), alcohol-specific, that is, "support directed to a person's alcohol use" (p. 594), and general social support play a vital role in recovery immediately following treatment and, as the recovery process

continues, the role of alcohol-specific support becomes increasingly important for sustained sobriety. However, for recovering college students, recovery length was not significantly related to social networks of abstinence support and relapse risks, disputing the role of structural social support for this particular, perhaps younger, population (Herbert, 2006).

Whereas structural support is thought to influence all groups of people with ongoing support that enhances physical and emotional well-being, the current study seeks to explore functional social support. In contrast to structural social support, functional social support is believed to provide a "buffering effect" for individuals dealing with specific stressful life events, such as addiction (Cohen, Gottlieb, & Underwood, 2000). Functional social support is defined as "social resources that persons perceive to be available or that are actually provided to them by nonprofessionals in the context of both formal support groups and informal helping relationships" (p. 4). As with structural social support, the benefits believed to be derived through the attainment of functional social support are improvements in psychological and physical health and well-being (Cohen, Mermelstein, Kamarck, & Hoberman, 1985; Salzer, 2002).

In this study, the types of support used for operationalizing functional support are (a) tangible support; (b) appraisal support; (c) self esteem support; (d) belonging (Cohen & McKay, 1984). Tangible or instrumental support consists of concrete material items (Cohen, Mermelstein, Kamarck, & Hoberman, 1985), such as food, clothes, furniture, and financial help, or the provision of specific

behavioral aid like transportation (Winemiller, Mitchell, Sutliff, & Cline, 1993). Appraisal support, also known as emotional support is exemplified by caring, empathy, trust, and love (Krause, 1986; Langford et al., 1997) from at least one person to another, creating a sense of esteem, attachment, and reassurance (Solomon, 2004). Simply put, appraisal support is having someone readily available with whom to talk about one's problems (Cohen, Mermelstein, Kamarck, & Hoberman, 1985). Self esteem support or validation is expression that optimistically influences a person's sense of worth, such as confirmation of the appropriateness or normalcy of a person's behavior through social comparison (Wills & Shinar, 2000). Belonging, otherwise known as companionship, occurs through the establishment of mutually valuable relationships through participation in social activities (Wills & Shinar, 2000). Informational support that is included in the replication model, although not included as a variable in this study, refers to information provided to persons for the purpose of problem-solving (Wills & Shinar, 2000).

Recovery

Traditional View of Substance Abuse Recovery. Recovery is a term frequently used in the medical and mental health fields when referring to physical and psychological conditions and has subsequently been adopted by the substance abuse field (Woodford, 2001). When individuals decide to enter recovery, they have an opportunity to make positive changes in their lifestyles. Most often, the initiation of recovery takes place through the traditional

Minnesota Model that features substance abstinence, spiritual principles, and a network of social support. According to Cook (1988), the Minnesota Model features four primary building blocks which are (a) the prospect of change; (b) the disease model of addiction that contends excessive substance use disturbs physical and mental health; (c) specific treatment objectives like abstinence; (d) the use of Twelve Step principles.

Recovery is an ongoing process is rather than the specific point in time when one stops using substances or the state of being substance free (McIntosh & McKeganey, 2001). Compared to abstinence alone, recovery is marked by personal growth (Cook, 1988). Allsop and Saunders (1989) break recovery down into a two-part process. During the first part of the recovery process, individuals recognize problems associated with substance abuse outweigh the benefits derived and they make the decision to stop using (Saunders & Allsop, 1987; Stall & Biernacki, 1986). Secondly, individuals develop coping skills and seek resources that enable them to establish and maintain substance free lives (Allsop & Saunders, 1989).

Prochaska and DiClemente (1986) offer a more intricate view of the recovery process that includes four stages. The first stage, pre-contemplation, exists when individuals are in denial, meaning they are unaware their substance use is a problem (Wallen, 1993). During the second stage, contemplation, individuals are willing to consider whether or not they have a problem with substance use. It is during this stage that persons may seek help to deal with

their substance use or they may be open to some type of intervention. The third stage of recovery, action, often occurs when people take desire chips at a Twelve Step meeting. Desire chips are coins that are offered to newcomers at Twelve Step meetings. Individuals who accept desire chips are said to be displaying an outward sign of an inward decision to move toward a recovery lifestyle. The final stage, maintenance, is characterized by the determination to remain abstinent. Individuals in the maintenance stage often rely on counseling, recovery programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), or a combination of these services (Cook, 1988). The Twelve Steps of AA and NA provide a blueprint for repairing damages accumulated during substance use, coping with everyday stressors in life, facilitating personal development, and developing a spiritual foundation.

In addition to working the Twelve Steps, participation in AA and NA requires regular attendance at Twelve Step meetings. These meetings provide not only a social network of similar peers but also a support network of mentors who are more experienced with sustaining recovery. Typically, individuals choose one of these mentors to use as a sponsor. A sponsor provides guidance through the Twelve Step process and information, advice and support in facing normal challenges in life without relying on substances. The spiritual principles of AA and NA encourage reliance on a Higher Power, prayer and meditation, staying in the here and now, making amends for past transgressions, and avoiding resentments. Lastly, the Twelve Step philosophy requires a

commitment to encourage other substance abusers to adopt a recovery way of life. The Minnesota Model continues to be the most utilized recovery oriented philosophy in community recovery groups and in professional treatment centers.

New Perspectives on Recovery. Not long ago, mental health and substance abuse were viewed as two separate circumstances. More recently, however, the two have been seen as similar and, for as many as half of those in mental health and substance abuse treatment settings, simultaneous conditions (Davidson & White, 2007). Mental health recovery, including the construct of substance abuse recovery, has evolved over the past several decades in part because of advocacy by substance abuse and mental health professionals who long to transform current mental health systems (Davidson & White, 2007). According to Davidson and White (2007),

> This transformation is meant to re-orient the current systems from their focus on acute care, symptom reduction, and maintenance of enduring disability to focus on promoting long-term recovery and full inclusion of people with mental illnesses and/or addictions in community life (p. 111).

Recovering individuals, advocates, addiction professionals, and state and federal agencies have expanded their view of recovery to include a greater level of personal growth that moves beyond abstinence and consistent involvement in the Twelve Step community. This is especially true for people who manage to obtain long-term recovery. This does not mean that people with long-term

recovery are encouraged to stop participating in Twelve Step Programs altogether. Rather, they are encouraged to branch out into growth in other areas, such as education, an assortment of spiritual paths, individual or group counseling, hobbies they enjoy, or whatever each individual determines may provide fulfillment or joy to their lives.

Mental health consumers also view the recovery process as one that includes insight, rebuilding a sense of self, the development of coping skills, and social support (Young & Ensing, 1999). From their perspective, the initiation of recovery starts with overcoming stuckness by acknowledging and accepting mental illness, having desire and motivation to change, and having a source of hope and inspiration found in spirituality or in other people. The middle phase is regaining what was lost and moving forward through empowerment, learning/self-redefinition, and a return to basic functioning that incorporates self-care. In addition to having a sense of well-being, the later phase of recovery offers new potentials of higher functioning that consists of finding meaning in life, improving vocational abilities, and engaging in advocacy for self and others.

Although recovering college students' definitions of recovery reflect the tenets of the Minnesota Model (i.e. abstinence from alcohol and/or drugs, belief in the Twelve Steps, recovery as an exclusive group), they also value the idea of human agency, putting forth the notion of personal choice and responsibility for their recovery (Baker, 2006). Additionally, recovering college students recognize that transformation takes place at the personal level, in relationships, and with

institutions, shedding light on the internal perceptions, decisions, and processes that take place on the recovery journey (Baker, 2006). These findings add credibility to the evolving view of recovery as something more than merely substance abstinence.

Young and Ensing's (1999) findings of insight, rebuilding a sense of self, empowerment, and use of social support and the themes of agency and the transformation process noted in Baker's (2006) inquiry support the use of social cognitive theory for the proposed investigation. Additionally, the results of Young and Ensing's (1999) and Baker's (2006) research beg for a dynamic, holistic, and inclusive definition of recovery that considers more than just maintained sobriety for a definition of substance abuse recovery. To accomplish this, the proposed investigation applies to substance abuse recovery a definition utilized in the field of mental health slightly modified for substance abuse recovery.

In 2006, the United States Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) offered ten fundamental components of recovery that are (a) self-direction; (b) individualized and person-centered; (c) empowerment; (d) holistic; (e) non-linear; (f) strengths-based; (g) peer support; (h) respect; (i) responsibility; (j) hope. Taking these aspects of recovery into account, SAMHSA (2006) issued a definition of mental health recovery that is in alignment with tenets of social cognitive theory. The description of recovery acknowledges the significance of agency, the full scope of the transformation process, and the suggestion of

Davidson and White (2007) that successful long-term sustained recovery includes "having a safe, dignified, and gratifying life in the presence of ongoing disability" (p. 112). The characteristics that SAMHSA applies to its definition and description of mental health recovery align well with the underpinnings of social cognitive theory and, therefore, are useful in the current study (p. 1).

> "Recovery is a journey of healing and transformation enabling a person with a substance abuse problem to live a substance-free, meaningful life in a community of his or her choice while striving to achieve his or her full potential".

The holistic approach toward mental health and recovery services recently adopted by mental health professionals and governmental agencies provides a hopeful outlook for people seeking treatment from substance abuse as well as long-term sustained recovery and a meaningful life. The completion of a college education offered by the Centers at the focus of this study could conceivably improve the quality of life for recovering individuals by promoting more than just a substance-free lifestyle. Bell et al. (2009) found that recovering students believed that college might not have been possible were it not for the program at Texas Tech University that provided "a ready-made recovery community" (p. 656).

Program development on college and university campuses is essential, especially given the widespread suicides and alcohol /drug related deaths at universities. Dr. John Sexton, the President of New York University, described

student wellness as the "single biggest growth element" present in higher education institutions, offering one reason for the increase of tuition and fees in recent years (Charlie Rose Interview, July, 2010). He went on to state "the best indicator of student wellness is the building of small communities" through programs in which students have the ability to find belonging with similar peers. Although he was speaking specifically about the widespread suicide rates at universities rather than drug and alcohol related issues, he endorsed the creation of small collegiate communities for specific populations. By sanctioning the provision of small communities as a form of providing students with a source of belonging, Dr. Sexton affirms the use of collegiate communities for the prevention of tragedies like suicide, or, in the case of recovering college students, relapse. Supporting Dr. Sexton's position, a collegiate recovery setting offers recovering students a sense of belonging that could conceivably support them in their recovery (Harris, Baker, & Cleveland, 2010).

Programs specifically targeting recovering college students offer recovering young adults who may have felt disenchanted or discouraged by the abundance of substance use in the collegiate atmosphere a supportive environment with like-minded peers, much like the small communities described by Sexton (2010) and Harris, Baker, and Cleveland (2010). Although recovering communities are often overshadowed by the shame and stigma that typically accompany substance abuse, the hope is that leaders in the field of higher education will see the enormous benefits of such programs, consequently

initiating facilities like the ones discussed in this research. Effective programs would provide recovering students with a safe place to reach their academic, personal, and professional goals, ideally preparing them for successful integration into society. With this in mind, the hypotheses for this study are as follows. (See Figure 1)

> ***Hypothesis one*** predicts, of the four sub-groups of social support, appraisal (emotional) support will be most strongly related to recovery.
>
> ***Hypothesis two*** predicts there will a positive relationship between recovering students' perceptions of overall (functional) social support and their overall level of recovery.

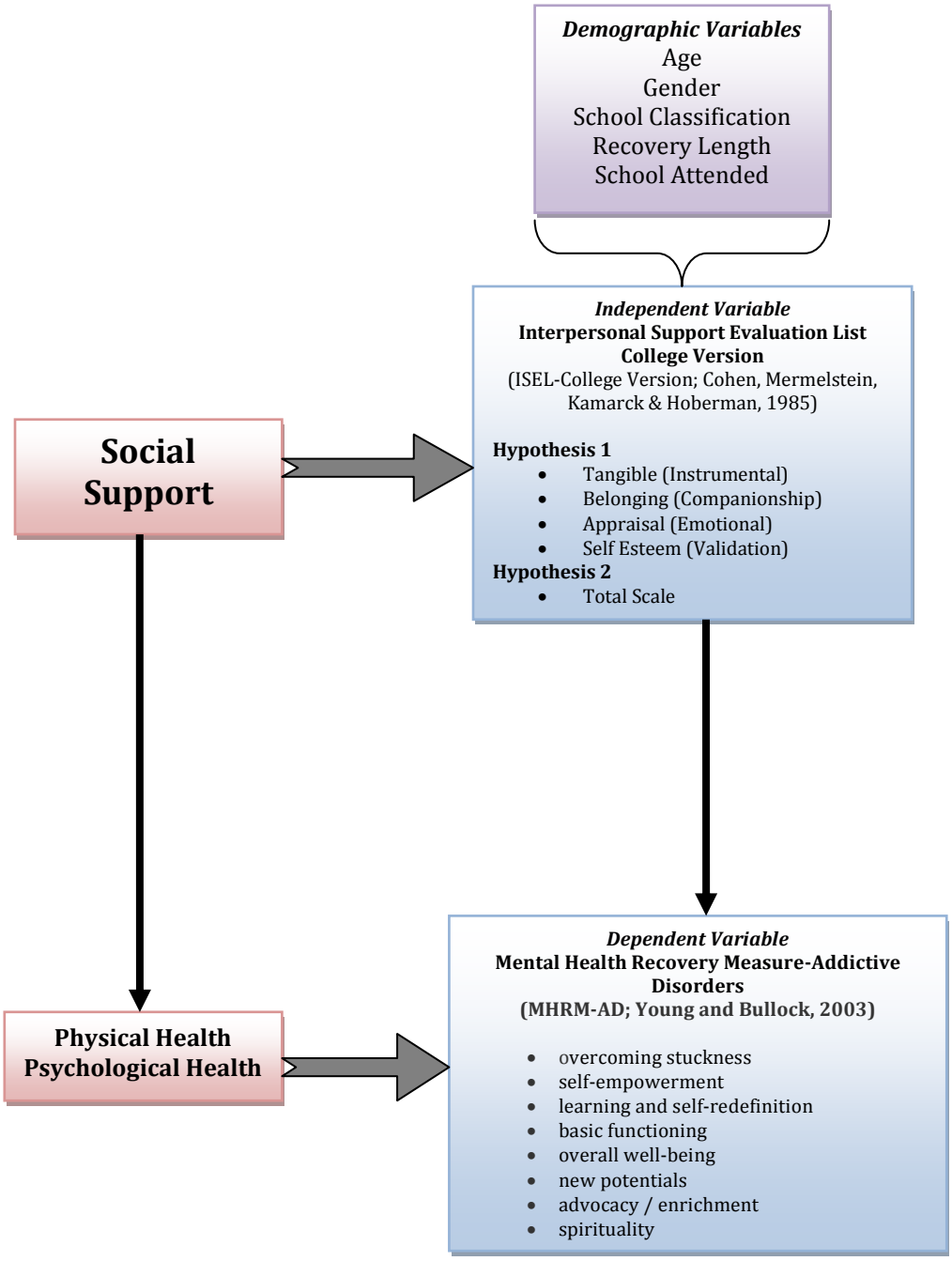

Figure 1. Hypotheses Model

CHAPTER III

METHODOLOGY

Procedures

This study uses secondary data from a longitudinal investigation of Collegiate Recovery Communities (CRCs) that was collected in the Fall 2010 semester through the Center for the Study of Addiction and Recovery (CSAR) at Texas Tech University (TTU). Four universities were chosen from the larger study (*N*=84). The CSAR Research Team obtained approval from the TTU Institutional Review Board (IRB) to conduct the investigation. Likewise, each research site Director obtained permission for data collection from their respective school administration based on the TTU IRB approval or through its own IRB approval process. Once the final school obtained IRB approval, TTU staff and graduate students traveled to each site and data collection began.

Recruitment of Participants. The Directors were contacted by email or phone and asked to designate a specific time and a secure place for data retrieval. Additionally, a designated contact person (other than the Director) was appointed at each location so Directors would not know the identities of participating students, avoiding any favoritism for participation or nonparticipation in the project on the part of the Director. Thus, participation in the study was confidential and voluntary. The students were recruited by the TTU research team by email through the Director of each CRC.

At the onset of data collection, the TTU researchers explained to students the voluntary nature of the study and the steps that would be taken to maintain confidentiality. Additionally, participants were told Center Directors would not view the data at any time. It was also explained that each participant was assigned a number and data associated with that number would remain anonymous. The Project Manager was to be the only person having the ability to link the data with the assigned number and the data were to remain locked and secure on the TTU campus. The students were given the phone numbers of whom they could contact if they had any questions or concerns because sometimes personal questions can cause stress for individuals. Lastly, participants at each site would have the option to enter their name in a drawing to be eligible for a $100.00 gift card. The participants then completed consent forms, returning a signed form and keeping a copy for themselves and they completed the surveys.

Sample. Approximately 200 students were participating in the CRCs that were at the four locations included in the study during the semester of data collection. Of those, 146 completed the questionnaires. The eligibility in this study required that students be between the ages of 18-26. Ultimately, 84 students participated in the study (49 males and 35 females: *M* age = 22.4 years, *SD* = 2.2). The ethnicity was mostly Caucasian (94%). Of the remainder, 2 participants were African American (3%), 1 Native American (1%), I Mexican-American (1%) and 1 participant chose "Other" (1%). Students' school

classification was reasonably divided, with freshmen comprising 19 %, sophomores 27 %, juniors 28 %, seniors 21 %. Five reported to be graduate students or "Other". School A had the smallest number of participants (12%). School B, School C, and School D had more participants, with 32%, 24% and 32%, respectively (See Table 1).

Each CRC has a unique set of requirements for admission into their programs. For the purpose of this study, it was assumed that all students would have had at least six months of continuous recovery at the time they were admitted into the program. The responses to the "Recovery Length" option on the survey indicated that 6 students had less than 7 months in recovery, revealing that some relapses had taken place. Seventy-five percent reported between 1 and 7 years in recovery. Regarding primary addiction, 47 (56%) considered alcohol to be their primary addiction and 37 (44%) reported drugs to be their primary addiction. All participants had completed at least one full semester of school while participating in their respective CRC prior to the semester of data collection.

Measures. *Perceived Social Support* was determined using the Interpersonal Support Evaluation List College Version (ISEL- Cohen, Mermelstein, Kamarck, & Hoberman, 1985). The ISEL is a 48-item self-report instrument intended to measure "perceived availability" of functional social support (p. 103). The instrument encompasses four 12-item subscales indicating the degree to which study participants perceive functional social support. The

types of support assessed by the ISEL are: (a) appraisal support (emotional) (b) validation support (Selfesteem); (c) tangible support; (d) belonging (companionship).

Each subscale has six statements indicating support and six reverse-scored statements that indicated no support. An example of a statement indicating positive support on the "tangible" subscale is, "I know someone who would loan me $50 so I could go away for the weekend". An example of a statement indicating no support on the "tangible" subscale is, "I don't know anyone who would loan me several hundred dollars to pay a doctor bill or dental bill". The original scale has two selections available for each statement that are (a) probably true (score = 1) and (b) probably false (score = 0). However, in this study, in order to capture a clearer value for social support, the selections offered were (a) definitely true (score = 4), (b) probably true (score = 3), (c) probably false (score = 2), or (d) definitely false (score = 1). The ISEL also provides a total score for overall perceived social support by adding the scores for all items on the scale (alpha = .89). On the subscales and the overall scale, higher scores signify higher levels of perceived support.

Recovery was assessed by the use of the Mental Health Recovery Measure (MHMR -AD Young & Bullock, 2003). The original MHMR is a 30-item self-report instrument designed to measure a person's perception of his or her own recovery from serious mental illness. Although a number of participants in the study may experience mental health problems, it is possible that some

participants could be offended by the mental health term. For this study, the MHRM was modified by either omitting the term mental illness or by replacing it with the term addictive disorder. For instance, the statement "I work hard towards my mental health recovery" is modified to say, "I work hard towards my recovery".

The domains of the MHRM (overcoming stuckness, self-empowerment; learning and self-redefinition, basic functioning, overall well-being, new potential, advocacy / enrichment, spirituality) seem comparable to domains that would measure overall recovery for substance abusers. Responses are selected from a 5-point Likert scale that range from 0 for "strongly disagree" to 4 for "strongly agree". Even though the MHRM consists of subscales, it is recommended the total score be summed, with higher scores indicating greater levels of self-perceived recovery. Internal consistency (alpha = .93) and test-retest reliability have been established in the MHRM (Bullock, 2003). Criterion validity has been established through correlations with already established measures (Breedlove, 2005; Bullock & Young, 2003). In this study, the MHRM-AD (Young & Bullock, 2003) reliability was established (alpha = .94)

CHAPTER IV

RESULTS

Correlations among Variables

Coding for the categorical variables and descriptive statistics are given in Table 1, and Pearson correlation coefficients for all variables are shown in Table 2. The correlations of primary interest for this study are between social support (variables 8-12) and recovery as measured by the MHRM (variable 13). There were significant correlations between recovery and the total social support scale ($r = .256$, $p < .05$) and also between recovery and one social support subscale, validation ($r = .244$, $p < .05$). Although these are modest correlations, indicating an overlap of five to six percent of the variance in the measures, they nevertheless provide some evidence for the hypothesized link between social support and recovery.

Also noteworthy in Table 2 are the correlations with length of recovery (variable 3). As would be expected, recovery length is positively correlated with age ($r = .28$, $p < .05$). It also is positively correlated with tangible social support ($r = .289$, $p < .01$). However, there is no significant correlation between length of recovery and the MHRM recovery measure, suggesting that the aspects of perceived recovery being measured by the MHRM do not increase for people who have lived with recovery for longer time periods, at least within the limits of the recovery periods encompassed by this study.

Multiple Regression Analyses

In addition to correlations, hypotheses were tested with multiple regression analysis. The purpose of employing multiple regression was to ascertain the unique effects accounted for by social support variables in relation to the criterion variable, MHRM recovery, when demographic/background variables were included in the analysis. Thus, in the following two regular (not stepwise) regression analyses, the set of predictor variables included age, gender, length of recovery, college classification, and school attended (coded as dummy variables).

In the first regression (Table 3), testing hypothesis 1, the four subscales of the ISEL were included with the above demographic/background variables as predictors of recovery. Results of this analysis were discrepant with the first-order correlations in two ways. The first was that in the regression analysis age was significantly (negatively) related to the recovery score. The second was the absence of a significant association between the validation subscale and recovery. These changes from the correlation analysis are likely due to the negative relationship of age with both validation and MHRM recovery (Table 2). Thus, although these relationships might be pursued in future research, it is concluded that there is no convincing evidence in support of hypothesis 1.

Hypothesis 2 predicted there would be a positive relationship between recovering students' perceptions of overall social support as measured by the

total score of the ISEL and students' self-assessed quality of recovery as measured by the MHRM. In this regression analysis (Table 4), age once again was a significant predictor variable, indicating that younger students perceived their recovery to be at a higher level than older students. Unlike the previous analysis, however, the relationship between social support using the total score of the ISEL measure and recovery was statistically significant. This constituted support for hypothesis 2.

Table 1. Variables

Variable	Number of Students	*M*	*SD*	*N*
Age	19 – 11			84
	20 – 10			
	21 – 13			
	22 – 7			
	23 – 15			
	24 – 9			
	25 – 11			
	26 - 8			
Gender	Males – 49			84
1= *Male*	Females - 35			
2 = *Female*				
Ethnicity	Caucasian – 78			83
1 = *African American*	African American – 2			
3 = *Caucasian*	Native American – 1			
5 = *Native American*	Hispanic – 1			
6 = *Hispanic*	Other – 1			
8 = *Other*				
Classification	Freshmen – 16			84
Freshmen = 1	Sophomore – 23			
Sophomore = 2	Junior – 23			
Junior = 3	Senior – 18			
Senior = 4	Other - 4			
Other = 5				
School	School 1 – 10			84
1 = *School 1*	School 2 – 27			
2 = *School 2*	School 3 – 20			
3 = *School 3*	School 4 – 27			
4 = *School 4*				
Recovery/ months	< 12 – 20	26.02	16.8	83
	13-24 – 24			
	25-36 – 24			
	37-48 – 6			
	> 49 – 9			

Table 2. Demographic, Social Support and Recovery Variables: Correlations (N = 84)

Variables	1	2	3	4	5	6	7	8	9	10
1. Age	–									
2. Gender	-.069	–								
3. Recovery/length	.280*	.109	–							
4. Classification	.524**	.016	.242*	–						
5. School 2	.145	.194	.217*	.027	–					
6. School 3	.118	-.132	-.155	-.084	-.385**	–				
7. School 4	-.083	-.168	.138	.149	-.474**	-.385**	–			
8. Appraisal	.322**	-.254*	.096	.189	.235*	.085	-.141	–		
9. Belonging	-.021	.053	-.056	-.116	-.008	.084	-.050	.216	–	
10. Tangible	.085	.118	.289**	.267*	.122	.030	.007	.106	.272*	–
11. Validation	-.151	-.051	.020	-.143	.114	-.063	.016	.100	.136	.247*
12. Total ISEL	.070	-.032	.127	.058	.166	.056	-.062	.520**	.686**	.642**
13. Total MHRM	-.140	-.198	.096	-.032	-.081	.068	.096	.101	.100	.190

**p < .05*
*** p < 01*

Table 2. Demographic, Social Support and Recovery Variables: Correlations (N = 84), continued.

	11	12	13
11	–		
12	.630**	–	
13	.244*	.256*	–

*p < .05
** p < 01

Table 3. Regression Analysis for Variables Predicting Students' Quality of Recovery, using ISEL Subscores (N= 78)

Variable	Model 1			Model 2		
	B	*SE B*	*β*	*B*	*SE B*	*β*
Age	-.081	.032	-.357*	-.071	.033	-.315*
Gender	-.194	.119	-.191	-.182	.124	-.178
Recovery in months	.006	.004	.209	.005	.004	.179
School classification	.067	.056	.168	.059	.060	.149
School 2 (dummy)	-.052	.210	-.048	-.166	.218	-.155
School 3 (dummy)	.096	.210	.082	.014	.215	.012
School 4 (dummy)	-.037	.214	-.034	-.105	.214	-.097
Appraisal				.101	.310	.043
Belonging				.046	.221	.026
Tangible				.271	.271	.135
Validation				.307	.218	.173
R^2		.042			.057	
F for change in R^2		1.475			1.414	

*$p < .05$

Table 4. Regression Analysis for the Variables Predicting College Students' Quality of Recovery, using ISEL Total Score (N= 78)

	Model 1			Model 2		
Variable	*B*	*SE B*	*β*	*B*	*SE B*	*β*
Age	-.078	.032	-.350*	-.074	.031	-.335*
Gender	-.188	.116	-.186	-.177	.114	-.175
Recovery in months	.006	.004	.204	.006	.004	.188
School classification	.071	.055	.182	.064	.053	.165
School 2 (dummy)	-.052	.206	-.049	-.140	.205	-1.32
School 3 (dummy)	.093	.208	.080	.019	.206	.016
School 4 (dummy)	-.056	.210	-.053	-.101	.206	-.094
ISEL Total				.731	.345	.238*
R^2		.036			.081	
F for change in R^2		1.421			1.865	

*$p < .05$

CHAPTER V

DISCUSSION

Primary Finding

This study is the first inquiry that assessed recovering college students through a national database from multiple universities. The intention of the study was to evaluate the Replication Model put forth in the curriculum, *Making an Opportunity on Your Campus: A Comprehensive Curriculum for Designing a Collegiate Recovery Community* (Harris, Baker & Thompson, 2005) used by the Center for the Study of Addiction and Recovery (CSAR) at Texas Tech University. This study evaluated one aspect of the model by determining the connection between perceived social support and perceived quality of recovery among recovering college students.

In both correlation and regression analyses (which controlled for demographic and background variables), social support, measured as the total ISEL score, was significantly related to students' perceptions of their recovery. This result supports the hypothesis of a positive relationship between these two variables: When students feel supported, they report higher levels of recovery as assessed by the MHRM. This finding provides empirical support for an important component of the CSAR Replication Model and suggests that students can benefit from campus recovery communities that emphasize social support. It may well be that these factors feed into each other over time: Social support

enhances progress in recovery, and this progress, in turn, enables students to take more advantage of social support opportunities.

A second hypothesis of the study was not supported in that significant relationships were not found between types of support (subscales of the ISEL--appraisal, belonging, tangible, validation) and perceptions of recovery. This could imply the need for a holistic approach of support for recovering students where students can access the all of the social support services combined. It could also mean that students rely on support based on their specific individual needs. For example, for some, emotional support from staff and other students may be the most important type of social support related to their recovery. For others, tangible support in the form of scholarships may be most important. It is the total social support scale, rather than subscales, that would capture components important for all members of a sample of students. This reinforces the importance, reflected in the program model, of providing an array of services for recovering students.

Additional Finding

An unanticipated finding of this study was the negative relationship obtained between age and the MHRM recovery scale. This relationship was negative in both the first-order correlations and regression analyses and was statistically significant in the regressions. It may be that younger students, in the earlier stages of recovery, are more likely to be experiencing a deep gratitude for recovery. In the field of addiction, this phenomenon is called a "pink cloud". Also,

the disease of addiction is progressive. Younger students may not have experienced substance abuse to the extent that older students have and therefore may not have as much difficulty maintaining their positive attitude toward recovery. Finally, it could be that younger students have more familial support or that they are not yet encountering some of the stress associated with developing romantic relationships or with graduating from college and being self-sufficient that may negatively impact perceived progress in recovery.

Future Research on the Recovery Program Model

This study on perceived social support in relation to recovery is a starting point for research into the CSAR Replication Model. There are many other directions this research might take, an important one being the validation of existing measurement instruments for this population. In this study, the relationship between social support and recovery, although significant, was not as strong as might be expected, given the hypothesized importance of social support for recovery on college campuses. This might be due to a variety of factors that could be explored, but the development or revision of measures to establish their validity is an important first step.

Future directions could also include qualitative methods such as structured interviews and focus groups. Structured interviews and focus groups could help clarify the meanings for this group, for example, of social support, recovery, and relapse. Qualitative methods also are useful in the initial stages of

measurement development and revision, mentioned above as an important direction for research.

A more comprehensive way of looking at the CRCs would be through program evaluation. A full-blown program evaluation would include all program components, assessment of multiple stakeholders, and comparison of sites. This type of investigation requires a major investment, but the information gained may be useful in determining the issues for more targeted research efforts, and the best directions to take as replication efforts move forward.

Conclusion

Until recently, there have been few programs to support recovering students on higher education campuses. However, as colleges and universities portray their institutions as promising places for young adults to seek higher education, parents (primarily) are insisting on the provision of safe environments that promote students' physical, mental, and emotional well-being. Collegiate Recovery Communities can offer support and a safe haven for this particularly vulnerable population, potentially making the difference between no college education and a college degree, or relapse versus sustained recovery. Based on this study, the curriculum offered by the Center for the Study of Addiction and Recovery at Texas Tech shows promise. More research is needed of CRCs so existing programs can continue to improve and administrators can see the value in implementing new programs. Research on the social support model could be improved upon through the development of new measures beginning

with a qualitative inquiry. Finally, research aimed at other areas of the program can be conducted to see what other factors may contribute to the well-being of recovering students.

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APPENDIX A

INTERPERSONAL SUPPORT EVALUATION LIST - COLLEGE VERSION

Continuing to think about your life and relationships overall, use the key to choose the selection that most fits what you think. Use the following key to guide your answers.

1 = Definitely False 2= False 3= Probably True 4= True

1. I know someone who I see or talk to often with whom I would feel perfectly comfortable talking about problems I might have budgeting my time between school and my social life.
2. I know someone who would loan me $50 so I could go away for the weekend.
3. Most people who know me well think highly of me.
4. Most of my friends think that I'm smart.
5. There are people at school or in town who I regularly run with, exercise with, or play sports with.
6. There isn't anyone at school or in town with whom I would feel perfectly comfortable talking about my feelings of loneliness and depression.
7. I hang out in a friend's room or apartment quite a lot.
8. Most of my friends don't do as well as I do in school.
9. I don't know anyone at school or in town who would loan me their car for a couple of hours.
10. I don't usually spend two evenings on the weekend doing something with others.
11. I don't know anyone at school or in town who makes my problems clearer and easier to understand.
12. If I decided at dinner time to take a study break this evening and go to a movie, I could easily find someone to go with me.
13. Most people are more attractive than I am.
14. I don't know anyone at school or in town who would get assignments for me from my teachers if I was sick.
15. People hang out in my room or apartment during the day or in the evening.
16. If I needed it, my family would provide me with an allowance and spending money.
17. Lately, when I've been troubled, I keep things to myself.

18. I know someone who would loan me $100 to help pay my tuition.
19. I know someone who I see or talk to often with whom I would feel perfectly comfortable talking about sexually transmitted diseases.
20. I will have a better future than most other people will.
21. I can get a date who I enjoy spending time with whenever I want.
22. I know someone who I see or talk to often with whom I would feel perfectly comfortable talking about any problems I might have adjusting to college life.
23. If I wanted a date for a party next weekend, I know someone at school or in town who would fix me up.
24. Most of my friends have more control over what happens to them than I.
25. I don't talk to a member of my family at least once a week.
26. I know someone who I see or talk to often with whom I would feel perfectly comfortable talking about any problems I might have meeting people.
27. I don't often get invited to do things with other people.
28. Most of my friends are more interesting than I am.
29. There isn't anyone at school or in town with whom I would feel perfectly comfortable talking about difficulties with my social life.
30. I belong to a group at school or in town that meets regularly or does things together regularly.
31. Most of my friends have not adjusted to college as easily as I have.
32. I know someone who would give me some old dishes if I moved into my own apartment.
33. I don't have friends at school or in town who would comfort me by showing some physical affection.
34. Even if I needed it m family would (or could) not give me money for tuition and books.
35. There isn't anyone at school or in town with whom I would feel perfectly comfortable talking about any problems I might have getting along with my parents.
36. Most people think I have a good sense of humor.
37. I know someone who I see or talk to often with whom I would feel perfectly comfortable discussing any sexual problems I might have.
38. I don't know anyone who would give me some old furniture if I moved.
39. Most of my friends are more popular than I am.

40. I am not a member of any social groups (such as church groups, clubs, teams, etc.)
41. I know someone who I see or talk to often with whom I would feel perfectly comfortable talking about any problems I might have with drugs.
42. I don't know anyone who would loan me several hundred dollars to pay a doctor bill or dental bill.
43. I know someone at school or in town who would bring my meals to my room or apartment if I were sick.
44. Lately, I often feel lonely, like I don't have anyone to reach out to.
45. Most of my friends are more satisfied or happier with themselves than I am.
46. There isn't anyone at school or in town with whom I would feel perfectly comfortable talking about any problems I might have with making friends.
47. I don't feel friendly with any teaching assistants, professors, campus or student officials.

*** Unintentionally omitted from the survey.

48. I don't know anyone at school or in town who would help me study for an exam by spending several hours reading me questions.

APPENDIX B

MENTAL HEALTH RECOVERY MEASURE FOR ADDICTIVE DISORDERS

(ADAPTED FROM THE MHRM, YOUNG & BULLOCK, 2003)

The goal of this questionnaire is to find out how you view your own current recovery process. The addictive disorder recovery process is complex and is different for each individual. There are no right or wrong answers. Please read each statement carefully, with regard to your own current recovery process, and indicate how much you agree or disagree with each item by filling in the appropriate circle.

SD = *Strongly Disagree* D = *Disagree* NS = *Not Sure*

A = *Agree* SA = *Strongly Agree*

		SD D NS A SA
1.	I work hard towards my addictive disorder recovery.	O O O O O
2.	Even though there are hard days, things are improving for me.	O O O O O
3.	I ask for help when I am not feeling well.	O O O O O
4.	I take risks to move forward with my recovery.	O O O O O
5.	I believe in myself.	O O O O O
6.	I have control over my addictive disorder problems.	O O O O O
7.	I am in control of my life.	O O O O O
8.	I socialize and make friends.	O O O O O
9.	Every day is a new opportunity for learning.	O O O O O
10.	I still grow and change in positive ways despite my addictive disorder problems.	O O O O O
11.	Even though I may still have problems, I value myself as a person of worth.	O O O O O
12.	I understand myself and have a good sense of who I am.	O O O O O
13.	I eat nutritious meals everyday.	O O O O O
14.	I go out and participate in enjoyable activities every week.	O O O O O
15.	I make the effort to get to know other people.	O O O O O

		SD D NS A SA
16.	I am comfortable with my use of prescribed medications.	0 0 0 0 0
17.	I feel good about myself.	0 0 0 0 0
18.	The way I think about things helps me to achieve my goals.	0 0 0 0 0
19.	My life is pretty normal.	0 0 0 0 0
20.	I feel at peace with myself.	0 0 0 0 0
21.	I maintain a positive attitude for weeks at a time.	0 0 0 0 0
22.	My quality of life will get better in the future.	0 0 0 0 0
23.	Every day that I get up, I do something productive.	0 0 0 0 0
24.	I am making progress towards my goals.	0 0 0 0 0
25.	When I am feeling low, my religious faith or spirituality helps me feel better.	0 0 0 0 0
26.	My religious faith or spirituality supports my recovery.	0 0 0 0 0
27.	I advocate for the rights of myself and others with addictive disorder problems.	0 0 0 0 0
28.	I engage in work or other activities that enrich myself and the world around me.	0 0 0 0 0
29.	I cope effectively with stigma associated with having an addictive disorder problem.	0 0 0 0 0
30.	I have enough money to spend on extra things or activities that enrich my life.	0 0 0 0 0

Thank you for completing this measure.

The MHRMAD has been adapted from the MHRM© that was developed with the help of mental health consumers by researchers at the University of Toledo, Department of Psychology. Research for the MHRM was supported through a grant from the Ohio Department of Mental Health, Office of Program Evaluation and Research. For further information, please contact Wesley A. Bullock, Ph.D. at (419) 530-2721 or email: wesley.bullock@utoledo.edu.