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Researchers have estimated that on any given college campus, 4% of students are in recovery from alcohol and/or other drug addiction (Harris, Baker, & Thompson, 2005). Over the past several years, Collegiate Recovery Programs (CRPs) and Collegiate Recovery Communities (CRCs) have started to become more widespread, focusing on the welfare of those students who identify as being in recovery from alcohol and/or other drug addiction. Despite the growing number of CRPs/CRCs in the country, many students have reported that the negative stigma associated with substance use disorders (SUDs) has stopped them from utilizing these recovery-based services (Mackert, Mabry, Hubbard, Grahovac, & Holleran Steiker, 2014). Although this statement has not yet been supported by empirical evidence, the effects of stigma on students seeking mental health services have been demonstrated. In fact, stigma has been identified as one of the greatest barriers to seeking mental health services for college students (Martin, 2010). It is also noteworthy that several studies have shown that substance use disorders are viewed as more stigmatized than any other mental health disorder (Corrigan, Kuwabara, & O'Shaughnessy, 2009; Livingston, Milne, Fang, & Amari, 2011; Room, 2005; Schomerus et al., 2011).

The purpose of this study was to fill this gap in the literature by exploring the stigma experienced by college students in recovery from alcohol and/or other drug addiction. The researcher conducted a qualitative research study using Photovoice

methodology to gain an in-depth, foundational understanding of how stigma was experienced by the participants involved in the study. Wang and Burris (1997), the founders of Photovoice, stated that this approach may be "particularly powerful for . . . people with socially stigmatized health conditions or status" (p. 370).

Participants in this study included undergraduate college students who self-identified as being in recovery from alcohol and/or other drug addiction. They were asked to take photographs that represented their experiences of stigma and to answer questions related to the portrayal of these experiences. The participants then shared and discussed these photographs in a focus group. Interpretative Phenomenological Analysis (IPA) was used to analyze the data. Participants identified several common themes that were present in both the focus group discussions and the photographs. These themes were then placed into categories and mapped onto Frost's (2011) model of social stigma in order to create a conceptual framework for understanding how college students in recovery from alcohol and/or other drug addiction experience stigma. The categories include: sources of stigma, experiences of stigma, consequences of stigma, coping and support strategies and intersectionality. Finally, implications for practice and research are discussed.

VOICES OF RECOVERY: AN EXPLORATION OF STIGMA EXPERIENCED BY COLLEGE STUDENTS IN RECOVERY FROM ALCOHOL AND/OR OTHER DRUG ADDICTION THROUGH PHOTOVOICE

by

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This photograph was taken after I summited a mountain on one of the most challenging hikes of my life; a hike that caused me to second-guess myself and my abilities throughout its duration. This doctoral program, although not physically strenuous, has challenged me with what seemed like unsurmountable obstacles at times. Had it not been for the support of those around me, I'm not sure I would have made it . . . but alas, here I am—nearing the summit.

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CHAPTER I

INTRODUCTION

In the United States, substance use disorders, illicit drug use, and binge drinking are more prevalent among young adults (18-25) than any other age group (Center for Behavioral Health Statistics and Quality, 2016). The 2014 National Institute of Health's *Monitoring the Future: National Survey Results on Drug Use* also showed that binge drinking and amphetamine use was greater among college students than their non-college attending peers (Johnston, O'Malley, Bachman, Schulenberg, & Miech, 2015). Historically, much of the focus for research and programming on college campuses has revolved around prevention, screening, and treatment (Laudet, Harris, Kimball, Winters, & Moberg, 2014). However, despite these efforts, the prevalence of student alcohol and other drug use has not decreased in the past two decades; in fact, the incidences of usage have increased over time (Johnston et al., 2015).

What has changed drastically in the past 20 years is the number of adolescents and young adults admitted to treatment for substance use disorders (SUDs) (Cleveland, Harris, Baker, Herbert, & Dean, 2007). This increase has resulted in an increase in the number of young adults who identify as being in recovery from SUDs (White, 2007b). Considering that almost half of young adults between the ages of 18 and 24 are enrolled in or have completed college (Kids Count Data Center, 2016), many of these individuals leaving treatment will end up in an institution of higher education. In fact, researchers

estimate that 4% of any given college population is made up of individuals currently in recovery from alcohol and/or other drug addiction (Harris, Baker, & Thompson, 2005).

At the same time, there also appears to be a paradigm shift happening in the field of addiction, moving from pathological, intervention based models towards a more recovery-oriented model of care (White, 2007b). The President's National Drug Strategy, a document distributed annually through the White House Office of National Drug Control Policy (ONDCP), has stressed the importance of supporting those in recovery, specifically calling for an increase in programs in institutions of higher education (Laudet et al., 2014). Many colleges and universities have responded to this need by establishing Collegiate Recovery Programs (CRPs) and Collegiate Recovery Communities (CRCs) to provide support for students in recovery from alcohol and/or other drug addiction (Laudet et al., 2014).

Since the 1980s, the number of CRPs/CRCs in the United States has grown exponentially. Currently, more than 75 CRPs/CRCs have been established in the U.S. (Harris, Kimball, Casiraghi, & Maison, 2014), most of which have been started within the past 5 years (Association of Recovery in Higher Education [ARHE], 2016b). These programs vary on many dimensions, including services offered, scope, students served, and definitions of recovery. However, all CRPs/CRCs seem to have one common goal: "to support and strengthen students in their recovery and to help them succeed academically" (Harris et al., 2014, p. 232). The Association of Recovery in Higher Education recognizes the importance of these programs and communities, identifying that

"the collegiate community is a fertile ground for supporting students in recovery and positively impacting the stigma associated with addiction" (ARHE, 2016a, para 2).

Despite the increasing number of CRPs/CRCs in the country, researchers have noted that the negative stigma associated with alcohol and/or other drug addiction and, by default, recovery, has stopped many students from utilizing these recovery-based services (Grahovac, Holleran Steiker, Sammons, & Millichamp, 2011; Harris et al., 2014; Mackert, Mabry, Hubbard, Grahovac, & Holleran Steiker, 2014), but this claim has not been substantiated by empirical research. This suggestion has, however, been supported by researchers focusing on mental health disorders, which have found stigma to be one of the greatest barriers to seeking mental health services for college students (Martin, 2010). Additionally, perceived stigma has also been attributed to premature treatment discontinuation (Sirey et al., 2001). Thus, many researchers and practitioners believe that decreases in stigma not only will increase rates of people seeking services, but will also increase rates of recovery (Livingston, Milne, Fang, & Amari, 2011; Mackert et al., 2014).

Stigma was defined by Erving Goffman (1963) as a personal attribute that resulted in a "spoiled identity" or the discrediting of that individual or group. Over time, however, the definition of stigma has changed to reflect more of a responsibility on the part of society (Frost, 2011). This shift places the roots of stigma at the systems or societal level rather than on the individual or group. This social stigma is a result of historical contexts and changes over time. For example, Livingston et al. (2011) defined

health-related stigma as "a socio-cultural process in which social groups are devalued, rejected, and excluded on the basis of a socially discredited health condition" (p. 107).

Although many researchers have sought to understand stigma in relation to mental health disorders, few have focused on the stigma associated with substance use disorders (Livingston et al., 2011), and even fewer have focused on the stigma associated with individuals in recovery from alcohol and/or other drug addiction (Anderson & Ripullo, 1996; Hill & Leeming, 2014). Although 'Substance Use Disorder' is a diagnosis in the Diagnostic and Statistical Manual (DSM), much of the research that has been done in regards to stigma specifically looks at mental health diagnoses as separate from substance use disorders, while a few have looked at individuals with dual diagnoses (e.g., Livingston et al., 2011). In reviewing relevant mental health and stigma literature, it is clear that several researchers have found that "people with a mental illness suffer high levels of stigmatization, which often leads to discrimination and marginalization" (Whitley & Campbell, 2014, p. 2). Several researchers have explored the negative impacts of stigma on individuals with severe mental illnesses (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Drapalski et al., 2013; Yanos, Roe, & Lysaker, 2010), a few of which confirmed that increased levels of stigma correlate with decreased levels of self-esteem (Link et al., 2001; Drapalski et al., 2013), which ultimately becomes a barrier to beliefs around recovery from mental illness (Drapalski et al., 2013; Yanos et al., 2010). It also has been suggested that "for some people the stigma of mental illness can cause even more negative impacts than the mental illness itself, with

disempowerment occurring on social, cultural, economic, and political levels" (Martin, 2010, p. 261).

College students are highly susceptible to the stigma associated with mental health disorders (Quinn, Wilson, MacIntyre, & Tinklin, 2009); in fact, stigma has been identified as one of the greatest barriers to seeking mental health services for college students (Martin, 2010). According to Chickering (1969) and Erikson (1968), many college students are in the developmental stage in which they are seeking connections with others and may be particularly concerned with how they are viewed by others (especially peers), making them a vulnerable population to the stereotypes and discrimination associated with stigma. Herman-Kinney and Kinney (2013) completed a study exploring the lived experiences of nondrinkers on college campuses and, although this study did not focus on students in recovery, it was evident that college students choosing not to drink alcohol experienced discrimination from their peers and went to great lengths to utilize stigma-management techniques to 'belong.' Other authors have indicated that the collegiate environment is not favorable to a recovery lifestyle (Harris et al., 2014). Thus, college students in recovery not only face stigma related to the admitting to having struggled or been diagnosed with a substance use disorder, but also face stigma surrounding abstinence, if this is their chosen path to recovery.

In looking at various models that have been created around stigma, Frost's (2011) model (Figure 1) seems to be the most comprehensive. This model covers both public and self-stigma by combining models that examine the perpetration of stigma with models that identify experiences of stigma. Through this model, Frost (2011) mapped

out how responses to experiences of stigma can result in either negative or positive outcomes. Although Frost mainly drew from theories of stigma in relation to race/ethnicity, gender, and sexual orientation, his model was used in this study as a tool for conceptualizing and addressing stigma experienced by individuals in recovery from alcohol and/or other drug addiction. This model was used in this study to provide a framework for understanding the multiple ways in which stigma can be enacted and experienced and provided a rationale for the need to explore how stigma is experienced before determining ways in which to change the outcomes of stigma.

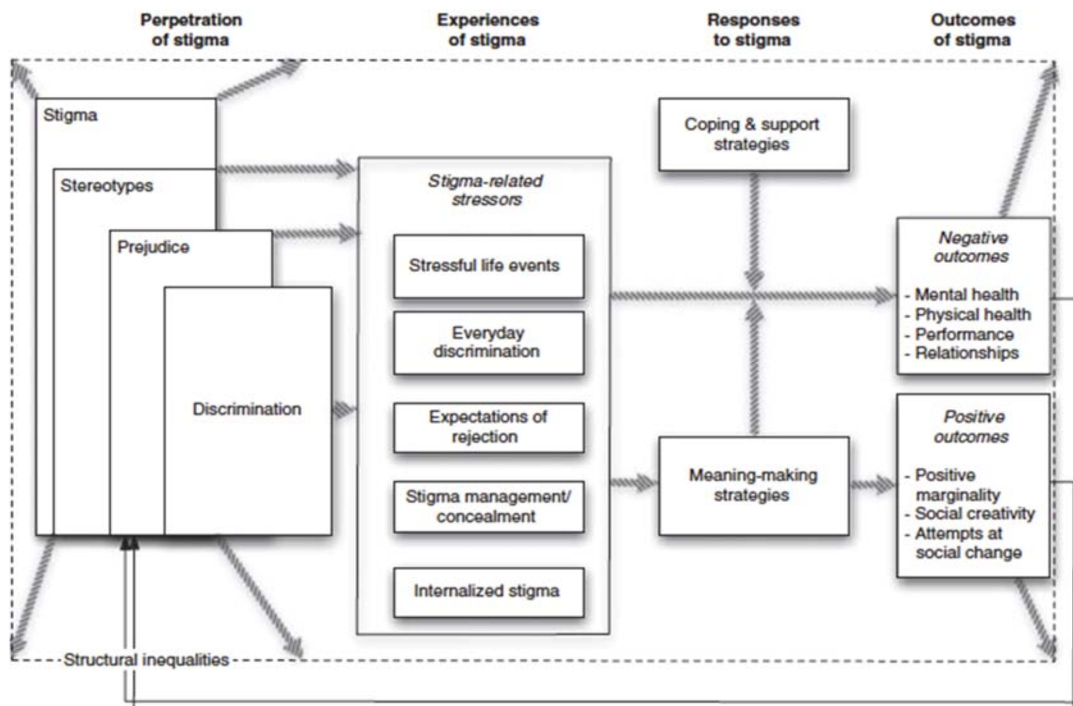

Figure 1. Process Model of Social Stigma and Its Consequences (Frost, 2011, p. 833).

Statement of the Problem

Even though researchers have estimated that, on any given college campus, 4% of students are in recovery from alcohol and/or other drug addiction (Harris et al., 2005), these students have been identified as a hidden group to both researchers and student affairs (Laudet et al., 2014). Over the past several years, CRPs/CRCs have started to become more widespread, focusing on the welfare of those students who identify as being in recovery from alcohol and/or other drug addiction (Harris et al., 2014). Despite the increasing number of CRPs/CRCs in the country, numerous authors have suggested that negative stigma associated with substance use disorders (SUDs) has stopped some students from utilizing these recovery-based services (e.g., Grahovac et al., 2011; Harris et al., 2014; Mackert et al., 2014). This statement has not yet been supported by empirical evidence; however, the effects of stigma on students seeking mental health services have been demonstrated. In fact, stigma has been identified as one of the greatest barriers to seeking mental health services for college students (Martin, 2010).

Up to this point, much of the research that has been completed in regards to substance use on college campuses has revolved around prevention and treatment, while there has been minimal research done with college students who are in recovery from alcohol and/or other drug addiction. Research that has been completed in this area has mostly been done by individuals involved in the creation or maintenance of CRPs/CRCs, and has consisted of descriptive statistics (Cleveland et al., 2007; Harris et al., 2014; Laudet et al., 2014; Laudet, Harris, Winters, Moberg, & Kimball, 2015). Many researchers in the field of collegiate recovery have stressed the importance of completing

more extensive research to be able to best support college students in recovery (Grahovac et al., 2011; Harris et al., 2014; Laudet et al., 2014). Even though several authors have mentioned that stigma associated with SUDs and recovery can be a potential barrier to services, no existing studies have targeted the stigmatic experiences of college students in recovery.

Purpose of the Study

Although stigma has been identified in the collegiate recovery literature as a barrier to recovery, little if any empirical research exists to substantiate this claim. Therefore, the purpose of this study was to begin to fill this gap by exploring the stigma experienced by college students in recovery from alcohol and/or other drug addiction.

Frost (2011) proposed a model (Figure 1) that integrated theories of the perpetration of stigma with theories of experiences of stigma to help determine ways in which people may experience positive outcomes from the stigma that is experienced as opposed to negative outcomes. However, Frost's (2011) model does not include research on how individuals with SUDs or individuals in recovery from alcohol and/or other drug addiction experience stigma. Although Frost noted that consequences of stigma-related stress that have been identified for many marginalized populations, including women and racial/sexual minorities, he emphasized that "there is a tremendous amount of variability in the ways stigmatized individuals and groups respond to experiences of stigma-related stress. Understanding the ways people and groups respond to stigma-related stress is an important endeavor in the psychological study of stigma" (Frost, 2011, p. 830). Because of the lack of existing research investigating the lived stigmatic experiences of college

students in recovery, a qualitative study exploring how stigma is experienced appeared to be the first step in filling this gap in the literature.

Need for the Study

Many researchers and practitioners believe that decreases in stigma will not only increase rates of people seeking services, but will also increase rates of recovery (Livingston et al., 2011). Using Frost's (2011) conceptual model of stigma, it becomes clear that to decrease stigma, or for individuals to have positive outcomes in response to stigma-related stress, we must first understand how stigma is experienced. This study served as an initial step in learning more about how college students in recovery experience stigma. With a research-based understanding of how this population experiences stigma, it may be possible to research ways to create positive outcomes of stigma-related stress and to decrease the perpetration of and negative responses to stigma. Ideally, this research may serve as a foundation for increasing rates of recovery and usage of recovery-based services, or CRPs/CRCs, on college campuses.

Research Question

This research study was designed to answer one broad question: How is stigma experienced by college students who identify as being in recovery from alcohol and/or other drug addiction?

Definition of Terms

According to Kelly, Saitz, and Wakeman (2016),

> The language used to describe health conditions reflects and influences our attitudes and approaches to addressing them, even to the extent of suggesting that a health condition is a moral, social, or criminal issue. The language and

> terminology we use is particularly important when it comes to highly stigmatized and life-threatening conditions, such as those relating to alcohol and other drugs. Scientific research has demonstrated that, whether we are aware of it, the use of certain terms implicitly generates biases that can influence the formation and effectiveness of our social and public health policies in addressing them. (p. 116)

In accordance with this belief and the research provided, the following terms are used throughout this research study:

Substance Use Disorder (SUD)

For this study, substance use disorders were defined using criteria from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). According to SAMHSA (2015),

> The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or other drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. (para. 1)

Use of the term *substance use disorder* is recognizable in much of the literature on recovery. However, for purposes of this study, participants did not have to be formally diagnosed with a substance use disorder to participate, rather they had to self-identify as being in recovery from alcohol and/or other drug addiction.

Addiction

Throughout the literature, some researchers use the term 'substance use disorders,' while others refer to alcohol and/or other drug 'addiction.' According to the American Society of Addiction Medicine (2011),

> Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use . . . Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships. (paras. 1-2)

Recovery

Recovery from alcohol and/or other drug addiction is a very personal experience and there are many pathways to getting there (Substance Abuse and Mental Health Services Administration, SAMHSA, 2012). Thus, many people have found it challenging to define the term 'recovery,' due to a concern that some definitions will be exclusive and not supportive of differing paths and views of recovery (White, 2007a). For this study, White's (2007a) proposed definition of recovery was used:

> Recovery is the experience (a process and a sustained status) through which individuals, families, and communities [negatively] impacted by severe alcohol and other drug problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by alcohol and other drug related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life. (p. 236)

Stigma

Although there has been a steady increase in social science research on stigma over the past two decades, the concept of stigma has been criticized as being "too vaguely defined and individually focused" (Link & Phelan, 2001, p. 363). In response to this, the definition of stigma has changed over time to reflect more of a responsibility on the part of society (Frost, 2011). This shift places the roots of stigma on the systems level or societal level rather than on the individual or group. Link and Phelan (2001) identified that "stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them" (p. 377). This is the definition that was utilized when referring to 'stigma' throughout Chapter II. When meeting with participants during the study, however, the researcher utilized Livingston et al.'s (2011) definition of health-related stigma: "a socio-cultural process in which social groups are devalued, rejected, and excluded on the basis of a socially discredited health condition" (p. 107), as it specifically identifies stigma in relation to health issues.

Summary of Remaining Chapters

This research study will be outlined in five chapters. Chapter I provides an overview of the study, including statement of the problem, purpose of the study, rationale and significance of the study, and definitions of key terms. Chapter II includes a literature review of the conceptual and empirical knowledge published in the areas of addiction, stigma, recovery, and specifically the field of collegiate recovery. Chapter III outlines the research methodology used for this study, which includes an overview of Photovoice as a research method, and interpretive phenomenological analysis. Chapter

III also reports methods and results of the pilot study. Chapter IV presents results of the study and Chapter V provides a discussion of the results, limitations of this study, implications for research and practice, and suggestions for future research.

CHAPTER II

REVIEW OF RELEVANT LITERATURE

Chapter I outlined the purpose of the current study and emphasized the lack of research in regards to how stigma is experienced by college students in recovery from alcohol and/or other drug addiction. The purpose of the current chapter is to provide a comprehensive review of the relevant literature and provide further detail regarding the gap in research with this population. The chapter begins with a review of the literature involving substance use on college campuses and the evolution of Collegiate Recovery Programs and Collegiate Recovery Communities in response to the increasing number of college students in recovery from alcohol and/or other drug addiction. Stigma is then explored in relation to mental health, substance use disorders, and college students, and recovery.

Alcohol and Other Drug Use Among College Students

Young adults between the ages of 18 and 25 are more likely to have diagnosable substance use disorders, use illicit drugs, and participate in binge drinking than any other age group (Center for Behavioral Health Statistics and Quality, 2016). In fact, it is estimated that over 16% of young adults between the ages of 18 and 25 meet the criteria for a substance use disorder. According to SAMHSA (2015),

> The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders . . . Substance use disorders occur when the

> recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. (para. 2)

Young adults ages 18-25 often include the traditional college-age population. The U.S. Census Bureau statistics show that about 50% of young adults between the ages of 18 and 24 are enrolled in or have completed college (Kids Count Data Center, 2016). Researchers have indicated that alcohol and/or other drug use is prevalent both with college students and their non-college attending peers (Johnston et al., 2015). However, the 2014 National Institute of Health's *Monitoring the Future National Survey Results on Drug Use* showed that binge drinking and amphetamine use is greater among college students than their peers who do not attend college (Johnston et al., 2015). Thirty-nine percent of college students report using illicit substances, whereas 35% of college students report heavy drinking on a regular basis (Johnston et al., 2015). Binge drinking, or drinking more than five drinks in a row, has been identified as one of the most concerning public health hazards for college students (Ham & Hope, 2003; Wechsler, Dowdall, Davenport, & Castillo, 1995).

Although many students who participate in binge drinking and other drug use do not develop substance use disorders, there are still negative consequences that can result from this usage. The high prevalence of substance use on college campuses has been associated with lower grade point averages, increased rates of drinking and driving, and increased rates of sexual assault and rape (Ham & Hope, 2003; Hingson, Zha, & Weitzman, 2009; Walters, Bennett, & Noto, 2000). Alcohol-related unintentional injury

deaths continue to increase over time and have been identified as one of the leading causes of death for college students (Hingson et al., 2009). It is clear that these consequences not only affect those students who may be struggling with alcohol and/or other drug related problems, but also impact their peers, particularly those who live on campuses that have high proportions of students participating in binge drinking and illicit drug use (Ham & Hope, 2003; Walters et al., 2000).

Historically, much of the focus for research and programming on alcohol and other drug use on college campuses has revolved around prevention, screening, and treatment (Laudet et al., 2014). Despite these efforts, however, the prevalence of student alcohol and other drug use has not decreased in the past two decades; in fact, the incidence of usage have actually increased over time (Johnston et al., 2015). Of concern is that the most prevalent onset for substance use disorders continues to be late adolescence and young adulthood (Baker, 2010).

Young Adult Development

Developmental psychologist Erik Erikson proposed a theory of ego development that emphasized adolescence as the most crucial period of identity development, which he identified as a critical psychosocial task (Erikson, 1968). “Although identity formation depends on many variables, society dictates an appropriate time for its achievement, using standards such as duration, intensity, and ritualization of adolescent and young adult development” (Lewis, 2006, p. 30). During this time, it is often assumed that individuals are experimenting with different ways of being in the world, before settling into a more ‘stable’ identity or more clear sense of self. Erikson saw this as the

"central threshold that one must pass through in order to adequately take hold of the responsibilities of adulthood" (Russell, Cleveland, & Wiebe, 2010, p. 24). The research that has been conducted around Erikson's theory of identity development appears to coincide with neurobiological research. "Neuroscientists have taken a keen interest in the development of the adolescent brain and discovered that, far from being a fixed entity by adolescence as once believed, it continues to expand its neuronal connections, especially in the prefrontal cortex: the part of the brain involved in reason, judgment, and decision making" (Lewis, 2006, p. 30).

At around the same time that Erikson was introducing his theory of ego development, Arthur Chickering was exploring a model of college student development (Chickering, 1969). Chickering's conceptual framework, however, focused solely on traditional age college students. He viewed this stage as a "distinct psychosocial phase defined by the emergence of certain inner capabilities and needs which interact with the demands of a particular college environment" and he viewed college campuses as "developmental communities" (Widick, Parker, & Lee Knefelkamp, 1978, p. 20). His developmental model included seven vectors of traditional age college student development. In each of these vectors, Chickering identified different developmental tasks, potential causes of concern and a variety of possible outcomes (Chickering, 1969; Widick et al., 1978). Throughout these vectors, Chickering aligns with much of Erikson's emphasis on identity formation, stating that "at one level of generalization, all the developmental vectors could be classified under the general heading 'identity formation'" (Chickering, 1969, p. 78). This seems to be a central developmental task

that both Chickering and Erikson focused on the development of a coherent and integrated sense of identity.

Scholl and Schmitt (2009) mapped out the 7-vector model created by Chickering (1969), and expounded upon by Chickering and Reisser (1993), to show how each vector could correlate with alcohol use disorder for traditional college-age students, mainly focusing on the use of alcohol in order to navigate each stage and its inherent developmental tasks. Scholl and Schmitt (2009) recognized that this utilization of alcohol to move through the stages of development can be problematic. They recognized that for many students in college, "alcohol use may be related to enhancing a client's sense of belonging" (Scholl & Schmitt, 2009, p. 61), which strongly connects to the idea that during this time of identity development, many adolescents and young adults look to their peers for approval.

Erikson (1968) suggested that during this stage many individuals seem to be "preoccupied with what they appear to be in the eyes of others as compared with what they feel they are, and with the question of how to connect the roles and skills cultivated earlier with the ideal prototypes of the day" (p. 128). Due to the high prevalence of substance use during late adolescence and early adulthood, the potential for peer influence on using substances during this identity formation phase in life is quite great. In fact, researchers have discovered that "the substance use status of peers is especially influential, predicting youths' substance use behavior" (Cimini et al., as cited in Laudet et al., 2014, p. 87).

Researchers have found that heavy substance use during adolescence and early adulthood can negatively impact this identity development (Lewis, 2006). In fact, Russell et al. (2010) suggested that heavy substance use by adolescents "may be one of the factors most likely to impede resolution of the identity stage" (p. 25). There are several reasons why substance use may be linked to challenges in identity development. It could be indicative of the fact that substances can impact social and emotional development, thus interrupting healthy identity development, or it could be that those facing identity challenges may turn to alcohol and/or other drugs to cope (Lewis, 2006). During this stage of identity development, experimentation with different ways of being, including using substances is quite typical and does not necessarily lead to a disruption of identity development; in fact, this experimentation can propel individuals into developing and understanding themselves more fully. However, for those whose experimentation turns into problematic use and addiction, it can negatively impact identity formation.

If identity development is disrupted due to substance use and addiction during adolescence, individuals who enter into recovery may face compounded challenges (Russell et al., 2010). In fact, researchers have found that disrupted identity development can negatively impact one's recovery from substance use disorders (White, Montgomery, Wampler, & Fischer, 2003). One of the biggest challenges for young adults in recovery is isolation. It is common for college students in recovery to isolate themselves from their peers as a result of normalized drinking and drugging on college campuses (Russell et al., 2010). This isolation, however, can negatively impact an already distorted sense of self created by problematic substance use in adolescence. Therefore, it is crucial for

college students in recovery to have social supports to help develop a healthy sense of self and to create a new narrative that allows them to distance themselves from problematic substance use that is no longer a part of their identity.

Collegiate Recovery

Over the past two decades, the number of young adults that have been admitted to substance use disorder treatment programs has increased exponentially (Cleveland et al., 2007). This increase in young adults completing treatment has resulted in an increase in the number of young adults identifying as being in recovery from alcohol and/or other drug addiction. Recovery has been viewed as a very personal experience with many pathways to getting there (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012; White, 2007a). As a result, many people have found it challenging to define the term 'recovery,' due to a concern that some definitions will be exclusive and not supportive of differing paths and views of recovery (White, 2007a). For the purpose of this study, White's (2007a) proposed definition of recovery will be used. He stated:

> Recovery is the experience (a process and a sustained status) through which individuals, families, and communities [negatively] impacted by severe alcohol and other drug problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by alcohol and other drug related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life. (p. 236)

Considering that almost half of young adults between the ages of 18 and 24 are enrolled in or have completed college (Kids Count Data Center, 2016), many individuals in this age range will end up in an institution of higher education. Researchers estimate that 4% of any given college population is made up of individuals currently in recovery

from alcohol and/or other drug addiction (Harris et al., 2005). As a result, it is important for people involved with colleges and universities to try to understand the experiences of students in recovery in order to help create an environment that fosters and supports recovery from alcohol and/or other drug addiction (Perron et al., 2011).

College students in recovery face many challenges. One of the major threats to their sobriety is that "college campuses are regularly characterized by a pro-drug culture in which substance use is considered the norm and a harmless rite of passage" (Perron et al., 2011, p. 51), often putting students in recovery at a potential risk for relapse. "It is hard to imagine individuals who are more threatened by an alcohol-centered social context than those who are trying to maintain recoveries from addictions" (Wiebe, Cleveland, & Harris, 2010, p. 2). Wiebe, Cleveland, and Harris (2010) spoke to the dangers to those in recovery trying to maintain their sobriety in a college environment, stating that:

> Faced with the prospect of risking their hard-won abstinence, many in recovery from substance abuse and addiction consider going to college, whether for the first time or as returning students, an unacceptable risk. Campus social environments present myriad challenges and difficulties for these vulnerable young men and women. They may have difficulty resisting social pressures toward group conformity in what appears to be an alcohol-saturated environment (Perkins, 2002). They may feel shut out of college social life, even the substance-free activities, where discussions often turn to recent or future events involving drug and alcohol use. They may experience stress from the constant bombardment of alcohol ads in and around the campus environment. (p. 3)

Shift in Recovery Paradigm

This need for institutions of higher education to recognize and provide support for students in recovery coincides with the paradigm shift that is currently happening in the

field of addiction (Laudet et al., 2014). According to White (2007a), the field has been in the process of making the much-needed transition from pathological and intervention based models towards recovery-oriented systems of care (ROSC). This effort has been greatly motivated by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). In an interview that White (2007b) conducted with Westley Clark, the director of CSAT, Clark identified that recovery is an instrumental construct in the substance use disorder field. Clark identified that the focus of recovery-focused systems of care focus not only on the individual in recovery, but

> the ability to receive ongoing contact and support from others, either through professional support or through a community of recovering peers. Recovery is more than an abstinence from alcohol and drugs; it's about building a full, meaningful, and productive life in the community. Our treatment systems must reflect and help people achieve this broader understanding of recovery. (White, 2007b, p. 8)

The movement to recovery-based systems of care has been widespread. In 2001, Faces and Voices of Recovery was established. This organization is

> dedicated to organizing and mobilizing the over 23 million Americans in recovery from addiction to alcohol and other drugs, [their] families, friends and allies into recovery community organizations and networks, to promote the right and resources to recover through advocacy, education and demonstrating the power and proof of long-term recovery. (Faces and Voices of Recovery, 2016, para. 1)

Along with movements from SAMHSA and Faces and Voices of Recovery, the White House Office of National Drug Control Policy (ONDCP) issued the annual President's National Drug Strategy in 2010 which established, for the first time ever, a

Recovery Branch at the ONDCP to support Americans in recovery (Office of National Drug Control Policy, 2011). The ONDCP has emphasized the importance of promoting recovery, specifically calling for an increase in peer-driven support programs in academic settings.

This movement from a focus on pathology to one of recovery is supported by the concept of 'capital recovery' (White & Cloud, 2008). Recovery capital (RC) constitutes the internal and external resources that can be utilized to begin and help maintain recovery from alcohol and/or drug addiction. This holistic concept of recovery includes personal recovery capital, which is made up of both physical factors such as access to food, shelter, finances, etc., as well as human factors which include an individual's beliefs and values, self-esteem and interpersonal skills. It also includes family and social recovery capital, which encompasses the presence of supportive familial and social relationships. The final aspect includes community recovery capital, which focuses on the attitudes, policies, and resources available to individuals in recovery from drug and/or alcohol addiction.

Collegiate Recovery Programs (CRPs) and Collegiate Recovery Communities (CRCs)

Many colleges and universities have responded to this paradigm shift and this need to provide students with recovery capital, by establishing Collegiate Recovery Programs (CRPs) or Collegiate Recovery Communities (CRCs) as a place to provide support for students in recovery. Since the 1980s, the number of CRPs and CRCs in the United States has grown exponentially. There are currently more than 75 CRPs/CRCs

(Harris et al., 2014), most of which have started within the past 5 years (ARHE, 2016b). All of these programs vary in a number of ways, including services offered, scope, students served, and definitions of recovery. However, they all seem to have one common goal: "to support and strengthen students in their recovery and to help them succeed academically" (Harris et al., 2014, p. 232).

Peer Social Model

The staff at Texas Tech University's (TTU's) Center for the Study of Addiction and Recovery (CSAR) created a curriculum back in 2005 to provide guidance for other colleges and universities interested in creating a CRP (Harris et al., 2005). Through this process, they surveyed marketing materials, visited multiple programs and interviewed several staff and students at CRPs around the country to establish a theoretical foundation for the curriculum (Baker, 2010). They decided on Salzer's (2002) peer-based social support framework, which is largely grounded in social comparison theory and social learning theory. This framework includes five domains of peer-driven support: (a) emotional support, (b) informational support, (c) instrumental support, (d) validation, and (e) companionship (Salzer, 2002). The team creating the curriculum came to the conclusion that it was crucial for CRPs to provide access to peer-driven support in all of the domains mentioned above to help students maintain and foster their recovery lifestyle, while also supporting them academically (Baker, 2010). Each of these domains is further broken down within the curriculum and together these domains create the theoretical foundation for the curriculum itself.

Figure 2. Types of Functional Support Provided by Collegiate Recovery Programs (Harris et al., 2014, p. 235).

Emotional support. The transition to college, or return to college, can be challenging for many individuals, as this is often a time when individuals move away from family and friends and are transitioning into young adulthood. This time can be especially challenging for those who identify as being in recovery from alcohol and/or other drug addiction, as they may be leaving behind their support network and entering an environment that may prove to be 'hostile' to their abstinent lifestyle (Harris, Baker, & Cleveland, 2010). Many CRPs and CRCs attempt to meet the emotional needs of students by connecting them with a support network as soon as they enter the collegiate environment, including pairing them up with mentors and/or roommates involved in the CRP/CRC immediately. The sense of community that is often established within CRCs/CRPs can assist in the transition to college, thus serving as a form of emotional

support. “To ensure that members are receiving the emotional support needed, CRC programs focus on harnessing the power of interaction between those with similar or shared experiences” and using this power to facilitate change” (Baker, 2010, p. 148).

Informational support. “Informational support is defined as advice or guidance to assist with problem-solving and evaluation for choosing between alternative actions to deal with a given problem” (Baker, 2010, p. 148). Informational support can take the form of academic assistance. Many programs offer academic tutoring and assistance for students involved in the program, providing instrumental support for students who need it (Harris et al., 2010). This domain can also include the teaching of new skills, including social skills, life skills, and job readiness (Baker, 2010). It is recognized that college students in recovery from alcohol and/other drug addiction may experience problems in areas concerning problem-solving and life skills if they used heavily during crucial developmental periods in their lives. Thus, it is the intent of this domain to assist students in these areas to help them maintain sobriety and experience success in institutions of higher education.

Instrumental support. “This type of support involves assisting recovering individuals with navigating societal systems” (Baker, 2010, p. 149). Many CRPs/CRCs offer weekly meetings, alcohol-free events, academic tutoring, etc. The mentoring program that many CRCs/CRPs have in place, serves as an initial attempt to assist new students with traversing this new territory and making them aware of all of the possible services. Mentors often inform new students of the services that are offered on campus, as well as provide information about local 12 step meetings and the transportation that is

available to attend these off-campus meetings (Harris et al., 2010). Other forms of instrumental support that the CRC/CRP can provide include scholarships for tuition and housing, assisting in finding daycare, helping fill out job applications, etc. Since many individuals in recovery from alcohol and/or other drug addiction may have stressed many of their instrumental support systems when they were active in their addiction, it is important to replenish these services, because "without instrumental support, the risk of relapse increases" (Baker, 2010, p. 149).

Validation support. "This type of support centers on the principle of social comparison. Validation results from the belief that one's actions and behaviors are appropriate or normal when compared with those of peers" (Baker, 2010, p. 149). Since drinking and drugging is often normalized on college campuses, it is important for students in recovery to be surrounded by peers who validate their own experiences of sobriety and recovery. This primary reference of peers helps establish a social identity that supports a recovery lifestyle. "If recovery students see that they are similar in thought and action to a group of their peers, recovery behaviors are reinforced and social stigma is reduced or eliminated resulting in validation" (Baker, 2010, p. 149).

Companionship support. Many CRPs and CRCs are founded on the belief that "successful recovery . . . occur[s] when individuals can be assimilated to healthy interpersonal relationships as well as community involvement" (Harris et al., 2014, p. 231). For college students in recovery, a "social environment supportive of recovery that fosters social connectedness is essential" (Laudet et al., 2014, p. 88). CRPs/CRCs attempt to provide a space for this social connectedness, which can, in turn, enhance an

individual's sense of belonging. Many programs have meetings or events that help establish this sense of belonging by encouraging members to share their own personal stories of recovery, echoing much of what people believe makes 12 step recovery programs successful (Harris et al., 2010). To enhance this community connection, many programs provide activities for students that do not revolve around the use of substances, including weekly meetings, support groups, alternative spring break options, sober living dorms, sober tailgate parties, and more.

Although many of these domains overlap in the services provided, it is evident that each domain in crucial in the maintaining the mission of CRPs/CRCs across the country: "to support and strengthen students in their recovery and to help them succeed academically" (Harris et al., 2014, p. 232).

Collegiate Recovery Research

Up to this point, much of the research that has been completed in regards to substance use on college campuses has revolved around prevention and treatment, while there has been minimal research done on college students who are in recovery from alcohol and/or other drug addiction, labeling them as a "hidden group to both researchers and college personnel" (Laudet et al., 2014, p. 88). Research that has been completed in this area has mostly been done by individuals involved in the creation or maintenance of CRPs and CRCs and has mostly been through the use of descriptive statistics. Outcome reports have been documented based on historical records at two of the country's original CRCs, Texas Tech University and Augsburg College, focusing on academic performance and relapse rates (Laudet et al., 2014). These outcome reports have shown that students

involved in CRCs have a higher GPA than other students in the university and the rate of graduation is higher for these students as well (Harris, Baker, Kimball, & Shumway, 2008). This research also showed that relapse rates are much lower than the national average for students involved in CRPs/CRCs (Laudet et al., 2015). It has been suggested in the literature that social support is the most critical factor in reducing relapse rates (Baker, 2010).

In 2011, Smock, Baker, Harris, and D'Sauza reviewed the literature on CRPs/CRCs and found that social support was the most frequently researched concept in the CRP/CRC literature to date. This literature review included a study conducted by Wiebe, Cleveland, and Dean (2010) which involved 73 active CRC participants. In the study, these researchers explored the temptations that these students faced in an 'abstinence-hostile' environment and the tactics they used to abstain from the use of these substances. The researchers discovered that students were more likely to be tempted to use alcohol and/or other drugs when they were faced with life challenges, including relationship and academic struggles, and they found that in order to avoid these temptations, students relied on the social support, both formally and informally, provided by membership within the CRC over any other tactic, including medication.

Cleveland and Groenendyk (2010) also conducted a study on social support of students involved in a CRC. They used daily diary data collections from 55 students looking at the factors that threaten and support recovery. Results from this study showed that these students were very active in the CRC and that this program provided them with a "web of social support" (p. 94), which helped normalize their experience of recovery

and provided them with a 'buffer' in an environment where drinking and drugging is often the normalized lifestyle.

Qualitative research that has been completed related to collegiate recovery is also minimal. Finch (2008) published an article containing a compilation of stories by students who were involved in collegiate recovery programs, but did not attempt to complete an empirical study. These stories were intended to highlight the importance of students being surrounded by recovery-based social supports, suggesting that without supports on campus, these students are more likely to drop out due to the prevalence of substance use on many college campuses and the threat that poses to those in recovery.

In one qualitative study, Bell et al. (2009a, 2009b) studied 15 college students, who were actively involved in a collegiate recovery program, having them complete semi-structured interviews exploring the different types of recovery identities and common challenges faced on a college campus. In regards to challenges faced, nearly all of the students indicated that academic rigor, which sometimes took precedence over their recovery, as well as the prevalence of alcohol and other drug use among their college-attending peers, were the biggest challenges they faced. Many acknowledged that exposure to the high prevalence of substance use posed a threat to their recovery maintenance, which some characterized as a matter of life and death (Bell et al., 2009b). Several students also indicated that they refrained from attending social events for fear of being misunderstood, leading to feelings of isolation. For those who attended social events, they often were hesitant to talk about their recovery because they were afraid people would treat them differently as a result (Bell et al., 2009a).

Terrion (2013) conducted a qualitative study exploring how students in recovery from addiction to alcohol and/or other drugs experienced post-secondary education, focusing on relationships and recovery capital. Through in-depth semi-structured interviews, Terrion (2013) explored how recovery capital was developed and maintained. Through this process, she also identified areas of difficulty and barriers that individuals experienced in their recovery capital during their post-secondary education. The study sample was made up of students who identified as being in recovery from addiction to alcohol and/or other drugs and individuals that met the researcher's criterion for being 'successful' students, suggesting that they had either completed their undergraduate degrees or were on their way to completing their degree. Terrion (2013) concluded that for this vulnerable and marginalized group of students, social and personal relationships were crucial in maintaining abstinence and academic success. This finding also aligns well with psychosocial theories about the importance of peers in identity development during traditional age college years.

Although minimal research has been completed in the field of collegiate recovery, much of the research that has been done has focused on the importance of social support for those in recovery from alcohol and/or other drug addiction. It has also been identified that students involved in CRCs /CRPs have greater academic success and decreased rates of relapse than their peers who are not involved with these programs. With the research that has been completed, along with the overwhelming recognition of the need for recovery-based services, the case for CRCs and CRPs is strong. One key area that is

addressed throughout the literature, yet has not been researched to date, is the stigma that is experienced by students in recovery from alcohol and/or other drug addiction.

Stigma

The word ‘stigma’ can be traced back to Greek origin, meaning ‘brand’ or ‘mark,’ referring to the tradition of branding slaves to permanently mark them as separate from the rest of society (Goffman, 1963; Whitley & Campbell, 2014). Erving Goffman (1963) later defined stigma as a personal attribute that resulted in a “spoiled identity” or the discrediting of an individual or group. He recognized that stigma reduced the bearer “from a whole and usual person to a tainted, discounted one” (p. 3). Goffman (1963) recognized that the attributes of an individual leading to a stigmatized identity could be ‘discredited,’ which he described as a visible marking that sets someone apart from the majority or privileged identity (e.g., the color of one’s skin, one’s perceived gender identity, etc.). He also noted that stigma can be connected to an aspect that is ‘discreditable,’ which he described as a concealed identity that can be discriminated against when discovered (e.g., sexual orientation, religion, mental health illness) (Goffman, 1963). Goffman (1963) stated that once these discreditable attributes are recognized by an observer, the identified individual can experience criticism and discrimination.

Although there has been a steady increase in social science research on stigma over the past two decades, the concept of stigma has been criticized as being “too vaguely defined and individually focused” (Link & Phelan, 2001, p. 363). In response to this, the definition of stigma has changed over time to reflect more of a responsibility on the part

of society (Frost, 2011). This shift places the roots of stigma on the systems level or societal level rather than on the individual or group. Link and Phelan (2001) identified that “stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them” (p. 377). They chose to use the term ‘label’ instead of ‘attribute’ or ‘mark,’ as a way to situate the stigma outside of the person being stigmatized and to recognize that the reason for the stigmatization is a result of social processes that are dependent on culturally created categories deemed significant in a particular time and space. They also emphasized the relational aspects of stigma, identifying that power, status loss, and discrimination are necessary in order for stigmatization to occur. The mere action of labeling or stereotyping, which could be associated with any group of individuals, is not enough to qualify as stigma (Link & Phelan, 2001).

Public Stigma versus Self-Stigma

Corrigan and Watson (2002a) recognized that stigma is multifaceted and they worked to distinguish between public stigma and self-stigma. Public, or ‘objective’ stigma is connected to the way that individuals are stereotyped and/or viewed as a result of an attribute prescribed to a culturally created category, which can include structural discrimination. Self-stigma, or subjective stigma, is related to the internalized response that one has to these judgments and stereotypes, either real or perceived. Ritsher, Otilingham, and Grajales (2003) stated that “regardless of the objective level of discrimination that an individual is exposed to, it is the subjective perception of being devalued and marginalized that directly affects a person’s sense of self-esteem and level

of distress" (p. 32). Internalized stigma of an individual can be seen as the "devaluation, shame, secrecy and withdrawal triggered by applying negative stereotypes to oneself" (Ritsher et al., 2003, p. 32).

Stigma with Mental Health Disorders

"The history of social psychiatry teaches us that cultural conceptions of mental illness have dramatic consequences for help seeking, stereotyping, and the kinds of treatment structures we create for people with mental illnesses" (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999, p. 1328). Livingston et al. (2011) defined health-related stigma as "a socio-cultural process in which social groups are devalued, rejected, and excluded on the basis of a socially discredited health condition" (p. 107). In looking at the mental health and stigma literature, it is clear that several researchers have found that "people with a mental illness suffer high levels of stigmatization, which often leads to discrimination and marginalization" (Whitley & Campbell, 2014, p. 2). A simple PsycInfo search in 2016, utilizing the terms 'stigma' and 'mental health' yields a result of over 7,000 articles.

Link et al. (1999) conducted a study in which they provided members of the general adult public with vignettes to assess their ability to identify mental illness and to determine their beliefs around the cause of various mental illnesses, their beliefs around the dangerousness of individuals with mental illness, and the amount of social distance that was desired from individuals with mental illness. These vignettes were a part of the MacArthur Mental Health Module General Social Survey and involved 1444 participants. Researchers discovered that people were more likely to identify schizophrenia and

depression as mental illnesses than alcohol and cocaine dependence. They also discovered that there was a strong perceived connection between mental health illness and dangerous behaviors/acts of violence. Participants in the study illustrated a desire for social distancing from individuals with mental illness. The researchers concluded that "if the symptoms of mental illnesses continue to be linked to fears of violence, people with mental illnesses will be negatively affected through rejection, through a reluctance to seek professional help for of stigmatization, and through fear-based exclusion" (Link et al., 1999). This study is a clear example of how substance use disorders are stigmatized, thus resulting in isolation for those struggling with the disease of addiction.

Several researchers also have explored the negative impacts of stigma on individuals with severe mental illnesses (Drapalskis et al., 2013; Link et al., 2001; Yanos et al., 2010). Link et al. (2001) conducted a study to determine the impact of stigma on self-esteem for individuals diagnosed with a mental illness. Their study involved 70 residents involved in a mental health community. It involved baseline measures and follow-ups at 6 and 24 months. These researchers discovered that participants who perceived higher levels of stigma and discrimination at baseline strongly correlated with lower levels of self-esteem at the 6- and 24-month marks, thus concluding that "stigma strongly influences the self-esteem of people who have mental illness"; in fact, they found the "magnitude and association [to be] startling and disturbing" (Link et al., 2001, p. 1625).

Drapalski et al. (2013) researched the effects of stigma on self-esteem, self-efficacy, and recovery orientation. Their study involved 100 participants who were

receiving outpatient mental health services, and over one-third of these participants endorsed experiencing moderate to severe levels of internalized stigma. The researchers utilized structural equation modeling to assess interrelationships between the aforementioned variables. Through their analysis, they discovered that greater internalized stigma was associated with lower levels of self-esteem, self-efficacy, and recovery orientation. This evidence suggested that stigma is a barrier to beliefs around the possibility of recovery from a mental illness (Drapalski et al., 2013).

Crowe, Averett, and Glass (2016) conducted a qualitative focus-group design study that looked at the relationship between mental illness stigma, psychological resilience, and help-seeking behaviors. Through their research, they concluded that these factors were, in fact, related, and were seen as 'multidirectional.' Participants suggested that stigma related to mental health illness decreased help-seeking and also decreased their own resilience. Researchers also recognized that if an individual is very resilient, this could lead to a decrease in stigmatization. These researchers concluded that "the current research clearly demonstrates participants' beliefs that experiencing social stigma related to seeking help does in fact impact a person's decision regarding whether or not to attend counseling" (p. 67).

Angermeyer and Dietrich (2006) completed a review of population studies in regards to the public's beliefs and attitudes towards mental illness. They explored the results of 33 national studies and 29 local and regional studies. These researchers discovered throughout their analysis that common misconceptions around mental health illness continue to prevail among the general public, resulting in widespread negative

beliefs and attitudes about individuals with mental illness, characterized by varying degrees of stigma depending on the diagnosis. They also discovered that substance use disorders were viewed as more stigmatized than schizophrenia, depression, and anxiety and that those who struggle with SUDs/addiction are often the most rejected.

Stigma with Substance Use Disorders/Addiction

In 1971, the President of the United States, Richard Nixon, made an announcement to the public stating that "America's public enemy number one in the United States is drug abuse" (Sharp, 1994, p. 1). The language that was used in this national address suggested that the very act of "abusing" drugs, not the drugs themselves, was the enemy, suggesting that drug addiction was an immoral behavior and one that needed to be 'fought' against. Nixon claimed that that only way to "fight and defeat this enemy [was] to wage a new, all-out offensive" (Sharp, 1994, p. 1). This proclamation launched what is known as the 'War on Drugs.' President Ronald Reagan expounded upon this 'War on Drugs' when he took office, calling for Americans "to mobilize for a national crusade against drugs to help us create an outspoken tolerance for drug use" (Rosenberger, 1996, p. 27). His wife, First Lady Nancy Reagan was most widely known for her 'Just Say No' campaign, which "tells citizens to rely on their inherent moral fortitude and eschew temptation" (Elwood, 1994, p. 1), once again simplifying the complexity of the disease of addiction by suggesting it is a choice steeped in morality.

In 1986, Congress passed the Anti-Drug Abuse Act, which was signed into law by President Reagan. This enacted new mandatory minimum sentences for drug offenses and disproportionately targeted African Americans in the United States (Alexander,

2012). It is important to note that when this drug war was launched, drug crimes were declining in the country. This 'war on drugs' was not about drug use, rather it was a "new system of racialized social control" (Alexander, 2012, p. 58).

> More than 2 million people found themselves behind bars at the turn of the twenty-first century, and millions more were relegated to the margins of mainstream society, banished to a political and social space…where discrimination in employment, housing, and access to education was perfectly legal, and where they could be denied the right to vote. (Alexander, 2012, p. 58)

During the height of the 'war on drugs,' black people were five times more likely to be arrested than white people even though they were using drugs at the same rate (Donzinger, 1996). Donzinger (1996) recognized that "police found more drugs in minority communities because that is where they looked for them. Had they pointed the drug war at college campuses, it is likely that our jails would now be filled overwhelmingly with university students" (p. 115). Since the 'war on drugs' was launched in 1971, incarceration in the United States has increased by more than 500% (The Sentencing Project, 2016). Researchers have shown that crime rates have not increased during this time; rather, incarceration for drug offenses can account for almost the entire increase in incarceration rates (Alexander, 2012).

Not only was the 'war on drugs' a violent enactment of social control of marginalized populations, it greatly impacted societal views of addiction. The 'war on drugs' initiated by the United States government, which increased the criminalization of substance use, has ultimately been a great contributor to the stigma of substance use disorders and addiction. Stigma has been described by many as a form of social control,

and in reference to substance usage, stigma may be used as a way to "discourage and marginalize unhealthy behaviors" (Livingston et al., 2011, p. 40). In 2011, the Global Commission on Drug Policy announced that "The global war on drugs has failed, with devastating consequences for individuals and societies around the world" (Global Commission on Drug Policy, 2011, p. 2).

In 1987, one year after the Anti-Drug Abuse Act was passed by the Reagan administration, the American Medical Association officially recognized addiction as a brain disease (Bettinardi-Angres & Angres, 2010). In October of 2016, the Office of National Drug Control Policy (ONDCP) initiated an effort to change the language of addiction, in an effort to utilize non-stigmatizing language for those struggling with alcohol and/or other drug related problems. The ONDCP (2016) recognized the role that stigmatizing language plays on help-seeking and treatment of those suffering from addiction. They published this draft statement:

> Substance use disorder (the severest form of which is commonly referred to as addiction), is a chronic brain disorder from which people can and do recover. Despite an increase in the understanding of the science of substance use disorders and their effect on the brain, research shows that people with substance use disorders are viewed more negatively than others. When certain terms are used, such as "abuser" instead of "individual with a substance use disorder," health care providers are more likely to assign blame and believe that an individual should be subjected to more punitive (e.g., jail sentence) rather than therapeutic measures. Negative attitudes have been found to adversely affect the quality of health care and treatment outcomes. Because stigma and shame may deter help-seeking behavior among individuals with substance use disorders and their families, the guidance draws attention to terminology that may cause confusion or perpetuate stigma. (ONDCP, 2016, para. 3)

This draft statement clearly acknowledges the negative effects of stigma on treatment and recovery of individuals with substance abuse disorders.

However, despite the neurobiological evidence that “addiction changes the brain in fundamental ways, disturbing a person’s normal hierarchy of needs and desires and substituting new priorities connected with procuring and using the drug” (National Institute on Drug Abuse, 2010, para. 1), many individuals do not accept that addiction is a disease and continue to view addiction as a moral failing or lack of will power (Bettinardi-Angres & Angres, 2010; Livingston et al., 2011, Perron et al., 2011). “Substance use disorders are often treated as a criminal issue, rather than a health concern” (Livingston et al., 2011, p. 40). This approach to addiction, along with archaic and stigmatizing language, can often result in feelings of shame for those struggling with addiction.

Although many researchers have sought to understand stigma in relation to mental health disorders, fewer have focused on the stigma associated with substance use disorders (Livingston et al., 2011). Although ‘Substance Use Disorder’ is a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), much of the research that has been done in regards to stigma specifically focuses on mental health diagnoses as separate from substance use disorders, while a few intentionally look at dual diagnoses. Perron et al. (2011) argued, however, that “given the high comorbidity between substance use disorders and . . . other mental illnesses, substance use problems cannot be considered separate from mental health issues” (p. 49).

Foucault's (1995) view on stigma is also of importance here. He claimed that stigmatized individuals are often targeted by the authorities and the public and become the bearers of undue scrutiny and surveillance. This 'disciplinary gaze' can be discrediting for individuals and can result in exacerbated feelings of shame and guilt (Schulze & Angermeyer, 2003; Whitley & Campbell, 2014). Researchers have shown that shame and stigma are often the main barriers for individuals seeking treatment for a substance use disorder (Finn, Bakshi, & Andréasson, 2014; Grant, 1997). Researchers in one research study exploring treatment barriers for those struggling with alcohol use disorder found that shame and stigma were prevalent throughout all of the focus groups and individual interviews (Finn et al., 2014). This shame was often connected to a fear that others would find out that something was wrong if they sought out treatment and they would be negatively judged or labeled as a result.

Over the years, several studies have shown that substance use disorders are viewed as more stigmatized than any other mental health disorder (Corrigan, Kuwabara, & O'Shaughnessy, 2009; Livingston et al., 2011; Room, 2005; Schomerus et al., 2011). One possible reason for this is that oftentimes those with a substance use disorder or addiction are viewed as having a choice about substance use. Corrigan et al. (2009) conducted a study using a stratified sample of individuals from around the United States, ending up with a total of 815 participants, in which they tested causal attribution and dangerousness models. This research study looked specifically at public stigma (not internalized, perceived, or self-stigma) of people who were labeled as having a mental illness, those who were labeled as having a drug addiction, and those who are physically

handicapped and confined to a wheelchair. Based on results from the study, the researchers concluded that individuals struggling with addiction were seen as more dangerous and induced more fear than those labeled with a mental health diagnosis and those who were physically handicapped. Individuals dealing with addiction also were seen as more responsible for their 'condition' and were less likely to be offered help and assistance than those with mental health issues or physical disabilities (Corrigan et al., 2009).

Phillips and Shaw (2013) expanded on this study by exploring causal attribution that is often connected to the stigma of substance use and addiction. With a sample size of 161, they compared the stigma of those using substances with smoking and obesity, which also are often labeled as behaviorally driven health conditions. Through this study, researchers discovered that those actively using substances were more highly stigmatized than any other group. Further, researchers also looked at the stigma of individuals in 'remission' or 'recovery' from substance use, smoking, and overeating. "A key finding of this research that had not been explored previously is that, although being in remission results in substantially less stigma for smoking and obesity, stigma is only slightly decreased for individuals in remission from substance use" (Phillips & Shaw, 2013, p. 251). This finding suggests that individuals in recovery from drug and/or alcohol addiction continue to experience stigma even when not actively using.

Stigma with SUD Recovery

There has been minimal research conducted on the stigma experienced by individuals in recovery from alcohol and/or other drug addiction. Three studies were

found, all of which reported incidents of stigma (Anderson & Ripullo, 1996; Hill & Leeming, 2014; Luoma, Twohig, Waltz, & Hayes, 2007); however, none of these studies focused on college students in recovery. Luoma et al. (2007) conducted a study examining the impact of stigma on individuals in recovery from substance use disorders. As rationale for their study, they began by stating that "there can be little doubt" that individuals in recovery from substance use disorders "face stigma in its various forms including enacted, perceived, and self-stigma" (Luoma et al., 2007, p. 1331). In this study, 197 participants completed surveys exploring their experiences of stigma. Researchers discovered that individuals in recovery commonly experience stigma and the "data supported the idea that the current treatment system may actually stigmatize people in recovery in that people with more prior episodes of treatment reported a greater frequency of stigma-related rejection, even after controlling for current functioning and demographic variables" (Luoma et al., 2007).

Hill and Leeming (2014) conducted semi-structured interviews with six individuals to explore how they viewed themselves as well as how they made sense of others' responses to their recovery status. They discovered that the negative stigma associated with substance use disorders, which carried into recovery, compounded the participants' hesitation to admit that they had a problem and to seek help initially. "They had feared gaining a shameful social identity and giving up a positive social identity as a drinker." The authors went so far as to state that "feeling that the self is in some way shameful in the eyes of others has been identified as one of the most difficult emotional experiences to repair" (Hill & Leeming, 2014, p. 768). Through this research, they

recognized that it is crucial for those in recovery from alcohol and/or other drug addiction to be able to share their stories and experiences and for topics such as shame and stigma to be addressed.

> Once in recovery, it is important for individuals to feel a part of a community or larger group. However, this can be challenging due to the government rhetoric that presents drug users as a serious threat to families and communities. This reinforces isolation and discrimination towards people who develop illicit drug problems. This harsh and dehumanizing experience undermines their ability to form relationships with the non-drug users, and tends to reinforce social isolation and subsequent dislocation. In the 'normal' world, from which they have been excluded, many feel vulnerable and lack confidence, and a drug-centered lifestyle is all that is on offer. Marginalized groups who are subject to individual and institutional discrimination can internalize the ascribed identity and come to believe that the discrimination is somehow warranted and justified. (Buchanan & Young, 2000, pp. 416–417)

Although there has been minimal research conducted that has explored the stigma experienced by individuals in recovery from drug and/or other alcohol addiction, the studies that have been done show that these individuals overwhelmingly experience incidents of stigma, whether perceived or enacted.

College Students and Stigma

According to Chickering (1969) and Erikson (1968), many college students are in the developmental stage in which they are seeking connections with others and may be particularly concerned with how they are viewed by others (especially peers), making them a vulnerable population to the stereotypes and discrimination associated with stigma. College students are highly susceptible to the stigma associated with mental health disorders (Eisenberg, Downs, Golberstein, & Zivin, 2009; Quinn et al., 2009). Eisenberg et al. (2009) made the case that colleges and universities "provide a unique

opportunity to identify, prevent, or treat mental disorders" (p. 523) as three-quarters of mental health illnesses have their first onset by age 24 and about half of American youth attend institutions of higher education. However, through the results of their survey including 5,555 participants from 13 universities, they discovered that experiences of personal stigma may inhibit help-seeking behavior and, in fact, concluded that stigma was one of the most prominent barriers for seeking help among college students.

Martin (2010) conducted a survey study with 54 respondents, the majority of whom had "not disclosed their mental health condition to university staff due to fears of discrimination and disadvantage arising from the stigma of mental illness" (pp. 271–272). Participants in the study identified stigma as a key issue for non-disclosure. Martin (2010) concluded that "addressing the stigma of mental illness is a first and crucial step in getting students to overcome their fears and concerns of disclosing to university staff and gaining access to the support they require to succeed in their studies" (p. 271).

Quinn et al. (2009) interviewed 12 students to complete an in-depth exploration of college students' experiences of mental illness and to gain a greater understanding of students' perspectives on support services available to them. As a result, researchers discovered that there was a general reluctance from participants to disclose challenges related to mental health for fear of stigmatization. They believed that this disclosure could negatively affect how people perceived them and could potentially be used against them in the future when applying for jobs. Participants also reported that this fear of being stigmatized and misunderstood resulted in a refusal to seek mental health services. The study suggests that "work needs to be done on encouraging a culture of acceptance

and support around mental health problems, to address the stigma attached to disclosing a difficulty and seeking help for it" (Quinn et al., 2009, p. 416). These researchers suggested that one way to encourage a culture of acceptance is to "draw on personal narratives of people with mental health problems" (p. 416).

The National Center on Addiction and Substance Abuse (2007) conducted a study including over 2,000 survey responses, in which 37% of college students reported that they would not seek help for problematic substance use because of fear of social stigma. Lally, O'Conghaile, Quigley, Bainbridge, and McDonald (2013) conducted a cross-sectional study to determine the association between levels of stigma and help-seeking behaviors of college students. They had 735 college students participate in the study and concluded that personal stigma, or self-stigma, was highly correlated with a decreased likelihood of seeking help. Further, they also recognized that the level of stigma was greatest for those college students under the age of 25.

Collegiate Recovery and Stigma

Despite the increasing number of CRPs in the country, it has been stated in the literature that the negative stigma associated with substance use disorders (SUDs) has stopped students from utilizing these recovery-based services (Grahovac et al., 2011; Harris et al., 2014; Mackert et al., 2014). This statement, however, has not been supported empirically to date. Perron et al. (2011) also recognized that the stigma associated with substance use disorders "creates challenges for students who want to be open about their recovery efforts, a necessary condition to build a supportive network of peers and access support services" (p. 48). It has been indicated in the literature that

college students in recovery not only face stigma related to the admittance of having struggled or been diagnosed with a substance use disorder, but they also face stigma surrounding abstinence, if this is their chosen path to recovery. Authors have indicated that "the collegiate environment is not conducive to a recovery lifestyle" (Harris et al., 2014, p. 229) for a variety of reasons. One of the main reasons is that binge drinking and excessive alcohol and other drug use is often normalized on a college campus, suggesting that students in recovery can face many challenges in this 'abstinence hostile environment' (Cleveland et al., 2007; Laudet et al., 2014), particularly if their chosen path to recovery includes abstaining from alcohol and other drugs.

Herman-Kinney and Kinney (2013) conducted a study exploring the lived experiences of nondrinkers on college campuses. Although this study did not focus on students in recovery, it was evident that college students choosing not to drink alcohol experienced discrimination from their peers and went to great lengths to utilize stigma-management techniques in order to 'belong.' Perron et al. (2011) suggested that "feeling isolated and stigmatized due to a substance use disorder may also lead to the development of new symptoms of depression or anxiety, or the worsening of preexisting symptoms, further threatening recovery" (p. 52).

Conceptual Stigma Model

In looking at various models that have been created around stigma, Frost's (2011) model (see Figure 1) seems to be the most comprehensive. This model covers both public and self-stigma by combining models that examine the perpetration of stigma with models that identify experiences of stigma. Through this model, Frost (2011) mapped

out how responses to experiences of stigma can result in either negative or positive outcomes. Although Frost mainly drew from theories of stigma in relation to race/ethnicity, gender, and sexual orientation, his model seems to provide a useful tool for conceptualizing and addressing stigma experienced by individuals in recovery from alcohol and/or other drug addiction. Frost's model was used in this study to provide a framework for understanding the multiple ways in which stigma can be enacted and experienced and to provide rationale for the need to explore how stigma is experienced before determining ways in which to change the outcomes of stigma. Since this model was based on theories of stigma in relation to race/ethnicity, gender, and sexual orientation, it is possible that this model will also allow for the intersectionality of stigma as well. Kulesza et al. (2016) conducted a study exploring addiction stigma and the intersectionality with race/ethnicity and gender. They highlighted the importance of understanding stigma through an intersectional lens, as

> the causes of disparities may be better understood by describing how the intersection between multiple social identities (racial/ethnic minority, women) and structural inequalities linked to these identities (racism, sexism) may adversely impact one's life experience (access to healthcare), thereby perpetuating disparity within marginalized groups. (p. 86)

They noted that individuals diagnosed with SUDs may be "treated less favorably if they also hold other status characteristics that are marginalized" (Kulesza et al., 2016, p. 86). This intersectionality of stigma was addressed in this study with participants.

Frost sought to explain the enactment of social stigma through the expression of structural inequalities, stereotypes, prejudice, and discrimination. In a study conducted

by Luoma et al. (2007), the majority of participants who were in recovery from alcohol and/or other drug addictions acknowledged directly experiencing social discrimination, defined by the authors as "difficulty in obtaining employment, reduced access to housing, poor support for treatment, or interpersonal rejection" (p. 1332). Through a systematic review of global population-based studies, Schomerus et al. (2011) discovered that individuals with substance use disorders are at a "particular risk of being structurally discriminated against" (p. 109) and they referenced several studies which suggested the public's acceptance of structural discrimination against those who had substance use disorders. Schomerus et al. (2011) also found that individuals with substance use disorders are at a higher risk of being negatively stereotyped and discriminated against. Livingston et al. (2011) recognized that "people with substance use disorders may experience stigma as a consequence of the culturally endorsed stereotypes that surround the health condition" (p. 40).

In his (2011) model, Frost connected the ways that stigma is acted out with how it may be experienced by groups or individuals. He identifies these experiences of stigma-related stress as stressful life events, everyday discrimination, expectations of rejection, stigma management, and internalized stigma. Frost (2011) recognized that

> There is a tremendous amount of variability in the ways stigmatized individuals and groups respond to experiences of stigma-related stress. Understanding the ways people and groups respond to stigma-related stress is an important endeavor in the psychological study of stigma. Not only is it necessary to understand the damaging effects of social stigma, it is equally if not more important to understand how the stigmatized are able to cope with, resist, and overcome the limiting consequences of stigma. (p. 830)

Although there has been research done that has explored the stigma experienced by individuals struggling with mental health disorders, there has been far less research done on the experiences of those who struggle with alcohol and/or other drug addiction (Livingston et al., 2011) and even fewer studies eliciting the voices of those in recovery from alcohol and/or other drug addiction. It is the researcher's hope that this study will begin to fill this gaping gap in the literature by exploring how stigma is experienced by college students in recovery from alcohol and/or other drug addiction.

Meaning Making and Stigma

Frost (2011) explored the potential to diminish the negative impacts of stigma or stigma-related stress through the process of meaning-making. He postulated that "if stigmatized individuals are able to engage in meaning-making processes that reduce the threat of stigma in their lives, they may be able to diminish and/or overcome its delimiting effects" (Frost, 2011, p. 831). Frost (2011) believed that critical feminist methods could assist in this meaning-making process with individuals. He discussed the limitations of quantitative methods in exploring how social stigma affects the lives of individuals or groups, proposing that these methods are too conflating of an individual's experience. He suggested the use of critical feminist approaches to research in order to "reveal agency and resiliency by highlighting the processes through which marginalized individuals make meaning of and respond to their experiences of stigma-related stress" (p. 832). Frost (2011) pointed out that making meaning of these experiences could, in turn, lead to activism and social change, thus changing the position of those who are stigmatized.

As a result, the purpose of the Photovoice methodology (Wang & Burris, 1997) utilized in this study is twofold. First, it was used to examine how stigma is experienced by college students in recovery, and second, it provided participants with a way of making meaning of the stigma that they experience. Photovoice encourages meaning-making throughout the entirety of the research process, which may result in a decrease in internalized stigma according to Frost (2011). Through taking photographs, participants are encouraged to make sense of how they experience their stigma through a different modality for articulating their experiences.

During the selection of photographs, participants are once again asked to make sense of their experience and to choose the most important aspects of what they want to share with the group. Meaning-making continues through the creation of narratives and descriptions of photos because participants go through the process of trying to find words to describe the experience that they have captured in the photograph. During group discussion and through the data analysis, participants continue to make meaning of their experiences by contextualizing their experience of stigma with others who are in recovery. Using Photovoice with individuals who have been stigmatized is in line with Marshall's (2007) explanation of art-based research, with a goal

> to transform perception: to change the way we see or interpret things. Transforming perceptions generates insight: new understandings and new perspectives that make sense of perceptions and experience in new ways. New insights represent new knowledge and they create new knowledge. (p. 25)

This research study is imbued with meaning-making activities, and although the purpose of the study was to learn more about how college students in recovery experience

stigma, the activities inherent in Photovoice are in alignment with Frost's (2011) proposal of the need for meaning-making as a response to stigma.

Summary

The purpose of this chapter was to provide a review of the literature on substance use disorders with traditional college age students, young adult development, collegiate recovery, stigma in relation to mental health and substance use disorders, and to provide a theoretical framework for the proposed study. The following chapter includes an in-depth look at the methodology utilized for this study, as well as the data analysis methods employed during this study.

CHAPTER III

METHODOLOGY

The purpose of this research study was to explore how college students in recovery from alcohol and/or other drug addiction experience stigma. A qualitative research study was conducted to gain an in-depth, foundational understanding of how stigma is experienced by the participants in this study. In this chapter, Photovoice, the qualitative methodology used in this study, will be described, including a rationale for use of this methodology and its theoretical framework. This chapter also includes information regarding participants in the study, procedures, and data collection, as well as an explanation of Interpretive Phenomenological Analysis (IPA), which was used to analyze data from the study.

Research Question

How is stigma experienced by college students who identify as being in recovery from alcohol and/or other drug addiction?

Photovoice

Photovoice is a community-based participatory research (CBPR) approach in which participants take photographs that depict aspects of their lives and then write narratives or answer proposed questions to accompany these images (Wang & Burris, 1997). "The Photovoice method is highly consistent with CBPR principles stressing empowerment and an emphasis on individual and community strengths, co-learning,

community capacity building, and balancing research" (Catalani & Minkler, 2010, p. 425). Wang and Burris (1997), the founders of Photovoice, stated that this approach may be "particularly powerful for . . . people with socially stigmatized health conditions or status" (p. 370) because taking photographs and creating accompanying narratives can serve as ways of making meaning of one's life and allow these individuals to communicate their experiences with their community and beyond. Ginicola, Smith, and Trzaska (2012) acknowledged that taking a photograph is a nonthreatening method that can allow an individual to convey meaning, struggle, and emotions that cannot easily be verbalized. Marshall (2007) stated that

> clarity and meaning are engendered when ideas, concepts, or information is transformed into visual images, objects, or visual experiences; allow[ing] information to be seen differently, in a fresh, more meaningful, persona, and experiential way. This transformation of concepts through imaging produces new insights and learning. (p. 23)

Photovoice Theoretical Framework

The theoretical foundation for Photovoice is based on critical consciousness, feminist theory, and documentary photography (Wang & Burris, 1997). The theory of critical consciousness, initially termed conscientization, was made popular by Paulo Freire (1970) in his book *Pedagogy of the Oppressed*. The term conscientization refers to an in-depth understanding of the world, which Freire believed led to liberation from oppression. Freire suggested that those being oppressed should be empowered to take a critical look at the systems in which they are involved to determine how these systems may be oppressive. It is only after this understanding occurs that individuals can make

changes. With college students in recovery in this study, the researcher asked students to identify systems or societal beliefs that may contribute to the stigma of being in recovery. Wang and Burris (1997) suggested Photovoice as a methodology for consciousness-raising. Through both the taking of photos and the critical discussions that follow, participants are encouraged to think about, explore, and exhibit aspects of their community that may be contributing to the challenges they are facing. These photos serve as a 'voice' for the individuals taking them and thus contribute to the deconstruction of the 'culture of silence' to which Freire (1970) referred.

In support of feminist theoretical underpinnings, the use of pictures as well as descriptions allows for a multidimensional exploration of an individual's life. "Those conducting feminist research not only recognize that the person is composed of many intersecting social constructed identities, but also understand that these intersecting multiple identities are fluid and complex" (Beckman, 2014, p. 168). It is important in working with individuals, especially those in recovery, to recognize the complexity of identity (Neale, Nettleton, & Pickering, 2011). When the identity of an individual is conflated to an attribute or characteristic, the potential for continued stigmatization of an already stigmatized population is possible. Photovoice also plays on another key tenet of feminist theory, the co-construction of knowledge. Wang and Burris (1997) stressed the importance of this construction of knowledge within a group, which happens through the sharing of experiences while working together to understand governing institutions and systems that affect their lives.

Although documentary photography can take many forms, traditionally it has been used as a way to record significant historical events. Photovoice takes this a step further, by providing cameras to participants within a community to record and document their lives and experiences from their own perspectives (Wang & Burris, 1997). Hagedorn (1994) stated that "photographs provide visual insights into and knowledge about various human conditions" that language cannot not attain (p. 44). In this way, "documentary photography has been characterized as the social conscience presented in visual imagery" (Wang & Burris, 1997, p. 371).

Participants

Wang (1999) identified the ideal group size for a photovoice research study as 7-10 participants and this study involved 8 participants. This number is also appropriate for IPA, although it could be considered to be a slightly larger population than needed for an in-depth analysis (Smith & Osborn, 2007). Participants for this study were either currently enrolled undergraduate college students from four-year universities, or graduates within the past six months from a four-year university. Participants were from two different public universities in North Carolina.

The researcher recruited participants between the ages of 18 and 29, which Arnett, Žukauskienė, and Sugimura (2014) identify as the new life stage of emerging adulthood. In 2015, the results of a national survey exploring the characteristics of students participating in CRPs were published indicating that the mean age for students involved in CRPs was 26 (Laudet et al., 2015). This suggests that although the traditional age for college students in the United States is between 18 and 22, many students in recovery are

nontraditional age college students, which, for many students, could be a result of returning to academia after getting treatment for a SUD. This survey also indicated that 75% of students involved in CRPs were below the age of 29 (Laudet et al., 2015), which solidified the age range for this study of 18-29.

Participants for this study also needed to self-identify as being in recovery from alcohol and/or other drug addiction for at least the past six months (including abstaining from mind-altering substances, other than caffeine and nicotine, during this time). This timeframe was chosen because studies have shown that the frontal lobe, which is involved in problem solving, decision making, judgment, and many other higher-level brain functions, is considerably different after 6 months of non-drug use (SAMHSA, 2005).

Participants for this study also were asked to meet the criteria of having experienced stigma as a result of being in recovery from alcohol and/or other drug addiction. There were no race, gender, or ethnicity restrictions, and participants did not have to 'prove' any previous formal diagnosis of a substance use disorder.

Procedures and Data Collection

The researcher began by obtaining the required IRB approvals for the study (see Appendix A) and by completing a pilot study that helped inform the full study. Once the study was approved by the researcher's dissertation committee and necessary changes were made, the researcher began recruiting participants. The researcher asked the CRP coordinators from five different universities to send a recruitment email to CRC/CRP members and/or to other students who may meet the criteria for the study (see Appendix

B). This email encouraged snowball sampling as well, requesting that it be passed along to people who may meet the criteria for participation. Second, the researcher reached out to pilot study participants requesting that they pass along the recruitment email to individuals whom they believe may be interested in participating. During the final meeting of the pilot study, participants suggested this as a form of recruitment and gave verbal consent to the researcher to recruit in this way.

Participant criteria were specified in the recruitment email and participants were informed that they would have the opportunity to earn up to $50 for completion of the study; $20 for the initial training and $30 for taking photographs and participating in the discussion session. Participants received incentives after each phase of the study and it was made clear that they did not have to complete the entire study in order to receive the initial incentive. In the recruitment email, participants were provided with a link and asked to fill out a brief Qualtrics survey (see Appendix C) to ensure that they met criteria for the study, provide the researcher with contact information, gather basic demographic information, and determine a date and time for the initial training. Participants also were asked whether or not they had access to a digital camera; however, it was made clear that this would not jeopardize their ability to participate in the study.

Once participants filled out the survey and it was clear they met criteria for the study, introductory sessions were scheduled. There were two one-hour introductory meetings at two different universities.

Introductory sessions focused on covering logistical and ethical considerations while also encouraging rapport building among participants. During these sessions, the

facilitator clarified time commitments required to participate in the study and informed participants of potential risks of being involved in the study. Participants were given an informed consent (see Appendix D) and allowed time to read the consent before proceeding with the training. The facilitator then presented participants with an introduction to Photovoice and provided examples of Photovoice projects that have been completed. Ethical considerations around taking photographs of others also were covered. Participants were encouraged not to take photographs of other people; however, if they chose to do so, they were asked to have those individuals sign a photo release form (see Appendix E).

During this initial session, the researcher also facilitated group discussion on the multi-faceted nature of stigma and provided participants with the definition by Livingston et al. (2011) who identified health-related stigma as “a socio-cultural process in which social groups are devalued, rejected, and excluded on the basis of a socially discredited health condition” (p. 107). During this session, the group also briefly discussed the possibility of a final photographic exhibit, which could potentially provide participants with a way to disseminate their experiences to a larger audience. Participants were informed that involvement in this photographic exhibit would be completely optional. The researcher then confirmed that all participants had access to cameras. Finally, participants were instructed to take as many photographs as they wanted before the discussion session, ultimately choosing 2-3 photographs that portrayed their experience of stigma connected to being a college student in recovery. Given the time commitment involved in this study, the number of photographs was limited so that all participants

could have a chance to share their photos within the time allotted for the discussion session.

Participants also were asked to write a title for each photograph and to answer a series of questions before the discussion session. Questions were modified from the SHOWED technique that is commonly used in Photovoice projects (Hergenrather, Rhodes, Cowan, Bardhoshi, & Pula, 2009) to more clearly address the topic being studied by the researcher. The questions included:

1. How does this image depict stigma?
2. Has your relationship with this stigma changed over time?
3. How does this image make you feel when you look at it?
4. What has been your experience taking/selecting this photograph?
5. Why does this situation exist?
6. What can be done about this? Personally? Systemically?
7. Have you had similar experiences of stigma in relation to any other ways in which you identify?

Participants were asked to submit their photographs, titles, and answers to questions via Qualtrics (see Appendix F) before the discussion session. They were informed that both their photographs and the answers to their questions would be shared with the group during the discussion session. The group then figured out a day/time for the discussion session. Participants were given their incentive of $20 at the end of the initial training as a sign of appreciation for their participation. Once the session was

over, participants were emailed the link to upload their photographs, along with a copy of the seven questions (see Appendix G).

After the initial training session, participants were split into three groups according to schools and schedules to encourage continued participation. One group consisted of two participants, while two groups consisted of three participants each. The purpose of splitting participants up for the discussion groups was two-fold. Splitting up participants into smaller groups allowed for more time for each participant to share and discuss their photographs without increasing the time commitment for participants and also permitted triangulation during the data analysis.

Each discussion session was approximately 1.5-2 hours long and took place between 1 and 3 weeks after the initial training session. During this session, each participant in the group had the photographs that they submitted and the answers to the modified SHOWED questions projected onto a screen and the facilitator led the group discussion. The facilitator loosely followed a focus group format to structure the discussion (see Appendix H). Each participant submitted 2-3 photographs, and the group was able to process all of the photographs and answers submitted by each participant in that particular group. The group formats were all similar in that the group would process one participant's photos and answers before moving on to the next group member's photographs and answers. Once all of the participants shared their photographs, the group had limited time to identify the themes that emerged as a group. Approximately 15 minutes of each group was spent identifying themes that were discussed. Since there was limited time for this, the majority of the themes in the results table were identified by the

research team. At the very end of the discussion, the group discussed the possibility of a photographic exhibit, which all participants supported.

Before participants left the group meeting, they were given the option to sign a consent form to use their photographs in future publications, presentations, etc. (see Appendix I). All participants chose to sign this consent form. Participants also were given their $30 incentive for participating in the discussion session. Once the discussion group was completed for each of the groups, the data was analyzed using IPA, which is outlined below.

Data Analysis

Although the creators of Photovoice offer some suggestions as to how to approach data analysis with a Photovoice research project, they leave a lot of interpretation up to the researcher. Hergenrather et al. (2009) conducted a review of 31 studies using Photovoice as their methodology and found that there was no single way to approach data analysis; in fact, many of the studies utilized different approaches to analyze the data. Brunsden and Goatcher (2007) suggested the use of Interpretive Phenomenological Analysis (IPA) for Photovoice research studies because it seems to be the most fitting form of analysis for both text and visual analysis when trying to understand lived experiences. In addition, the double hermeneutics inherent in IPA include the participants making sense of their photos both individually and as a group, and then the researcher attempting to make sense of participants' reported experiences (Brunsden & Goatcher, 2007; Smith & Osborn, 2007).

Interpretive Phenomenological Analysis

IPA

> involves detailed examination of the participant's lifeworld; it attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event, as opposed to an attempt to produce and objective statement of the object or event itself. (Smith & Osborn, 2007, p. 53)

The purpose of using IPA in this study was to explore the depth of participants' experience of stigma because of being in recovery, not the frequency of those experiences. The researcher also was interested in how these individuals made sense of this stigma, which was encouraged through taking photographs and answering the modified SHOWED questions. This is in alignment with the theoretical foundation of IPA that "human beings are not passive perceivers of an objective reality, but rather that they come to interpret and understand their world by formulating their own biographical stories into a form that makes sense to them" (Brocki &Wearden, 2006, p. 88). The analysis then comes through the form of making sense of the 'stories' that these individuals have constructed in response to their experience of stigma.

IPA also takes symbolic interactionism into account, recognizing that a person cannot be 'understood' without considering one's social context (Smith & Osborn, 2007). This is important when considering stigma experienced by an individual as evidenced by Frost's (2011) model (Figure 1) and the various literature explored in Chapter II. Stigma is a multifaceted concept, one that is not easily understood without looking at both social and personal contexts. Smith and Osborn asserted that

> IPA is a suitable approach when one is trying to find out how individuals are perceiving the particular situations they are facing, how they are making sense of their personal and social world. IPA is especially useful when one is concerned with complexity, process, or novelty. (p. 55)

This is precisely what is needed with a nuanced study involving identity and stigma.

Although IPA is often used as a method of analysis for semi-structured interviews with individuals, Brocki and Wearden (2006) conducted a thorough literature review on the use of IPA in health psychology and asserted that IPA is "flexible enough to allow for the use of differing data collection methods" (p. 94), citing a few studies which used IPA to analyze focus group discussions. IPA was used in this study to analyze the group discussion(s) which were transcribed by a professional transcription service. The individuals transcribing the focus groups signed a confidentiality form before transcribing the sessions (see Appendix J).

For the analysis portion of the study, the primary investigator established a research team made up of three members; two coders and one auditor. The primary investigator and another researcher coded the data, while another individual audited the information once the themes were identified by the coders. Before data analysis began, the coders bracketed their biases in relation to the various aspects of this study, namely substance use disorder/addiction and recovery. The write-ups of these potential biases were then sent to the auditor so that she could use this information to check for biases inherent in the data analysis. The coder team was made up of one researcher who identifies as being in recovery from alcohol and/or other drug addiction and one researcher who does not identify as a member of the recovery community, to help

account for potential blind spots or biases that may be present as a result of these identifications.

The two coders independently began data analysis by closely and thoroughly reading the group discussion transcripts, which also included each individual's photographs, the title of the photographs, and the responses to the modified SHOWED questions for each of their selected images. Participants either chose to read these responses aloud to the group or had the group read them silently in which case the researcher added these responses into the transcription and clearly indicated that these were read silently by the participants. The transcriptions also included the themes that were briefly explored and identified by each group of participants. Coders independently read through each transcript several times, taking notes throughout each reading. Smith and Osborn (2007) suggested leaving large margins on each side of the transcript to leave room for annotation and comments. They also recommended that the coder make notes on the left side of the margin through each reading, including whatever may be interesting or seemingly significant to the reader. This would include participants' use of language, any content that seems noteworthy, any expression of emotion, or any insights the reader has, along with possible initial interpretations.

Once the coders read through the transcript several times and made annotations and comments throughout, coders followed Smith and Osborn's (2007) suggestion that they utilize the right margin to begin to identify themes that emerge. "Here the initial notes are transformed into concise phrases which aim to capture the essential quality of what was found in the text" (Smith & Osborn, 2007, p. 68). Because these phrases and

themes may be more abstract in nature, it was crucial for the coder to constantly refer back to the original transcript to check for potential assumptions and distortions and to make sure that the phrase is in alignment with the participant's original words.

Once these initial phrases/themes were identified, each coder then attempted to find connections between the themes and create a list of identified themes, clustering the themes that were similar conceptually. This was done for each of the three transcripts. The researchers then looked at each of their list of themes that were present within each group and compared these themes across the groups. These themes had to be supported by the original transcripts in order to be seen as an overall theme; otherwise, it was noted that these themes only showed up in certain groups but not across all groups. A final list of themes was then created by each coder.

Prior to the two coders meeting virtually, the principal investigator looked over the themes identified by both coders and cross-referenced these with Frost's (2011) model of social stigma. She then created a table to display the themes that were identified by both coders and how these mapped onto Frost's (2011) model. The researcher ensured that the themes identified by participants during the focus groups were included in the table and that it was noted whether themes showed up across groups or merely within one or two groups.

Coders then met virtually to discuss the table and explore any differences they had in how these themes should be categorized and/or labeled. Both coders agreed that although Frost's (2011) model was fitting for the themes identified, the model did not

fully encapsulate all of the themes. Subsequently, the table was expanded to include these additional topics/themes.

Once the table of themes was agreed upon, the principal investigator sent the group transcripts, which included the participants' photographs, titles, and answers to the modified SHOWED questions, along with the table of themes to the auditor for review. The auditor then reviewed the themes identified. The auditor informed the coders that she did not see any blatant bias coming through the data analysis. She provided the coders with a few suggestions for adding onto particular themes and encouraged coders to expand beyond Frost's model. The principal researcher then finalized the data analysis by updating this table of themes and sent this off to the two other members of the research team for final approval (Smith & Osborn, 2007). These themes were then translated into a narrative, which can be found in Chapter IV. When writing up the results, the researcher placed the corresponding photographs into the sections according to the description of the photograph and its "best-fit" corresponding theme.

Bracketing

For the primary researcher for this study, it was crucial to recognize any implicit and explicit biases she holds that may have influenced the study in any way. While she continued to reflect upon these biases throughout the study and throughout the data analysis, this was the bracketing statement that was sent to the auditor:

As a white female, I try to be aware of the privileges that I experience because of those intersections of identity. I think it is also noteworthy that I do not identify as a person in long-term recovery and have not struggled with alcohol and/or other drug

addiction at any point in my life, therefore adding another privileged identity to the mix, especially when addressing this study. I have had, and continue to have, very close people in my life both in active addiction and in recovery. It is these close relationships that led me to want to work with individuals struggling with addiction and those in long-term recovery.

I have worked in the field of addiction for several years now and I am a Licensed Clinical Addiction Specialist (LCAS). In 2012, I was asked to open a transitional living program for young adult men with a primary diagnosis of substance use disorder. I believe this is when I became acutely aware of the stigma that young adults in recovery experience. I worked very closely with the young men (ages 18-28) who lived at the facility and spent many hours discussing their reentry into the 'real world.' For many of them, college had been marked as a time/place when/where they experienced an overwhelming amount of alcohol and substance use, some of them not using substances prior to that point. As I looked over college applications, drove them to initial advising appointments, talked with them about the pros and cons of going back to school versus working a part-time/full-time job, I noticed the fear that was present for so many of them when they talked about returning to school. Several questions were asked: "How was it possible to attend college without drinking and drugging? Can I still go to parties? Listen to live music? Date? What happens when my friends find out that I'm in recovery? Will they stop inviting me places? What if my professors find out? Will they automatically assume that I lie and cheat?" The fear of being stigmatized led to a concealment of their recovery identity, which ended up creating problems for many of them. After all, social

support has been seen as one of the most important indicators of a successful recovery. The stigma that is associated with individuals with substance use disorders seems so hurtful and pervasive in our society, something I feel I contributed to in subtle ways until I began working with these clients.

I understand that my emphatic belief that college students who are in recovery from alcohol and/or other drug addiction experience stigma is limiting to those who may not, in fact, experience stigma. I need to be sure to remain aware that the participants of this study may have very different experiences than the young men I worked with in the transitional living program. These will all need to be bracketed during the study and during data analysis.

It is also noteworthy to reflect on the fact that I am an art therapist and possess a strong belief that alternative forms of expression can accentuate one's exploration of a topic and can be more powerful than simply stating something in words. I am also aware that the methodology being used may actually be a deterrent for some participants, as they may be uncomfortable with expressing themselves through art. The methodology is fitting for this project for the reasons mentioned in this chapter, however, it is important for me to reflect on this background and the various aspects of what this may mean in relation to this study.

The second coder also wrote-up his potential biases (Appendix L) and these were also sent to the auditor for review.

Pilot Study

Purpose

The purpose of the pilot study was to test the various steps of the Photovoice process and the procedures outlined above, beginning with participant recruitment and ending with the group discussion session. Participants in the pilot study also were invited to have their photographs displayed in the final photographic exhibit. During the group discussion session, the researcher asked for participant feedback to gain a better understanding of what worked and what did not work so that changes could be made before implementing the full study.

Research Questions

The pilot study addressed the following research questions in order to help inform the full study:

Research Question 1: Are participants able to express how they experience stigma through the use of photography and the questions provided?

Research Question 2: Do the procedural steps outlined in the proposed study need adjustment before conducting the full study?

Participants

The researcher chose to implement the same criteria for pilot study participants as participants in the full study. This included currently enrolled undergraduate college students who are at least 18 years of age, who self-identify as being in recovery from alcohol and/or other drug addiction for at least the past 6 months (including abstaining from mind-altering substances, other than caffeine and nicotine, during this time) and

who reported having experienced stigma as a result of this identification. Because of feedback from the CRP director, however, the researcher decided to include individuals who graduated from college within the past year, which will not be criteria added for the full study. The pilot study consisted of three individuals, all of whom met the criteria mentioned above, and were currently enrolled in undergraduate college/university courses.

Recruitment

Recruitment for the pilot study proved to be more challenging than initially expected. In the Fall of 2016, the researcher attained permission from three different universities to recruit for both the pilot study and the full study. The researcher first attempted to recruit for the pilot study from the institution where she is currently employed. After weeks of attempting to recruit, the researcher was unable to identify a single participant meeting the criteria for the pilot study. This could be connected to the nature of anonymity often associated with those in recovery, stigma in relation to a recovery identity, unsuccessful attempts to contact those who can identify these students, no students who meet the given criteria, or any other number of reasons. As this recruitment neared the end of the Fall semester, the researcher waited until the Spring semester to continue recruitment. The researcher reached out to the director of the CRP at a local institution and she passed along the email to several involved students. Eligible participants were slow to sign up, but eventually a meeting was scheduled and three participants who meet the criteria above attended the initial meeting.

Procedure and Results

Participants filled out the survey on Qualtrics to ensure that they met the criteria for participation and to enquire about day/time availability (see Appendix K). The survey used for the pilot study focused on eligibility for the study rather than gathering demographic data. The only demographic question asked was in regards to the university attended. Thus, the researcher can only speculate as to how these participants identify in regards to such variables as gender, race, and ethnicity. Through discussions, however, the researcher did discover that all the participants were over the age of 34. More demographic information will be updated on the Qualtrics survey for the full study. Once the session was scheduled based on participant availability, the researcher sent a follow-up email with details for the initial training session.

During the initial meeting, the researcher handed out adult consent forms to each of the participants and had them read through the consent forms, answering any questions that arose. The researcher then presented participants with a background on Photovoice, including different ways Photovoice has been used in the past. The researcher also talked about stigma, providing participants with the definition provided in Chapter I. The researcher then talked more about this research study and provided participants with the questions that they would be asked to consider for each photograph that they selected as a representation of stigma. These questions included:

1. How does this image depict stigma?
2. Has your relationship with this stigma changed over time?
3. How does this image make you feel?

4. What has been your experience taking/selecting this photograph?
5. Why does this situation exist?
6. What can you do about it?

During this session, the researcher also discussed the ethics involved in photographing other individuals. The researcher provided examples of images that would require a release of information and those that would not. She also provided participants with release forms in case they decided to take photographs of other individuals. The group then scheduled a time for the discussion meeting and the researcher gave participants their incentive. After the session, the researcher sent a follow-up email that included the link to the Qualtrics survey, where participants were asked to upload their photographs, provide a title for these photographs, and answer the modified SHOWED questions.

The researcher held the discussion group two and half weeks after the initial training, per the request of the participants. Only 2 of the 3 initial participants attended the discussion session. The researcher sent an email out to the participant who did not show up, requesting feedback on the initial training if she wanted to share information about her experience, but the researcher did not hear back from her. Both remaining participants uploaded photographs and responded to the questions prompted on the Qualtrics survey prior to attending the session. These photographs, along with their titles and the answers to the modified SHOWED questions, were all added to a PowerPoint presentation prior to the start of the discussion. These PowerPoint slides were then presented in the discussion session. The facilitator led the discussion, initially showing

the group each photograph, then showing them the answers to the questions and then returning to the photograph for a group discussion. The group then participated in a dialogue that was initiated by these questions.

1. Can you connect with this image or with the photographer's description of stigma in relation to this image? If so, how?
2. Why do you think this stigma exists?

This was repeated for each image that was submitted.

Once the photographs were discussed, we identified themes together as a group. Some of the identified themes included the following:

- The belief that society sees individuals in recovery as damaged/spoiled. Both participants attributed this to mainstream media and movies, and recognized that this is from a lack of awareness of the disease of addiction.
- They thought that the required anonymity inherent in many recovery communities may exacerbate the negative view of those in recovery. They asked the question: if it isn't bad, why do we need to protect our identities?
- Both participants felt that the self-stigma experienced by those in recovery is more detrimental than the social/public stigma.
- Being active in a recovery community has helped to reduce their own perceived stigma, both by doing their own work and by being surrounded by those with similar experiences.

- Recognition of difficulty getting younger students (traditional college age students) to become actively involved in the recovery community due to lack of awareness and stigma.
- Both participants believed that their experiences of being in recovery have helped decrease their negative judgments towards others, including ascribing stigma to people with different marginalized identities.
- Sharing their recovery stories helped in reducing stigma

The facilitator then asked participants to provide feedback based on their experience of the pilot study. Once participants provided feedback, incentives for the discussion session were handed out to participants and they were thanked for their participation in the pilot study.

Participant Feedback

The researcher solicited feedback from participants at the end of the discussion session. First, to assist with recruitment for the full study, the researcher asked why participants signed up for the study, if there was hesitation in signing up, and if the incentives seemed appropriate for participation in the study. One participant mentioned that she signed up for the study because she is very interested in research and is also interested in exploring more about stigma and its impact on those in recovery. The other participant stated that he signed up because he likes to be able to share his story with others. Both participants stated that they were most interested in helping to find a way to diminish the stigma associated with individuals in recovery, and did not hesitate to sign up for the study. The researcher also asked for suggestions for how to recruit participants

moving forward. These participants suggested attending a meeting and informing students of the study face-to-face. They both also stated that they would be happy to pass along the recruitment email to other individuals in recovery as a method of recruitment. Both participants stated that they felt the incentives were more than adequate and agreed that incentives could be a helpful tool in recruiting college student participants.

The researcher asked for feedback on the accessibility of the Qualtrics surveys; both participants stated that the platform was easy to use and easy to access. They reported that they did not have any difficulties with the initial survey or with uploading their photographs. However, both requested that the questions be emailed to them ahead of time so that they had time to think about them before uploading their photographs on Qualtrics. Both participants agreed that use of their cell phone cameras was sufficient for the project. When asked about the training session, participants both stated that they felt that the directions were clear. When asked about the number of photographs requested, they stated that they felt it was fine to ask for 2-3, but encouraged the researcher to mention that it was okay if they only came up with one photograph (as one participant did). They suggested that the researcher may want to have a longer discussion session scheduled if there were more participants, as they seemed to take up the entire 1.5 hours of time with just two participants.

Both participants reported that they appreciated the methodology and the challenge of trying to portray their experiences of stigma through photographs. One participant stated that he felt he could gain a bigger perspective of stigma with this population in general, not just his own experiences of stigma, because of this

methodology. Both participants stated that they liked the idea of a final photographic exhibit and both agreed to display their photographs in the exhibit. They suggested that the exhibit either coincide with a recovery event on campus or to be a part of the ARHE conference in July in Washington, DC.

Modifications for Full Study

As a result of the pilot study, several changes will be made to the full study:

- Add demographic information to initial Qualtrics forms
- Attempt to attend CRC/CRP meeting to recruit participants face-to-face
- Include snowball sampling in recruitment tactic and have pilot study participants assist in the recruitment process
- Change definition of stigma on training session PowerPoint from: "stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them" (Link & Phelan, 2001, p. 377) to "a socio-cultural process in which social groups are devalued, rejected, and excluded on the basis of a socially discredited health condition" (Livingston et al., 2011, p. 107).
- Email participants the modified SHOWED questions along with a link to upload their photos after training session
- Increase discussion session from 1.5 hours to 2 hours
- Encourage participants to submit 2-3 photographs, while stating that one photograph will be sufficient

- During the discussion session, give each participant 20-30 minutes (depending on size of group) to choose which photograph(s) they want to focus on discussing in the group session.
- Explore the possibility of having a photographic exhibit at ARHE conference before presenting to participants in full study

CHAPTER IV

RESULTS

In the first chapter, the researcher provided an introduction to the study, including a statement of the problem, the purpose of the study, and the rationale and significance of the study. The second chapter included a more in-depth literature review of the conceptual and empirical knowledge published in the areas of addiction, stigma, recovery, and specifically the field of collegiate recovery. In the third chapter, the researcher focused on the methodology for this study, including an overview of Photovoice as a research method and interpretive phenomenological analysis for data analysis. Results of this study are presented in this chapter.

Research Question

This Photovoice study was guided by the following research question:
How is stigma experienced by college students who identify as being in recovery from alcohol and/or other drug addiction?

Participants

The researcher asked the CRC/CRP coordinators from five different universities to send a recruitment email to CRC/CRP members and/or to other students who may meet the criteria for the study (see Appendix B). This email encouraged snowball sampling as well, requesting that it be passed along to people who may meet the criteria for participation. Second, the researcher reached out to pilot study participants requesting

that they pass along the recruitment email to individuals whom they believe may be interested in participating. The criteria for inclusion initially included 18- to 25-year-olds, but after having difficulty recruiting participants and after receiving emails from individuals expressing interest who met all other criteria except the age limit, the researcher returned to the literature and found research to support the shift to individuals ages 18-29 (Arnett et al., 2014; Laudet et al., 2015). Participants were encouraged to fill out a Qualtrics survey (Appendix C) online if they were interested in participating. This survey asked basic demographic questions and ensured that participants met study requirements in order to participate. A total of eight participants completed the initial survey and all of these participants followed the study through to completion.

All eight participants met the following criteria: (a) were between the ages of 18 and 29; (b) were currently enrolled as an undergraduate student at a four-year institution or graduated from a four-year institution within the past six months; (c) self-identified as being in recovery from alcohol and/or other drug addiction; (d) abstained from the use of mind-altering substances for the past six months (caffeine and nicotine not included); and, (e) had experienced stigma as a result of their identification as an individual in recovery from alcohol and/or other drug addiction. Ages of the eight participants ranged from 20 to 29 ($M = 24$, $SD = 3.1$). Seven of the eight participants were currently enrolled in four-year institutions during the time of the study, while one participant had graduated with his undergraduate degree within the past six months. These participants were located at two different universities. No students expressed interest in the study from the three other universities that the researcher reached out to. Six of the eight participants

indicated that they were actively engaged in the collegiate recovery program/community on campus, while two participants reported that they were not engaged with these programs/communities.

In the initial Qualtrics survey, the researcher provided blank boxes for the participants to identify their own race/ethnicity and gender identity. For "please indicate how you identify your race/ethnicity," five participants answered "white," one answered "multiracial," one answered "Asian/Pacific islander/Hispanic/Caucasian," and one answered "I don't." For "please indicate how you identify in regards to gender," five answered "male," two answered "female," and one answered "trans."

Procedures and Results

To conduct this study on the lived experiences of college students in recovery, the researcher utilized a modified version of Photovoice methodology (Wang & Burris, 1997) and analysis was conducted using Interpretive Phenomenological Analysis (IPA), (Smith & Osborn, 2007).

Preparation for Photovoice

In preparation for conducting the Photovoice study, the researcher took the following steps:

- conducted a review of the literature on the topic of collegiate recovery and stigma
- identified a gap in the literature in terms of research with this population
- selected Photovoice as an appropriate research methodology in order to explore the lived stigmatic experiences of college students in recovery

- constructed a team of two coders and one auditor in order to analyze the data using interpretive phenomenological analysis
- had members of the research team bracket their biases prior to interacting with or analyzing data
- gained approval by the IRB and letters of consent from various universities
- recruited participants

Analysis

Although the creators of Photovoice offer some suggestions as to how to approach data analysis with a Photovoice research project, they leave a lot of interpretation up to the researcher. Brunsden and Goatcher (2007) suggested the use of Interpretive Phenomenological Analysis (IPA) for Photovoice research studies because it seems to be the most fitting form of analysis for both text and visual analysis when trying to understand lived experiences. In addition, the double hermeneutics inherent in IPA include the participants making sense of their photos both individually and as a group, and then the researcher attempting to make sense of the participants' reported experiences (Brunsden & Goatcher, 2007; Smith & Osborn, 2007).

For the analysis portion of the study, the primary investigator established a research team made up of three members: two coders and one auditor. The primary investigator and another researcher coded the data, while another individual audited the information once the categories and themes were identified by the coders. The two coders began data analysis by closely and thoroughly reading the group discussion transcripts, which also included each individual's photographs, the title of the photograph

and the responses to the modified SHOWED questions for each of their selected images. These questions included:

1. How does this image depict stigma?
2. Has your relationship with this stigma changed over time?
3. How does this image make you feel when you look at it?
4. What has been your experience taking/selecting this photograph?
5. Why does this situation exist?
6. What can be done about this? personally? systemically?
7. Have you had similar experiences of stigma in relation to any other ways in which you identify?

During the focus groups, participants either chose to read these responses aloud to the group or had the group read them silently in which case the researcher added these responses into the transcription and clearly indicated that these were read silently by the participants. Transcriptions also included the themes that were briefly explored and identified by each group of participants. Coders independently read through each transcript several times, taking notes throughout each reading. They then identified phrases/themes and connections in order to create a list of identified themes, clustering the ideas that were similar conceptually. This was done for each of the three transcripts. Researchers then reviewed each list of themes that were present within each group and compared these themes across the groups. These themes had to be supported by the original transcripts in order to be seen as an overall theme; otherwise it was noted that

these themes only showed up in certain groups but not across all groups. A final list of themes was then created by each coder independently.

Prior to the two coders meeting virtually, the principal investigator looked over the themes identified by both coders and cross-referenced these with Frost's (2011) model of social stigma. She then created a table to display the themes that were identified by both coders and how these mapped onto Frost's (2011) model, placing these themes into categories and subcategories. The researcher ensured that the themes identified by participants during the focus groups were included in the table and that it was noted whether themes showed up across groups or merely within one or two groups.

Coders then met virtually to discuss the table and explore any differences they had in how these themes should be categorized and/or labeled. Both coders agreed that although Frost's (2011) model was fitting for the themes identified, the model did not fully encapsulate all of the themes. Subsequently, the table was expanded to include these additional categories/themes.

Once the table of themes was agreed upon, the principal investigator sent the group transcripts, which included the participants' photographs, titles, and answers to the modified SHOWED questions, along with the table of categories and themes to the auditor for review. The auditor then reviewed the table in accordance with the transcripts. The auditor informed the coders that she did not see any blatant biases coming through the data analysis. She provided the coders with a few suggestions for adding onto particular themes and encouraged the coders desire to expand beyond Frost's model adding categories that were appropriate. The principal researcher then finalized

the data analysis by updating this table of categories and themes and sent this off to the two other members of the research team for final approval (Smith & Osborn, 2007).

Results

After coding, the principal investigator mapped the themes identified by her and another coder onto Frost's (2011) model of social stigma, adding additional categories/themes found by the coders that did not fit into the structured model. Frost identified the different experiences of stigma as: stressful life events, everyday discrimination, expectations of rejection, stigma management, and internalized stigma. He also identified consequences of stigma and coping and support strategies as separate categories. However, in discussing stigma experienced by college students in recovery from alcohol and/or other drug addiction, other categories and themes were present during the focus group discussions. These included sources of stigma and the intersectionality of stigma. These were each recognized by the research team as their own separate categories. In order to make sense of these findings in a table format, categories and sub-categories were established and the themes identified in the focus groups were placed into these categories and sub-categories. The categories include: Sources of Stigma, Experiences of Stigma, Consequences of Stigma, Coping and Support Strategies, and Intersectionality. Some of these categories were broken up into subcategories as well. Table 1 includes the categories/subcategories/themes identified by the coders. Each of these will then be described in more detail. The categories, subcategories, and themes will be designated by the following headings:

Category

Subcategory.

Theme.

Table 1

Common Experiences of Stigma Identified by College Students in Recovery

Category	Subcategory	Themes	Focus Groups
Sources of Stigma		• Self • Media/Society • 12 steps/Anonymity • Government rhetoric	• 1, 2, 3 • 1, 2, 3 • 2, 3 • 2
Experiences of Stigma	Stressful life events	• Discrimination in workplace/school	• 2, 3
	Everyday Discrimination	• Negative view of addiction/recovery** • Conflation of identity • Lack of understanding • Normalization of drinking/drugging in college	• 1, 2, 3 • 1, 2, 3 • 1, 2, 3 • 1, 2, 3
	Expectations of Rejection	• Fear of how others will view them • Expectations of judgment/rejection even when not present*	• 1, 2, 3 • 1, 2, 3
	Stigma Management	• Concealing stigmatized identity • Avoiding social interactions • Caution about who to open up to • Feel need to explain	• 1, 2, 3 • 1, 2, 3 • 1, 2, 3 • 1, 2, 3
	Internalized Stigma	• Shame • Self-pity	• 1, 2, 3 • 1, 2
Consequences of Stigma		• Loneliness/Isolation** • Fear of missing out/not fitting in • Questioning addiction due to familial/friends' lack of education	• 1, 2, 3 • 1, 2, 3 • 1, 2, 3

Table 1

Cont.

Category	Subcategory	Themes	Focus Groups
Coping and Support Strategies	Individual/ Personal Level	• Time in recovery • Self-awareness/Self-acceptance** • Compassion towards others**	• 1, 2, 3 • 1, 2, 3 • 1, 2, 3
	Group/Societal Level	• Community/social support* • Education • Personal experience (family and friends)	• 1, 2, 3 • 1, 2, 3 • 1, 2
Intersectionality		• Intersectionality of stigma	• 1, 2, 3

Note. *Participant-identified theme (number of asterisks = number of focus groups it was a participant-identified theme).

Sources of Stigma

Throughout the focus groups, it became apparent that there were several sources contributing to the stigma experienced by participants. This became a category separate from what was identified in Frost's (2011) model. These sources of stigma included: self, media/society, 12 step philosophy/anonymity, and government rhetoric.

Sources of Stigma subcategory. There were no subcategories denoted for Source of Stigma.

Self. Participants identified 'self' as a source of stigma in all three focus groups. Oftentimes, this was referred to as self-stigma and will be discussed more in-depth as internalized stigma when 'experiences of stigma' are discussed. Self was identified as the source of stigma more frequently than any other source of stigma. In fact, one

participant said “I’ve criticized myself more than I have overtly experienced.” Another participant shared this photograph:

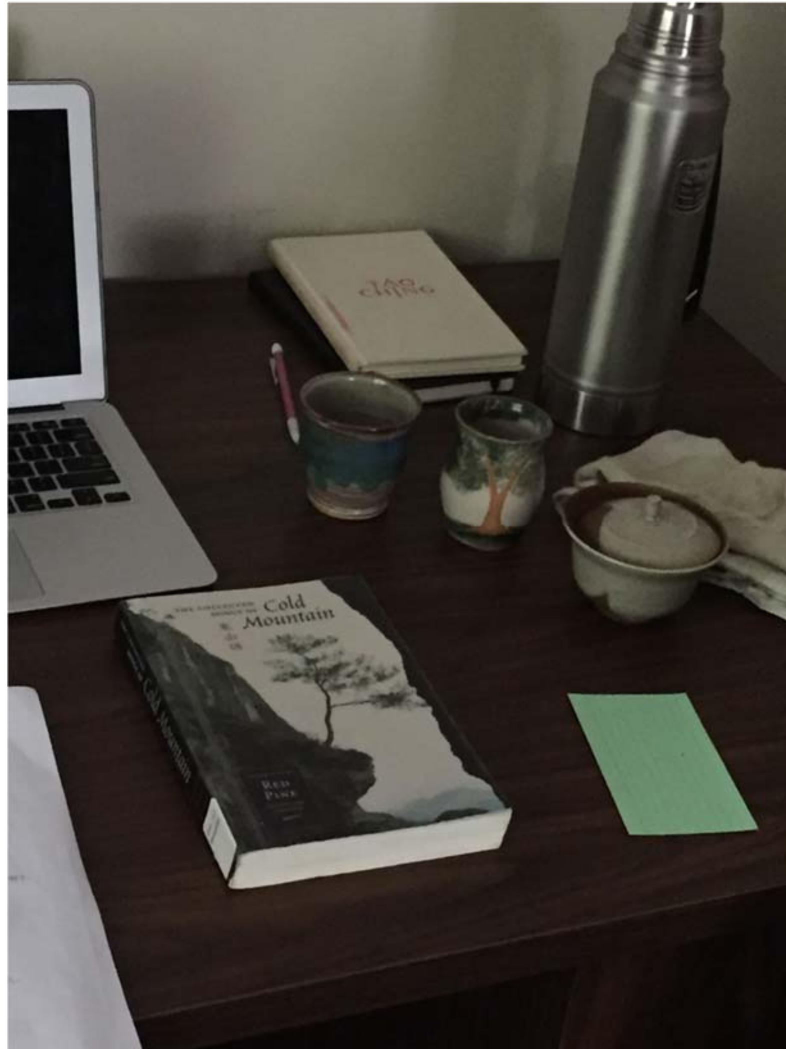

Figure 3. Tea with Cold Mountain.

He stated that he chose this image because it reminded him of when he first returned to school and chose to isolate, similar to the Daoist Zen who chose to live in a cave, because he thought everyone else would be drinking and he would not fit in. As a

result, this participant said “I felt like I was critiquing the outside world, making up their perceptions of it, and then pushing them back on myself and making stigmas up.” Although self was cited as a common source of stigma, one participant recognized that this source of stigma is based on external experiences of stigma that have occurred in the past, an observation that was mutually agreed upon by members of the group. He stated: “I still believe that they secretly believe that I’m different, even though they’re not going to say it. Some people may or may not [but] there is a reason I think that, I didn’t just make that up, I don’t think that people just get ideas like that for no reason.”

Media/Society. Although many participants identified ‘self’ as a source of stigma, media and society also were identified as sources of stigma. One participant said “I believe that TV shows and movies portray drunks and alcoholics as ‘others’ who can never be saved,” while another participant in a different focus group commented that “the ides of people with substance use disorders being ‘burn outs’ is [consistent] with how the media perpetuates it.” In fact, another participant stated “I hate saying this but I think the media portrays the alcoholic/addict as a man who is homeless or a man who beats his wife.”

This idea that the media perpetuates this negative view of addiction, and in turn, recovery, was brought up several times throughout the focus groups. One participant even referred to the ‘reality’ TV show, ‘Intervention,’ as a source of miseducation surrounding the disease of addiction and the myths around treatment and recovery. In discussions, this particular source of stigma was often connected to the idea of media or society being stuck in a ‘moralistic’ view of addiction rather than believing or adhering to

the disease model of addiction. When asked, “What can be done about this?,” many participants alluded to education, which will be addressed in a subsequent section. This need for education around the disease of addiction was echoed among focus group members. One member stated “I believe education surrounding addiction needs to be more accurate and that the media needs to stop perpetuating faulty belief systems surrounding addiction.”

12-step philosophy/anonymity. Another source identified as a theme in two of the three focus groups related to anonymity and the 12-step philosophy. Compared to the sources mentioned above, this source did not seem to get the same consensus from participants as a source of stigma. However, it was mentioned emphatically by 2 group members and bears recognition. In regards to 12 step programming being a source of stigma, one participant stated: “I have experienced some animosity and stigma from people who say “you don’t practice ‘the program’ as you should be practicing it. Whether it’s because I don’t go to enough meetings or I don’t work on a particular step with a sponsor and . . . people don’t view me as working a solid program.” This participant and another participant in his focus group, identified feeling ‘othered’ by the 12-step community if they did not follow the direct path that was laid out for them through AA/NA. Some participants focused on the idea of anonymity and its potential to perpetuate stigma to people outside of the AA/NA community. One participant stated,

> it’s almost like we’re creating this positive feedback in which we don’t want to talk about it because we don’t want people to look bad upon us but then they’re going to be like “Oh, they’re not talking about it because there’s something bad about it.” We don’t want people to know about it because we don’t want them to

> see us as an alcoholic whereas if we just broke through somehow then it would be different.

Another participant agreed, stating,

> I think there's so much shame and embarrassment about being an addict and a lot of that is because of the stigma. No one wants to hear about it. You don't want to talk about it. Because no one's talking about it, it I must be bad. You would talk about it if it was good.

One participant chose to try and depict their relationship with anonymity through a photograph:

Figure 4. Silenced. Blurred by researcher for confidentiality purposes.

> This image depicts the stigma that alcoholics want to be anonymous or do not want people to know they have the disease of addiction. The stigma also plays a dual role in that I do not think anyone wants to hear about me talk about my recovery. In reality there are many addicts who are comfortable talking about their recovery and many individuals who want to learn more about addiction and recovery.

Another participant viewed the idea of anonymity differently, suggesting that it was not in fact a source of stigma, but rather the philosophy of anonymity was developed in order to combat the stereotype of addiction. He stated,

> My understanding is that anonymity is like the suffering that I experienced doesn't just reside within me; it resides within everybody. Also when you do have an organization, in the traditions and some of the steps within 12 step fellowships, the anonymity pieces were created because they don't want to have a spokesperson. People are on their own paths and they don't want to have society look at them and identify them as the spokesperson.

Although the theme of 12 step programming/philosophy, including the foundational tenant of anonymity, was considered a source of stigma for many participants, it was not identified as frequently as sources such as self, media/society, or friends/family/classmates.

Government rhetoric. Another source of stigma identified as a theme in one of the focus groups was the government, either through rhetoric by government officials or policies enacted. In the first focus group, the 'war on drugs' was addressed by participants as a source of stigma. One participant noted that "the government's 'war on drugs' perpetuated this [moral view of addiction]." Another participant shared this photograph:

Figure 5. 145 and Lennox.

In explaining this photograph, he stated,

> I heard about this intersection in a hip hop song one time and they were talking about selling crack cocaine at that intersection . . . This is an image of where most people would probably guess the run of the mill drug addict comes from like high rise projects. A project in an inner city.

He identified the government's 'war on drugs' as the source of this stigma, portraying the "inner cities as the front line on the war on drugs." He added that "there were not that many white faces, it was located in inner cities and it was 'bad people.'"

Not only was the "war on drugs" instrumental in stigmatizing addiction, but one participant identified the 'Just Say No' campaign, initiated by former first lady Nancy Reagan as a source of stigma that contributed to the lack of understanding of addiction as a disease. Other participants recognized that the rhetoric of the current administration

seems to be harming progress that has been made in the past several years to negate the stigma of addiction. One participant addressed the current Attorney General's rhetoric on addiction and the potential harm of this rhetoric, questioning the actual progress being made in stigma reduction. He stated,

> All they see is the guy who is getting elected to take care of this is saying marijuana is the problem again. It's been proven that it is not the issue. And he said that two weeks ago on national television. So it's like, is this the world that I have created for myself to believe that these stigmas are being reduced on a national scale or is it actually happening? . . . Is something major actually being done and like what are the steps being taken forwards, backwards, left, right?

Experiences of Stigma

The research question for this particular study was: How is stigma experienced by college students who identify as being in recovery from alcohol and/or other drug addiction? In order to consider the answer to this question, the researcher looked to models of stigma experienced by other populations. Frost (2011) developed a model (Figure 1) of social stigma that portrayed both the perpetration of stigma and the experiences of stigma. Although Frost mainly drew from theories of stigma in relation to race/ethnicity, gender, and sexual orientation, his model seems to provide a useful tool for conceptualizing and addressing stigma experienced by individuals in recovery from alcohol and/or other drug addiction. Frost identified the stigma-related stress experienced by those who are stigmatized in categories labeled: stressful life events, everyday discrimination, expectations of rejection, stigma management and internalized stigma. During data analysis, the coders did not refer to Frost's model, but rather compared their

common themes to the model once they were established. The themes fit nicely into the categories identified in the model in the following ways:

Stressful life events. Frost (2011) stated that "stigma-related stressful life events are acute stressors in that they occur relatively infrequently (compared to other stressors) and tend to stem from an isolated event. These manifest in direct experiences of discrimination or other events brought on by prejudice" (p. 826). Although this experience of stigma was the least frequently described experience of stigma discussed in the focus groups, it was still present, particularly in the second focus group in terms of discrimination in the workplace and school setting.

Discrimination in workplace/school. One participant discussed the fact that those who have dealt with addiction and faced legal charges as a result are frequently discriminated against in the workplace. Another participant corroborated this concern, stating,

> There are laws against discrimination in the workforce. You can sue people for saying, if I wasn't hired because I was a woman I could sue them, but I can't say that if I have [criminal?] charges. It's their right to say something but it is discrimination. That's real. I think it is, maybe that's because I'm in that bubble of people, but you're discriminating against somebody because they did something positive with their life, honestly. This person is in recovery. This person is doing something amazing with their life. Just because you didn't face that battle doesn't mean that that person is less than you or not capable of a job. Maybe I am getting angry, I don't know. It just makes me really, really sad.

One participant also expressed concerns about not being able to get into medical school because of discrimination towards individuals in recovery. He mentioned that a pre-health advisor at his university "said that no one has ever identified as an alcoholic

and has been accepted into med school," adding "there is so much competition for med school and high paying jobs so why take chances on someone with a drug history?" Another commented on these statements by expressing the thought that "it's quite literally a disease and it's so obvious the workforce and the university system still does not acknowledge that and that makes me . . . disappointed in society--that we haven't reached this point where this still isn't a problem." This blatant life-altering discrimination was not discussed much during the focus groups; however, subtler forms of everyday discrimination seemed to be frequently discussed.

Everyday discrimination. Frost (2011) recognized that "although forms of everyday discrimination may be of a smaller magnitude than stigma-related life events, their chronicity produces a cumulative stress effect that can potentially be equally distressing" (p. 826). Instances of 'everyday discrimination' were present in all three focus groups. This subcategory included four of the identified themes: negative view of addiction/recovery; lack of understanding; conflation of identity; and, normalization of drinking and drugging in college. Each of these themes is discussed in the following paragraphs.

Negative view of addiction/recovery. Many of the participants in the focus groups mentioned the fact that people often have negative views both of people struggling with addiction and those in recovery. These negative views affected how participants experienced being in recovery. One participant stated: "I just feel people view alcoholics as damaged goods and not as individuals who can be productive to

society." He chose to depict this stigma in the photograph titled "Damaged But Works Just Fine":

Figure 6. Damaged But Works Just Fine.

> The tears in my sleeping pad represent the hardship of overcoming an addiction. I believe that if someone identifies as an alcoholic, or people think a person is an alcoholic, then they dismiss them as damaged goods. They're unsalvageable.

> These patches have kept my sleeping pad alive. A couple are from coals, another is from a nail and one, not in the photo, is from, well I don't remember what it's from honestly. This sleeping pad still works. It works just as well as it did when I bought it new. That is how I feel about how individuals should see alcoholics. We've suffered from bumps in the road but we can be brought back to new with a little love and care. We can get back on our feet and still carry out normal lives.

This negative view of addiction then elicited a fear of rejection and judgement from participants, which will be discussed in the following section. Participants suggested that it is these negative beliefs that formed the stereotypes that many people have of those in addiction or recovery. One participant said, "If you have a problem, then you're a burden and weak in our society. We tend to judge each other quickly and we throw all alcoholics in with the worst of those stereotypes." Another participant in another focus group touched on this by stating, "We're conditioned to believe people who are addicts or homeless or partying too much are bad people, and not people who have experienced bad situations." These stereotypes often led to a conflation of identities, which participants talked about as well.

Conflation of identity. In all three focus groups, participants explored the idea that conflating an individual identity to fully be contained by the label of 'alcoholic' or 'addict' was problematic. One participant chose to depict this in a photograph titled 'Identity.'

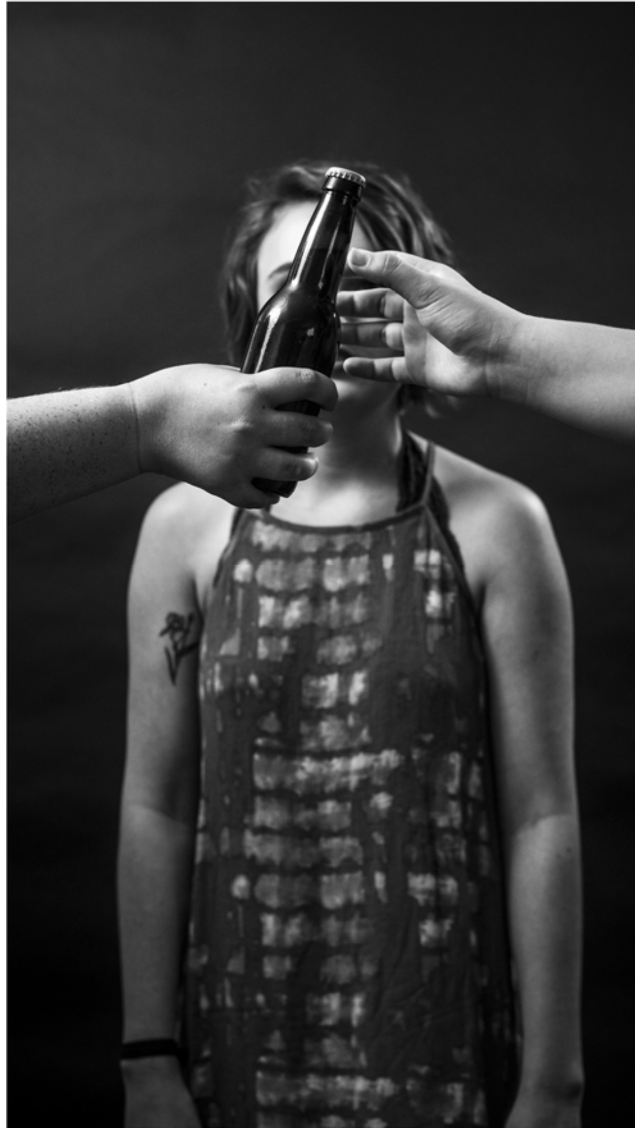

Figure 7. Identity.

In response to this photograph, she stated,

> To me this image represents the self-imposed stigma and societal stigma of how the substance becomes the individual. When I was drinking I believed alcohol was so much a part of my identify that I could not comprehend who I was without it. I felt that if I identified as an alcoholic the only characteristic people would acknowledge about me was my disease and not other personal characteristics. Society puts out this idea that an alcoholic has to look like an alcoholic. Covering

> my face is supposed to show how society feels I should look like this stereotype of my disease. How I should be the drink itself.

This labeling then connects to both everyday discrimination as well as other stressful life events. One participant stated that "alcoholics and addicts, once labeled, are faced with an inordinate amount of obstacles to be welcomed back into society." For one participant, these stereotypes led to a fear of returning to school. He stated,

> it was really nerve-wracking for me going back to school clean because I was still really finding myself and realizing again that there is not just one aspect of my identity, that it is all different pieces within myself and there is no one-word definition of who I am.

Another participant said,

> when people want to pin you to a label that you may completely identify with, that one label in their mind becomes your whole identity rather than that label being a small portion of your space and the rest of it being filled up with personality, and history, and stuff that people tend to forget.

These negative views of addiction and stereotypes leading to conflation of identities also led to participants feeling misunderstood.

Lack of understanding. Throughout the three focus groups, the lack of understanding exhibited by people who are not in recovery came up several times. Not only did many participants express feeling misunderstood because of the negative view of addiction and recovery, but several participants shared sentiments similar to one participant's view that "people just don't understand and talking about it is wasted words sometimes." Several participants discussed encounters with 'normies,' identified as

individuals not struggling with addiction or in active recovery, who could not comprehend the complexity of recovery and the need for sobriety. One participant shared that he was thinking about a hypothetical situation in which he imagined he approached a friend of his who knows he is actively involved in recovery, and said:

> "Yeah, I'm thinking about getting high today or drinking today," his [friend's] first thought, only semi jokingly, would be "Let's go to a bar." I mean come on. I think a lot of people just don't understand how life or death it is.

Much of this lack of understanding also focused around addiction being seen as a moral or ethical issue rather than a disease model. One participant chose to depict this stigma in a photograph titled "Roses in a Forgotten Greenhouse":

Figure 8. Roses in a Forgotten Greenhouse.

He stated,

> This picture portrays the stigma that addiction is a moral or ethical choice. I found these roses growing in a forgotten greenhouse. It created this internal discussion about what my outer self looks like and what is actually going on inside of me. And how those two things don't always align. As in, on the outside it could look like I am just this unkept greenhouse in the middle of nowhere with no meaning or life, but on closer examination there is something on the inside, that could be seen as having a sense of beauty.

Normalization of drinking/drugging in college. Throughout the focus groups, it came up quite frequently that the normalization of drinking and drugging on a college campus was experienced by many participants as a subtle form of everyday discrimination. It was recognized that both students and teachers alike discussed drinking as a normal part of college culture. One participant stated "I've had teachers talk about alcohol in class and I'm like, why are you bringing that into the classroom?" A few participants talked about the disconnect in trying to communicate with other students when the conversation often turned to drinking and partying, leading one participant to question "how do [we] connect with other people in a genuine way while honoring our experience as recovering addicts?" One participant stated "now my stigma manifests itself in the fact that I'm in a college environment where drinking is the norm, and I can't join in those same festivities, because of where my drinking brought me up until this point."

Expectations of rejection. Frost (2011) wrote that

> Not all forms of stigma-related stress involve identifiable forms of discrimination or even contact with a perpetrator of stigma. Because stigmatized individuals and groups live within societies structured in ways that perpetuate social stigma, people who are stigmatized may enter into social interactions with an expectation that they will be rejected by others because of their stigmatized social status. This expectation of rejection, regardless of whether or not rejection actually occurs, produces a cognitive burden that constitutes stigma-related stress. (pp. 826–827)

Many participants in this study expressed feeling as if they expected to be judged or rejected by others. Many of these experiences were connected to the everyday discrimination experiences mentioned above. The expectations of rejection subcategory included two of the identified themes: fear of how they will be perceived by others and recognition of expectations of rejection even when rejection/discrimination was not present.

Fear of how others will view them. In all three of the focus groups, participants brought up a fear of how others would view them if they knew they were in recovery. One participant stated,

> I think a really big part of my daily life is how much I am not only valuing myself, but how much value I'm placing in other peoples' opinions of me and how I let that affect me on a day-to-day basis.

Another participant depicted this fear in a photograph that he shared with the group:

Figure 9. The Other Shoe.

He stated,

> This picture depicts stigma in that it represents my waiting for the other shoe to drop. For a long time after I started attending university while in recovery I had this anxious feeling that despite life going swimmingly something or someone would come out and stigmatize me due to addiction. This was a form of perceived self-stigma in that no one was overtly stigmatizing me, but I was worried that someone would any minute.

It appeared this this fear of how participants would be viewed or perceived by others was connected to everyday experiences of stigma and impacted how they managed this stigma. One participant clearly stated: "I'm scared of what people think about me as an alcoholic." Another participant depicted this fear in a photograph titled "On Fire":

Figure 10. On Fire.

He described his fear of opening up to others, whether about being in recovery or struggling while in recovery, and acknowledged that he has “gone through waves of really being open about feelings to waves of fear and rejection, feeling judged, and less than.”

Another participant, who worked with children at a local elementary school as a part of her degree, said that she found herself "wondering if people were going to trust me with their kids if they know I'm a recovering addict." One participant questioned: "Is that actually something that people are projecting onto me or this something that I'm fearful that people are going to project onto me and can we really know?" These expectations of judgement and/or rejection even when they are not present was the next theme identified by both the coders and one of the focus groups.

Expectations of judgment/ rejection even when not present. Focus group one identified this as a common theme in their discussion. This theme often came up in discussion after expressing a fear of what others may think if they found out that a participant was in recovery. Many participants acknowledged that these expectations of rejection were often unfounded in the particular circumstance they were describing. One participant said "a lot of the times when I've tried to explore what people really think, [I discover] they don't really think what I think they think."

Even though many participants recognized that rejection was not often present, they continued to expect rejection and judgement if they shared that they were in recovery. One participant said: "I still believe that they secretly believe I'm different, even though they're not going to say it." Another participant described these feelings:

> I think one thing that I did very early on in recovery, is that I would talk to my parents or my girlfriend and I would be like that person hates me or they are upset with me for not showing up to a party or something like that. And people would reassure me but that didn't make me feel more secure about these preconceived notions I had. I think there have been very few times where someone has outwardly questioned why I wasn't drinking or showing up at parties or things like that. I would tell them I was in recovery and they would accept and

> understand that, but afterwards it's like all internal, it's me, I'm stressing out about it or me being concerned I'm not making myself present enough, even though I know those situations wouldn't be good for me. So I think I convinced myself that other people hate me or think less of me even though someone could tell me to my face that that is the exact opposite of what they are thinking and I won't be able to internalize that positive feedback.

Another participant recognized that these expectations of judgement and rejection come from different sources of stigma, stating: "there is a reason I think that, I didn't just make that up, I don't think that people get ideas like that for no reason. Like some time in my past that really happened, but then I applied it to every situation afterwards even if it isn't true or correct." These expectations of rejection led to varying degrees of stigma management.

Stigma management. Frost (2011) recognized that

> In response to the potential for rejection and discrimination, people who are stigmatized face an additional chronic stressor with regard to their management of how and whether a stigmatized identity or characteristic is made visible to or concealed from others. People with concealable stigmas (e.g., sexual minorities, people with mental health disorders), are constantly faced with the decision to conceal or make visible their stigmatized statuses. Although concealing one's stigmatized status from others can be protective, in that it may allow one to avoid discrimination, stigma concealment is stressful because it produces cognitive burden resulting from fear of discovery. (p. 827)

Although being in recovery is a concealable stigmatized identity, many participants also experienced stigma and discrimination from other intersectional identities, which will be discussed in a subsequent section. The idea of stigma management was brought up in all three focus groups and was labeled as a subcategory in Frost's (2011) model. This subcategory included four of the identified themes: the act of concealing the stigmatized

identity, avoiding social interactions in order to manage stigma, caution about who to open up to about being in recovery, and feeling the need to explain recovery if unconcealed.

Concealing stigmatized identity. Feeling the need to conceal the stigmatized identity of being in recovery came up quite frequently in the three focus groups. One participant chose to depict this need to conceal this part of himself in the following photograph and description:

Figure 11. A Distant Ghost.

> This image depicts stigma in that it represents the way in which I perceived it necessary to hide the aspects of myself that related to addiction. When I did mention specific details about my life in active addiction or even aspects of my current recovery I was often meet with shock, awe, and even what appeared to be disgust. I even experienced others distancing themselves more after such

> disclosures. I had times when I felt as if my life before recovery was a ghost of myself.

Other participants also discussed the need to hide this aspect of themselves. One participant described how she concealed this part of her identity when she first returned to school: “I continued going to parties, and instead of carrying a red solo cup, I carried a soda or a Red Bull, so as to not seem like I was hiding from the fun.” She felt the need to hide her identity in order to be seen as not ‘hiding from the fun.’ While some chose to conceal this part of their identity in various ways, other participants described the need to avoid social situations in order to manage the stigma associated with recovery and addiction.

Avoiding social situations. The idea of avoiding social situations in order to avoid rejection or judgement was present in all three focus groups as well. This was mainly addressed in reference to parties and other events where drinking and drugging was potentially present. One participant said,

> I find that sometimes I will just isolate myself instead of putting myself into situations, like drinking and stuff. Because sometimes it is just not fun being in those situations, where you’re the only one who is not drinking or smoking.

Another participant stated, “I will avoid parties and close myself off from people to avoid the awkwardness of not drinking at a social event.”

When the idea of avoiding social situations was brought up, it was often done so in regards to early recovery. Many participants explained that as they began to feel more comfortable in their recovery, they were less likely to avoid social situations out of fear.

This will be discussed more in the section regarding 'What helps?' Regardless of time in recovery, however, many participants discussed the fact that they were careful about disclosing the fact that they were in recovery.

Caution about who to open up to. Recognizing the need for discernment and caution in disclosing this stigmatized part of their identity was discussed in all three focus groups. One participant stated,

> Once I become good friends with someone who doesn't have problems, a "normi" if you will, I let them in on my addiction and then they're usually accepting. So I just normally don't straight up meet someone and just let them know that I don't drink alcohol because I'm an alcoholic. Usually I get to know the person before I open up to them. I don't really tell people I'm an alcoholic because I don't want people to dismiss me. I don't tell them until I'm sure they know who I am. Once they see the real me then I let them in on my life. I think that they would view me through biased eyes, if I let them know I'm an alcoholic before letting them get to know me.

This protectiveness around their identity was also seen as something that happened over time. One participant identified that "I've learned to be a better judge of the receptiveness of those I would be sharing such details with." Another participant recognized that over time it was helpful to figure out "not just who, but how much to share and that level of it doesn't have to be all or nothing or either/or; figuring out that that doesn't make that friend or the confident less than or like a B-list friend if they don't know X, Y, and Z." Another participant stated, "I don't need to explain everything to everyone. It's okay for me to say no thank you, without giving an explanation." One participant chose to depict this discernment in a photograph titled "Privacy":

Figure 12. Privacy.

She stated,

> I don’t need to open my heart to everyone, I don’t need to open my truth to everyone. I can choose and pick what I share and I think because I’ve dealt with so much disrespect throughout my entire life, I just didn’t understand how to do that; I didn’t know that I didn’t have to totally open up to everybody. I think that is a big part of what that photograph is about.

While some participants found it empowering to not have to explain their situation to others, many participants felt the need to explain more about their recovery or history with addiction once this stigmatized identity was revealed.

Feeling the need to explain. Several participants described feeling the need to explain their situation once others knew they were in recovery. One participant stated that when

> someone has offered me a drink and saying no doesn't feel like enough, but it's also not exactly fun to like tell every person when you first meet them at a party or otherwise that you're in recovery. It's like a much longer conversation than just leaving it at that.

Another participant recalled a time when he ran into someone that he had not seen since before he went off to treatment. He said,

> We locked eyes and I just turned and walked away because it is very easy to just go up to someone and talk to them but if its someone that I know from before going to rehab I always feel an instant shame and that I would have to explain why I'm here but I really don't.

Another participant responded to the story above by stating that she "feel[s] obligated to explain." She described returning to school after getting treatment and felt that she had to explain to everyone why she was gone and why she was in recovery.

Internalized stigma. Frost (2011) stated that

> internalized stigma refers to the application of negative social meanings of stigma to one's self-concept . . . Stigma is socially constructed; not an inherently negative characteristic of individuals. However, given people who are stigmatized live their daily lives within societies that are shaped by social stigma, the socially generated negative meanings surrounding stigmatized characteristics and

> identities can easily be internalized and attached to the self. The result is socially generated but internally perpetuated self-devaluation. Internalized stigma can persist even in the absence of direct perpetrators of stigma, and is thought by some to never completely subside. (p. 827)

The concept of internalized stigma was present in all three focus groups and was referred to quite frequently. In one focus group, a participant answered the question "why does this situation exist?," by stating, "The situation of my stigma exists because I feel a lot of self-doubt, self-isolation, and self-pity when it comes to recovery." The internalized stigma subcategory included two identified themes: shame and self-pity.

Shame. Feelings of shame were present in all three focus groups. One participant stated, "I think there's so much shame and embarrassment about being an addict and a lot of that is because of stigma." Another said, "In my time in sobriety, I've felt a lot of shame for who I was previously, and who I am now. That factor has been constant and consistent, but has manifested itself in many different ways." One participant recognized the internalized stigma that he was experiencing and commented, "Now, however, the stigma is more internal, and introspective, and has resulted in me feeling a lot of shame for the past."

Self-pity. Self-pity was a theme that came up in two of the three focus groups. It was described as an internalized experience of stigma. One participant shared this photograph and this description:

Figure 13. Steps.

> In this image, I'm carrying all of my weight on my back and I'm walking alone. I'm in the middle of a colorful area, surrounded by beautiful sights, and groups of happy people, but I can't necessarily enjoy it because I'm worrying about what's going on around me and because I'm alone. This is what sobriety, recovery, and the stigma associated with the two feel like for me. There's so much for me to grasp and so much beauty to experience, but I'm plagued by feelings of self-pity and isolation. It feels as though everyone else has commonalities and the freedom to experience all the world has to offer, while I'm limited and unable to relate with others. From the outside, it may look like I elect to be alone and have made the decision to live my life this way out of my own free will, but really it was a difficult decision, one I have to grapple with in isolation.

This feeling of self-pity was often connected to feelings of isolation, which will be described more in the section related to consequences of stigma. In regards to self-pity another participant stated: "I fall into self-pity and think I cannot be normal and regular with others," while another participant stated: "People pity us; therefore, we sometimes pity ourselves."

Consequences of Stigma

Frost (2011) recognized that "the types of negative consequences of stigma depend largely on the stigmatized population under investigation, suggesting that the negative consequences of stigma are contextually dependent and often domain-specific" (p. 828). Throughout these focus groups, several consequences of stigma were present in the group discussions. This category included three different identified themes: loneliness and isolation, fear of missing out/not fitting in, and questioning addiction.

Consequences of Stigma subcategory. There were no subcategories denoted for Consequences of Stigma.

Loneliness/Isolation. This was perhaps one of the most common themes present in the focus group discussions and was identified by two of the focus groups as a common theme. Several of the photographs and descriptions submitted included this theme.

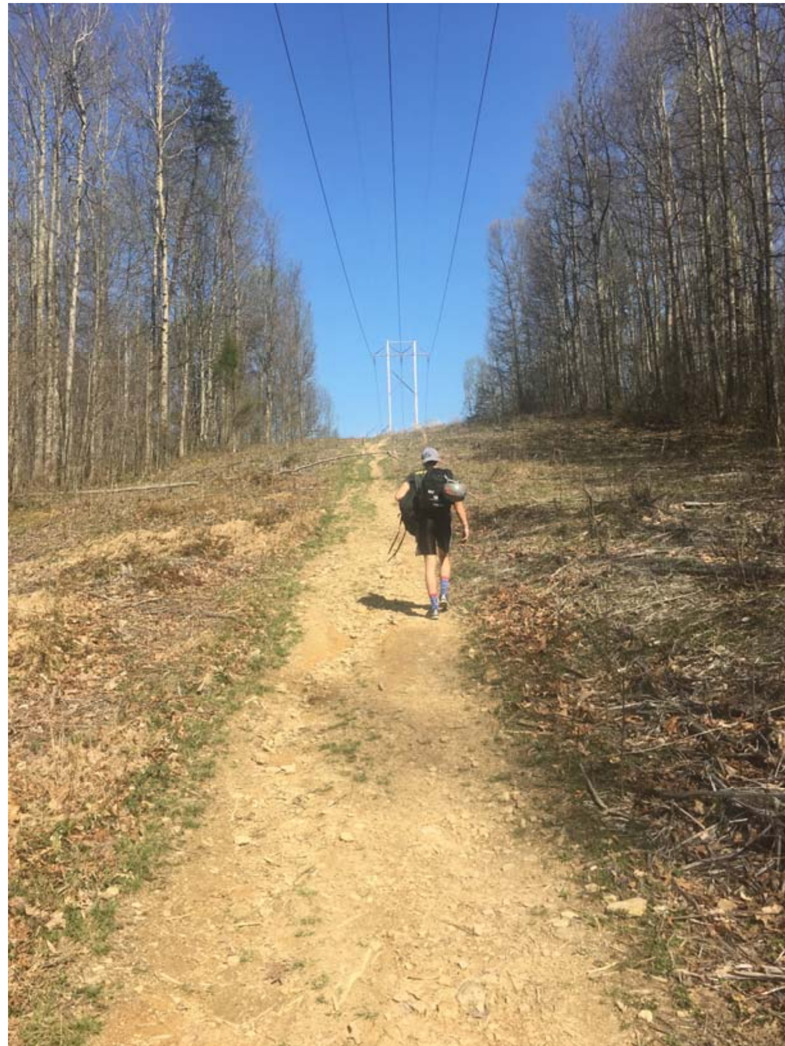

Figure 14. Alone.

In response to the photograph above, the participant said,

> this individual is by himself, ahead of us, and just not part of the group. Sometimes I feel I'm a little bit separated from the group because I usually can't connect on those type of recreational levels . . . I sometimes feel quite alone from others because I miss out on the connections made from going out to parties and getting drunk. Instead I find myself on weekends by myself late at night.

One participant talked about the isolation and loneliness she experienced and the stigma management that she used to make it seem as if she was not experiencing such consequences, explaining that "I turned to social media to attempt to present myself as someone with a fulfilled life, even though I felt deeply isolated every single minute of the day." Some participants recognized the harm that isolating themselves from others and feelings of loneliness could potentially have on their sobriety. One participant mentioned: "even in other hours of the day I would isolate myself mentally and socially and that was really toxic, and it like led me to like the same thoughts that provoked my drinking in the first place." This isolation often led to a fear of missing out or exacerbated feelings that a participant did not fit in.

Fear of missing out/Not fitting in. The idea of missing out on social connections and/or this feeling of not fitting in was present in all three focus groups. One participant chose to depict this in a photograph titled "Don't Fit In." He described the photograph as:

> Self-stigma in the sense of feeling different or less than, to the point of wanting to isolate from friends. I guess my bigger picture upon that is that it is mainly in my head. I know that's completely in my head with current standing friends, with new people it isn't, but with friends that I've had before and after recovery, my tendency to think of myself still as different and not fitting in is manifested in the desire to, like a vicious cycle, to want to isolate and then feeling more different and wanting to isolate more and eventually separating completely from this friends.

Figure 15. Don’t Fit In.

Another participant mentioned, “I don’t feel unhappy about my decisions to stay home instead of go out, but I do sometimes wonder if I’m missing out on my life out of fear that I’ll drink again.” Another participant followed up on this comment by stating that “having that fear of drinking and not going out and missing out on your life, I have definitely experienced that at times in my sobriety.” Another participant expressed this feeling of not fitting in with other students through his photograph titled “Diverge”:

Figure 16. Diverge.

This image represents a self-stigma I imposed upon myself in my relations to other students. I believe that university is a time that many undergo significant changes in their identity and concept of self. While I most assuredly experienced such changes, I often felt that my path led in a different direction with a divide between myself and others. Although I definitely perceived more of a divide that actually existed, due to my age, prior life experiences, and recovery life-style, I often felt apart from other students. I felt I had to avoid or at least be cautious of relationships with other students because of my recovery.

Questioning addiction. The idea of questioning one's own addiction based on the societal views of addiction was a consequence that was expressed in all three focus groups. One participant chose to depict this in an image:

Figure 17. Isolation.

> This image is meant to show how society believes that an alcoholic isolates him or herself from the rest of the world. While this is somewhat true about many addicts, isolation can take many different forms. I was interacting with my friends and family as a normal drinker, especially my friends, since binge drinking and overdrinking is normalized, and even valued as a good character trait in college. My isolation was not obvious since I was continuing to go to school, hang out with friends, see my family and go to work. My isolation was really unseen in that I would binge drink alone, meaning no one knew how much I was really drinking because they weren't seeing that part. The stigma actually convinced me I did not have a problem for a long time since my form of isolation was not as apparent and clear.

This questioning of addiction because of the normalization of drinking and drugging in college was something that was addressed by a few participants. One stated, "I questioned whether or not I was an alcoholic because maybe blacking out was a sign of alcoholism, or maybe it was just because I'm in college."

Coping and Support Strategies

Frost (2011) stated,

> The connections between social stigma and its consequences are not universal. There is a tremendous amount of variability in the ways stigmatized individuals and groups respond to experiences of stigma-related stress (Frost, 2011a). Understanding the ways people and groups respond to stigma-related stress is an important endeavor in the psychological study of stigma. Not only is it necessary to understand the damaging effects of social stigma, it is equally if not more important to understand how the stigmatized are able to cope with, resist, and overcome the limiting consequences of stigma. (p. 830)

Frost (2011) breaks up the category of coping and social support into two subcategories: Individual/personal and group/societal. There were themes present in all of the focus group discussions that fall under both of these subcategories.

Individual/personal level. The individual/personal level coping strategies discussed in the focus groups included their identified themes: time in recovery, self-awareness/self-acceptance, and compassion and understanding and compassion towards others.

Time in recovery. The concept of connecting the amount of time in recovery to how individuals experience and cope with the social stigma of addiction and recovery was present in all three focus groups. One participant noted, "As I become more comfortable, both with myself and with my friends, the stigma has had less power over

me." Another participant commented that "I believe that the longer I am in recovery, these interactions will just start to become normal and this barrier that I perceive will no longer exist." One participant stated, "Although it's still difficult to be in recovery (and probably will never stop being difficult), I no longer feel ashamed to be a 'recovering' anything." While another participant recognized that her relationship to the social stigma had changed over time, she stated,

> My relationship now with the stigma is that I'm someone beyond my disease. Alcoholism is just a piece of me but it does not define me. It is one of many elements of the complex person that I am. I still face a societal stigma of having to look like an alcoholic but I understand the disease as diverse and a disease that affects many different types of people with different faces. Therefore, I am more comfortable now than I was before.

Another participant stated,

> I still face invalidation sometimes but the longer I am in recovery the less people question my disease is real. I also, overtime, have become more willing to talk about my disease with others when they show interest in learning. This, I believe, helps me and them in some way.

Self-awareness/self-acceptance. The need for self-awareness and self-acceptance in order to cope with stigma was identified as a common theme in two of the three focus groups and the theme itself was present in all three focus group discussions. One participant identified this as personal empowerment and depicted this need in the following photograph:

Figure 18. Personal Empowerment.

She stated,

> For me recovery is about personal empowerment, ownership, and awareness. Self-awareness awakens a lot strength. I am working to heal this stigma by practicing making choices that help me feel and acknowledge, "I am in charge of my own life. I don't have to give my power up because I am an addict."

One participant in another focus group stated that "it wasn't until I began to actively work on myself and seek out experiences that made me feel fulfilled (rather than made others believe I was), that I began to feel the stigma, particularly the self-stigma, reduce." Another participant identified this shift by stating, "I was finally able to be present at events and active in the lives of my friends and peers because I was finally happy with myself and my own recovery journey."

Compassion and understanding towards others. The need for compassion and acceptance and understanding of others was another theme that was present in all three focus groups and was identified by participants as a common theme in two of the three focus groups. Many participants described the need to be patient with others because they do not understand the disease of addiction. This patience and understanding often helped diminish the stigma that those in recovery were experiencing. One participant stated "I think I learned a lot about myself through understanding the lives of others," while another participant responded to that comment by stating, "understanding the human experience was important in my growth."

Group/societal level. Group level coping strategies along with thoughts around what is needed in society to deal with and shift stigma related to addiction and recovery were discussed in all of the focus group discussions. This subcategory included the following identified themes: need for community and social support; need for societal education about addiction and recovery; and importance of knowing someone in recovery to aid in understanding the disease.

Need for community and social support. The need for community and social support was discussed in all three focus groups and was identified by participants as a common theme in one of the focus groups. Oftentimes, the concept of the importance of community was discussed in relation to being involved in a recovery community and having friends who were in recovery, although this was not always the case. One participant recognized that "personally surrounding myself with people who are dealing with the same disease and stigmas has helped me greatly." Another participant in another

focus group depicted the importance of community to combat the stigma of recovery and addiction in a photograph titled “The Lone Ranger.”

Figure 19. The Lone Ranger.

He stated that this photograph illustrated the idea that many people have to fight the disease on their own. When he first entered recovery, he thought this was the case as well, until he began to recognize that there was a strong recovery community in which he felt like he belonged. He believes that the idea that you have to fight this alone for the rest of your life contributes to the societal view of stigma.

Another participant talked about the importance of community when he said,

> when you are in your recovery and you commit yourself to a program, there's like a moment in like every sober person's life I think that like has, you know, that glowing recovery where you can tell that they've needed a community, rely on the community, and the community came through. And that's like a really weird thought because up until I knew what AA was or recovery or anything like that, the narrative that I've been told since I was a child is that you can do this life alone. Like you can make money for yourself and you can discipline yourself, but it's like to rewire that and to think no we need to do this as a group, it's tough because everything that's been thrown my way is like you're number one, look out for yourself. This is the narrative that is being shoved down our throat. And like how tough of a thing that is for someone who is already struggling identity to be like, yeah, that's actually not the way.

Still another participant recognized the need for both familial social support and the need for his recovery community in order to work through the stigma he experienced as a result of being in recovery. He shared the photograph titled "Black and White #1." He shared that his relationship with his sister and other family members have helped get him to where he is today. He also stated,

> I realized the value of community, generally concerning people in recovery—from anything, that when I shared my experience, an experience that previously made me feel so misguidedly selfish and alone, it began to establish connections. The people I looked up to in recovery would laugh or nod knowing exactly what I meant, because they had some the same thing, or something similar to my stories.

Figure 20. Black and White #1.

Need for education/conversation. The need for education was present in all three focus groups and was a prevalent theme throughout. In responding to the question "Why does this situation exist?," one participant stated, "I believe this situation exists because of the lack of education surrounding addiction" and then followed up by recognizing the need to educate others on the disease of addiction. One participant stated, "I think systemically, we need a shift in the way we educate youths about substances (and substance abuse) and we need a shift in the ways in which we talk about people who are

dealing with such issues." Another participant recognized that opening "the conversation to the public that addiction is pervasive and affects a variety of people regardless of their age, gender, social status, race, or ethnicity could change how society views the addict in general."

Some participants agreed that education needed to happen but questioned if that would make a difference on the stigma of those struggling with addiction or in recovery from alcohol and/or other drugs. One participant stated,

> I think education would help but I think it would be complicated. I don't know if education would be able to account for people who really have no grounding for what this looks like in reality, or being what an addict feels like.

This questioning of whether education would actually make a difference led to discussions on the importance of having personal experience or loved ones dealing with addiction in order to change perspectives of addiction and recovery.

Personal experiences. Similar to the need for community, participants in two of the three focus groups identified that having personal experiences of addiction, or knowing loved ones struggling with the disease, helped with understanding the disease of addiction and therefore coping with the resulting stigmas. In talking about how to shift stigmas, one participant stated,

> Personally, I think the greatest change in my life comes whenever I have a conversation with another. People are more apt to change their opinions or sympathize when they know that someone they personally know is going through these problems. We are not just statistics.

This topic came up a few times when participants were talking about their parents' own shifts in perspectives in regards to the disease of addiction. One participant shared:

> my mom had to go through an extreme change in her perspective. I remember before I was using drugs and alcohol, she thought they were kind of piece of shit people and then after I got sober I guess through my experience she started believing that people had a disease. And now people who she would've like years ago would've written off those people, she now is not like that, which is a beautiful thing. But it took a lot of suffering in my life and her life for that to happen. So I don't know how that can change for others.

Intersectionality of Stigma

Since Frost (2011) drew from theories of stigma in relation to race/ethnicity, gender, and sexual orientation to create his model of social stigma, the primary researcher was hopeful that this model could address the intersectionality of stigma in relation to multiple identities of participants. As one of the modified SHOWED questions, the researcher asked participants "Have you had similar experiences of stigma in relation to any other ways in which you identify?" As a result, the idea of experiencing stigma in relation to other forms of identity was present in these focus group discussions. This was identified as a category separate from any category identified in Frost's (2011) stigma model. Similar to experiences of stigma in relation to different identities, stigma in relation to addiction or recovery was based on the idea of "othering" those in recovery. Some of the participants did not experience the intersectionality of stigmatized identities and noted this in their answers, while others spoke about the impacts of stigma in relation to racial, ethnic and gender identities that coalesced with the stigma of being in recovery

or, in some cases, were cited as the foundation for the addiction in the first place. One participant used this photograph to depict these layers of stigma:

Figure 21. Reflection. Blurred by researcher for confidentiality purposes.

She stated,

> In this image, I took a photograph of an older photograph of myself, one that I took when I was about fourteen years old, the age I was when I first started drinking. One thing I do when I'm feeling isolated or different from others is think back to a time in which I didn't feel that way. When I first started drinking, I drank to get rid of stigma. I felt different than everyone else at all times, except when I was at a party or otherwise getting drunk or high with others. It dropped my inhibitions and made me like everyone else. Later on down the line, the stigma came back, only this time because I was drinking too much, and making a fool of myself. Now my stigma manifests itself in the fact that I'm in a college environment where drinking is the norm, and I can't join in on those same festivities, because of where my drinking brought me up until this point. So I call

> this photo Reflection, because I'm looking back on my former self at many points in time and understanding how it got me to where I am now.

She continued by stating,

> I'm a black, queer woman who grew up in the conservative white suburbs of North Carolina, so I've experienced a few levels of discrimination or othering in my life, many of which drove me to drink in the first place. I think the difference is, it's not socially acceptable to outwardly bash people of color or homosexuals in modern times, but people are still very apt to outwardly talk badly about people dealing with substance abuse issues.

Another participant said,

> I would drink because I was different, then getting clean I really thought I was different because you base it off society's standards, so when everyone else was drinking while I'm not, and then it was just like—well what am I then?

Summary

The purpose of Chapter IV was to present the results of the Photovoice study. This study included eight participants exploring their experiences of stigma as college students in recovery from alcohol and/or other drug addiction. Participants submitted photographs and answered modified SHOWED questions as a way of exploring these experiences. These were then shared in a focus group format. IPA was used for data analysis in order to find the common themes throughout the focus groups. These themes were then mapped onto Frost's (2011) model of social stigma and categories were added in order to include all of the themes addressed. The categories, subcategories, and themes that were identified in the master table agreed upon by the research team were discussed throughout this chapter. In the following chapter, the researcher will: discuss

these results in relation to the existing literature; offer suggestions and implications for collegiate recovery programs, counselors, and counselor educators; share implications for further research; and, discuss limitations of the study.

CHAPTER V

DISCUSSION

In Chapter I, the researcher provided an introduction to the study along with an overview of the literature related to the study. That chapter also included a rationale for and need for the study. In Chapter II, the researcher provided a more in-depth review of the conceptual and empirical knowledge published in the areas of addiction, stigma, and recovery. The researcher outlined the methodology for this study in Chapter III, including an overview of Photovoice as a research method and Interpretive Phenomenological Analysis (IPA) for data analysis. In Chapter IV, the researcher provided the results of this study. In this current chapter, the researcher provides a discussion of the results in consideration with the current literature, a synopsis of the Photovoice photograph exhibit, limitations of this study, implications for the research findings, and suggestions for future research.

Discussion of Results

The results of this study will first be discussed in relation to the research question and then will be examined within the context of the existing literature, which was described in Chapter II.

Research Question

In line with a lot of qualitative research studies, this study had one overarching research question: How is stigma experienced by college students who identify as being in recovery from alcohol and/or other drug addiction?

In order to answer this question, the researcher conducted a Photovoice study in which eight participants were asked to take 2-3 photographs of their experiences of stigma, past or present, and to answer the following modified SHOWED questions:

1. How does this image depict stigma?
2. Has your relationship with this stigma changed over time?
3. How does this image make you feel when you look at it?
4. What has been your experience taking/selecting this photograph?
5. Why does this situation exist?
6. What can be done about this? Personally? Systemically?
7. Have you had similar experiences of stigma in relation to any other ways in which you identify?

The participants were also asked to partake in a focus group discussion in which their photographs and their answers to the modified SHOWED questions were shared with and processed by the other group members.

Once these focus groups were complete, the primary investigator and a second coder used Interpretive Phenomenological Analysis to identify the various themes that arose in the focus group transcripts. The primary investigator then mapped these onto Frost's (2011) stigma model with the recognition that expansion/modifications of the

model were necessary in order to capture all of the themes identified. This master list of categories and themes (see Table 1) was then confirmed by both the second coder and the auditor.

Frost (2011) identified the different experiences of stigma as: stressful life events, everyday discrimination, expectations of rejection, stigma management, and internalized stigma. He also identified consequences of stigma and coping and support strategies, which have been labeled in this study as separate categories. In addition, both coders identified themes that were present during the focus group discussions which required the establishment of additional categories. These categories included sources of stigma and the intersectionality of stigma. In order to make sense of these findings, categories and subcategories were established and the themes identified in the focus groups were placed into these categories and subcategories. These categories include: Sources of Stigma, Experiences of Stigma, Consequences of Stigma, Coping and Support Strategies, and Intersectionality. Some of these categories were broken up into subcategories as well (see Table 1).

Comparison to Existing Literature

The results from this study have been situated in the context of existing empirical and conceptual literature in relation to the literature review completed in Chapter II. They have been broken down into the categories and subcategories present in Table 1.

Sources of stigma. Although Frost (2011) did not identify sources of stigma in his model of social stigma, this was discussed throughout all of the focus groups. The themes identified under the category 'sources of stigma' included: self, media/society,

12-step philosophy/anonymity, and government rhetoric. Although sources of stigma for college students in recovery have not been clearly identified in the literature, there is existing literature differentiating public versus self-stigma in relation to stigma in general. Corrigan and Watson (2002a) recognized that stigma is multifaceted and they worked to distinguish between public stigma and self-stigma. Public, or 'objective' stigma is connected to the way that individuals are stereotyped and/or viewed as a result of a particular attribute prescribed to a culturally created category, which can include structural discrimination. Self-stigma, or subjective stigma, is related to the internalized response that one has to these judgments and stereotypes, either real or perceived.

In the three focus groups, both public (media/society, government rhetoric, and 12-step/anonymity) and self-stigma (self) were signified by participants. Self-stigma was identified by the coders as the most common source of stigma in all three focus groups, although this question was not specifically asked by the researcher. One participant clearly stated "I've criticized myself more than I have overtly experienced." These experiences of self-stigma were the focus of much of the focus group discussions and were directly related to how participants experienced the stigma of being in recovery from alcohol and/or other drug addiction. Self-stigma will be also discussed in comparison to the literature in the section regarding internalized stigma.

Media/society was identified as another source of stigma in the focus group discussions. Participants labeled movies, TV shows, and the news all of sources of stigma. One participant said, "I believe that TV shows and movies portray drunks and alcoholics as 'others' who can never be saved," while another participant in a different

focus group commented that "the ides of people with substance use disorders being 'burn outs' is [consistent] with how the media perpetuates it."

This finding is consistent with those of Cape (2003) who conducted an analysis of how drug and alcohol use is portrayed in movies and asserted that "one of the most profound influences in this technologically driven era is the portrayal of drug use in the media" (p. 163). Cape recognized that movies have the power to influence social norms and values and that stereotypes are used, as a system of signifiers, to convey a message to viewers rapidly. In the research he conducted on substance use and addiction on films, Cape concluded that people struggling with addiction fell into four different categories of stereotypes. One of the most stigmatized of these identities was categorized as the 'demonized addict/homicidal maniac.' Cape also identified that many movies portray those struggling with addiction as

> losers, wasters, fools, etc. and carry within the movie political propaganda according to the predominant political power. The incidental drug user as part of the routinized background stereotype, is portrayed within this category as a notational shortcut for 'bad person.' (p. 168)

This analysis is in alignment with one participant's assertion that stigma exists

> because the media in the early 90s and early 2000s portrayed the drug wars as the inner cities as the front line on the war on drugs. There were not that many white faces, it was located in inner cities and it was 'bad people.'

This source of stigma is then connected to the following source of stigma: government rhetoric.

Although government rhetoric was not identified as a source of stigma in all of the focus groups, it was mentioned emphatically by 2 group members and bears recognition. The discussion about this among participants aligns with literature and the history of U.S. public policy on addictions in the past 50 years. In 1971, President Richard Nixon announced that "America's public enemy number one in the United States is drug abuse" (Sharp, 1994, p. 1). The language that was used in this national address suggested that the very act of "abusing" drugs, not the drugs themselves, was the enemy, implying that drug addiction was an immoral behavior and one that needed to be 'fought' against. One participant in the current study recognized that "the government's 'war on drugs' perpetuated this [moral view of addiction]," which was cited frequently in the focus group discussions as a core misunderstanding that often perpetuated the stigma of addiction and recovery. This belief that addiction can be attributed to a moral failing was also promoted by former first lady, Nancy Reagan and her 'Just Say No' campaign, which encouraged "citizens to rely on their inherent moral fortitude and eschew temptation" (Elwood, 1994, p. 1). This statement once again simplified the complexity of the disease of addiction by suggesting it is a choice steeped in morality. One participant identified the 'Just Say No' campaign, as a source of stigma which aided in the lack of understanding of the disease of addiction.

Twelve steps/anonymity was another source of stigma identified by a few participants in the focus group discussions. Participants indicated that other paths to recovery that were not in alignment with the 12-step philosophy were often viewed as 'less than.' Whereas some participants talked about one of the foundational tenets of the

12-step program, anonymity, and its potential to perpetuate stigma to people outside of the AA/NA community. This source of stigma has not been clearly identified in the literature, but could potentially be an influential study, especially for the 12-step community.

Experiences of stigma. The overarching question for this research study was, "How is stigma experienced by college students who identify as being in recovery from alcohol and/or other drug addiction?" These experiences were mapped out using the subcategories identified in Frost's (2011) model under the category 'experiences of stigma,' which included stressful life events, everyday discrimination, expectations of rejection, stigma management, and internalized stigma.

Stressful life events. As identified in Chapter IV, Frost (2011) suggested that 'stressful life events' should be considered as "acute stressors in that they occur relatively infrequently (compared to other stressors) and tend to stem from an isolated event. These manifest in direct experiences of discrimination or other events brought on by prejudice" (p. 826). This stressor showed up in the focus group discussions less frequently than other experiences of stigma, but was still present in the form of discrimination both in the workplace and in the school environment. Several participants described this discrimination related to the inability to be accepted into post-graduate programs as well as to difficulty finding jobs, noting that the system continues to structurally discriminate against those with substance use disorders. This is in alignment with the literature on discrimination in relation to substance use disorders. Schomerus et al. (2011) concluded that individuals with substance use disorders are at a "particular risk of being structurally

discriminated against" (p. 109). Moreover, they referenced several studies which suggested that the public accepts structural discrimination against those who had substance use disorders.

Everyday discrimination. Instances of 'everyday discrimination' were present in all three focus groups and these were identified as a subcategory of 'experiences of stigma.' This subcategory was broken up into 4 different themes: negative view of addiction/recovery, lack of understanding, conflation of identity, and normalization of drinking and drugging in college.

Many participants in the focus groups mentioned the fact that people often have negative views both of people struggling with addiction and those in recovery. These negative views affected how participants experienced being in recovery. One participant stated, "I just feel people view alcoholics as damaged goods and not as individuals who can be productive to society." This negative view of addiction/substance use disorders is supported in the literature as well. Angermeyer and Dietrich (2006) completed a review of population studies that looked at the public's beliefs and attitudes towards mental illness. They discovered that common misconceptions around mental illness continue to prevail among the general public, resulting in widespread negative beliefs and attitudes about individuals with mental illness that are characterized by varying degrees of stigma depending on the diagnosis.

Angermeyer and Dietrich (2006) also found that substance use disorders were viewed more negatively than schizophrenia, depression, and anxiety, and that those who struggle with SUDs/addiction are often the most rejected. This research study, along

with others, reveals a negative view of individuals diagnosed with substance use disorders—one which participants in this study described experiencing. This negative view was often associated with the idea that addiction is still seen by many as a moral or ethical choice. The idea that many people still refuse to see addiction as a disease was echoed throughout the focus groups and was clearly connected to the stigma experienced by participants. This theme was labeled as a 'lack of understanding' and was also put in the subcategory of 'everyday discrimination,' although it is not as present in the current literature.

The theme 'conflation of identity' emerged in each focus group discussion, and is positioned under the subcategory of everyday discrimination. Several participants discussed feeling that once they were labeled as an 'addict' or 'alcoholic,' people often saw this as the entirety of who they were, rather than recognizing the multi-faceted nature of their identity. One participant stated,

> when people want to pin you to a label that you may completely identify with, that one label in their mind becomes your whole identity rather than that label being a small portion of your space and the rest of it being filled up with personality, and history, and stuff that people tend to forget.

This conflation of one's identity is often at the core of stigmatization and coincides with much of the original literature on stigma. In fact, Erving Goffman (1963), who is often recognized as one of the most influential sociologists of the 20th century, focused much of his research on stigma and recognized that stigma reduced the bearer "from a whole and usual person to a tainted, discounted one" (p. 3).

The normalization of drinking and drugging on college campuses was also identified by many participants as a way of experiencing everyday discrimination. Often this theme was presented as a subtle way of feeling 'othered' by peers and teachers alike when topics of drinking and partying were blatantly discussed or mentioned as if everyone was participating in these activities. This experience is in alignment with much of the literature on the advocacy for collegiate recovery that suggests that "college campuses are regularly characterized by a pro-drug culture in which substance use is considered the norm and a harmless rite of passage" (Perron et al., 2011, p. 51). Wiebe, Cleveland, and Harris (2010) commented that

> college students in recovery may feel shut out of college social life, even the substance-free activities, where discussions often turn to recent or future events involving drug and alcohol use. They may experience stress from the constant bombardment of alcohol ads in and around the campus environment. (p. 3)

This experience of being 'othered' as a result of the normalization of drinking and drugging was corroborated by many of the participants. One participant stated "now my stigma manifests itself in the fact that I'm in a college environment where drinking is the norm, and I can't join in those same festivities, because of where my drinking brought me up until this point."

Expectations of rejection. Expectations of rejection was labeled as a subcategory under 'Experiences of stigma' in Frost's (2011) social stigma model. He identified that

> not all forms of stigma-related stress involve identifiable forms of discrimination or even contact with a perpetrator of stigma. Because stigmatized individuals and groups live within societies structured in ways that perpetuate social stigma, people who are stigmatized may enter into social interactions with an expectation

> that they will be rejected by others because of their stigmatized social status. This expectation of rejection, regardless of whether or not rejection actually occurs, produces a cognitive burden that constitutes stigma-related stress. (pp. 826–827)

Many focus group participants expressed expectations of being be judged or rejected by others once it was discovered that they were in recovery. Many of these experiences were connected to the everyday occurrences of discrimination mentioned above. Expectations of rejection were split into two themes: fear of how they will be perceived by others and recognition of expectations of rejection even when rejection/discrimination was not present.

According to developmental psychology literature, this expectation of rejection that Frost (2011) identified as an experience of stigma may be especially detrimental to traditional college age students. According to Chickering (1969) and Erikson (1968), many college students are in the developmental stage in which they are seeking connections with others and may be particularly concerned with how they are viewed by others (especially peers), making them vulnerable to the stereotypes and discrimination associated with stigma. Erikson (1968) suggested that during this stage many individuals seem to be "preoccupied with what they appear to be in the eyes of others as compared with what they feel they are, and with the question of how to connect the roles and skills cultivated earlier with the ideal prototypes of the day" (p. 128). This was addressed throughout the focus groups in relation to both fear of how participants would be perceived by others and the recognition of expectations of rejection even when rejection/discrimination was not present. One participant recognized this preoccupation and stated,

> I think a really big part of my daily life is how much I am not only valuing myself, but how much value I'm placing in other peoples' opinions of me and how I let that affect me on a day-to-day basis.

Whereas, another participant stated,

> For a long time after I started attending university while in recovery I had this anxious feeling that despite life going swimmingly something or someone would come out and stigmatize me due to addiction. This was a form of perceived self-stigma in that no one was overtly stigmatizing me, but I was worried that someone would any minute.

These themes were quite common in many of the focus group discussions, and the recognition that these expectations of rejection were present even if there was no actual rejection was a common theme identified by participants.

Stigma management. Stigma management was another subcategory of experiences of stigma identified in Frost's (2011) social stigma model. He recognized that

> In response to the potential for rejection and discrimination, people who are stigmatized face an additional chronic stressor with regard to their management of how and whether a stigmatized identity or characteristic is made visible to or concealed from others. People with concealable stigmas (e.g., sexual minorities, people with mental health disorders), are constantly faced with the decision to conceal or make visible their stigmatized statuses. Although concealing one's stigmatized status from others can be protective, in that it may allow one to avoid discrimination, stigma concealment is stressful because it produces cognitive burden resulting from fear of discovery. (p. 827)

Although being in recovery is a concealable stigmatized identity, many participants in this study also experienced stigma and discrimination from other intersectional identities, which will be discussed in a subsequent section. The idea of stigma management was

brought up in all three focus groups. This subcategory included four identified themes: the act of concealing the stigmatized identity, avoiding social interactions in order to manage stigma, caution about who to open up to about being in recovery, and feeling the need to explain recovery if unconcealed.

In regards to the literature on concealable stigmatized identities, Goffman (1963) noted that stigma can be connected to any aspect of someone that is 'discreditable,' which he described as a concealed identity that can be discriminated against when discovered (e.g., sexual orientation, religion, mental health illness; Goffman, 1963). Goffman (1963) stated that once these discreditable attributes are recognized by an observer, the identified individual can experience criticism and discrimination. This need or desire to keep this identity concealed came up several times throughout each of the focus groups. One participant said,

> I perceived it necessary to hide the aspects of myself that related to addiction. When I did mention specific details about my life in active addiction or even aspects of my current recovery I was often meet with shock, awe, and even what appeared to be disgust.

The desire to conceal one's stigmatized identity was discussed throughout focus group meetings. It is important to note that stigma management in the literature is often connected to a decrease in help-seeking behaviors. Help-seeking behaviors was not something that was specifically discussed in the focus groups, but stigma is often a leading factor in college students not reaching out for help in relation to mental health disorders (Martin, 2010). Martin (2010) conducted a survey study with 54 respondents, the majority of whom had "not disclosed their mental health condition to university staff

due to fears of discrimination and disadvantage arising from the stigma of mental illness" (pp. 271–272). Participants in the study identified stigma as a key issue for non-disclosure. It is important to note that due to the strategy used for the current study of recruiting participants through collegiate recovery programs, students who have not sought help because of experiences of stigma, despite self-identifying as being in recovery, may not be represented in the sample for this study.

The other themes present in this subcategory included: avoiding social interactions in order to manage stigma, caution about who to open up to about being in recovery, and feeling the need to explain recovery if unconcealed. A few of these themes are addressed in the conceptual literature on collegiate recovery, but not extensively. These experiences were often connected to everyday experiences of discrimination or stigma and the expectations of rejection connected to those.

Internalized stigma. Internalized stigma was another subcategory of experiences of stigma identified within Frost's (2011) social stigma model. Frost (2011) stated that

> internalized stigma refers to the application of negative social meanings of stigma to one's self-concept . . . Stigma is socially constructed; not an inherently negative characteristic of individuals. However, given people who are stigmatized live their daily lives within societies that are shaped by social stigma, the socially generated negative meanings surrounding stigmatized characteristics and identities can easily be internalized and attached to the self. The result is socially generated but internally perpetuated self-devaluation. Internalized stigma can persist even in the absence of direct perpetrators of stigma, and is thought by some to never completely subside. (p. 827)

The concept of internalized stigma was present in all three focus groups and was referred to quite frequently. In one focus group, a participant answered the question

"Why does this situation exist?" by stating, "The situation of my stigma exists because I feel a lot of self-doubt, self-isolation, and self-pity when it comes to recovery." The internalized stigma subcategory included two identified themes: shame and self-pity.

Feelings of shame were shared in all of the focus group discussions. The concept of shame as an experience of internalized stigma is commonly discussed in the literature. Ritsher et al. (2003) stated that "regardless of the objective level of discrimination that an individual is exposed to, it is the subjective perception of being devalued and marginalized that directly affects a person's sense of self-esteem and level of distress" (p. 32). Internalized stigma of an individual has been described as the "devaluation, shame, secrecy and withdrawal triggered by applying negative stereotypes to oneself" (Ritsher et al., 2003, p. 32). One participant identified with this view of internalized stigma. She stated, "I think there's so much shame and embarrassment about being an addict and a lot of that is because of stigma."

Although not as prevalent a theme in the literature, self-pity was discussed in two of the three focus group discussions. This would meet the criteria for internalized stigma, as one participant described these feelings as: "People pity us; therefore, we sometimes pity ourselves." Another described her experience of being in recovery as:

> There's so much for me to grasp and so much beauty to experience, but I'm plagued by feelings of self-pity and isolation. It feels as though everyone else has commonalities and the freedom to experience all the world has to offer, while I'm limited and unable to relate with others.

Consequences of stigma. 'Consequences of stigma' was created as a category separate from 'experiences of stigma' although many of the concepts overlap. Throughout these focus groups, several consequences of stigma were present in the group discussions. These were separated into different themes including: loneliness and isolation, fear of missing out/not fitting in, and questioning addiction.

Loneliness and isolation was one of the most frequently discussed topics in the discussion groups. This theme is prevalent in the literature and has been identified as one of the biggest challenges for young adults in recovery (Russell et al., 2010). In one qualitative study, Bell et al. (2009a, 2009b) had 15 college students, who were actively involved in a collegiate recovery program, complete semi-structured interviews exploring the different types of recovery identities and common challenges faced on a college campus. In this study, several students indicated that they refrained from attending social events for fear of being misunderstood, which led to feelings of isolation (Bell et al., 2009a). Several of participants in the current study portrayed these feelings of loneliness and isolation in their photographs. Often, this isolating behavior led participants to feel as if they were missing out or not fitting in with their peers. This theme can be found in the conceptual literature on collegiate recovery, but is not as prevalent in the empirical literature. Perhaps this is due to the fact that this response is quite qualitative in nature and there are very few qualitative studies exploring the lived experiences of college students in recovery.

Another theme that was placed into the category of 'consequences of stigma' was based on comments from a few participants who questioned their addiction/substance use

disorder because of the normalization of drinking and drugging on college campuses. One stated, “I questioned whether or not I was an alcoholic because maybe blacking out was a sign of alcoholism, or maybe it was just because I’m in college.” The concept of the normalization of drinking and drugging on college campuses and the threat this poses to college students in recovery is prevalent throughout the literature (Perron et al., 2011; Wiebe, Cleveland, & Harris, 2010), often putting students in recovery at a potential risk for relapse. However, the concept of one questioning their addiction as a result is hard to find in the literature. This theme that was identified in the focus group discussions could add an additional layer to the potential threat that college students in recovery may face as a result of the normalization of drinking and drugging on college campuses.

Coping and support strategies. Frost (2011) identified the importance of coping and support strategies, and these strategies were discussed in the focus group discussions. Consequently, for the purpose of this study, this theme has been labeled as a separate category. Frost (2011) stated,

> The connections between social stigma and its consequences are not universal. There is a tremendous amount of variability in the ways stigmatized individuals and groups respond to experiences of stigma-related stress (Frost, 2011a). Understanding the ways people and groups respond to stigma-related stress is an important endeavor in the psychological study of stigma. Not only is it necessary to understand the damaging effects of social stigma, it is equally if not more important to understand how the stigmatized are able to cope with, resist, and overcome the limiting consequences of stigma. (p. 830)

Frost (2011) divided his analysis of coping and social support into two different categories: individual-level coping and group-level coping. These two levels both emerged through the focus group discussions. Individual-level coping strategies

discussed in the focus groups included three of the identified themes: time in recovery, self-awareness/self-acceptance, and compassion and understanding towards others. Group level-coping strategies and thoughts about what is needed in society to deal with and shift stigma related to addiction and recovery was also discussed in the focus groups. This category included the themes: need for community and social support, the need for societal education about addiction and recovery, and the importance of knowing someone in recovery to aid in an understanding of the disease.

The main theme in this category that was explored in the focus groups was the need for community and social support. This theme also happens to be the most frequently researched concept in the CRP/CRC literature to date (Smock et al., 2011). Baker (2010) suggested that social support is the most critical factor in reducing relapse rates. This recognition of the need for community and social support is the foundation for the development of CRPs/CRCs in this country. In researching CRPs and CRCs, it was found that many attempts to meet the emotional needs of students by connecting them with a support network as soon as they enter the collegiate environment, including immediately pairing them up with mentors and/or roommates involved in the CRP/CRC. "To ensure that members are receiving the emotional support needed, CRC programs focus on harnessing the power of interaction between those with similar or shared experiences" and using this power to facilitate change" (Baker, 2010, p. 148). This need or desire to be connected with those who have had/are having similar experiences was brought up many times in the focus group discussions. One participant recognized that

"personally surrounding myself with people who are dealing with the same disease and stigmas has helped me greatly."

Since drinking and drugging is often normalized on college campuses, it is particularly important for students in recovery to be surrounded by peers who validate their own experiences of sobriety and recovery. This primary reference of peers helps establish a social identity that supports a recovery lifestyle. "If recovery students see that they are similar in thought and action to a group of their peers, recovery behaviors are reinforced and social stigma is reduced or eliminated resulting in validation" (Baker, 2010, p. 149).

For college students in recovery, a "social environment supportive of recovery that fosters social connectedness is essential" (Laudet et al., 2014, p. 88). CRPs/CRCs attempt to provide a space for this social connectedness, which can, in turn, enhance an individual's sense of belonging. Many programs have meetings or events that help establish this sense of belonging by encouraging members to share their own personal stories of recovery, echoing much of what people believe makes 12-step recovery programs successful (Harris et al., 2010). A few of the participants in the focus groups shared that participating in the study itself was helpful in making these connections; they felt it was a way in which they were able to share part of their story with other students in recovery. Although not all of the study participants were actively engaged in their University's CRP/CRC, they all acknowledged the need for community and social support in their recovery process.

Intersectionality of stigma. Because Frost (2011) drew from theories of stigma in relation to race/ethnicity, gender, and sexual orientation to create his model of social stigma, the researcher was hopeful that this model could address the intersectionality of stigma in relation to multiple identities of participants. As one of the modified SHOWED questions, the researcher asked participants "Have you had similar experiences of stigma in relation to any other ways in which you identify?" This led to discussions of how participants experienced stigma in relation to other aspects of their identities. Similar to stigma in relation to other marginalized identities, stigma in relation to addiction or recovery was based on the idea of "othering" those in recovery. Some of the participants did not experience the intersectionality of stigmatized identities. In their answers, they often cited whiteness, identifying as male, and heterosexuality as reasons that they did not experience stigma related to other aspects of their identity. One participant commented that he had not experienced stigma in relation to other aspects of his identity, stating that "[I am a] White, straight male, and I have a privileged spot in society." Other participants who identified similarly recognized that, although they may not experience much stigma in relation to other aspects of their identity, they did experience the intersections of stereotypes. One participant, who identified as a white, cisgender, male stated,

> I think people put labels on me quite quickly when I identify with anything. As a climber, I think people either see me as an adrenaline junky or a dirt bag hippie. As a person trying to get a biology degree people see me as a successful and smart person. None of these are completely true. We are more complex than these labels assume, same with the label of alcoholic. We are more complex than just an alcoholic. We are brothers, we are fathers, mothers, business owners, etc.

Several participants spoke about the impacts of stigma in relation to racial, ethnic and gender identities that coalesced with the stigma of being in recovery or, in some cases, was cited as the foundation for the addiction in the first place. One participant stated: "I'm a black, queer woman who grew up in the conservative white suburbs of North Carolina, so I've experienced a few levels of discrimination or othering in my life, many of which drove me to drink in the first place." Another participant mentioned a similar sentiment, suggesting that he believed he started drinking as a result of stigmatization and othering, it was how he tried to fit in. The experiences shared by participants who claimed other identities that are often marginalized by society, supports the suggestion made by Kulesza et al. (2016) that stigma should be understood through an intersectional lens. In a study exploring addiction stigma and the intersectionality with race/ethnicity and gender, they noted that individuals diagnosed with SUDs may be "treated less favorably if they also hold other status characteristics that are marginalized" (Kulesza et al., 2016, p. 86).

These findings also support the methodology used for this study. The use of pictures as well as descriptions allowed for a multidimensional exploration of an individual's life. One participant stated, "I think in terms of when research is done, it is the human experience that is missing, so it is really cool that you are doing this because it gives a voice to people and makes it real and not just a statistic." It is important in working with individuals, especially those in recovery, to recognize the complexity of identity (Neale et al., 2011). When the identity of an individual is conflated to an

attribute or characteristic, the potential for continued stigmatization of an already stigmatized population is possible.

Photovoice Photo Exhibit

As a part of the Photovoice study, participants were informed during the introductory session of the potential of an optional Photovoice exhibit at the end of the study. During the pilot study, participants suggested that the photos be displayed at the National ARHE conference in Washington, DC. This idea was discussed with the participants in the full study and it was received very positively. One participant stated "I think it could contribute to education in the sense that the way I felt powerful using a picture to tell the story. I would hope that people could receive a story from the picture." Another participant stated,

> I think I feel inclined to do it mostly because if that could affect somebody else that's really cool. Or even for somebody in recovery, regardless of who it was, was able to walk by and say "Yeah, that's what my experience was like," it would kind of be validating as well.

The primary investigator contacted the coordinator of the ARHE conference and set up a time and place for the photographs to be displayed. All of the eight full study participants signed releases to have their photographs used in publication and in the photographic exhibit. The primary investigator contacted them closer to the time of the conference to ensure the continued desire to have their photographs displayed. The primary investigator heard back from 6 of the 8 participants, so she had those participants' photographs printed, along with their descriptions on 16x20 foam core poster boards (see Figures 22 and 23).

Figure 22. Photovoice Exhibit at ARHE National Conference A. Photograph edited by researcher for confidentiality purposes.

Figure 23. Photovoice Exhibit at ARHE National Conference B. Photograph edited by researcher for confidentiality purposes.

All of the participants who responded also chose to have their name displayed along with a write-up of the photo describing how the image portrayed their experience

of stigma. The primary investigator also sent emails to participants inviting them to the exhibit if they were in attendance at the conference.

During the photographic exhibit, the primary investigator administered optional surveys for attendees to fill out. On the forms, the primary investigator asked attendees to “Please describe your experience of the Photovoice photographic exhibit.” They were also prompted to check a box if they were comfortable with having their comments shared anonymously. One observer wrote,

> I loved this. I am not in recovery myself, but I have had two family members who struggled with addiction until they ultimately passed away due to their addiction. These photos captured the shame that they felt. This project dove into the perspective of people in recovery who could all identify with this stigma and shame. You can see it in the photos, it’s deep rooted and this study allows for the education of people who don’t understand the stigma they reinforce by staying silent or just by simple actions.

Another stated, “I found it powerful! Emotional. I was moved by the images—the words were almost superfluous. Almost. Such important research . . . Beautiful. Sophisticated.” Another acknowledged that “this project provides a voice to a marginalized sub-population of students” and thanked both the participants and the researcher for their contributions. No study participants attended the Photovoice exhibit.

Implications

Implications for College Counselors

This study has the potential to offer college counselors a framework through which to better understand the stigma that college students in recovery may experience so that they can better support these students. Participants in this study clearly indicated that

stigma does not cease to exist once an individual is in recovery and this study may be helpful in combatting that assumption if it is held by a college counselor. The focus of the group discussions revolved around feelings of self-stigma and this topic could be very appropriate to address in individual counseling sessions. Feelings such as shame, self-pity, and loneliness could be acknowledged and processed in individual counseling sessions. Although results of this study are not generalizable, they can provide a guide for college counselors to assess for these feelings during counseling sessions, especially with students who self-identify as being recovery from alcohol and/or other drug addiction.

Recognizing that social support and community were identified by study participants as being essential for diminishing stigma could prompt college counselors to encourage students to reach out to different organizations for support. These organizations could include the University's CRP/CRC (if available), the local 12-step community, or other additional supports on campus or within the community. If these resources are not available on campus, college counselors could use the results of this study to help advocate for the creation of a CRP/CRC within the institution. The results from this study could also help college counselors to begin to develop anti-stigma campaigns on campus in an effort to decrease the public stigma in hopes that more students in recovery may reach out for services as needed. Understanding the experiences of stigma perceived by students in recovery could be beneficial not only to college counselors, but counselors-in-training, novice counselors, and experienced counselors in a variety of settings as well. Also, considering the participants' positive

responses to the methodology, this study could help encourage counselors to use alternative modalities in counseling, particularly photography, as a way of having clients express their experiences of stigma.

Implications for Counselor Educators

The findings of this study could be useful to integrate into an addictions counseling class in order to provide counselors-in-training with a more robust understanding of recovery and the struggles that ensue even after treatment. It was noted several times throughout the focus group discussions that participants felt a need for educating others on the disease model, so this would be instrumental in an addictions counseling course, along with teaching the history of addiction models over time. It would also behoove counselor educators to address the stigma experienced by those struggling with addiction/substance use disorders as well as those in recovery. A foundational understanding of stigma and the 'othering' that occurs as a result is crucial to help counselors-in-training develop knowledge and understanding about all marginalized identities so that they can approach these individuals with some knowledge, curiosity, and compassion.

Implications for Student Affairs Personnel

Researchers estimate that 4% of any given college population is made up of individuals currently in recovery from alcohol and/or other drug addiction (Harris et al., 2005). As a result, it is important for people involved with colleges and universities, particularly student affairs, to try to understand the experiences of students in recovery in order to help create an environment that fosters and supports recovery from alcohol

and/or other drug addiction (Perron et al., 2011). Over the past several years, Collegiate Recovery Programs (CRPs) and Collegiate Recovery Communities (CRCs) have started to become more widespread, focusing on the welfare of those students who identify as being in recovery from alcohol and/or other drug addiction. Despite the growing number of CRPs/CRCs in the country, many students have reported that the negative stigma associated with substance use disorders (SUDs) has stopped them from utilizing these recovery-based services (Mackert et al., 2014). Martin (2010) found that "addressing the stigma of mental illness is a first and crucial step in getting students to overcome their fears and concerns of disclosing to university staff and gaining access to the support they require to succeed in their studies" (p. 271).

The findings of this study can provide student affairs personnel with a foundational understanding of how college students in recovery may experience stigma in hopes that this understanding can begin to shape targeted anti-stigma efforts and campaigns. It has been noted in the literature that an understanding of how stigma is experienced is crucial in order to run a successful anti-stigma campaign (Schomerus et al., 2011). Such efforts could prove to be beneficial because researchers and practitioners believe that decreases in stigma will not only increase rates of people seeking services, but also increase rates of recovery (Livingston et al., 2011; Mackert et al., 2014), which could benefit the college community as a whole. Information from this study could also provide student affairs personnel with a rationale for the need for CRPs/CRCs in institutions where they do not currently exist. Finally, student affairs staff could develop

outreach programming for their institutions to help provide help and support to this underserved college population.

Recommendations for Future Research

The researcher hopes that the findings from this study will provide a grounding for future studies on stigma experienced by college students in recovery. There is very little research available on the topic of collegiate recovery, so this project provides some preliminary foundation on which to build future research projects. Frost (2011) stated,

> There is a tremendous amount of variability in the ways stigmatized individuals and groups respond to experiences of stigma-related stress. Understanding the ways people and groups respond to stigma-related stress is an important endeavor in the psychological study of stigma. Not only is it necessary to understand the damaging effects of social stigma, it is equally if not more important to understand how the stigmatized are able to cope with, resist, and overcome the limiting consequences of stigma. (p. 830)

Future researchers could potentially use this foundational understanding of how college students may experience stigma in order to research and develop ways to help college students in recovery deal with this stigma and to begin to establish effective anti-stigma campaigns on college campuses. These research findings could also be used as a rationale for a study exploring the effectiveness of CRPs/CRCs in reducing the stigma experienced by students in recovery. It is noteworthy that this study was made up of students who were actively engaged in their University's CRP/CRC and students who were not involved at all. It may be an interesting research study to explore how students from these different groups experience stigma differently.

During the focus group discussions, participants mentioned that the longer they were in sustained recovery, the less stigma they experienced. It may be interesting for researchers to track this stigma in relation to recovery developmental levels.

Research involving the intersectionality of stigma experienced by marginalized populations in recovery from alcohol and/or other drug addiction is another area that seems to have a large gap in the research literature. Understanding how stigma is associated with different aspects of one's identity could help inform counselors, counselor educators, and student affairs personnel on the complexities of stigma. The researcher encourages future research with people who identify with stigmatized and marginalized identities to explore the stigma through the lens of critical race theory.

The participants noted the importance of the methodology in having their voices heard during the study and this feedback could help inform researchers looking to use Photovoice in research. This methodology allows for the complexities of identities to emerge, which could be especially important for individuals who are marginalized by society. Unprompted, one participant stated,

> I think that is really cool about the research project that you are doing with the photographs in general because I feel like this would be completely different if art wasn't included and there is something that is really powerful about that because each person who is going to experience it is going to have their own response to the artwork and that is going to resonate with them in their own ways. I think in terms of like when research is done, it is the human experience that is missing, so it is really cool that you are doing this because it gives a voice to people and makes it real and not just a statistic.

It may be interesting for future researchers to utilize Photovoice as an intervention as well as a methodology, but exploring the internalized stigma that is experienced prior to

utilizing Photovoice and after the project/study is completed. This could also allow for more time to explore common themes within the groups in relation to their images.

Limitations

Though several important themes emerged within the current study, it is important to acknowledge a number of limitations existing throughout the various phases of the study, specifically in recruitment and study design. Regarding recruitment, the researcher initially faced difficulty in recruiting the number of participants needed for the study between the ages of 18 and 25. A few people who had been emailed about the study, emailed the researcher stating that they were interested but did not meet the age requirements. As a response, the researcher modified inclusion criteria to expand the age range to 29 years old. Although this shift was backed by literature both in the field of young adult life stages and in the collegiate recovery community, it may have impacted the results of this study, as this would constitute two separate groups of college students—both 'traditional' age and 'nontraditional' age.

Another limitation to this study was the fact that stigma was chosen by the researcher as the focus for the study. This designation could have discouraged students from signing up if they did not see this as an important topic, did not relate to experiences of stigma, or felt too vulnerable exploring stigma directly. It has been suggested in the literature that stigma is the leading cause for college students not reaching out for help in relation to mental health disorders (Martin, 2010). It is possible that many college students who have experienced stigma as a result of being in recovery may not have reached out to their University's CRP/CRC for support. The primary investigator

reached out and relied upon CRP/CRC director connections to recruit students, so many students who may have met the criteria for the study may not have received an email regarding the study.

Another possible limitation of this study is inherent in the criteria that participants had to meet in order to participate. The fact that participants had to have abstained from the use of mind-altering substances for the past 6 months may have prohibited students who self-identify as being in recovery and have experienced stigma as a result, from participating in the study.

Also, it should be noted that although the sample of participants had a more diverse racial and ethnic make-up than the overall population of those involved in CRPs/CRCs around the country (Laudet et al., 2015), this sample lacks quite a bit of racial and ethnic diversity in relation to college campuses around the country (National Center for Education Statistics, 2017). This limitation may speak to the need for CRPs/CRCs to be more accessible to and inclusive of people of color.

The lack of diversity among the research team should also be noted. Both coders and the auditor are Caucasian, and all are in heterosexual partnerships. Two members of the team are female, and one male. One of the coders identified as being in long-term recovery, while two of the members of the research team do not identify as being in recovery or have ever been diagnosed with a substance use disorder.

Similar to most participatory research projects, one limitation of Photovoice, and this project in particular, was the amount of time required of participants. Participants were asked to participate in a Photovoice training, take photos on their own time, and

participate in a group discussion session. Although incentives were provided for participants, there had to be a personal buy-in in order for students to sign up for and continue to participate in the study. The timing of the study, near the end of the semester, also may have played a role in the amount of students willing to participate. Another possible limitation of this methodology is that Photovoice can potentially be exploitative, as can many other forms of research; however, it seems as if the use of images can increase this potential. The researcher encouraged participants to use personal judgment in taking and sharing photographs that they were comfortable exploring in a group setting. The researcher also made it clear to participants that participation in the photographic exhibit and the sharing of photographs in presentations and publications was completely optional.

Conclusion

The purpose of this study was to address the gap in research and to answer the following research question: How is stigma experienced by college students who identify as being in recovery from alcohol and/or other drug addiction? Participants in this study provided the researcher with rich and in-depth information regarding this question by sharing their lived experiences with the researcher and with the greater community through focus groups and a photographic exhibit. The researcher is hopeful that the findings and implications of this study may provide counselors, counselor educators, student affairs personnel and researchers with some foundational, nuanced perspectives of how college students in recovery from alcohol and/or other drug addiction may experience stigma. Through gaining a more in-depth perspective, perhaps these

professionals will be able to more knowledgeably conceptualize, counsel, and connect with the those in recovery from alcohol and/or other drug addictions.

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APPENDIX A

IRB APPROVAL

THE UNIVERSITY of NORTH CAROLINA
GREENSBORO

OFFICE OF RESEARCH INTEGRITY
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To: Kelly Spencer
Counsel and Ed Development
50 Highland St. Asheville, NC, 28801

From: UNCG IRB

Authorized signature on behalf of IRB

Approval Date: 10/26/2016
Expiration Date of Approval: 10/25/2017

RE: Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)
Submission Type: Initial
Expedited Category: 6.Voice/image research recordings,7.Surveys/interviews/focus groups
Study #: 16-0324
Study Title: Voices of Recovery: An Exploration of Stigma Experienced by College Students in Recovery from Alcohol and/or Other Drug Addiction

This submission has been approved by the IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

Study Description:

This study will explore how college students in recovery from alcohol and/or other drug addiction, experience stigma. A qualitative research study will be conducted in order to gain an in-depth, foundational understanding of how stigma is experienced by this particular population. This study will be done using Photovoice, a participatory research approach in which participants take photographs that depict aspects of their lives and then write narratives to accompany these images. These photographs and narratives, along with transcripts of the group meetings, will serve as the data for this research.

Investigator's Responsibilities

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

Signed letters, along with stamped copies of consent forms and other recruitment materials will be scanned to you in a separate email. **Stamped consent forms must be used unless the IRB has given you approval to waive this requirement.** Please notify the ORI office immediately if you have an issue with the stamped consents forms.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented (use the modification application available at http://integrity.uncg.edu/institutional-review-board/). Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB using the "Unanticipated Problem-Adverse Event Form" at the same website.

Please be aware that valid human subjects training and signed statements of confidentiality for all members of research team need to be kept on file with the lead investigator. Please note that you will also need to remain in compliance with the university "Access To and Retention of Research Data" Policy which can be found :http://policy.uncg.edu/university-policies/research_data/.

CC:

APPENDIX B

RECRUITMENT EMAIL

Subject Line: Research study seeking voices of people in recovery

Kelly Moore Spencer, a professor at MHU, is finishing up her doctoral work through UNCG and is inviting students to participate in her dissertation research study. You are receiving this email because you may meet the criteria needed to participate in the study. The purpose of the study is to explore the stigma experienced by college students who identify as being in recovery from alcohol and/or other drug addiction.

In order to participate in this study, you must be between the ages of 18 and 29, and currently enrolled as an undergraduate student at a 4-year institution, or have graduated in the past 6 months. The researcher is looking for students who self-identify as being in recovery from alcohol and/or other drug addiction. Although the researcher understands that there are multiple pathways and definitions of recovery, for the purpose of this study, participants must have abstained from the use of mind-altering substances (other than caffeine and nicotine) for the past 6 months. The researcher is also seeking out students who have experienced stigma as a result of being in recovery. This could include incidents of discrimination, negative stereotyping, feelings of isolation, rejection, etc. There are no race, gender, or ethnicity restrictions.

If you take part in this study, it will require at least 3+ hours of your time, which will consist of two in-person meetings. The initial meeting will be an introduction to the study and the use of photography in research. Then you will be asked to take photographs of how you have, or continue to, experience stigma as a result of being in recovery. You will then meet again in order to discuss 1-3 of your photographs with the group. You may also have the option of displaying these photographs in a final photographic exhibit, but this will be completely optional. You will have the opportunity to earn up to $50 for your time ($20 for the initial training session and $30 for the discussion session). To be able to take part in this study, individuals must be able to attend an introductory training session (you will be given options for days/times when filling out the survey which is linked below).

If you are interested in participating in the study, please fill out the Qualtrics survey by clicking on this link: Photovoice Survey - Full Study. Your responses to this survey will be confidential.

If you know of any other individuals who may meet the criteria mentioned above and may be interested in participating in this study, please feel free to pass this email along.

If you have any questions about the study, please email Kelly Moore Spencer at klmoore6@uncg.edu.

Thanks so much for considering participation in this study!

Approved IRB
3/27/17

APPENDIX C

INITIAL QUALTRICS SURVEY

Photovoice with Students in Recovery – Phase 2

Q1 Thank you for your interest in this study. You will be asked a few questions to confirm that you meet the criteria for the proposed study.

Q2 Are you between the ages of 18 and 29?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip to End of Survey

Q3 Are you currently enrolled as an undergraduate student at a 4-year institution or have you graduated from a 4-year institution within the past 6 months?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip to End of Survey

Q4 Do you consider yourself to be in recovery from alcohol and/or other drug addiction?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip to End of Survey

Q5 Have you abstained from the use of mind-altering substances for the past 6 months (caffeine and nicotine not included)?
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip to End of Survey

Q6 Have you ever experienced any stigma due to your identity as an individual in recovery from alcohol and/or other drug addiction? This could include incidents of discrimination, negative stereotyping, feelings of isolation, rejection, etc.
- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip to End of Survey

Q7 Do you have access to a digital camera or smart phone with photo-taking capabilities? *This will not impact your eligibility for the study.
- ❍ Yes (1)
- ❍ No (2)

Q8 Please indicate any and all of the dates and times that you may be available to participate in the introductory training session. It will be about an hour long in length. If you are unable to make any of the following times but are interested in participating, please email me at klmoore6@uncg.edu with some dates and times that you may be available. Thanks!
- ❑ TBD
- ❑ TBD
- ❑ TBD

Q9 You have met all of the criteria to participate in this study! This study will require at least 3 hours of your time. You will be compensated financially for each step of the study and are free to drop out of the study at any time. If you are interested in participating, please provide your contact information below.

Q10 First Name

Q11 Age

Q12 Name of university you are currently attending or graduated from in the past 6 months

Q13 Are you actively involved in your university's collegiate recovery community/program?
- ❍ Yes
- ❍ No

Q14 Please indicate how you identify your race/ethnicity

Q15 Please indicate how you identify in regards to gender

Q16 Can you please briefly explain why you are interested in this study

Q17 Please indicate your preferred method of contact and provide corresponding contact information. In providing your information, you are consenting to receiving an email with information regarding the study and/or the researcher leaving a voicemail with information regarding the study.

- ❑ Email (1) ____________________
- ❑ Phone (2) ____________________

APPENDIX D

ADULT CONSENT FORM

The University of North Carolina at Greensboro

Project Title: **Voices of Recovery: An Exploration of Stigma Experienced by College Students in Recovery from Alcohol and/or Other Drug Addiction**

Principal Investigator: Kelly Moore Spencer, MS, LPCS, LCAS, ATR-BC
Faculty Advisor: Dr. James Benshoff

What are some general things you should know about research studies?
You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. There may or may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with the researcher or with your university. Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study.

You should keep a copy of this consent form. If you have any questions about this study at any time, you should ask the researcher named in this consent form. Her contact information is below.

What is the study about?
The purpose of this study is to hear the voices of college students who identify as being in recovery from alcohol and/or other drug addiction. More specifically, I am interested in hearing more about the stigma that you may experience or have experienced in the past as a result of being in recovery. To do this, I am asking you to represent your voice both through photographs and through group discussions.

Why are you asking me?
I am seeking students who are currently enrolled at 4-year institutions at the undergraduate level (or have graduated in the past 6 months) between the ages of 18 and 29 who self-identify as being in recovery from alcohol and/or other drug addiction for at least the past 6 months (including abstaining from other mind-altering substances during this time) and have experienced some form of stigma as a result. This could include incidents of discrimination, negative stereotyping, feelings of isolation, rejection, etc.

What will you ask me to do if I agree to be in the study?
If you agree to participate in this study, you will be asked to participate in an initial1-hour training session. After this session, you will also be asked to take photographs that portray how you have experienced or continue to experience stigma as a college student in recovery.

Of the pictures you take, you will be asked to submit 2-3 photographs, along with titles and answers to proposed questions, that best depict your experience of stigma as a college student in recovery. These will be submitted electronically, via Qualtrics. If you photograph other individuals, you will need to obtain written consent from the individual being photographed. Please do not take any photographs of minors. We will explore alternative ways to capture individuals during our first training that will not need consent (unidentifiable photographs).

Once you have taken and submitted these pictures, you will be asked to participate in a group discussion. This discussion will last approximately 2 hours, in which we will discuss the photographs and the answers to the questions in relation to the photographs. We will also explore common themes that are presented within the group.

You may have the option to display your photographs in the final photographic exhibit, which may take place at a location separate from your institution. You are welcome to attend this exhibit whether or not you have given consent to displaying your photographs.

There is minimal risk to participating in this study. Reflecting on moments that have created difficulties in your life may create negative feelings. If these arise, you can stop participating at any time. Resources for counseling services are listed below. If you have any questions about this study specifically, please feel free to contact Kelly Moore Spencer at klmoore6@uncg.edu

Is there any audio/video recording?
Yes, I will be audio recording our group sessions. These sessions will be transcribed and used for data purposes. Some of your quotes may be used in the dissemination of the data, but you will not be identifiable. Because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things you say on the recording cannot be guaranteed although the researcher will try to limit access to the recording.

With your permission, the photographs and your narratives may be displayed at a photographic exhibit at the end of the study. You can opt out/in of the exhibit at any time during the study.

What are the risks to me?
The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. As

mentioned, depending on the moments you decide to capture in photographs, you may experience some negative emotions as a result. If this occurs, please contact any mental health providers you may be working with or the counseling resources at the end of the survey.

Additionally, although the results of this research project will be confidential, there is potential to be able to identify you depending on what pictures you choose to share in the group. It is also important to note that although the researcher will discuss the importance of confidentiality in a group setting, she will not have control over what group members share with others outside of the group meetings. If you have questions, want more information, or have suggestions, please contact Kelly Moore Spencer, at klmoore6@uncg.edu or Dr. James Benshoff at benshoff@uncg.edu. If you have any concerns about your rights, how you are being treated, concerns or complaints about this project, or benefits or risks associated with being in this study, please contact the UNCG Office of Research Integrity toll-free at (855)-251-2351.

Should you need any additional resources, I refer you to following organizations:

- UNCA Counseling Center - 828.251.6520
- UNCA Collegiate Recovery Community - https://healthandcounseling.unca.edu/collegiate-recovery-community
- UNC-CH Counseling Center - 919-966-2281
- Carolina Recovery Program - https://studentwellness.unc.edu/our-services/carolina-recovery-program
- UNCG Counseling Center - 336-334-5874
- UNCG Spartan Recovery Program - https://shs.uncg.edu/srp
- WCU Counseling Center - 828.227.7469
- WCU Catamounts for Recovery - http://www.wcu.edu/experience/health-and-wellness/caps/catamounts-for-recovery.aspx

Are there any benefits to *society* as a result of me taking part in this research?
Counselors, friends, family members, and the collegiate community may gain information and a better understating from seeing your perspective through pictures, as well as hearing your stories and explanations that connect to those photographs. This better understanding may lead to better support for college students in recovery and may impact the stigma of those who identify as being in recovery.

Are there any benefits to *me* for taking part in this research study?
There are no direct benefits to you for participating in this study. You may experience increased positive feelings about yourself as a result of sharing your story and experiences related to being a college student in recovery. By reflecting on these experiences, you may identify personal strengths and resources that you can continue to draw upon.

Will I get paid for being in the study? Will it cost me anything?
Participation in this study will not cost you anything financially. You will have the opportunity to get $50 for involvement in all steps of the process. You will get $20 cash for completion of the initial training and $30 cash for completion of the discussion session. The researcher will pay for printing costs if you choose to display your photographs in the final photographic exhibit.

How will you keep my information confidential?
All information obtained in this study is strictly confidential unless disclosure is required by law. I will collect your narratives after our group session and I will store these, along with the recordings of the sessions, in a locked filing cabinet until transcription. I will store all study-related electronic data securely using a password-protected computer.

Since you will be submitting your photographs electronically and your initial Qualtrics survey was completed online, absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing.

What if I want to leave the study?
You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of the data that has been collected, be destroyed unless it is in a de-identifiable state. The investigator also has the right to stop your participation at any time.

What about new information/changes in the study?
If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

Consent
By participating in the research activities, you are agreeing that you read, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By participating in the research activities, you are agreeing that you are 18 years of age or older and are agreeing to participate.

APPENDIX E

RELEASE FORM FOR INDIVIDUALS IN PHOTOS

Photovoice Project: Photography Release Form

Project title: Voices of Recovery: An Exploration of Stigma Experienced by College Students in Recovery from Alcohol and/or Other Drug Addiction

Principal Investigator: Kelly Moore Spencer

Permission to images:

I ______________________________(person being photographed) grant permission to ______________________________ (photographer's name) and the dissertation study being carried out by *Kelly Moore Spencer* through *The University of North Carolina at Greensboro* the right to use photographs/images of me in connection with the *Voices of Recovery* photovoice research project.

By signing my name below, I understand and agree that, unless otherwise stated in writing, *Kelly Moore Spencer* assumes that permission is granted to use my photographs for project related reports, publications, exhibits and presentations that are likely to result from this project. I understand that researchers, policy makers, students, and possibly people from my community will see my photo.

____ ________________

Signature of individual being photographed Date

____ ________________

Photographer signature Date

Approved IRB
10/26/16

APPENDIX F

PHOTOVOICE PHOTO SUBMISSIONS: QUALTRICS

Q1 Participant Name or Pseudonym

Q2 Photograph 1 (upload)

Q3 Photograph 1 - Title

Q4 1. How does this image depict stigma?

Q5 2. Has your relationship with this stigma changed over time?

Q6 3. How does this image make you feel when you look at it?

Q7 4. What has been your experience taking/selecting this photograph?

Q8 5. Why does this situation exist?

Q9 6. What can What can be done about this? personally? systemically?

Q10 7. Have you had similar experiences of stigma in relation to any other ways in which you identify?

(Repeated for Photographs 2 and 3)

Thank you for submitting your photographs. I look forward to seeing you at the discussion!

APPENDIX G

FOLLOW-UP EMAIL

Subject Line: Link to upload photographs

Hi Folks,

Thanks again for your participation in this research project. I am looking forward to meeting again soon. Before our next session, please be sure to upload your photographs here: Photovoice Photo Submissions. You will also be asked to provide a title and to answer these questions for each photo:

1. How does this image depict stigma?

2. Has your relationship with this stigma changed over time?

3. How does this image make you feel?

4. What has been your experience taking/selecting this photograph?

5. Why does this situation exist?

6. What can be done about this? personally? systemically?

7. Have you had similar experiences of stigma in relation to any other ways in which you identify?

Please upload your photographs at least 24 hours before we are scheduled to meet, as this will help ensure that I can upload them to a PowerPoint presentation before our discussion.

Please let me know if you have any questions.

Thanks again,
Kelly

APPENDIX H

FOCUS GROUP GUIDE

Focus Group Guide

Hello, everyone and thank you for being here today. Your participation in the study is greatly appreciated. I know that this study requires quite a bit of your time.

Today, we will be talking about the photographs that you have chosen, along with their captions and titles. As each photograph is projected onto the screen up here, I will ask the photographer to state the title and then I will show their answers the following questions:

1. How does this image depict stigma?
2. Has your relationship with this stigma changed over time?
3. How does this image make you feel when you look at it?
4. What has been your experience taking/selecting this photograph?
5. Why does this situation exist?
6. What could be done about this? personally? systemically?
7. Have you had similar experiences of stigma in relation to any other ways in which you identify?

Once this information has been shared with the group, I will ask the group the following questions in regards to the photograph on display:

1. How does this image make you feel?
2. Can you connect with this image or with the photographer's description of stigma in relation to this image? If so, how?
3. Why do you think this stigma exists?
4. What can we, as a group, do about it?

Through using this structure, I am hoping to provide a space for individuals to have their voice and intentions heard in regards to the photographs, while also allowing a space for group contemplation and conversation.

Does anyone have any questions before we get started?

[Group facilitator will then guide discussion given the format listed above]

[Once all photographs have been discussed…]

Thank you all for taking the time to explore these photographs more in depth.

Now, please take a moment to think about all of the information that we just talked about and consider any themes you feel have emerged from our discussion.

[Facilitate discussion about themes by repeating group member words and asking if the group is in agreement.]

Now, before group discussion ends, I'd like to discuss your responses to the question "What can we do about it?" more in depth.

Historically, photovoice projects and studies were used to impact communities by raising awareness. For the purpose of this study, I would like to hear your thoughts about the possibility of a final photographic exhibit. There is no pressure to have your photographs displayed, but I'd like for us to discuss the possible outcomes of such an event. Who should we invite? When/where should we host it, etc.?

[Facilitate discussion regarding final exhibit]

Full Study Ending:
[After discussion concludes, the group facilitator will thank the participants and give incentives to participants].

Thank you all for you time and energy today. This study would not be possible without you. If you have any questions at any time, please do not hesitate to email me at klmoore6@uncg.edu.

I will email you in regards to the details for the final photographic exhibit. If, over time, you decide that you have changed your mind about displaying your photographs, please just let me know.

APPENDIX I

PHOTOGRAPH RELEASE FORM

Photovoice Project: Photography Release Form

Project title: Voices of Recovery: An Exploration of Stigma Experienced by College Students in Recovery from Alcohol and/or Other Drug Addiction

Principal Investigator: Kelly Moore Spencer

Permission to images:

I ______________________________ (photographer's name) grant *Kelly Moore Spencer* from *The University of North Carolina at Greensboro* the right to use photographs/images of me and/or taken by me in connection with the *Voices of Recovery* photovoice research project.

By signing my name below, I understand and agree that, unless otherwise stated in writing, *Kelly Moore Spencer* assumes that permission is granted to use my photographs for project related reports, publications, exhibits and presentations that are likely to result from this project. I understand that researchers, policy makers, students, and possibly people from my community will see my photo.

Print Name or Pseudonym ___________________________

Signature of person who took photograph: __________________________

Signature of person in photograph (if applicable) _____________________________

Date ___________________

Please indicate how you would like the photograph to be credited:
(circle one and fill in blank, if applicable)

Your name: ____________________ Your Pseudonym:___________________ Anonymous

Approved IRB
10/26/16

APPENDIX J

CONFIDENTIALITY FORM: TRANSCRIPTION SERVICE

Project title: Voices of Recovery: An Exploration of Stigma Experienced by College Students in Recovery from Alcohol and/or Other Drug Addiction

Principal Investigator: Kelly Moore Spencer

I ____________________________ (please print first and last name) understand that the information that I will read and/or hear in the focus groups, audio recordings or transcripts may be of a sensitive nature. I will keep confidential any information concerning the information contained in the interview audio recording or transcript.

____ __________________

Signature of Transcriber Date

APPENDIX K

PILOT STUDY: INITIAL QUALTRICS SURVEY

Photovoice with Students in Recovery - Pilot Study

Q1 Thank you for your interest in this study. You will be asked a few questions to confirm that you meet the criteria for the proposed study.

Q2 Are you over the age of 18?

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip to End of Survey

Q3 Are you currently enrolled as an undergraduate student or have you graduated from college within the last year?

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip to End of Survey

Q4 Do you consider yourself to be in recovery from alcohol and/or other drug addiction? For the purpose of this study, recovery will be defined as:
"the experience (a process and a sustained status) through which individuals, families, and communities [negatively] impacted by severe alcohol and other drug problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by alcohol and other drug related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life." (White, 2007, p. 236)

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip to End of Survey

Q5 Have you abstained from the use of mind-altering substances for the past 6 months (caffeine and nicotine not included)?

- ❍ Yes (1)
- ❍ No (2)

If No Is Selected, Then Skip to End of Survey

Q6 Have you ever experienced any stigma due to your identity as an individual in recovery from drug and/or alcohol addiction?

- Yes (1)
- No (2)

If No Is Selected, Then Skip to End of Survey

Q7 Do you have access to a digital camera or smart phone with photo-taking capabilities? *This will not impact your eligibility for the study.

- Yes (1)
- No (2)

Q8 Please indicate any and all of the dates and times that you may be available to participate in the introductory training session. It will be about an hour long in length. If you are unable to make any of the following times but are interested in participating, please email me at klmoore6@uncg.edu with some dates and times that you may be available. Thanks!

- [ ] Monday, January 16th, 10:00-11:00am
- [ ] Monday, January 16th, 5:00-6:00pm

Q9 You have met all of the criteria to participate in this study! This study will require at least 3 hours of your time. You will be compensated financially for each step of the study and are free to drop out of the study at any time. If you are interested in participating, please provide your contact information below.

Q10 First Name

Q11 Name of college/university

Q12 Please indicate your preferred method of contact and provide corresponding contact information. In providing your information, you are consenting to receiving an email with information regarding the study and/or the researcher leaving a voicemail with information regarding the study.

- Email (1) ____________________
- Phone (2) ____________________

APPENDIX L

SECOND CODER BRACKETING

As a research consultant and coder for this study, it is crucial to acknowledge any implicit and explicit biases that I have that may influence this study. I will attempt to bracket my biases throughout my participation in this study.

As a white male from an upper-middle class socioeconomic status, I acknowledge and try to remain aware of the privilege that I have. This privilege was very present during my arrest on drug-related charges nearly 11 years ago. I often reflect upon my involvement with the criminal justice system in gratitude, but also know that my experience would have been very different were I not a white male with enough family and material capital to post bail, have a place to stay, hire a lawyer, go to treatment, have transportation, and get a job. As a person in long-term recovery myself, this will significantly influence the way I interpret the data.

I have worked in the helping professions since prior to my arrest and since my arrest, was able to achieve a master's degree in rehabilitation counseling and doctoral degree in counselor education. During my career, I have worked in a variety of settings including a residential treatment center for youth, vocational rehabilitation agency, school system, community mental health and addiction treatment, private practice, collegiate recovery programs, and higher education. Regardless of where I worked, people with substance use disorders were always an area of interest and passion.

Although most of my career focused on treatment, I was asked to build a collegiate recovery program in 2015. Although I didn't know what these programs were

initially, I soon became immersed in this concept and my professional role transitioned to one of after-care and recovery support. This position provides the opportunity accentuate my identity as a person in recovery, an identity that had led to professional consequences in the past. My time in collegiate recovery programs and the larger recovery movement are by far the most enriching aspects of my personal and professional lives. Because I have received both professional consequences and benefits from my recovery status, I will need to be aware of how these experiences influence my participation in this research.

My work with collegiate recovery programs also cause me to reflect upon my own undergraduate experiences. I feel some regret and wonder what would have happened if a collegiate recovery program would have been in place when I had my first alcohol violation the first weekend of school. Rather than be consumed with this regret, I am blessed to be able to support college students as they consider and enhance their recovery.

As I participate in this study, I need to bracket both the experiences that I deem as positive as well as negative. Both will have an influence on my interpretation of the data, and I need to remain mindful that others might not share the same experiences. During the study, I will bracket and document the internal reactions to the data in order to identify my bias and limit its influence on the data analysis.