

Overcoming alcohol and other drug addiction as a process of social identity transition : the social identity model of recovery (SIMOR)

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Defining recovery

As a concept that is still relatively new to alcohol and other drug policy and practice, there is as yet no established definition of recovery from addiction. The Betty Ford Institute Consensus Panel defines recovery from substance dependence as a “voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship” (2007, p. 222). This position is consistent with the UK Drug Policy Commission statement on recovery as “voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society” (2008, p.6). These definitions emphasise a process of ‘personal’ transformation that is evident in observable outcomes across multiple domains of functioning and supported by abstinence or increased control over substance use.

In contrast, client-led perspectives on recovery, such as Valentine’s (2011) statement “you are in recovery if you say you are” (p.264), emphasise the importance of the subjective experience of change. This definition is consistent with the mental health recovery model advanced by Deegan (1988). She argues that recovery constitutes the lived experience of people as they accept and overcome the challenge of disability, “recovering a new sense of self and of purpose within and beyond the limits of the disability” (Deegan, 1988, p.54).

These two types of definitions differ, with the former based on external and observable behaviours and the latter on subjective states and experiences. What they have in common is their failure to identify the mechanisms of change, or the social context in which change occurs. Instead, both focus on the characteristics of those ‘in recovery’ or who regard themselves as ‘recovered’. Yet, when it comes to matters of policy and practice, knowing how to identify a person who is ‘in recovery’ tells us very little about how to assist them in their recovery journey.

The purpose of this paper is to describe a conceptual framework that explains how the transition to recovery can occur, together with the social and psychological dynamics that underpin it. The paper introduces a new and key aspect of recovery, involving social identity change, and outlines how this is implicated in both the initiation and the maintenance of recovery pathways. While there has been considerable literature on the role of individual identity change in recovery, the role of social identity has largely been neglected (but see Frings & Albery, 2014).

To address this lacuna, in the present paper we examine the contribution of social identity processes to recovery using the example of Alcoholics Anonymous (AA). This program provides the basis for a strong social identity that supplants a salient addict identity to support recovery. In this context, we consider the role of social connections in the recovery journey (e.g., changes in friendship networks and group memberships), and the resulting impact on identity and self-definition. A key argument here is that identity change is bound up with AA group membership and its capacity to furnish active members with a new sense of social identity.

Recovery as a process of social group change

Existing evidence from the alcohol and other drugs (AOD) field highlights the important role of social groups in recovery. More specifically, a review of evidence supports claims that simply belonging to one or more social groups or networks is supportive of recovery (Best et al., 2010). This emphasis is consistent with related observations that groups and their associated norms influence a range of substance-related outcomes including the initiation and maintenance of substance use (Hawkins, Catalano & Miller, 1992), attrition from treatment (Dobkin, Civita, Paraherakis & Gill, 2002), as well as risk of relapse following AOD treatment (Hser, Grella, Hsieh, Anglin & Brown, 1999).

Additional support for this argument comes from a study of 141 cocaine-dependent individuals by Zywiak and colleagues (2009). This found that patients who had better treatment outcomes typically had larger social networks, more frequent contact with their social network, and an increase over time in the proportion of people in their social network who did not use any substances, including alcohol. In other words, amongst people with problems relating to cocaine use, those with the best outcomes were more socially connected, particularly with social groups whose norms were not supportive of continued substance use.

Further evidence for the centrality of social processes in recovery is provided by Litt, Kadden, Kabela-Cormier and Petry (2007, 2009). In this randomized controlled trial, people who completed residential detoxification from alcohol were randomly allocated to either standard aftercare or to a 'network support' intervention that involved developing a relationship with at least one non-drinking peer. Compared to standard aftercare, those who added at least one non-drinking member to their social network showed a 27% increase at 12 months post-treatment in the likelihood of treatment success (defined as being without alcohol 90% of the time). Furthermore, this increase in the likelihood of treatment success emerged despite no pre- to post-treatment change in the number of people who drank alcohol in their social network. This suggests that it was the addition of non-drinking peers that accounted for improved outcomes.

Increasing the availability and appropriateness of recovery-oriented social networks may also be crucial to long-term recovery from addiction. Beattie and Longabaugh (1999) reported that whilst both general social support and abstinence-specific support predicted abstinence at three months post-treatment amongst formerly alcohol-dependent people, only social support for abstinence predicted longer-term abstinence (at 15 months post-treatment). Similarly, Longabaugh, Wirtz, Zywiak and O'Malley (2010) found that greater opposition to a person's drinking from within their social network predicted more days without alcohol use

both during and after treatment, and fewer heavy drinking days post-treatment. In addition, less frequent drinking within the person's social network predicted more days without alcohol use during and after treatment. On this basis, the authors concluded that transition to sustained recovery was underpinned by a move from a social network supportive of problematic drinking to one supportive of recovery. Additionally, Zywiak, Longabaugh, and Wirtz (2002) found that, while alcohol-dependent patients with larger networks and a higher proportion of non-drinking network members showed better long-term treatment outcomes, these effects were moderated by the patient's frequency of contact with the social network (this being taken as an index of their investment in that network).

Frequency of contact with a recovery-oriented social network is important because it determines exposure to both recovery values and processes (Longabaugh et al, 2010; Moos, 2007), and the creation of a social environment in which an emerging sense of self as 'non-using' or 'in recovery' can be nurtured and shaped by the norms, values and expectations of the group (Best et al., 2008; Best et al., 2012). Furthermore, the benefits of social support for recovery (which may take the form of information or practical assistance, emotional support and a sense of belonging) appear to be dependent on the degree to which those providing support are perceived to be relevant, similar, and connected to the self. Thus, support is likely to be most effective (i.e., most likely to be welcomed and taken on board) when those who provide it are seen to embody a shared sense of identity (i.e. as 'one of us'; Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005; Jetten, Haslam, Haslam, Dingle, & Jones, 2014).

In line with this reasoning, research with adolescents has found that the negative effects of support for continued substance use coming from substance-using social networks are reduced when adolescents do not see members of these networks as similar to themselves. Conversely, the positive effects of recovery support from non-substance using social network members are enhanced when adolescents rate these network members as similar to themselves (Vik, Grizzle, & Brown, 1992). On this basis, researchers have concluded

that the degree to which adolescents perceive members of their social network as similar to themselves moderates the impact of social network support on their recovery, as well as their risk of relapse post-treatment.

Recovery as a process of identity change

The idea that identity change is central to recovery was first advanced by Biernacki (1986) who argued that, in order to achieve recovery, "addicts must fashion new identities, perspectives and social world involvements wherein the addict identity is excluded or dramatically depreciated" (Biernacki, 1986, p.141). Building on this theme, McIntosh and McKeganey (2000, 2002) collected the recovery narratives of 70 former addicts in Glasgow, Scotland, and concluded that, through substance misuse, the addicts' "identities have been seriously damaged by their addiction" (McIntosh & McKeganey, 2002, p.152). On this basis, they argued that recovery required the restoration of a currently 'spoiled' identity.

In a critique of this conclusion, Neale, Nettleton and Pickering (2011) contend that the notion of a spoiled identity is pejorative and that it neglects the range of alternative identities available to individuals across different social contexts (e.g., as father, daughter, neighbour, etc.) and overemphasises the salience and primacy of the identity associated with substance misuse. More recently, Radcliffe (2011) extended the argument around multi-faceted identity in a paper on recovery from substance abuse among pregnant women and new mothers. This argued that participants' motivation for recovery occurred in the context of an emerging 'maternal' identity, which is often perceived to be 'spoiled' in the eyes of health and welfare professionals as a consequence of the mothers' substance abuse. Yet, for women who currently or formerly abused a substance, their pregnancy provided a turning point, or 'second chance', allowing them to construct a "normal, unremarkable, and un-stigmatised motherhood" identity that supported their transition to recovery (Radcliffe, 2011, p. 984). On this basis, Radcliffe argued that shared narratives of recovery, and recognition of the

legitimacy of alternate identities by others, were crucial for the stability of the mothers' recovery.

Through such work it can be seen that both Biernacki, and McIntosh and McKeganey, hold to a conceptualisation of identity that emphasises a particular identity related to substance use. This ignores other identities that the person may hold, the wider social context of groups they may belong to, and the impact of their social network on substance-related behaviour. In this regard, the value of taking a social identity perspective — as we do in the *Social Identity Model Of Recovery (SIMOR)* outlined below — is that it avoids framing addiction and recovery in moralistic terms, as the 'un-spoiling' of a spoiled identity. Instead, it frames recovery as involving changes in a person's social world that coincide with changes in a socially derived sense of self, thus broadening appreciation of the ways in which recovery can occur.

The Social Identity Model Of Recovery (SIMOR)

The Social Identity Model Of Recovery (SIMOR) applies the Social Identity Approach to the process of recovery from addiction. This model frames the mechanism of recovery as a process of social identity change in which a person's most salient identity shifts from being defined by membership of a group whose norms and values revolve around substance abuse to being defined by membership of a group whose norms and values encourage recovery. This emerging sense of self is shared with others in recovery, thus strengthening the individual's sense of belongingness within recovery-oriented groups. This social identity gradually embodies the norms, values, beliefs and language of recovery-oriented groups. This, in turn, helps shape and make sense of changes in substance-related behaviour, and reinforces a new social identity.

SIMOR builds on two complementary theories – Social Identity Theory (SIT) and Self-Categorisation Theory (SCT). Social Identity Theory proposes that, in a range of social contexts, people's sense of self is derived from their membership of various social groups. The

resulting social identities serve to structure (and restructure) a person's perception and behaviour — their values, norms and goals; their orientations, relationships and interactions; what they think, what they do, and what they want to achieve (Tajfel & Turner, 1979; see also Haslam, 2014). Self-Categorisation Theory explains not only when and why groups come to define the self, but also how particular individuals achieve standing within the group. The theory argues that increasing status within a group is achieved as individuals become increasingly representative of a group, and that representativeness is achieved by embodying perceptions and expectations of what in-group members have in common, and of what distinguishes them from relevant out-groups (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987).

In this way, groups not only provide a sense of belonging, purpose and support (Cruwys et al., 2014; Dingle, Brander, Ballantyne, & Baker, 2012; Haslam & Reicher, 2006; Jetten, Haslam & Haslam, 2012), but also provide a basis for *social influence* (Turner, 1991). As noted earlier in discussing the influence of social networks on adolescent substance use, individuals are more willing to be guided by others when those others are seen as 'one of us' rather than 'one of them'. As Hogg and Reid observe, in these terms, social influence can be understood as "the internalisation of a contextually salient in-group norm, which serves as the basis for self-definition, and thus attitude and behaviour regulation" (2006, p14).

The extent to which one's sense of self is derived from membership of a group will have a range of consequences for both perception and action. According to SCT, the extent to which a given social identity comes to define the self in a particular environment arises from an interaction of two factors: *accessibility* and *fit* (Bruner, 1957; Turner, Oakes, Haslam & McGarty, 1994). The accessibility of a given social identity will tend to be higher if it has been a basis for self-definition and behaviour in the past, particularly in a similar social environment (Millward & Haslam, 2013; Peteraf & Shanley, 1997). The fit of a given social identity arises from meaningful patterns of perceived intra-group similarity and inter-group difference in the

situation at hand, such that the relative differences between those defined as "us" (the in-group) are perceived to be smaller than the differences between "us" and "them" (the comparison out-groups). In a recovery context, this means that a recovery-based social identity is more likely to become salient to the extent that individuals consider themselves to be relatively *similar to* other recovery group members and to be relatively *different from* the members of groups engaged in substance abuse.

One previous study that provides evidence of these processes at work involved the observation of British students transitioning from home to university life (Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009; Jetten, Iyer, Tsivrikos, & Young, 2008). In this, students were found to be more comfortable in assuming a 'university student' identity, and thus adjusted more successfully to university life, if this identity was compatible with their other social identities, both in the present (because the new identity fitted with values and beliefs derived from the other groups of which they were members) and in the past (because the new identity was more accessible due to a similar social identity having previously been enacted in a similar environment). This meant that the transition to a new 'university student' identity proved particularly challenging for those students for whom this identity was incompatible with previous and existing group memberships, something that tended to be more true for students from working-class families where education was less valued.

This analysis suggests that challenges in recovery from addiction are likely to be experienced when a recovery-based identity is fundamentally inconsistent with social identities that have previously been enacted, or where the person starting their recovery journey maintains involvement with, or commitment to, any group (including family) whose values and beliefs incorporate active substance abuse. In this way, the social identity approach offers an explanation for the beneficial effects of group membership found in previous research (e.g. Best et al., 2012, Zywiak et al., 2009). However, it cannot be assumed that all the groups to which individuals belong have a positive impact on physical and

psychological wellbeing (Haslam, Reicher & Levine, 2012; Jetten et al. 2014), nor that they all promote healthy behaviours (Oyserman, Fryberg & Yoder, 2007). Because groups are strong determinants of self-definition (Turner, 1991), strong affiliation with a group that is discriminated against and socially excluded due to involvement in deviant norms and activities (e.g. groups of injecting drug users) may also increase group members' health vulnerability and reduce subjective wellbeing and self-esteem (Schofield et al., 2001). Social exclusion and stigma around addictive behaviours may also lead using group members to identify more strongly with one another, seeing themselves as different from any other social group, and thereby reinforcing membership.

However, as SIMOR highlights, this need not prevent recovery, provided there is a basis from which to develop or strengthen other group memberships that support recovery. In particular, if a person self-categorizes as a member of a recovery-oriented group comprising former users, they will internalise the shared characteristics of the group as part of the self, and this new self-categorisation will typically involve distancing themselves from, and diminishing identification with, using groups due to their inconsistency with the characteristics of the recovery group.

This means that when (and to the extent that) people come to define themselves in terms of a recovery-based social identity (i.e., as 'us in recovery'), their behaviour will be informed by the normative expectations associated with that identity (e.g., avoiding environments and people associated with substance abuse). Their identification with a recovery group will shape their understanding of substance-related events (e.g. an offer to go to the pub with friends) and their response to it (rejection on the grounds that it would put their recovery at risk). In sum, group memberships exert influence on individuals through the transmission of social norms which are internalised, and shape subsequent attitudes and behaviour. Identification with the group increases exposure to its norms and values, as well as

receptivity to them. This increases the likelihood the group's norms will be integrated into one's own sense of self ('who I am').

Once salient, such positive social identities act as resources that support psychological health and adjustment (Jetten, Haslam, Iyer, & Haslam, 2010; Jetten et al., 2014). Along these lines, there is evidence that internalised group memberships become personal resources that support positive adaptation to change in times of life transition (Jetten et al., 2012). For example, Haslam and colleagues (2008) found that life satisfaction among patients recovering from stroke was greater for those who belonged to more social groups before their stroke, and who retained more of those group memberships following their stroke. In addition, the formation of new group memberships following a traumatic event has been found to predict fewer symptoms of traumatic stress over time, after controlling for individual differences in posttraumatic symptoms at baseline (Jones et al., 2012). This is because, to the extent that people identify with them, groups provide a basis for a sense of belonging, meaning, support, and efficacy (Cruwys, Haslam, Dingle, Haslam & Jetten, 2014; Haslam, Jetten, Postmes & Haslam, 2009), and social identities provide a reservoir of social resources that the individual can draw on in their recovery journey. An emerging recovery-based social identity can also help to make sense of new decisions around situations and groups associated with the previous using lifestyle and may also contribute to a sense of self-efficacy that reinforces the utility of the recovery-based identity and increases the perceived desirability of recovery group membership.

By applying a social identity approach, recovery can be conceptualised as involving the emergence of a new sense of self, encompassing a history of substance abuse, yet embedded within new, health-promoting social groups. Here, recovery is seen not as a personal attribute that can be observed and measured (Best & Lubman, 2012), but rather as a socially mediated process, facilitated and structured by changes in group membership and resulting in the internalisation of a new social identity. This social identity exerts influence on individual

values, beliefs and action and is reinforced and made more salient by successful use in challenging situations.

Factors that *maintain* recovery are primarily social; recovery involves moving away from the using social network and actively engaging with an alternative social network that includes other people in recovery. However, it is important to note that the factors that *initiate* recovery often relate to becoming tired with one's lifestyle, and these can often be brought to a head by a crisis event (Best et al., 2008). Indeed, although not highlighted in the literature, there is also the possibility that changes in social identity may in turn accelerate the process of becoming 'tired of the lifestyle'.

Clearly there are challenges in initiating this transition. In part, these can arise from a lack of awareness of, or wariness of, pro-social or recovery groups, something that can be exacerbated by the social exclusion that results from a heavy substance-using lifestyle. Nevertheless, there is evidence that even a single positive group experience, in the face of multiple negative ones, can provide the necessary scaffolding to help vulnerable and excluded individuals seek out meaningful groups and supportive networks (Cruwys et al, 2014). This suggests that even deep-seated experiences of isolation can be challenged in the process of initiating the recovery transition.

Setting the scene for initial contact with recovery-oriented groups is one of the primary motives of an 'assertive linkage' approach that supports individuals to engage with various groups. Testing this approach, both Timko et al. (2006) and Manning et al. (2012) have demonstrated the benefits of using peers to support active engagement in groups. In each of these trials, peers linked to specialist treatment providers acted as 'connectors' between socially isolated clients and pro-social groups, resulting in both increased engagement in group activity and better substance use outcomes. Similarly, Litt and colleagues (2009) reported a 27% reduction in the likelihood of alcohol relapse in the year following residential

detoxification amongst members of a trial group assigned to a 'network support' condition that involved adding one person to their social network who neither drank alcohol nor used other substances. The effectiveness of assertive linkage approaches points both to ways in which the initiation of group engagement can occur for excluded individuals and to the role of the group in building resilience by promoting engagement and a sense of belonging (Jones & Jetten, 2011). SIMOR argues that motivation to change can be initiated through two processes. The first involves increasing exposure to recovery-oriented groups that are perceived to be attractive to the individual. Second, motivation to change may also be precipitated by a crisis event (e.g., loss of a relationship or of a job) which may enhance the desire to change through increasing tiredness with a substance-using lifestyle. This may also occur through engagement with a recovery-oriented group as part of specialist treatment programmes (e.g., participation in 12-step meetings), or through encouragement and enthusiasm from friends. Thus, the initial drive may be to escape the adverse and stigmatised consequences of a substance-using lifestyle, but the catalyst and mechanism for change lies in the changing social dynamics that an individual experiences as they transition between using and recovery-oriented groups. This causes the person to move away from the using groups and to engage more actively with recovery-oriented groups.

In SIMOR we argue that there are at least two key phases in the recovery transition (see Figure 1) although, in reality, this process is likely to be experienced as a gradual transition in social identity and related behaviours. The journey towards recovery proceeds alongside initial exposure to recovery groups in the context of ambivalence towards an existing social identity linked to *active substance use*. This transitioning occurs as a recovery-based social identity becomes more accessible and increasingly salient and as the using identity, while still salient and accessible, starts to diminish. As the sense of identity associated with recovery-oriented groups stabilises, becoming highly accessible and salient, the using identity diminishes in salience and relevance.

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The new recovery-oriented social identity may take time to develop as this requires a fundamental shift in group memberships, values and goals, that occurs alongside growing recognition of the incompatibility of this identity with the values of the using group. Indeed, this may explain why rates of relapse are so high early in recovery. Nevertheless, if factors prompting initial attraction to a recovery group can overcome its perceived incompatibility, participation in the recovery group may offer new values and norms that 'fit' with the individual's recovery aims.

The transition to a maintained state of stable recovery (represented on the right of Figure 1) involves ongoing involvement with recovery-oriented groups whose mechanisms of impact include social learning and social control thereby shaping social identity. Here the salience and stability of a recovery-focused identity will grow as the individual becomes actively engaged in recovery groups. Moreover, as this identity becomes internalised the influence of using group values and norms significantly diminishes. In response, the recovery-focused identity becomes the more accessible and meaningful social identity, thus supporting recovery maintenance.

The result of this entire process is a transition in social identity — from one that is predominantly using-based to one that is recovery-focused. The latter is then sustained and maintained through active participation in recovery-oriented group activities. While the identity associated with substance use is not altogether lost or discarded, its salience diminishes as the 'fit' of the new recovery-based identity increases and that of the substance use-based identity diminishes. Over time, this reduces the likelihood of the using-based identity providing a basis for behaviour.

A similar process of social transition has been highlighted by Longabaugh and colleagues (2010) in predicting increased abstinent days from alcohol. SIMOR is also consistent

with evidence reported by Buckingham, Frings and Albery (2013) that both substance users and smokers are more likely to remain abstinent if they identify strongly with a recovery group. In other words, as former users come to identify more strongly with recovery-oriented groups, and less strongly with using groups, their likelihood of sustained recovery increases.

More recently, Frings and Albery (2014) have also developed a Social Identity Model of Cessation Maintenance (SIMCM), which draws on previous research showing that [therapeutic group interventions that create a sense of shared identification are the basis for cure or, in the present context, recovery \(see Haslam et al., 2010, 2014; Jetten et al., 2012\)](#). Like SIMOR, this model highlights the importance of social identity processes in recovery maintenance, but [approaches this from a social cognitive perspective, positing that attendance of a group therapy necessarily results in a recovery identity for each individual within the group and, through this, that an individual increases their self-efficacy to maintain recovery.](#) ~~#~~The model applies this specifically to group therapy for addiction, seeing this as a ~~scaffold from vehicle through~~ which to promote ~~and strengthen~~ a positive recovery-based identity ~~that individual members can draw on in negotiating their current lifestyle~~. This is a significant contribution to the field, but SIMOR offers a number of important developments on this model. First, it characterises recovery from addiction as a process of social identity ~~change~~[transition within a changing social context](#); drawing on social identity theorising [from a systemic, rather than an individual, perspective](#) to explain how this transition occurs. Second, SIMOR highlights the point that therapy groups, such as AA, are not the only source from which a person can develop a recovery-based identity. We argue that [engaging with other informal non-using groups can achieve result in similar outcomes.](#) ~~and, as~~ there are more of them offering a greater variety in experiences, ~~they these groups~~ can provide the basis for multiple sources of support in the recovery transition. Third, SIMOR highlights multiple phases within the recovery process, [recognising that group memberships are continually being negotiated and proposing that shifts in social identity may well be initiated prior to a conscious investment in not simply](#)

Comment [MB1]: I read this paper again and, although the authors would like this to be about group membership, I think it was actually more about the application of social labels to oneself and the link to self-efficacy (around drug-refusal I guess??) which was linked to abstinence/relapse. The link to groups was tenuous – it just happened in the first study that the participants were members of AA/NA.

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recovery. [Consequently, SIMOR suggests a transition in social identity is being negotiated throughout the recovery process and is consolidated during recovery](#) maintenance. SIMOR draws on social identity approaches to understand how recovery is initiated, produced, and maintained whilst also recognising, and accounting for, the possibility of relapse. Thus while SIMCM makes an important contribution by recognising the central role that social identity and group process play in addiction treatment outcomes, SIMOR seeks to take this analysis further by characterising recovery transition in terms of an interplay between [social identities](#) ~~memberships of various groups that, some of which~~ promote non-using, or at least non-harmful using, norms over addictive using norms, and examining how these dynamics play out in the process of [social](#) identity change.

Alcoholics Anonymous (AA): A model of effective social intervention for alcohol abuse

If this model accurately represents the social identity transition in recovery, then the social processes identified as critical in recovery from addiction should be evident in successful recovery group-based, peer-driven programs. In this regard, AA offers an appropriate test case as it provides the most widely available community support programme for problem drinkers (Kelly & Yeterian, 2008). AA is a mutual aid organisation for peers to support each other to overcome an addiction to alcohol, based on 12 steps and 12 traditions that members work through over time (e.g., Step 1 requires members to admit that they are powerless over alcohol). AA is used as a case study for the current paper because, with more than 2.1 million members and 100,766 groups in 150 countries, it is the mutual aid recovery group with the largest membership and the strongest empirical evidence base. Nevertheless, we would draw obvious parallels to other mutual aid groups (such as Narcotics Anonymous and SMART Recovery) as well as other peer-based recovery groups and services.

Meta-analytic reviews report a positive association between AA participation and abstinence, as well as reductions in substance-related health care costs (Tonigan, Toscova &

Miller, 1996). The efficacy of AA involvement in supporting recovery is also evident across a diverse range of populations (see Emrick, Tonigan, Montgomery & Little, 1993; Moos & Moos, 2006). Additionally, and in line with SIMOR's theoretical analysis, higher rates of attendance at AA meetings have been associated both with greater rates of abstinence from alcohol and an increase in the number of non-drinking friends (Humphreys, Mankowski, Moos & Finney, 1999).

Such evidence suggests that the process of categorising oneself as a member of a group that values abstinence provides a plausible explanation for the efficacy of the recovery model promoted and utilised by AA. Put simply, AA offers a positive recovery-based social identity that is accessible for members to use as a basis for self-definition. This identity is largely defined by the norms and values of AA's prescribed social behaviours and traditions, which are laid out in the AA "Big Book" (Alcoholics Anonymous, 1939) and that are discussed in many AA meetings. This is reinforced by a shared lexis ('fake it til you make it', 'one day at a time', 'rock bottom' etc.), the deployment of which denotes association with AA and fosters identification with the group. The frequent deployment of the AA lexicon may be indicative not only of internalisation of a recovery identity but also may imply some level of implicit identity (Frings & Albery, 2014). Indeed, 12-step fellowships may be unique in containing a range of rituals and practices that serve as warrants of membership and that, when enacted, clearly convey engagement with, and adherence to, the ideology outlined in the Big Book. In serving to embed the recovery identity, such rituals and practices are likely to have significant implications for perceptions and recognition of group membership and hence for the sustainability of a recovery-based social identity. Furthermore, AA promotes meaningful and pro-social behaviour by emphasising the need to make amends and to help others as central to the recovery journey (Humphreys, 2004).

In this regard, it is noteworthy that many of AA's prescribed practices are inherently social. New members are encouraged to seek out 'sponsors' (people in recovery themselves

who act as personal guides for the recovery journey) and to speak to as many 'experienced' members as possible. Accepting that one is powerless over one's use of alcohol and therefore in need of support, the sharing of one's own story and the structure of the sponsor system all serve to generate active engagement and membership, thus binding individuals to AA on an ongoing basis. Furthermore, the principle of 'keeping it by giving it away' speaks to a process whereby individuals protect their own ongoing recovery by helping others around them achieve this as well. A substantial proportion of the efficacy of AA in supporting recovery is therefore achieved not merely through attendance itself but rather through active participation at meetings (Kelly, 2013), thus embedding members within the group in ways that encourage them to embody and live out the group's norms and values.

In addition, higher levels of engagement in AA-related helping activity (e.g., helping to organise meetings, taking on administrative roles and so on) have been associated with greater abstinence, and lower levels of depression, at one and three years follow-up (Pagano, Friend, Tonigan & Stout, 2004; Zemore, 2007). Expanding on this, Pagano and colleagues (2013) found that active helping in AA meetings was associated with greater abstinence at ten years follow-up compared to standard professionally delivered alcohol treatment interventions. In other words, the more members are immersed in the activities and roles of the recovery group, the more they benefit from their membership of that group.

SIMOR as a basis for understanding AA efficacy

The impact and effectiveness of AA can readily be explained from a social identity perspective. To recap, the principal tenet of the social identity approach is that individuals internalise group characteristics as elements of the self (Turner et al., 1987) and that social identities become increasingly salient as a function of their meaningfulness and successful application in everyday situations and activities. In these terms, it is the perception of the self

as belonging to a group that provides the foundations for self-definition in social terms (Turner et al., 1994).

In AA, new members' initial attendance is said to be precipitated by "hitting rock bottom" (Alcoholics Anonymous, 1939). As Best and colleagues (2008) note, this is typically understood as a culmination of the adverse effects of their drinking reaching a crisis point, and it is this understanding that provokes early engagement with recovery groups. When first attending AA, new members are greeted by existing members, who encourage them to commit time and energy to active engagement in the group. New members actively engage by attending 90 meetings in 90 days, by finding a sponsor to guide them through the 12-step program, by 'working' the 12 steps, and by speaking to established members ('recovery elders') both during and after meetings. In this way, the efficacy of AA for new members can be seen to result partly from the availability and support of recovery role models who are established members and who provide identity-based *leadership* by seeking to exemplify the norms and values of AA (Haslam, Reicher & Platow, 2011). Established members are encouraged to 'keep it [their sobriety] by giving it away' and do so by engaging with and encouraging new members through formal and informal mentoring, assisting them to actively engage in AA meetings and support. By having a sponsor and identifying a 'home group', new members are incorporated into the social world of AA. This facilitates the internalisation of the norms and values of the 12-step fellowship and the adoption of an AA-based social identity.

The foregoing analysis is consistent with the work of Moos (2007), who has argued that one of the effective elements of mutual aid groups like AA is the availability of opportunities for social learning provided by the observation of group members who are further into their recovery journeys. Moos goes further to argue that it is not just role models that AA offers but also an implicit expectation that new members will learn and conform to the group's norms to achieve and maintain membership, a process he refers to as 'social control'.

In addition, opportunities for social learning by observing and imitating the recovery behaviours of more experienced peers in recovery promotes the development of coping skills, and positive attitudes, beliefs and expectations, that support sustained recovery.

In line with SIMOR's emphasis on the changing structure of identity-based networks, Kelly and colleagues (2012) also found that it was the influence of AA engagement on social network change, together with increases in abstinence self-efficacy, that were crucial to recovery from alcohol addiction. This is reflected in the literature around social networks and recovery. As discussed earlier, individuals who form new social networks with non-substance using peers are more likely to sustain abstinence (Best et al, 2012; Kelly, Hoepfner, Stout & Pagano, 2012), and those who report larger social networks and greater frequency of contact with their social network show more positive outcomes post-treatment (Zywiak et al., 2002). As the individual cultivates their recovery-based social identity through immersion in AA activities and internalisation of AA values, so the social identity associated with their using group is diminished (Buckingham et al., 2013).

The established importance of social network support for long-term recovery (see Best et al., 2012; Dobkin et al., 2002; Litt et al., 2009; Longabaugh et al., 2010; Pagano et al., 2004) speaks to the underlying effect of social influence and social control on the transmission of recovery behaviours (Best & Lubman, 2012). More specifically, individuals are only likely to take on board the values, goals, messages, and support from networks of people with whom they can already identify. Without a basis for shared identification, there is little motivation to engage with well-intentioned others, a point that underscores the central role of social identification in achieving such influence. As outlined in our model, there is an established role for assertive linkage to recovery and other pro-social groups (e.g., Manning et al, 2012; Litt et al, 2009) led by either peers or professionals. Nevertheless, more work is clearly needed to assess the impact of such interventions on perceptions of support and the growth of recovery capital (Cloud & Granfield, 2008).

There are also critical practice implications for professional and peer services relating to the importance of assertive linkage to community groups. For many alcohol and drug users who have lost or broken their ties with recovery-supportive networks and who do not have access to recovery groups, assertive linkage in the form of practical support (e.g., providing transport) and emotional support (e.g., encouraging and accompanying people to recovery meetings) is essential. This has important implications for treatment services engaged in recovery planning as it highlights the need to initiate active engagement with recovery-oriented groups, and to provide concrete advice and support around the process of transitioning from using-based to recovery-based groups.

SIMOR also offers an approach that is complementary to specialist alcohol treatment in targeting social and contextual factors that are inadequately addressed ~~in~~by pharmacotherapies and ~~most~~many psychological interventions. For policy makers, the implications of the SIMOR approach relate to the need to enhance acute therapies and promote social engagement strategies that can help initiate and sustain recovery-supportive lifestyles in the community, both during and after formal treatment. And, while the example we have used to illustrate the current model focuses on alcohol recovery, similar issues of social identity change and assertive linkage to supportive community groups apply not only to addictions to other substances, but also to other forms of social exclusion and stigma ~~(e.g.,~~ such as those associated with obesity, homelessness and mental health problems such as anxiety and depression (e.g., see Crabtree, Haslam, Postmes & Haslam, 2010; Cruwys et al., 2014).

There are also research implications related to the generalisability of the model in terms of individual differences and addiction-related factors. For example, one emergent research hypothesis might be that those who are not actively engaged in social groups, ~~and~~ who are introverted and who avoid group situations may be less receptive to or find less relevance in interventions promoting social identity change. A second empirical question that

arises from such an assumption is whether the model is less applicable to the experiences of those who are not involved in using in groups, and instead use in isolation, or to those who have little engagement with such groups in group-based social situations. The limited evidence from assertive linkage studies would suggest the model is similarly applicable to a range of experiences. Likewise, it is possible that those whose addictive behaviours do not lead to social exclusion or stigmatisation (as may be the case with some less problematic or entrenched drinkers) may have limited motivation to ~~embark on the~~ consider a social identity transition as suggested in the SIMOR model. In related research, Cruwys and colleagues (2014) have also found little evidence that individual differences (e.g., in extroversion) explain substantial variation in responsiveness to group-based interventions. At the same time, the model presented in Figure 1 provides an important basis for empirically testing the effects of identity salience and fit ~~of~~ at varying phases of recovery. Those still actively using would be hypothesised to identify more strongly with using groups, while those in an early phase of recovery would be more likely to report a diminishing using identity in tandem with a growing recovery-based social identity. The transition to a recovery-based social identity should then be considerably more salient by the time the individual achieves stability in their recovery.

Comment [MB2]: Isn't this saying the same thing as the first half of the sentence...?

These various issues also raise wider questions about the testability of the model. Our sense is that these are best addressed through empirical work, and indeed some of this is already underway with this population. In two existing papers based in drug and alcohol therapeutic communities (Dingle et al, 2014; Beckwith, Best, Lubman, Dingle, & Perryman, 2015), the authors have demonstrated that new entrants whose identification with the therapeutic community increased in the first two weeks of treatment (which related to a decrease in using group-based identity) had significantly better retention and completion rates. Similarly, better post-treatment outcomes were observed among participants who reported stronger recovery-based social identities following discharge from treatment. Both these studies demonstrate the predictive importance of a social identity shift in the recovery

transition. Another longitudinal study is currently underway across four therapeutic communities in Australia that will further assess the impact of group belonging and social identity change on recovery pathways whilst controlling for other possible explanations (e.g., individual differences, addiction severity, demographic factors and context). Importantly, this research will also assess the relationship between social identity change, treatment outcomes, quality of life and recovery capital.

Conclusion: Recovery as a socially embedded process

Rather than locating recovery solely in individual processes, we argue that recovery is more usefully framed as a social process, underpinned by transitions in social network composition that includes the addition of new recovery-oriented groups, where such groups are perceived as attractive, beneficial and relevant (Jetten et al, 2014), and involves the [concurrent](#) emergence of a new recovery-based social identity. These changes are sustained and supported through group processes of social influence, through the transmission of [new](#) recovery-oriented norms and values, and through the social control that comes from internalising these norms and values (Moos, 2007). The social processes embedded in Alcoholics Anonymous, an enduring and successful peer-based mutual aid group, provide an effective and tangible case study through which to examine the role of group-based social influence on social identity change in recovery. To better understand recovery, we need to move away from the view that it is simply an individualised personal journey and see it instead as a socially embedded process of successful social identity transition.

Declaration of Interest

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