Recovery identity and wellbeing: is it better to be 'recovered' or 'in recovery'?

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Abstract

While there has been debate about the meaning of recovery, there has been little discussion about how people characterise their own recovery experience, in particular whether people describe themselves as 'recovered' (as with a therapeutic community (TC) philosophy) or as 'in recovery' (typically those engaged in 12-step). The paper assesses differences in wellbeing as a function of recovery self-ascriptions, based on the UK Life in Recovery survey. Those who described themselves as 'recovered' or 'ex-addicts' reported better psychological health and lower identification with addicts and recovery, and showed stronger recovery functioning. There are clearly multiple pathways to recovery, and philosophy may impact on both trajectory of recovery and the social identity mechanisms underpinning change.

Keywords: Recovery definition; Wellbeing; Social identity; Addiction identity

Introduction

Recovery has become a core concept in our understanding of the process of transition from active addiction to some form of remission (White, 2008). There have been a number of attempts to develop consensus definitions of addiction recovery, most notably from the UK Drug Policy Commission (2008) and the Betty Ford Institute Consensus Group (2007). Both of these definitions have been predicated on three factors - involving positive changes in active participation in society, improvements in global health and wellbeing, and reductions or elimination of substance use. However, the term remains contested (e.g. Valentine, 2011; Wincup, 2016). It has been challenged on political grounds (Harper & Speed, 2002), on the extent to which it can be considered as an externally observable state (Best, 2014), and as an unsuitable goal for some (McKeganey, 2014).

A significant challenge in attempting to define recovery relates to the underlying philosophical assumptions about recovery that are related to specific models of change. Two in particular will be contrasted in the analysis presented below, and those relate to the differentiation between the model of recovery outlined in therapeutic communities ('TC') approaches (De Leon, 2000) and the model outlined in 12-step mutual aid writings (Kelly, 2016). Although not considered in the consensus group definitions, recovery differs fundamentally between these two approaches, in that within the TC model recovery is a state that has been achieved (i.e. 'I am recovered' or 'I am an ex-addict'). In contrast, within the 12-step model, recovery is a never-ending journey of growth and development where the individual continues to be 'in recovery' and if they consider themselves to be 'recovered' then they are at heightened risk of relapse. According to Denzin (1987), people attending AA members know that they will have the 'disease' of addiction until they die. Smith's (2007) study of AA's social world suggests that AA members frame their condition as a 'sickness' to be treated with aid of a sponsor and participation with AA's 12 Step.

The ascription of the label and the internalisation of the values of recovery also have implications in the formation of their identity, social identity and related issues of belonging. There is long-standing

literature (e.g. Biernacki, 1986; McIntosh & McKeganey, 2000) suggesting that recovery is associated with a change in identity, with McIntosh and McKeganey in particular speaking about the restoration of a 'spoiled identity'. Biernacki argued that “addicts must fashion new identities, perspectives and social world involvements wherein the addict identity is excluded or dramatically depreciated” (p. 141). More recent writing in this area has suggested that the identity change that takes place relates not only to personal identity but also to social identity (Frings & Albery, 2014; Best et al, 2016). Within this framework, recovery is predicated on developing a sense of positive identity that is based on the membership of valued groups that are positive and supportive of recovery. This notion of group transition is central to recovery - Longabaugh and colleagues (2010) have argued that switching from groups supportive of drinking to groups supportive of recovery is a key part of a recovery journey.

Similarly, Litt et al (2007) have shown that adding one friend in recovery to a social network supports efforts to remain abstinent. Kelly et al (2012: 297) assert that attendance at AA exerts a ‘protective and positive social influence’, while Blonigen et al (2011) report reductions in depression, impulsivity and alcohol use, as well as an increase in psychological well-being, resulting from AA membership. In essence, as a person becomes part of the group, so too does the group become part of the person; as the individual absorbs salient messages pertaining to norms of behaviour and conduct, immersion in a group’s positive culture of self-development and growth become valued goals for the individual. (Jetten et al, 2012). Thus there is growing evidence specific to the idea that recovery involves a change in social networks and identity.

Beckwith et al (2015) examined the shift in social identification from addict groups to recovery groups in a cohort of residents in one Australian TC and found that the stronger this transition in the initial weeks of treatment, the longer the residents were typically retained in treatment (with length of stay known to be a proxy indicator of positive outcomes). Using a sample from the same TC setting, Dingle et al (2014) went further in showing significantly better outcomes (in terms of

substance use and offending) among those who reported the most marked increases in recovery identity and the greatest reductions in 'addict' identity between entering the TC and returning to the community.

The purpose of the current paper is to examine the impact of social connectedness and social identity on wellbeing in recovery, with a primary hypothesis that higher levels of wellbeing are associated with more social connectedness and a stronger social identity around recovery. The secondary research question is whether philosophy of recovery is associated with wellbeing. There are two subordinate hypotheses resulting from this: 1. those who see themselves as recovered will have lower social identification with both addict and recovery populations, and 2. this group will experience less conflict between addict and recovery identities and consequently will report better quality of life and wellbeing compared to those who perceive themselves as being 'in recovery' as an ongoing process.

Method

The data reported here are based on the UK Life in Recovery (LIR) survey (Best et al, 2015). The survey was based on work done previously in the US and Australia. In 2012, the US recovery advocacy organisation Faces and Voices of Recovery (FAVOR) published the findings of an online survey of people in recovery which measured the changes in a range of aspects of their wellbeing from the time of their active use to their recovery. In 2014, an Australian version of the US survey was developed, resulting in a sample of 573 successful completions. The UK survey instrument involved a few minor amendments to the questionnaire format and to the method of distribution but essentially we have retained as much of the US and Australian survey as possible to allow comparisons across the three countries.

The UK Life in Recovery 2015 survey was distributed through a web-link to a Survey Monkey version of the survey. This link was distributed to a wide range of recovery groups and communities across the UK, based on the personal networks of the authors. In addition, social media sites and

individuals 'shared' the survey link (e.g. retweeted/liked), with others interested in recovery. The survey, comprising 143 items, took approximately 20 minutes to complete. Also copying the Australian approach, hard copies were made available for those who did not have access to or were not comfortable completing the online version.

While the majority of the items were directly taken from the FAVOR survey, additions were made to include measures of social identity from the Exeter Identity Transition Scales (EXITS) (12 items) (Haslam et al. 2008).

However, the core component of the instrument was divided into key life domains, categorised as being impacted upon most significantly by active addiction status:

- Family and relationships
- Finances
- Psychological and physical health
- Employment, education and training
- Contact with the criminal justice system

To capture differences in the experiences of respondents between active addiction and recovery, a 'then and now' design was adopted, covering the same key life domains in both stages. The survey used subscales to assess these domains variously using measures and scoring based on Likert scales, semantic differential scales, dichotomous questions, open-ended questions, narrative questions and others. More detailed information on the survey design and item scoring is available at Best et al. (2015).

A further section was designed to identify respondents' self-ascription of their own current recovery status by selecting one of the following four categories:

- Medically assisted (MAR)
- In recovery

- Recovered
- Used to have an alcohol or drug problem but no longer do

The category labels were chosen from the existing addiction and recovery literature and not further defined in the survey as the intent was to enable the participant to self-identify.

The project was approved by the ethics committee of the Faculty of Development and Society at Sheffield Hallam University.

Participants: The survey data were collected between March and June 2015. A total of 802 UK Life in Recovery 2015 surveys were completed, primarily online but with a small sub-sample of hard copies completed and returned to the research team. Data were provided on gender by 790 respondents of whom 53.1% were male and 46.9% female. In terms of age categories, 24.6% were aged between 50 and 59; 19.4% were aged between 30 and 39; 13.9% were aged 60 or older; 3.8% were aged between 21 and 29; and 0.3% were aged between 18 and 20. The majority of the participants lived in England (90.4%), 3.4% in Scotland, 2.8% in Wales and 3.5% in other countries.

Of the 770 people who answered the question, 293 (38.1%) reported that they had dependent children with a mean of 1.7 children under the age of 18 and a range of 1-15 children in this age range. With regards to employment, 58.0% were working full-time, part-time or were self-employed; 20.5% were unemployed or on disability allowances; 9.5% reported that they were retired; 5.3% that they were students; and 3.0% that they worked as volunteers.

Results

Statistical analysis: Analyses were conducted using the Statistical Package for Social Sciences (SPSS), version 22. Bivariate analyses included correlation analyses and ANOVAs with continuous variables and chi-squared analyses for categorical variables. Significant ANOVA tests were followed by post-hoc tests (i.e. Scheffe).

Categorisation of recovery self-identity

The most basic categorisation was around the self-perception of recovery status with 678 individuals (84.5% of the sample) offering a classification; 124 people (15.5%) did not respond to this question. The most common category was 'in recovery' (n=519, 76.5%), followed by 'used to have a drug or alcohol problem but don't anymore' (n=76, 11.7%), 'recovered' (n=56, 8.3%). A small sub-sample (n=24, 3.5%) described themselves as in 'medication-assisted recovery'. For the purposes of the current analysis, the 'recovered' and 'used to have a problem but don't any more' groups were merged to create single 'recovered' group for the purpose of further analysis. The longest time in recovery was reported by those who described their recovery status as 'in recovery' (M=8.6, SD=8.4), followed by those 'recovered' (M=7.6, SD=6.6) with the lowest rates among those in 'medication-assisted recovery' (M=5.3, SD=11.6). This difference in length of time in recovery was not statistically significant (F=2.18, p=0.11).

Wellbeing, social support and social networks

As is shown in Table 1, there are clear and consistent relationships between wellbeing and measures of social connections and social identity.

INSERT TABLE 1 ABOUT HERE

Better quality of life is associated with both greater social connectedness and with greater identification with both using groups and recovery groups. Physical and psychological health are not associated with identification with users, but strongly with people in recovery, and both are also positively associated with social connections and linkages.

INSERT TABLE 2 ABOUT HERE

Recovery status and wellbeing

Table 2 overviews the differences in some of the basic wellbeing measures between the three recovery status groups. While the results were statistically significant, for physical health and quality

of life, post-hoc Scheffe tests indicated that the significant difference was between the MAR and the other two groups. For psychological health, there was an additional difference with significantly lower psychological health among those who described themselves as being 'in recovery'. A series of chi-square analyses show that those in MAR typically fare significantly more poorly than the other two groups across a series of indicators for life in recovery. Those who classify themselves as 'recovered' reported lower levels of untreated mental health problems in recovery, higher levels of volunteering and better occupational outcomes across a range of measures than those who describe themselves as 'in recovery'. In contrast, those who report themselves to be 'in recovery' reported lower rates of involvement in family violence as either victims or perpetrators during their time in recovery.

Social identity and belonging

The second key area for investigation in this paper is the extent to which differences in perceptions of recovery status are associated with differences in social networks and social identity. Table 3 outlines the differences between the groups in these areas.

INSERT TABLE 3 ABOUT HERE

It is notable that it is the MAR group who have the lowest rate of active users in their social networks, and those who see themselves as 'recovered' who have the highest rate of active users in the network, contrary to the study hypotheses. In contrast, and in line with study hypotheses, it is those who described themselves as 'in recovery' who have the highest rate of people in recovery in their social networks. 82.8% of those 'in recovery' reported that more than half of their social network was also in recovery. Although the 'in recovery' group had the highest mean scores for identification with current users, post-hoc tests showed no significant between group differences. In contrast, the level of identification with people in recovery was significantly greater (measured on post-hoc Scheffe tests) than those either in MAR or who regarded themselves as 'recovered'.

Discussion

There is still relatively little empirical research on the subject of addiction recovery and much of what does exist assumes a homogeneity of approaches and philosophies (Best, 2014) that does not reflect the complexity, subjectivity and non-linearity of recovery (Valentine, 2011). The current paper uses an online national survey (Best et al, 2015) to explore the relationship between wellbeing in recovery and social factors and found that, as predicted by the Social Cure (Jetten et al, 2012), people in recovery who are linked to a more diverse range of social groups have higher levels of wellbeing. Likewise, the more social groups their friends are linked in to, the better their wellbeing. This is consistent with the 'CHIME' mental health recovery model that assumes Connections is one of the five core components of effective recovery support (along with Hope, Identity, Meaning and Empowerment; Leamy et al, 2011). It is also consistent with a literature that suggests that the more strongly individuals in recovery develop positive and prosocial networks the stronger their recovery journeys will be (Longabaugh et al, 2010; Litt et al, 2007). As has been suggested in previous research with TC populations (Beckwith et al, 2015; Dingle et al, 2015), there was also a positive association between a stronger recovery identity and better reported wellbeing.

However, the paper also set about to address a second question that used perceived status of recovery (based on an assumption about underlying philosophies) as a method for testing the link between pathways to recovery and social network effects. The conceptual model underpinning this test was based on a social cure suggesting that overcoming incompatible identities (addict and recovery) would result in reduced perceptions of dissonance (Jetten et al, 2014) and would allow for more effective social reintegration in recovery. This is a test of the underpinnings of a T C approach (as outlined by De Leon, 2000) where the individual who completes the programme is seen as 'recovered' and a 12-step model (as outlined by Denzin, 1987) where the identity shift is more subtle, from 'active addict' to 'recovering addict' (or being 'in recovery').

There was only partial support for this model, with slightly higher scores on all of the wellbeing measures reported by the group who perceived themselves as 'recovered' (although this difference was only significant for psychological health). In terms of their current functioning, the 'recovered' group also showed slightly higher rates of volunteering and employment and slightly better average work ratings, and slightly lower rates of untreated mental health problems at the time of survey completion. In contrast, the 'in recovery' group had lower rates of recent involvement in domestic violence as victims or perpetrators. This would appear to be a critical finding, and one meritous of further research investigation, particularly separating out whether the individual is reporting victimisation or perpetration of domestic violence. This would then allow an assessment of the extent to which this effect is a consequence in changes in the individual's own behaviour or that of their partner. Consistently, the small sub-population who described themselves as in 'medication-assisted recovery' reported markedly worse functioning in each of the areas measured.

While surprisingly, the people who described themselves as 'recovered' or 'no longer an addict' were slightly more likely to spend time with active addicts, the remainder of the social network and identity effects were in the predicted direction. Thus, those 'in recovery' were not only more likely to spend more time with other people in recovery, they were also markedly more likely to report higher levels of identification with people in recovery and with active addicts. From a social identity perspective this is important, as the social networks of people who are recovered are different from those in recovery as they are less based on addict or recovery identification. This distinction may be particularly important for people who desire to completely move away from addiction and recovery social worlds and networks and who wish to create new identities not involving addiction or recovery.

The relationship between beliefs about recovery and social network changes (particularly involvement in groups that are or are not explicitly linked to recovery) requires further investigation and one of the main limitations of using the Life In Recovery online survey format is that it does not

assess the treatment history or mutual aid experiences of those taking part. We are unable to assess the extent to which recovery identity is actually related to engagement and satisfaction with either 12-step mutual aid groups or with specialist treatment services (including the population who overlap and have experience with both). This online and anonymous format also precludes us from understanding the reason for participation or the understandings such individuals had about recovery. Finally, the UK ethnic minority and LGBT population is underrepresented in this survey sample, as are recovering persons in prisons and from those in the younger recovery community. Exploring the recovery experiences of individuals in minority communities remains under researched and future work is necessary in order to build a more complete picture. However, this study reflects a critical step in establishing differences in wellbeing as a function of recovery self-ascriptions. This work will continue with additional research in both the UK and internationally. Of note, since the conclusion of the UK survey, Life in Recovery surveys have been completed in Canada and are currently being collected in South Africa.

Nonetheless, this paper explores the relationship between recovery models and pathways and key aspects of ongoing recovery. As the science of addiction recovery continues to develop, it will be increasingly important for us to understand how recovery models are different and how they are adopted and adapted psychologically by those who engage with different approaches. This is particularly important where 12-step approaches are clearly at odds with other recovery philosophies, with significant implications for personal and social identity, and related social group engagement and belonging. While networks and social support are clearly critical to recovery, the supports that will work to encourage sustained recovery journeys are likely to vary as a consequence of the model of addiction and recovery that the individual adheres to.

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