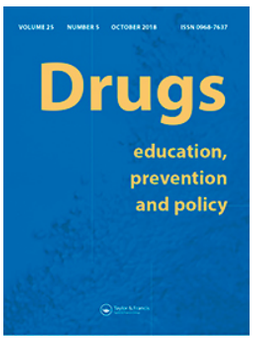

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Recovery and identity: a five-year follow-up of persons treated in 12-step-related programs

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ABSTRACT

Recovery is an established term used to describe positive processes of change concerning problems related to alcohol and other drugs (AOD). The present article investigates first-person experiences of recovery self-identification over time in clients who have completed 12-step programs with a positive outcome (sobriety). The data comprises qualitative interviews with 47 individuals five years after the first post-treatment interview, analyzed in a process inspired by reflexive thematic analysis. Although all the individuals had continued their recovery, their recovery paths and how they identified themselves in relation to their AOD problems had taken different directions. Thus, many of the individuals described their recovery in a broader sense which ranges from abstinence to moderation. Some individuals perceived themselves as no longer in recovery. The multitude of recovery processes described in the study underlines the need for acceptance and respect for individual identity processes. Furthermore, the importance is stressed of supporting an individual's perceptions of how their recovery process should best be outlined. The results should not be interpreted as a critique of the 12-step approach. Instead, there is a need for variety over time in the support and treatment options available for people in need of treatment for AOD problems.

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Recovery; alcohol; drugs; identity; process of change; 12-step; alcohol anonymous

Introduction

Recovery is an established term used to describe the positive processes of change concerning problems related to alcohol and other drugs (AOD). While an early definition of recovery by the Betty Ford Institute Consensus Panel (2007) discussed 'personal health and citizenship' (p. 222), the definition focused mainly on sobriety. However, a vast body of research suggests that recovery cannot be reduced to abstinence but should include growth in various life domains such as personal health, well-being and financial situation (e.g. Kaskutas et al., 2014; Laudet & White, 2010; Neale et al., 2015; Witkiewitz et al., 2019). A review of how the term recovery is used in the literature on addiction treatment concludes that it is widely understood as a long-term process, and that family and societal support are important while professional treatment plays a limited role (Borelli et al., 2017). However, various forms of external support during the first five years are recognized as important for improving the likelihood that individuals will sustain their recovery (Dennis et al., 2014). A recent interdisciplinary bi-annual collaboration among recovery researchers and professionals in the United States, the *Recovery Science Research Collaborative* (RSRC), derived a working definition of recovery as 'an individualized, intentional, dynamic, and relational process involving sustained efforts to improve wellness' (Ashford et al., 2019, p.183). The suggested definition is based on analyses of the key concepts and terms in current definitions. The focus on improving wellness means that the suggested definition does not stress sobriety in itself as a necessary part of recovery. The RSRC points out that this 'intentionally allows for a broader set of parameters focusing on self-defined criteria of the process, be that abstinence, moderation or medication use' (Ashford et al., 2019, p. 185).

Not everyone with a former significant AOD problem adopts the identity of recovering (Kelly et al., 2018). This was shown in a nationally representative US survey of individuals resolving a significant AOD problem, where somewhat more than half of the respondents identified themselves as either 'never being in recovery' (39.5%) or 'no longer in recovery' (15.4%) (op. cit.). Kelly et al. (2018) points out that little is known about adoption and change with regard to self-identification as in recovery as people come to terms with, and gain new perspectives on, their AOD histories. In the neighboring and often overlapping field of mental health, where the recovery orientation is established in both research and health policy, it is emphasized that identity processes are an important aspect of the recovery journey. This is stressed for example by Leamy et al. (2011) in a systematic analysis of conceptualizations of recovery in research on mental health, resulting in a recovery framework with the acronym CHIME, where the I stands for identity changes. The CHIME framework has in turn been used in a systematic review of the narratives of individual service users recovering from severe and

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enduring mental illness, where it was stressed that the identity theme was the least explored (Stuart et al., 2017).

People affiliated with the 12-step philosophy often use the term *in recovery* (Irvine, 1999, p. 59; Roe et al., 2007) and clients who have completed a 12-step program with a successful outcome (i.e. sobriety) are prone to identify themselves as in recovery. This was also the case for participants in a Swedish research project who were describing their recovery process approximately six months after they completed a 12-step or 12-step-inspired treatment program (Skogens & von Greiff, 2014, 2016; von Greiff & Skogens, 2014, 2017). A majority of those clients were re-interviewed five years later. The focus was on the participants' recovery processes since the first interview. This article investigates first-person experience of recovery self-identification over time. The specific research question investigated how the clients currently identify themselves in relation to their former AOD-related problems.

Recovery and identity

In behavioral science, identity is often used synonymously with self-image and refers to how people perceive themselves. From a social constructionist perspective, identity construction is an ongoing process that is affected by a number of factors. Theories on the narrative construction of identity (e.g. Giddens, 1991) make it possible to combine subjective and temporal aspects of identity. Narrative strategies involve incorporating our past and future selves. According to Howard (2006), the creation of identity can be described as a strategy in which the individual is able to act strategically by choosing a particular narrative strategy at any given time. Identity changes are described as influenced by a person's intentions and interpretations, but also by context. According to Goffman (1963), this means that a person may have different identities in different contexts, and that identity is something you do, not something you have.

Howard (2006) describes two conflicting orientations regarding an individual's identity: a *temporary expecting orientation*, which is a forward-looking and changeable identity; and a *permanent accepting orientation*, which is stable/static and characterized by acceptance of that identity (2006, p. 308). She uses the recovery identity to illustrate how these orientations can be expressed. Howard (2006) emphasizes that it may be relevant and important for people to label their problems in the initial phases of the recovery process, but that these labels can become limiting in later phases. In a study investigating people who formerly identified with emotional disorder labels (including substance use disorder) but have since chosen to discard them, Howard (2008) uses the term *disidentification process* (p. 177) to describe a process that can be challenging and characterized by tension as a consequence of existential, interactional and cultural obstacles.

Some studies highlight how people in recovery emphasize the need to get to know and redefine themselves as a central part of the process (Biernacki, 1986; Dekkers et al., 2020; McIntosh & McKeganey, 2000). This change of social identity (Best et al., 2016) is an ingredient in the 12-step programs in which the participants in this study had participated. A high level of attendance at and participation in Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) meetings is encouraged in the approach. Through the process of working through the 12 Steps towards recovery, the program provides the basis for a strong social identity to supplant the salient addict identity and support recovery (Best et al., 2016). Moreover, as Cain (1991) points out, the storytelling that is an essential part of the 12-step movement is used as a narrative strategy for identity change.

Previous research has shown that identity changes can occur independently of changes in patterns of substance use (Martinelli et al., 2020; Witkiewitz et al., 2019, 2020). Other researchers question the need for a change of social identity during the recovery process (e.g. Fomiatti et al., 2017; Neale et al., 2011). As described above, there is a fairly wide scientific consensus that the term recovery describes a process of change. Apart from this, there is an ongoing discussion for example on how this process should be described, and whether it includes sobriety and identity changes. Thus, in contrast to research on mental disorders where recovery often includes a reshaped (Romano et al., 2010) or reconstructed sense of self (Davidson & Strauss, 1992) in order to manage their illness, recovery from AOD problems do not necessary implicate change of sense of self in relation to the defined problems. By investigating the views of clients who have taken part in, and adopted, the 12-step process, and who five years before described themselves as in recovery, this study describes how they identify themselves in relation to their former AOD problems and sheds light on the first-person experience of a process of change.

Material and methods

The data is based on clients who took part in three Swedish projects focused on first-person experiences of initiating and maintaining a recovery process among clients treated for AOD-related problems. Clients were recruited through treatment units (outpatient and inpatient) in seven Swedish city districts. In order to recruit interviewees who were able to reflect on their process of change, the client had to be at the end of, or to have recently completed, a post-treatment intervention,[1] and be judged by a professional to be in a positive change process regarding their AOD-related problems. In the initial interviews, all the clients declared that consumption of alcohol or use of other drugs in any form was not an option. After the interview, the clients were asked whether they would allow renewed contact after five years and they all gave their permission ($n = 75$). Follow-up interviews were conducted with 53 individuals, 47 individuals of whom were included in the present article. The majority of those not interviewed were impossible to reach with the contact information available (a five-year old telephone number did not work and no number was found in internet searches). Three individuals declined to participate and one had died. Since the focus of the present study is on recovery self-identification over time in relation to *former* AOD-related problems,

those with recent relapses or ongoing AOD problems were excluded from the analysis ($n = 6$).

The majority of the follow-up interviews were conducted by telephone but some were conducted face-to-face. The interviews were recorded and transcribed verbatim within 48 hours. Both authors were responsible for the entire process of collecting and analyzing the data for the initial and the follow-up study. The follow-up interviews began with the interviewer providing a brief summary of how the interviewed person (IP) had described their process of change last time. From this starting point, the IP was asked to describe the past five years in terms of both possible so-called relapses and retention and/or resumption of positive change. Questions were also asked about so-called recovery markers (Martinelli et al., 2020), such as social networks, housing and occupation. In addition, the interview guide dealt with questions about treatment contacts during the follow-up period (frequency, extent and type), views of the IP's own and others' alcohol consumption, and factors that were important to the continuation or resumption of positive change.

Analysis

After transcription, the material was first analyzed thematically (Braun & Clarke, 2006) by coding the interview passages according to the subjects raised. After listening to the interviews again and scrutinizing the transcripts, the material was categorized and summarized by selecting relevant parts from each transcript. Several codes were identified and by iteratively analyzing and compiling summaries and codes in an increasingly condensed form, themes were created at an aggregate level in a process of going back and forth between the transcripts and the emerging themes, refining and defining the themes as described by Braun and Clarke (op. cit.). Three overarching themes were identified, all of which contained several sub-themes: recovery processes among young adults (Skogens & von Greiff, 2020); abstinence versus controlled drinking (von Greiff & Skogens, 2020); and identity (present article). Both the first and the follow-up interviews were re-analyzed for this article, with a focus on descriptions of recovery self-identification in relation to former AOD problems during the follow-up period. Inspired by reflexive thematic analysis (TA) (Braun & Clarke, 2020), previous research and theory were used as a lens through which the analysis and interpretation took place. The analysis process was characterized by reading, reflection, questioning, pondering, writing, and leaving and returning to the material. Two overarching themes were identified, each theme contained three sub-themes.

All the quotes are followed by a number that refers to a specific interviewee; gender is marked by a W for women and an M for men.

Ethics

This research project was scrutinized and approved by the Ethical Review Board in Stockholm, Sweden (2018/1770-32; 2018/1973-32)

Table 1. Living situation, occupation, sobriety and mental health at first interview and at follow-up.

	First interview	Follow-up interview
Living situation		
Living alone	26 (55)	16 (34)
Living with children	4 (9)	3 (6)
Living with children and partner	10 (21)	14 (30)
Living with partner	7 (15)	14 (30)
Occupation		
Work	26 (55)	33 (70)
Studies	6 (13)	4 (9)
Unemployed/sick leave	11 (23)	4 (9)
Retired	2 (4)	4 (9)
Parental leave	2 (4)	2 (4)
Sobriety		
Yes	47 (100)	29 (62)
No	0	18 (38)
Mental health problems[a]		
Yes	35 (76)	23 (49)
No	11 (24)	24 (51)

[a]Missing information for one IP, first interview.
Numbers and percent (%). $N = 47$.

Results

The study included 32 women[2] and 15 men ($n = 47$[3]) aged between 25 and 75 at the second interview (m = 44, md = 41). The number of IPs that live alone has decreased at follow-up and regarding occupation, fewer IPs are unemployed (see Table 1, below). At the time of the first interview, no one was consuming alcohol or using other drugs. Five years later, the majority were still sober but there was a significant group of 18 people who reported moderate alcohol consumption. Mental health had improved between the first and the follow-up interviews. However, half the IPs reported continuing mental health problems at the follow-up.

At the first interview, all the interviewees described themselves as sober and in an ongoing recovery process (Skogens & von Greiff, 2016; von Greiff & Skogens, 2017). The IPs had undergone 12-step or 12-step-inspired treatments, and the recovery process often revolved around step work and AA/NA/Cocaine Anonymous (CA) meetings. Identity was clearly related to the AOD problems the IPs had been treated for and was often described in terms of 'sober alcoholic' and 'dependent personality'. Thus, all the IPs defined themselves as in recovery. The analysis of the follow-up interviews showed that the past five years had been characterized by a continuing recovery process. Two central themes emerged from an identity perspective: one in which the AOD problems was still a central part of the IP's identity and another in which the AOD problems no longer formed a central part of their identity.

The AOD problems still a Central part of the IP's identity

For the IPs in the first theme, the identity of being *in recovery* (as described by Irvine, 1999) was still central to their self-image. Three sub-themes were also identified: 'actively remaining or reinforcing an identity related to AOD problems'; 'balancing different roles/identities' and 'an internalized identity of being dependent.

Actively remaining or reinforcing an identity related to AOD problems

The IPs in the first sub-theme identified strongly with being in recovery. In their second interviews, they repeatedly related to a recovery identity when describing the development of other identities, for example, relating life changes such as becoming a parent to how new contacts with other parents were handled vis-à-vis the importance of being honest about previous AOD problems. Thus, the description of the participant's own identity was based on the ongoing recovery process and other roles were adapted or related to this:

> My recovery is ongoing since I still have the disease. I continue to work on my dependence alongside living my ordinary life. I identify as being dependent and this is important to me. But I also identify as a colleague, mother, spouse; those sorts of things. (IP27, W)

The above quote illustrates the recovery identity as an axis or foundation on which other roles can be developed. IP 27 already had a socially integrated life at the time of the first interview and the five-year follow-up period was described as not having entailed any major external changes. Instead, it was characterized by life as a working parent with small children and an underlying disease. She described periods of mental health problems in the past five years and how the meetings still constituted a source of support and help with managing life. Thus, the recovery identity constituted a stable foundation that did not change despite identification in other areas. In other words, fully embracing and actively relating to the recovery identity was an important piece of the puzzle to achieve a sustainable recovery.

Since the first interview, some had chosen to intensify their involvement in AA or other self-help groups, such as NA or CA, through sponsorship, meetings, and so on. Others had used their experience of the 12-step treatment in their professional lives. One man described how he had achieved a recovery identity through training and increased participation in meetings, and the significance this had for him:

> I've really deepened my involvement in AA and CA. I've been studying since we last met so now I'm a trained alcohol and drug therapist. I have greater insight into the fact that substance dependence really has to be handled as a disease throughout your life in order to be able to live a good life … .It's more settled in me and not frightening. Last time I said that life was good, that I had a positive outlook and I really think I had that. But the dependency leads to pitfalls and life feels fragile – that holds true for a lot of people – but the disease doesn't frighten me like it used to do … .The dependency is part of my personality. I socialize with dependent people, and talk about dependency with people who are not dependent. I have studied it so yes, it's part of my identity. (IP6, M)

IP 6 is also an example of a recovery identity where the description of being in recovery is similar to the rhetoric found in the AA movement: 'If I stop working on it [the steps], a dangerous situation will develop. People do relapse after 10–25 years of sobriety, and what they usually have in common is that they'd stopped actively working in the steps.' He expressed no need to change his views of five years before on the identity he has in relation to former AOD problems. Instead, the labelling of himself as dependent had been reinforced.

Balancing different roles/identities

Unlike those who actively retained or intensified their recovery identity in the follow-up period, those in the second subtheme tried to balance different identities. Rather than emphasizing the recovery identity as hierarchically affecting other identities or roles, they identified several parallel roles. A young woman who was still active in AA described how she handled different roles in relation to the recovery identity:

> For all this time we've [the IP and her spouse] kept on going to meetings and sponsoring and helping others, because that is the most important thing. But it's been hard, as when you have children and other friends it's not the first thing you say: 'I'm an alcoholic and a drug addict'. So you change your identity. I've become a mum. I've also worked in the prison and probation service, and there I haven't told anyone that much about myself. It's a tool, absolutely, but it's not the first thing you tell somebody. So, it's been difficult to change, or to keep my old identity, as I must never forget that I'm an alcoholic and a drug addict. Cos now I socialize with mums who only drink wine on Fridays and Saturdays; and who just enjoy themselves and go to dinner parties. (IP26, W).

IP 26 described maintaining a recovery identity even though life changes involved new roles and identities. These new roles were more compatible with the identity of being in recovery for some IPs than for others. She spoke about balancing between roles where the identity related to the former AOD problem was sometimes important, sometimes important but hidden, and sometimes not important at all. Another aspect that distinguished those with an intensified recovery identity from those balancing between different identities was that the latter seemed to use a broader toolbox to handle 'crises' than just AA meetings and step work. IP 26 described it as follows:

> Sometimes I feel lousy. I'm afraid of life and stressed out and I only want something to help me unwind. Then it's easy to think of alcohol, not drugs but alcohol, which is easy to get hold of. But I have so many tools I can use. I can call a friend on the program or I can talk to my husband who also attends meetings and who is quite spiritual. Or I go to a psychologist … breathing, mindfulness and stuff like that. That's what helps me. I also go to church a lot.

An internalized identity as being dependent

The third sub-theme involves those who expressed gratitude for what the AA community had given them but no longer considered themselves in need of such support since they had internalized the 12-steps and built up an internal sense of security. However, like those who had intensified or were balancing their recovery identity, recovery from AOD problems still formed a fundamental part of their identity. When the interviewer asked why the 12-step community was no longer relevant, IP 41 answered:

> How can I explain it … It's so firmly ingrained in me what to do. I don't feel that I need help today. I've got a fantastic life, I live my life without alcohol, there's nothing odd about it … I feel safe

> and secure in my sobriety. I have my life … Even though I no longer go to meetings, I have the steps ingrained in me. (IP 41, W)

IP 41 described in the first interview how the period after treatment was characterized by intensive meeting participation, step work and learning about the disease, and how the community contributed to a new social network. In the follow-up period, a sense of security in her sobriety was established. This, together with a lack of time, resulted in a distance from the 'newly sober': 'I don't have as much time anymore. I've come a bit too far from the newly sober … When you're going to help others it's important that there aren't too many differences'. She described how she did not have to meet others to be reminded about the steps and that these had been internalized;

> I'm grateful that I can still remember how bad I felt and the anxiety I experienced before I had treatment, the demeaning life, the self-loathing. I never want to go there again, that gives me a sense of security … I have the steps with me; daily inventories and making amends, these are the things that come quite naturally to me … Even though I'm confident in my sobriety, I can never be sure that I'll never have a glass again. Because the disease consists of a mental obsession and a physical allergy …

At the same time as IP 41 stressed a sense of confidence in not needing meetings anymore, she underlined the importance of the identity of being in recovery and that her disease was still there.

Some IPs who recognized the importance of AA in their recovery process nonetheless acknowledged that they had had doubts about AA in recent years and felt the need for a complementary approach. However, this was not a matter of an articulated ambivalence about their own identity as 'dependent' or a matter of questioning AA, but more that their own mental fragility clashed with the harsh jargon of members:

> In parallel with my life, which was working out well, there was so much shame in me, that I was different, that there was something wrong with me in a way others weren't. Just the fact that I alternated so much between one day thinking life was great – no problems – and the next day I was like a little rock, or under a rock, and I was so ashamed … So, I searched further – I've always read a lot, absorbed everything that has been written about high sensitivity, HSP, and recognized myself in it … .There's something very rigid about AA, step work and that … it's a bit tough – you don't 'have' a relapse you 'take' one and you've planned it for a long time and blah blah blah and that's the whole approach. Gestalt therapy has made me take a softer approach, that we're people who seek help from all quarters. AA clashes a bit with what helps me the most and that's self-compassion and mindfulness and getting help from the psychiatric services. (IP19, W)

For others, it was more about an insight gained since the last interview that a recovery identity is not just related to AOD. Those IPs emphasized step work, attending meetings and maintaining sobriety to ensure a sustainable recovery, but the challenge was to also deal with other addictions or problems. One woman who despite her relatively young age had many years of abuse and several prison sentences behind her had linked 'anxiety and bad moods' to AOD problems in the first interview, but now described a different approach:

> I really have a problem with dependency: no matter what I do, I do it too much. I started training a year ago and I ended up training almost 7 days a week and got completely into it. So, in the end I had to limit myself and finally stop. When I started eating shakes six months ago to lose weight, I ended up replacing all meals with shakes. I'm really a very addictive type of person and go crazy in almost everything I do. It doesn't matter if it's exercise, food or … I live with the addictive disease (IP 13, W)

She described a sense of security in her sobriety that was based on a view of herself as having a disease; that her identity as having a problem with dependency was central, but unlike in the first interview, her dependency identification was about her addiction not only to substances but also to exercise, food, and so on. Thus, the recovery identity for some of the IPs in this theme could be described as remaining but going beyond AOD problems.

The AOD problems not a Central part of the IP's identity

The main feature of this theme was that the IPs no longer talked about their AOD problems as a central part of how they perceived or described themselves. Three sub-themes were detected: 'identifying AOD problems as related to mental health problems'; 'questioning and replacing the recovery identity'; and 'recovery no longer included in the identity'.

Identifying AOD problems as related to mental health problems

All the IPs in this sub-theme shared a realization that their AOD problems were related to mental health problems. After dealing with their mental health problems, they concluded that it was possible to drink alcohol in a way that did not cause them or their social context any problems. They described drinking on a few occasions (a handful per year) and in small amounts (one or two drinks). Dealing with their mental health problems did not necessary mean that these issues were 'resolved', or had even changed. The man below provides a good example. He spends long hours working and described how he enjoys a drink or two but does not like to get drunk. However, drunkenness was not the defined problem, but that too many drinks triggered anxiety. Even when asked directly, he did not describe drinking in itself as a challenge connected to AOD problems but that drinking to excess defeated the purpose of drinking – to have a good time:

> I drink alcohol maybe two or three times a year; it doesn't happen often but I like it.
>
> **Interviewer:** Why don't you drink more often? Is this something that you've thought about?
>
> Yeah, it's quite simple; for me, alcohol is something associated with a lot of anxiety.
>
> **Interviewer:** When you drink a glass of wine because it's nice, do you worry that it'll get out of control?
>
> No, I drink very seldom. I don't have any problems controlling it. It's just that I know what happens if it gets too much. I become

> the guy sitting in the corner crying; how much fun is that really? That's not why you drink when you go out drinking. (IP 50, M)

He stressed that his (former) AOD problems were connected to 'flight behavior': 'you go into flight mode. As long as you do that, you're stuck, you get nowhere. When you start to realize that you're actually the one calling the shots, who decides how you want to live your life, that's when you start to heal'. He sensed that he had taken control of his life, including his alcohol use. Having problems with AOD was no longer part of his identity. Rather, he described how this sense of control had helped him to endure periods of not feeling good: '[you have to learn] that it's OK to have shitty days, even shitty months'. Thus, his identity as someone who had problems with AOD had changed to being someone who had control over his life but still had some mental health issues.

There are similarities between the above IP and the following IP in terms of an identity linked to enduring mental health issues rather than persistent AOD problems. However, IP 35 below described this not as 'taking control', but as accepting it as part of his identity:

> I don't dwell on drug thoughts and drug cravings. But I do sense that feeling of being different, the feeling of that was why I used to take drugs, that feeling is still strong … .
>
> **Interviewer:** I've been thinking of what you said earlier, that you took drugs because you felt that you were different, that when sober you are reminded of being different and alone in a certain sense?
>
> This feeling used to be part of and a reason for me taking drugs. Now I've accepted this more and don't need … That's how it is, I can't go around and hang out with people who take drugs just to belong to a group. But I haven't really found mine I would say. It used to be the 12-step community, but it's the same as the druggie community, you have a common goal, to recover or to talk about how to get drugs. I haven't found my niche yet. (IP35, M)

IP 35 identified himself as 'being a bit different'. He described how he used to feel at home in the 'addict context' and later in the 12-step movement. Since he no longer used drugs or alcohol in a problematic way, this context was now out of the question for him. However, he could not be part of the 12-step movement either since he identified himself as an alcohol user, not as someone in recovery. His own identity and sense of self were important to him and he did not want to deviate from this or hide it in order to be part of a community or social context. Nonetheless, he recognized this was a problem for him and missed belonging to a subgroup.

These two examples illustrate the common features expressed in this theme: getting to know yourself, connecting former AOD problems with issues such as personality, social problems during childhood and psychiatric diagnoses, and a desire not to include AOD problems in their current identities. Thus, the change in the latter – not being a person with AOD problems – seems to rely on a newly formed identity – being a person with certain mental health issues – that can be described as an orientation towards an identity as a person with agency in terms of handling personal difficulties.

Questioning and replacing the recovery identity

The identity transition described by the IPs in this sub-theme at some point included a process of struggle with conflicting identities in relation to self-help groups (AA/NA) and their strong emphasis on sobriety. This illustrates how while it may be both relevant and important for people to label their problems in the initial phases of recovery, these labels may be limiting in later phases. This calling into question and transformation between phases can present challenges for a positive recovery process, as IP 7 described:

> … I don't go to meetings anymore. I didn't have my own thoughts [five years ago]. It was like a sect, my thoughts were those of alcoholics anonymous and narcotics anonymous and I saw myself through their eyes in a way that became quite harsh … .I'm grateful that I'm not there anymore because I was too hard on myself – it didn't suit me … .It was kind of a salvation, but I think I could have fixed it without the 12-step program with people around me who cared and were supportive … .I still have some difficulties with relationships – well, many people have I suppose … .Before, I drank to numb myself; I had nothing of value in my life, I might as well die. Now, I have so much to value in my life that I want to have access to everything good, including going out and having a drink or celebrating with champagne sometimes. So, we'll see. I can't say that I won't relapse, because I've heard so much about that – a part of me says that this is the first step towards relapse but my gut feeling is that it's cool, that I can be cool because I trust myself. (IP7, W)

IP 7 described how she used to think that the treatment in the 12-step program rescued her but, after some time in recovery, she found that it was not right for her. Now, her life was valuable to her and while she sometimes drank alcohol to enjoy life, it was not to escape from herself or from a chaotic life. She distanced herself from who she was during her earlier recovery process and explicitly questioned AA/NA. She expressed self-esteem and self-confidence, and believed that the route she had taken was the right one for her. The doubts that she described came from what she had heard and been told. Even if she was clear that her current identity did not concur with the perspectives shared in AA/NA, she was unable to fully trust her own feelings and sense of self. Thus, the AA/NA narrative seemed to cast a shadow that presented an obstacle to believing in herself.

Both IPs 7 and 21 had suffered many years of AOD problems as well as other social problems even before they were teenagers. In their first interview, they described the importance of redefining themselves and how the 12-step treatment, followed by joining AA/NA communities, had been central to that process. Later, they both described a process of questioning their own identification with the 12-step principles. This process of identity transformation was even more strongly expressed by IP 21:

> I'm not teetotal anymore. I drink on odd occasions and this has been a process. I have much to thank NA for and a lot of it was good for me. It was very important for making me believe in myself. To start finding ways to … what it is that makes things go overboard and … there are other ways than the dogmatic ones in AA. … It was like losing a big part of my family when I chose to leave – it was like leaving a Christian sect-like constellation. But I think that the path forward for me has been to take on board the understanding of myself that I gained in my treatment along with all that has happened and how I grew up and at the same time,

what NA gave me in terms of self-reflection … .I think it's about my attitude to life and that opening and contrast that I see; that's how I handled things then and I'm able to go back to my emotional state, how I handled reality, how I handled things. Today, I can still end up in the same emotional state – that it's hard - but I see other solutions. It's about getting through it and creating what it is you want and this is sometimes hard, sometimes easy.

Interviewer: The NA concept was important back then, helpful. Would you still agree with that picture?

Absolutely. It was like a crutch during a shaky start, when I was really vulnerable. You change your life and your perception of reality completely. If you have people in the same situation, fighting for the same things and sharing, this is a crutch. (IP21, W)

IP 7 above believed that she might have managed to recover from her AOD problems even without the 12-step treatment and AA/NA groups. In contrast, IP 21 stressed that NA was central to how she built up an ability to believe in herself. Both IPs described how the process of questioning the AA/NA perspective required a great deal of strength and effort, and that it was a painful process. Both described how they drank alcohol socially. However, not staying sober was not the main reason for distancing themselves from AA/NA communities. The central reason was that they felt that the principles of the communities no longer conformed with how they identified themselves. This identity conflict is maybe why the break was so painful.

Recovery no longer included in the identity

The IPs in the third sub-theme no longer identified themselves as having AOD problems but this process was not described as painful. Nor did they perceive their identity as conflicting with the AA/NA philosophy; they simply no longer needed support from self-help groups since AOD problems were something they had put behind them:

Interviewer: What was important with the meetings?

Meeting people who were drug free; it was fun to hear their stories. Now I don't need meetings. I don't have a drug problem, don't have cravings. As soon as I've earned some money, I go travelling, I go for a week's holiday. (IP2, M)

Interviewer: How do you manage to stay away, or isn't that relevant anymore?

(I) work, take care of the family, spend time with normal friends. I don't go looking for it. I don't want that life, I've had it. … I drink beer on special occasions, but not very often. Maybe once every second month, if that.

Interviewer: So, you've put it behind you. Do you feel far removed from it?

I don't want it. If I wanted it, I could just make a call but I don't want it. I'm not tempted. I did some laboring and then retrained as a crane operator. I really like it and I have paid my debts to the Enforcement Authority. I still have some other debts, but I have a repayment plan. In a few years maybe, I'll be able to take out a loan and buy a house. (IP3, M)

In the first interview, IP 2 described how he had lived a marginalized life with drugs for 18 years before he began his recovery process. In the second interview, these problems were no longer part of his identity. IP 3 also had a long history of AOD problems. They both went through 12-step treatment and frequently attended AA/NA meetings after that. One difference between them was that during the interview five years ago, IP 3 described the break with his criminal identity as the hardest part. IP 2, who had also served several prison sentences, mainly described himself as struggling with an identity change in relation to his AOD problem. In the second interview, however, they both stressed that they no longer identified themselves as someone who related to these problems. This process happened without any period of conflict, criticism or struggle, and they explained that they simply got on with living their lives. Thus, the main difference between the process described by IP 2 and IP 3, and that of IP 7 and IP 21 described above was that the latter experienced the self-help group perspective as conflicting with their internal sense of self (Who am I?) while the identity change described by the former was more external (My problems with crime and AODs are over but I am very much the same as a person). Hence, the former did not need the support of self-help groups anymore but did not need to redefine their former problems or their identity.

Discussion

The results of the study adhere to the recovery paradigm, which challenges the conceptualization of addiction as a biologically driven phenomenon (e.g. Heather et al., 2018, p. 250). The results suggest that recovery processes from AOD-related problems are diverse in both length and character, and that AOD problems can be a symptom of other issues. The results also show that recovery processes are heterogeneous in terms of the issues they raise around identity change and sobriety.

All the IPs in this study had gone through a 12-step-inspired treatment. In addition, all were sober just after the end of the treatment and positive about the perspectives communicated to them in the AA/NA communities. They often continued to attend both during and after their treatment. Although all the IPs had continued their recovery over the next five years, their recovery paths and how they identified themselves in relation to their AOD problems had taken different directions. Thus, many of the IPs described their recovery in the broader sense defined by Ashford et al. (2019), which ranges from abstinence to moderation. Some IPs perceived themselves as no longer in recovery (Kelly et al., 2018).

For some individuals in the study, the concept of AA/NA suited their identity and they intensified their involvement or continued to attend meetings, in line with the pathways of recovery reported by Laudet et al. (2002). Others no longer attended meetings but, as Kaskutas et al. (2007) suggests, this was not a sign of disidentification (Howard, 2008) but rather that the perspective had been internalized in their identity. Thus, the narrative strategies provided by AA/NA (Irvine, 1999) were used to shape their recovery identity.

It is not possible to identify the reasons for the differences between the paths chosen by the IPs. However, the mere presence of differences suggests that along with a continuing

recovery process, individual agency is also growing. Even if during the first interview the IPs described vastly different social situations on entering treatment, they had in common that they did not believe that they were capable of dealing with their AOD problems on their own. Thus, they were in this sense vulnerable and had limited trust in their own agency. Now, five years later, their decision to stay in the 12-step movement or to internalize the perspective might be based to a greater extent on them identifying their own perceptions of their AOD problems. This is also what Gordon and Willig (2020) found when interviewing people in recovery who were active members of AA/NA groups. The interviewees constructed themselves as exercising agency in consciously and self-reflexively taking up a position within the AA/NA discourse.

The results of the present study support previous research suggesting that for many the recovery process is accompanied by an identity change (Biernacki, 1986; Best et al., 2016; Dekkers et al., 2020; McIntosh & McKeganey, 2000). However, temporal aspects add nuance to the view that identity change means replacing an identity as an 'addict' with a new identity. Although early recovery (Betty Ford Institute Consensus Panel, 2007) for the IPs in the present study was expressed in terms of an identity as a 'former addict', which Ebaugh (1988) describes as an 'ex'-identity related to the former status, the results suggest that for some individuals the process involved continuing the identity change and questioning or leaving behind the identity of a former addict or dependent person. Thus, labels such as dependent or former addict can be perceived as both a relief and a barrier (Howard, 2006). Some of the interviewees perceived an identity of being in recovery and defined as dependent as limiting. For the subgroup of IPs who questioned and replaced the recovery identity, the process had many similarities with the descriptions in Howard's study of people who had chosen to renounce an identification with a former emotional disorder (Howard, 2008). As in Howard's study, the process was described a disidentification process involving some sort of tension and questioning of identification in relation to former AOD problems. However, this tension was not experienced by all the IPs who argued that AOD problems were no longer a central part of their identity. For some, the change in relation to their former problems was described as a struggle but once this struggle was over, the problems with AOD were something they were able to leave behind without any of the above conflict and tension – a process similar to the process of maturing out described in Winnick (1962).

As in previous research (Martinelli et al., 2020), experience of mental health issues was common among the interviewees. While the identity of being in recovery was related to AOD problems for those in the first theme and this was not the central part of the identity for those in the second theme, some in the latter theme related the recovery identity to mental health. This is in line with research that indicates that individuals reporting both mental health and AOD problems describe their recovery process from AOD problems as something with a possible ending, while mental health problems to a larger extent are referred to as something you have to learn to handle, and as being a part of your identity at least for a longer period of time (Skogens et al., 2018). Thus, those who identified their AOD problems as related to mental health problems perceived that they had recovered *from* their AOD problems, as defined by the amelioration of symptoms (Davidson & Roe, 2007), sometimes to the extent of allowing unproblematic drinking. Their recovery process with regard to mental health issues was more like the concept of being in recovery or, as Davidson and Roe (2007) defines it, recovery *in*, referring to the process of living one's life in the presence of a vulnerability and using your own resources to cope with this.

Research on recovery processes underlines that such processes take time and involve areas beyond the specific problem (i.e. Best et al., 2018, Martinelli et al., 2020). The findings of this study support this. However, the results also suggest that the focus on recovery as a process can lead to stagnation in a continuous recovery stage, which is a hindrance to putting a problem behind you and getting on with life, as well as to other processes of change that might be more important to the individual. This was most salient when it came to dealing with mental health issues. In addition, some IPs simply stated that the AOD-related problems were problems they used to have but did not have anymore (Kelly et al., 2018). Thus, an identity that includes a completed recovery process from AOD problems could encompass identification with recovery from other serious problems, but individuals might also perceive their recovery process to be complete and no longer part of their identity even without relating the former AOD problems to mental health issues. Change processes that are perceived as central to or important in the IPs life are not necessarily related to severe problems, but might simply concern 'ordinary' life issues. In the study, this appears to be related, among other things, to becoming a parent, paying off debts or other changes in life circumstances. Thus, attention should be paid to both subjective and temporal aspects when investigating recovery processes for different problems.

Limitations

Women are overrepresented in the present study, which could mean that the results are more applicable to women. For example, the descriptions of change processes being more painful and 'conflictual' were predominantly expressed by women, while those who described that they left their AOD problems behind in an uncomplicated way were men. This particular difference may also be linked to age as these women were younger. Gender differences will need to be further investigated as the qualitative approach in the present study did not allow for gender comparisons. The IPs in the study had all gone through the 12-step treatment with a positive outcome. They are therefore a selected group. However, since the entire group was positive about the 12-step concept five years before, this selection implies a strength in the conclusions on recovery as an individual identity process that varies over time.

Conclusions

The multitude of recovery processes described by the IPs in the study underline the need for acceptance of and respect for individual identity processes. Furthermore, it is important to support individuals' own perceptions of how their recovery process should best be outlined. These results should be interpreted not as a critique of the 12-step treatment or the AA/NA philosophy, but as a demonstration of the need for variety over time in the support and treatment options available for people in need of assistance with AOD problems. This underlines the importance of trusting and involving the individuals own agency and perspective in professional support for AOD problems. At the same time, it is salient to recognize the vulnerability that often accompanies individuals seeking professional help and support for their problems. These aspects can be balanced by including the individual in for example, the process of treatment choice. An important task for the professional in this process might be to offer transparent and informative available scientific knowledge in terms of the risks and possibilities of other treatment goals than sobriety.

Notes

1. Usually by weekly follow-up in individual or group meetings with treatment staff.
2. Women predominated because of the focus on women in the second segment of the initial projects.
3. Self-reported AOD problems at treatment intake: alcohol $n = 14$ (30%); drugs $n = 8$ (17%); polydrug $n = 25$ (53%).

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