*Tales of hope: Social identity and learning lessons from others in Alcoholics Anonymous: A test of the Social Identity Model of Cessation Maintenance.*

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## Abstract

Social identities can facilitate positive recovery outcomes for people overcoming addiction. However, the mechanism through which such protective effects emerge are unclear. The social identity model of cessation maintenance posits that one such process may be contextualisation (the creation of meaning around relevant future events and actions which act in a protective fashion). The current paper tested the role of contextualisation by exploring the role of a common feature of addiction meetings, the sharing of a personal recovery story. Data were collected from an online sample of 170 members of Alcoholics Anonymous [AA] (mean age 45.4 years, 50% male). Participants rated their social identification with AA before reading an archetypal tale of hope. They then completed measures of contextualisation (the perceived self-relevance and utility of the tale) and measures of perceived quit efficacy and costs of relapse to self and others. Identity, relevance and utility positively related to quit efficacy and perceived cost of relapse to the self. High identification with AA was also related to higher story relevance and utility. However, no mediation relationship between identity and efficacy via story relevance or utility was observed. Perceived cost to self increased in line with identity, with an additional joint indirect mediation of social identity via both meditators. These findings provide a clear pattern of results linking identity to contextualisation (story relevance and utility) and contextualisation to outcome measures. They also support the role of contextualisation as an important component of group processes more generally.

Keywords: *identity; recovery story; alcoholics anonymous; relapse; efficacy*

# Tales of hope: The effects of shared social identity on learning lessons from others in Alcoholics Anonymous: A test of the Social Identity Model of Cessation Maintenance.

An emerging body of work provides support for the notion that social identities (aspects of the self that are associated with social groups or categories, see Tajfel and Turner, 1979) may be important for addiction recovery. However, the mechanisms which underpin the effects of social identity in this area are relatively under-researched. The current paper aims to explore the role of one potential mechanism, *contextualisation* (the creation of meaning around events which act in a protective fashion), using hypotheses generated from the Social Identity Model of Cessation Maintenance (SIMCM; see Frings & Albery, 2015; 2017)

### Social identity and addiction

In the field of addiction recovery, social identity has been linked to more positive outcomes in various domains. For instance, social connections with a higher percentage of non-using others is related to better post treatment/cessation outcomes for people facing substance addictions, including alcohol and other drugs (i.e. Best et al., 2016; Bliuc, Best, & Beckwith, 2017). However, evidence also suggests that there may be particular psychological processes associated with identities *specifically* connected to being ‘in recovery’ (or being an ex-…, or similar). Buckingham, Frings and Albery (2013) measured levels of social identity amongst groups of people seeking non-residential treatment to stop an addictive behaviour (members of Alcoholic Anonymous and/or Narcotics Anonymous and smokers). Greater identification with, and preference for being in recovery/an ex-smoker (relative to being an active addict/smoker) was linked to fewer lapses in the recent past. These factors were also linked to increased confidence (efficacy) about future cessation maintenance. Amongst a residential treatment sample, differences in addict and non-addict identities increased over time, with greater differences prospectively predicting treatment success (Dingle, Stark, Cruwys, & Best, 2015). Similarly, Beckwith, Best, Dingle, Perryman and Lubman (2015) observed identifying with a treatment community (and decreasing identity with being a user) during early stages of recovery positively predicted treatment retention. Although there is a growing recognition that social identity is a vital aspect of the ‘recovery journey’ and an important predictor of success, little work has directly investigated the processes which underpin such protective properties. Some potential factors of relevance are highlighted in the SIMCM.

### The social identity model of cessation maintenance

SIMCM argues that identities function to help people maintain their recovery through a variety of processes (see Figure 1). These are hypothesised to have both explicit (conscious/reflective) and implicit (automatic) aspects (see Frings & Albery (2017) for a full exposition). Briefly, SIMCM argues that the effects of social identities associated with recovery will only occur to the extent to which the identity is accessible at a social cognitive level (i.e. is ‘activated’) (signified by the vertical line from the ‘Social cognitive moderators’ box in Figure 1). The ease with which this activation occurs is thought to be dependent in part upon the level of complexity and accessibility of the identity. SIMCM posits that membership of groups such as the Fellowships (i.e. Alcoholics\Gamblers\ Narcotics Anonymous) and other treatment groups is one form of activity which can generate an identity (i.e. as a recovering alcoholic, or a member of an Alcoholics Anonymous group). Once such identities are generated (by this, or other means) their effects are mediated by social identity and cognitive processes. For example, once an identity is activated, individuals sees themselves as possessing more of the attributes they perceive to be typical to the group (see Turner et al., 1987 for an in-depth discussion of such self-categorisation effects). In the context of AA, such attributes include, amongst others, feeling efficacious in quit attempts, being increasingly resilient, and recognising the cost of relapse to both the self and others (Buckingham et al., 2013; Frings, Collins, Long, Pinto, & Albery, 2016). Interacting with these self-categorisation effects, other group based factors also promote cessation (Kelly, 2017). These include processes such as social support and control and the opportunity for positive differentiation between the ingroup and outgroups (see Frings et al., 2016). The focus of the current paper is SIMCM’s prediction that higher levels of social identity associated with recovery lead to a different understanding of what recovery journey experiences mean, how they relate to both quit efficacy (the belief one can maintain one’s cessation) and the perceived negative impacts of relapse on both the self and others – a process SIMCM refers to as *contextualisation*.

### A screenshot of a cell phone  Description generated with high confidence

### Figure 1: The social identity model of cessation maintenance (Frings & Albery, 2017).

### The role of contextualisation

How we understand the causes, wider meaning and effects of our behaviour is an important driver of our decision making. Perspectives such as the health belief model (Janz & Becker, 1984), protection motivation theory (Maddux & Rogers, 1983) and the prototype willingness model (Gerrard, Gibbons, Houlihan, Stock, & Pomery, 2008) consider such evaluations (known as *expectancy-outcome evaluations*) as a direct driver of intention and subsequent behaviour (see Abraham & Sheeran, 2013; Mullan, Norman, Boer, & Seydel, 1996). These processes also seem to operate in the domain of addiction. For example, fiscal incentivisation of abstinence (e.g. providing payments for quitting and maintaining abstinence) has been shown to reduce smoke quit failure amongst pregnant women (Tappin et al., 2015). Events which force a reconceptualization of the meaning of one’s behaviour (such as highlighting or representing oneself being ‘addicted’ or an ‘addict’, or making the harm to others especially salient) can also trigger attempts to engage in abstinence or harm reduction attempts, or increase resolve to maintain such attempts (Dingle, Cruwys, & Frings, 2015; Meijer, Gebhardt, Dijkstra, Willemsen, & Van Laar, 2015). In a sample of SMART[[1]](#footnote-1) and Fellowship group members, higher levels of identity with the group were directly associated with higher perceived costs of a relapse to the self and to the group (Frings et al., 2016). In a group setting, the current paper (and SIMCM) refers to these processes broadly as *contextualisation* (as they provide meaning around events which are potentially protective). Although previous work in this area (see above) hints at the importance of contextualisation, no research to date has identified any specific process (or ‘active ingredient’, see Moos, 2007) which may encourage beneficial contextualisation of addiction related behaviours in group contexts. The current paper aims to explore the role of one common feature of fellowship meetings – shared narratives – as a vehicle for identity-driven contextualisation.

### Tales of hope and self-categorisation

The telling of, and listening to, life stories and narratives is a powerful tool used in many therapeutic contexts. Sharing stories which contain a cautionary message and, often, a solution to a problem or way out of a difficult situation is a common activity in Fellowship meetings, and an important part of the movement’s ‘Big Book’ (Alcoholics Anonymous, 2001). Such anti-drug narratives comprise stories, morals, lessons and reflections which can assist people to learn by other’s experiences (see Banerjee & Greene, 2012). In the current study, we refer to such narratives as *tales of hope*, but similar concepts are also referred to in treatment contexts as ‘narratives of redemption / recovery’ or ‘shares’. Similar to narratives shared in other domains, tales of hope are told through the lens of present circumstance, and link past experience with future aspirations (Adams, 2008; Järvinen, 2004; Mead, Murphy, & Dewey, 1934). They are a social, interactional, event - affecting (and being affected by) the social context they are recounted in (Järvinen & Ravn, 2015). They can also be considered as ‘tools to understand, negotiate, and make sense of situations we encounter’ (Adams, 2008, pg. 175; see also McAdams & Guo, 2015, for more on life narration) *.* Finally, they are a way of understanding the relationship between the self, addiction and self-control (or lack thereof) (Bailey, 2005; Davies, 1992, 1998)*.*

In the context of AA, we argue that tales of hope can provide a positive vision of the future, aspirational goals and bring events such as relapse into a socially shared narrative (Banerjee & Greene, 2012; Jensen, 2000; Kaskutas et al., 2005). From a SIMCM perspective, one protective function such tales of hope may have is to contextualise what a relapse will mean in terms of cost to the self and others. For example, tales of hope often highlight the personal costs of lapsing (i.e. spoiled relationships, loss of abstinence). They may bring to one’s attention the cost of relapse to significant social others such friends, family, and the fellowship group itself. As such they may be a protective ‘active ingredient’ of AA membership.

Tales of hope may be seen as more or less self-relevant to different group members. It is also possible that the more self-relevant tales are perceived to be, the more useful their content is perceived as being in helping one’s own recovery (a concept we here term as *utility*). SIMCM is based on the social identity perspective (e.g. Jetten, Haslam, & Haslam, 2012; Tajfel & Turner, 1979) which argues that identity is context dependent, and that the specific self which guides behaviour can range from individual (‘self as I’) to group based (‘self as group member’). A key psychological process in SCT is *ingroup homogeneity* – when group members, in particular high identifiers, perceive themselves as more similar to (and interchangeable with) other group members (Mullen & Hu, 1989). In the context of the current study, this provides a basis for the prediction that the more strongly an individual identifies with a group, the more they should see stories shared by a group member as self-relevant, and the more they feel the message will assist their own recovery maintenance. Such messages should influence outcomes which predict future cessation maintenance, such as quit efficacy and cost of future relapse to the self and the group (see e.g. Buckingham et al., 2013; Frings et al., 2016). Thus, we predict a mediation model, outlined in Figure 2, in which identity relates to how relevant and useful a story is (which we here term perceived story *relevance* and *utility* respectively), and all three factors relate to outcomes. Specifically, we predicted that higher levels of social identification with AA would relate to increased perceived relevance and utility of a tale of hope, and that these relationships would mediate a positive relationship between social identification and (i) perceived cost of relapse and (ii) quit efficacy.

Figure 2: Proposed mediation model

The aims of the current study were to test the links between social identity as an AA member and perceived self-relevance of tales of hope and also between all these factors and well-established proxy variables for cessation maintenance (perceived quit efficacy and perceived cost of relapse to the self and groups, (i.e. Buckingham et al., 2013; Gulliver, Hughes, Solomon, & Dey, 2006; Miller, Westerberg, Harris, & Tonigan, 1996). This was achieved by measuring these variables cross-sectionally amongst an online sample of AA members.

## Materials and methods

### Participants

Participants were recruited using a snowball methodology. An initial call for participants to take part in a short study exploring the psychological underpinnings of AA were placed on two relevant ‘reddit’ forums, on one of the author’s psychology-based blog and via online social networks (Facebook and Twitter). The calls included a request to forward to interested parties. These calls were subsequently reposted to other channels by other people. A sample of 237 members of Alcoholics Anonymous was recruited. Of these, 170 completed the survey fully and were included in the final analysis. The mean age of the final sample ranged from 19-71 years (*M* = 45.40, *SD* = 13.21). Eighty-five (50%) were male, 84 (49.4%) female and one participant (0.6%) self-reported as female-to-male. These participants reported attending between 0 to 50 AA meetings in a usual month (*M* = 13.13, *SD* = 8.68). They reported their current quit attempt length to be between 0 and 500 months (*M*= 92.85, *SD* = 112.42) and between 0 and 999 prior quit attempts (*M* = 21.57, *SD* = 97.55)[[2]](#footnote-2).

### Design

A cross-sectional design was adopted. Measured variables included AA social identity, perceived relevance and perceived utility of a tale of hope, quit efficacy and perceived cost of relapse to self and others.

### Materials

*Social identity*. Level of identification with AA was measured using the multi-component in-group identification scale (Leach et al., 2008). This fourteen item scale has items related to solidarity with the group (i.e. ‘I feel a bond with AA’), satisfaction (‘I am glad to be an AA member’), centrality (‘The fact I am an AA member is an important part of my identity’), self-stereotyping (‘I have a lot in common with the average AA member’) and ingroup heterogeneity (‘AA members have a lot in common with each other’). All items are recorded on seven-point Likert scales, anchored 1 (*Very strongly disagree)* and 7 (*Very strongly agree)*). In the current study, internal reliability for this scale was good (Cronbach’s α = 0.94).

*Tale of hope****.*** An archetypal tale of hope was generated by an experienced alcohol treatment clinician, with consultation with AA members. The tale can be seen in the supplementary materials[[3]](#footnote-3).

*Personal relevance.* Personal relevance was measured using 4 items, all rated on seven-point Likert-type scales (1 = *Very strongly disagree*, 7 = *Very strongly agree*). The items were ‘This story has strong similarities with my own experience.’, ‘This story is directly relevant to me’, ‘This story struck a chord with me’ and ‘I am able to identify a lot with the character in this story’. Internal reliability for this variable was good (Cronbach’s α =.94). A mean score was calculated, with higher scores representing greater relevance.[[4]](#footnote-4)

Tale utility scale. The level of personal utility participants perceived in the tale of hope was measured with 5 items, using the same anchors as the personal relevance scale. The items were ‘This story has taught me lessons about my own experience’, ‘I can apply lessons from the current story to myself’, ’Hearing this story is likely to be beneficial to my own recovery’, ‘I can take at least one thing away from this story which will be useful’ and ‘This story has made me think about how I should behave in the future.’ Internal reliability for this variable was good (Cronbach’s α = .93). A mean score was calculated, with higher scores representing greater utility.

 Quit efficacy. Perceived quit efficacy was measured using an established scale (Buckingham et al., 2013) consisting of four items (‘I can remain abstinent’,’ I can manage my addiction’, ‘It is unlikely that I will remain alcohol free’ (reverse scored) and ‘I think I can achieve recovery’ using the same 7 point scales as personal relevance. Internal reliability for this variable was low but acceptable (Cronbach’s α = .58). Removing one item (I can manage my addiction) improved this marginally to .60. A mean score was calculated, with higher scores representing greater efficacy.

Perceived cost. The cost of a relapse on self and others was measured in the same way as in Frings et al., (2016). Each dimension was measured on 7-point scales (1 = *Not at all*, 7 = *Very much*) by asking participants to ‘*Imagine you suffered a ‘lapse’ (a short return to your drinking) next week. How much do you think it would have a negative impact on the factors below*. The items were each presented twice, targeting firstly the self and then the group. The items were ‘Negative to [yourself / other group’s members]’, ‘Harmful to [yourself / your group members]’, ‘A costly problem for [yourself / for the group]’. Internal reliabilities for both scales were good (Cronbach’s αs => .86). For each scale, a mean score was calculated, with higher scores representing greater perceived cost.

### Procedure.

Upon being directed to the website, participants gave informed consent, and completed the measures in the order described above, before answering demographic questions. Finally, they were thanked for their time and debriefed.

## Results

To examine the relationships between social identity, perceived story relevance and utility and outcome measures (quit efficacy, cost to self/group) zero order Pearson’s correlations were undertaken (See Table 1 for full details, alongside mean values and standard deviations for all variables). Social identification with AA was positively related to perceived story relevance and utility, quit efficacy and perceived cost to self. Story relevance was related to story utility, quit efficacy and perceived cost to self. Story utility also correlated positively with quit efficacy and cost to self. Between subject t-tests revealed no differences in these variables according to gender (*p*s >.23)

Table 1

Descriptive statistics and Pearson’s r correlations between measured variables.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Measure | Mean (SD) | 1 | 2 | 3 | 4 | 5 | 6 |
| 1. Social Identity | 5.60 (1.19) | - |  |  |  |  |  |
| 2. Perceived story relevance  | 4.80 (1.68) | .317\*\* | - |  |  |  |  |
| 3. Perceived story utility | 4.56 (1.63) | .301\*\* | .603\*\* | - |  |  |  |
| 4. Quit efficacy | 5.79 (1.17) | .322\*\* | .161\* | .167\* | - |  |  |
| 5. Perceived cost to self | 6.64 (1.04) | .185\* | .209\*\* | .244\*\* | .220\*\* | - |  |
| 6. Perceived cost to group | 3.67 (1.87) | .103 | .066 | .093 | .127 | .284\*\* | - |

*Note.* N = 170. \**p* < .05, two-tailed. \*\**p* < .01, two-tailed.

### Meditation analysis

The zero order correlations gave us confidence to proceed to test our mediation analysis with quit efficacy and cost to self as outcome measures, using the Process model (Hayes, 2013). For each model, model 4 (mediation) was selected, with social identity as the predictor, and perceived story relevance and utility as mediators. In each case, 5000 bootstrap samples were taken, and 95% confidence intervals tested. Coefficient values for each path in these models (and indirect effects) can be seen in Table 2 and 3. For both models, we also tested the effect of adding length of current quit attempt (see Buckingham et al., 2013). The pattern of results between these models and those not containing a covariate did not differ.

#### *Quit efficacy model*. The overall model was significant, *R*2 = .11, *F*(3,166) = 6.83, *p* = .002. Social identity was positively related to efficacy, perceived story relevance and perceived story utility. Neither perceived story relevance nor utility related to efficacy, and no indirect effects of identity were observed.

Table 2:
Quit efficacy mediation model statistics.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Path tested* | *Co-efficient value (standard error)* | *t* | *p* | *CIs (upper, lower)* |
| ID->Efficacy | 0.27 (.73) | 3.77 | <.001 | 0.13, 0.42 |
| ID->Relevance | 0.45 (.10) | 4.33 | <.001 | 0.24, 0.65 |
| ID -> Utility | 0.41 (.10) | 4.10 | <.001 | 0.21, 0.61 |
| Relevance-> Efficacy | 0.22 (.06) | 0.35 | .725 | -0.10, 0.14 |
| Utility-> Efficacy | 0.04 (.64) | 0.63 | .527 | -0.09, 0.17 |
| ID-> Relevance-> Efficacy | 0.01 (.03) | -- | -- | -0.05, 0.68 |
| ID-> Utility-> Efficacy | 0.02 (.03) | -- | -- | -0.03, 0.98 |
| Combined indirect effect | 0.03 (.03) | -- | -- | -0.03, 0.09 |

*Note:* Pathways tested can be seen in Figure 2. Confidence intervals (*CI*s) indicate upper/lower 95% confidence intervals of the respective path’s coefficient.

#### *Cost to self model.* The overall model was significant, *R*2 = .08, *F*(3,166) = 4.58, *p* = .004. Social identity was positively related to efficacy, perceived story relevance and perceived story utility. Neither perceived story relevance nor utility related to efficacy, and neither indirect effects of social identity was independently observed. However, the combined positive indirect effect of identity on cost to self via both mediators was significant.

Table 3:

Cost to self-mediation model statistics

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Path tested* | *Co-efficient value (standard error)* | *t* | *p* | *CIs (upper, lower)* |
| ID->Efficacy | 0.10 (.07) | 1.41 | .160 | -0.04, 0.23 |
| ID->Relevance | 0.45 (.10) | 4.33 | <.001 | 0.24, 0.65 |
| ID -> Utility | 0.41 (.10) | 4.10 | <.001 | 0.21, 0.61 |
| Relevance-> Efficacy | 0.05 (.06) | 0.77 | .443 | -0.07, 0.16 |
| Utility-> Efficacy | 0.11 (.06) | 1.78 | .081 | -0.01, 0.22 |
| ID-> Relevance-> Efficacy | 0.02 (.02) | -- | -- | -0.02, 0.08 |
| ID-> Utility-> Efficacy | 0.04 (.03) | -- | -- | 0.01, 0.13 |
| Combined indirect effect | 0.06 (.04) | -- | -- | 0.01, 0.16 |

*Note:* Pathways tested can be seen in Figure 2. Confidence intervals (*CI*s) indicate upper/lower 95% confidence intervals of the respective path’s coefficient.

## Discussion

Although the relationship between identification with the recovery related social category and positive cessation outcomes is increasingly well documented, little research has directly investigated which processes may underpin this observation. The current study aimed to test a prediction generated by the social identity model of cessation maintenance (Frings & Albery, 2015; 2017) that the *contextualisation* of experiences may be a protective factor associated with identifying with a treatment group (in this case, AA). It was hypothesised that the more people identified with being an AA member, the more relevant they should see an archetypal ‘tale of hope’ and the more they feel they can use the information and lessons learned in their own recovery. We also predicted that such story relevance and utility should mediate the relationship between identity and relevant health outcomes (quit efficacy, and the perceived cost of relapse to self and others).

The findings of the study partially support these hypotheses. Both levels of identity, perceived relevance and utility both had significant positive relationships with quit efficacy and with perceived cost of relapse to the self. High identification with being an AA member was also related to how relevant the story was perceived to be and the extent which it had utility. However, no mediation relationship was observed. In relation to perceived cost to self, the same zero order effects were present (and cost to self itself linked to efficacy). In addition, an overall indirect effect of identity on cost to self, via story relevance and utility was observed. No effects were observed linking identity to cost to others. Taken together, these findings partially support SIMCM – a clear pattern of results linking identity to contextualisation (story relevance and utility), and contextualisation to established proxies of recovery outcomes was observed. However, the findings also present further questions – the lack of clear mediation observed in the current study suggests that links between identity and active ingredients such as contextualisation may themselves be moderated by other factors. The identification and testing of these present a good target for new research which could refine SIMCM.

The findings also differ slightly from those observed in previous research in this area investigating the link between identity and the perceived cost of relapse to the group. For instance, the other work has shown that high levels of identity link to both high costs to the self and the group (Frings et al., 2016). In the current study, cost to the group was not directly linked to identity.

There are several limitations of the current research which present opportunities for future work in this area. Sampling in the current study was self-selecting. The snowball methodology used provided a large sample of a hard to reach population, but this technique may also mean that some sub-populations were not invited to take part. These could include those who choose not to use online groups, or perhaps those who use forums associated with a different profile of user (for example, younger vs. older members). However, it is worth noting the range of time in AA was very broad in the current sample, suggesting generalisability on that dimension, if not across the full member profile. The nature of the sample may also explain the relatively low internal reliability of our efficacy scale - internalisation of ideas around control of addictive behaviours may lead to differential responses towards some items (i.e. ‘I can manage my addiction’, which may conflict with AA concepts around ‘being powerless over alcohol’) relative to others (i.e. ’I think I can achieve recovery, which is not’). One interesting question in the current study is the extent to which the differences in scale reliability between this sample and others (i.e. Buckingham et al., 2012) could be explained by length of time in AA, or other factors. For instance, future research could explore how endorsement of AA norms vary within individuals over time, and how this links to identity change.

 It is also possible that the effects of identity on factors such as contextualisation and quit efficacy may change over the duration of membership. Although this question is outside the scope of the current study, and analysis in this vein was precluded by the sample size, it would be interesting to explore if the meaning of ‘being a member of AA’ changes over the long-term recovery journey. Future research could, for example, explore both the changing intensity of AA involvement (i.e. number of meetings attended a week/month) and how extensive its impact is (i.e. the range of activities which people feel their identity is relevant to). In the present study, the diversity of membership lengths can also be seen as a strength as it suggests that these effects do, to some extent, hold across a long period.

The current study anticipated the effects of identity on efficacy and cost to be mediated by the perceived utility and relevance of the tale. The individual, zero order, correlations between these variables were generally as expected for both quit efficacy and cost to self. However, we did not find the expected mediation for quit efficacy and we also observed only joint indirect effect for cost the self. This lack of full mediation may be explained by relatively high covariance between our two mediators (which reduces the maximum unique variance available in a predictive model) or it could reflect other unmeasured variables which impact these relationships. Examination of the 95% confidence intervals for indirect effects suggest that a small reduction in covariance may have led to significant mediation, but this remains an open question the current study. However, the current study did establish statistically significant relationships between each step of the proposed mediation. An important additional consideration is that cross-sectional mediation models do not differentiate between uni- and bi-directional relationships between variables. While SIMCM (perhaps pragmatically) suggests that social identification drives group processes, it is also likely that such processes reinforce identity reciprocally.

The current study also did not show any relationship between identity and the cost to the group of a relapse (as in Frings et al., 2016). Although contrary to our expectations, this distinction between individual and group processes is also reflected in the literature to the extent that effects of individual level perceptions of efficacy are consistently reported, whilst group level efficacy is not. This is an important question for future research.

A number of possible moderators of the current effects could be envisaged. Sharing tales of hope may also be a different experience when it occurs in a real-life meeting, as opposed to an online survey. For instance, the effects may interact with heightened arousal, increased self-categorisation and monitoring others behaviour all of which are associated with being physically co-present with other group members (Abrams, Hopthrow, Hulbert, & Frings, 2006; Guerin, 1986; Turner et al., 1987). Equally, the message source may also be important. Stories relayed by more senior group members may well be seen as having greater utility than those made by very new members (whose stories could perhaps serve a more socialising function). This could be due to the content (reflecting a longer recovery journey to draw on) or message source effects (e.g. Chaiken, 1980; Chaiken, Liberman, & Eagly, 1989). Story repetition may reduce impact (generating ‘I’ve heard it all before’ responses), or familiarity could also serve to strengthen the effects. In addition, some stories will be similar to the listeners’ actual experiences than others, which may impact their effects on utility and relevance. The effects of sharing ones’ own story may also differ from listening to one. This could be compounded by altering the content of the narrative – not all stories in AA are ‘tales of hope ‘as defined in the current paper - some may focus more on negative (or, perhaps, positive) experiences, without other themes (such as the future) being prominent. Both the message and delivery of a given story will likely affect how it received. Finally, alongside the effects observed in the current study, storytelling may reinforce identity by acting as public signal of authentic membership of the group and a public endorsement of normative group narratives.

The current work also concentrated on the effects of identity with the treatment group but did not consider social connections with the wider world - especially with other people who are not involved in addictive behaviours. Models such as the social identity model of recovery (SIMOR, Best et al., 2016) suggest that such social connections are highly important. SIMCM argues that one way in which such social connections have an effect on recovery outcomes is through contextualisation. Examples of this form of contextualisation may include people displaying normative behaviours in relation to problematic behaviour which is different from individuals using problematically (i.e. moderate drinking, or abstaining), and also by providing alternative ‘ways to behave’ which are more effective and protective (alternative leisure activities for example). Future work testing the role of these possible processes in a broader non-addiction related setting would help refine both SIMCM and SIMOR.

As we wished to investigate the effects of identity per se in a way which could be generalised with other research both within and beyond the field of addition, we chose not to use instruments optimised for AA populations (i.e. AA Affiliation Scale or Kelly's Commitment to Sobriety Scale; Humphreys, Kaskutas, & Weisner, 1998; Kelly & Greene, 2014). Rather, we used established scales drawn from the broader social psychological literature. Although this approach may not capture as fine-grained variance as would deploying specifically designed tools, they conceptually tap into the same constructs. Furthermore, we would tentatively argue that using more generic scales increases the generalisability of our effects (i.e. to other treatment modes) and potentially allows for more direct comparison of addiction identity effects with other domains. We also focussed on efficacy and perceived cost to groups, rather than behavioural outcomes such as actual lapses (either self-reported retrospectively or independently measured prospectively). Although intentions and efficacy do not completely co-vary with actual behaviour we argue these measures are useful in the current context. Indeed previous work has shown correlations between health related efficacy and subsequent behaviours generally - for instance in the Health Action Process Approach model (HAPA; Schwarzer, 2008) - and within the addiction literature efficacy has been robustly linked with retrospective reports of lapse and prospective predictors of abstinence in various domains (e.g. Buckingham et al., 2013; Gulliver et al., 2006; Miller et al., 1996).

The current research did not consider factors which may predict identity and could conceivably interact with the identity/contextualisation link. For instance, recent research has suggested that people are more likely to maintain group memberships dependent upon their pattern of anxious and avoidant attachment types (Marshall, Albery, & Frings, 2018). The opportunity to help others (which may be a function sharing stories fulfils) has also been shown to be important in fellowship settings (Hutchinson, Cox, & Frings, in press). We also adopted a design which, in line with other work described above, did not employ repeated measures (i.e. recorded efficacy before and after the tale was presented). However, it also runs the risk of generating significant demand characteristics (to the extent that it highlights to participants that change in a variable is important). Given the limited number of scales we could include in the current study and maintain participant engagement, we would not have been able to adequately camouflage a repeated measures scale and deemed a single measurement was appropriate. However, this approach, combined with a cross-sectional / non-experimental design does mean that it is impossible to demonstrate causational relationships between our variables. In a similar vein, as in any cross-sectional study, alternative arrangements of variables (as predictors, meditators, outcomes, moderators, moderated meditators etc) are possible. In the current study we tested fit against an a-priori conceptual model but did not test other alternatives. This analysis decision reflected a desire to minimise familywise type 1 error rates and subsequent (mis)interpretations.

The findings have a number of theoretical and applied implications. Theoretically formalising a concept of contextualisation as the creation of meaning around events and behaviours provides a way to differentiate these types of effects from other group-based effects observed both within and beyond the field of addiction. These include processes such as increases in self-esteem (i.e. Jetten et al., 2015), perceived behavioural control and positive attributions (i.e. Buckingham et al., 2013; Greenaway et al., 2015) and social support (i.e. Frings et al., 2016; Haslam, O’Brien, Jetten, Vormedal, & Penna, 2005). Although these factors are likely to be highly interactive, and perhaps impossible to disentangle fully, the concept of contextualisation highlights the importance of re-defining the meaning of *events* and *future actions*, as opposed to factors which affect immediate psychological states. The findings also show partial support for SIMCM’s assertion that one of the important elements of social identity is the contextualisation of experience (here, reading a tale of hope), which seem to be more meaningful to high identifying participants. In the current study contextualisation was linked with greater confidence in maintaining sobriety. This provides support for the role of contextualisation, and future research could expand on this aspect by examining which features of tales of hope are causational, whether the ‘dose’ is important (i.e. perhaps the number of repetitions driven in part by the length of time people have been attending AA), and scoping which other forms of contextualisation may be present. It could also examine other ways through which contextualisation occurs.

Although this research is not mature enough to make specific recommendations about group facilitation, it does confirm the assumption that inclusion of story sharing should be considered as part of a toolkit for group treatment facilitators and begins to outline the processes which underpin the effects of such ‘meaning making’. Furthermore, it also suggests that sharing stories is particularly impactful upon people who identify strongly with the group, suggesting that generating a sense of identity should be a priority when considering the conduct of groups.

In conclusion, the current study suggests that social identities linked with recovery may be operating in part because they have contextualised the meaning of participating in addictive behaviour. When sharing of stories which contain advice and lessons, group members may be providing, and receiving important guidance and normative behavioural standards which are protective in nature.

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Appendix: Tale of hope

‘I started drinking a couple of nights a week which progressed onto drinking every night a week mainly to de-stress after work and to be able to cope with seeing my partner and children after a long day of work. The weekends would be a little more flexible as I would be able to drink during the day as we usually had alcohol with all our meals. As the years went on I found myself getting more stressed with work and irritated with life so that I felt like I NEEDED to have a daily drink, this is when I started drinking spirits as they were stronger and I received the effects of these quicker. I started mixing the spirit with a mixer and then this progressed onto drinking these neat for again a quicker effect. I would no longer use a glass to pour my spirit in; I would drink out of the bottle. I would no longer take sips from the bottle, I would start to gulp my drink as fast as I could. This would leave me in a state of unconsciousness and I would often wake up and not know how I had gotten there. I would lie to my family about my drinking and I would hide/ stash bottles of drink around the house so nobody could get to them. I would use chewing gum, mints, mouthwash, garlic and spicy foods to mask the smell of the alcohol on my breath and eye drops to mask my bloody shot eyes. I stopped going to work as I would drink on shift, I stopped showering, brushing my teeth and stopped getting dressed in the day. I even wet myself. My partner and children had enough and left me and this gave me more of an excuse to drink. My friends didn’t want to know me anymore as they were fed up of looking after me, my elderly parents were worried sick to the point they were getting ill themselves. I had lost everyone and everything around me. I was desperate for help so I got in touch with a drug and alcohol service and I started to attend therapy sessions. It was really good speaking to others in my area that had similar problems as I did who managed to stay sober. I continued to go to therapy groups, I even went to AA meetings, my relationships were building with my family and friends and I even went back to work. Life was good. Life was so good I thought I was ‘cured’; I thought it would be ok to have one small drink, so I did. I started having one small drink on an occasion and believed I could now control my alcohol consumption. I started to have one small drink a week which turned into a drink a day and then I was back drinking just as much or more than what I was drinking before recovery. Everything crumbled, my friends and family did not want to know me anymore and I had lost my job once again. I was completely and utterly depressed and would blame my drinking on the depression but it was the drinking that caused my depression in the first place. I knew I couldn’t go on like this; I was going to either die an alcoholic death or end up committing suicide. I went back to the organization and I received help. I am now sober and have been for 1 year now. I still get as much help as I need and will try and work on myself everyday to be the best partner and parent I can be. I don’t use alcohol to get me through the days anymore and I certainly don’t feel like I need to. I have different ways of coping now. I can truly say I can live life on life’s terms without picking up a drink or a drug and that’s a miracle for someone like me. ‘

1. Self Management And Recovery Training: A cognitive-behavioural, secular alternative to the Fellowship model, see Horvath (2000). [↑](#footnote-ref-1)
2. One participant reported 999 quit attempts. Although one option would be to assume this was an erroneous response, it is also possible that, contextualised within AA, a response of 999 could be meaningful. When removing this participant, quit efficacy ranged from 0-100, with a mean of 12.52, and a standard deviation of 24.40. [↑](#footnote-ref-2)
3. Although different individuals will likely respond to different tales and narratives, we used only one tale to minimise burden on participants. In the design of the tale we attempted to capture generic themes which occur often in AA settings (see Davies, 1992, 1998)) [↑](#footnote-ref-3)
4. An oblimin factor analysis was conducted on all story relevance and utility items. Another item, ‘If I reflect on this story, it will help me better understand myself was also included in the questionnaire. Two factors were identified, the first with an eigenvalue of 6.55, the second with 1.45 (third factor eigen value = 0.43). The rotated structure matrix revealed all variables loaded highly onto one or other factor. In each case, the higher loading was > .86, with a loading of <.50 on the other, with the exception of the ‘reflection item’ which loaded 0.77/0.80 respectively (as such was discarded from inclusion in the final scales). Items were placed into the scales outlined in the main text of the basis of highest loadings. [↑](#footnote-ref-4)