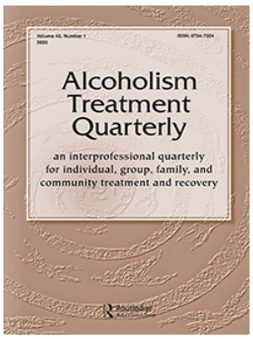

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Shaking off the Invisibility Cloak in Alcohol Use Disorder: A Foucauldian Discourse Analysis of Stigma and Negotiating Identity in Abstinence

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ABSTRACT

Although many studies on mental health stigma have been conducted, stigma and Alcohol Use Disorder (AUD) remains an under-researched area. This study sought to explore how participants manage a stigmatized identity, and which processes are involved in this. A small sample of male ($n = 5$) and female ($n = 1$) participants who had previously attended alcohol recovery services and had abstained for a minimum of 12 months were interviewed. The data was analyzed using Foucauldian Discourse Analysis (FDA) to explore how they positioned themselves within discourses of addiction and recovery. By using Identity Processes Theory (IPT) as a framework, it was possible to examine identity threats experienced by participants and how they mitigated identity threats. Analysis of the data revealed three themes: ambivalence, coping as "old me" and coping as "new me." There was no one-size-fits-all approach to managing identity for participants, however using FDA and IPT, identity threats that emerged from the assumptions of alcoholism were examined in addition to how stigmatization was experienced and mitigated by participants. These findings illustrate the complexity of processes involved in managing a stigmatized identity for those with AUD, and the need for further research.

KEYWORDS

Alcohol abstinence; identity processes theory; foucauldian discourse analysis; stigma

Introduction

Problem drinking is attributed to 5.3%, or approximately three million deaths worldwide, according to the World Health Organization (2022). Public Health England (2023b) estimate that the total number of deaths caused solely by alcohol has increased by 89% in the past twenty years, with a 20% rise in the year 2020. These deaths disproportionately affect the most deprived communities, with the number of deaths five times higher here than in the most affluent areas (Public Health England, 2016). Scores from The Alcohol Use Disorders Identification Test (AUDIT) questionnaire, a screening tool to assess problem drinking, indicate that 1% of adults are potentially alcohol dependent in the UK (NHS England, 2024); with just 84,697 in treatment (Public Health England, 2023a). AUD not

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only has health implications, but also social implications, which can prevent individuals with AUD seeking treatment.

Stigma

One of the most significant barriers for treatment-seeking in AUD is the stigma surrounding it (Hammarlund et al., 2018; Keyes et al., 2010; Mekonen et al., 2021). Stigma is a term that can be challenging to define. Link and Phelan (2001) define stigma in terms of interrelated factors,

> People distinguish and label human differences [. . .] dominant cultural beliefs link labeled persons to undesirable characteristics—to negative stereotypes. . . labeled persons are placed in distinct categories so as to accomplish some degree of separation of "us" from "them." [. . .] labeled persons experience status loss and discrimination that lead to unequal outcomes [. . .] stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination. [p. 367]

Stigma can fall into the category of "public," whereby stereotypes are placed upon individuals in the stigmatized group, resulting in prejudice and discrimination toward the group (P. W. Corrigan & Kosyluk, 2014), or "internalised," where people belonging to a stigmatized group take on the stereotypes and prejudices projected by the general population (Corrigan & Rao, 2012). Stigmatizers' aims involve exploitation, control, and exclusion in order to keep people "down," "in" or "away" (Link & Phelan, 2014). In the case of AUD, the stigma of the disorder may serve as one motive for discouraging individuals from violating societal norms, which include the ability to control one's drinking, however evidence suggests that this may fail or even backfire (Morris et al., 2024).

Those who are perceived to have problems controlling their alcohol consumption may be labeled (for example, as "alcoholic"). Although a lay notion of addiction continually changes according to social perspectives on morality and deviancy (Room, 1985), addiction has become associated with amorality (Bailey, 2005). Attached to this label are stereotypes, including that someone with AUD is unpredictable and responsible for their condition (Corrigan et al., 2016; Schomerus et al., 2011) as well as lacking in willpower (Hill & Leeming, 2014), including by healthcare professionals (Soh et al., 2019). Individuals with AUD being blamed for their condition results in so-called subtle prejudice, culminating in feelings of indifference toward this group, while blatant prejudice stems from a fear of unpredictability (Nieweglowski et al., 2018). Perpetuating this stigma is language like "alcoholic" and "alcohol abuser" resulting in greater explicit and implicit negative bias than person-first language such as "an individual with Alcohol Use Disorder" (Ashford et al., 2018). Although the use of the term "alcoholic" has decreased, it remains in 30–40% of research articles in the scientific community (Shi et al., 2022).

For individuals with AUD, the stigma does not end when they change their drinking or associated problems. While drinking alcohol is normative in many western societies, abstaining may also be considered deviant behavior (Paton-Simpson, 2001). The stigmatizing "alcoholic" identity can persist even in sobriety, with residual stigma evident (Heslin et al., 2012; Latner et al., 2012; Nieweglowski et al., 2018). The double deviancy of abstaining from alcohol as well as having previously possessed the "alcoholic" identity means that

those in recovery from AUD are among the most stigmatized, even years into sobriety. Such stigma and discrimination for those no longer drinking can lead to reluctance to disclose a non-drinking identity in order to avoid mockery, exclusion from social events or condemnation (Romo et al., 2016). Individuals whose recovery does not focus on abstinence also face stigma through the perceived deviancy of a non-abstinent recovery goal, highlighting the need for other recovery measures beyond drinking, which have been underlined (Votaw & Witkiewitz, 2023; Witkiewitz & Tucker, 2021).

Reviews comparing the stigma of AUD with that of psychiatric disorders, such as depression and schizophrenia, have established that those with AUD are regarded more negatively than those with any other mental health or medical problems (Kilian et al., 2021; Kummetat et al., 2022; Schomerus et al., 2011). Despite growing endorsement of AUD as a disease, in order to reduce the level of blame apportioned to those with AUD, a decrease in stigma has not been detected (Pescosolido et al., 2010; Schomerus et al., 2014). Since stigma is one of the main barriers to treatment-seeking and is linked with lower confidence in maintaining one's recovery (Keyes et al., 2010; May et al., 2019), it is an area that merits further research.

It is important to recognize various definitions of recovery. The United Kingdom Drug Policy Commission suggests recovery to be: "voluntarily sustained control over substance use which maximises health and well-being and participation in the rights, roles, and responsibilities of society" (2008, p. 6), while many other definitions position recovery as centered around maintenance of abstinence from alcohol (Witkiewitz, 2020). Though these definitions focus on external behaviors, they miss the key internal processes involved and how individuals cope with the ongoing stigma surrounding AUD. Ultimately, the crucial element of recovery, according to research, is the personal transformation that occurs; for those in recovery from AUD, the importance of a valued identity is clear. Research has identified that individuals recovering from AUD avoid felt stigma by creating new identities for themselves (Heslin et al., 2012; Hill & Leeming, 2014; Romo & Obiol, 2023), separating the former "unaware" drinking self from the current sober self. Best et al. (2016) highlight the positive impact on selfhood from the creation of a new recovery-based social identity. However, this does not inform how individuals cope with stigma outside of recovery-oriented groups. Breakwell's (1986) Identity Process Theory (IPT) offers a lens through which to explore such threatened identities, allowing for a nuanced approach to processes involved in identity transformation.

Identity Processes Theory (IPT)

According to Breakwell (1986), identity is conceptualized as a "dynamic social product" (1986, p. 9). Thus, rather than identity as something we "are," it is something we "do." This does not mean that the physical being is not a key contributor to identity, Breakwell (1986) contends that one's sex, race, and physical capability are the foundation of identity. However, the salience of the physical being decreases as other identity facets develop.

The IPT model identifies three core processes: assimilation, accommodation, and evaluation. Assimilation involves integrating new elements supplied by the social world into one's identity structure, while accommodation is adjusting the current identity structure in order to allow for the new elements to fit. Evaluation involves ascribing a value and meaning to the content of identity, which is determined by

social values. Breakwell (1986) does not differentiate social and personal identity and instead proposes that as individuals navigate different social roles, assuming the social identity related to each one, they layer these social identities. Personal identity is the result of this layering of social identities, comprising each assimilation and accommodation of the social identities. Since many recovery definitions include abstaining from alcohol, for those in recovery, changes in the value placed on abstinence are a key element of the recovery process, along with the assimilation/accommodation of a nondrinker identity.

Breakwell further contends that there are three main principles, or ideal end states, for identity: distinctiveness, continuity, and self-esteem (1986). The later addition of self-efficacy (Bandura, 1997) and belonging (Jaspal & Breakwell, 2014) should also be noted. Identity threats transpire when the processes of identity cannot comply with the principles of identity. Such a threat could arise internally; whereby a person pursues the adjustment of their place in the social matrix to satisfy one of the identity principles, which then jeopardizes a different principle. Membership of a new social group, for example, could enhance self-esteem but challenge the principle of continuity since continuity relates to seeing oneself as congruent across time. In the context of AUD, threats to identity are something that individuals must negotiate as part of their transformation since a social identity as a nondrinker must be assimilated and accommodated into their identity structure. Such perceived identity threats result in the deployment of threat-management coping strategies (Breakwell, 1986), which can be intrapsychic (denial, for example) in nature, intergroup (joining a recovery-based social group) or interpersonal (passing as part of a non-stigmatized group). However, Breakwell (1986) is explicit in the implications of strategies such as passing as leading to a sense of disequilibrium on an intrapsychic level. Therefore, the interpersonal strategies may not fully address the sense of identity threat. While a discredited or discrediting stigma is visible or apparent, the stigma of AUD is not, making it a discreditable stigma (Goffman, 1963). It is therefore possible to employ interpersonal strategies such as passing as a member of a non-stigmatized group; that of someone who is able to control their alcohol intake, as well as intrapsychic and intergroup strategies.

Discursive approach

Although Breakwell's model focuses heavily on internal process, there is an argument that suggests that examining identity as discursive practices is warranted. Coyle (2007) argues that examining identity from a discursive lens is beneficial, specifically when using Discursive Psychology and Foucauldian Discourse Analysis (FDA) as these approaches argue that talk is action and that they capture the "doing" of identity as opposed to the "being" of identity. As Breakwell theorizes that identity is "done," this suggests that it is a product that is enacted by the individual. Therefore, to explore negotiating one's identity in light of the stigma attached to addiction, and potential situational identity threats, an FDA approach will be used here. Furthermore, as most research focuses on addiction or relapse rates, this research offers an insight into the identity of individuals in recovery, and the challenges they face on an intrapsychic and interpersonal level.

Materials and methods

Design

Scholars have proposed the sharing of more humanizing narratives of those with lived experience of AUD (Hill & Leeming, 2014; McCartney, 2022), and in particular conducting qualitative studies to explore how individuals manage their identities in relation to stigma (Meisenbach, 2010). Although arguments have been made for the use of more naturally occurring data than that of semi-structured interviews, if it is acknowledged that identities are not merely internal processes but are enacted in social settings, which indicates the appropriateness of this method and approach.

Given that AUD is stigmatized in society, it is appropriate to examine the power structures apparent in discourses of addiction. Using FDA will enable the focus to be on the discourses available to the participants when negotiating their identity as a stigmatized group member, to examine how participants manage their identities, which are neither of person in active addiction nor a non-addicted individual.

Participants

There were six participants who had at least one year of abstinence. Such a period of abstinence was chosen for the inclusion criteria since this is classed as "sustained" remission from AUD (DSM–5; American Psychiatric Association, 2013), which suggests increased stability for participants. A mental health diagnosis in the past three months was also included in exclusion criteria, with diagnoses beyond this time considered as being managed. Due to the complexity of the potential sample, and to respect the confidentiality and agency of participants, a "snowballing" technique was used to recruit six people, who were provided with the researchers university and work contact information. Demographics of participants are provided in Table 1.

Materials

A research schedule was used and interviews were recorded and transcribed using MS Teams for online interviews and using an encrypted Dictaphone for in-person interviews. Participants were provided with a research information form, invitation to participate form, an informed consent form and a debriefing form.

Table 1. Demographics of participants.

Name	Gender	Age	Years of abstinence
Jessie	female	31	4
John	male	69	20
Rupert	male	70	3
Jim	male	31	1
Toby	male	57	23
Matilda	male	45	2

Procedure

Participants contacted the researcher via the university to express an interest in the study. Once written consent was obtained from online participants, an interview time was arranged, and participants met with the researcher either at the local drug and alcohol service or on MS Teams. Interviews lasted between 21 and 49 minutes with a mean length of 32:43. After the interview, participants were verbally debriefed and provided with a debrief form (either via e-mail or a paper version), detailing how to withdraw from the study.

Analytic strategy

Once all the interviews were completed, they were transcribed verbatim. Each interview was read through at least three times, to gain familiarity with each transcript, and sections regarded as particularly relevant to the research question were highlighted. The transcripts were subsequently coded, and codes were grouped into four main themes, which then merged into three. Main themes were divided into subthemes, and pertinent extracts were identified for analysis. Each individual extract was analyzed in this manner. Discursive objects within the extracts were highlighted, and notes were made on discursive resources used by speakers and how these contributed to the action orientation of each participant. The subject position was then identified for each extract and appropriate terminology was found to label the discourses. Finally, the purpose of the subject position in relation to managing identity was analyzed.

Although most participants identified as former "alcoholics," this report uses person-first language (e.g. "a person with AUD," "a person in recovery") in order to avoid perpetuating stigmatizing attitudes that arise from identity-first language (e.g. "an alcoholic") (Ashford et al., 2018). Where the term "alcoholic' is used, this is done to denote the discursive object rather than to label the individuals to whom the object refers.

Ethical considerations

Before commencing this research project, the British Psychological Society's (British Psychological Society BPS, 2009) code of conduct and ethical guidelines for conducting psychological research were reviewed by the researcher. The researcher was granted approval to conduct this study by The University of Derby's Ethics Committee.

Results

Participants were found to use all three coping strategies outlined by Breakwell (1986) to manage the stigma of AUD. Intrapsychic strategies such as reframing and acceptance were employed, while intergroup strategies such as joining recovery-based social groups (e.g. Alcoholics Anonymous) were also used. There was also evidence of distancing as posited by Haughton (2022) who identified that denial as Breakwell contends (1986) was not always possible, but distancing from stereotypes can be utilized. In terms of interpersonal strategies, participants managed disclosure of a former AUD identity in different ways, with some individuals exercising caution about self-disclosure and some openly disclosing it.

Theme one – ambivalence

Rather than being constructed in binary terms, ambivalence to change appeared on a continuum, both in terms of the amount of ambivalence, and in terms of time. While some participants constructed themselves in biomedical discourses, with a subject position of "passive patient" seen in health discourses (Mosher & Danoff-Burg, 2009), involving a requirement to accept care from those in the subject position of "experts;" for others ambivalence was sustained even after making the decision to cease drinking.

> Jessie: I didn't want to go, to be honest. It was very much my parents who were the only ones that were talking to me at the time, who kind of ushered me down there . . . (lines 176–178)

This discourse, regarding Jessie's decision to go to rehab, positions her as a passive patient, going along with the wishes of others; her parents. Jessie uses the qualifier "very much" to emphasize a lack of agency. Being "ushered" by her parents calls upon the repertoire of parents always wanting what is best for their child, and also puts Jessie in the subject position of being a "good" daughter by complying with this act. Jim also constructs his decision as having been influenced by other people:

> Jim: I didn't really want to stop drinking, umm I recognized it would be good if I could for a bit umm and so I went to rehab on the advice of other people. (lines 47–48)

The use of the word "good" here denotes a discourse of healthism, in which good health is favored (Crawford, 1980), so Jim is constructing himself as a responsible citizen; someone who shows self-discipline by paying attention to health. Both Jessie and Jim construct themselves as needing to relinquish control or agency to external "expert" sources in order to regain self-control.

While not every participant constructed experiences mirroring hegemonic discourses of "rock bottom," each person had a turning point, aligning with findings from AA members on "a range of bottoms" (Young, 2011), involving introspection. Here, Rupert reflects on receiving advice from a liaison officer while in custody, having been arrested for drink-driving:

> Rupert: he said, "you should go to the local drug and alcohol service, they're doing really good work." And I'd already been and walked away from that and thought "that's a load of shit." I didn't like that bastard cos he was covered in tattoos, and he was very very aggressive. (lines 168–172)

Rupert then describes his own turning point:

> . . . partly cos of the realisation that this is actually fucking ridiculous, you know. You are a reasonably educated person, you- you know. What the fuck are you doing? (lines 187–189)

Rupert's decision to stop drinking is constructed as a response to an event that poses a threat to his identity as a law-abiding citizen; being arrested. He constructs himself as being different from the workshop facilitator with "tattoos," drawing on a repertoire of tattoos indicating deviance, reinforced by the notion of being "covered" in them. Discourses of "control" (Reith, 2004) frame aggression as something to avoid. This, along with the double use of "very" to exacerbate how "aggressive" this individual was, positions Rupert as sensible for walking away from the support. Although being labeled as an "offender" aligns with stereotypes of those with AUD as criminals controlled by a need for their substance

(Nieweglowski et al., 2018), Rupert positions himself as having acted out of character, using the repertoire of educated people as morally "good," and therefore not "bad" criminals.

For Jessie, the turning point occurred in an AA meeting, when she realized she could switch from one group membership to another.

> Jessie: I just noticed the people on the left-hand side of the room were all really, really . . . it wasn't planned like this, but really het-up and debating every minute detail in this book . . . (lines 92–94)
>
> [. . .]
>
> . . . and don't get me wrong, like I agree with some of that stuff. But then when I looked at the other side of the room, and they were just getting on with their reading, and they weren't all . . . I couldn't see all their blood pressures all raised and getting all het-up and arguing about this, this and this. (lines 95–99)

Again, a discourse of a lack of control, characterized as being "het-up," is constructed as being problematic for Jessie. For Matilda, ambivalence continued even after making the decision to stop drinking and go to a rehabilitation facility.

> Matilda: Rehab was awful, I hated it. Every second of it. Horrific. Most horrific experience of my life. I couldn't stand it. I lasted a lot through grit. It was awful; they pull you apart to put you back together . . . (lines 95–99)

The "patient" discourse constructed here appears to contradict the others' constructions of themselves as welcoming interventions from "experts." In order to retain a sense of agency and self-efficacy, Matilda frames the medical interventions as something to endure, which does not align with repertoires of rehab as a pleasant experience where others take care of and "fix" those with AUD.

Theme two – coping as "old me"

One theme that emerged was how participants managed their identity, negotiating stereotypes of AUD and distancing themselves from such stereotypes while in active addiction. Dominant discourses portraying those with AUD as dysfunctional, unhygienic, and homeless allowed some participants to construct their own drinking as unproblematic whilst in active addiction, a kind of "valid denial" (Morris et al., 2020) which enabled participants to resist the loss of self-esteem of being in a stigmatized group.

> Toby: he staggers about, he gets a bit noisy. He lays on the floor, where he drops, he'll leave a mess where he's been. So, lose- all moral compass goes out of the window and doesn't give a flying about anything . . . (lines 20–22)
>
> [. . .]
>
> I do-so I naturally separate my-I was an alcoholic but separate myself from say the gentleman I just mentioned, I didn't roll about on the floor and . . . or did I? [laughs] But no, I don't think I did. I suppose I called myself a professional drinker, which [exhales] is the same as dependent drinker. (lines 26–29)

Here Toby uses an example of someone he knows to construct an archetypal, out of control "alcoholic," whilst creating distance between his own actions and those of "the

gentleman." A loss of control is constructed here as problematic and equated with a lack of morality with one's moral compass going "out the window." Toby's use of the discursive device "naturally," to indicate an uncontroversial opinion, one that anybody would make, highlights the distance he creates between his own former identity and that of "the gentleman." Constructing himself as a "professional" drinker allows Toby to position his drinking as non-problematic since he is still a functioning (working) member of society, dichotomizing his own drinking and that of "the gentleman."Similarly, Rupert constructs himself as a responsible person:

> Rupert: It wasn't me because I had money and I had a house and I had a career and all that kind of thing . . . (lines 82-83)
>
> I was confident, but I can't be an alcoholic, I'm going to the gym and I'm fit . . . (lines 140–141)

Once again, a discourse of functioning well, or "success," is used to place Rupert in the subject position of an individual in control, and prospering, defying a loss of self-efficacy. Constructing one's drinking as problem-free and othering irresponsible drinkers has been seen in many discourses on AUD (Macfarlane & Tuffin, 2010; Madden et al., 2019; Morris et al., 2022). Matilda also discusses the way in which being in possession of material goods facilitated the low problem recognition of his problematic drinking:

> . . . I thought well, having all the good things made it acceptable, made a difference, cos look what I've got! Look at the things, I can show you the things! And it made it, yeah it made me just forget about the bad bits and just focus on getting more bloody things, yeah. Yeah. (lines 376–385)

Matilda constructs himself as affluent and prosperous, in possession of "things" purchased thanks to a "successful career," in order to distance himself from the stereotypes of people with AUD being impoverished or incapable. Doing so allows Matilda to construct his drinking as unproblematic and resist a loss of self-efficacy.

Although most participants reported to have not experienced stigma when asked, examples of the stigma and discrimination experienced involved strangers, loved ones, doctors, and organizations, as well as self-stigma. One participant, Jessie, outlines her experience of enacted stigma from medical professionals:

> Jessie: I heard my consultant, say to a nurse, "Oh, is that the pisshead in bed six that I've got to go and see next?" And I walked back to- I didn't say anything I walked back to my bed. And that was that. (lines 349–351)
>
> . . . I do remember this appointment with another consultant and he sat there with his shoes off . . .
>
> I just thought that's very, I don't know, weird, unprofessional thing to do. Almost like this isn't real, this isn't a real consultation because she's just a, you know, whatever. (lines 396–401)

In both situations, Jessie constructed herself as a legitimate object of stigma, worthy of this kind of treatment. The additional element of being in the healthcare system and positioned as the passive patient who does not question the "expert" doctors adds another layer to this, demonstrating the power of dominant discourses portraying those with AUD as to blame, of bad character or of less value than others, and the self-stigmatization evident here.

In summary, participants drew upon repertoires of AUD, as people who are in poverty and living outside of mainstream society; "the deadbeats and the downtrodden" (John, line 9); "a street homeless person that's a bit smelly and no one really wants to talk to" (Jim, lines 153–154) and "drinking out of brown paper bags" (Rupert, line 32). This facilitated their constructions of their own drinking as unproblematic since this did not reflect their own experiences with alcohol. Participants accepted that the hegemonic social representation of alcohol addiction remains largely negative, and indifference toward AUD was a key feature of participants' talk; "providing it doesn't affect your life or your family, you don't give a shit" (Rupert lines 11–12). Such indifference, described as "subtle prejudice" (Nieweglowski et al., 2018), has been found to arise from seeing those with AUD as to blame for their disorder.

Theme three – coping as "new me"

Participants constructed their new identities as more positive than their former identities. Stigma was generally accepted as part of their identity, and social interactions managed in light of this. Reframing was used by some to cope with stigma, while for others a former AUD identity did not present a significant part of their identity. Subthemes include ongoing experience of stigma in abstinence, reframing AUD and a shift in social group membership. Enacted stigma by institutions was highlighted by participants. Here, Jessie discusses policing from the Driver and Vehicle Licensing Agency (DVLA):

> Jessie: . . . essentially, they remind me every year that I'm an alcoholic or that I was an alcoholic. They require a lot of information from me every single year, so they can reevaluate my driving license, and this has been going on for four or five years. (lines 323–325)

Notably, this is the only time during the interview that Jessie refers to herself as an "alcoholic" in the present tense, which may be a response to the DVLA's ongoing surveillance of her. Such surveillance relies on the notion that AUD is a chronically relapsing disorder. Toby also mentions an experience of felt stigma as an ongoing experience:

> Toby: You're treated different by say, when I went- I had to get life insurance for the pub. They wouldn't give it to me until I was two years clean and things and I had to go for tests and things . . . (lines 133–135)

Toby's experience again points to discourses of AUD as chronic, with people needing to "prove" their sobriety in order to receive the same treatment as non-stigmatized individuals. The word "clean" positions Toby as acceptable and reflects stereotypes of people with addiction as "dirty." In this case, the word clean does not refer to physical appearance, but a lack of substances inside the body, drawing on repertoires of addiction making people dirty both in terms of personal hygiene, and inside too; a much more profound message.

Most participants report being selective with whom they disclose their former AUD status, with some employing a humor shield as a buffer to ease the tension between them and non-stigmatized people. Matilda was the exception; constructing self-disclosure as a means of avoiding further questions, openly displaying his stigma and remaining indifferent to treatment as an out-group:

Matilda: Some people can be quite shocked. Umm, but people generally are alright. After- I think it shocks quite a lot of people and I don- [laughs] I quite like it cos it shuts 'em up [laughs]. So, to me I can just go "I'm an alcoholic" and they'll go [gasps], and then leave me be. So I'm like, ooh lovely, that works well. (lines 268–271)

Matilda uses the taboo of addiction to his own advantage; positioning himself as the one with the choice about creating distance; the reverse of common repertoires of stigma with the non-stigmatized individual being the one to recoil. Self-disclosure is constructed as a kind of test for Matilda to gauge whether the listener is "alright" with AUD or not. Again, this contrasts with dominant discourses and creates a role reversal of the non-stigmatized person evaluating the stigmatized individual.

Another strategy participants used to manage their identities is reframing addiction. For Toby and John, like participants in previous studies (Duff Gordon & Willig, 2021; Hill & Leeming, 2014), this meant constructing the addicted part of their identity as a separate entity to create distance between the former and current self:

> Toby: once you sort of say you don't want to do it, the bully side of it will disappear for a while because the nature of bullies is they sod off, but they will then endeavor to get you back, hook line and sinker at some point and they can be devious, it can be a scream in your face, a tap on the shoulder when you're feeling really good, when you're bad, when you're feeling angry, when you're anxious, when you're celebrating, any time. (lines 64–69)

> John: it's a monster hiding around every corner, it's out in the front garden doing fricking calisthenics, waiting for me to have a weak moment . . . (lines 17–19)

[. . .]

> you know, my disease hasn't gone away. I've just learned how to lasso that fucker and [chuckles] and rein it in in a little bit. (lines 185–186)

John positions himself as needing to self-police to avoid the "monster" escaping and running amok, while Toby places himself in the subject position of being the underdog; David, standing up to Goliath; the "bully." The use of the idiom "hook, line and sinker" serves to position Toby as a potential victim of deception by the "bully," reducing culpability. Like John, Toby constructs his addicted self as a predator, waiting to seduce its prey at any vulnerable moment, which confirms repertoires of addiction as a chronic disorder.

Although Toby personifies his addicted self, John constructs his as a dangerous animal needing to be constrained with a "lasso," placing him in the subject position of a jailer, keeping the prisoner (his addicted self) inside in order to protect others. Also noteworthy is the way John constructs his addicted self as physically strong, further highlighting the enormous task of keeping his "disease" at bay. In positioning themselves as susceptible to being overcome by the "monster" and "bully," Toby and John are positioned as needing to self-police. According to Foucault (1982), self-surveillance such as this puts the individual on both sides of the power dichotomy; both the subject and object of power. Jim and Jessie, meanwhile, report abstinence has given them the ability to reframe:

> Jim: I'm a bit more [pause] you know, I guess, aware that life isn't all just good. Like you make wrong decisions, and it doesn't mean you're a terrible person, you can sort of learn from them. (lines 90–92)

> Jessie: That just happens to be part of me. And I quite like that part of me, because it taught me a lot. (lines 434–435)

Both position themselves as having more awareness now; skills gained from AUD. This ability to see one's past alcohol misuse as a kind of blessing in disguise has been noted in other research exploring stigma management in AUD (Hill & Leeming, 2014; Romo & Obiol, 2023) and a distinction between "retributive self-blamers," who see themselves as unchanging, versus "scaffolding self-blamers," such as Jim and Jessie, who see themselves as capable of change, has been suggested by Snoek and colleagues (Snoek et al., 2021) As is often the case in "messy" discourse which can be full of contradictions (Potter & Wetherell, 1987), Toby constructs addiction through biomedical discourses, with the strength of the substance itself positioned as the reason for addiction:

> Toby: You've only at some point found a painkiller, if you like, for something, it's done you some-it's done something positive for you to at some point. Why be ashamed of that? The fact that it's gone out of control is the nature of the substance you've chose. And, like me, I discovered I had an addictive personality . . . (lines 105–108)

The use of the generalized pronoun "you" serves to normalize AUD; to construct it as something common in the general population, while the term "painkiller" draws on psychological discourses of addiction as emotional regulation, enabling Toby to evade responsibility for the stigma in addition to making sense of self-medication discourses. This consequently positions him as blameless and at the mercy of addictive substances. The essentialist repertoire of having an "addictive personality" positions addiction as inevitable, removing the question of choice in dominant discourses of addiction.

Toby goes on to say that his "addictive nature" still comes out: "I keep myself grounded by the fact I still will open a packet of biscuits and eat the lot. A family size bar of galaxy; I'll eat the lot. A family sized tub of ice cream; I'll eat the lot. I've got an addictive nature." (lines 174–176). This contrasts significantly with the aforementioned construction of the substance itself as addictive and calls upon hegemonic social representations of addiction as chronic, positioning Toby as needing to "feed" his addiction by other means.

Discussion

The aim of this project was to explore how individuals in recovery from AUD manage their identities to cope with the ongoing stigma of the disorder, even in abstinence. Foucault's (1979) phrase "where there is power, there is resistance" (p. 95) provides a relevant backdrop to the first theme identified within the data of this study. As perhaps one would expect in such a marginalized group, participants constructed their experiences as laden with ambivalence, which was the first theme identified. For some, the catalyst for change came as a result of going along with others' recommendations, resulting from the identity principle of belonging being met while in a rehabilitation facilitation, while one participant resisted input from "expert others" throughout a stay in a rehabilitation facility. In terms of "rock-bottom" hegemonic discourses, this was something not all participants constructed.

The second theme, coping as "old me," centered around participants' experiences of public and internalized stigma. Some participants called on discourses of AUD containing stereotypes to create distance between themselves and "problem drinkers." Although

Breakwell (1986) argues that denial is a salient intrapsychic strategy, it does not account for participants drawing on repertoires of addiction such as this. The discourses available to them involve drinking becoming problematic when one is unable to work, maintain personal hygiene and when one drinks on the street (Nieweglowski et al., 2018). Rather than denial, the coping strategy appears to be another form of resistance; distancing (Haughton, 2022).

The third, and final theme, focused on current coping strategies for dealing with stigma, titled coping as "new me." Notably, although all participants discussed positive feelings toward belonging to recovery-based communities, responses to disclosing a former AUD status were varied, with some participants showing extreme caution, others employing humor or privacy shields depending on the situation, and one in particular being completely open with it, showing indifference to the stigma. Notably, IPT does not account for openly displaying one's stigma as an interpersonal strategy.

Limitations of the study are mainly due to sampling. Snowball sampling was implemented, and it is noted that this is a relatively limited sample. A further limitation to the sample is the gender bias, which was weighted toward males, with only one female participant. This highlights a key area for future research, especially since 46% of AA members are female (Alcoholics Anonymous, 2022) and given the increased stigma toward women with AUD (Tyler et al., 2019).

Efforts should continue to be made to reduce the stigma of AUD, beginning with sharing stories from across the spectrum of individuals' lived experience (Gronholm et al., 2017; McCartney, 2022), including individuals whose recoveries involve a reduction rather than abstinence from alcohol. The continuous framing of AUD as personal responsibility by the alcohol industry (Maani Hessari & Petticrew, 2018) and "safe" drinking guidelines, which do not account for people who only drink at the weekend (such as Rupert, in this study) do little to reduce the stigma or encourage problem recognition among harmful drinkers.

Finally, research on stigma around addiction remains scant, especially when compared with the same research on stigma around mental illness. Nieweglowski and colleagues (2018) found over 1000 evidence-based studies on stigma and mental illness, while Corrigan and colleagues (Corrigan et al., 2017) found the number of studies on stigma in addiction to be far lower, with 243 papers, of which many were opinion papers rather than empirical research. If stigma is to be reduced, far more research is needed, to avoid research replicating the same indifference shown by so much of the public toward this issue. Although the study gained a limited sample, it has illustrated how the AUD recovery identity is contextually enacted, showing its complexity and the need for further research.

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References

Alcoholics Anonymous. (2022). *2022 membership survey*. https://www.alcoholics-anonymous.org.uk/download/1/Library/Documents/AA%20Surveys/AA-GSB-Membership-Survey-Pamphlet-2022-07.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.) https://doi.org/10.1176/appi.books.9780890425596

Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. *Drug & Alcohol Dependence*, *189*, 131–138. https://doi.org/10.1016/j.drugalcdep.2018.05.005

Bailey, L. (2005). Control and desire: The issue of identity in popular discourses of addiction. *Addiction Research & Theory*, *13*(6), 535–543. https://doi.org/10.1080/16066350500338195

Bandura, A. (1997). *Self-efficacy: The exercise of control*. Freeman.

Best, D., Beckwith, M., Haslam, C., Alexander Haslam, S., Jetten, J., Mawson, E., & Lubman, D. I. (2016). Overcoming alcohol and other drug addiction as a process of social identity transition: The social identity model of recovery (SIMOR). *Addiction Research & Theory*, *24*(2), 111–123. https://doi.org/10.3109/16066359.2015.1075980

Breakwell, G. M. (1986). *Coping with threatened identities* (1st ed.) Psychology Press. https://doi.org/10.4324/9781315733913

British Psychological Society. (2009). *Code of ethics and conduct*. The British Psychological Society.

Corrigan, P., Schomerus, G., Shuman, V., Kraus, D., Perlick, D., Harnish, A., Kulesza, M., Kane-Willis, K., Qin, S., & Smelson, D. (2017). Developing a research agenda for understanding the stigma of addictions part I: Lessons from the mental health stigma literature. *The American Journal on Addictions*, *26*(1), 59–66. https://doi.org/10.1111/ajad.12458

Corrigan, P. W., Bink, A. B., Schmidt, A., Jones, N., & Rüsch, N. (2016). What is the impact of self-stigma? Loss of self-respect and the "why try" effect. *Journal of Mental Health*, *25*(1), 10–15. https://doi.org/10.3109/09638237.2015.1021902

Corrigan, P. W., & Kosyluk, K. A. (2014). Mental illness stigma: Types, constructs, and vehicles for change. In P. W. Corrigan (Ed.), *The stigma of disease and disability: Understanding causes and overcoming injustices* (pp. 35–56). American Psychological Association. https://doi.org/10.1037/14297-003

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *The Canadian Journal of Psychiatry*, *57*(8), 464–469. https://doi.org/10.1177/070674371205700804

Coyle, A. (2007). Discourse analysis. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 98–116). Sage.

Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services: Planning, Administration, Evaluation*, *10*(3), 365–388. https://doi.org/10.2190/3H2H-3XJN-3KAY-G9NY

Duff Gordon, C., & Willig, C. (2021). Surrender to win: Constructions of 12-step recovery from alcoholism and drug addiction. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *25*(6), 651–668. https://doi.org/10.1177/1363459320912837

Foucault, M. (1979). *Discipline and punish: The birth of the prison*. Penguin Books.

Foucault, M. (1982). The subject and power. *Critical Inquiry*, *8*(4), 777–795. https://doi.org/10.1086/448181

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Penguin Books.

Gronholm, P. C., Henderson, C., Deb, T., & Thornicroft, G. (2017). Interventions to reduce discrimination and stigma: The state of the art. *Social Psychiatry & Psychiatric Epidemiology*, *52*(3), 249–258. https://doi.org/10.1007/s00127-017-1341-9

Hammarlund, R., Crapanzane, K. A., Luce, L., Mulligan, L., & Ward, K. M. (2018). Review of the effects of self-stigma and perceived social stigma on the treatment-seeking decisions of individuals with drug- and alcohol-use disorders. *Substance Abuse and Rehabilitation*, *23*(9), 115–136.

Haughton, M. J. (2022). *It's like, we're in Blackpool innit': A discourse analysis of identities of young women living in a deprived seaside town in North West England* [Doctoral Dissertation]. Lancaster University, Lancaster University Research Directory.

Heslin, K. C., Singzon, T., Aimiuwu, O., Sheridan, D., & Hamilton, A. (2012). From personal tragedy to personal challenge: Responses to stigma among sober living home residents and operators. *Sociology of Health & Illness*, *34*(3), 379–395. https://doi.org/10.1111/j.1467-9566.2011.01376.x

Hill, J. V., & Leeming, D. (2014). Reconstructing 'the alcoholic': Recovering from alcohol addiction and the stigma this entails. *International Journal of Mental Health and Addiction*, *12*(6), 759–771. https://doi.org/10.1007/s11469-014-9508-z

Jaspal, R., & Breakwell, G. (2014). *Identity process theory*. Cambridge University Press.

Keyes, K. M., Hatzenbuehler, M. L., McLaughlin, K. A., Link, B., Olfson, M., Grant, B. F., & Hasin, D. (2010). Stigma and treatment for alcohol disorders in the United States. *American Journal of Epidemiology*, *172*(12), 1364–1372. https://doi.org/10.1093/aje/kwq304

Kilian, C., Manthey, J., Carr, S., Hanschmidt, F., Rehm, J., Speerforck, S., & Schomerus, G. (2021). Stigmatization of people with alcohol use disorders: An updated systematic review of population studies. *Alcoholism, Clinical and Experimental Research*, *45*(5), 899–911. https://doi.org/10.1111/acer.14598

Kummetat, J. L., Leonhard, A., Manthey, J., Speerforck, S., & Schomerus, G. (2022). Understanding the association between alcohol stigma and alcohol consumption within Europe: A cross-sectional exploratory study. *European Addiction Research*, *28*(6), 442–450. https://doi.org/10.1159/000526200

Latner, J. D., Ebneter, D. S., & O'Brien, K. S. (2012). Residual obesity stigma: An experimental investigation of bias against obese and lean targets differing in weight-loss history. *Obesity*, *20*(10), 2035–2038. https://doi.org/10.1038/oby.2012.55

Link, B. G., & Phelan, J. (2014). Stigma power. *Social Science & Medicine*, *103*(1), 24–32. https://doi.org/10.1016/j.socscimed.2013.07.035

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Maani Hessari, N., & Petticrew, M. (2018). What does the alcohol industry mean by 'Responsible drinking'? A comparative analysis. *Journal of Public Health*, *40*(1), 90–97. https://doi.org/10.1093/pubmed/fdx040

Macfarlane, A., & Tuffin, K. (2010). Constructing the drinker in talk about alcoholics. *New Zealand Journal of Psychology*, *39*(3), 46.

Madden, M., Morris, S., Stewart, D., Atkin, K., Gough, B., McCambridge, J., & Francis, J. M. (2019). Conceptualising alcohol consumption in relation to long-term health conditions: Exploring risk in interviewee accounts of drinking and taking medications. *PLOS ONE*, *14*(11), e0224706. https://doi.org/10.1371/journal.pone.0224706

May, C., Nielsen, A. S., & Bilberg, R. (2019). Barriers to treatment for alcohol dependence. *Journal of Drug and Alcohol Research*, *8*, Artikel 236083. https://doi.org/10.4303/jdar/236083

McCartney, D. (2022). The role of peers in SUD stigma change: A personal perspective. In G. Schomerus & P. Corrigan (Eds.), *The stigma of substance use disorders* (pp. 193–212). Cambridge University Press. https://doi.org/10.1017/9781108936972.011

Meisenbach, R. J. (2010). Stigma management communication: A theory and agenda for applied research on how individuals manage moments of stigmatized identity. *Journal of Applied Communication Research*, *38*(3), 268–292. https://doi.org/10.1080/00909882.2010.490841

Mekonen, T., Chan, G. C. K., Connor, J., Hall, W., Hides, L., & Leung, J. (2021). Treatment rates for alcohol use disorders: A systematic review and meta-analysis. *Addiction*, *116*(10), 2617–2634. https://doi.org/10.1111/add.15357

Morris, J., Albery, I. P., Heather, N., & Moss, A. C. (2020). Continuum beliefs are associated with higher problem recognition than binary beliefs among harmful drinkers without addiction experience. *Addictive Behaviors*, *105*, 106292. https://doi.org/10.1016/j.addbeh.2020.106292

Morris, J., Cox, S., Moss, A. C., & Reavey, P. (2022). Drinkers like us? The availability of relatable drinking reduction narratives for people with alcohol use disorders. *Addiction Research & Theory*, *31*(1), 1–8. https://doi.org/10.1080/16066359.2022.2099544

Morris, J., Kummetat, J. L., & Schomerus, G. (2024). Can 'justified disapproval' be separated from addiction stigma? An empirical focus is required. *Addiction Research & Theory*, 1–10. https://doi.org/10.1080/16066359.2024.2394424

Mosher, C. E., & Danoff-Burg, S. (2009). Cancer patients vs. cancer survivors. *Journal of Language & Social Psychology*, *28*(1), 72–84.

NHS England. (2024). *Health survey for England, 2022 part 1*. https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2022-part-1

Nieweglowski, K., Corrigan, P. W., Tyas, T., Tooley, A., Dubke, R., Lara, J., Washington, L., Sayer, J., & Sheehan, L. (2018). Exploring the public stigma of substance use disorder through community-based participatory research. *Addiction Research & Theory*, *26*(4), 323–329. https://doi.org/10.1080/16066359.2017.1409890

Paton-Simpson, G. (2001). Socially obligatory drinking: A sociological analysis of norms governing minimum drinking levels. *Contemporary Drug Problems*, *28*(1), 133–177. https://doi.org/10.1177/009145090102800105

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *The American Journal of Psychiatry*, *167*(11), 1321–1330. https://doi.org/10.1176/appi.ajp.2010.09121743

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. Sage Publications.

Public Health England. (2016). *Health matters: Harmful drinking and alcohol dependence. House of commons committee of public accounts*. Retrieved November 16, 2023, from https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence#:~:text=Public%20Health%20England%20(%20PHE%20)%20wants,and%20alcohol%20dependence%20in%20adults

Public Health England. (2023a). Adult substance misuse treatment statistics 2021 to 2022: report. House of Commons Committee of Public Accounts. Retrieved November 16, 2023, from. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2021-to-2022/adult-substance-misuse-treatment-statistics-2021-to-2022-report

Public Health England. (2023b). *Alcohol treatment services [review of alcohol treatment services]. House of commons committee of public accounts*. Retrieved November 16, 2023, from https://committees.parliament.uk/publications/40045/documents/195525/default/

Reith, G. (2004). Consumption and its discontents: Addiction, identity, and the problems of freedom. *The British Journal of Sociology*, *55*(2), 283–300. https://doi.org/10.1111/j.1468-4446.2004.00019.x

Romo, L. K., Dinsmore, D. R., & Watterson, T. C. (2016). "Coming out" as an alcoholic: How former problem drinkers negotiate disclosure of their nondrinking identity. *Health Communication*, *31*(3), 336–345. https://doi.org/10.1080/10410236.2014.954090

Romo, L. K., & Obiol, M. E. (2023). How people in recovery manage the stigma of being an alcoholic. *Health Communication*, 1–11. https://doi.org/10.1080/10410236.2021.1983339

Room, R. (1985). Dependence and society. *British Journal of Addiction*, *80*(2), 133–139. https://doi.org/10.1111/j.1360-0443.1985.tb03263.x

Schomerus, G., Lucht, M., Holzinger, A., Matschinger, H., Carta, M. G., & Angermeyer, M. C. (2011). The stigma of alcohol dependence compared with other mental disorders: A review of population studies. *Alcohol & Alcoholism*, *46*(2), 105–112. https://doi.org/10.1093/alcalc/agq089

Schomerus, G., Matschinger, H., & Angermeyer, M. C. (2014). Attitudes towards alcohol dependence and affected individuals: Persistence of negative stereotypes and illness beliefs between 1990 and 2011. *European Addiction Research*, *20*(6), 293–299. https://doi.org/10.1159/000362407

Shi, H. D., McKee, S. A., & Cosgrove, K. P. (2022). Why language matters in alcohol research: Reducing stigma. *Alcoholism, Clinical and Experimental Research*, *46*(6), 1103–1109. https://doi.org/10.1111/acer.14840

Snoek, A., McGeer, V., Brandenburg, D., & Kennett, J. (2021). Managing shame and guilt in addiction: A pathway to recovery. *Addictive Behaviors*, *120*, 106954. https://doi.org/10.1016/j.addbeh.2021.106954

Soh, K. C., Lim, W. S., Cheang, K. M., & Chan, K. L. (2019). Stigma towards alcohol use disorder: Comparing healthcare workers with the general population. *General Hospital Psychiatry*, *58*, 39–44. https://doi.org/10.1016/j.genhosppsych.2019.01.001

Tyler, N., Miles, H. L., Karadag, B., & Rogers, G. (2019). An updated picture of the mental health needs of male and female prisoners in the UK: Prevalence, comorbidity, and gender differences. *Social Psychiatry & Psychiatric Epidemiology*, *54*(9), 1143–1152. https://doi.org/10.1007/s00127-019-01690-1

United Kingdom Drug Policy Commission. (2008). *Reducing drug use, reducing offending: Are programmes for problem drug-using offenders in the UK supported by the evidence?* The Stationary Office.

Votaw, V. R., & Witkiewitz, K. (2023). The clinical benefits of non-abstinent outcomes in alcohol use disorder treatment: Evidence from clinical trials and treatment implications. *Alcohol and Alcohol-Related Diseases*, 341–364. https://doi.org/10.1007/978-3-031-32483-3_20

Witkiewitz, K. (2020). What is recovery? *Alcohol Research: Current Reviews*, *40*(3). https://doi.org/10.35946/arcr.v40.3.01

Witkiewitz, K., & Tucker, J. A. (2021). Dynamic pathways to recovery from alcohol use disorder. In A. Tucker, Jalie, & K. Witkiewitz (Eds.), *Dynamic pathways to recovery from alcohol use disorder* (pp. 415–426). Cambridge University Press. https://doi.org/10.1017/9781108976213.030

World Health Organization. (2022, May 9). *Alcohol*. World Health Organisation. https://www.who.int/news-room/fact-sheets/detail/alcohol#:~:text=Worldwide%2C%203%20million%20deaths%20every

Young, L. B. (2011). Hitting bottom: Help seeking among alcoholics anonymous members. *Journal of Social Work Practice in the Addictions*, *11*(4), 321–335. https://doi.org/10.1080/1533256X.2011.618067