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How People in Recovery Manage the Stigma of Being an Alcoholic

Lynsey K. Romo and Mary E. Obiol

Department of Communication, North Carolina State University

ABSTRACT

Although stigma can jeopardize the recovery efforts of people who formerly misused substances, potentially leading to relapse, how people in recovery for alcoholism manage stigma has not been comprehensively or systematically examined. Using stigma management communication theory (SMC) and in-depth interviews of 22 adults in recovery, this investigation uncovered the six main strategies participants used to negotiate the stigma of being an alcoholic. Consistent with the tenets of SMC, interviewees *accepted, evaded responsibility for, reduced offensiveness of, avoided, denied,* and/or *ignored/displayed* the stigma, depending on whether they accepted or challenged that the stigma of being an alcoholic applied to themselves and/or the public's perception. Findings inform practical strategies to help individuals in recovery effectively manage stigma while sustaining their sobriety. The study also suggests ways programs such as Alcoholics Anonymous and treatment centers can use communication to break down recovery barriers.

Over 20 million Americans have a substance use disorder (Substance Abuse and Mental Health Services Administration, 2020). In addition to its health, economic, and interpersonal costs (e.g., National Institute on Alcohol Abuse and Alcoholism, 2021; National Institute on Drug Abuse, 2020), alcoholism and addiction are extremely stigmatized (e.g., Alcoholics Anonymous, 2001; Hammarlund et al., 2018; Schomerus, 2014). People who misuse substances are commonly blamed for their condition and viewed as dangerous (Corrigan et al., 2009; Schomerus et al., 2011), lacking willpower, and subjects of "moral condemnation" (Hill & Leeming, 2014, p. 769). Even their relatives experience courtesy stigma (O'Shay-Wallace, 2020). Stigma also poses a significant barrier to seeking or complying with treatment (e.g., Hammarlund et al., 2018; Saunders et al., 2006) because people do not want to admit they have a problem and be labeled an alcoholic or addict (National Center on Addiction and Substance Abuse, 2007).

Compounding matters, stigma persists even after substance misuse ends and is "what differentiates addiction from other diseases" (Ginspoon, 2018). Recovering alcoholics are particularly stigmatized (e.g., Romo, 2018; Romo et al., 2016), as their alcoholic identity and threat of relapse can follow them even after they become sober, resulting in residual stigma (e.g., Heslin et al., 2012; Romo & Campau, in press) and recidivism and performance concerns (Lublin, 2006). People in recovery experience enacted and felt stigma, including being excluded from social events, mocked, judged, looked down upon, feeling self-conscious, and reluctant to disclose their past for fear of professional repercussions (e.g., Romo et al., 2016). Stigma can also make it harder for people in recovery to seek social support (Hill & Leeming, 2014) and less confident in their ability to reject a drink (Schomerus et al., 2011). Indeed, felt stigma or shame about one's past problem drinking is associated with relapse (e.g., Randles & Tracy, 2013; Wiechelt & Sales, 2001). Stigma could not only explain why people are reluctant to quit using substances (Cunningham et al., 1993) but why sobriety is often temporary (e.g., Lilienfeld & Arkowitz, 2011; Stein & Forgoine, 2011) despite "more deaths, illness, and disabilities [resulting] from substance use than from any other preventable health condition" (National Institute on Drug Abuse, 2020). Despite these challenges, recovery is possible, with 10% of U.S. adults identifying as in recovery from substance misuse (Office of Alcoholism and Substance Abuse Services, 2012). While scholars (e.g., Meisenbach, 2010; Shih, 2004; Van Vliet, 2008) have urged for a better understanding of strategies people use to respond and become resilient to stigma, it is particularly important to examine how stigma affects people in recovery (Laudet & White, 2008; Schomerus et al., 2011), as the stigma they experience and internalize could jeopardize recovery efforts (e.g., McGaffin et al., 2013; Sawer et al., 2020; Schomerus, 2014). Thus, using the lens of stigma management communication theory (SMC; Meisenbach, 2010) and semi-structured interviews of adults in recovery, we sought to understand how people in recovery manage the stigma of being an alcoholic.

Stigma management communication theory

Stigma is an attribute that reflects a tainted and devalued identity that deviates from the norm (Goffman, 1963). A stigma that is discredited or discrediting is already known or obvious, whereas a discreditable stigma is unknown or unapparent (Goffman, 1963). Stigma comes from labeling differences and stereotyping undesirable characteristics, which then separates the stigmatized from the non-stigmatized and leads to status loss and discrimination of the lower power

CONTACT Lynsey K. Romo lkromo@ncsu.edu Department of Communication, North Carolina State University, 201 Winston Hall (Box 8104), Raleigh, NC 27695, USA

group (Link & Phelan, 2001, 2006). Stigma serves to keep people down (exploitation and domination), keep people in (norm violation), and keep people away (disease avoidance; Phelan et al., 2008). Stigma is associated with such negative outcomes as social rejection, withdrawal, hopelessness (Gray, 2002), and chronic stress (Link & Phelan, 2006). Additionally, people with stigmatized traits are at risk of self-isolating and/or becoming depressed, anxious, uncertain, or hostile (Goffman, 1963). Broadly, individuals can respond to stigma in such ways as correcting their failing; reframing the stigma as a blessing in disguise; and passing (Goffman, 1963). While such strategies provide useful insight into general stigma management, SMC (Meisenbach, 2010) offers a more comprehensive communication-based lens for applied research to understand how people manage their stigmatized identities.

Specifically, SMC posits that stigma management varies depending on the extent to which the stigmatized accepts or challenges the public understanding of the stigma (i.e., agrees with the status quo or seeks to change it) and accepts or challenges that the stigma applies to themselves. Meisenbach (2010) organizes stigma management into four quadrants with six corresponding strategies: accept public understanding of stigma/accept stigma applies to self (*accepting*); accept public understanding of stigma/challenge that stigma applies to self (*evading responsibility for; reducing offensiveness of*); challenge public understanding of stigma/accept that stigma applies to self (*avoiding*); and challenge public understanding of stigma/challenge that stigma applies to self (*denying; ignoring/displaying the stigma*). These strategies consist of 23 possible sub-strategies (see Appendix A). Scholars have applied SMC to a variety of stigmatized contexts ranging from burn survivors (Noltensmeyer & Meisenbach, 2016) and veterans with combat-related PTSD (Roscoe, 2021) to relatives of people who misuse substances (O'Shay-Wallace, 2020). Germane to our study, family members largely accepted courtesy stigma by hiding the substance misuse and avoiding the topic due to stigma concerns. Some accepted the stigma but attempted to challenge the public's perception of it by evading responsibility (e.g., making attributions for their family member's drug misuse), whereas others challenged the stigma's application to themselves and their family as well as the public's perception through denial (e.g., they were good parents and should not be stigmatized) and by ignoring/displaying courtesy stigma – not viewing themselves as stigmatized since they were not personally misusing substances (O'Shay-Wallace, 2020).

Although stigma management is fundamentally communicative (e.g., Smith, 2007) and communication scholars have examined stigma in a variety of contexts, including (non) disclosure of one's recovery (e.g., Romo & Campau, in press; Romo et al., 2016), stigma strategies have been "unorganized and partial" (Meisenbach, 2010, p. 273). Indeed, our examination of the recovery literature suggests individuals employ numerous stigma management strategies, although they are not explicitly labeled as such. We next review this literature and demonstrate how the integrated, comprehensive framework of SMC offers numerous strategies that shed light on vulnerability and resilience in the face of stigma-based threats (Meisenbach, 2010).

Review of the recovery literature

Substance misuse is considered a blemish of individual character (Goffman, 1963) that extends even into recovery. People in recovery for substance misuse manage stigma by carefully (a) weighing the risks of (non) disclosure of their recovery status, (b) seeking and providing social support, and (c) reframing their identity. First, as being a nondrinker in general (Romo, 2012), as well as abstaining from alcohol and other drugs because one is in recovery, are dual stigmatized conditions that are often discreditable, people in recovery must manage disclosure, determining to whom and when to reveal their alcoholic or addict status (e.g., Romo & Campau, in press; Romo et al., 2016). Although concealing a stigmatized identity has been associated with diminished physical and psychological quality of life (Quinn et al., 2017), participants in several studies (e.g., Romo, 2018; Romo & Campau, in press; Romo et al., 2016) chose to pass as "normal" (Goffman, 1963) when they perceived risks of "coming out" as a person in recovery were too personally or professionally great. Others chose to reveal their recovery status because they viewed the benefits of holding themselves accountable to their sobriety or helping or bonding with others outweighed the stigma risks, or because they were forced to disclose in a professional context (Romo et al., 2015, 2016).

Second, people in recovery have widely sought connection and fellowship from the recovery community to manage shame and stigma. Collegiate recovery programs and communities (e.g., Romo & Campau, in press) and Alcoholics Anonymous (AA) serve as major sources of caring and supportive relationships for people in recovery. AA is premised on fellowship with people in active addiction as well as in recovery, through a 12-step approach in which members share their experiences with others, turn to a higher power, and make amends for past wrongdoings (Alcoholics Anonymous, 2001). Helping others in recovery contributed more to staying sober than assisting others at home or work (Pagano et al., 2009), underscoring the importance of providing social support to sustain recovery (e.g., McIntosh & McKeganey, 2001). AA also provides a valuable outlet for members to confront and talk openly about stigma as well as shame with likeminded others (e.g., Vaillant, 2005; Yeh et al., 2008). Acceptance of shame is critical in facilitating self-forgiveness for people in recovery (McGaffin et al., 2013); indeed, "giving back" through participation in AA lessened the power of shame and helped people maintain their sobriety (Sawer et al., 2020).

Third, a fundamental tenet of recovery groups such as AA involves members, even after becoming sober, accepting and identifying themselves as an alcoholic or addict (Alcoholics Anonymous [AA], 2001) despite the stigma associated with those terms (Faces and Voices of Recovery, 2013; Trimpey, 1994). Part of negotiating stigma involves a person in recovery "crystallizing a new identity formed around esteem, capability, and feeling lovable and worthy" (Potter-Efron, 2002, p. 34). Hill and Leeming (2014) found people in recovery resisted stigma by accepting their alcoholism but conceiving of themselves as having an "aware alcoholic self," a restored true self that was able to regain control over alcohol versus their stigmatized "previously unaware self" governed by alcohol. This

reframing enabled participants to mitigate stigma and self-esteem threats by distancing themselves from their previous negative identity. Additionally, college students who previously misused substances sought to minimize stigma by reframing themselves as "in recovery" as opposed to addicts or alcoholics. Some of these students even engaged in advocacy to share their recovery journey and debunk stereotypes surrounding addiction (Romo & Campau, in press). Relatedly, some people who formerly misused alcohol or drugs emphasized the strength and sense of responsibility they experienced from being in recovery, repositioning recovery as a positive that helped them better cope with adversity and manage felt stigma and shame (Heslin et al., 2012), consistent with viewing stigma as a blessing in disguise (Goffman, 1963). The aforementioned research reflects recent macro-level reframing efforts to destigmatize addiction. Indeed, the nonprofit Faces and Voices of Recovery was largely created to empower people who formerly misused substances to adopt recovery messaging; for example, associating as a person in long-term recovery from alcohol misuse as opposed to an alcoholic (2013). Additionally, Google recently established a recovery resources hub featuring a compilation of recovery resources (i.e., recovery support groups) and stories of overcoming addiction and thriving in recovery to reframe and combat stigma (Google, 2020).

While the above studies touch on ways people in recovery have managed stigma, missing from the literature is a clear, focused examination of the stigma communication processes enacted by people in recovery. In fact, although AA refers to the stigma facing alcoholics (AA, 2001), it does not provide specific recommendations for managing stigma other than remaining anonymous. Since stigmas can shift over time and vary by degree as society and people's views change (Meisenbach, 2010), a more nuanced look at how people in recovery manage the stigma surrounding alcoholism is needed. Therefore, stigma management communication theory (Meisenbach, 2010) provides a useful framework for explicating how people in recovery make sense of and manage stigma. As repairing one's spoiled identity is critical to recovery (McIntosh & McKeganey, 2001) yet understudied (Larkin & Griffiths, 2002), we designed this study to examine how adults in recovery for a substance use disorder communicatively managed stigma. As all of our participants had formerly misused alcohol (some in conjunction with other substances) and thus are considered alcoholics, even in recovery (AA, 2001), we explored the following research question: How do people in recovery manage the stigma of being an alcoholic?

Method

Participants

As argued by several scholars (e.g., Hill & Leeming, 2014; Larkin & Griffiths, 2002; Shinebourne & Smith, 2011), capturing sober individuals' lived experiences is needed to better understand how the recovery process is managed. In keeping with the qualitative methodology and interviewing techniques deployed in applications of SMC and Meisenbach's (2010) call for a greater reliance on the stigmatized individual's perspective, 22 adults who self-identified as in long-term recovery for substance misuse participated in in-depth interviews about their experiences entering into and sustaining their recovery. Fifty-five percent of participants (n = 12) were male and 45% (n = 10) were female. Nineteen participants identified as Caucasian/White, one identified as Black, and two identified as Hispanic. Interviewees' ages ranged from 25 to 71 (M = 37.5). Interviewees' highest level of education consisted of high school (n = 2), some college (n = 5), currently in college (n = 3) or graduate school (n = 1), undergraduate degree (n = 6), and graduate degree (n = 5). Participants worked in such industries as recruiting, marketing/sales, programming, and recovery outreach counseling and administration. At the time of the interviews, 12 lived in North Carolina, four in Georgia, and three in California, Pennsylvania, Tennessee, and Texas respectively. Participants had been in recovery from one to 31.5 years (M = 9.9 years).

Procedure

Following Institutional Review Board approval, we recruited participants through word of mouth, snowball sampling, and social media posts. We conducted interviews between April and October 2019 and did not provide compensation. All but two in-person interviews occurred over the phone, based on interview and participant geography and preference. The interviews lasted roughly 40 to 115 minutes (M = 71 minutes).

Instruments and analysis

We informed interviewees they were participating in a study about how people in sustained recovery from a substance use disorder entered into and maintained their recovery. After participants provided their consent to participate and chose a pseudonym to protect their privacy, we told them they could skip any questions or stop the interview at any time. Next, we asked interviewees a variety of preliminary demographic items (e.g., their age, sex, race, occupation, length of recovery) before questioning them about such topics as their pathway to recovery and how they managed any struggles maintaining their recovery (e.g., What has been the hardest part of maintaining your sobriety? How do you feel your career or relationships have been helped or hurt by being in recovery?). While the interviews followed a standardized interview schedule, we asked follow-up questions and probed when relevant. All interviews were audio recorded and transcribed in their entirety by the researchers and professional transcribers. We verified their accuracy by comparing transcripts to the audio recordings, editing as needed.

After immersing herself in the transcripts and recording reflections on the data (Tracy, 2020), the first author used the constant comparative method (Glaser & Strauss, 1967; Lincoln & Guba, 1985) to organize, interpret, and code the data. Through open coding and comparing the transcripts to one another, the first author identified communication phenomena and generated preliminary codes related to vulnerability, shame, disclosure, identity, personal and professional struggles and rewards, coping skills, advocacy, stigma, and social support. She then returned to the transcripts to conduct second-level coding to narrow the broader codes into more focused

concepts and themes, including disclosure of recovery and negotiation of stigma (particularly felt or internal stigma or shame) to maintain one's preferred identity and professional and personal relationships. It was during this stage she concluded that stigma management was at the core of the study, cutting across the numerous codes and providing a cohesive framework to understand how people in long-term recovery managed intrapersonal and interpersonal challenges to their sobriety. Thus, we did not enter the investigation with SMC (Meisenbach, 2010) as our framework, but it emerged as a useful lens to unpack what was happening in the data, and we subsequently better familiarized ourselves with SMC and SMC-informed research. Both authors next separately reviewed the data from a SMC perspective, engaging in a theoretically-driven thematic analysis guided by SMC (consistent with Roscoe's analysis, 2021). We adopted Braun and Clarke (2006, 2019) six-stage inductive approach to thematic analysis (TA), particularly aligning our analysis with their recent re-articulation of reflexive TA (Braun & Clarke, 2019). We individually manually coded for instances of stigma acceptance and challenge (both from the perspective of the stigmatized and their perception of the public understanding) and how participants managed stigma, using constant comparative techniques (Glaser & Strauss, 1967; Lincoln & Guba, 1985) to define and isolate themes across transcripts. We reconciled and refined the codes, which we supported with participant exemplars, before constructing the study's final strategies/themes.

Reflexivity and trustworthiness

As interpretive researchers, it is important to acknowledge the biases and subjectivity scholars bring to knowledge production (Tracy, 2010). While neither author is in recovery, we both have or have had close relationships with people in recovery and seek to accurately give voice to the recovery community and generate research-based communication strategies to support recovery efforts. These personal experiences and connections to the topic likely shaped the way we related to the study. Additionally, our two research assistants identify as persons in long-term recovery. While they were extremely valuable in providing insight into interview question development and recruiting participants, we recognize the loss of objectivity that can occur with lived experience (Unluer, 2012). Thus, while one interview was conducted by one research assistant and two were jointly conducted with the other research assistant and the first author, after debriefing and refining interview questions the first author interviewed the subsequent participants. In this way, we sought to minimize any incorrect assumptions that can accompany insider status (Unluer, 2012). Furthermore, to lend trustworthiness and credibility to our analysis (Tracy, 2010), we engaged in peer debriefing, exemplar identification, and member checking (Lincoln & Guba, 1985). First, the authors regularly debriefed to discuss the data throughout our analysis. We also shared our findings with a member of the recovery community unrelated to the study, who provided feedback on the identified themes. Additionally, we kept detailed notes, which informed our analysis and selection of participant exemplars (Lincoln & Guba, 1985), helping us to incorporate multivocality through thick, rich description. Following data analysis, we conducted member reflections (Tracy, 2010) or member checking (Lincoln & Guba, 1985) by emailing the findings to the study's participants. The seven interviewees who responded (32% of the sample) indicated the results aligned with their experiences.

Results

We found participants used all six strategies under the four main quadrants of SMC (Meisenbach, 2010) to manage the stigma of being an alcoholic. These strategies and the individual sub-strategies that emerged from our data include: *accepting* (use humor to ease comfort, display/disclose stigma, bond with the stigmatized, isolate self); *avoiding* (stop stigma behavior, hide/deny stigma attribute, distance self from stigma, avoid stigma situations); *evading responsibility for* (framing stigma as provocation, unintentional); *reducing offensiveness of* (transcend/reframe, minimizing, bolster/refocus), *denying* (discredit discreditors, provide evidence/information); and *ignoring/displaying* (advocacy, a new sub-strategy we identified). We also isolated a few blends of these strategies: denying, reducing offensiveness of, and evading responsibility.

Accepting

By using the accepting strategy, participants both accepted the "alcoholic" stigma applied to self and accepted public understanding of stigma or the status quo. When accepting, participants considered the stigma a part of their identity (Meisenbach, 2010). A sub-strategy of accepting, particularly employed by male participants, was the *use of humor to ease comfort*. Humor, more commonly self-deprecating humor, reduces tension between the non-stigmatized individual and others (Meisenbach, 2010). Justin (age 52, 13 years in recovery) and Jon (age 40, 11.5 years in recovery) both said they would make comments along the lines of: "'I'm allergic to alcohol. I break out in handcuffs'" when asked why they were not drinking. As Jorge (age 34, nearly 4 years in recovery), pointed out: "It makes other people laugh but it makes me feel better about it too" when explaining why he also engaged in humor to deflect from his stigma. Many participants also engaged in the accepting sub-strategy of *displaying/disclosing stigma. Displaying/disclosing* stigma typically refers to engaging in the stigmatized behavior and activities (Meisenbach, 2010). However, as interviewees were in active recovery and displaying, or participating in stigmatized behavior, would lead to relapse, in our study this strategy refers to openly disclosing one's recovering alcoholic status. Participants viewed such honesty as particularly important in building relationships, despite the stigma surrounding alcoholism. As Bob (age 30, 9 years in recovery) explained: "I actually have a rule for myself that like if I do go on the first date, I tell people that I'm sober just so I don't find myself in any kind of weird positions later on." As Leticia (age 37, in recovery 14 years) proudly admitted, while she acknowledged the stigma, she was not embarrassed by it: "I ain't ashamed to talk about nothing that I have done . . . Because if you don't like it, you're either gonna like me or love me or not like me or love me, it's what it is." Both Bob and Leticia felt it important to be open about their past or "display"

their sobriety when trying to establish new and genuine relationships. The act of *displaying/disclosing* stigma when dating and forming new relationships closely relates to another aspect of accepting stigma: *bonding with the stigmatized*. Bob stated connecting with a group of male peers was one of the most important aspects of managing stigma and sustaining his recovery: " . . . We developed a level of emotional vulnerability that I think is completely absent in most of the male population that, you know, helped us. Where you could have fun and do normal things and, but also, support each other." Conversely, Piper (age 29, over 7 years in recovery) said she would seek out AA meetings when she traveled to meet people and stay sober: "It's kind of a security blanket to know that wherever I go, you know, I'm going to meet people who are like me." Georgeann (age 59, 4 years in recovery) was initially reluctant to attend AA due to stigma, as she did not want to acknowledge she was a person with alcoholism. She said after finally attending: "I remember being surprised that there were so many people just like me there. They 'got' me and understood how I thought and had been through things similar to me. I found out that I wasn't unique or alone anymore." Despite accepting the public and personal understanding of the stigma around alcoholism, participants thrived from the social support they provided and received from others in recovery.

In contrast, some participants who accepted stigma on personal and public fronts admitted to *isolating* from others due to felt stigma or shame, particularly earlier in their recovery process. For instance, as Ebenezer (age 34, 5 years in recovery) recalled: "I had long stretches of no dating, complete celibacy, um, no partners whatsoever . . . You know, it was definitely a weird period when I first got out of the program." Ebenezer isolated from others, particularly romantic partners, due to stigma concerns. Anne (age 26, 1.5 years in recovery) said her instinct was to avoid people after initially abstaining from substances, but realized that bonding helped her better manage stigma, as isolation was "a scary place to be and it's a dark place to be because like I am always alone." For Anne, isolating was an unhealthy way to avoid stigma. Participants were adamant that prolonged periods of isolation could lead to relapse.

Avoiding

When an individual accepts public understanding of stigma but challenges the stigma applies to self, they are partaking in the avoiding stigma management strategy (Meisenbach, 2010). The first way participants avoided their stigma was by *stopping the stigma behavior* (drinking alcohol) all together, consistent with the notion of correcting one's failing (Goffman, 1963). Although participants had to discontinue the stigmatized behavior in order to become sober, it was necessary for them to accept that the stigma attribute, alcoholic, applied to themselves to take the first step to recovery. Next, participants *hid/denied* the stigma attribute or symbol (Goffman, 1963) by pretending to drink alcohol when they were actually consuming a nonalcoholic beverage. Beatrice (age 32, 1.5 years in recovery) and Hank (age 29, 2.4 years in recovery) described bringing nonalcoholic drinks to events, specifically Kombucha, to convey the impression they were unproblematic drinkers. As Hank attested: "I will often get like a Coke or Sprite and have them put a . . . lemon or whatever so that it looks like a drink." Zoro (age 25, 1 year in recovery) admitted he acted drunk around drinkers to avoid standing out as a nondrinker: " . . . I can even fake being drunk to make people feel like I want to be like them, I can get along with drunk people . . . ." By falsifying a drink or intoxication, participants were able to pass as "normal" (Goffman, 1963) drinkers, conceal their recovery, and continue to have fun without feeling or being stigmatized. It is also important to note that AA members in general *hide/deny* their stigma by following the 12th tradition of the program: anonymity. Remaining anonymous (hiding) helps combat stigma that is associated with acknowledging one's struggles with alcohol and attending (Alcoholics Anonymous, 2001).

Along with hiding the stigma attribute, participants commonly *distanced themselves* from their stigma by using labels, thus conceptualizing stigma as separate from one's identity (Meisenbach, 2010). Most interviewees did not describe themselves as an alcoholic or addict because they viewed the words as not only contributing to internal shame but a negative public understanding of addiction. Although considering oneself an alcoholic, despite sobriety, is a tenet of AA (2001), participants largely perceived the word alcoholic implied to others that they were still in active addiction, leading to greater stigma. As Justin shared: "I don't say, you know, like, 'I'm a drunk' or 'I'm an alcoholic.' [I say] 'I'm a person in long-term recovery.'" Similarly, Andi (age 25, in recovery 3 years) stated: "I say 'long-term recovery' because, um, I think recovery, people still think it means I'm still like, trying to get sober." She believed "long-term recovery" clarified she was far along in her sobriety. Some participants used other labels when they sensed confusion around recovery in general. For instance, when asked why he was not drinking, Jon explained: "I was an addict for many years and life sucked and I got sober and just don't touch it now because it's not good for me." Heather (age 60, 10 years in recovery) was an exception. She did not identify with the labels of sober, clean, former problem drinker, former or recovering alcoholic or addict, or recovery. As she perceived all of these terms as too stigmatizing, she only described herself as a nondrinker.

Reducing shame and changing public understanding can also be achieved by *avoiding stigma situations*, which calls for people to circumvent stigmatizing settings, communication, and behaviors (Meisenbach, 2010), e.g., where it could become known interviewees were not drinking because they were alcoholics (Meisenbach, 2010). As opposed to isolating, avoiding stigma situations involves finding alternative activities to help individuals stay sober and avoid being stigmatized. Ophelia (25, roughly 1 year and 5 months in recovery) suggested recovering alcoholics should: "Go hiking, like go skateboarding, you know, like try activities that give you that adrenaline rush without using or drinking and umm see how it makes you feel . . . ." Shane (age 29, 6.5 years in recovery) shared when he was invited to bars during work conferences he would usually "take the rental car to go to exercise and enjoy health and fitness." By choosing the gym, he prevented others from uncovering he was a nondrinker in recovery.

Evading responsibility

Evading responsibility for one's stigma enables people to accept the stigma applies to self while challenging public understanding of the stigma (Meisenbach, 2010). The individual seeks to combat societal stigma by blaming outside factors and minimizing their own responsibility (Meisenbach, 2010). The sub-strategies of *provocation* and *unintentionality* emerged as salient in our study. With respect to *provocation*, some participants asserted they inherited alcoholism from relatives, which caused them to misuse substances. Jack (age 57, 31.5 years in recovery) voiced that he "grew up around it" and Ophelia explained: "I have a history of alcoholism in my family." Further, several participants used disease terminology to evade responsibility for their stigma and challenge public understanding, asserting their former problem drinking was unintentional and thus not their fault. Piper (age 29, 7 years in recovery) described people with addiction as "being sick," and Rebecca (age 25, 5 years in recovery) stated that people with alcoholism " . . . have a disease. And they can't drink because of that. There's people with diabetes who can't have sugar, you know?" She went on to say people in recovery should not be stigmatized because their bodies "can't handle [alcohol] like other people." Similarly, Beatrice (age 32, 1.5 years in recovery) equated alcoholism to being allergic to alcohol: "It's just an allergy. If I was allergic to peanut butter I wouldn't eat peanut butter, right? It's like so simple when you really break it down." Referring to alcoholism as a health condition such as a disease or allergy helped participants diffuse the stigma associated with alcoholism. Heather again was an exception. She perceived viewing alcoholism as a disease as contributing to stigma because it would be an admission that something was wrong with her – that she was ill and could relapse at any time.

Reducing offensiveness

Similar to evading responsibility, participants sought to reduce the offensiveness of stigma when they accepted stigma applied to self, but challenged the public understanding of the stigma. The main way people in recovery for alcoholism were able to challenge the status quo was to *transcend and reframe* the stigma (consistent with Goffman, 1963) by emphasizing the value of recovering from alcoholism. Participants overwhelmingly asserted going into recovery dramatically improved their personal and professional lives. Hank acknowledged that although many people perceived abstaining from substances as: "'Oh my God, my whole life is over' – and I did look at it for a decent amount of time like that," he now viewed his recovery as a sense of opportunity: "The forest's burned down, so now I can make the forest look however I want." Recovery offered Hank a fresh start on life. Similarly, Justin stated his life after becoming a recovering alcoholic was "just better than anything I could have imagined." In fact, several interviewees maintained their lives were much richer having gone through recovery and they would not be as fulfilled if they had not been alcoholics. As Biff (age 52, 29 years in recovery) explained: "I don't think I would be who I am . . . I don't think my quality of life would be as good if I was able to just drink with impunity." The vast majority of participants said being a recovering alcoholic helped make them who they were today, and the skills and confidence they gained from overcoming substance misuse strengthened all elements of their lives. The ability of those in recovery to view their substance misuse as a positive attribute, even a blessing in disguise (Goffman, 1963), demonstrates ways people can transcend and reframe stigma.

Participants also engaged in *minimizing* (e.g., explaining stigma does not harm or burden others) to reduce the offensiveness of their alcoholism (Meisenbach, 2010). Mostly evident in professional situations, interviewees downplayed the significance of their past substance misuse in order to establish credibility and counter stigma by emphasizing their present reality. Anne (age 26, 1.5 years in recovery) was upfront when applying for jobs: "'When I was younger . . . I was irresponsible with alcohol and I got caught. And it's not something that's a part of my life anymore but I just want to be honest with you.'" Leticia also told a potential employer: "So you're looking at my background but that's not who I am anymore. You see that I've not gotten into more trouble." By mitigating their past actions, participants were able to reassure employers they were good people who had made mistakes in the past. Although they believed stigma existed, these participants were adamant about challenging the public's understanding surrounding alcoholism. Interviewees also reduced offensiveness of the stigma via *bolster/refocus*, a strategy used to highlight other parts of one's identity rather than emphasizing the stigmatized attribute (Meisenbach, 2010). Georgeann employed *bolster/refocus* when she stated: "I've always had a real thing about being a hardworking, reliable employee." Despite her alcoholism she underscored more positive attributes. Similarly, Nora (age 36, approximately 7 years in recovery), shared: "Most of the time when people find out about like my past or that I'm in recovery they're usually just kind of shocked that I've ever done a drug before in my life." Nora regularly highlighted other qualities – her personality, work ethic, social skills, appearance – that enabled her to exude personal characteristics that overshadowed also being a person in recovery for alcoholism.

Denying

Other participants, who challenged both the public understanding of the stigma and that stigma applied to self, denied the stigma. A sub-strategy of denying, *discrediting discreditors*, refers to denying others' credibility and right to stigmatize (Meisenbach, 2010). For instance, Shane discredited discreditors by stating: "The people that consumed the most amounts of alcohol were the ones who actually gave me the most push back and resistance." Since others seemed to be misusing substances themselves, Shane reasoned they were not credible enough to stigmatize him. Additionally, consistent with the notion that stigma can help the stigmatized "re-assess the limitations of normals" (Goffman, 1963, p. 11), some interviewees acknowledged everyone struggled with something at some point in their lives (as Elliott, (age 38, 11.5 years in recovery) put it: "I think there's something wrong with everybody") and thus did not have the right to judge others. As Zoro (age 25, 1 year in recovery) said: "Those are the kinds of people who are like superficial ass motherfuckers who are like

judgmental, like, I don't know, have you never had a problem in your life? Like what the fuck?" As no one is perfect, participants believed their alcoholism should not be stigmatized and that recovery should be viewed as a badge of honor. Another sub-strategy of denying is *providing evidence/information*; in other words, displaying traits and behaviors that refute the stigma. In contrast to *bolster/refocus, providing evidence/information* helps one deny the negative stereotypes that accompany their stigma attribute (Meisenbach, 2010). As Rebecca stated: "I deserve to be able to work for a company that has alcohol around because I'm a human being. I'm not some crazy monster thing." The way Rebecca emphasized her humanity defied the negative stereotype that people with alcoholism were "monsters" or less than human. Numerous interviewees spoke about their accomplishments despite and often because of their recovery, helping them refute stigma and negative stereotypes.

Ignoring/displaying

Ignoring and displaying one's stigma also entails both challenging the stigma applies to self and the public understanding, ignoring enacted stigma or stigmatized situations and continuing to display the attribute (Meisenbach, 2010). Unlike passive acceptance, ignoring/displaying can change the public's perception of the stigma rather than accepting the status quo (Meisenbach, 2010). Consistent with Romo and Campau (in press), several participants used *advocacy* to ignore/display their stigma to potentially modify public understanding surrounding recovery. For instance, Leticia described advocating for addiction services during a beauty competition, saying she would use the crown to fund addiction and mental health services: "I'm all about addiction and mental health because I'm 14 years clean . . . and they just looked at me like, 'Huh? Huh?'" Leticia was able to ignore others' confusion and disapproval while still speaking up about recovery (*display*). Advocating, regardless of potential backlash, helped participants combat public understanding of alcoholism and continue to display their recovery to help others. Similarly, developing workplace recovery support groups and sharing experiences allowed participants such as Shane and Beatrice to advocate against stigma, emphasizing that recovery is possible and positive despite dominant societal messages.

Blending

Consistent with other research, in which people used evading responsibility and denying and accepting and denying together (e.g., Roscoe, 2021), some participants blended strategies to combat stigma, indicating that SMC (Meisenbach, 2010)'s strategies are not always distinct but can be used in tandem. For example, Elliott blended both *providing evidence/information* and *unintentionality* when he explained: " . . . I'm not a bad person. I'm just an addict that needed to be treated . . . " Elliott meant he was not the stereotypical "bad alcoholic" (*provide evidence/info.*) but had a disease (*unintentionality*). *Unintentionality* and *provide evidence/info*. are sub-strategies of two conflicting main strategies (evading responsibility and denying), which parallels the blending patterns found in research concerning veterans with PTSD (Roscoe, 2021). Additionally, Rebecca blended the sub-strategies *bolster/refocus, provide evidence/info*, and *transcend/reframe* in saying: "I've been so much more successful than I ever would have been if I haven't even gone through this . . . I feel like I've way more solidified who I am as a person and my values." Rebecca's comment illustrates she was successful (*providing evidence/info.*) and solid in her values (*bolster/refocus*), thanks to her recovery (*transcend/reframe*). Interviewees also demonstrated blending between *transcend/reframe* and *bolster/refocus*. Bob stating: "I've attained like an incredible amount of knowledge and tools that have helped me not only overcome my substance use disorder but also navigate every aspect of my life . . . " highlighted that he was a more mature and knowledgeable person (*bolster/refocus*) while also explaining how his addiction changed his life (*transcend/reframe*). Blending strategies enabled participants to make a more convincing claim that challenged the public understanding of their stigma and helped manage their shame.

Discussion

Heeding a call to better understand how people become resilient to stigma (Meisenbach, 2010; Shih, 2004; Van Vliet, 2008), particularly in a long-term recovery context (Laudet & White, 2008), our study uncovered how people in recovery made sense of and managed the stigma of being an alcoholic depending on whether they accepted or challenged that the stigma applied to themselves and/or the public consciousness. Despite the transitory nature of stigma (Meisenbach, 2010), our results indicate that alcoholism is still widely stigmatized in society, even after people have stopped drinking and are in recovery. Our findings support and extend recovery research by incorporating existing strategies into the unified framework of SMC and illustrating how stigma management varies depending on acceptance and/or challenge of stigma For example, while not situated in the language of SMC, the notion that people who feel stigmatized and perceive a public stigma bond and seek the support of others in recovery is rampant in the literature (e.g., Romo & Campau, in press; Vaillant, 2005; Yeh et al., 2008) and a strategy consistent with a major tenet of AA (2001). Romo et al. (2015, 2016) found nondrinkers in general and those in recovery used humor to smooth over interactions with drinkers and manage face and stigma threats.

Our finding that participants who accepted the public understanding of stigma but challenged it applied to them *avoided stigmatizing situations* and *hid* their stigma by passing as a normal drinker is also supported by the literature (Romo et al., 2015, 2016), as is the idea of *distancing via labeling* – calling oneself a person in recovery as versus an alcoholic or addict (Faces and Voices of Recovery, 2013; Romo & Campau, in press). Interviewees who challenged the public understanding of stigma yet accepted the stigma applied to them *evaded responsibility* for the stigma. The act of *provocation* aligns closely with research on the genetic transmission of alcoholism (e.g., NIAAA, 2003) and participants' engagement in *unintentionality*, labeling their alcoholism as a sickness or disease, is consistent with the disease model of alcoholism reflected by AA (2001), the American Society of Addiction Medicine (2019) and considerable research (e.g., Leshner, 1997). In this way,

participants made an external as opposed to an internal attribution (blaming alcoholism on a disease or genetics – both out of their control as opposed to a personal moral failing or choice), which is considerably less face threatening than blaming themselves and helped combat social stigma and shame. Furthermore, reframing being a person with alcoholism as a positive trait (Goffman, 1963; Heslin et al., 2012) and attributing shame to external factors and not a reflection of one's character (Van Vliet, 2008) parallels strategies used by participants who challenged the public understanding of stigma yet accepted it applied to them by reducing its offensiveness. *Discrediting discreditors* and *providing evidence/information* contrary to the stigma emerged as strategies interviewees who both challenged the public understanding of the stigma and its application to themselves used, consistent with previous literature on shame management (Van Vliet, 2008), as did engaging in advocacy to debunk myths about alcoholism and change the narrative (Romo & Campau, in press). Through its SMC framing, our study offers an integrated set of options for managing recovery-related stigma.

Theoretical contributions

Our investigation offers several theoretical contributions. First, our study displays the nuanced nature of stigma management, suggesting that strategies are not either/or but can be both, in the case of blended techniques. SMC should account for the simultaneous use of multiple strategies, as individuals are concurrently navigating their own feelings about their stigma as well as the public's view (Roscoe, 2021). Additionally, we found not all SMC strategies foster resilience. In some cases, it could be harmful to deny that a stigma attribute applies to self or partake in *displaying/disclosing* the stigma attribute, particularly pertaining to physical or mental health. For example, just as an alcoholic should stop consuming alcohol, a person who self-harms should not continue to engage in their stigmatized trait (*displaying/disclosing*), in the same way that someone with an eating disorder should not partake in their stigmatized behavior. Similarly, *minimizing* one's stigma (reassuring others it does not harm them) could be an attempt to justify one's unhealthy behavior. *Isolating* could cause someone in recovery to relapse or continue their insalubrious conduct. Furthermore, we recommend adding *advocacy* as a sub-strategy under ignoring/displaying. Ignoring/displaying involves ignoring public stigma while continuing to display the stigmatized trait. Interviewees who engaged in ignoring/displaying did so through *advocacy*. *Advocacy* enabled participants to discount stereotypes and negative feedback associated with alcoholism by using their voices to speak up for others who battled alcoholism or other types of substance misuse (displaying). *Advocacy* also helped interviewees connect with others in recovery and could potentially blend with the bonding with the stigmatized aspect of SMC. Regardless of stigma attribute, *advocacy* could be a valuable tool to reframe and resist stigma.

Practical applications

This investigation showcases a variety of unified, research-based techniques people in recovery can use depending on whether they accept or challenge the stigma of being an alcoholic applies to them and/or is reflected by the public's understanding of stigma. These strategies are not only useful for stigma management, but as all participants were in long-term recovery and had successfully abstained from substances for an average of nearly 10 years, this study highlights how stigma management likely fostered the resilience needed to maintain one's sobriety. After all, unmanaged stigma can compromise individuals' recovery efforts (e.g., McGaffin et al., 2013; Sawer et al., 2020; Schomerus, 2014) and have life or death consequences (National Institute on Drug Abuse, 2020). While AA stresses the importance of bonding with others in recovery and learning how to disclose that one no longer drinks (AA, 2001), it does not address stigma. Lack of effective stigma management techniques may explain why those who attempt to abstain from substances often struggle: it is suggested that approximately 40% of people discontinue AA their first year (Lilienfeld & Arkowitz, 2011) and only 8–12% of AA members stay sober for more than a year (Stein & Forgoine, 2011). It would be useful to test the efficaciousness of our strategies before incorporating them into AA's programming and sharing our results with other recovery organizations, addiction counselors, and rehabilitation and treatment centers to provide people who formerly misused substances or are attempting to quit with tangible communication messaging and skills they can use to manage stigma and support their sobriety. Ideally, by equipping people in recovery or contemplating recovery with strategies we can change cultural and internal perceptions of stigma surrounding substance misuse. Minimizing stigma and shame around alcohol dependence will help people enter into recovery (Sawer et al., 2020) and sustain their sobriety. Additionally, it would be beneficial to offer these strategies to those who lack access to AA or rehab or do not consider these programs useful recovery tools. For example, by creating infographics of stigma management strategies as part of a social media campaign or through a partnership with Google, or developing and disseminating brochures in doctors' offices or collegiate student health centers, SMC-framed strategies could be shared with the general public in hopes of facilitating and sustaining recovery through strategic communication.

As this investigation underscores that no one standard recovery path (e.g., Romo & Campau, in press) or approach to stigma management exists (Meisenbach, 2010), people in recovery should be encouraged to choose the stigma management technique(s) they find most comfortable and that best aligns with their beliefs, values, and perceptions of stigma. For instance, while several participants referred to themselves as in recovery, others voiced the general public is unfamiliar with the idea of recovery or believes recovery means people are in the midst of quitting using substances or that long-term recovery is impossible. Even if participants shared the number of years they had been in recovery, the lack of a universal definition of recovery (Laudet, 2007) could cause confusion and contribute to stigma. Consequentially, some interviewees described themselves as sober. Sober may be a less stigmatizing and more precise term to succinctly convey the message that an individual no longer uses substances. While recovery has become the preferred terminology of the addiction community and can help minimize shame, it may be inadvertently

reinforcing public stigma. Indeed, even the disease model of alcoholism implies that alcoholism is a chronic condition (as does AA's "one day at a time" mantra). Laudet (2007) cautions that unless society understands people in recovery really can stop drinking indefinitely, "the connotation of chronicity carries the danger that addiction remains viewed as a permanent scar on the once-dependent individual, and discrimination can result" (p. 244). Heather denied the stigma attribute "being an alcoholic" applied to her and relatedly did not identify with the disease model, or as a person in recovery. Although Heather was an outlier in our study, her mindset aligns with Rational Recovery, an alterantive to AA to help people permanently stop drinking by emphasizing free will to decide to never drink again instead of viewing one's self as flawed, spiritually deficient, a victim, or sick with a disease that could flare up at any time. Rational Recovery seeks to reduce stigma by not using the word addict or alcoholic or holding meetings (Trimpey, 1994). While Heather did not mention this program, denying the stigma attribute (alcoholism) helped her manage stigma and stay sober, reinforcing that effective stigma management strategies can vary.

Future directions and limitations

Several opportunities for future research exist. SMC is premised on stigma management varying depending on the stigmatized accepting or challenging whether the stigma applies to themselves as well as the public understanding of the stigma. However, SMC does not distinguish among the different manifestations of stigma (e.g., felt, enacted). Stigma is used as a blanket term and perceptions of self-stigma are enmeshed with people's perceptions of others' views of stigma. In our study, whether one agreed the stigma applied to them and the stigma management strategies they deployed seemed related to the extent they felt shame or felt stigma. Although including the distinction between felt and enacted stigma could compromise SMC's parsimony, it could help understand an individual's stigma management communication choices and account for the multiple layers of stigma present in certain conditions such as alcoholism. Additionally, while we identified SMC-informed strategies that likely enabled recovering alcoholics to maintain long-term recovery, it is unclear what motivated strategy use aside from whether participants felt stigma applied to them and/or was perceived by the public. It is possible sex differences and length of recovery, as well as interpersonal context (as suggested by Noltensmeyer & Meisenbach, 2016) are related to strategies. Indeed, our investigation suggests more men than women used *humor* to manage stigma, and people who were in recovery longer seemed less likely to internalize stigma and more likely to challenge public perceptions. A future investigation that examines these potential influences on stigma management would be valuable. Furthermore, although SMC is premised on soliciting communication management strategies from the stigmatized's perspective, it would be useful to understand the effects strategies related to challenging public perceptions of stigma and word choice (sober vs. recovery) have on those not in recovery. Scholars could thus test SMC and determine the effectiveness of attempts to change the status quo through stigma management communication.

Although this study captured more participants' experiences than most SMC-framed and qualitative recovery investigations and consisted of roughly equal numbers of males and females, it is limited by its predominately-White sample. Additionally, while participants held a variety of occupations, roughly 32% worked in the recovery field, likely making them more comfortable talking about their recovery and perhaps not facing or perceiving as much stigma. However, that the majority of participants worked outside of recovery provides valuable insight into how people in the real world manage stigma.

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ORCID

Lynsey K. Romo http://orcid.org/0000-0002-7233-8540

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Appendix A

Table A1. Stigma management communication strategies.

	Accept that stigma applies to self	Challenge that stigma applies to self
Accept public understanding of stigma (status quo)	**I. Accepting** –Passive (silent) acceptance *–Display/Disclose stigma* –Apologize *–Use humor to ease comfort* –Blame stigma for negative outcomes *–Isolate self* *–Bond with stigmatized*	**II. Avoiding** *–Hide/deny stigma attribute* *–Avoid stigma situations* *–Stop stigma behavior* *–Distance self from stigma* –Make favorable social comparison
Challenge public understanding of stigma (change)	**III. Evading responsibility for** *–Provocation* –Defeasibility *–Unintentional* **IV. Reducing offensiveness of** *–Bolster/refocus* *–Minimizing* *–Transcend/reframe*	**V. Denying** –Simply *–Logically* *–Discredit discreditors* *– Provide evidence/info* –Highlight logical fallacies **VI. Ignoring/Displaying** *–Advocacy*

[a]Italicized indicate strategies our participants used.
[b]Underlined and italicized indicates advocacy as a new emergent strategy.
Table reproduced from Meisenbach (2010), p. 278.