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COMMENTARY

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Why stigma matters in addressing alcohol harm

James Morris[1] | **Georg Schomerus**[2]

[1]Centre for Addictive Behaviours Research, School of Applied Sciences, London South Bank University, London, United Kingdom

[2]University of Leipzig Department of Psychiatry, University of Leipzig Medical Center, Leipzig, Germany

Correspondence
Dr James Morris, Centre for Addictive Behaviours Research, School of Applied Sciences, London South Bank University, London, UK.
Email: morrij24@lsbu.ac.uk

Abstract

Alcohol problems are amongst the most stigmatised of conditions, resulting in multiple additional harms for people with alcohol use disorder. Alcohol stigma encompasses widely endorsed negative stereotypes leading to prejudice and discrimination towards people with alcohol use disorder. Self-stigma further harms individuals through preventing and undermining recovery. The persistence of alcohol stigma highlights the limitations of an illness model of alcohol use disorder for stigma reduction; in fact, many groups inadvertently reinforce stigma by emphasising the artificial line between 'normal' drinkers and the pathologised 'alcoholic other'. A public health case for alcohol stigma reduction highlights the need to address this societal false dichotomisation of problem drinkers. Promoting a continuum-aligned model of alcohol use disorder, a dynamic model of responsibility, and other evidence-led approaches such as person-first language by key stakeholders are recommended.

KEYWORDS
alcohol, policy, recovery, stigma, treatment

1 | BACKGROUND

Stigma is broadly identified as a process of social devaluation in which people become targets for discrimination and status loss as a result of perceived difference and labelling [1]. For instance, people perceived to have alcohol problems may be labelled (e.g., as an "alcoholic"), triggering negative stereotypes such as being dangerous, unpredictable, unable to recover or to blame [2–4].

When such stereotypes are prevalent in society (i.e., public stigma), they form part of a prejudicial master narrative that shapes how people understand and respond to an issue [5,6]. Internalised or self-stigma occurs when people belonging to a stigmatised group are aware and apply such beliefs to themselves [7], while anticipated stigma can harm independently, for example, via label avoidance [8,9]. Many other important stigma factors have been identified including the role of power, structural determinants and multiple variables affecting the extent and ways in which stigma can harm [10–12].

2 | THE PERVASIVENESS OF ALCOHOL STIGMA

The stigma of alcohol problems remains persistently high—more so than many other medical, substance or mental health problems—and is pervasive in its prevalence and harmful consequences [13,14]. Alcohol stigma is well established as a major barrier to help-seeking and treatment engagement [15–17] and multiple forms of overt or subtle discrimination against people with alcohol use disorder (AUD), including by healthcare practitioners [13,18,19].

Stigma also hinders recovery outcomes, for instance, through reduced self-efficacy, the 'why try' effect or reduced social support [2,20–22]. Alcohol stigma is embedded within experiences of guilt and shame which are often integral to addiction and the complex identity processes involved in recovery [23–25]. Stereotypes about alcohol problems have further costs, particularly ideas of AUD as always severe, fixed or uncontrollable [26,27]. Other stereotype-orientated beliefs such as 'abstinence is always necessary to recover

from AUD' undermines self-change, health outcomes and other public health goals [27,28].

3 | ALCOHOL STIGMA AS A PUBLIC HEALTH ISSUE

The high societal stigma towards alcohol problems reflects a problematic set of ideas and narratives that dominate public beliefs and attitudes towards *who* constitutes so-called problem drinkers [27]. Most people with AUD (irrespective of classification approach) do not have severe problems or need lifelong abstinence and are aware of the high costs of being labelled as 'problem drinkers' by others [29]. In turn, it has been proposed that many people with AUD may inadvertently perpetrate stigma by *othering* so-called problem drinkers [30,31] as seen across multiple AUD group identities [30,32–35].

In this way, stereotypes about extreme forms of alcohol problems—particularly loss of control or irresponsible or dangerous behaviour—become normatively reinforced through public stigma as a means to separate and protect the drinking behaviours of the 'responsible' majority. This stigmatising master narrative has been identified as a driver of the low problem recognition characteristic amongst larger populations of people with lower severity AUDs [30,36,37].

Othering is especially evident in the context of representations of AUD as 'alcoholism' as particularly stigma-laden. For instance, the use of the term 'alcoholic' is associated with higher implicit and explicit stigma [38] and lower problem recognition [30], while resolving the stigma of an alcoholic identity in recovery contexts can be a complex process [23,39]. Thus, calls have been made to promote continuum understandings of AUD [40], which may ameliorate stigma by reducing a perceived fundamental difference between 'us' and 'them' [41,42] and increasing acceptability of drinking reduction goals as valid route to 'recovery' [27,28,43].

Nonetheless, complex and potentially mixed effects exist around different AUD framings and their potential stigma consequences [44,45]. A disease concept of alcoholism in part came about in an attempt to alleviate blame embedded within a moral model of addiction [46,47]. More recently, proponents of the brain disease model of addiction have argued that disease attributions reduce stigma (e.g., [48]). However, such claims have been questioned on several grounds [4,49]. Notably, despite greater public endorsement of AUD as a 'disease like any other', the heavy public stigma of alcohol problems appears unimpeded [50–52], and on some measures has even increased, particularly with regard to blame [52,53]. Thus, blame remains an important component of alcohol stigma which may be somewhat reduced, but far from eliminated, by illness-orientated models of AUD [54–56]. Indeed, self-identification amongst Alcoholics Anonymous members is in part a way to resolve the stigmatised identity, though again these effects may involve 'mixed blessings' [23,27,57,58]. Illness models may carry other costs including prognostic pessimism, that is, reduced beliefs in a person's capacity to recover [4,59–61], poorer recovery outcomes [4,62] and indeed lower problem recognition [30].

The advancement of a disease model of addiction has therefore failed to deliver *public* stigma reduction, including in the case of alcohol problems [4,63]. Arguably, it has instead contributed to the neurobiological othering of people with alcohol problems as a distinct and pathologised outgroup 'in need' of treatment [64,65], undermining the wide heterogeneity of AUD and recognition of natural recovery [40,66]. This may explain why certain alcohol industry actors have sought to frame alcohol problems in line with disease models [47,67].

Another public health challenge is the belief that stigma towards AUD may be a force for good by serving to disincentivise heavy drinking or nudge change, as debated in the context of tobacco smoking [68,69]. However, we argue that such a claim conflates stigma with broader behavioural norms and narratives which are important influences on drinking behaviours [4,19]. Rather, stigma—as opposed to other normative influences—exists as fundamentally harmful [19]. For instance, *social norms* may positively influence drinking behaviours, but *stigma* itself is by definition a process which harms. Notably, discrimination is an integral part of Link and Phelan's influential stigma model [11]. Keeping within this strict definition of stigma, it could only be argued that by hurting a few (i.e., those with more severe AUD), an overall net positive effect is achieved for society. But this ethically flawed argument (i.e., accepting discrimination against those with more severe AUD to deter others) does not seem to reflect the reality of alcohol stigma. The limited available empirical evidence in fact suggests alcohol stigma is embedded *within* heavy drinking cultures, rather than serving as a positive force [14].

4 | ADDRESSING THE STIGMA OF ALCOHOL PROBLEMS

Despite these impacts, the stigma of alcohol problems, and effective strategies to reduce it, remain under-researched. Calls for evidence-led approaches to addiction stigma-related action include a focus on person-first language, communicating prognostic optimism (i.e., the belief that

people can recover), sharing humanising narratives and an emphasis on societal over individual causes [70]. Such calls emphasise that stigma reduction cannot rely on tackling stereotypes, prejudice and discrimination, but must engender affirming attitudes that promote respect and capacity for change [2] with meaningful involvement and leadership by people with lived experience [19,71].

In the context of mental health stigma, a recent systematic review and meta-analysis found continuum beliefs to be associated with lower stigma, particularly where they reduced notions of 'us versus them' [42]. Indeed, an emergent alcohol-specific evidence base points to the benefits of continuum or associated psychological models as favourable to alcoholism-associated concepts on measures of problem recognition and stigma (see [73] for a review). Nonetheless, in some contexts, such as where blame may feature heavily (e.g., in the treatment of alcohol-related liver disease), an illness model may be yet be beneficial [55,56]. Regardless of illness models, humanising narratives of recovery in the context of AUD featuring the voices of people with lived experience are supported [71]. To counter the pervasive blame associated with AUD, emphasising responsibility without blame has been proposed [72]. Furthermore, a *dynamic model of responsibility* which places individual responsibility in the context of societal responsibility, including effective alcohol policies, may hold promise [19].

5 | CONCLUSION

Efforts to address alcohol stigma are hampered by several misunderstandings and myths about the nature of alcohol use and problems, particularly the master narrative of 'alcoholism' as a severe and disease-orientated condition, while simultaneously blaming individuals for their condition. This serves stigmatising processes via perceptions of a fundamental difference in 'problem drinkers' as driver for separation, othering and discrimination, in turn undermining help-seeking, self-change and non-abstinent recovery. Furthermore, stigma can seem an intangible concept, one which just requires 'calling out', or may be mistakenly assumed to have a protective role via normative influence.

A number of actions for policy-makers, clinicians, researchers and other stakeholders have been identified to support this agenda [2,4,70]. This includes a focus on prioritising evidence-led approaches, which must reflect the many complex framing and context-related factors [49], including in considering the roles of people with lived experience [4,19]. Nonetheless, dissipating the still dominant narrative of alcoholism and its associated stereotypes in all contexts outside of self-labelling (i.e., within Alcoholics Anonymous) is an essential first-line strategy. This includes within alcohol research and practice where stigmatising terminology still persists in journal names, manuscripts [73] and clinical settings [18,19]. Doing so will help shift the public towards a non-stigmatising master narrative within which efforts to address the structural and other aspects of alcohol stigma can be advanced.

ORCID

James Morris https://orcid.org/0000-0002-7048-8844

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