CHAPTER 19

BEFORE “ROCK BOTTOM”? PROBLEM FRAMING EFFECTS ON STIGMA AND CHANGE AMONGST HARMFUL DRINKERS

James Morris

Introduction

In this paper I argue that a disease model of addiction has significant costs for problem recognition and stigma in the context of alcohol use and problems. This argument applies broadly to disease model understandings through which people are seen as fundamentally different (i.e., 'alcoholics' versus other drinkers), but particularly when this difference is underpinned by perceived biological difference, notably in the brain disease model of addiction. Whilst the presented case may apply similarly to other addictions and indeed mental health issues, and draws on literature not limited to alcohol, I focus here on alcohol as the most widely used and socially sanctioned addictive drug. Yet despite widespread acceptance of perceived 'non-problematic' drinking, public attitudes consistently show alcohol problems to be one of the most – if not the most – stigmatized of common conditions (e.g., Kilian et al., 2021; Schomerus et al., 2011). For instance, problem drinkers are widely seen and portrayed as being a danger to others, unpredictable, having themselves to blame, being in denial, or being of weak or deficient character (Crisp et al., 2005; Nieweglowski et al., 2018). Such prejudicial attitudes are deeply embedded within a characterization of 'problem drinking' as a *severe* condition, particularly embodied by the 'disease of alcoholism'. Indeed, simple use of the label 'alcoholic' prompts greater implicit and explicit stigma reactions compared with the term 'alcohol use disorder' (Ashford et al., 2018).

Associated with the public image of alcohol problems as severe in nature, disease model stereotypes reify an alcoholism concept in which there are two distinct groups: 'normal' drinkers, and alcoholics who have an 'allergy' to alcohol (Alcoholics Anonymous, 2001). Whilst there is notable variation in the ways in which both individuals and academics alike interpret or apply disease models, there is little doubt that common alcoholism stereotypes prevail in problem drinking discourse as a key component of stigma (Schomerus et al., 2014). Notions such as denial, rock bottom, and the idea that abstinence is the only route to recovery are therefore embedded within public belief systems pertaining to *who qualifies* as a problem drinker (Witkiewitz et al., 2021).

Stigma and shame are consistently identified as the most pervasive barriers to seeking alcohol treatment and support (May et al., 2019), such that people "fear being labelled alcoholics and subsequently experiencing loss of status and discrimination" (Schomerus et al., 2011, p.105). In turn, many heavy drinkers construct a 'problem free' drinking identity by emphasizing control over their drinking and responsibilities, as contrasted with the diseased and

dysfunctional ‘alcoholic other’. This practice of *othering* is seen in many health and social contexts where threats to the self – either as health, social or stigma consequences – are managed by emphasizing a clear boundary between one’s own ‘safe’ and ‘responsible’ practices and those of the inauspicious *other* (Powell & Menedian, 2016). Indeed, a number of drinking groups have been shown to point to other types of drinker as ‘the problem’, for instance projecting on to the excess of hedonistic ‘binge drinkers’, or to the uncontrolled physically dependent ‘alcoholic’ (Parke et al., 2018; Wilson et al., 2013). In tandem, harmful drinkers display extreme levels of unrealistic optimism in dismissing their own susceptibility to alcohol harms and addiction (Morris et al., 2020; Weinstein, 1980).

Accordingly, low problem recognition as a lack of explicit recognition of one’s own harmful drinking is evident amongst non-help seeking problem drinkers (May et al., 2019; Morris et al., 2020). However, in the context of common public and recovery-oriented narratives, low problem recognition is commonly termed *denial* (Dare & Derigne, 2010). Yet the denial concept again operates on the basis of a severe characterization – a schematic that siphons thoughts towards the ‘alcoholic in denial’ who, despite so obviously having ‘lost control’ to all observers, refuses to accept or change their predicament. The prerequisite for overcoming denial is therefore assumed to be ‘hitting bottom’, such that pretense can no longer be maintained and the drinker finally makes resolution to change (Humphreys, 2000).

Whilst the subjectivity of “hitting rock bottom” has been identified within recovery narratives (Young, 2011b), public beliefs are synonymous with the more extreme negative stereotypes of so-called alcoholism. The denial concept has thus been critiqued as failing to address the myriad reasons why people may not openly ‘admit’ to their drinking problem (Pickard, 2016), though there has been limited exploration of alcohol problem recognition as a more nuanced process across different groups. For instance, whilst a lack of awareness or a state of ambivalence have been periodically identified as barriers to treatment, there has been limited exploration of the range of factors that may influence problem recognition and, indeed, to what extent it may be an important component of behavior change at various degrees of problem severity (Morris et al., 2020; Young, 2011a).

Before ‘rock bottom’

In the UK, harmful drinkers are categorized as regularly drinking at levels of above 35 units per week for women or 50 units per week for men, based on epidemiological data indicating the presence of physiological or psychological harms at this level (Royal College of

Psychiatrists, 1987; WHO, 2018). Harmful drinkers are also commonly identified as scoring above 16 on the Alcohol Use Disorders Identification Test (AUDIT) whilst those with moderate or severe dependence are commonly distinguished as the group 'in need' of treatment (NICE, 2011; Public Health England, 2017). Harmful drinkers, however, outnumber the target treatment population by more than 2:1 (Public Health England, 2019), yet receive limited interventions and may be less likely to benefit from community brief interventions than those with lower severity 'hazardous' drinking (Khadjesari et al., 2018; McCambridge & Saitz, 2017).

A public health gap therefore exists for a population of harmful drinkers who are highly motivated to construct their drinking as 'non-problematic' and are readily able to do so by drawing on stereotypes of the alcoholic other. Harmful drinkers, despite the existence of negative effects on their health or well-being, are still functioning sufficiently to avoid the *social* categorization of problem drinking. As such, they have been described as existing in the "grey area between normal social drinking and being a smelly tramp" (Khadjesari et al., 2015; p.6). However, these drinkers know they are not 'alcoholics' and value alcohol highly, both in terms of their social identities and its important functional roles such as an important 'de-stressor' (Orford et al., 2009; Parke et al., 2018). In turn, they are acutely resistant to implications that their drinking is problematic and, understandably in the context of the arguments above, do not see a need to seek treatment or pursue sobriety. Whilst some public policy changes may be seen as recognizing the problematic false dichotomization of problem drinking – notably via DSM-5's shift to assess alcohol use disorder severity – there is clearly much further to go in shifting the public heuristic at large.

Negotiating the grey area?

How might such drinkers be prompted to re-evaluate low problem recognition such that they might reduce their alcohol consumption, or at least more objectively consider its risks and future consequences? In line with the alcoholism model, they logically identify themselves as far from 'rock bottom' or 'needing' treatment, particularly as the consequences of heavy consumption may not be evident or obviously associated with their alcohol use (e.g., high blood pressure as a prevalent alcohol-attributable factor). As such, a binary disease model of alcoholism allows heavy drinkers to legitimately cast their own drinking status as non-problematic: a type of "valid denial" (Morris et al., 2020). Even those with degrees of dependence but yet to adopt a problem drinking identity appear to project onto more stereotyped images of 'alcoholics' as true problem drinkers (Wallhed Finn et al., 2014).

Offering potential to counter low problem recognition are alternative framings that directly counter the binary schematic of a disease model. Continuum beliefs, for example, frame alcohol use and harms as existing on a spectrum whereby there are no clear distinctions or categories between problem and non-problem drinkers. Continuum beliefs have been found to be associated with higher levels of problem recognition amongst harmful drinkers compared with a binary disease model or control, potentially because continuum beliefs reduce the perceived threats posed by problem drinking stigma (Morris et al., 2020). One study has found that a similar psychosocial model of alcohol problems fared favorably against a disease model framing on a number of measures relevant to recovery amongst lower severity dependent drinkers (Wiens & Walker, 2015). Similarly, another study found that a psychological framing of alcohol problems was associated with lower stigma versus disease and moral models (Rundle et al., 2021). A compensatory growth message promoting the malleability of addiction, when compared to a disease model reflecting a fixed nature, was associated with greater self-efficacy and help-seeking behaviors (Burnette et al., 2019).

Elsewhere, disease model framings have been associated with a number of negative effects, both in the context of addiction and mental health. Endorsement of disease model or associated beliefs such as 'one drink, one drunk' have long been associated with self-fulfilling prophecy type effects concerning poorer treatment outcomes (Heather et al., 1982; Miller et al., 1996), with more recent studies also pointing to the negative implications of perceptions of uncontrollability as per a disease model (Spada & Wells, 2010). Believing oneself to be genetically susceptible to 'alcoholism' has been associated with less perceived personal control, mediated by higher negative and lower positive affect (Dar-Nimrod et al., 2013), likely reflecting the *self-stigma* of internalizing disease model aligned stereotypes (Corrigan et al., 2016).

Despite claims, the disease model does not reduce stigma

Evidence therefore continues to build that a disease model is insufficient – and likely counter-productive – to stigma reduction at large. Irrespective of how self-labelling interacts with stigma within recovery contexts, public stigma towards people with mental health or addiction issues has failed to recede over recent decades, despite growing endorsement of these as biogenetic conditions (Pescosolido et al., 2010; Schomerus et al., 2011). Yet Nora Volkow, director of the National Institute on Drug Abuse, states:

> "If we embrace the concept of addiction as a chronic disease in which drugs have disrupted the most fundamental brain circuits that enable us to do something that we

> take for granted—make a decision and follow it through—we will be able to decrease the stigma…Once people understand the underlying pathology of addiction, people with the disease…will simply, nonjudgmentally, receive the help they need, like a child with diabetes or a person with heart disease or cancer. They won't have to feel that shame, or feel inferior, because people understand that they are suffering from a disease that should be treated like any other" (Volkow, 2015, NIDA website).

Central to this *addiction as disease stigma reduction argument* lies blame, the stereotype by which 'addicts' are deemed morally responsible for their condition. According to attribution theory, the perceived controllability of a condition predicts the level of blameworthiness, such that less control equals less blame and in turn less stigma. Thus, portraying addiction as a 'disease like any other' is an ostensibly logical approach and indeed partially supported via a narrow blame-focused view of stigma. However, as a rationale for public stigma reduction, this argument suffers from major conceptual flaws, as borne out in the broader empirical stigma literature.

Notably, addiction stigma compromises far more than a single stereotype of blame, but rather is a process of social devaluation resulting in discrimination at individual and structural levels (Link & Phelan, 2001). A person labelled as an alcoholic does not need to be blamed to be stigmatized; indeed attitudes are commonly mistaken as directly related to discrimination in ostensibly 'anti-stigma' programs (Rolling, 2020). For example, a person may not blame an individual for their condition, but still desire social distance and treat them differently. Indeed, even diseases where there is less blame still invoke significant stigma because the awareness of *disease in itself* evokes emotive responses such as fear (Else-Quest & Jackson, 2013). As such, whilst meta-analysis has that found biogenetic attributions towards people with mental health or addiction problems are associated with less blame, they are also associated with greater perceived danger, more desire for social distance, and lower belief in a person's potential to recover (Kvaale et al., 2013). These two-way effects have been termed the 'mixed blessing' model (Haslam & Kvaale, 2015). However, framing these effects as a 'mixed blessing' seems generous when accounting for the net stigma effects which appear to confer more negative than positive implications, particularly when focusing on the enacted consequences of stigma such as discrimination (Goldberg, 2017). Further, a meta-analysis of neuroscientific attributions found the same negative effects of social distance, perceived dangerousness and prognostic pessimism, but no effect on reduced blame (Loughman & Haslam, 2018).

It is therefore evident that a significant public stigma surrounding problem drinking persists and, rather than reducing it, empirical evidence shows disease model attributions are deeply embedded *within* the problem. At its core, a disease model emphasizes *difference*, which in turn promotes separation – two central stages of the stigma process (Link & Phelan, 2001). Under a disease model, problem drinkers are seen in the eyes of society as a distinct and *spoiled outgroup*, which the majority group are implicitly motivated to reify and 'other' to normalize and protect their own 'problem free' drinking status (Schomerus et al., 2011). This is not to comment on the role of alcoholic self-labelling or disease model beliefs as a personal process of sense-making or recovery as seen within Alcoholics Anonymous, other than to note that the task of resolving or managing the stigmatized alcoholic identity appears an important one both within and outside recovery contexts (Hill & Leeming, 2014; Romo et al., 2016). However, as long as the problem drinking identity remains one in which the problem is marked as severe, uncontrollable and as a disease in some form, the false binary between 'alcoholics' and everyone else will remain salient, damaging levels of public stigma will persist, and the threshold for problem recognition will be high.

Diversifying problem drinking narratives

To reiterate, it should be made clear here that I do not intend to critique the role of the disease model *within* recovery contexts in which self-labelling and disease concepts are integral. As implied above, such narratives form part of the sense-making process that often comes with identifying and resolving 'illness' and self-stigma (Cruwys & Gunaseelan, 2016; Leventhal & Meyer, 1980). Indeed, scholars point to varied and metaphorical ways in which disease model ideas are or were intended to be used, such as *alcoholism as a folk disease* or as a uniquely personal spiritual process (Dossett & Metcalf-White, 2019; Rodin, 1981). Rather, the point is that the conceptualization of problem drinking as alcoholism has ubiquitously saturated problem drinking discourse and sense-making across society at large. As such, many inferences about problem drinking misappropriate the terminology of alcoholism and its embedded meanings as a severe, irreversible and uncontrollable disease.

The shades of grey that form the continuum of alcohol use and problems are therefore largely unavailable to the public mindset. However, laying the blame at the door of the disease model itself would be unfair, given both the innate human necessity for cognitive simplification in sense-making processes, and the long history and evolution of the alcoholism concept (Levine, 1978). Nonetheless, an *explanatory vacuum* (Oettingen et al., 2006) exists and policy makers and others with influence should acknowledge that a public health aligned

continuum model is yet to hold sufficient space. This likely accounts in part for the failure of public health policies such as attempts to routinise alcohol brief interventions for lower severity AUD groups (Aira et al., 2003). Similarly, the widespread dismissal of low risk drinking guidelines also appears to reflect a failure to facilitate recognition that not being an alcoholic does not mean immunity from alcohol harm or dependence. Instead, drinkers commonly state they 'know their own limits', again highlighting conformity to norms of control and meeting responsibilities as a mechanism of self-exemption (Khadjesari et al., 2018; Lovatt et al., 2015; Parke et al., 2018).

How best to foster a more nuanced conceptualization of the alcohol use and harm continuum that may help enhance problem recognition and reduce stigma? Studies have shown that short vignettes are capable of shifting such beliefs in experimental studies (Morris et al., 2020). Within these, contact with individuals, even via short video clips, can foster greater continuum beliefs compared to equivalent factually-delivered messages, and in turn reduce stigma (Corrigan, et al., 2017). Broadly, such vignettes draw on mechanisms of narrative persuasion, where by identification with a character can reduce defensive reactions and enable more objective message processing (Shen et al., 2015). As such, perceived similarity with a person experiencing problems may enhance problem recognition and decrease stigma, potentially mediated by reduced anxiety and increased empathy (Pettigrew & Tropp, 2008).

Whilst the precise mechanisms require further investigation, it seems that enabling people to conceptualize alcohol problems on a continuum, particularly via relatable and non-threatening narratives, is beneficial for problem recognition. Indeed, further evidence of this has been demonstrated by a recent natural experiment resulting in what has been described as the 'Adrian Chiles effect' after the British TV broadcaster and journalist publicly explored his alcohol use in 2018 BBC documentary entitled 'Drinkers like me'. In the program, Chiles meets with a number of experts and people with varying lived experiences of problem drinking, and openly discusses the many possible explanations, causes and routes to 'recovery'. In doing so, the program demonstrates a nuanced picture of alcohol use and harms, essentially dissecting the limitations of the simplistic inferences commonly drawn from disease model stereotypes (Morris & Melia, 2019). In the wake of the show and amidst an apparent positive media and audience reaction, alcohol services and support apps reported significant surges in demand (Garnett et al., 2021).

One further advantage of promoting a continuum model may be to foster routes to recovery that do not require shifts in social identity. In recent years the role of social identity transition, i.e., from seeing oneself as a 'drinker' to someone 'in recovery', has been proposed as integral to successful treatment and recovery (Best et al., 2016; Frings & Albery, 2016; Moos, 2007). However, social identity shifts may be more applicable where alcohol problems are more severe and more likely to require building recovery capital such as abstinence or recovery-oriented peer networks. Indeed, a key barrier to problem recognition as an important first step to recovery may be the identity threat to one's current positive drinking self-view, and the subsequent implications of giving up alcohol or needing to engage in treatment (Morris et al., 2021). In turn, people may *deflect* a problem drinking label to protect themselves both from stigma and the consequences of identifying oneself as having a problem (Morris et al., 2021; Thoits, 2016; Young, 2011a). A continuum model, in which a distinct problem group does not exist, may therefore promote problem recognition by averting the need for identity deflection or shifts, particularly where drinking reduction goals and natural recovery can be achieved (Witkiewitz et al., 2020; 2021).

Evidence based stigma-reduction: moving beyond the disease model

The arguments set out here against a disease model of alcoholism are therefore made on the basis of two key but interrelated arguments. First, that a disease model creates a false binary in the public mindset between 'alcoholics' and everyone else, hindering problem recognition by enabling separation from the alcoholic other. This in turn inadvertently feeds public stigma, within which disease model aligned negative stereotypes drive processes of separation, difference and discrimination. These two issues are mutually reinforcing: higher stigma equates to greater difference of the stigmatized outgroup, in turn heightening the threshold and costs of adopting a problem drinking identity. In contrast, continuum aligned alternatives emphasize similarity over difference, presenting a self-evaluative framework that alleviates threat-provoking defensive responses such as fear and anxiety in response to identity threat (Morris et al., 2021; So et al., 2019).

This argument is consistent with urgent calls for evidence-based approaches to address addiction stigma. Key strategies have been identified as promoting person-first language, communicating prognostic optimism, sharing humanizing narratives, and emphasizing societal rather than individual causes of addiction problems (McGinty & Barry, 2020). Person-first language involves abandoning reductionist labels such as 'alcoholic' as deeply embedded within disease model stereotypes. Enhancing the public's belief in the potential for

people to recover is advocated as part of stigma reduction owing to the harmful consequences of seeing addiction as chronic and persistent (Witte et al., 2019). Equally, prognostic optimism is essential for recovery given the role of self-efficacy, again found to be undermined when seeing problems as an 'uncontrollable' disease. Sharing humanizing narratives is the aim of many well-intentioned anti-stigma campaigns which foster the use of personal testimonies as a potentially effective strategy. However, many such campaigns potentially reinforce stigmatizing ideas via disease model narratives in which separation and difference are integral. These well-meaning campaigns may be inadvertently delivering a mixed blessing effect, and potentially increasing enacted stigma. Finally, calls to emphasize societal rather than individual causes of addiction problems are logically undermined by disease model framings in which alcoholism is seen as a biogenetic problem located within the individual or their brain. Accordingly, the individual is seen as fundamentally different due to their pathology, leaving environmental factors (which are also associated with less blame, e.g., Weine et al., 2016) overlooked.

In conclusion, a disease model of alcoholism, irrespective of its scientific validity, is argued to be counter to public health goals of alcohol stigma reduction, problem recognition, natural recovery and treatment engagement. Once more, this is not to say people should not self-identify with disease model concepts or to suggest Alcoholics Anonymous should cease to exist, but that, outside of these contexts, an increasingly robust evidence base demonstrates the negative consequences of disease model attributions. Whilst further research is required to understand the extent of and mechanisms underlying these effects, it is now time to press forward with evidence-led strategies to reduce the pervasive stigma around alcohol problems. This means that professional and academic bodies must lead the way in challenging disease model conceptualizations, renaming 'alcoholism'-named journals or bodies, and fostering a diverse range of lived experiences and policy measures that emphasize the continuum of alcohol use and harm.

References

Aira, M., Kauhanen, J., Larivaara, P., & Rautio, P. (2003). Factors influencing inquiry about patients' alcohol consumption by primary health care physicians: qualitative semi-structured interview study. *Family Practice*, *20*(3), 270–275. https://doi.org/10.1093/fampra/cmg307

Alcoholics Anonymous. (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism* (4th ed.). Alcoholics Anonymous World Services. https://www.aa.org/pages/en_us/alcoholics-anonymous

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

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), pp. 111–123). https://doi.org/10.3109/16066359.2015.1075980

Burnette, J. L., Forsyth, R. B., Desmarais, S. L., & Hoyt, C. L. (2019). Mindsets of Addiction: Implications for Treatment Intentions. *Journal of Social & Clinical Psychology*, *38*(5), 367–394. https://doi.org/10.1521/jscp.2019.38.5.367

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., Schmidt, A., Bink, A. B., Nieweglowski, K., Al-Khouja, M. A., Qin, S., & Discont, S. (2017). Changing public stigma with continuum beliefs. *Journal of Mental Health*, 26(5), 411-418. https://doi.org/10.1080/09638237.2016.1207224

Crisp, A., Gelder, M., Goddard, E., & Meltzer, H. (2005). Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA)*, *4*(2), 106–113. http://www.ncbi.nlm.nih.gov/pubmed/16633526

Cruwys, T., & Gunaseelan, S. (2016). “Depression is who i am”: Mental illness identity, stigma and wellbeing. *Journal of Affective Disorders*, *189*, 36–42. https://doi.org/10.1016/j.jad.2015.09.012

Dar-Nimrod, I., Zuckerman, M., & Duberstein, P. R. (2013). The effects of learning about one’s own genetic susceptibility to alcoholism: A randomized experiment. *Genetics in Medicine*, *15*(2), 132–138. https://doi.org/10.1038/gim.2012.111

Dare, P. A. S., & Derigne, L. (2010). Denial in alcohol and other drug use disorders: A critique of theory. *Addiction Research & Theory*, *18*(2), 181–193. https://doi.org/10.3109/16066350902770441

Dossett, W., & Metcalf-White, L. (2019). Religion, spirituality and addiction recovery: Introduction. *Implicit Religion, 22*(2), 95–100). https://doi.org/10.1558/imre.40695

Else-Quest, N. M., & Jackson, T. L. (2013). Cancer stigma. In P. W. Corrigan (Ed.), *The stigma of disease and disability: Understanding causes and overcoming injustices.* (pp. 165–181). American Psychological Association. https://doi.org/10.1037/14297-009

Frings, D., & Albery, I. P. (2016). The social identity model of cessation maintenance. In S. Buckingham & D. Best (Eds.), *Addiction, behavioural cchange and social identity*. Taylor & Francis.

Garnett, C., Perski, O., Beard, E., Michie, S., West, R., & Brown, J. (2021). The impact of celebrity influence and national media coverage on users of an alcohol reduction app: A natural experiment. *BMC Public Health*, *21*(1), 30. https://doi.org/10.1186/s12889-020-10011-0

Goldberg, D. S. (2017). On stigma & health. *Journal of Law, Medicine & Ethics*, *45*(4), 475–

483. https://doi.org/10.1177/1073110517750581

Haslam, N., & Kvaale, E. P. (2015). Biogenetic explanations of mental disorder: The mixed-blessings model. *Current Directions in Psychological Science*, *24*(5), 399–404. https://doi.org/10.1177/0963721415588082

Heather, N., Winton, A., & Rollnick, S. (1982). An empirical test of "A cultural delusion of alcoholics." *Psychological Reports*, *50*(2), 379–382. https://doi.org/10.2466/pr0.1982.50.2.379

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). https://doi.org/10.1007/s11469-014-9508-z

Humphreys, K. (2000). Community narratives and personal stories in alcoholics anonymous. *Journal of Community Psychology*, *28*(5), 495–506. https://doi.org/10.1002/1520-6629(200009)28:5<495::AID-JCOP3>3.0.CO;2-W

Khadjesari, Z., Stevenson, F., Godfrey, C., & Murray, E. (2015). Negotiating the "grey area between normal social drinking and being a smelly tramp": A qualitative study of people searching for help online to reduce their drinking. *Health Expectations*, *18*(6), 2011–2020. https://doi.org/10.1111/hex.12351

Khadjesari, Z., Stevenson, F., Toner, P., Linke, S., Milward, J., & Murray, E. (2018). 'I'm not a real boozer': a qualitative study of primary care patients' views on drinking and its consequences. *Journal of Public Health*. https://doi.org/10.1093/pubmed/fdy067

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 & Experimental Research*, May 10, Online ahead of print. https://doi.org/10.1111/acer.14598

Kvaale, E. P., Haslam, N., & Gottdiener, W. H. (2013). The "side effects" of medicalization: A meta-analytic review of how biogenetic explanations affect stigma. In *Clinical Psychology Review, 33* (6), 782–794). https://doi.org/10.1016/j.cpr.2013.06.002

Leventhal, H., & Meyer, D. (1980). The common sense representation of illness danger. In S. Rachman (Ed)., Medical Psychology (Vol. 2, pp. 7-30). Pergamon. https://scholar.google.co.uk/scholar?hl=en&as_sdt=0%2C5&q=Leventhal%2C+Meyer+and+Nerenz+%281980%29&btnG=

Levine, H. G. (1978). The discovery of addiction. Changing conceptions of habitual drunkenness in America. *Journal of Studies on Alcohol*, *39*(1), 143–174. https://doi.org/10.15288/jsa.1978.39.143

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

Loughman, A., & Haslam, N. (2018). Neuroscientific explanations and the stigma of mental disorder: a meta-analytic study. *Cognitive Research: Principles and Implications*, *3*(1), 1–12. https://doi.org/10.1186/s41235-018-0136-1

Lovatt, M., Eadie, D., Meier, P. S., Li, J., Bauld, L., Hastings, G., & Holmes, J. (2015). Lay epidemiology and the interpretation of low-risk drinking guidelines by adults in the United Kingdom. *Addiction*, *110*(12), 1912–1919. https://doi.org/10.1111/add.13072

May, C., Nielsen, A. S., & Bilberg, R. (2019). Barriers to treatment for alcohol dependence. *Journal of Drug & Alcohol Research, 8*(2), 1–17). https://doi.org/10.4303/jdar/236083

McCambridge, J., & Saitz, R. (2017). Rethinking brief interventions for alcohol in general practice. *BMJ (Online)*, *356*. https://doi.org/10.1136/bmj.j116

McGinty, E. E., & Barry, C. L. (2020). Stigma reduction to combat the addiction crisis — Developing an evidence base. *New England Journal of Medicine*, *382*(14), 1291–1292. https://doi.org/10.1056/nejmp2000227

Miller, W. R., Westerberg, V. S., Harris, R. J., & Tonigan, J. S. (1996). What predicts relapse? Prospective testing of antecedent models. *Addiction*, *91*(12s1), 155–172. https://doi.org/10.1046/j.1360-0443.91.12s1.7.x

Moos, R. H. (2007). Theory-based active ingredients of effective treatments for substance use disorders. *Drug & Alcohol Dependence, 88*(2–3), pp. 109–121). https://doi.org/10.1016/j.drugalcdep.2006.10.010

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., Albery, I. P., Moss, A. C., & Heather, N. (2021). Promoting problem recognition amongst harmful drinkers: A conceptual model for problem framing factors. In D. Frings & I. P. Albery (Eds), *The handbook of alcohol use* (pp. 221–236). Elsevier. https://doi.org/10.1016/b978-0-12-816720-5.00026-8

Morris, J., & Melia, C. (2019). Challenging the language of alcohol problems. *Psychologist*, *32*, 36–39. https://thepsychologist.bps.org.uk/volume-32/july-2019/challenging-language-alcohol-problems

NICE. (2011). *Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence [CG115]*. The British Psychological Society and The Royal College of Psychiatrists. https://www.nice.org.uk/guidance/cg115/evidence

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

Oettingen, G., Grant, H., Smith, P. K., Skinner, M., & Gollwitzer, P. M. (2006). Nonconscious goal pursuit: Acting in an explanatory vacuum. *Journal of Experimental Social Psychology*, *42*(5), 668–675. https://doi.org/10.1016/j.jesp.2005.10.003

Orford, J., Martin, O., & Rolfe, A. (2009). *Birmingham Untreated Heavy Drinkers Project*. Department of Health. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215795/dh_123886.pdf

Parke, H., Michalska, ., Russell, A., Moss, A. C., Holdsworth, C., Ling, J., & Larsen, J. (2018). Understanding drinking among midlife men in the United Kingdom: A systematic review of qualitative studies. *Addictive Behaviors Reports*, *8*, 85–94. https://doi.org/10.1016/J.ABREP.2018.08.001

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. *American Journal of Psychiatry*, *167*(11), 1321–1330. https://doi.org/10.1176/appi.ajp.2010.09121743

Pettigrew, T. F., & Tropp, L. R. (2008). How does intergroup contact reduce prejudice? Meta-analytic tests of three mediatorsy. *European Journal of Social Psychology*, *38*(6), 922–934. https://doi.org/10.1002/ejsp.504

Pickard, H. (2016). Denial in addiction. *Mind and Language*, *31*(3), 277–299. https://doi.org/10.1111/mila.12106

Powell, J. A., & Menedian, S. S. (2016). The problem of othering: Towards inclusiveness and belonging. *Othering and Belonging*, *1*, 14–39. http://www.otheringandbelonging.org/the-problem-of-othering/

Public Health England. (2017). *Alcohol: applying all our health*. Guidance paper. Author. https://www.gov.uk/government/publications/alcohol-applying-all-our-health/alcohol-applying-all-our-health

Public Health England. (2019). *Health matters: Identifying and offering brief advice to tobacco and alcohol users*. Author. https://publichealthmatters.blog.gov.uk/2019/03/21/health-matters-identifying-and-offering-brief-advice-to-tobacco-and-alcohol-users/

Rodin, M. B. (1981). Alcoholism as a folk disease. The paradox of beliefs and choice of therapy in an urban American community. *Journal of Studies on Alcohol*, *42*(9), 822–835. https://doi.org/10.15288/jsa.1981.42.822

Rolling, J. H. (2020). Paradigms lost. *Studies in Art Education*, *61*(4), 356–360. https://doi.org/10.1080/00393541.2020.1820840

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

Royal College of Psychiatrists. (1987). *Alcohol: Our favourite drug.* Tavistock.

Rundle, S. M., Cunningham, J. A., & Hendershot, C. S. (2021). Implications of addiction diagnosis and addiction beliefs for public stigma: A cross-national experimental study. *Drug & Alcohol Review*. Jan 25, Online ahead of print. https://doi.org/10.1111/dar.13244

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). https://academic.oup.com/alcalc/article/46/2/105/198339

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

Shen, F., Sheer, V. C., & Li, R. (2015). Impact of narratives on persuasion in health communication: A meta-analysis. *Journal of Advertising*, *44*(2), 105–113. https://doi.org/10.1080/00913367.2015.1018467

So, J., Kuang, K., & Cho, H. (2019). Information Seeking Upon Exposure to Risk Messages: Predictors, Outcomes, and Mediating Roles of Health Information Seeking. *Communication Research*, *46*(5), 663–687. https://doi.org/10.1177/0093650216679536

Spada, M. M., & Wells, A. (2010). Metacognitions across the continuum of drinking behaviour. *Personality & Individual Differences*, *49*(5), 425–429. https://doi.org/10.1016/j.paid.2010.04.011

Thoits, P. A. (2016). "I'm not mentally ill": Identity deflection as a form of stigma resistance. *Journal of Health and Social Behavior*, *57*(2), 135–151. https://doi.org/10.1177/0022146516641164

Volkow, N. D. (2015). *Addiction is a disease of free will*. https://www.drugabuse.gov/about-nida/noras-blog/2015/06/addiction-disease-free-will

Wallhed Finn, S., Bakshi, A.-S., & Andréasson, S. (2014). Alcohol consumption, dependence, and treatment barriers: perceptions among nontreatment seekers with alcohol dependence. *Substance Use & Misuse*, *49*(6), 762–769. https://doi.org/10.3109/10826084.2014.891616

Weine, E. R., Kim, N. S., & Lincoln, A. K. (2016). Understanding lay assessments of alcohol use disorder: Need for treatment and associated stigma. *Alcohol and Alcoholism*, *51*(1), 98–105. https://doi.org/10.1093/ALCALC/AGV069

Weinstein, N. D. (1980). Unrealistic optimism about future life events. *Journal of Personality & Social Psychology*, *39*(5), 806–820. https://doi.org/10.1037/0022-3514.39.5.806

WHO. (2018). *International classification of diseases*, 11th Revision (ICD-11). World Health Organization. https://www.who.int/classifications/icd/en/

Wiens, T. K., & Walker, L. J. (2015). The chronic disease concept of addiction: Helpful or harmful? *Addiction Research & Theory*, *23*(4), 309–321. https://doi.org/10.3109/16066359.2014.987760

Wilson, G. B., Kaner, E. F. S., Crosland, A., Ling, J., McCabe, K., & Haighton, C. A. (2013). A qualitative study of alcohol, health and identities among UK adults in later life. *PLoS ONE*, *8*(8), e71792. https://doi.org/10.1371/journal.pone.0071792

Witkiewitz, K., Montes, K. S., Schwebel, F. J., & Tucker, J. A. (2020). What Is recovery? *Alcohol Research : Current Reviews*, *40*(3), 01. https://doi.org/10.35946/arcr.v40.3.01

Witkiewitz, K., Morris, J., & Tucker, J. A. (2021). Commentary on Henssler et al .: The public health case for promoting and valuing drinking reductions in the treatment of alcohol use disorder. *Addiction*, Feb 7, Online ahead of print. https://doi.org/10.1111/add.15429

Witte, T. H., Wright, A., & Stinson, E. A. (2019). Factors Influencing Stigma Toward Individuals Who Have Substance Use Disorders. *Substance Use & Misuse*, *54*(7), 1115–1124. https://doi.org/10.1080/10826084.2018.1560469

Young, L. B. (2011a). Joe Sixpack: Normality, deviance, and the disease model of alcoholism. *Culture & Psychology*, *17*(3), 378–397. https://doi.org/10.1177/1354067X11408133

Young, L. B. (2011b). 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