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Dynamic labeling discernment: Contextual importance of self-identifiers for individuals in recovery

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Abstract

Recent studies associate identifiers, such as “alcoholic/addict”, with stigma, discrimination, and service deficits. Yet, little is known about why and how self-identifiers are chosen. This study analyzed qualitative responses from individuals (N = 42) in recovery from substance use disorders (SUDs) concerning their use of “alcoholic/addict” or “person with a SUD”. Evaluative structure and generative theories were developed via latent content analysis and grounded theory. Secondary analysis evidenced four thematic constructs: contextual significance, flexibility/rigidity, leveraging identity to counteract stigma, and indications of identity integration/disintegration. Some individuals indicated the contextual utility of certain identifiers, regardless of associated stigma and bias.

Keywords

substance use disorder; recovery; self-identification; stigma; bias

Introduction

Group identification and membership is an important aspect of substance use disorder (SUD) recovery. Recent research exploring the impact of chosen linguistic descriptions of people in recovery (Ashford, Brown, Curtis, & 2018a; Ashford, Brown, & Curtis, 2018b; Ashford, Brown, & Curtis, 2018c; Kelly, Dow, & Westerhoff, 2010; Kelly & Westerhoff, 2009) links the lack of person-first language to stigma, as well as explicit and implicit bias. Labels such as “alcoholic” and “addict” are considered pejorative when used outside of the context of self-identification, particularly when such labels are used by policy makers, clinicians, and healthcare staff (Ashford et al., 2018b). However, many individuals self-identify using this seemingly pejorative language, particularly within mutual aid 12-Step groups (Tkach, 2018). Research on self-identification and self-labeling among individuals in recovery is needed, both within and outside of mutual aid 12-step groups. Even less is known about the effects of various self-identifiers or the contexts and fluidity of self-identifiers within the recovering community. The current study seeks to examine the

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qualitative aspects and comparisons between the use of the term “alcoholic/addict” and the term “person with a SUD” as these terms relate to one’s own individual recovery identity.

Identity is a central aspect of recovery and is related to social support mechanisms (Buckingham, Frings, & Albery, 2013; Verhaeghe, Bracke, & Bruynooghe, 2008), group membership (Buckingham et al., 2013), and sense of community (McMillan & Chavis, 1986). Language and identifying terms to describe or signify oneself as being in recovery serve several functions and may appear within multiple contexts, such as group membership signaling, advocate identity, clinical self-disclosure, and professional identification (Ashford, Brown, McDaniel, & Curtis, 2019b). Given the propensity for certain labels to elicit negative bias and stigma, it is important to understand the use of identifiers across multiple contexts (Kelly & Westerhoff, 2009). The majority of the existing research evidence stops short of suggesting what personal identifiers one should use, or the contexts under which certain labels may be empowering or disempowering (Ashford et al., 2018b; Kelly et al., 2010). Therefore, eliciting qualitative information from individuals in recovery is important to understand which identifiers are used and in what settings they are deemed appropriate by those who maintain recovery identities.

The ability to hold and appropriately integrate multiple complex and meaningful identities is a hallmark of healthy adult psychosocial functioning (Abes, Jones, & McEwen, 2007; Wethington, Moen, Glasgow, & Pillemer, 2000), while coordinating these identities into multiple ecologies is a sign of stable identity constructs (Mastrotheodoros & Motti-Stefanidi, 2017). Therefore, being able to hold multiple complex identities promotes integrated self-concepts, while single identities being held across multiple ecologies and settings demonstrate valued roles and prioritized identities (Linville, 1987; Syed & McLean, 2015). For example, a person may identify themselves as a mother, a director of an organization, and a member of a church or group. Taken together and integrated, this promotes a positive sense of self (Syed & McLean, 2015). When, or if, there are conflicts between these identities, the ability to prioritize also demonstrates a healthy value system within multiple roles (Schwartz, Zamboanga, Luyckx, Meca, & Ritchie, 2013). In this example, the role of motherhood may supersede church attendance in the case of a sick child. This action of integrating, prioritizing, and leveraging roles and identities is key to recovery as well.

Recovery sustainment is often a molar activity, defined as an activity having momentum of its own, with significant meaning and intent by the participant (Bronfenbrenner, 1979). As an ongoing direct molar activity, the maintenance of the recovery identity is often central to the lives of people in recovery from SUD (Dingle, Cruwys, & Frings, 2015). Adding an additional layer to the complexity of molar activity to maintain identity, people in recovery from an SUD often face stigma and discrimination, as SUD is one of the most highly stigmatized diseases throughout the world (Room, Rehm, Trotter, Paglia, & Üstün, 2001). Goffman characterizes stigma as a “spoiled identity” which requires maintenance in order to counteract (Goffman, 1964). Link and Phelan (2001) explain stigma further as a dynamic and multi-layered construct consisting of labels and stereotypes, or inappropriately generalized beliefs about a certain group of individuals. A person who identifies as being in recovery must deal with the latent stigma, bias, discrimination, and marginalized aspects of

having a SUD (Ahern, Stuber, & Galea, 2007; Room, 2005) long after they have achieved stable recovery, either through systemic discrimination (barriers to housing vis-à-vis criminal record, etc.), mistrust from family and close associates, or through general suspicion from a society that has little understanding of long-term recovery (Kulesza, Larimer, & Rao, 2014). Individuals that choose to publicly advocate for themselves face this bias head on, and have developed strategies in recent years to discuss their past and their recovery by tailoring their identity to the public space (Faces and Voices of Recovery, 2013).

Individuals in recovery likely hold multiple identities in addition to their recovery identity in their daily lives. Some of these identities and the context in which they are held may be at odds with their recovery identity as one may wish to avoid or manage bias and stigma. The management of the recovery identity may also be highlighted, suppressed, altered, or even concealed, depending on the social context, in what Goffman (1959) referred to in his dramaturgical model. This impression management performance may either call for front staging or back staging an individual's recovery identity as they seek to establish themselves within their daily activity and social interactions. For example, one may conceal their recovery identity while in a place of employment, presenting their work identity (front staging), while still covertly prioritizing their recovery identity (back staging). Goffman (1959) also points out that we are self-aware of our presentation to others, adjusting accordingly, and the degree to which we self-disclose certain parts of ourselves depends on the degree of intimacy with others.

This study is an attempt to capture the qualitative complexities of recovery identities at the personal and public levels, as well as within the advocacy space. The fluidity with which one may characterize themselves as a person in recovery may be a transient target, often changing across setting, audience, and with group membership. Classically, recovery identities have been shaped by mutual aid 12-Step group membership, as these are some of the most long-standing social organizations to directly address SUD and help individuals enter into and sustain recovery (White, 1998). A central piece of mutual aid 12-Step ideology relies on the admittance that the individual does in fact struggle with substances. This is the first of the 12-Steps, admitting that one is powerless over a particular substance (Alcoholics Anonymous, 2001). This is often signified by the anonymous introductions that occur within the mutual aid group space, for example- "I am (First Name), and I am an alcoholic." This customary and traditional introduction has long shaped how individuals in recovery identify themselves, seemingly through the reclamation of the pejorative term "alcoholic/addict". This label signifies that the individual has the "capacity to be honest with themselves" and that the characterization of troubles with substances closely aligns with the group constructs thereof, as outlined in the group's literature. This is a deliberate and purposeful presentation of the self through the front staging of their recovery identity that is a performative social act of membership and acknowledgement, thereby both offering and signifying intimacy with the group and the respective norms, assumptions, and values. However, as recovery support and mutual aid have expanded, less is known about how identity is handled in other contexts.

In recent years, recovery supports have diversified. No longer are mutual aid 12-Step groups the sole proprietor of widely available support (Young People in Recovery, 2018). Other

groups of similar structure and dynamics based on peer-to-peer mutual aid have emerged (SMART Recovery, LifeRing, Wellbriety, Celebrate Recovery, Refuge Recovery, etc.; Young People in Recovery, 2018). Additionally, pathways to recovery have diversified, and the understanding of recovery trajectories as processes rather than outcomes have added nuance to the contours of recovery conceptualization (Brown & Ashford, 2019). In recent years, a formal advocacy and political organization of recovery has occurred, often composed of people in recovery (White, 2007). This has brought about new terms and definitions, as well as new ways in which people identify themselves, such as “person with a SUD” or a “person in long-term recovery” (Ashford, Brown, & Curtis, 2019a; Faces and Voices of Recovery, 2013). In this study we examine how people feel about traditional (e.g., “addict/alcoholic”) and alternative (e.g., “person with a SUD”) self-labeling terms of identity, and under what situations and settings these terms are utilized. Additionally, we examine how individuals may leverage certain aspects of their identities to either juxtapose themselves to common misperceptions about individuals with SUD, or to gain social acceptance by reformulating their identities into more acceptable terms.

Methods

Eleven open-ended questions (Table 1) were given to ($n = 42$) individuals who self-reported being in recovery from SUD as part of a larger ($N = 54$) mixed methods survey on recovery language. Digital snowball sampling (Faugier & Sargeant, 1997; Hill, Dean, & Murphy, 2014) via social media platforms (e.g., Facebook) were used to access recovery-specific populations and groups. A link to a Qualtrics survey was provided on the digital recruitment flyer. Consent was required for participation, and respondents had to confirm they were in recovery. The survey was open to anyone in recovery, over the age of 18, who consented to the survey. Permission to conduct the study was obtained through the institutional review board at Kennesaw State University.

Participants

Participants were mostly white (95.2%), female (57.1%), heterosexual (69%), and married (52.4%). Most also resided in their own apartment or home (90.5%), were employed full-time (73.8%), and had an annual household income of \$50,000 or more (69%). Nearly half (47.6%) had obtained a postgraduate or professional degree. Participants ranged in age from 24-64 years ($\bar{x} = 42$, $SD = 11.622$). All participants considered themselves in recovery, with an average recovery length over 12 years ($\bar{x} = 12.3$, $SD = 9.985$).

Analysis

Open-ended qualitative coding was utilized (Silverman, 2011), with latent content analysis (Bengtsson, 2016) and grounded theory (Glaser & Strauss, 1967) applied to formulate the evaluative structure of the data. Each investigator was given responses with no directives as to a specific method to approach the data. Initial data points were separated for each question. Investigators had no continuity between responses and were asked to evaluate each answer to each question as distinct items. After initial processing, thematic elements of the data were discussed, as well as more grounded or generative theories that emerged from the data.

Themes were formulated by consensus and generally tested a) whether individuals leverage their identities to avoid stigma, b) if those with less rigid identity constructs were better able to discuss contextual factors which shape the adoption of specific labels across various settings, and c) fluidity of identity, contextual label altering, and the leveraging of identity to inform others, all of which allude to integrated identity for those who have complex self-labeling schemes. Investigators then created a more structured means of secondary analysis for complete response sets and cross-case analysis, beginning with key theoretical constructs regarding the flexibility or rigidity of the responses, contextual factors offered by the respondent answers, and interpretive coding for utility and intent of terminology in relation to the responses (see Figure 1).

Results

In all, 42 participants responded to the qualitative questions. Responses are included to provide context and are presented with the anonymous participant identification number, question number, gender, and age (e.g., –5.5, *Male*, 48 would be participant 5, a 48 year old male, responding to question 5). Some participants preferred to self-identify as an “alcoholic or addict” (n = 16), while others preferred “person with a SUD” (n = 6). A larger proportion, however, reported using both terms, depending on context (n = 20). “Alcoholic/addict” was characterized as a point of connection, a form of empowerment, and an expression of personal truth while also being identified as potentially stigmatizing by both endorers of “alcoholic/addict” labels and endorers of “person with a SUD”. “Person with a SUD” was characterized as less stigmatizing by some, although others felt that both were equally stigmatized or not stigmatized at all.

Additionally, while some endorsed “person with a SUD” as “clinical” or as reflecting a medical condition, others decried this terminology for being “too clinical”, “unemotional”, “cumbersome”, or “dispassionate”. Some participants did additionally note that “person with SUD” helped them compartmentalize SUD as a piece of their identity, as opposed to the entirety of who they are. Additionally, multiple participants preferred a recovery/recovering identity (n = 16) over either given term.

Many reported that individuals should be allowed to identify in the way that makes them most comfortable, but that “person with a SUD” was preferable when referring to someone else, especially if an individual has not established how they wish to be identified.

On one hand I think people should feel free to label themselves in whatever way they want to, in any situation. On the other hand, I do bristle when I hear people say ‘I am an alcoholic or addict’ in public forums. I think it helps when the person goes on to describe what they mean by alcoholic or addict and why they choose to label themselves that way. I think it is different when lay people or people who don’t work in a related field use it to label themselves publicly than when professionals do. I think it offensive when someone uses the label to describe someone else. –5.5, Male, 48

In addition to self-identification preferences, there was a relative consensus for most participants that context was of the utmost importance. Most agreed that people in recovery,

especially within mutual-aid settings, could identify how they choose, but that clinicians, policy-makers, researchers, and journalists, as well as anybody addressing public audiences, should use “SUD” language over “alcoholic/addict”.

Along this recognition of contextual relevance, thematic analysis revealed a relative spectrum of flexibility and rigidity. Upon secondary thematic coding, 23 participants reflected particularly flexible responses, 7 were particularly rigid, and 12 either oscillated between flexible and rigid indicators, or showed no indication either way. Examples of rigid responses would include unilateral disavowal of either label (i.e., “alcoholic/addict” or “person with SUD”), whereas flexible responses were denoted by the acknowledgement of the importance of context.

Most respondents were able to see a primary personal value in one or the other, attach contextual appropriateness to each, and describe situations where they might use one term or the other in order to reduce, leverage, or manage the role of stigma and bias. This speaks to the management aspects of identity control, self-monitoring, and self-disclosure outlined in Goffman’s work (1959). Individuals tend to understand intuitively that the presentation of their recovery identities must be tailored in accordance with social externalities. Labels that leverage socially acceptable responses are front staged and modified, while the individual may learn more toward a different label back stage.

The term alcoholic is not offensive or stigmatizing to me. However, in understanding that another person may see it this way - I alter my approach in how I identify. My story is the same, but if I’m going to help reduce stigma around addiction, I try to speak to others in a way that is helpful and non-abrasive to them.
–27.5, Female, 32

Additionally, results demonstrated contextual variance and utilization of specific labels within specific contexts. Among the more rigid respondents, SUD language was generally preferable, and these participants were more likely to establish a professional identity as their point of authority (e.g., “I’m a clinician...”), whereas more flexible respondents were more likely to leverage their recovery identity as their source of authority.

A fair amount of intrapersonal complexity was apparent within the response set, as some respondents seemed to contradict previous statements in later answers. Individuals preferring “person with SUD” language were, at times, also likely to concede use of the terms “alcoholic/addict”, specifically in mutual-aid settings or for social connectivity. Similarly, participants preferring “alcoholic/addict” language also acknowledged the potential stigma associated with such terms. Multiple respondents (n = 7) noted that stigma and preconceptions exist regardless of what language is used.

There is no need to change the wording for others to simply treat me any differently. Their opinions of me will not change just because I change the wording.
–6.8, Male, 45

In both cases, while certain preferences existed, additional factors influenced those preferences.

Discussion

Through the grounded theory approach, participant responses generated multiple thematic constructs. Among these were the distinctions that participants found pertinent, the concept of fluidity in identifier modification, the act of leveraging identity in various contexts, and the importance of identity integration. While additional themes existed, these constructs were particularly salient and warranted secondary analysis.

Distinctions based on context

Many respondents amended their answers to attach the qualifier of “recovering/recovered”, noting that neither term reflected the capacity for hope and change, nor their current reality.

Addict/alcoholic often implies recovery, but SUD does not. Furthermore, someone with 10 years clean/sober may likely still identify as addict/alcoholic but after all that time why would anyone think they still qualify as having a SUD. I think ‘Recovery’ is the missing key word here that would serve to clarify either word.
–2.8, Male, 34

Personally, I don’t identify as either, although I did for many years. I am not currently an alcoholic or addict. I’m in Long-term recovery. –25.1, Female, 39

Interestingly, some participants made distinctions about person-first language. Person-first language and “substance use disorder” (as opposed to addiction) are frequently associated, although not synonymous. Despite this fact, respondents noted the value of person-first language over other modes of assigning identifiers.

It’s person-first. It means I’m so much more than JUST an “addict” or “alcoholic.” These terms are not person-centered. –19.3, Female, 40

Person first language is affirmative and empowering. –3.8, Male, 34

Label flexibility

Respondents identified two main contexts in which stigma was perceived to run the highest—with the general public and within professional or employment settings. Respondents gave several reasons as to why their preference was to use “person with a SUD” rather than “alcoholic/addict” within these settings.

I would probably only use this term in a professional setting to soften the language, especially towards more sensitive or resistance ‘participants’. –2.4, Male, 34

There is a subtle value attribution within these contexts. Broadly, the variations of setting that required nuanced leveraging of labels included the general professional environment, and within the clinical setting. Both the professional and clinical setting required discernment and label switching for individuals that might otherwise identify as an “addict” within mutual aid 12-Step groups. Participants generally did not feel that clinical settings that involve treating SUD warrant the use of the word “addict”, but rather the more person-centric label of “person with SUD”.

Implicit in this distinction is that in order for a clinical person in recovery to identify themselves, or a client, the person-first label was the ethical choice, presumably to create a non-pejorative understanding centered on the person rather than the substance issues. Person-first language usage is an increasingly common practice in the mental health field as well (Jensen et al., 2013). Yet these individuals, within their own recovery space, often affirmed using the term “alcoholic/addict” to signal group membership and recovery status. One hypothesis that may be formed here is that the individual sees “alcoholic/addict” as disempowering, stigmatizing, and negative in one context, and a filial, perhaps empowering, identifier in another.

I work with a bunch of clinicians that are well versed on the need for person first language. People in recovery without a clinical background I would think find a sense of pride and comradery in ‘alcohol/addict’. People who are not in recovery and do not have a clinician background I would imagine have the subconscious negative connotation with alcoholic/addict and could very well be confused by the term SUD. –22.11, Female, 30

This fluidity is a conscious and deliberate switching arrived from discernment of context. Even for those in a non-clinical work environment, or when addressing the public, label switching illustrates where the degree of perceived stigma exists, as well as the context in which label switching is a self-preservative attempt to minimize such stigma and accentuate the person themselves.

Person first language implies that I am who I am before any type of clinical disorder. I am so many things and starting out by saying I’m ‘a person with’ allows space to add on. Yes, I have a substance use disorder, but I ALSO have 2 college degrees, and a healthy romantic partnership, and incredible social support, and a job that I love. Calling it a substance use disorder also allows me to separate it from who I am as a being with a soul. –22.3, Female, 30

Leveraging identity within context

Some respondents spoke of leveraging their identities to provoke a juxtaposition between common assumptions about people who have issues with substances against who they are today. This involved illustrating for others the difference between their psychological associations with a particular label and the person claiming that label.

[In response to “Under what conditions might you switch between (i. e., use one rather than the other) “addict/alcoholic” and “person with a substance use disorder”?”] *To invoke emotional response when speaking of recovery to help emphasize change.* –16.9, Female, 64

As we see here there is a social performance to create a living antithesis to common assumptions attached to certain labels. It is a type of advocacy in an effort to challenge taken for granted truths (stigmatizing associations or negative bias) about the label of “alcoholic/addict”.

That person can think what they want when I say ‘alcoholic’, it doesn’t bother me at this point. I think it’s good for ‘normal’ people to know that yes, it can be that

housewife at the grocery store, not just the old man under the bridge. –17.2, Female, 46

By attempting to juxtapose “alcoholic/addict” with “housewife”, the respondent is borrowing against stigma to create a purposive cognitive dissonance within her social group, by then revealing her own label.

Signaling group membership by identifying as an “alcoholic/addict” within mutual aid 12-step groups was also a consistent theme. For respondents, this identifier represented a point of connection and bonding.

These terms [alcoholic/addict] help me identify with the world-wide recovering community. When combined with ‘recovering’ they are emblematic of success, and they are terms of pride. –7.2, Male, 63

Both sets of labels (i.e., “alcoholic/addict” and “person with SUD”) were also a direct source of empowerment.

If I had to really think about it...it’s [alcoholic/addict] a reminder of who and what I am. There is great comfort in finally knowing why I drank differently than my friends. It’s empowering to me. –32.2, Female, 28

Stopping the use of these terms [alcoholic/addict] and finding different language [person with SUD] to describe myself has fuelled my self-efficacy. –3.10, Male, 49

Yet, context is still a prime influence on a label’s utility.

These words [alcoholic/addict] have powerful and ultimately empowering meaning to me within the context of 12 step fellowship, particularly early on when they allowed me to come to terms with my condition. –11.1, Male, 53

Identity integration vs. disintegration

Complexity in identity and nuanced use of identity labels are signifiers of an integrated identity (Syed & McLean, 2015). An integrated identity is defined through relationships and structural realities (Stets & Burke, 2003). This is particularly true when different aspects of one’s life contain cultural or traditional values unique to those identities, such as first and second-generation immigrants who hold bi-cultural affinities. However, cultural value systems of individual spheres of life are also varied. Corporate office culture, mutual aid 12-Step communities, clinical workers, and other investments of identity create separate and unique identity signifiers based on the structure of one’s life and roles. Previous research suggests individuals who invest too heavily in any one identity, or who struggle to invest in positive identities, experience negative consequences (Linville, 1987; Luyckx, Goossens, Soenens, & Beyers, 2005; Schwartz et al., 2013). The consequences can range from social stigma, ostracization, to negative self-image and self-stigma. It is important for adults to see themselves as both similar to others and unique in their own way (Erikson, 1968). It is possible that rigid reactions to identity labels widely held by others is a form of bias, regardless of the nature of the labels. Many pejorative labels are also reclaimed by the groups whom they were meant to disparage (Galinsky et al., 2013). This reclaiming of pejorative labels is a political act of power reclamation through language (Bianchi, 2014).

Rigid denial of linguistic signifiers when given dichotomous choices between single identities tells us little about the other experiences, roles, and identities held by individual respondents in this study. However, given some of the negative responses, we can see that these labels do bring up a sense of antagonism, or perhaps shame, for some.

Painful reminders of active addiction. The words elicit the idea of current use, and don't represent a person who has formerly dealt with active addiction. They are also non-clinical terms and degrade the disease model of addiction. While they may be helpful in mutual aid support group settings, outside of those venues they are degrading terms. -9.1, Male, 38

The term [person with a SUD] unwittingly stigmatizes the world-wide recovering community. The ivory tower seems unconcerned about the consequences of denigrating well-known and widely used terms. -7.3, Male, 63

Whether this antagonism is healthy, or whether it is related to negative personal experience is unknown. It is also unknown how rigid respondents characterizes others who may use labels that cause antagonism in themselves. This may be better understood by the study of where the individual situates their expertise on the labels themselves.

I am in the addiction field, and therefore able to determine and diagnose when individuals meet diagnostic criteria for such a diagnosis. -9.7, Male, 38

[In response to "Do you feel these terms ("addict/alcoholic" and "person with a substance use disorder") can be used interchangeably? If so, why? If not, why not?"] *Yes, and because I'm a recovering addict myself.* -40.8, Female, 26

We see from these examples that integrated identity, so far as these labels are concerned, occurs more often than not. Most respondents have a clear and concise understanding of how they identify themselves and others, and the context in which these terms are used.

Limitations

The largely homogenous sample of respondents in this study limits the generalizability of the findings. Any study that does not have adequate ethnic, socioeconomic, and regional representation will inherently be limited in applicability. A contributing factor may have been the use of digital snowball sampling methodology, as this may have centralized participants within a certain proximal group. Future studies may choose alternative methodology to attempt to recruit a more diverse sample. Educational and earning status may have a particularly profound effect on the results discussed here. Additionally, clinical employment of respondents skews the results, particularly as it related to the use of the term "person with a SUD". A representative sample of lay populations who are clinically naive may be the best way to determine the perception of these labels in future studies.

Conclusion

Individuals in recovery appear to hold a complex understanding of themselves and their identity labels as they relate to individual recovery status. Recovering individuals may leverage their identity to garner social acceptance, particularly in professional, clinical, or public settings, while selecting the terminology "person with a SUD" in those settings to

alleviate the perceived or actual risk of being stigmatized. Additionally, others may leverage against stigma, choosing the “alcoholic/addict” label to create cognitive dissonance for others as an act of advocacy. Most, however, have a dual distinction for themselves and others, using the “alcoholic/addict” signifier primarily as a membership qualifier within mutual aid 12-Step groups, and “person with a SUD” outside of such groups. This dynamic discernment is an important mechanism to individuals in recovery and helps to explain the relationship between language choice and perceived stigma.

This study highlights the ways in which recovery labels are becoming more complex as individuals become more conscious of the stigma associated with SUD. This is particularly true in higher earning, well-educated individuals in recovery, or those working in clinical environments. The sample drawn for this study captures a small portion of the recovery population and as such may tell a very limited story. However, it may also offer a glimpse of the future for many others in recovery, as the use of different labels becomes more common, and the use of language training regarding recovery identities proliferates. This is the first exploratory study that directly examines the dichotomous recovery identity labels as a trending issue within the recovery space. Further side-by-side comparisons will require the addition of qualifiers as well, such as amending the “alcoholic/addict” label to include “recover/recovering” and a separate label for “person in recovery” or “person living in recovery”.

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Figure 1. Qualitative analysis process. This figure describes the analysis process for this study.

Table 1**Qualitative Response Questions**

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1. Describe what the words “Alcoholic/Addict” means to you personally. Please be as descriptive as possible.
 2. If you use this word to self-identify, what are you signifying when you say, “I am an alcoholic/addict”? Please be as descriptive as possible. If you do not use this term to self-identify, please type “N/A”.
 3. Describe what the phrase “person with a substance use disorder” means to you personally. Please be as descriptive as possible.
 4. If you use the term to self-identify, what are you signifying when you say “person with a substance use disorder”. Please be as descriptive as possible. If you do not use this term to self-identify, please type “N/A”.
 5. Under what conditions might the term “Alcoholic” be offensive or stigmatizing to you? Please be as descriptive as possible.
 6. Under what conditions might the term “Addict” be offensive or stigmatizing to you? Please be as descriptive as possible.
 7. Under what conditions might you use the phrase “person with a substance use disorder” as opposed to “addict/alcoholic”?
 8. Do you feel these terms (“addict/alcoholic” and “person with a substance use disorder”) can be used interchangeably? If so, why? If not, why not?
 9. Under what conditions might you switch between (i.e., use one rather than the other) “addict/alcoholic” and “person with a substance use disorder”?
 10. Do you feel these terms (“addict/alcoholic” and “person with a substance use disorder”) mean the same thing to you personally? Please explain why or why not.
 11. Do you feel these words (“addict/alcoholic” and “person with a substance use disorder”) mean the same to other people you might encounter every day? Please explain why or why not.
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