

The Sober Professor: Reflections on the Sober Paradox, Sober Phobia, and Disclosing an Alcohol Recovery Identity in Academia

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journals.sagepub.com/home/cdx**Victoria F. Burns¹** 

Abstract

Fueled by stigma, individuals in, or seeking recovery from addiction struggle with disclosure across personal and professional life domains. Guided by the concepts of stigma and alcogenic environments, this paper explores the risks, benefits, and paradoxes of disclosing an alcohol addiction recovery identity from the perspective of an assistant professor in a Canadian university context. It argues that disclosure can be a promising way to strengthen personal recovery, combat self and public stigma, help build community, model authenticity and transparency in teaching and research roles, shift university drinking culture, and provide a safer environment for others to disclose and/or seek help for addiction. Policy and practice recommendations are provided.

Keywords

stigma, alcohol addiction, recovery, disclosure, academia, alcogenic environments

Upon reading Ross et al.'s (2020) "'Coming out': Stigma, reflexivity, and the drug researcher's drug use," in recent edition of this journal, I was inspired to start piecing together my personal journal entries with relevant scholarly texts—which evolved into this paper. Even though Ross and colleagues focused on drug researcher's disclosure of active illicit drug use, I remarked several parallel risks and benefits related to the paradoxical stigma I experienced disclosing a recovery identity in a Western academic environment where "everything is telling you to drink" (Hill et al., 2018, p. 457).

Paralyzed by internalized sober phobia and stigma, for the first 5 years of my sobriety, I worked tirelessly to conceal my recovery identity. As an addiction researcher and social work educator, the constant "calculus of disclosure" (Black & Miles, 2002, p. 688) was not only exhausting, but starting to negatively affect my teaching, research, and quality of my own recovery. Both as a sober PhD student and junior faculty member, academia was one of the last places I felt safe disclosing. Based on personal

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encounters with other academics in recovery, I know I am not alone in experiencing this stigma-fueled duality. Although candidly sharing the personal details in the following pages make me nervous, as the well-known adage in recovery communities suggests, secrets not only “keep us sick,” but reinforce self and social stigma (Corrigan et al., 2015).

Definitional Clarifications

Addiction. In recognizing the shifting and inconsistent nature of addiction terminology (e.g., substance abuse, substance misuse, substance use disorder, harmful substance use, etc.) (Kelly et al., 2016), this paper refers primarily to addiction and substance use disorder (SUD). Addiction is defined broadly as the compulsion to use, and inability to stop or control use of a substance despite negative consequences (Centre for Addiction and Mental Health, 2021). SUD is the adopted lexicon of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5) (American Psychiatric Association, 2013) and is defined across 11 symptoms (e.g., loss of control, craving, withdrawal), and three levels of severity (mild, moderate, and severe).

Recovery. Several definitions of recovery have been put forward by various stakeholders (e.g., scientific community, practitioners, and people who identify as being in “recovery”) (Kaskutas et al., 2014). Definitions include both abstinence (Betty Ford Institute Consensus Panel, 2007) and non-abstinence-based approaches (Witkiewitz et al., 2020). Although I self-identify as being in recovery, which includes abstinence, this paper acknowledges that people can resolve their addiction problems without taking on a “recovery” identity (Kelly et al., 2017). It also recognizes that recovery is a process with many pathways that go beyond substance use to “encompass improved functioning in all life areas and the realization of individual aspirations” (Best & Hamer, 2021, p. 717).

Alcohol: Harms and Prevalence

Ethanol, the main psychoactive compound in alcohol, is classified as a class one carcinogen and neurotoxin (Amin et al., 2018), and contributes to over 3 million deaths each year (World Health Organization [WHO], 2018). The social and economic burden of alcohol is greater than all other illicit drugs combined (Gowing et al., 2015; WHO, 2018). Even in low-level consumption, alcohol increases the risk of several cancers, dementia, mental illness, and a significantly weakened immune system (Roswall & Weiderpass, 2015). Social impacts include family breakdown, increased risk of domestic violence, sexual assault, and accidents (Brooks et al., 2019).

Despite its recognized harms, most adults in the Western secular world drink alcohol to some degree, and increasingly at problematic rates. From 1990 to 2010 alcohol increased from the sixth to the third leading risk factor for death and disability globally (Lim et al., 2012). Findings from a large USA-based epidemiological study revealed that at least one in eight Americans who drink meet the criteria for a SUD (Grant et al., 2017). Further, more than 66 million American reported more consuming harmful amounts of alcohol in the past month (i.e., consuming five or more standard drinks within 2 hours). Along similar lines, in 2020, 78% of Canadians reported using alcohol in the past year, a quarter of whom (approximately 9.5 million) reporting heavy drinking (above low-risk guidelines) at least once a month (Canadian Institute for Health Information, 2020). An estimated 22 million Americans have resolved a significant alcohol and/or other drug problems (Kelly et al., 2017), yet treatment is often sought out in secret, and/or avoided because of stigma (Corrigan et al., 2017; Earnshaw et al., 2019; Room, 2005).

Alcohol is the most common drug used among employed people and accounts for \$14.6 billion direct (e.g., hospital) and indirect costs (e.g., lost productivity) in Canada every year (Rehm et al., 2007). Although the specific prevalence of academics with SUDs is unknown, workplace stress,

coupled with drinking norms in the workplace are associated with higher incidence of alcohol use (Frone, 2019). Although most employed adults do not have a clinically diagnosed SUD, according to a Canadian survey, nearly 80% of people in recovery are employed (McQuaid, 2017). Considering that workplace stress and burnout are prominent among academics (Colacion-Quiros & Gemora, 2016), coupled with the strong drinking culture of campus life (Hill et al., 2018; Romo 2012), the prevalence of harmful alcohol use among academics may be higher than national Canadian estimates. While education and higher socioeconomic status may act as protection against SUDs, higher status and privilege may reinforce the stigma of being labeled as having a drinking problem, thus acting as barriers for academics to seek help (Boyd et al., 2011).

Guiding Concepts

Addiction stigma. Stigma occurs in a social context where a person is understood by others to have “undesired differentness” (Goffman, 1963, p. 5), leading to the process of othering and a sense of self that is abnormal, deviant, flawed, or spoiled (Goffman, 1963). That *undesired differentness* is deeply discrediting, reducing the person to from a whole person to a set of dehumanizing attributes (e.g., “alky,” “drunk”, etc.). Avery and Avery (2019) define addiction stigma as “negative attitudes towards those suffering from a SUD that one, arise on account of the SUD itself, and two, are likely to impact physical, psychological, social or professional well being” (p. 2). Like all stigma, the degree to which addiction stigma is experienced depends on power dynamics operating within social hierarchies (Link & Phelan, 2001), and social norms (e.g., alcohol culture) (Petronio, 2002).

Disclosure. The concept of disclosure is tied to stigma as it implies a need for concealment or a secret life. Disclosure or self-disclosure refers to the process of communicating information about oneself verbally to another person (Cozby, 1973). Concealing an important part of the self can lead to physical, social, emotional, psychological, and existential distress (Follmer et al., 2020; Ragins, 2008). For example, a USA-based survey focusing on 13 different categories of concealable stigmatized identities (e.g., mental illness, weight/appearance concerns, sexually related activity, history of childhood sexual abuse/rape, addiction), found that anticipated stigma (believing others would devalue you if you disclosed) had a negative effect on psychological health and well-being (Quinn & Chaudoir, 2009). Disclosers tend to experience relief after rectifying discrepant realities, resulting in increased psychological health and wellness (Prince, 2017; Wax et al., 2018). For instance, Corrigan and colleagues’ (2015) randomized control trial found that participants who publicly disclosed their mental illness had a significant reduction in self-stigma. Disclosing a stigmatized identity, such as addiction, involves a constant risk-benefit analysis to determine whether, when, and how to disclose (Petronio, 2002). Importantly, the disclosure decision-making process is also affected by a person’s social location (e.g., race, ethnicity, gender, disability), and cultural norms and expectations (Petronio, 2002), such as university drinking culture.

Disclosing a Non-Drinking Identity: The Role of Alcogenic Environments

Western university campuses and workplaces are known to be alcogenic environments, meaning the consumption of alcohol, often to excess, is widely accepted, expected, and even encouraged (Hill et al., 2018; Romo et al., 2015, 2016). Alcohol culture is fueled by Big Alcohol, a 1.5 trillion global industry that banks on repeat customers (Jernigan & Ross, 2020; Petticrew et al., 2020). Much of the way we view drinking is packaged and sold to us by clever marketing, that affects drinking behavior and health consequences (Babor et al., 2010). College campuses are often saturated with alcohol-related advertising and activities centered on drinking (Romo, 2012). Similarly, drinking in the Western workplace has

become so normalized, that in many places “the keg is becoming the new water cooler” (Silverman, 2013, para. 1).

Fueled by alcohol culture, difficulties disclosing a current or past problem with alcohol is significant because alcohol carries a double stigma associated with drinking “too much” (e.g., alcohol addiction), and “not drinking enough” (e.g., moderation or sobriety). For example, a review of 17 population studies examining the stigma of alcoholism compared to other mental, medical, or social conditions (e.g., schizophrenia, severe depression, eating disorders, dementia, paralysis) found that people with alcohol dependence are viewed as much more responsible for their behaviors, which reinforces exclusion and discrimination (Schomerus et al., 2011). Similarly, in a World Health Organization–funded study, out of 18 conditions—including obesity, homelessness, chronic mental disorder, and crime—alcoholism ranked near the top (fourth) in terms of social disapproval or stigma across 14 different countries (Room et al., 2001). The stigma associated with moralizing and individualizing alcoholism creates barriers to disclosing and seeking help when a problem starts to arise (Corrigan et al., 2017).

Disclosing a sober identity in alcogenic environments, such as college campuses is also experienced as stigmatizing for non-drinkers. For instance, A New Zealand–based study found that university students who drink heavily are viewed positively and as sociable compared to moderate drinkers and abstainers, who are labeled using derogative terminology (e.g., “weirdo,” “killjoy,” “Grandma”) (Robertson & Tustin, 2018). Similarly, a USA-based study that examined the everyday experiences of sober students who decided to remain “dry” (i.e., defined as “abstainers,” who never drank alcohol, and “desistors,” who once drank alcohol but chose not to so do anymore) while living on a “wet” campus, found that non-drinkers were viewed as “social deviants” and were referred to as “losers, freaks, pussies, and nerds” (Herman-Kinney & Kinney, 2013, p. 71). Along similar lines, Romo (2012) found that non-drinking college students concealed their non-drinking identity and engaged in stigma management tactics (e.g., always holding a cup at parties). Further, students feared that if they disclosed, they might be perceived as judgmental toward drinkers. Correspondingly, Conroy and Visser (2014) found that non-drinking college students engaged in a variety of deception tactics (e.g., saying they were taking antibiotics) to avoid the usual flurry of questions about their non-drinking status.

Findings from the organizational behavior literature also suggest that the prominence of drinking culture in secular Western workplaces prevents employees from disclosing a non-drinking status. For instance, a USA-based qualitative study found that fears of non-belonging coupled with the belief that not drinking was culturally deviant led non-drinking workers to conceal they were non-drinkers (Romo et al., 2015). Similarly, an Australian-based qualitative study on working adults who had recently stopped or significantly reduced their alcohol consumption, found that these actions were stigmatizing as they violated the cultural expectations of drinking alcohol (Bartram et al., 2017). Similar to the findings with students (Romo, 2012), the employees changed their activities, relationships, and social interactions to avoid confrontation, discomfort, and further marginalization. For instance, Romo et al. (2016) examined the disclosure experiences of employed adults who were former problematic drinkers. Having spent most of their lives as heavy drinkers, becoming abstinent represented a major shift in their identities, which complicated their disclosure decisions and experiences. Romo et al. (2016) also found that if participants were asked directly about their abstinence, they crafted socially acceptable excuses (e.g., helped them lose weight, medication, health reasons, designated driver) to avoid harassment and/or being perceived as judgmental toward drinkers. In contrast, when participants calculated that the benefits (e.g., inspiring others, maintaining sobriety, or building relationships) outweighed the risks of stigma, they would disclose.

Taken together, while research has explored the disclosure experiences of former problem drinkers in work and college contexts, scant research has considered the complicated process of disclosing an alcohol addiction-recovery identity, from the perspective of university professors. This is a significant

oversight, considering that over the past 2 decades, harmful alcohol use has been on the rise among the university professoriate (Colacion-Quiros & Gemora, 2016). This paper redresses this gap in the literature by sharing my alcohol story, and exploring the unique risks, benefits, and paradoxes I experienced disclosing my addiction-recovery identity in a Western university context.

My Addiction Recovery Story

Romanticizing the Bottle: My Budding Addiction

Alcohol addiction runs deep on both sides of my family. I started experimenting with alcohol with my peers in seventh grade (age 12). In high school, I drank sporadically, but my drinking opportunities were curtailed by a non-drinking older boyfriend, coupled with my commitment to over-achieving academically and in my extracurriculars. My drinking career started in earnest when I was 18 and moved to France, as an international student. There was a constant flow of parties that centered around drinking. Binge drinking, passing out and/or blacking out, and hangovers were not only common but expected. Aware of my family history of alcoholism, I often worried about my drinking. I often drank more than I planned. Most mornings I woke up filled with shame and remorse about what I had done the night before. Some nights, when the bars closed, I retreated home to continue drinking on my own—it was as though I lacked an off switch. When I raised my drinking concerns with my peers, they reassured me, I didn't have a problem. Their ability to normalize my drinking granted me the permission I needed to continue drinking—I just had to learn how to control it better. It was reassuring because I could not imagine a life without alcohol. Convinced that I was the problem, not alcohol, I dedicated the next 15 years of my life trying to figure out how to safely control and enjoy my drug of choice.

When I returned home from France, I was 19, legal drinking age in my home province. I continued to “work hard and play hard” through my undergraduate, master's, and into my PhD—successfully concealing my growing addiction behind a strong work ethic, accolades, and academic excellence. However, by the time I started my PhD, I was firmly leading a double life. By day, I was a wife, fully funded doctoral student, homeowner, dog mom, published author, and sessional instructor at a top university. As soon as alcohol entered my system, all bets were off. I often compared my drinking to a game of Russian Roulette. Sometimes, I could have a few glasses of wine and call it a night. But more often than not, I would become a different person, and be propelled into oblivion.

Despite my best efforts to control by drinking, including hiring different psychotherapists, and employing various harm reduction tactics (e.g., swearing off spirits, drinking on a full stomach, only drinking at home, buying more expensive wines, etc.), my growing addiction was more powerful than me. I would successfully stop for a week or two at a time, to “prove” to myself that I didn't have a problem. Still, the negative consequences I experienced because of drinking were not enough evidence to consider stopping completely. I thought my 2011 diagnosis of type one diabetes—a chronic, life-threatening autoimmune disease would finally be my ticket to “drinking normally.” Now with daily insulin injections on board, I was warned by my endocrinologist that my body could no longer tolerate my usual amounts of alcohol—that it would kill me. Unfortunately, knowledge alone isn't enough; addiction defies all logic—I continued drinking.

Planting the Recovery Seed

About a month before starting my recovery journey, I was invited George¹'s Halloween costume party. George was a fellow PhD student. Ladle of sangria in hand, I asked why he wasn't drinking. He casually replied that he had been in recovery for 25 years. I understood what he meant, but it was the first time I heard someone use recovery as an identity claim. Even more striking was that I sensed an

underdone of pride in his voice, which confused me further. George had not had a drink in 25 years and seemed to be enjoying himself—it was something I had never witnessed or believed possible.

The next morning, as I dry-heaved and swallowed pain killers, I couldn't shake the conversation I'd had with George. Similar to the students in previous research (Herman-Kinney & Kinney, 2013, Robertson & Tustin, 2018), my identity was wrapped up in drinking. All my friends drank. I judged "teatottallers" harshly and didn't want any part of a "boring sober" life—but George wasn't living up to that stereotype. I continued to drink for another month, but that night at the Halloween party, the recovery seed was firmly planted.

November 23, 2013, less than a month after George's party, and the day after my 32nd birthday, I had my last drunk. What was supposed to be a couple of birthday drinks with friends and my husband turned into a 16-hour blackout followed by another emergency room visit. I could not understand how it happened again. I had the master plan to drink in safety: three chaperones, only beer and wine, no hard stuff, taxi home. Yet, once again, the plan failed miserably. Full of shame, remorse, self-loathing, I knew I could no longer live this way. I was emotionally, physically, and spiritually bankrupt—a hollow shell. Although I did not consciously choose life over death, I knew that I was done. It was my time. Everyone has a time: that day in the hospital was mine.

Newly sober, I had no idea how to live without alcohol—I was isolated, restless, and feeling sorry for myself. George was the only person I knew who didn't drink—and we had just met. I associated recovery with what I saw on television and in films, dull 12-step meetings in dingy church basements drinking bad coffee out of Styrofoam cups. Unsure what to do, I mustered up the courage to call George. Unknowingly brainwashed by alcohol culture, I explained that I thought my life would be over if I stopped drinking. He understood my struggle and fears because he lived it himself. He explained that he found relief in abstinence, that it was more "fun." The coupling of abstinence and "fun" seemed like the ultimate paradox, but George exuded fun and freedom. He suggested trying Alcoholics Anonymous (AA) (Alcoholics Anonymous World Service, 2001), as one way to help me get sober and build community—but reinforced that it was not the only way. I wanted what he had, which at the time catalyzed my entry into recovery. Today, sober for more than 7 years, I realize that George's candor and dismissiveness toward addiction stigma destabilized my sober phobia, which not only planted the seed that sobriety was possible, but desirable.

Leading a Double Life in Recovery

Stopping drinking has been the most difficult albeit rewarding decision I have ever made. No longer wasting time on benders or nursing hangovers, my life instantly became more manageable. However, new forms of unmanageability, duplicity, and stress stemmed from leading a double life *in recovery*. In her book *Women who Run with the Wolves*, Clarissa Pinkola Estes (1992) writes that where there is a shaming secret, there is "always a dead zone in the woman's psyche" (p. 408). I knew that I did not get sober to continue leading a double life, but addiction stigma prevented me from disclosing. In agreement with Goffman (1963), stigmatized individuals are continually faced with decisions about whether "to display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where" (p. 42). As the following sections describe, my disclosure journey took place over time, was far from a linear or binary process, and continues to unfold to this day.

My Disclosure Timeline

In early sobriety, I revealed my recovery status to a select group of people whom I deemed to be safe, including close family members/friends, my therapist, and peers in recovery. I trusted these individuals to respect my privacy and treat me with respect, non-judgment, and compassion. I experimented with

telling some of my drinking family members and friends and was frequently met with ridicule and/or disbelief. Even though they knew I had several near-death experiences involving alcohol, alcohol-culture justified sober phobic comments such as “you weren’t that bad,” “so we can’t drink around you anymore?” or “how are you ever going to have fun?” were common.

Even though I lived in a large metropolis, I snuck around to my AA meetings. In AA, I met a few professionals in long-term recovery who cautioned me about disclosure, particularly in the workplace. They warned me of the risks of professional disclosure, which are highlighted in the literature, including job discrimination, labeling, being passed over for promotions, or even being let go (Brohan et al., 2012). I listened and started attending French-language meetings more often to reduce the risk of possibly crossing paths with a student or colleague.

My classmates/former drinking companions were some of the first to notice that I stopped drinking. Echoing previous research on concealing a non-drinking identity (Bartram et al., 2017; Romo, 2018), to reduce stigma, I crafted a collection of creative, more socially acceptable scripts (e.g., being on medication, needing to drive, having type one diabetes). Often, my peers would be satisfied with these excuses. However, sometimes I would be probed further with questions like “I know other diabetics who can drink, why can’t you?” which eventually led to avoiding most social situations outside of my recovery community. Academic conferences were particularly triggering as drinking was a key component of social activities.

Silenced by shame, for the entirety of my PhD, I kept my recovery secret from my co-supervisors. Following a successful dissertation defense, one of my supervisors popped a bottle of champagne, kindly offering me the first glass. I politely declined. Once, twice, three times, until he said, “C’mon, Victoria, it’s not like you’re an alcoholic!” I recall that a familiar wave of shame came over me. I’m not sure why, but I didn’t use my usual excuse of having type one diabetes. Similar to the students in Romo’s (2012) study, I took the glass and pretended to drink in order to “pass” and avoid making a scene. I held it in my hand for the toast, then promptly discarded it in the trash can. After the defense, at a restaurant, I was pressured again to join in on some celebratory wine with my committee members. I declined and this time used my diabetes as an excuse—which they accepted. I was fortunate that I had my husband by my side that day, who was also a non-drinker (he stopped drinking in partnership with me). I am a spiritual person and believe something larger than myself protected me that day; and has continued to keep me safe each time alcohol culture has whispered in my ear (e.g., through pro-drinking marketing ads and internet memes) (Jernigan et al., 2017), in addition to every encounter where I have been pressured to drink and/or am ridiculed for abstaining.

About a year into my postdoctoral work focusing partly on harm reduction strategies to support older people experiencing homelessness, I visited a neighboring city to observe an innovative harm reduction outreach team. Shadowing the addiction nurse that week, I became increasingly frustrated with concealing my lived experience with addiction. That same week, I was fortunate to have the opportunity to attend a lecture by leading addiction and trauma expert Dr. Gabor Maté. After the talk, I waited in line to get my copy of his book *In the Realm of Hungry Ghosts: Close Encounters with Addiction* (Maté, 2008) signed. In the 2 minutes that the publicist allotted us, I shared with Dr. Maté that I has been sober several years and struggling with disclosure, and that it was negatively affecting my work and recovery. I recall him telling me that there is power in vulnerability, and that we owe it to the world to pay it forward. His words prompted me to think of my bookshelf lined with addiction and “quit lit” memoirs, and how these intimate stories were central to my own recovery journey. I knew Dr. Maté was right, that disclosure was a way to combat addiction stigma, thus part of a broader social justice agenda, but I was still paralyzed by fear.

The following morning, during a conversation about the limitations and benefits of harm reduction versus abstinence, it felt appropriate to disclose to the nurse I had been shadowing. Her response surprised me: “What? You? You don’t look like an alcoholic!” Once again, I felt the familiar heat wave

of shame come over me. After this encounter, I decided it was still too much of a risk to disclose professionally and did not disclose in academic circles for another year.

Conflicting Encounters With Sober Academics

The following summer, disclosure was at the forefront of my mind. I attended one of my favorite research conferences in the United States, where I experienced two conflicting encounters related to disclosure. I met Julia, a social work PhD student who had published an article outlining her epistemological journey—and how being in recovery from addiction shaped her experience (Read, 2016). I was in awe of her bravery and asked how she felt about being so candid in her article. She admitted that she was terrified throughout the entire writing process; when she finally submitted the paper, she felt at once waves of fear and relief. However, she also stated that she didn't get sober to live a double life, that if an employer couldn't accept her, she would work elsewhere.

After a full day of conference sessions, a group of scholars adjourned to a popular restaurant. I sat next to Jim, and noticed he was also not ordering alcohol—I had a feeling he was part of my “sober club”—it's a sixth sense. I was relieved to find a sober peer at the conference as I was starting to feel very isolated and triggered by all the drinking. After exchanging resources on local recovery meetings, he shared that he had been sober for several years but was not open about it in academia. In contrast to the LGBTQ+ course he taught, where he openly shared about his lived experience, in his addictions course, he concealed his addiction-recovery identity. Given the scarcity of tenure-track positions, it was too risky, he explained.

Our conversation made me take pause. Once again, I thought about my conversation with Gabor Maté. My shame started to transform into anger. It seemed unjust that being in recovery was so secretive, so shameful in academia, even in addiction circles. Not only was I personally proud of my sobriety, but I also knew it had saved my life. I got to thinking about cancer survivors, how loud and proud they are for their second chance at life. Imagine if they were all silenced by shame? Where would people find hope to continue battling? I was also angry with myself. My silence was reinforcing the stigma my social work code of ethics and values taught me to fight against (Canadian Association of Social Workers [CASW], 2005). I felt like a hypocrite. But still unemployed, I did not want to do anything to risk my career.

Transitioning From Sober Student to Sober Professor

In 2017, after a grueling 13-hour interview, I was thrilled when I was selected for a tenure-track position at a large research-intensive university. I was grateful to have a senior faculty member help me transition into my new position. When I shared with her that I was in recovery, and she advised me not to disclose my recovery status until I achieved tenure. However, I found myself increasingly in situations where I felt the necessity to disclose in my teaching and research roles. For example, during one of my undergraduate social work classes, one outspoken student stated, “I refuse to work with alcoholics because they are all dishonest and could stop if they wanted to.” Wanting to challenge the negative stereotype using my own lived experience, I chose not to, as the threat of stigma was too great.

Shortly after what had transpired in the classroom, I met Sam for coffee. A former academic, Sam was a community research partner for a study I was leading. Having worked in homelessness and addiction sector for decades, there was something warm and non-judgmental in his demeanor that made me feel safe sharing my disclosure predicament. He understood the unique risks of disclosing a stigmatized identity in academia, and compared it to the homelessness sector, where the wounded healer model is common (White, 2000). “In my business, lived experience gives you street cred,” he said. “I don't see why it shouldn't be in academia as well.” He encouraged me to disclose. His approach was to “seek advice” from my dean with regard to how to navigate the teachable moments and research connections that were being missed because of stigma.

A few months after I disclosed to Sam, I sat down with the campus chaplain to discuss the tensions I was feeling about disclosure. He explained that over his decade long career, he had counseled several faculty and staff on mental health issues but had no experience with substance addiction disclosure. This was surprising to me, considering the high rates of addiction (Grant et al., 2017), coupled with the fact that there were more than 6,500 faculty and staff at our institution. Similar to Sam's advice, he suggested that I first reach out to my dean and ask how to proceed, explain that several teachable moments had come up in the classroom, that I had been advised to remain silent because it could compromise getting tenure.

Shortly after the meeting with Sam, I scheduled a meeting with my dean. When disclosing stigmatized identities, one of the most important components is trust (Capell et al., 2016). It is also more common to disclose to a supervisor than a colleague (Romo, 2018). I was fortunate that my dean had a personality, demeanor, and reputation that instilled a sense of safety and trust. When I shared with my dean that I had reached the point where I could not hide anymore; that no job, not even a coveted tenure-track position, was worth sacrificing my values or my recovery. In the end, he could not have been more supportive. Reassured that my career would not be on the line, I felt instant relief. The way I approached my teaching and research was about to change, for the better.

Disclosing as an Educator

In the winter of 2019, I was teaching a small social work seminar where sharing about self is encouraged. About midway through the semester, I was facilitating a discussion on self-care. A student bravely disclosed that she struggled with addiction and that much of her self-care stemmed from her 12-step peer-support groups. As with George's casual candor, I was moved by my student's openness about her recovery. I decided to validate her experience by sharing that much of my self-care practices also centered around my own program of recovery, which included but not limited to 12-step programs. In agreement with Gates (2011), who suggests that positive self-disclosure from educators is an effective strategy to practice authenticity and integrity, students overwhelmingly expressed that my self-disclosure created greater safety in the class for them to share more openly. Correspondingly, my teaching scores, thank-you notes, overall engagement, and final grades provided further evidence of effective teaching and learning.

As Gabor Maté had alluded to in our brief conversation, opening up about my addiction in a positive way, may help clear the path for others to seek help and embody their whole selves. For instance, this past term I had two students disclose that they were in recovery, that this was first class where they disclosed, and that they felt safe doing so because I was open about my experiences. In agreement with Vest (2020), more academics need to come forward with their experiences of addiction-recovery because "if we don't have people in the classroom who share about their lived experience of addiction, we are doing a disservice to the entire university because those students go back to their communities, and they think that substance use disorder doesn't exist because it was never brought up in their classrooms" (n.p.).

Disclosing as a Researcher

The stress resulting from concealing my addiction-recovery identity was particularly acute in my role as a qualitative addiction researcher. According to Ragins (2008), the decision to disclose stigmatized identities depends on many factors, including centrality to one's identity. Sometimes referred to as "mesearch" (Gardner et al., 2017) or "self-relevant research" (Devendorf, 2020), academics, especially social scientists, tend to research topics they have a personal stake in or experience with (Ross et al., 2020). On several occasions, I found that concealment prevented me from fully engaging with my research colleagues and participants. During my research interviews with people experiencing homelessness, it often felt appropriate to self-disclose in order to build safety and rapport, manage power

relations (Holstein & Gubrium, 1995), and minimize othering (Ross et al., 2020), especially when I sensed participants had shame around their own addictions. As a qualitative researcher, not disclosing also felt like “bad science” because I was “falling short of several qualitative methodological and ethical principles, including reflexivity and transparency” (Ross et al., 2020, p. 2).

One of the most memorable conversations I had in recovery regarding professional disclosure was at an AA meeting with a tenured English professor who had been sober for over 20 years. When I asked her if she was open about her recovery at work, she replied, “My recovery is like my athlete’s foot. I wouldn’t tell my students or colleagues about foot fungus, why would I tell them about being in recovery?” This was her experience, but I could not separate my lived experience from my work, it was the linchpin holding it together.

With the reassurance and support from my dean, I was ready to discard the mask once and for all. I received a grant to begin studying addiction disclosure experiences among university faculty members (Burns et al., in press). Similar to my experiences in the classroom, when appropriate, I intentionally disclose in addiction research, policy, and practice circles—because it brings a lived experience perspective that is largely absent (Read, 2016; Ross et al., 2020; Stull, 202; Sussman, 2021).

While I often choose to disclose, I am aware that disclosure in research and practice (including the classroom) needs to be used cautiously to avoid self-disclosures that are “excessive, gratuitous or self-serving” (Poindexter, 2003, p. 401). Also, I have yet to share my experience in research interviews with drug users themselves and recognize that the risk of sharing a “similar” experience from a privileged positionality may paradoxically exemplify differences (Abell et al., 2006). Overall, in agreement with Stull et al. (2021) I believe that there is a need for more open disclosure from addiction researchers with addiction, as a means to “access insights and understandings that are unavailable to addiction researchers without similar experiences, and also reduce stigma, and ultimately bring greater awareness to the human-ness and heterogeneity of addiction” (p. 1).

Disclosing Publicly

A final step in my disclosure journey has been “going public” through social media, and most recently by sharing my story in this peer-reviewed manuscript. Relatedly, I recently started an Instagram page called *@recoveringacademics* a community collective for academics in recovery and allies who are committed to addiction recovery research and social justice. The page is profiling academics in recovery, with hopes to build community and combat addiction stigma by celebrating recovery identities, as Dr. Wendy Dossett (personal communication, April 11, 2021) expressed:

Academia exerts powerful and toxic identity orthodoxies which make addressing stigma within universities particularly challenging. I commend the *@recoveringacademics* initiative for legitimising and celebrating a recovery identity, my identity, in what can sometimes be an inhospitable environment. Let’s make our universities recovery-friendly!

In 2020, as a Covid-19 quarantine project, I started a personal Instagram account called *@betesand-bites* to conduct disability and recovery advocacy. In the past year, my personal Instagram page has gained more than 5,000 followers, which includes people from diverse social locations around the world. I received direct messages from people who are “sober curious,” who are inspired to give sobriety a try after learning about my story. I have also participated in several audio podcasts (e.g., *Sober is Dope*, *Sober Gratitude*) where I have discussed the importance of sharing our stories to combat addiction stigma. While “recovering out loud” on social media has bolstered my recovery by reducing my own shame and connecting with the online sober community, it is important to acknowledge that various identity markers (gender, race/ethnicity, class, age) affect a person’s ability to disclose addiction-recovery safely (Kulesza et al., 2016).

Disclosure Risks and Privileges

I am a white, cis-gendered, educated, middle-class woman with invisible disabilities, all of which affected the risks of disclosing an addiction-recovery identity across various life domains. For instance, considering that women experience more denigrating attitudes (e.g., unfit mother, promiscuous) disclosing an addiction identity compared to men (Spooner et al., 2015), my gender may have put me at greater risk of discrimination. Second, negotiating several invisible disabilities (e.g., type one diabetes) reinforced the risk of disclosure, as I was used to experiencing invalidation and misunderstanding, which is common when disclosing invisible disabilities in the workplace (Prince, 2017).

My pre-tenure status also put me at greater disclosure risk. Even though I was aware of the increased casualization of university teaching (Klopper & Power, 2014) and associated scarcity of tenure-track positions, I had the security of an understanding dean and the privilege of union support. It is important to note that the tenure process is also somewhat specific to North America (AAUP, n.d.). Academic tenure in the United States and Canada is an indefinite appointment that protects university professions from dismissal and safeguards the intellectual freedom to develop and disseminate unpopular or controversial thoughts (AAUP, n.d.). It generally takes 5 years to achieve tenure status—which shifts the professorial rank from assistant to associate. In many countries (e.g., Australia), academics never secure a permanent or tenured position, and so the “wait for tenure” option is unrealistic and may never present itself (Klopper & Power, 2014).

When a person is already prone to being marginalized at work because of race and ethnicity, they are less likely to disclose and/or seek help for mental health issues (Wong et al., 2017). I had the privilege of not experiencing systemic discrimination tied to the color of my skin, that increases the risks of addiction while also reducing access to rehabilitation and recovery (Mendoza et al., 2019). While a full discussion on race, stigma, and addiction is beyond the scope of this paper, it is important to note that addiction treatment innovations have primarily targeted white communities, while people from racialized groups—including Black, Hispanic, and Indigenous communities—have been disproportionately targeted and punished for drug use compared to whites (Kulesza et al., 2016).

Drug choice also affects a person’s risk of discrimination. It is more acceptable to disclose legal drug use (e.g., alcohol) than illegal drug use, such as heroin and psychedelics (Roche et al., 2019). Although alcohol carries unique forms of stigma related to alcohol culture, it remains a legal drug and therefore reduces the stigma of disclosing compared to that of prohibited drugs. Relatedly, admitting past use is different than admitting current use. Research shows that length of time in recovery is an important part of the decision-making process of disclosing one’s addiction recovery (Brohan et al., 2012). I had 5 years sober when I started to disclose at work and more publicly. For instance, the participants in Romo et al. (2016) with more time sober, felt more secure with their sober identity and were more likely to disclose compared to those who were sober for 3 years or less. Correspondingly, in a news article, Valentish (2017) discusses the tensions of disclosing current drug use among researchers, pointing out that ““In the US redemptive recovery is acceptable, since it supports the dominant narrative of abstinence” (para x). In Canada, and other parts of the Western world (e.g., Europe, Australia, New Zealand), recovery is less mainstream compared to the USA, where collegiate recovery programs (Vest et al., 2021), and “recovering out loud” public figures and advocacy groups combatting anonymity are more common (Mikhitarian, 2015). Less visibility leads to greater misunderstandings of addiction and recovery, which can reduce positive claims to identity, thus reinforcing stigma and non-disclosure.

I was also privileged to be part of a faculty of social work, a discipline oriented toward social justice (CASW, 2005), with strong social science underpinnings, where deep immersion in the field is common (Hammersley, 2015). Along similar lines, there may be more understanding, legitimacy, and leeway to disclose in qualitative research where transparency and reflexivity is encouraged, in comparison to quantitative research (Ross et al., 2020). However, as with nursing and medicine, social

work is a professional faculty that may be riskier than other disciplines (e.g., sociology, gender studies, anthropology) because a record of harmful substance use could affect professional licensure (Ross et al., 2020).

Ultimately, additional research is needed to understand how various identity markers (e.g., gender, age, race, status in an organization, type of drug used) affect addiction disclosure decisions in academic settings. Whether an academic decides to disclose an addiction recovery identity is a deeply personal decision. It took me years of trial and error to reach the point where I couldn't hide anymore. In the end, my decision to disclose came down to a question of social justice, coupled with the preservation of my own mental health and recovery.

Recommendations and Next Steps

Raising Awareness About Alcoholic Environments and the Sober Paradox

A driving force in my continued use of alcohol was the entrenchment and normalization of alcohol, that I found to be particularly acute in the university context. To reduce the stigma associated with sobriety or even moderation, there is a need to increase awareness about how alcoholic environments promote drinking. Prior to getting sober, I was the first to contribute to alcohol culture, by engaging in seemingly innocuous behaviors, such as making drinking jokes, assuming people drank, and judging non-drinkers harshly. There are still occasions where I am triggered by its insidious messaging. For example, a colleague recently asked if I wanted to “work on our course outline together over wine.” Even though she meant no harm, I felt self-conscious. Not assuming people drink is a relatively simple, day-to-day action that can help destabilize alcohol culture, hence promote inclusion for non-drinkers, and combat self and public stigma.

The pervasiveness and taken-for-granted nature of alcohol culture makes it extremely difficult to *unlearn* it on our own. Therefore, at a more upstream level, there is a compelling case for a public health approach to prevention and interventions. For example, similar to what has been done in the tobacco industry, there is a need to encourage more ethical, responsible marketing of alcohol (Jernigan et al., 2017). Examples include restricting alcohol sponsorship of events and controlling overt signage outside liquor establishments that promote drinking (e.g., restricting two for one drink specials) and including health information and warning labels on alcohol packaging and campaigns (Stockwell et al., 2020). Ultimately, to reduce the sobriety stigma, increasing awareness about the truth about alcohol culture, including more transparency about alcohol harms, are promising ways forward.

Creating Recovery-Friendly Campuses

Catalyzed by my own experiences with addiction and the findings of a recent study on faculty member addiction stigma (Burns et al., in press), I am leading an emerging campus wide initiative working toward promoting recovery from addiction, building community, and combatting addiction stigma on campus. Specifically, the University of Calgary Recovery Community is inspired by two frameworks: Recovery Friendly Workplaces (RFW) and Collegiate Recovery Programs (CRPs).

Recovery-friendly workplace. Similar to LGBTQ+ friendly workplaces (Wax et al., 2018), there is a need for recovery-friendly workplaces where people who are in recovery or seeking recovery from addiction feel safe disclosing. There is a promising RFW movement launched in 2018 by Governor Sununu in New Hampshire, USA. A RFW is an initiative that “challenges stigma and empowers workplaces to provide support for employees in recovery and those impacted by substance use disorders” (Recovery Friendly Workplace, 2019, n.d.). To date, the RFW model has been adopted by over 280 workplaces representing nearly 70,000 employees across the state of New Hampshire. The zero cost RFW certification includes partnering with a RFW advisor who guides a variety of organizations through

educational trainings and stigma reduction programming (Recovery Friendly Workplace, 2019). Importantly, knowing that an organization is recovery friendly, helps reduce the stigma of disclosure, as employees have more assurance that if they disclose, they will be met with support rather than discrimination and punishment.

Collegiate recovery programs. A Collegiate Recovery Programs (CRP) is a “college [or university] provided, supportive environment within the campus culture that reinforces the decision to engage in a lifestyle of recovery from substance use. It is designed to provide an educational opportunity alongside recovery support to ensure that students do not have to sacrifice one for the other” (Association of Recovery in Higher Education, 2021, n.p.). There are currently 138 CRPs across the USA (Vest et al., 2021), and two in Canada (University of British Columbia and University of Windsor). While CRP programming is diverse, “best practices” include dedicated university staff, peer support, built-in sober spaces, and alcohol-free events and college residences (Vest et al., 2021). Building from existing CRP models, this study supports the implementation of intentional recovery programming for all university members, including faculty who are struggling with addiction. Similar to these programs, peer support models and recovery coaching could be implemented in the workplace to support faculty and staff at various stages of their recovery journeys.

Finally, having more members of our campus community disclose an addiction-recovery identity, helps reduce addiction stigma while also providing sober role models for others (Wessel, 2017). In agreement with Supki and Lindsay (2017) abstaining from alcohol needs to be viewed as part of a positive claim to identity. George was the first academic I encountered who was sober, something I never thought possible. In hindsight, he was the recovery role model I needed to show me that sobriety was not only possible, but desirable. The United-States based organization Faces and Voices of Recovery has provided much of the driving force for the “loud and proud” recovery revolution, arguing that secrecy and anonymity has fueled the lack of public awareness of what recovery is, which inadvertently contributes to ongoing stigma (White, 2007). Ultimately, having more members of the campus community “recover out loud” is needed to raise awareness, reduce stigma, build community and connections, and pave the way for others to come forward and seek help.

Conclusion

Guided by the concepts of stigma and alcogenic environments, this paper explores the disclosure experience of an assistant professor in long-term recovery from alcohol addiction. By revealing the unique risks, benefits, and paradoxes of disclosing a recovery identity, it argues that disclosure can be a promising way to strengthen recovery, combat self and public stigma, help build community, model authenticity and transparency in teaching and research roles, shift university drinking culture, and provide a safer environment for others to disclose and/or seek help. Importantly, there is no one-size-fits all to recovery or disclosure. By raising awareness about the hidden stress academics may encounter when navigating addiction disclosure decisions, my hope is that academic contexts become more inclusive regardless of where an individual falls on the addiction-recovery spectrum.

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Note

1. Names and identifying details have been changed to protect privacy.

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