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Project Report

Personal identity loss, alcohol dependency and intervention

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Acknowledgements

Thank you to the research project and Manchester Metropolitan University for supporting the research.

Thank you to the participants who took the time and showed resilience in sharing their stories.

‘I am surrounded by people who drink…. I’m no different from anybody else but to them, I’m the alkie’.

Main Report

Introduction

What is the problem?

Personal identity or individual identity ‘is not internal or asocial’ (Mclaughlin, 2012, p.30). It is in continual flux and change dependent on not only how the individual perceives themselves but also how society, as a collective and constructive power, chooses to ‘impose, destroy or erase [personal] identities’ (Pathak, 2017, p.118).

For people living with alcohol dependency, the imposed identity of alcoholic, weak, dangerous and solely responsible for their dependency works to remove their status within society, rendering them invisible and their personal identity removed, due to an ‘acceptance of social discrimination’ (Kilian, *et al*., 2021 p. 909; Schomerus *et al.,* 2011; Fukuyama, 2019). Therefore, people living with alcohol dependency comprise one of the most stigmatised groups (Schomerus *et al.*, 2011).

What has been done to address the problem so far?

Existing literature identifies that people living with alcohol dependency see strength and joy within their drinking culture. However, this is not the case for those who have lost their personal identity and struggle to maintain their existence. In some cases they absorb the view of others and in doing so dehumanise themselves, taking away their own voice within the world in which they live. The literature also highlights how intervention, when delivered correctly, can support alcohol dependent people to start to regain their personal identity and re-build themselves (Mackintosh and Knight, 2012).

What is currently unknown?

The perspectives of the individual are insignificant to that of the views held by society, reinforcing that these people are invisible and unworthy (Schomerus *et al.,* 2011; Fukuyama, 2019; Kilian, *et al*., 2021).

There is a plethora of research linking alcohol dependency to social identity, housing and ill health. However, the gap within the literature is significant when addressing the loss of personal identity for people living with alcohol dependency as a standalone topic, therefore failing to inform practice, develop knowledge and give people living with alcohol dependency an identity outside of their dependency.

What is not clear is how people living with alcohol dependency perceive their own identity when seeking recovery. This is due to the lack of studies that demonstrate validity, credibility or relevance, highlighting a need for additional research, which can be replicated and add weight in the field of alcohol dependency.

Aim and objectives of the research

To explore the loss of identity in people living with alcohol dependency and how it might impact interventions.

Objectives:

1. Use narratives to explore identity and its role in people living with alcohol dependency

2. Using information on role identity to inform intervention and practice

‘She didn’t have a real Mum, yer, the real person that I am. I just felt like someone had taken a big section out of me’

Methods

Design

A hermeneutic phenomenological approach was taken, guided by constructionism, which supported the use of open and deep interviews (Roller and Lavrakas, 2015), which later allowed the audio data to be used for interpretive transcript analysis (Fuster-Guillen, 2019; Lapadat and Lindsay 1999).

Setting

The interviews took place face-to-face, within a detox project, Manchester, UK.

Participants

Narratives were collected from participants, living with alcohol dependency, during the summer of 2023. There was an equal split of male to female, aged between 27-70 years. The participants were referred to detox either by statutory services or self referred; some only completing the 7 day detox and others going onto residential rehabilitation. The number of previous detoxes varied from one to six. There was a diverse range of social and economic backgrounds.

Sampling Method

Non-probability, purposeful sampling was used to recruit the participants. This was to solely address people living with alcohol dependency that were in a residential detox project, therefore making the population (people living with alcohol dependency) into a mutually exclusive/limited subgroup (Patton, 2002).

Participant Recruitment

Weekly Community Meetings were attended by the researcher to explain the research and allow questions to be asked face to face before participation. Other group sessions were attended, one to two times per week, resulting in 9 more visits outside of the data collection. This supported capturing interest in the research and how support could be provided to potential participants on a 1:1 basis. Ten participants were recruited.

Data collection methods, instruments and technologies

Interviews were chosen due to the decision to use Hermeneutic Phenomenology and the use of the Biographical Narrative Interpretive Method (Wengraf, 2004). Within this method one open question is asked to support the participant to tell their life-story how they wish to tell it, with minimal interference, unless support to answer the research question is required. The approach reduced the participant being silenced allowing their narrative to be heard.

Data analysis

All ten narratives were transcribed from the audio recordings. A naturalised approach to the transcription supported the research, therefore included were all pauses and filler sounds i.e., erm, you know, like etc., as language gives meaning and constitutes real-life phenomena, with verbal and non-verbal languages and interactions shaping communicative meanings (Schegloff, 1997; Widodo, 2014).

Ethical Issues

Ethical approval was obtained from MMU via EthOS (Ref: 50054) and the Research Committee of the project.

‘There was nothing left that makes you human’

Findings

Historical Loss

All 10 participants had experienced a previous loss before either their introduction to alcohol or their increase in alcohol consumption. The loss was either presented in terms of structure/routine, mental health, relationship/family breakdown and child abuse. Child abuse is a devastating power in terms of essential identity development during childhood (Muldoon et al, 2024), upheaval of familial roots and organisational change.

‘They stopped me seeing him, so since November, I have been drinking quite a bit. I won’t say heavily drinking, 6-7 cans Kestrels super strong, 9% larger but I used…as soon as I woke up in the morning, it was open a can and a can would last me 3 hours and it would last all day….I need to start having [my grandson] again’

Numerous Losses

Not only was there a loss of personal identity, but there was also a plethora of other losses (ambiguous and disfranchised), in terms of geographical loss (displacement). Other losses were; maternal loss, loss of positive mental health, loss of physical health, familial loss, relationship loss, loss of freedom (not only physical and mental but judicial), loss of gender norms, employment loss and loss of healthcare engagement, finally the loss of time, either through blackouts, hospital admissions/ GP appointments, detox or intoxication. Familial loss was present in all 10 narratives.

‘And again my mother died quite early in her age at 62, my step father died quite early in his age, 55 I think and I inherited my grandmother who dies at age 92, so looking after a granny, trying to do my job, working away from home, looking after 4 kids…. I am not making it excuses but it is no wonder I did what I did to chill out and relax, you know’.

Findings

Layers of loss

The above demonstrates a move away from a narrow, medicalised view of loss, as it addresses fundamental layers of what it is to be human (Charmaz, 1983), taking into consideration the traumatic experience of alcohol dependence and that the layers that are lost for each person are without sequence and ungeneralisable. This highlights how individualised each person living with alcohol dependency needs to be supported, as each stage is personal to the experience.

Physical Loss

Within the narratives, addressing physical loss alone, a person living with alcohol dependency can observe a dramatic change within their own self-image. There is a shift to increase their alcohol consumption, which results in self-neglect and creates a metamorphosis of a disappearing former self into an unrecognisable self and an inability to be psychologically present (Testoni et at, 2020; Boss, 2016). However, the loss of their former self is dismissed, discredited, not validated.

'I had to have the drips and all the intravenous, to get fluid back in me, because I had nothing left, you know fluid wise. Potassium levels had gone. Sodium levels, you know, everything that makes a person. The vitamins, there was no, what you call it, I had nothing inside me apart from alcohol. That was keeping me going, just the alcohol.'

Identity: Lost, Gained and Enforced

In relation to personal identity, three levels were distinguished in this research, which were either through self-identification, or how the participants interpreted the views of others:

1 **Identity Lost**

2 **Identity Gained**

3 **Identity Enforced**

‘It’s taken my friendships away because I have to pretend that I am okay.’

Identity Lost

In terms of identity lost (e.g., mother, husband, son, employee, dependable, mentally well, father, friend, wife, functioning, reliable, trustworthy), all the participants experienced this and none noted that they were supported to grieve, or that professionals acknowledged the levels of exhaustion the participants carried.

Lost identity also came to light when some participants discussed who they wanted to be within their social networks, once they have been through the detox process and no longer had the identity of someone who consumed alcohol. This is a clear challenge to previous models that people living with alcohol dependency are and always will be an *alcoholic* (Rudy, 1986). This came through as a strong sense of grief because the alcohol dependent identity had offered them something to pin themselves to, as if a sense of comfort, stability and escape from something chaotic; therefore, as Mohr et al, (2017) and (Dickter et al, 2014) note, alcohol becomes a means of escaping the self.

The loss of identity also created a sense of fear, to the point where some participants were not fully ready to let go and stated that they would still drink, suggesting that a 7 day detox may not address wider issues, such as take into account underlying factors for a person's alcohol dependency and there may be a greater need for flexible and bespoke treatments.

'I am known as the guy who comes in here with a bottle of whiskey and he drinks and because he lives next door, he can just walk down. Now I am going to turn up without a drink. So there is so much that has changed me as a person. I am keen to do this and the change that is going to occur, it frightens me.'

When it came to professional interaction the participants felt that their identity was lost within preconceived ideas of alcohol dependency. This was in terms of how physical intervention was given, the tone at which the participants were spoken to, how professionals saw the participants' alcohol dependency and a reduction in consumption as the participants' primary and sole need, also some participants felt invisible due to generic and process driven assessments.

'I don't think GPs really understand and when you do to A&E and when you say you are alcohol dependent, erm. I feel like I am walking around with a label on my head. Not that anyone says anything.'

Identity Gained

Identity gained, was seen positively, as it enabled the participants to connect with the wider community, giving a sense of camaraderie and belonging, or a justification for their alcohol dependency. This occurred more so for those with poor mental health, who were using alcohol to self-medicate; they and the World Health Organisation (2001) agreed, being mentally unwell has a greater stigma. This suggests some participants had not received the correct professional support, information and guidance on alcohol dependency and its impact, nor had they received any mental health intervention, hence the need to self-medicate. In Manchester (UK), for those who live with alcohol dependency, 70% to 80% also have mental health difficulties (Greater Manchester Mental Health NHS, 2024). However, in the UK, there is not a standard statutory agency funded to offer specialist support. NICE (2016) guidelines (Coexisting severe mental illness and substance misuse: community health and social care services) encourage all stakeholders to step up in meeting the person's needs. However, there needs to be caution given, as from the collected narratives it is clear that the interpretation of an identity is individualistic and cannot be taken for granted in carrying the same meaning for all people living with alcohol dependency.

‘I had a really good job … Erm, everything was fine and then because of my mental health, I had to leave that job, so I left. Everything from there went down hill, before that I had never touch alcohol. I hate the smell of it, I hate being around it, I hate everything, about, that came with it but one day. One day the feelings got too much and I went to the shop, I decided ‘I’m gonna buy a small bottle’ just to numb myself. So I did that, it started off little by little, then all of a sudden it became everyday.’

‘’That’s because she’s an alkie’. So they all think I’m an alkie, well obviously, I’m an alkie, otherwise I wouldn’t be here but I am not, see I do not drink as much as them’.

Identity Enforced

When addressing an enforced identity, this presented itself as something that was socially attached to the individual. This identity had extreme connotations, which the participants tried to create a disconnect between themselves and the identity that was being enforced. This was also true when the participants were enforcing a personal identity upon themselves; Koob (2013), West and Brown (2013), Furnham and Lowick (1984) and McCord et al (1959) support this, as they suggested this is due to the participants potentially fighting against their social conditioning of the views around alcohol dependency. The enforced identity was believed to be unjust and not a true representation of who the participant was, even if they had self labelled and taken on the enforced identity of alcoholic, 'alkie' or 'weak'.

'But it's the clinical thing, that's what pisses me off. They won't look at me because I use alcohol […] It's probably written on my records 'alckie' or 'Molly Mop drinks a lot of alcohol' […] Erm, I am 'Molly Mop the alckie from down the street'. I've got a label and it feels horrible. Horrible.'

The enforced identity within the narratives invoked anger and frustration from the participants. This presented itself in the participant justifying their dependency, in terms of pushing their previous loss or creating a hierarchy to demonstrate that they are better than the enforced identity. Therefore, they never fully took ownership and distanced themselves from the enforced identity, resulting in a continual conflict. The enforced identity also called for the participant to fight to be seen as their preferred personal identity and someone that was being forced to fit within the social norms of labelling and discrimination.

'When I was in hospital, the nurses did not treat me any differently but I remember one doctor come, you know when they put the curtain around to talk to you? He literally shouted it out to the whole bay. Saying stuff like 'oh yer your back again because it's your alcohol''

Identity Enforced

However, some participants seemed to take ownership of the enforced identity to reduce further exclusion and minimise any grief associated with the enforced identity, e.g., I'm the alkie. Taking on the negative and stigmatising label gave the participant power, as once the participant had labelled themselves as 'the alkie' the label became less stigmatising and as Bianchi et al (2024) and Galinsky et al (2013) suggested, less powerful in terms of its derogatory meaning.

Enforced identity was what all participants were fighting against and this appeared to carry the biggest burden for healing and recovery due to the emotional weight of stigmatisation. The stage at which a specific identity was enforced by self, or others was dictated significantly by culture, religious beliefs, the level of professional intervention and the stage at which the participant's alcohol dependency became known to others and discriminated against, either through smell, the inhibition of functioning (including social isolation) or antisocial behaviour.

'It was only 6 months ago that I found out of some of what people had been saying and I wanted to go out and smash their faces in because they are all alcoholics themselves.'

'I have tried to engage with mental health services and stuff like that but they are very… they won't touch you, they won't…unless you're not drinking, they are basically like 'you know you're an alcoholic, that's your problem. If you stop drinking, it will get…' the thing is I have had periods of abstinence […] I felt let down with the mental health service, I felt let down with the doctors, I kinda felt just shunned because they just wanted to keep putting me on tablets and that did not help, so I just kept drinking, kept drinking.'

Recommendations

1

Time and space needs to be given to the individual to explore how each change or loss in their personal identity has impacted on their social wellbeing and their inability to retrain their habitual drinking patterns. This should be done through key worker sessions before and during detox via assessments, interviews and 1:1 support, to allow time to explore the person's journey through change of identity. Therefore, staff will then be able to address the individual's wellness, taking into consideration the numerous losses that preceded the person's alcohol dependency and how societal stigma, discrimination and loss has led to a plethora of changes within the individual's personal identity.

2

It should always be acknowledged, by all professionals and staff working in the field of alcohol dependency, that individuals living with alcohol dependency are battling with numerous personal identity changes at different stages of their alcohol dependency, with no set timeline from person to person, as this is dependent on their social, cultural and environmental background.

3

Staff and professionals need to acknowledge and reflect on their own bias and judgements of people living with alcohol dependency and ensure they seek extensive and effective supervision to guarantee that any held stigma and/or bias is eradicated. This can be done through reflective case study pieces, which are then discussed in supervision where supportive conversations can take place.

'…I feel that leaves me living in that cocoon and when I am alone, it just means one thing'

4

When working in partnership with people living with alcohol dependency, the environment is essential, as it must harnesses the essence of respect, home, safety, privacy and nature, as this will guarantee a reduction in discriminatory and stigmatising practices and aid wellness.

5

The participants in this study stated that they experienced oppressive language, that is entrenched within the disease model of addiction from various professionals, for example, ‘alcoholic’, ‘morally weak’, ‘alkie’. Therefore, we need to move away from this discriminatory language from all aspects of practice. Following this will support the removal of an enforced identity and greater outcomes for people living with alcohol dependency.

In summary

People living with alcohol dependency need to be given time and space to explore and grieve for their previous loss. They need to work alongside professionals to understand their identity journey and the impact negative generic assessments and processes can have on someone who is already severely stigmatised. Also, just as important, providers need to ensure environments have strong elements of home and nature, so as to harness an open conversation of a person’s personal identity and the impact this has on a person’s recovery.

‘One is too many, a thousand is never enough’

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‘I did mess up, I made a mistake, I relapsed but they kicked me out and again that’s rejection.’