Advanced International Journal for Research (AIJFR)
E-ISSN: 3048-7641 ● Website: www.aijfr.com ● Email: editor@aijfr.com

Alcoholics Anonymous as a Protective Enclave: Reconsidering the Role of Internalized Stigma in Psycho-Spiritual Wellbeing Among Recovering Alcoholics Members in Mokokchung Town, Nagaland

Temjensunep Longchar

Research Scholar, Faculty of Theology and Religious Studies

Abstract

Internalized stigma is widely recognized as a significant barrier to recovery from Alcohol Use Disorder (AUD). Individuals who internalize negative societal perceptions regarding alcoholism frequently experience shame, social isolation, reduced self-esteem, and poorer psychological outcomes. Although extensive research has demonstrated the adverse effects of stigma on recovery, limited attention has been given to the role of recovery-support communities in mitigating these effects. This study examined the relationship between internalized stigma and psycho-spiritual wellbeing among Alcoholics Anonymous (AA) members in Mokokchung Town, Nagaland. A quantitative descriptive was employed using purposive sampling design involving 108 AA members. Data were collected using the Alcohol Recovery and Wellbeing Scale (ARWS) and the Psycho-Spiritual Wellbeing Scale (P-SWBS). Pearson correlation and independent samples t-test analyses were conducted to examine the association between internalized stigma and psycho-spiritual wellbeing. Findings revealed a weak negative relationship between internalized stigma and psycho-spiritual wellbeing ($r = –.147$, $p > .05$). Participants reporting lower levels of stigma demonstrated slightly higher psycho-spiritual wellbeing than those reporting higher stigma; however, the difference was not statistically significant, $t(106) = 1.07$, $p = .286$. Contrary to expectations and much of the existing literature, internalized stigma did not emerge as a significant predictor of psycho-spiritual wellbeing. The findings suggest that participation in AA may provide protective social and spiritual resources that buffer the detrimental effects of stigma through fellowship, shared recovery identity, social support, and spiritual growth. The study contributes to addiction recovery literature by highlighting the potential buffering role of AA within a culturally and spiritually distinctive context.

Keywords: Alcoholics Anonymous, internalized stigma, psycho-spiritual wellbeing, recovery, spirituality, social support, recovery capital.

1. Introduction

Alcohol Use Disorder (AUD) is a disease which is considered as a public health crisis affecting individuals all over the world. It affects individuals not only in their physical but also in their psychological, social, and spiritual domains. Beyond the direct consequences of alcohol dependence, individuals with AUD frequently encounter stigma, which remains one of the most pervasive barrier to treatment seeking, recovery participation, and overall wellbeing (Tripathi et al., 2025). Stigma is defined as the devaluation, labeling, and discrimination directed toward individuals perceived as socially undesirable or morally deficient (Corrigan & Rao, 2012). Among people with AUD, stigma operates both externally through social rejection and discrimination, and internally through self-stigma, whereby individuals internalize negative societal beliefs about alcoholism (Schomerus et al., 2010; Yang et al., 2017).

Internalized stigma can also be particularly harmful because it affects how individuals see themselves. This impacts their recovery journey as they themselves see them as failures. Looking at the wider literatures, self-stigma is consistently linked with increased feelings of shame, guilt, worthlessness, social withdrawal, reduced self-efficacy, poorer mental health outcomes, and a heightened risk of relapse (Crozier et al., 2023; Matthews, 2019; Lamb & Kougiali, 2024). Due to these factors, stigma is widely recognized as a critical psychosocial factor that influences recovery process among individuals with alcohol dependence.

However, recovery from AUD is not solely determined by the presence or absence of stigma. Contemporary recovery literature emphasizes the importance of social support, community belonging, and spiritual resources in promoting sustained recovery and wellbeing. Alcoholics Anonymous (AA), one of the most widely utilized mutual-help recovery fellowships worldwide, provides a distinctive recovery environment characterized by peer support, shared experiences, accountability, acceptance, and spiritual growth (Kelly et al., 2020). Through participation in AA, members are encouraged to reconstruct their identities around recovery rather than addiction, fostering a sense of belonging and personal transformation (Alcoholics Anonymous World Services, 2001; Kelly et al., 2020).

Within such an environment, the relationship between stigma and wellbeing may differ a lot from patterns observed in the broader society. The supportive nature of AA may be particularly relevant in mitigating the adverse effects of stigma. Unlike broader social environments where individuals with AUD may face judgment and exclusion, AA promotes confidentiality, mutual acceptance, and shared vulnerability (Wnuk, 2022). Such characteristics may reduce feelings of shame and social isolation while strengthening recovery-oriented identities and psychosocial resilience. Consequently, the relationship between internalized stigma and wellbeing among AA members may differ from patterns commonly observed in clinical or community-based populations. Existing studies from India have examined stigma in substance use disorders (Panda et al., 2020) and the role of family support in recovery (Yanthan & Singh, 2019), but no study has specifically investigated whether AA participation buffers the negative effects of internalized stigma on psycho-spiritual wellbeing, particularly within the socio-cultural context of Northeast India.

The present study is situated within Mokokchung Town, Nagaland, a predominantly Christian and close-knit society where alcohol use is shaped by both cultural and religious norms. Although alcohol consumption is legally prohibited under the Nagaland Liquor Total Prohibition Act of 1989 and is often regarded as a moral and spiritual concern, however, alcohol-related problems continue to affect many

individuals and families. Within this socio-cultural context, persons struggling with alcohol dependence may experience heightened shame and social disapproval. Simultaneously, AA fellowships function as alternative communities that offer acceptance, support, and opportunities for spiritual growth. Whether this environment alters the typical stigma-wellbeing relationship remains unknown.

Therefore, this study was guided by the following research question: How does internalized stigma and denial relate to psycho-spiritual wellbeing among Alcoholics Anonymous members in Mokokchung town?

Based on existing stigma literature (Schomerus et al., 2010; Zia & Mackenzie, 2021; Kulesza et al., 2017), it is hypothesized that higher levels of internalized stigma and denial would be negatively associated with psycho-spiritual wellbeing among AA members in Mokokchung town. however, given the supportive and spiritually grounded nature of AA fellowship, it is also considered the possibility that this relationship might be weaker than observed in general community samples.

2. Method

2.1 Study Design and Participants

The study employed a quantitative cross-sectional research design. The sample consisted of 108 Alcoholics Anonymous members from various AA fellowship groups in Mokokchung Town, Nagaland.

2.2 Sampling Technique

A purposive sampling technique was employed to recruit participants for the study. This non-probability sampling method was considered appropriate because the study specifically targeted individuals who were active members of AA and possessed first-hand experience of alcohol recovery. Participants were selected based on predetermined inclusion criteria, including active participation in AA fellowship and willingness to participate in the study.

2.3 Data Collection

Data were collected through a structured questionnaire administered to eligible AA members in Mokokchung Town, Nagaland. Prior to data collection, permission was obtained from the relevant AA group representatives, and eligible participants were invited to take part in the study. The purpose, procedures, and voluntary nature of the study were explained to all participants, and written informed consent was obtained before participation.

Ethical approval for the study was granted by the University Research Ethics Committee (UREC), Martin Luther Christian University, Shillong (Ref: III/DDSR-Th/UREC Theology/20/2021-2426, dated May 29, 2025). Participants were assured that their responses would remain confidential and anonymous and that they could withdraw from the study at any stage without any negative consequences. The questionnaire included demographic items, the Alcohol Recovery and Wellbeing Scale, and the Psycho-Spiritual Wellbeing Scale. A total of 108 completed questionnaires were retained for statistical analysis.

2.4 Instruments

Data were collected using a structured questionnaire comprising demographic information, the Alcohol Recovery and Wellbeing Scale (ARWS), and the Psycho-Spiritual Wellbeing Scale (P-SWBS).

2.4.1 Alcohol Recovery and Wellbeing Scale (ARWS)

The Alcohol Recovery and Wellbeing Scale (ARWS) was developed by the researcher to assess multidimensional recovery experiences among AA members. The scale was specifically designed to capture psycho-spiritual and socio-cultural aspects of recovery relevant to the study context. The ARWS consists of 54 items organized into nine dimensions: Anxiety, Depression, and Stress; Family Relationship and Social Support; Spiritual Progress; AA 12-Step Participation and Sobriety; Stigma and Denial; Spirituality; Physical Health; Relationship with Others; and Changes in Economic Stability. Responses were measured on a five-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). The scale demonstrated excellent internal consistency in the present study, with a Cronbach's alpha coefficient of .95, indicating high reliability.

2.4.2 Psycho-Spiritual Wellbeing Scale

Psycho-spiritual wellbeing was assessed using the Psycho-Spiritual Wellbeing Scale (P-SWBS) developed by Egunjobi, Habimana, and Onye. The instrument consists of 25 items distributed across five dimensions: self-awareness, connectedness, meaningfulness, compassion, and self-transcendence. These domains collectively assess the multidimensional nature of psycho-spiritual wellbeing. Responses were recorded on a five-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), with higher scores indicating greater psycho-spiritual wellbeing. The scale demonstrated excellent reliability in the present study (Cronbach's $\alpha = .95$). Previous validation studies have established its construct and domain validity, supporting its suitability for assessing psycho-spiritual wellbeing among individuals in recovery.

2.5 Data Analysis

Data were analyzed using SPSS. Pearson correlation examined the bivirate relationship between internalized stigma/denial and psycho-spiritual wellbeing. An independent samples t-test compared between low-stigma and high-stigma groups (median split; median = 15.00). Simple linear regression assessed the predictive effect of stigma on psycho-spiritual wellbeing. Statistical significance was established at the .05 level.

3. Results

3.1 Demographic Characteristics

The sample consisted of 108 male AA members. The majority of participants (48.1%) were aged 35-44 years, followed by 29.6% aged 45-54 years. Most participants (63.0%) were married, and 59.3% had been AA members for five years or more. Regarding sobriety duration 58.3% had maintained sobriety for more than one year. The majority (91.7%) lived with family or relatives, and 43.5% held graduate degrees.

3.2 Correlation Between Internalized Stigma and Psycho-Spiritual Wellbeing

Table 1

Correlation between internalized stigma and psycho-spiritual well-being

Variables	Internalized Stigma and Denial	Psycho-Spiritual Wellbeing
Internalized Stigma and Denial	-	-.147
Psycho-Spiritual Wellbeing	-.147	-

Note: *n*=108, *p* > .05

To examine the relationship between internalized stigma and psycho-spiritual wellbeing among AA members in Mokokchung town, Pearson correlation analysis was conducted. The results revealed a weak negative correlation between internalized stigma and psycho-spiritual wellbeing (r = –.147, *p* > .05), indicating that higher levels of stigma were associated with slightly lower levels of psycho-spiritual wellbeing. However, the relationship was not statistically significant (Table 1).

Table 2

Independent Samples t-test Comparing Psycho-Spiritual Wellbeing by Internalized Stigma Level

Stigma Group	*n*	*M*	*SD*	t(106)	*p*
Low Stigma	76	3.76	0.56	1.07	.286
High Stigma	32	3.63	0.68		

Note: Participants were divided into Low and High Stigma groups using a median split of the stigma and denial scores (median = 15.00). The dependent Variable was Psycho-Spiritual Wellbeing.

To further explore differences in psycho-spiritual wellbeing based on stigma levels, participants were categorized into low-stigma and high-stigma groups using a median split procedure. An independent samples t-test showed that participants in the low-stigma group (M = 3.76, SD = 0.56) reported slightly higher psycho-spiritual wellbeing than those in the high-stigma group (M = 3.63, SD = 0.68). Nevertheless, the difference between the groups was not statistically significant, t(106) = 1.07, *p* = .286 (Table 2).

Table 3

Regression Analysis

Predictor	B	SE
Internalized Stigma and Denial	3.79	0.39

Note: R=.34, R^2=.11, F(1,106)=6.67, *p*=.002

Simple linear regression (Table 3) indicated a significant model, $F(1,106)=6.67$, $p=.002$, with a correlation coefficient $R=.34$ and $R^2=.11$. This suggests that internalized stigma and denial explained only 11% of the variance in psycho-spiritual wellbeing—a small effect size.

These findings indicate that internalized stigma and denial were not significantly associated with psycho-spiritual wellbeing among AA members in Mokokchung town. Although the direction of the relationship was consistent with the hypothesis, the effect size was weak and failed to reach statistical significance. Therefore, the hypothesis proposing a negative association between internalized stigma and psycho-spiritual wellbeing was not supported.

4. Discussion

The central finding of this study—that internalized stigma demonstrated only a weak, non-significant association with psycho-spiritual wellbeing among AA members in Mokokchung town—challenges the widely accepted assumption that stigma is an inevitable and powerful barrier to recovery (Schomerus, 2013; Yang et al., 2017). Within the broader literature, stigma is consistently linked to shame, social isolation, diminished self-worth, and poorer mental health outcomes among individuals with substance use disorders (Crozier et al., 2023; Matthews, 2019; Panda et al., 2020). However, the present findings suggest that within the specific context of the AA fellowship in Mokokchung town, these negative effects are substantially mitigated. Several explanations may account for this outcome.

First, Cohen and Wills' (1985) Stress-Buffering Model proposes that social support protects individuals from the negative effects of stressful experiences—including stigma—by providing resources that redefine the threat and enhance coping. Within AA, the structure of AA's 12-steps model may function as a protective social environment that reduces the psychological burden associated with stigma. AA meetings encourage members to openly share personal experiences within a non-judgmental atmosphere characterized by empathy, acceptance, and mutual understanding. Such interactions may normalize recovery challenges and reduce feelings of shame and social isolation.

Second, the Social Identity Model of Recovery (Best et al., 2015) suggest that recovery is facilitated when individuals shift from an identity defined by addiction to an identity defined by recovery membership. Within AA, members are not defined by their past drinking but by their commitment to sobriety and mutual support. AA promotes the development of a recovery-oriented identity. Rather than defining themselves by addiction, members increasingly identify with a community committed to growth, sobriety, and service (Frings et al., 2019). This identity transformation may weaken the influence of negative societal labels and reduce the internalization of stigma. This social support appears to serve as a critical buffering mechanism. The presence of peers who have faced similar struggles may diminish feelings of alienation and reinforce a sense of belonging. Within such supportive environments, the positive effects of fellowship, spirituality, and social connectedness may outweigh the negative influence of stigma on psycho-spiritual wellbeing.

Thirdly, one mechanism on why stigma loses its power within AA is because of AA's non-judgemental ethos. The core principles of AA—confidentially, mutual support, and shared experiences—create an environment where members can disclose their struggles without fear of condemnation. Unlike the broader, which often views individuals with AUD as morally weak or lacking self-control, AA reframes addiction as a disease and recovery as a spiritual journey (Kurtz, 2002). This reframing allows members to shed self-blame and receive validation from peers who share similar experiences.

Another mechanism is the integration of Christian values. In the context of Mokokchung town—a predominantly Christian community where forgiveness, grace, and redemption are central theological themes—AA's spiritual language resonates deeply with local cultural values. The church's emphasis on new life and second chances reinforces AA's message of transformation, creating overlapping communities of acceptance. As Grim and Grim (2019) note, when faith communities operate as supportive rather than punitive structures, they can significantly reduce the social toxicity of stigma. Additionally, the restorative practices of the AA-12 steps where in the amends process (Step 9) and ongoing moral inventory (Step 10) allow individuals to address past harms not through avoidance or denial, but through concrete actions of reconciliation. This process of "moral repair" restores dignity and moral agency—precisely the dimensions most eroded by stigma (Moutray, 2020).

The findings therefore suggest that while stigma remains a reality for many recovering alcoholics, its impact may be substantially reduced within recovery environments characterized by acceptance, spiritual engagement, and strong interpersonal support. The presents findings also invite a reconsideration of the role of stigma in theoretical models of addiction recovery. Rather than viewing stigma solely as a static, individual-barrier, it may be more usefully conceptualized as a socially mediated variable shaped by cultural norms, spiritual values, and community context. Within the bio-psycho-social-spiritual model of recovery (Engel, 2012), stigma is understood not merely as a psychological burden but as a relational-spiritual disruption that can be repaired through acceptance, grace, and belonging.

The parent thesis articulates this well: *"By providing a safe space where participants feel understood and accepted, AA serves as a protective agent against the psychological damage caused by public stigma and shame. Therefore, we see a diminished stigma within the unique psychological and spiritual framework of the AA community, creating a healthy environment for individuals to work on their psycho-spiritual wellbeing and remain committed to sobriety."*

Effective recovery interventions, therefore, must focus not only on reducing and internalized stigma through awareness campaign but also on cultivating spiritual and communal environments that promote dignity and connection. The antidote to stigma lies not merely in information but in the creation of compassionate communities—such as AA and faith-based fellowships—that embody forgiveness, hope, and relational restoration.

6. Conclusion

This study examined the relationship between internalized stigma and psycho-spiritual wellbeing among Alcoholics Anonymous members in Mokokchung Town, Nagaland. Contrary to expectations, internalized stigma demonstrated only a weak and statistically insignificant relationship with psycho-spiritual wellbeing. The findings suggest that Alcoholics Anonymous may provide important social and spiritual resources that mitigate the harmful effects of stigma. Through fellowship, shared identity, spiritual growth, and supportive relationships, AA appears to create a recovery environment that promotes resilience and psycho-spiritual wellbeing despite the continued presence of stigma. These findings contribute to a growing body of evidence emphasizing the importance of recovery-oriented communities in fostering holistic recovery and long-term wellbeing.

Future research should examine stigma-wellbeing relationships longitudinally, include female participants through targeted recruitment strategies, and compare AA members with non-AA samples to further isolate the protective mechanisms identified here.

Conflict of Interest

The author declares no conflict of interest. This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. The author has no financial or personal relationships that could inappropriately influence or bias the content of this paper.

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