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# Personal Privacy and Public Recovery Advocacy

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A central strategy of the new recovery movement is sharing our stories in public and professional venues to change public perceptions and public policies related to addiction and recovery. Drawing from earlier social movements, we learned that "contact strategies"—increasing personal contact between marginalized and mainstream populations—is one of the most effective means of reducing stigma and discrimination and expanding opportunities for full community participation. Public attitudes toward those recovering from alcohol and other drug problems become more positive when members of the public have positive exposure to people living in long-term recovery with whom they can identify.

We also learned that there were limitations to this approach of public recovery storytelling. Changing personal attitudes of those exposed to our stories left in place much of the institutional machinery (e.g., laws, policies, and historical practices) that negatively affected individuals and families experiencing alcohol and other drug problems. Twenty years into the new recovery advocacy movement, discrimination against us remains pervasive. We must remain vigilant to prevent appropriation of our stories by others to support unrelated agendas. When this happens, we experience further marginalization.

People in recovery face discriminatory barriers in housing, employment, education, professional licensure, health care, and numerous arenas of public participation (such as voting and holding public office). Laws and regulations intended to protect us from discrimination remain unenforced. Addiction treatment remains of uneven quality, often lacking in long-term recovery orientation, and limited in its accessibility and affordability. Too many communities lack long-term recovery support services. And people in recovery continue to be excluded from meaningful representation within alcohol and drug and criminal justice policy discussions and decisions.

It is in this context that we must be clear about what our public recovery storytelling can and cannot achieve, and relatedly, who precisely is responsible for eliminating entrenched policies and practices that have such a direct impact on our lives.

There is a paradox within our anti-stigma efforts. We must challenge oppressive barriers to recovery and full participation in community life. As Frederick Douglass so clearly and eloquently stated, "Power concedes nothing without a demand." Historical inertia and personal and institutional self-interests sustain structures of oppression until

they are challenged. Who will pose such a challenge if not people in recovery? Yet the ultimate responsibility for dismantling discriminatory practices rests upon the shoulders of the systems within which such oppressive machinery continues to operate. The responsibility to eliminate discrimination rests with those who discriminate. By itself, telling the perfect recovery story will not end discriminatory practices.

So where does recovery storytelling fit into all this? Our stories are a means of humanizing addiction and recovery—a means of challenging the myths, misconceptions, and caricatures that have let others objectify and isolate us. Our stories are an invitation for people to reconsider the sources of and solutions to alcohol and other drug problems. Our stories are a means of building relationships that embrace us within the human family—as people who share the dreams and aspirations of others. Our stories, directly or indirectly, also constitute Douglass' demand to change the structures that have prevented embrace of our humanity and rendered us people to be feared, shunned, or punished. This involves far more than changing people's perceptions, attitudes, and behaviors toward those with lived experience of addiction and recovery. It involves identifying and eliminating the precise mechanisms (e.g., policies and practices) through which social shunning and discrimination have been institutionalized.

This is not to suggest that people in recovery have no role to play in this change process nor that we should passively embrace a victim status in the face of such systemic challenges. We can take responsibility for our own personal and family recovery, make amends to those we have harmed, and reach out to others still suffering. We can participate in recovery-focused research (to create a science of recovery that can challenge recovery misconceptions), participate in protests and advocacy efforts, offer our recovery stories in public and professional educational venues, and represent our lived experience within policy-making settings. Such actions have contributed to numerous positive changes.

Our stories possess immense power as long as we recognize our stories alone will not create recovery-friendly social institutions or recovery-inclusive communities. We must not allow our stories to stand as superficial window-dressings while discrimination remains pervasive, even among some of the very groups and institutions who on the surface support our storytelling. Our stories must support specific calls for institutional change. We must hold individuals and institutions that discriminate accountable until they eliminate such conditions.

How we craft and communicate our stories for public/professional consumption is an important element of this process of social change. Recovery advocacy organizations have a responsibility to prepare and support the vanguard of individuals who heed the call of this public story-sharing ministry. This includes building a community ethic that protects those who possess the bravery and privilege of sharing their recovery stories in public forums. Collecting our stories without meaningful

dialogue about how our stories will be used and the protections we will be afforded is unacceptable.

This is the first in a continuing series of blogs on personal privacy and public recovery advocacy. We hope it will set recovery storytelling within a larger context. The remaining blogs will explore the risks of public recovery storytelling, the ethics of public recovery story sharing, and suggest guidelines on protecting personal privacy and safety within the context of public recovery storytelling. The impetus for this series comes from our knowledge of individuals who have experienced unanticipated harm related to their advocacy efforts.

## The Risks of Public Recovery

### Public Recovery Storytelling: Spectrum of Risks

Individuals, family members, organizations, and the recovery advocacy movement reap benefits from public recovery storytelling, but these same parties are also at risk for injury as an inadvertent outcome of such public storytelling.

Individuals and family members may experience the therapeutic effects of their advocacy activities, but there are also accompanying risks of personal embarrassment or humiliation, exposure to acts of social shunning or discrimination, and, at worst, destabilization of personal and family recovery. Moving recovery from the private to public arena entails navigating these risks.

Youth and other individuals at early stages of recovery may be particularly vulnerable for such injuries. The media story of recovery is most often told from the perspective of the recovery initiate rather than from the perspective of long-term recovery. We best represent the story of recovery when we speak from panels representing diverse pathways, styles, and stages of addiction recovery. Young people and others in early recovery possess heightened vulnerability and should be carefully screened for public recovery advocacy activities. They should be oriented to the benefits and risks of public recovery disclosure via an informed consent process and given structure and support when involved in public recovery advocacy. If a person experiences a recurrence of AOD use and related problems who has earlier served as public recovery advocate, their prior experience as a visible recovery advocate can pose a significant obstacle (via shame, resentment, etc.) to recovery restabilization.

> *There is a zone of service and connection to community within advocacy work, and we must do a regular gut check to make sure we remain within that zone and not drift into advocacy as an assertion of ego. The intensity of camera lights, the proffered microphone, and seeing our published words and images can be as intoxicating and destructive as any drug if we allow ourselves to be seduced by them. If we shift our focus from the power of the message to our power as a messenger, we risk, like Icarus of myth, flying towards the sun and our own self-destruction. To avoid that, we have to speak as a community of recovering people and avoid*

*becoming recovery celebrities—even on the smallest of stages.* (White, 2013)

The decision to pursue public recovery advocacy is best made in consideration of family and loved ones. While the zealous new recovery initiate may feel called to this public storytelling role, they must consider the potential effects of public disclosure on family members and loved ones. After considering such effects, some advocates have postponed their roles as public speakers until their children are at an age that minimizes any potentially negative effects upon them. Those involved in public recovery storytelling have found it helpful to orient family members and loved ones on the content of the story, the venues in which it will be shared, and how to best respond to questions that may arise from its presentation.

The reputations of organizations sponsoring public recovery storytelling and the larger recovery advocacy movement can be injured when speakers are not provided support, guidance, and vetting by the community for suitability and readiness for public recovery story sharing. This is particularly true in the case of the perceived "fall from grace" of a visible recovery advocate. In such circumstances, individuals and families suffering from addiction may be less hopeful and less likely to seek help because of such damaged reputations, and policymakers may be less amenable to supporting recovery advocacy organizations.

**Recovery Storytelling: The Risk of Conflicting Agendas**

Information related to addiction and recovery is disseminated through a wide variety of public venues: television, film, newspapers, magazines, the Internet, and through a broad spectrum of public and professional meetings. Representatives from these venues often approach recovery advocates for interviews or presentations related to their recovery experiences. Such opportunities are a means of carrying a message of hope to those affected by alcohol and other drug problems and a platform for advocating pro-recovery social policies and programs.

In spite of the potential benefits of public recovery storytelling, public recovery disclosure as we have noted can pose risks to multiple parties. A starting point for risk management related to public recovery story-sharing is the recognition that the interests of the multiple parties involved in such events may be congruent or in conflict. Requests for interviews or presentations often come with hidden agendas—planned narratives that meet the interests of those doing the inviting. Those inviting our stories may distort them to support agendas and talking points incongruent with the goals of recovery advocacy.

For example, distorted media coverage of active addiction fuels social stigma and contributes to the discrimination that many people in recovery face as they enter the recovery process. When media representatives interview people in recovery, they often want the most dramatic, traumatic, and sensationalist details related to one's

addiction but seek or report few details on the actual processes of recovery or the regenerative and transformative effects of long-term personal and family recovery.

It is said that if you are not at the table, you are on the menu. This has never been any truer than with the use of our stories. We must have pointed dialogue about how our narratives are used while having meaningful discussions across our diverse community on the messages we are trying to convey. These discussions must include how our stories can have unintended consequences and we must work together to ensure that our stories serve our common interests and our shared vision of an inclusive world free from stigma and discrimination.

This is all a way of saying there is much to consider in the decision to share our story, our decisions on how that story can be best presented to different audiences, and how we can best protect ourselves and other parties through this process.

**Pillars of Stigma and Recovery Storytelling**, stigma

A central goal of public recovery self-disclosure is to challenge myths and misconceptions about addiction and recovery through the elements of our personal stories. Recovery advocates must avoid contributing to false narratives by having selective parts of our stories appropriated while ignoring the central recovery message.

Addiction/treatment/recovery-related social stigma and its untoward consequences rests on old and new misconceptions regarding the sources and solutions to alcohol and other drug problems. Such key pillars of belief about the nature of addiction, addiction treatment, and addiction recovery constitute the structural supports of addiction-related social stigma. Below are examples of such pillars (in the stigmatized language in which they have been historically conveyed) and how our stories can be hijacked to support these false narratives.

<u>Addiction is a product of moral turpitude (badness)</u> that is best prevented and discouraged by public shaming and other forms of punishment. Acts flowing from this premise began with American colonies forcing those convicted of public intoxication to wear the letter D (for “Drunkard”) on their clothing or to be set in stock in the town square under a sign reading “drunkard.” The moral turpitude pillar continues to feed social shunning, serves as grounds for divorce, and provides a rationale for political disenfranchisement and discrimination in housing, employment, education, and medical benefits. Overemphasizing or exaggerating the “bad people” we were in the addiction portion of our stories inadvertently feeds this view.

<u>Addicts pass on their degeneracy (“bad seed”) to their children</u>. This pillar of belief has resulted in the inclusion of addicted people in mandatory sterilization laws, surgical sterilization without consent during institutionalization, and loss of parental custody and related legal rights. It also feeds false narratives that paint the children of addicted parents with the same brush, e.g., false narratives of “crack babies” as a “biological underclass.”

The addict is an infectious agent who must be closely surveilled and isolated from the community. This pillar of belief provided the rationale for inebriate penal colonies, prolonged institutionalization in psychiatric asylums, prolonged surveillance (addict registries, prolonged probation/parole), and fed the modern era of mass incarceration.

Addicts pose the greatest threat to the community when they associate with each other. This belief undergirded laws banning addict fraternization and probation or parole violations for associating with other addicts. “Loitering addict” laws provided for the arrest of known addicts for simply being in the presence of other individuals identified as addicts. Policies that dissuade recovery networking and the inclusion of recovery voices in matters that affect us may well be rooted in earlier biases against addicts being with each other.

Addiction does not discriminate. Actually, it does! It was with the purest of intentions that the tagline of "addiction does not discriminate" became one of the public education mantras in the wake of the "opioid epidemic." It was a way of saying, "See...it could happen to anyone... and now you should care." This narrative sought to normalize (AKA Whiten) addiction by projecting the image of “innocent,” (AKA White), middle-class children and their parents deserving of public resources to support their care. Such care was advocated as an alternative to arrest and incarceration for the “deserving” (AKA White people of means), while addiction in communities of color continued to be stigmatized, de-medicalized, and criminalized.

Stating that alcohol and other drug problems cross boundaries of race and class in the United States obscures the inordinate toll addiction and drug policies have long taken and continues to take on communities of color and other historically marginalized populations. The addiction vulnerability of these communities stems from historical trauma; social, economic, and political marginalization; and related disparities in access to prevention, harm reduction, early intervention, treatment, and recovery support services. An ethical framework of public messaging and education would call for equity of policy application and resource allocation across all affected communities. Ideally, recovery storytelling would include the stories of people from diverse backgrounds and living circumstances. It is important that through our stories we convey the reality of recovery, the varieties of recovery experience, and the challenges of recovery across cultural contexts.

Addiction is untreatable (“Once a junkie, always a junkie.”) This pillar of belief feeds personal, public, and professional pessimism about addiction and provides the rational for prolonged institutionalization/incarceration as well as justification for harmful and potentially lethal treatment experiments. In the U.S., the latter have included brain surgeries, indiscriminate use of chemo- and electroconvulsive therapies, toxic drug withdrawal procedures, and other harmful treatment methods. Portraying the role treatment played within our recovery stories and the nature and positive effects of modern treatment challenges this misconception.

Treatment Works! is a counter misconception in that it suggests the presence of a uniform protocol of addiction treatment in the U.S. that achieves consistently positive clinical outcomes. It also ignores widespread addiction treatments that lack empirical evidence of their effectiveness as well as the presence of treatments more focused on financial profit than long-term recovery outcomes. This central marketing slogan of the treatment industry misrepresents the highly variable outcomes of addiction treatment, which span minimal, moderate, and optimal effects, as well as harmful effects. Addiction is a treatable condition, but recovery outcomes depend upon numerous personal, clinical, and environmental factors. Great care must be taken in how our stories are used by the addiction treatment industry. What we are offering as advocates is living proof of long-term recovery, not an advertisement for a particular proprietary approach to addiction treatment. (See HERE for full critique of this slogan.)

Recovery is not possible until an addicted individual "hits bottom." Actually, most people recover from addiction long before hitting bottom" (losing everything). Addiction-related loss and pain in the absence of hope is an invitation for continued self-destruction. Recovery initiation is the fruit of addiction-related consequences interacting with sources of hope for a healthier and more meaningful life. The "hit bottom" premise suggests that recovery responsibility rests solely with the individual—that there is little family or community can do until that point of individual awakening arrives. This constitutes an invitation for family and community abandonment of those suffering from addiction. This premise is untrue, is not applied to other medical conditions, and should be forever discarded within the addictions arena. We must not let our story be twisted to support this supposition even if we were one of those who did hit bottom and lost everything.

Addiction recovery is the exception to the rule. Actually, recovery is the norm; individuals who do not achieve sustainable recovery are the exceptions. Those who struggle with recovery stability are distinguished by higher problem severity, co-occurring problems that make recovery initiation and recovery more difficult, and fewer natural recovery supports in the community. Even people with the most severe addiction problems can and do recover with more intense and prolonged recovery support resources. We must repel any effort to cast our recovery as the heroic "exception to the rule" and convey the consistent message that no one need die of addiction. Recovery is far more than possible; it is the probable long-term outcome for those who experience alcohol- and other drug-related problems.

Addiction recovery is a brief episode that allows one to then get on with their life. For people with mild to moderate levels of addiction severity who possess substantial recovery capital, recovery may be just that. However, for those escaping addictions marked by severity, complexity, and chronicity, recovery is a prolonged process comparable to the assertive and sustained management needed for other chronic medical conditions. It is important in our stories to acknowledge variability of addiction

severity and recovery support resources. Our recovery story is just that—our personal story; it is not the whole addiction/recovery story.

Media channels frequently tell the story of addiction recovery only as a personal story rather than a larger story of the role of family and community in addiction and recovery. The prevalence and severity of addiction are profoundly influenced by social, economic, and political contexts. The recovery tipping point has as much to do with family and community resources and capacity for resource mobilization as it does what is going on inside the addicted person. We serve best when we present our journey from addiction to recovery within these larger contexts and extoll the role of family and community in the recovery process.

Addiction recovery is only achieved through a particular type of professional treatment, lifelong affiliation with a recovery mutual aid society, and lifelong abstinence from alcohol and illicit drugs. Actually, people recover from substance use disorders with, and without, treatment, and through diverse approaches to treatment and recovery support. People achieve recovery with and without involvement in recovery mutual aid groups. Professional- and peer-supported pathways of recovery constitute particular styles of recovery, not the only pathways to recovery. Those involved in treatment and recovery mutual aid represent more severe and prolonged patterns of addiction. There are secular, spiritual, and religious pathways to alcohol and other drug (AOD) problem resolution, and AOD problems can be resolved through styles of sustained abstinence or through decelerated patterns of drug use (the latter most viable for individuals with less severe AOD problems and greater social supports). Our personal story illustrates one within many pathways and styles through which people resolve AOD problems. We preface our stories with “In my experience…” and “What I have observed is…” We are sharing our experiential knowledge, not universal truths that have stood the tests of science or application across diverse cultural contexts.

The above pillars of belief (and the degrading caricatures that often accompany them) serve the interests of multiple parties. They aim to socially stigmatize and discourage drug use. They disparage groups with whom the drug is, correctly or incorrectly, associated. They justify surveillance and over-policing of marginalized communities. And they feed institutional profit. Collectively, these pillars define us as a people as outsiders--outcasts for whom doors of entry into the human community should remain closed.

Our goals run counter to these interests. Our intent is to elicit what Isabel Wilkerson has christened “radical empathy”—the ability of listeners to emotionally project themselves into our experience to the point that they move beyond tolerance and compassion to actions that include us within the human community. This requires framing our stories to elicit conscious awareness that addiction is only one of many forms of woundedness that can and do touch all of our lives, and that recovery mirrors the promise of healing that can follow. The challenge we face is to assure that our

recovery stories serve this higher purpose and not feed false narratives that are part of the problem.

## The Ethics of Public Recovery Self-disclosure

Ethics involves the application of moral principles to promote good and prevent harm. Ethical decision-making within our service and advocacy activities is an assessment of the ratio of potential benefits to potential harms in any course of action—with a particular emphasis on “first do no harm.”

Such decision-making involves asking ourselves three questions. First, what parties could benefit or experience harm in this situation (and what is the degree and duration of such benefit or harm)? In our advocacy roles, it is helpful to assess such potential benefits and harms related to ourselves, our families, organizations with whom we are associated, the recovery advocacy movement, and the community.

Second, are there any laws, policies, or historical practices that offer guidance in this situation? This question illuminates the complexities between law and ethics: actions may be legal and ethical, unethical and illegal, legal but unethical, or illegal but ethical.

Third, what ethical values are most applicable to this situation and what course of action would these values suggest? Self-disclosure as an ethical issue has been explored in both professional and peer recovery support contexts (See HERE and HERE), but little attention has been focused on ethical concerns related to self-disclosure within the context of public recovery advocacy. Several traditional ethical values inform decisions related to disclosure of our personal recovery stories in public or professional settings.

*Beneficence* is the ethical command to help others and not exploit the service context. It invites us to share our story as a means of helping individuals and families suffering from addiction and commands us to focus that story on those in need rather than as an act of self-aggrandizement or a means of pursuing our own interests.

> *Nonmaleficence* is the ethical command to do no harm. In the context of public recovery storytelling, it forces us to assess the timing and the intended and unintended consequences of our public disclosures on ourselves and other parties.
>
> *Honesty* demands that the recovery story be a truthful representation of our experience. Honesty and candor challenge us as advocates to speak truth to power even when lacking confidence in the authority of our own voice.
>
> *Fidelity* calls upon us to keep our promises. It asks us to remain faithful to pledges we have made to individuals and organizations. It asks us not to

make promise that we cannot keep and to adhere to commitments made in the context of our story sharing.

*Justice* requires that we acknowledge disparities in recovery opportunities and resources and calls on us to seek equity in such opportunities and resources.

*Discretion* calls upon us to protect our own privacy, the privacy of our family, and the privacy of others in the presentation of our story. Public recovery storytelling is an act of public service; it is not public therapy or a platform for airing personal grievances.

*Self-protection* calls upon us in our service roles to avoid harm to self, family, and others. It is an acknowledgment of the legitimacy of tending to our own safety and health. It is a recognition that risks of harm to self and others exist within the public storytelling arena.

There are also values deeply imbedded within the history of communities of recovery that can inform recovery storytelling within public and professional arenas.

*Humility* reminds us of the dangers of ego-inflation and that we speak not for ourselves but for the experiences and needs of all people seeking and in recovery. (See earlier blog on distinction between recovery rock stars and recovery custodians)

*Gratitude* is a call to give credit where it is due and to express our thanks to individuals and organizations that made our story possible. We offer our own story in thanks for the meaning we drew from the stories of others at a time we were most desperate of the hope they offered.

*Respect/Tolerance* is a recognition of the spirituality of imperfection—that we are all wounded in some way, that through this shared brokenness and healing, we share a profound connectedness. It is an extension of humility and empathy—seeing ourselves in the lives of others and respecting multiple pathways and styles of recovery.

*Service* is the call to carry a message of recovery to all those who continue to suffer from addiction and related problems. We do that as an act of altruism and as a perpetual step in our own self-healing.

There are many decisions involved in public recovery storytelling. Filtering these decisions through a model of ethical decision-making and core values of recovery can help minimize risk to self and other parties.

**Guidelines for Personal Safety and Public Recovery Self-disclosure**

*He who shows himself at every place will someday look for a place to hide*. –African Proverb

## The Decision to Disclose

Before disclosing our recovery status or details of our addiction/recovery experiences at a public level, we suggest giving careful thought to such questions as:

- Is this the right time in my recovery to share my recovery story at a public level? Will this strengthen my recovery or would it be a diversion from more critically needed recovery activities?

- Are there any negative effects for myself, my family, my community, and organizations within whom I am associated that could result from sharing my story in public or professional settings?

- Could such story sharing subject me to discrimination in housing, education, employment, health care, or social and business opportunities? Could it have any legal ramifications?

- Do I have a support system that could help me manage any such effects if they should arise?

- Will I be sharing my story alone or alongside other people in recovery?

- Do the potential benefits of public disclosure as a community service outweigh the potential personal risks?

- Who is controlling how my disclosure will be used and is there an explicit right for me to have the final edit on what elements of my disclosure are presented?

## Purpose of Public Disclosure

Many people in recovery will have shared their recovery story with family and friends, with medical and treatment professionals, and with other people in recovery before the opportunity for public recovery disclosure arises. Public disclosure is different from any of these preceding situations and involves a different purpose and style of storytelling.

Public recovery storytelling is about service to a larger cause than self. It is the use of self and one's own story as a catalyst for personal and social change. With each story sharing opportunity, we prepare ourselves by asking key questions. What do I want members of this audience to understand, feel, and do? How can I present my story in a way that will achieve those goals? How can what I do today contribute to the larger goals of the recovery advocacy movement?

It is important that addiction treatment and recovery community organizations provide a process of informed consent when inviting individuals to share their stories in public and

professional contexts. This involves a clear statement of the potential benefits and risks of public disclosure and screening out individuals for whom such disclosures present an unacceptable level of risk. Asking individuals currently receiving services to participate in public story sharing or marketing activities is coercive and exploitive.

**Disclosure Preparation**

Many of the risks involved in public recovery story sharing can be avoided with adequate orientation and training. Messaging training has been an effective tool used by Faces and Voices of Recovery and other recovery advocacy organizations to prepare people for this unique service ministry. Messaging training spans both the intent and content of public story sharing and the mechanics of effective story sharing (e.g., language, tone, adaptation for different cultural contexts and audiences, etc.). Pursuing these activities within an established recovery community organization helps assure peer and supervisory support for the “ups and downs” of such sharing experiences.

**Public Self-disclosure and 12-Step Anonymity**

AA, the precursor of all 12-Step programs, promulgated a tradition of personal anonymity at the level of press as both a protective device for AA and as a spiritual principle. Public disclosure of recovery status and sharing one’s recovery story without reference to affiliation with a particular 12-Step program complies with the letter of 12-Step traditions (See Advocacy with Anonymity), but it may not always meet the spirit of the Traditions. This could occur when advocacy is used as a stage for assertion of self (flowing from ego / narcissism / pride and the desire for personal recognition) rather than as a platform for acts of service flowing from remorse, gratitude, humility, and a commitment to service. For members of 12-Step fellowships, adhering to anonymity traditions (in letter AND spirit) in public recovery story sharing is recommended as a protection both for 12-Step programs and for the protection of the recovery advocate.

**Timing of Disclosure**

Our capacities (energy, abilities, competing needs and demands) for recovery advocacy ebb and flow over time. It is appropriate to ask ourselves if this is the optimal time for public recovery story sharing, whether this is the first time we have such opportunity or whether we need to take a break from such activities during times of personal distress or competing demands that require our focused attention. Warning signs indicating the latter include losing emotional control over the content of our story sharing (via unplanned expressions of frustration, resentment, anger, sorrow) or experiencing boredom or a loss of energy in our public story sharing. Difficult experiences and emotions can be referenced strategically within our talks (once we have emotional control over them), but public and professional meetings are not the appropriate venues to work out unresolved traumas of the past or present. When we drift across that line, it is time to take a break from this public service role.

## Scope and Focus of Disclosure

People in addiction recovery have many stories they can share. There is the life preceding the onset of drug use, one's addiction career, the turning point of recovery initiation, and the story of one's personal and family life in and beyond recovery. All of these may be touched on in public recovery story sharing, but the emphasis of this story must be on the recovery story and the lessons drawn from it. Great care is required with the media to maintain this focus. There are dangers that others hijack a recovery story intended to lower stigma in a way that fuels stigma, social marginalization, and the criminalization of addiction. We best serve the advocacy movement and protect ourselves by maintaining a focus on the recovery side of our stories and how we escaped the chaos and drama of addiction.

## Depth of Disclosure

There exists a continuum of intimacy defining the degree of risk in public recovery story sharing. There are experiences, feelings, and thoughts known only to ourselves that we have not shared with anyone else. There are experiences, feelings, and thoughts we have shared with only within our most trusted relationships. There are the communications we have expressed only within the context of professional counseling, within a sponsorship relationship, or recovery mutual aid meetings. And there are things about ourselves we have shared widely with those we encounter in our daily lives. Such communications range from high emotional risk to low emotional risk. The question is: Where does sharing our recovery story in professional or public meetings, in media interviews, or on social media fit in this continuum?

All recovery story sharing at a public level involves potential risks to ourselves and other parties, but those risks increase in tandem with the level of detail about our experiences contained within those stories. The category "people in recovery" includes highly armored people who are unable to trust others enough to share their real experiences, feelings, and thoughts. Others in this category enter recovery with no armor and no boundaries to facilitate the nuances of self-disclosure and self-protection in different settings and relationships. People existing on the extremes of this continuum from overly guarded to completely unguarded may need greater time in recovery prior to recovery story sharing at a public level. All people on this continuum need guidance and discipline to manage the depth of public recovery disclosure and the discipline to maintain this boundary over time.

Training and supervision related to public recovery disclosure can provide a safe setting in which we can address such questions as the following:

- What is the level of risks (who could experience harm and to what degree?) in the following story sharing venues: a social media post; a radio, television or newspaper interview; speaking at a recovery celebration event; speaking to a professional audience; or speaking to a public audience; writing an article or memoir about our recovery experience?

- What parts of my story are not appropriate to share publicly? (We want to break no-talk rules related to addiction/recovery, but we want to avoid disclosures that are so intimate in detail that they pose threats to our own emotional health or repel those who hear our story.)

- What aspects of my past or present experience remain too emotionally intense to include in my public recovery story? (These are the boundaries we need to define BEFORE we stand before an audience or sit for an interview! Message training and peer supervision can assist this process.)

- Have I avoided referencing other people's stories who might experience harm or discomfort resulting from my disclosure? (It is best to get permission for inclusion of others within our stories, e.g., spouse, family members.)

- Have I fully explored why I am sharing my story and sought feedback from other people who know me to understand the nuances and potential unintended consequences of disclosure?

**Facing Criticism of Public Disclosure**

As a final note, it is not unusual for individuals disclosing their recovery story at a public level to draw criticism for such activities from expected and unexpected quarters. You may be accused of "grandstanding," "ripping off the program," violating program traditions," or be caught in the crossfires of various ideological debates. Some will comment on what you should have or shouldn't have included in what you shared. Our advice is to have one or more people you are close to who can help you sort such feedback. And to positively use what you can and disregard the rest. Do know that such criticism is inevitable and can help us refine our message and its delivery—even when the criticism is unfounded and prompted by spurious motives.

**Closing**

We have tried in this paper to explore the purpose, contexts, and risks of sharing our recovery stories at a public level and to explore some of the ethical issues involved in recovery story sharing. It is our hope that these discussions and suggested guidelines will serve as a catalyst for discussion and a tool for the training of recovery advocates who choose to join the vanguard of people who are putting a face and voice to the recovery experience.

Our stories have the power to achieve many things, but we must not embrace total responsibility for eliminating addiction/recovery-related stigma. Those individuals and institutions who spawned and perpetuated stigma and discrimination bear that responsibility. What we can do is offer our stories and our larger advocacy activities to offer hope to wounded individuals, families, and communities and do so in a way that protects our own health and safety.