International Journal of Sexual Health

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/wijs20

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James B. Moran, Abigail P. Masterson, Caroline Eaton, Taylor K. Rohleen & Liana S. E. Hone

To cite this article: James B. Moran, Abigail P. Masterson, Caroline Eaton, Taylor K. Rohleen & Liana S. E. Hone (18 Dec 2024): Sexual Activity and Sexual Well-Being Among Sober Adults: The Role of Felt Sobriety Stigma, International Journal of Sexual Health, DOI: 10.1080/19317611.2024.2439346

To link to this article: https://doi.org/10.1080/19317611.2024.2439346

Published online: 18 Dec 2024.

INTERNATIONAL JOURNAL OF SEXUAL HEALTH
https://doi.org/10.1080/19317611.2024.2439346

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Sexual Activity and Sexual Well-Being Among Sober Adults: The Role of Felt Sobriety Stigma

James B. Moran, Abigail P. Masterson, Caroline Eaton, Taylor K. Rohleen and Liana S. E. Hone

University of Florida, Gainesville, FL

ABSTRACT

Objectives: To explore the relationship between experiences of stigma and sexual activity and sexual well-being among sober individuals.
Methods: Two-hundred and thirty-eight sexually active, sober adults reported on their sobriety length, experiences of sobriety stigma, sexual activity, and sexual well-being.
Results: Sobriety length was not related to either outcome. However, sobriety stigma was negatively related to sexual activity and sexual well-being.
Conclusion: Sobriety stigma has implications not only for relapse prevention, but also for sexual health and well-being interventions. Efforts to reduce stigma among sober individuals may lead to more successful sexual health and well-being promotion initiatives.

ARTICLE HISTORY
Received 30 January 2024
Revised 30 November 2024
Accepted 3 December 2024

KEYWORDS
Sexual health; sexual well-being; sobriety; stigma; felt stigma

Sobriety length

Maintaining sobriety from alcohol is a complex experience and may take several attempts to achieve long-term abstinence (Carmona, 2022; Sliedrecht et al., 2019), but positive benefits accumulate as sobriety length increases. Sober adults report that their sobriety is often redemptive and leads to an increased likelihood of engaging in positive health behaviors (Dunlop & Tracy, 2013). Additionally, those who remain sober longer tend to report increased rates of exercise, lower relapse rates, and lower levels of depression (Islam et al., 2023; Patterson et al., 2020, 2021). They are also more likely to focus on social support to reinforce positive aspects of sobriety (Luciano et al., 2014).

Sobriety length's role in sexual activity and sexual well-being

Consuming more than the recommended amount of alcohol (1 drink per day for women; 2 drinks per day for men; Centers for Disease Control and Prevention (CDC), 2022) can have detrimental effects on mental and physical health (Gomez et al., 2023) and can also negatively impact sexual health (e.g., sexual activity, function, and response; George, 2019). For example, those who consume alcohol report experiencing higher rates of sexual dysfunction (Ghosh et al., 2022; Li et al., 2021; Sobczak, 2009), both acute (e.g., increased time to reach orgasm, decreased vaginal lubrication, dyspareunia; Covington & Kohen, 1984; Ghadigaonkar & Murthy, 2019) and chronic (e.g., erectile dysfunction, testosterone production; Crowe & George, 1989). Acute effects resolve after blood-alcohol content returns to zero (George, 2019), but chronic effects may persist even after long-term sobriety is achieved (Van Thiel et al., 1983; c.f. Johnson et al., 2004). Thus, sobriety may coincide with increases in and improvements to sexual activity as alcohol-related sexual issues (e.g., sexual dysfunction, sexual regret) decrease.

Sobriety stigma

Sobriety is beneficial to health (Patterson et al., 2020); however, those who are sober report experiencing stigma (Cheers et al., 2021), and these experiences have been linked to adverse health outcomes (Turan et al., 2019; Vanable et al.,

CONTACT Liana S. E. Hone lhone@ufl.edu University of Florida, P.O. Box 118210, Gainesville, FL.

2006). According to the Health Stigma and Discrimination framework (Stangl et al., 2019), stigma experiences are both experienced (external) and felt (internalized), and both impact health outcomes. For example, internalized and external stigma both have important effects such as poorer mental health and greater physical symptoms (e.g., nausea, fatigue, appetite loss) and lower CD4 count in people with HIV (Earnshaw & Chaudoir, 2009; Earnshaw et al., 2013). Sobriety stigma is the neglect and persecution of those who do not drink (Vilsaint et al., 2020). Sober adults often report being judged by peers for being sober and are viewed as unsocial, not part of the ingroup, or health-pretentious (Cheers et al., 2021; Conroy & de Visser, 2014; Herring et al., 2014; Zimmermann & Sieverding, 2011). Moreover, individuals who drink alcohol have classified nondrinkers as a "threat to fun," a "threat to connection," and "a threat to self" (Cheers et al., 2021). Twenty-five percent of those in recovery report experiencing some type of sobriety discrimination (Vilsaint et al., 2020), indicating sobriety stigma may be an understudied contributor to poor health outcomes.

Sobriety stigma's role in sexual activity and sexual well-being

Stigma in general can negatively affect sexual activity and sexual well-being (Flanders et al., 2022; Layland et al., 2020; Li et al., 2021). Here, we define sexual activity as the frequency of engaging in sexual behaviors and the number of sexual partners in a given time. Sexual well-being has largely been used as an umbrella term to cover all positive aspects of sex (Byers & Rehman, 2014; Štulhofer et al., 2019). However, here, we define sexual well-being as all aspects, both negative and positive, including sexual distress, satisfaction, emotional fulfillment, and sexual fantasies (Gerymski, 2021).

Sexual activity and sexual well-being are proxy to sexual health as positive and more frequent sexual interactions have been found to be associated with sexual health (Mitchell et al., 2021; Mollaioli et al., 2021). Moreover, according to the World Health Organization (WHO), sexual health is the all-encompassing term for one's engagement and enjoyment of their sexuality (Mitchell et al., 2021).

There are many stigmatized identities (e.g., race, sexual orientation, and living with HIV) that negatively influence sexual well-being and health (Ford et al., 2021). For example, stigma that is external or enacted/affected by others (e.g., being rejected) has negative effects on relationship formation (Castro et al., 2019), and stigma that is internalized (e.g., felt stigma) has been related to reduced HIV testing frequency, less condom use, and higher instances of psychological distress (Herek et al., 2009; Krueger et al., 2020). More specifically, people who experience stigma often have more difficulty disclosing information to others and advocating for their sexual health due to fear and anxiety (Li et al., 2016; Slade et al., 2007). While there is limited research on how sobriety stigma impacts health and well-being generally, prior research has documented effects of sobriety stigma on psychological distress, quality of life, and recovery capital (Vilsaint et al., 2020). Thus, similar to other types of stigma, it follows that sobriety stigma, both external and internalized, may play a critical, yet understudied role in adverse sexual health outcomes.

Overall, stigma is broadly related to detrimental health outcomes (Laird et al., 2020) and the effects of stigma on health outcomes can vary over time (Randles & Tracy, 2013; Romo et al., 2016). For example, stigma and judgment toward those in alcohol recovery are tightly related to relapse (Randles & Tracy, 2013), especially early in sobriety (Luciano et al., 2014). Additionally, the negative effects of stigma may be high when a stigmatized identity is new (e.g., recently diagnosed HIV positive status; Vanable et al., 2006) and decline as an individual acclimates to this new identity. Taken together, both sobriety length and sobriety stigma may be intricately related to sexual health and well-being.

Current study

We conducted an exploratory analysis with cross-sectional data to examine the relationship between sobriety length, sobriety stigma, and sexual activity and sexual well-being among sober, sexually active individuals. We hypothesized

sobriety length would be positively related to sexual activity and sexual well-being. We also hypothesized sobriety stigma, in the form of internalized (felt stigma) and external (other's attitudes) would be negatively related to sexual activity and sexual well-being.

Method

Participants

Based on power analyses, 316 participants were sought to achieve adequate (80%) power to detect a small-to-moderate relationship of ($r = 0.25$) between key variables. We collected data from 550 Prolific users who were currently single (not in a committed relationship) and residing in the United States. Participants were included if they met common thresholds for inclusion including selecting a four or higher on self-report honesty Likert scale and selecting the correct response on two attention checks (Vésteinsdóttir et al., 2019). Our sample included participants who were sober—that is, they currently did not drink alcohol, but they did drink alcohol at some point in their lifetime—and who had made their sexual debut. In total, $n = 312$ participants did not meet these inclusion criteria.

Our analytic sample was 238 adults, (M age = 27.46; $SD = 4.71$; range = 18–35). The sample self-identified as White 55.5%, 17.6% Black, 4.6% East Asian, 7.6% Latinx, 0.8% Native American, 1.7% South Asian, 4.2% Southeast Asian, and 8% multiethnic. The sample identified as 89.92% cisgender (6.60% identified as transgender, 3.48% preferred not to say). Most of the participants identified as a man (53.36%), and 39.91% identified as a woman, 2.52% identified as non-binary, and 7.14% identified with multiple genders. The sample had diverse sexual identities: 60.9% identified as straight, 6.7% as gay or lesbian, 22.2% as bisexual, 1.3% as asexual, 3.8% as pansexual, and 5.1% as other (i.e., aromantic, demisexual, questioning, queer, an option not listed, or preferred not to answer).

Procedure

Participants accessed our survey via Prolific, a crowd sourcing website, in November 2022. The survey was advertised for "18-years old and older who do not consume alcohol." After agreeing to participate via an informed consent form, they were asked a battery of survey questions asking about their sobriety, their sexual activity and sexual well-being as well as sobriety stigma questions. Finally, they responded to a demographic questionnaire, were debriefed, and then paid $6.00. All participants were consented, and all research was approved by the authors' Institutional Review Board (IRB# 202201572).

Measures

Sexual activity

Participants completed a 2-item sexual activity survey assessing changes in their sexual activity since becoming sober on a Likert scale of 0 (Much less) to 4 (Much more). We asked, "For the following questions, please report your perception of how your sexual behaviors have changed since you have cut back from drinking: (1) Frequency of sexual activity; and (2) Number of partners. A sexual activity mean composite was created for the two items, with higher scores indicating more sexual activity ($r = 0.84$).

Sexual well-being

Participants then completed the 5-item Short Sexual Well-Being Scale (Gerymski, 2021). Participants were asked to, "Indicate to what extent you agree with each statement using the following scale, since you have become sober," on a Likert Scale of 1 (Strongly disagree) to 7 (Strongly agree). The items were: "The frequency of my sexual relations is satisfactory for me," "There is nothing disturbing in my sex life," "There's a lot of physical pleasure in my sex life," "I consider myself sexually fulfilled," and "I have no trouble realizing my sexual fantasies." A mean composite was created for the five items, with higher scores indicating better sexual well-being ($\alpha = 0.89$).

Sobriety stigma

To assess stigma, we used two different measures. Felt Sobriety-Related Stigma (adapted from Laird et al., 2020) measures feelings about sobriety stigma derived from internalized feelings. Other

Person's Attitudes Toward Abstinence (Katainen et al., 2022) measures direct experiences with being judged for not drinking and feelings about sobriety stigma is derived from external forces.

Felt sobriety-related stigma

Participants completed the Health-Related Stigma Scale (Laird et al., 2020), which was designed for use in cancer research and adapted for sobriety research. It comprises a 9-item measure that assesses feelings of stigma toward sobriety. The scale is measured using a Likert scale of 1 (Strongly disagree) to 5 (Strongly agree). For example, "I feel different from other people because of my sobriety." A mean composite ($\alpha = 0.88$) was created for the nine items, with higher scores indicating more felt sobriety stigma.

Other person's attitudes toward abstinence

Participants then responded to the Other Person's Attitudes Toward Abstinence (Katainen et al., 2022), which is a 9-item scale that assesses participants' experience with people's behavior toward their abstinence, on a Likert scale of 1 (Never) to 4 (Often). For example, "You have felt like an outsider in a situation where others consume alcohol," "You have been prompted to explain or justify why you do not drink," "You have felt that others are avoiding you because you do not drink," "You have ended up in an argument because you do not drink (no matter who started the argument)," "You have experienced problems in your social relationships because you do not drink." A mean composite ($\alpha = 0.88$) was created with higher scores indicating more negative experiences.

Sobriety length

Participants were asked to report their number of days of sobriety (standardized).

Demographics

Participants were asked to indicate their age in years, gender, if they identified as transgender, their sexual orientation, race, and ethnicity.

Analysis plan

Analyses were conducted in IBM SPSS Statistics (Version 27). Correlations were conducted to assess the relationships between the focal variables (Sobriety Length, and Sobriety Stigma [Felt Stigma and Other People's Attitudes]) and the outcome variables (sexual Activity and sexual Well-being). We then ran two separate multivariable linear regression models to assess the relationship between our focal variables of interest and our outcomes variables. All statistical tests were 2-tailed and set at $p < .05$.

Results

Table 1 displays the results of bivariate correlations between all key variables. Sexual activity was not related to sobriety length, $r = -0.04$, $p = .53$, but was negatively related to Felt Sobriety-Related Stigma (internalized) stigma, $r = -0.27$, $p < .001$, and Other Person's Attitudes Toward Abstinence (external stigma), $r = -0.20$, $p = .002$. Sexual well-being was not related to sobriety length, $r = 0.06$, $p = .34$, but was negatively related to Felt Sobriety-Related Stigma, $r = -0.22$, $p < .001$, and Other Person's Attitudes Toward Abstinence, $r = -0.19$, $p = .03$. See Table 2 for two separate linear regressions, with the focal variable of sobriety length, Felt Stigma, and Other Person's Attitudes Toward Abstinence related two separate outcome variables of sexual activity and sexual well-being.

Sexual activity

The model testing effects of sobriety length, Felt Stigma, and Other Person's Attitudes Toward Abstinence on sexual activity was significant, $R = 0.26$, $p < .001$. The only statistically significant variable was Felt Stigma, which was negatively related to sexual activity, $\beta = -0.24$. The other variables were not significant ($ps > 0.068$).

Sexual well-being

A similar pattern emerged in the model testing effects of sobriety length, Felt Stigma, and Other Person's Attitudes Toward Abstinence, which was significant, $R = 0.24$, $p = .004$. Again, the only

Table 1. Relationship between sexual activity, sexual well-being, sobriety length, and stigma.

Variables	M (SD)	1	2	3	4
1. Sobriety Length	0.00 (1.00)	1			
2. Felt Sobriety-Related Stigma	1.73 (0.78)	−0.05	1		
3. Other Person's Attitudes Toward Abstinence	1.66 (0.63)	−0.08	0.65**	1	
4. Sexual Activity	1.62 (0.74)	−0.04	−0.27**	−0.20**	1
5. Sexual Well-Being	4.23 (1.37)	0.06	−0.23**	−0.19*	0.37**

Note: *$p < .05$; **$p < .01$.

Table 2. Regression of sexual activity and sexual well-being on sobriety length and sobriety stigma.

	Coefficients						
	Unstandardized		Standardized			95% Confidence Interval	
Model	B	SE	B	T	Sig	Lower CI	Upper CI
			Sexual activity				
Sobriety Length	−0.10	0.12	−0.06	−0.87	0.38	−0.34	0.13
Felt Stigma	−0.22	0.08	−0.24	−2.88	.004**	−0.38	−0.07
Other's Attitudes	−0.04	0.09	−0.04	−0.40	.68	−0.23	0.15
			Sexual well-being				
Sobriety Length	0.14	0.22	0.04	0.44	0.52	−0.28	0.56
Felt Stigma	−0.30	0.15	−0.17	−2.60	0.04**	−0.58	−0.01
Other's Attitudes	−0.16	0.18	−0.08	−0.92	0.35	−0.52	0.18

Note: ***: $p < .001$; **: $p < .05$. The statistics reported are two separate linear regressions.

significant variable was Felt Stigma, which negatively related sexual well-being, $\beta = -0.17$; the other variables were not significant ($ps > 0.35$).

Ancillary results

Experiences of stigma may change as sobriety length increases. Thus, we tested the interaction effects of sobriety length and Felt Stigma, and sobriety length and Other Person's Attitudes Toward Abstinence on both outcomes. For sexual activity, the model was significant ($p < .001$); however, the interaction between sobriety length and Felt Stigma was not significant ($p = .79$), nor was the interaction between sobriety length and Other Person's Attitudes Toward Abstinence ($p = .19$). Felt Stigma remained the only significant variable ($\beta = -0.23$, $p = .004$). For sexual well-being, a similar pattern emerged. The model with the interaction terms included was significant ($p = .02$); however, neither interaction term was significant ($ps > 0.68$). Again, Felt Stigma remained the only significant variable ($\beta = -0.30$, $p = .04$).

Discussion

Here, we sought to understand how sobriety length and sobriety stigma—using measures of Felt Sobriety-Related Stigma and Other Person's Attitudes Toward Abstinence—affect sober individuals' sexual activity and sexual well-being. Contrary to hypotheses, sobriety length was not associated with sexual activity or well-being (controlling for stigma). However, as hypothesized, Felt Sobriety-Related Stigma (but not Other Person's Attitudes Toward Abstinence) was related to sexual activity and sexual well-being (controlling for sobriety length and Other Person's Attitudes). That is, those who felt more stigma reported less sexual activity and lower sexual well-being. This significant—albeit small—relationship between internalized stigma (Felt Sobriety-Related Stigma) and sexual behavior adds to a growing body of research on negative sexual health outcomes related to internalizing stigma.

Results of our exploratory analyses conceptually replicate previous research and future research on sobriety stigma and other sexual health outcomes should be more comprehensive. For instance, in a large sample of sexual minority men, those who report higher scores of Felt Stigma toward their sexuality report fewer sexual partners, more psychological distress, less condom use, and less familiarity with pre-exposure prophylaxis (Krueger et al., 2020). It would be interesting to explore whether sobriety stigma also influences these sexual health outcomes given Felt Stigma is reported by those who self-report sobriety stigma, but that sobriety stigma is not equivalent to sexual orientation stigma in terms being an analogous identity or being

stigmatized in the same context. Not drinking is seen as violating social norms (Bartram et al., 2017) and there is evidence that sober individuals can feel psychological distress (Paton-Simpson, 2001), so it is possible that these other health outcomes may be affected by sobriety stigma. Interestingly, external judgments toward sobriety (Other People's Attitudes Toward Abstinence) were not significantly related to sexual activity or well-being in our model when controlling for sobriety length and Felt Sobriety-Related Stigma, although there were significant negative bivariate correlations between Other People's Attitudes Toward Abstinence and both sexual activity and sexual well-being. Although Other People's Attitudes Toward Abstinence (external) was negatively related to both sexual activity and sexual well-being, when included in the model with Felt Stigma (internalized), the effect was no longer observed. This suggests that the driver of sexual well-being among sober adults—when it comes to stigma—might be feeling judgment from others. Our findings suggest that individuals who experience higher levels of felt stigma regarding sobriety tend to engage in less sexual activity and report lower levels of sexual well-being. Additionally, sobriety length did not significantly influence these outcomes, nor did other's judgements (i.e., external sobriety stigma). This highlights the strong impact of felt stigma on sexual activity and sexual well-being, regardless of certain personal and external factors.

Implications

The mechanism for Felt Stigma driving the effect of the relationship between stigma and our outcomes (sexual activity and sexual well-being) could stem from previously experiencing negative social interactions, as unsupportive interactions are also associated with reduced wellbeing (Hutton et al., 2013). While we did not explicitly measure this, it is possible those in our sample have experienced negative reactions to their sobriety. This is consistent with prior research revealing those who identify as sober often feel like they experience social exclusion (Jacobs et al., 2018) and are sometimes threatened with violence (Paton-Simpson, 2001) or physically attacked (Herman-Kinney & Kinney, 2013).

It is also worth considering whether the mechanism underlying this relationship stems from the fact that sobriety is a concealable identity. Disclosing a concealable stigmatized identity (e.g., mental illness, family addiction, HIV status) is associated with reporting lower levels of well-being (Chaudoir & Quinn, 2010). That is, that those who disclose a stigmatized identity and are faced with social rejection or blaming that can have psychologically detrimental effects which can impact their decisions to disclose to others leading to lower social support and therefore, lower quality of life. Many sober individuals report experiencing sobriety stigma and here, we find that sober individuals who perceive, for example, that they feel different from other people due to their identity, also report lower sexual well-being.

If the mechanism underlying this relationship stems from sobriety being a concealable identity, separate but complementary pathways need to be understood. First, it could be the case that sober adults perceive they will be judged when disclosing to a potential partner that they are sober. This disclosure could cause some individuals to experience adverse health outcomes (e.g., stress). This anticipated stress may cause sober adults to avoid disclosure interactions and forgo sexual opportunities that might otherwise be fulfilling, thereby decreasing well-being. Second, if sober individuals do disclose, they may be concerned that their potential partner will react negatively. For example, fear of disclosing HIV-status is related to lower well-being (Chaudoir & Quinn, 2010).

Designing evidence-based interventions to assist people with disclosures may be the first step in improving the disclosure approach (Chaudoir et al., 2011). For sober individuals, determining how to disclose (e.g., before a first date) may alleviate stress and promote sexual well-being. For example, interventions that promote social support of sober individuals who plan on disclosing their sobriety to a potential partner may be particularly efficacious because individuals in recovery who report more social support report greater quality of life (Doogan

et al., 2019; Feeney & Collins, 2015; Islam et al., 2023; Strada et al., 2017).

Creating person-centered solutions for effectively disclosing sobriety status by incorporating knowledge of how peer pressure and subjective norms may be involved may also reduce the burden of stigma. Drinking is a cross-cultural behavioral norm (Slingerland, 2021); individuals violating this norm are judged for not being part of the in-group, or being perceived as health pretentious (Cheers et al., 2021). Focusing on ways to navigate peer pressure that is derived from these norms may alleviate pressure associated with disclosure and associated stigma.

Moreover, a strong sense of sober identity could be a buffer against peer pressure. In qualitative work, college students who take a strong stance or are adamant about not drinking may be better perceived than nondrinkers who say, "I might have one" (Conroy & de Visser, 2014). Sober individuals might create a strong sense of sober identity through the use of the social media platform TikTok: Approximately 82% of the videos on TikTok related to attempts to cut down on or abstain from substances highlight a strong social identity of recovery and 45% highlighted social support (Russell et al., 2021). TikTok may be a valuable platform for changing social norms and enabling people who are in recovery or trying to get sober to shift their perspective while using the platform as a source of social support.

Limitations

This cross-sectional study is not without limitations. First, longitudinal studies following individuals through their transition to sobriety are needed to understand what environmental or individual factors might impact Felt Stigma, sexual activity, and sexual well-being. Here, we applied a cross-sectional methodology. While useful for exploring correlations—like the relationship between felt sobriety stigma and sexual activity and sexual well-being—we cannot establish causality and we cannot accurately capture long-term trends or changes in activity or well-being across sobriety. Therefore, we hope future research applies a longitudinal research design to these questions.

Second, sober individuals may not frequent venues (e.g., bars, clubs, parties) where hookups and casual sex are common (Hone et al., 2020, 2023) and therefore may have fewer opportunities to interact with potential new sex partners, but we did not differentiate between new and previous sex partners in our sexual activity measure. Future work should distinguish between new and previous partner sexual activity and investigate how sober adults initiate casual sexual encounters (if any) and how often their efforts result in a casual sexual encounter. Likewise, future research should aim to study how sober individuals reenter the dating scene and whether and to what extent they experience sobriety stigma on dating apps or other alcohol-associated contexts.

Third, our sample was half White and predominantly heterosexual. Demographic differences should be investigated in future research as these factors vary with cultural drinking norms. Fourth, measuring external stigma via Other Person's Attitudes Toward Abstinence does not fully capture attitudes specific to sexual partners. Therefore, modeling sexual partners' attitudes toward sobriety using dyadic data may yield unique results. Additionally, future research should design specific sobriety stigma measures. The Health-Related Stigma Scale (Laird et al., 2020) was designed for use in cancer research. We adapted this measure so that we might assess sobriety stigma and the adapted measure yielded high reliability but validating scales measuring sober individuals' experiences is essential. Finally, given our exclusion criteria, we fell short of obtaining data from the number of participants needed to achieve adequate power; however, a post hoc power analysis revealed we obtained the power to observe a small relationship, $r = 0.11$, and previous work suggests that samples greater than 240 can detect an effect of $r = 0.21$ (Ledgerwood, 2019). Nevertheless, future research should seek larger and more diverse samples.

Future directions

This is the first exploratory study of the relationship between sobriety stigma and sexual health outcomes, and several questions may warrant future examination in light of these findings.

Twenty-five percent of those in recovery report experiencing some type of sobriety discrimination which raises the question of whether those in recovery who do not experience stigma are perhaps resilient in some way or even experience some sort of respect that may or may not be linked to sexual health outcomes. Moreover, it remains unclear whether those who have never had a drink (versus those who previously drank and are now in recovery) experience similar rates of sobriety stigma and downstream sexual health outcomes. Sobriety stigma is a new area of research with many nuances that may be empirically tested.

Moreover, this work focused on the exclusion and judgment of others based on their sober identity. Future research should also explore the inverse of stigma and judgment and focus on support and respect. Experimental research has revealed an understanding-normality effect: When participants are randomized and provided an explanation for why someone exhibited alcohol use disorder behaviors versus provided no explanation, participants who receive an explanation report less stigmatized attitudes toward that individual (Weine et al., 2016). Similar experiments providing sobriety knowledge might provide useful information on how we might decrease sobriety stigma.

Conclusion

This study documents the relationship between sobriety length, stigma, and sexual activity and sexual well-being. Sobriety is an understudied area but affects aspects of sexual health. Destigmatizing sobriety may lead to more successful sexual health promotion initiatives, with the added benefit of improving overall health as there is a strong positive correlation between sexual well-being and a higher quality of life (Stephenson & Meston, 2015). Given this link, future relapse prevention efforts might consider focusing on minimizing stigma, reinforcing the importance of social support, and effectively promoting positive health outcomes related to sexual well-being, which in turn can increase quality of life (Ford et al., 2021). Ultimately, more aspects of sobriety stigma should be studied, and future research should devote resources to understanding the sexual lives of sober individuals.

Conflict of interest statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

Funding

Preparation of this manuscript was supported in part by grants and contracts from the National Institute on Alcohol Abuse and Alcoholism: L30AA027013 (PI: Liana S.E. Hone) and T32AA025877 (PI: Robert Cook).

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