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Abstract

One hundred and seventy million people worldwide live with chronic hepatitis C. Heavy alcohol use plays a key role in progression of the illness and is a contraindication to hepatitis C treatment. Despite the ubiquity of alcohol in Western society as a marker of celebration and sociability, there has been little research addressing the meanings of alcohol use and the dilemmas involved in ceasing or limiting consumption for affected people. This article fills a gap in the literature by addressing the meanings and practices of alcohol use for people with hepatitis C. Data are drawn from a qualitative study exploring the experiences of 40 people living with hepatitis C in New Zealand and Australia. Participants described a number of tensions and dilemmas involved in their relationship with alcohol, illustrating a complex and under-researched interplay of factors that inform drinking practice.

Keywords

alcohol and alcoholism; communication, doctor-patient; decision making; hepatitis C; risk, behaviors

Hepatitis C is a blood-borne virus which, in industrialized countries, is largely confined to people who inject, or have injected, illicit drugs. Infection with the virus progresses to chronic illness in 75% of individuals and is a leading cause of end-stage liver disease and carcinoma (Dore, 2001). Hepatitis C is a highly stigmatized disease, largely because of its association with injecting drug use, infectiousness, and chronicity (Harris, 2009). Despite more than 170 million people, or 3% of the global population, living with the chronic illness (World Health Organization, 2002), qualitative research involving people living with hepatitis C is still at a nascent stage. In particular, there is a dearth of qualitative research exploring affected people's relationship with alcohol. Alcohol use has been posited as the most important controllable factor in hepatitis C progression (Duggan & Duggan, 2007), with clinical research consistently showing that heavy alcohol use significantly increases the progression of liver disease and reduces the effectiveness of hepatitis C treatments (Jamal & Morgan, 2003; Mabee, Crippen, & Lee, 1998). The ubiquity and normalization of alcohol use in Western culture can create tensions for people who have been medically recommended to cease or limit their consumption. With this article I aim to fill a gap in the literature by addressing the practices, meanings, and dilemmas regarding alcohol use for hepatitis C-positive participants of a qualitative research study based in New Zealand and Australia.

The majority of research on alcohol and hepatitis C is clinical and/or quantitative, with only one qualitative study (Stoller et al., 2006; Stoller et al., 2009) documented in the literature. Although there is some knowledge about the drinking practices of people with hepatitis C, the meanings of alcohol use for people living with the illness have not been explored. A large amount of clinical literature documents the detrimental effect of heavy alcohol use on hepatitis C progression (see, for example, Anand & Thornby, 2005; Szabo et al., 2006), with a smaller number of primarily quantitative studies exploring the drinking practices of people with hepatitis C (Campbell et al., 2006; Costenbader, Zule, & Coomes, 2007; Loguercio et al., 2000; McCusker, 2001; Watson et al., 2007). The documented percentages of research participants who continue to drink after hepatitis C diagnosis range from 26% (McCusker, 2001) to 68% (Loguercio et al., 2000). Hepatitis C diagnosis and medical advice about alcohol consumption have been found to cause a reduction in alcohol use (McCusker, 2001), but other research shows that alcohol risk awareness

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has limited impact on consumption levels, even during hepatitis C treatment (Costenbader et al., 2007; Loguercio et al., 2000). These studies did not elucidate the way in which risk awareness was acquired, or other contextual variables which might affect consumption levels. Nor did these studies examine the centrality of alcohol in social interactions, including the formation and maintenance of close personal relationships.

To date, there has been one published study on hepatitis C and alcohol use which has a qualitative component (Stoller et al., 2006; Stoller et al., 2009). Stoller and colleagues' mixed methods study addressed the drinking decisions of 42 "non-problematic" drinkers with hepatitis C. The two articles reporting on this study are interesting in that the researchers posited participants' light to moderate drinking as problematic, stating unequivocally that any alcohol consumption increases hepatitis C progression. Stoller et al. (2009) cited the first study to show that minimal amounts of alcohol consumption increase fibrosis progression in people with hepatitis C (Westin et al., 2002). Findings from that study, however, need to be interpreted with caution given the small amount of cases, the retrospective design, and the small differences in alcohol consumption between people with progressive and non-progressive fibrosis (Jamal & Morgan, 2003). Although it is accepted that heavy alcohol use (<50g/day) significantly increases the progression of hepatic fibrosis, cirrhosis, and end-stage liver disease, it is important to note that there is no consistent evidence that low to moderate alcohol consumption (>40g/day) progresses hepatitis C-related liver damage (Jamal & Morgan, 2003; Monto et al., 2004; Peters & Terrault, 2002). In line with these findings, many medical professionals and health promotion materials advise alcohol reduction rather than cessation (Duggan & Duggan, 2007).

Alcohol cessation is, however, recommended for individuals undergoing interferon-based treatment for hepatitis C (Mabee et al., 1998; Mochida, Ohnishi, Matsuo, Kakihara, & Fujiwara, 1996; Peters & Terrault, 2002). Clinical studies have found that alcohol use compromises the efficacy of interferon, both before (Mochida et al., 1996) and during treatment (Loguercio et al., 2000), with interferon response rates being inversely proportional to the amount of alcohol consumed. Heavy alcohol consumption has been noted as a potential hepatitis C treatment barrier for individuals who inject drugs (Watson et al., 2007). Although injecting drug use is no longer an exclusion criteria for hepatitis C treatment in Australia, a number of studies have shown that a substantial minority of people who currently inject drugs are drinking more than recommended limits (Gossop, Browne, Stewart, & Marsden, 2003; Watson et al., 2007). As there were no currently injecting participants in the current study, I do not comment

on drinking patterns in this group or their relations with treatment agencies.

The concept of pleasure seldom appears in the literature on alcohol use and hepatitis C. A common research and health-promotion focus on clinical markers can elide a consideration of the contexts of drinking practices and the pleasurable, social, and/or pain-relieving uses that alcohol has for some people. A study that explored the self-described benefits and drawbacks of alcohol consumption for 500 British heavy drinkers found that notions of pleasure were foremost in participants' descriptions of their reasons for drinking (Orford et al., 2002). The authors recommended that health promotion efforts engage with the idea of pleasure, as well as acknowledge that heavy drinkers were likely to view their drinking predominately in a beneficial light (Orford et al., 2002). However, as O'Malley & Valverde (2004) stated, health-promotion materials tend to encode pleasure as "risk," because to mention pleasure could be seen as encouraging consumers rather than "neutrally" informing them of their choices.

Method

In this article, I draw on a qualitative research study of 40 people living with chronic hepatitis C: 20 residing in Auckland, New Zealand, and 20 in Sydney, Australia. The aims of the research study were to explore the ways in which participants' discursive, intersubjective, and embodied experiences interacted to inform their practices around and understandings of living with hepatitis C. A phenomenologically informed research design was used for this study. This methodology was chosen for its emphasis on researcher reflexivity and on attending to experience from the research participant's point of view. Analysis was conducted on various themes that arose from the data. One theme that arose was the relationship participants had with alcohol, in particular, the way in which medical advice and social pressures impacted on participants' relationship to alcohol and their concept of self.

Ethical Considerations

Approval for this research was obtained from the University of Auckland Human Research Ethics Committee and the University of New South Wales Human Research Ethics Committee in 2004 and 2006 respectively. The interviews commenced after participants read a study information statement and had provided written consent. Confidentiality and anonymity were assured. Pseudonyms have been used for all participants, for the purpose of this and other research articles.

Recruitment

Participants were recruited by a research notice distributed through the New Zealand Hepatitis C Resource Centre, The Hepatitis C Council of New South Wales, the Auckland and Sydney Narcotics Anonymous fellowships, and an Australasian peer-based hepatitis C Web site. The only criterion for participation was that each individual had to have, or had to have once had, hepatitis C. No financial incentive or remuneration was offered to participate in interviews. Approximately 50 individuals responded to the advertisements in Sydney and Auckland, with a sample of 20 selected for each site. In selecting the sample, I aimed for a gender balance and wide age range.

Participant Characteristics

Both the Auckland and Sydney samples consisted of 11 women and 9 men. Participants ranged in age from 25 to 63 years, with a median age of 47. Participants were diagnosed between 1989 and 2006, with 21 stating that they had lived with the virus for more than 20 years. Although 34 participants identified having injected drugs in the past, none identified as currently injecting. Two former injectors were on methadone maintenance. Twenty-four participants were abstinent from alcohol at the time of the interview and had maintained abstinence for a range of 6 months to 18 years. It is important to take into account that 15 of the 24 nondrinking participants were members of Narcotics Anonymous, which requires abstinence from all mood-altering drugs. Therefore, for these participants, ceasing alcohol use had less to do with hepatitis C than with the management of their prior drug and/or alcohol dependence. Concerns regarding alcohol use did not figure significantly in the narratives of Narcotics Anonymous members; therefore, this article is primarily focused on the remaining 25 participants, 9 of whom were abstinent but did not belong to Narcotics Anonymous, 9 who were occasional or light drinkers, and 7 who were regular heavy drinkers. Twelve of these participants resided in Auckland, New Zealand, and 13 resided in Sydney, Australia.

Data Collection and Analysis

Semistructured, in-depth interviews were conducted with participants in Auckland in 2004 and in Sydney in 2006. Interviews lasted from 1 to 2 hours and were loosely structured around central themes. An opening prompt for each interview was, "Tell me about how you first found out you had hepatitis C," with following questions addressing areas such as experiences of disclosure, stigma, impact of hepatitis C on relationships, and medical

encounters, as well as views on and experiences of hepatitis C treatment. Within this format there was space for new topics to emerge and for the participant to take the lead, bringing up issues that were of importance to him or her. Interviews were transcribed verbatim and analyzed with attention to individual narrative form and structure as well as thematic commonalities and differences.

Findings

Analysis of participants' alcohol-related narratives uncovered four broad themes: medical messages about alcohol use, abstinence as "the right thing to do," the experiences of heavy drinkers, and notions of pleasure. These themes are discussed in turn and illustrated by quotations from participants.

Medical Messages

A central theme in participants' narratives involved the messages they had received from medical professionals about alcohol use. The medical encounter was one situation in which participants most commonly disclosed their hepatitis C status, and might have been the first time that they were told that alcohol use could speed hepatitis C progression. Not all participants, however, were given this information by their health care providers. Participants recounted a diversity of messages received from medical professionals about alcohol; a number were advised to reduce or cease their alcohol use, whereas others recalled being told that their alcohol consumption was of no concern, or stated that they received no alcohol-related information. Isobel said, "I've never even had a doctor tell me I shouldn't be drinking with hep [hepatitis] C. Most of my friends drink copious amounts, who've got it. And they don't appear to have ever been advised otherwise." Rebecca, a daily drinker, similarly related, "Whenever I mentioned drinking to doctors, they just kind of looked the other way. . . . They just didn't think it was a problem. It was like, 'What are you worried about?'"

The apparent lack of definitive advice to limit or cease drinking by some medical professionals, as suggested by Isobel and Rebecca, might reflect the dearth of clinical evidence that moderate drinking affects hepatitis C progression. Although Isobel and Rebecca both mentioned heavy consumption, it was unclear in the interviews how open they were with practitioners about their drinking practices. Rebecca, for example, told me that she had been a daily drinker, but this might not have come out in her medical interaction. It appears, however, that Rebecca did offer her doctors opportunities for discussing her alcohol consumption, but these seem to have been negated: "They just kind of looked the other way."

Medical advice regarding alcohol consumption appeared, within this small study, to be partially dependant on clinical liver function test results. Henry, also a regular drinker, was told to cease alcohol use after his blood tests came back showing high liver function levels. He said, "My [alanine aminotransferase] readings were, oh I can't recall, I think nearly 200. . . . [Then the specialist] told me to stay off the grog straight for six months and I nearly fell off the chair!" Clinical markers such as alanine aminotransferase (ALT) levels do not necessarily provide an accurate indication of liver damage or symptom severity (Miller, Hiller, & Shaw, 2001). A number of authors have reported significant liver damage in hepatitis C patients with persistently normal ALT levels (Naito et al., 1994; Puoti et al, 2005). Therefore, alcohol consumption advice based on liver function counts might overlook some patients with significant damage, or unduly worry others with high liver levels but minimal fibrosis. More concerning, normal liver function counts were often cited by high-alcohol-consuming participants as a reason why they could continue drinking, a finding additionally explored in the section on heavy drinkers.

Another medical situation in which participants described seeking alcohol-related advice was that involving interferon-based hepatitis C treatment. Despite the potentially detrimental effect of any alcohol use on the efficacy of interferon (Loguercio et al., 2000), participants were rarely advised to abstain from alcohol for the duration of their treatment. Rebecca recounted,

When I started the treatment, they [doctors] said, "You've got to have at least two alcohol-free days a week." And like it was about Week five and I counted on my fingers, I'd had like three alcohol-free days in five weeks.

Similarly, Luke was told to limit his alcohol use during treatment, but for him this did not constitute a strong enough warning. He reflected,

I certainly drink a lot; it's part of my work, my social scene and everything. And I kept saying, "Are you sure it's all right to drink?" And whenever anybody says to me, like the nurse or the specialist, "Yeah, it's okay, you can have a glass or two. But just don't binge drink or don't overdo it," that's a green light to me. It's either you can or you can't. . . . Because I drank all throughout treatment. I actually had really big nights sometimes.

Luke's treatment was unsuccessful. Although this might be attributed to a number of factors, including coinfection with HIV and his viral genotype, Luke wondered what part his drinking played in the failure to clear the virus.

He said that if he had received unequivocal advice to cease drinking for the duration of treatment, he felt he would have been able to "give it his best shot."

Abstinence as "The Right Thing to Do"

Only two participants, Henry and Jack, reported being advised to abstain from alcohol by medical professionals. Despite abstinence rarely being promoted by health care workers or in health promotion materials (Duggan & Duggan, 2007), many participants spoke of abstaining from alcohol as "the right thing to do." These references were not specific to hepatitis C treatment, but referred to living with hepatitis C more generally. David said,

I tried to do all the right things and I still do, no alcohol, although I occasionally, very occasionally, maybe once a month I'll have a light beer. But essentially it is low fat, no alcohol, low fiber, and exercise.

David's narrative can be read as that of the responsible individual who has incorporated generalized health-promotion messages about healthy living into his lifestyle. This coupling of responsibility with abstinence, however, could be a double-edged sword, leading to feelings of guilt and anxiety if abstinence was not maintained. Claire said,

I love beer, and so, I'd have one beer and that was it. And you know I said to the specialist, "Is that gonna make a difference?" He said, "If you can stop at one, it won't." But I still felt guilty having that one, and really bad.

Some participants found that a diagnosis of hepatitis C, and accompanying recommendations to reduce alcohol consumption, brought their consumption practices into stark relief for the first time, as Luke described:

Since all this [diagnosis], I've really stepped back and had a look at you know, friends and life, and all that type of thing. And I thought, you know, shit, every time I left the house, if I wasn't going to work I would have had a drink in my hand within half an hour.

For Luke, socializing with friends, family, and workmates involved frequent alcohol consumption. He was known as a drinker. This, coupled with his reluctance to disclose his hepatitis C status, posed a dilemma: how was he to "do the right thing" and reduce alcohol use without arousing others' curiosity? This dilemma was faced by many participants. Claire described her friends' desire to

know why she wasn't drinking, and the frustration this entailed:

They were saying, "Why aren't you drinking?" These are people that I haven't told [about my hepatitis C]. "Are you pregnant?" "No! I'm not pregnant," you know. "Leave me alone. I'm on a detox diet. Just go away!"

The ubiquitous nature of alcohol consumption in many social settings can cause the nondrinker to feel self-conscious and alienated from the growing intoxication of their companions. This, accompanied by a felt pressure to justify their abstinence, caused some participants to stop attending social gatherings. As Rose said, "It was hard going out because I didn't drink. So I didn't go out."

Participants who continued to drink also described feeling judged by others. Alexis, for example, disclosed on a peer-based hepatitis C Web site that she was a regular drinker. She related how this disclosure elicited reactions of shock and unsolicited advice from other members that she should cease drinking, saying, "I am healthy, I drink, that's what I said on the [Web site] you know, I drink, I'm healthy, and that seems to shock people." Alexis's statement that she was healthy and drank appeared to be an uncomfortable juxtaposition for some members of the Web site, who viewed being healthy as conditional on abstinence. Although Alexis referred to these reactions in a relatively blasé manner, they appeared to reinforce her decision to forthwith primarily post medical information on the Web site and limit personal disclosures. It is also possible that other Web site members who drank might, in viewing this correspondence, have felt less welcome or less inclined to post about their consumption practices, thus reinforcing an impression that the majority of the Web site members limited or abstained from alcohol.

Heavy Drinkers

Seven participants described consuming large amounts of alcohol on a regular basis. They all said that they had been medically advised to cut down on their alcohol consumption, and most had done so to varying degrees. This reduction, however, was usually not to physician-recommended levels. Alexis said,

I used to drink a bottle of scotch every three days. My bottle of scotch now lasts about a week. I think I am going pretty good you know. . . . And I think, okay, I should stop, but I can't stop, I can't stop that. It would be good if I even could do one day a week. . . . But my liver functions aren't too bad.

Alexis's statement shows an interesting tension between wanting to adhere to medical recommendations to have some alcohol-free days, yet using biomedical markers such as liver function levels to partially justify her continued alcohol consumption. Alexis also said she "can't stop" drinking. Her perceived inability to cease her alcohol use did not mean that she did not care about her health or was oblivious to medical recommendations. It might instead reflect how negotiating medical and social expectations to reduce alcohol use can be particularly difficult for people living with hepatitis C who have an alcohol dependency. One way that Alexis can be seen to alleviate this tension was by using one set of medical discourses to strategically negotiate or negate the other.

Jack had also been medically advised to reduce or cease his consumption. He was practically housebound from the symptoms of advanced liver cirrhosis and drank two to four "full strength" beers a night. Jack had been told that his alcohol consumption would kill him, but stated that his few beers a night were one of the few pleasures he had left in his life:

I could do with a few more beers a night. The way I look at it, is that I am going to die anyway. I figure I am going to die in the next five years so I am quite philosophical about the whole thing. If you are going to die you are going to die, you know. . . . People die of heart attacks in their 40s, so ah [I could live to] 52, 57, maybe 60.

Jack's narrative might point to an underlying alcohol dependency; however, his attitude to alcohol and acceptance of death can also be seen as an expression of agency in constrained circumstances. In resisting his doctors' admonishments to stop drinking, Jack can be seen to make a considered prioritization of pleasure, thus challenging the dominant Western scientific position that death is something to be avoided.

Annie described the highest alcohol consumption of all study participants. She was diagnosed with hepatitis C in 1989, and said that she did not modify her alcohol consumption, continuing to drink one to two cases of beer (24 to 48 bottles) each week. Annie's general health appeared to be good, as were her liver function levels. Like Alexis, she used these clinical markers to rationalize her alcohol use and defy her doctor:

I am drinking alcohol, which my doctor knows. The doctor I had, not the one I am seeing now, he doesn't know about it. The doctor said, "You are drinking two cases of piss a week; your liver is going to be through the roof." I said, "Well, the liver is the only organ that regenerates itself isn't

it?" He said, "No, your liver will be scarred to buggery and cirrhotised to hell." I said, "Well doctor, how about we make a small wager about that?" He said, "No, I don't make bets with patients." He said, "I'll do your liver tests and you can come back here and I'll give you the bad news." And I said, "What if it's not bad, can I have an extra box of valium?" He said, "No you can't." And I said, "Well, I must get something for it," and he said, "Well the news won't be good, I promise you." And I went back and there was nothing wrong, the levels were fantastic. The only thing he said was that the triglycerides were a tiny little bit elevated. The ALTs were normal. And that is on two cases of piss a week. Only beer though. I think beer is good for it [the liver].

Annie actively used biomedical knowledge, such as the liver's ability to regenerate, to challenge her doctor and dispute his advice to reduce her drinking. She dramatized her narrative, placing herself in the active role, teasing and bargaining with her doctor. Notably, however, she stated that her current doctor did not know about her drinking. Although Annie was adept at defending her alcohol use, she chose not to disclose her drinking patterns to future health care workers; thus relieving herself of potential negative judgments.

Annie's narrative was strategic. She told of having agency in the medical encounter, and her suppositions about the safety of her drinking were affirmed by clinical tests. How much of this story was true we cannot know but, more importantly, it highlights a complex set of relationships between the authority of medical knowledge and the autonomy of patients to appropriate that knowledge and establish some sense of control. Annie used humor and the language of biomedicine to establish, within an often constraining medical discourse, her own sense of personal agency and creativity. Alexis, like Annie, can also be seen to have used biomedical claims to truth and the notion of the "expert patient" to position her alcohol use as congruent with an informed neoliberal rationality. A biomedical discourse is often manifestly inadequate for explaining the complex and contextual reasons for particular practices (Williams, 2000). It might, however, provide an avenue for participants to enact a degree of resistance while adhering to socially respected narratives of rationality.

Pleasure

A cultural encoding of pleasurable consumption as "risk" can be seen to inform the narratives of all of the participants in this study, from Claire who expressed guilt over one drink to Alexis who was careful to justify her use

with reference to clinical markers. Participants in this study did not refer to pleasure as often as the participants of the large British research project by Orford et al. (2002). A reason for this might be that the participants of Orford et al.'s study had not received any treatment for their heavy alcohol use, and therefore were less influenced by medical imperatives and accompanying health-promotion discourses of risk and rationality. Participants of the current study could also have been accustomed to self-censoring experiential narratives of pleasure in their encounters with physicians. In the context of the medical encounter, displaying knowledge of risk markers such as liver function levels might be more effective at conveying an image of rational subjectivity than appeals to pleasure.

Some participants, however, did talk about the pleasures that alcohol consumption provided. Bianca, a former heroin user, said,

I have a huge problem with it [abstinence], huge, because I love a glass of wine . . . so every glass I have I count. It takes the pleasure out of it. . . . And after where I have come from it is sort of like nothing, compared to my history. You sort of think, "Well, you have got your life in control and you have a couple of drinks from time to time, and now you are not even allowed that." I do hate that part of it, I really do.

For Bianca, the pleasure of drinking was compromised by her knowledge of the risk it possibly entailed. This awareness could be experienced as intrusive, especially in light of a history during which greater risks were regularly taken. Like Bianca, the majority of study participants had a history of illicit and injecting drug use. For some, alcohol was a socially acceptable and reasonably nonproblematic alternative. It is understandable, therefore, why participants could be reluctant to cease or reduce their alcohol consumption. As Jack said to his specialist, "Look, I've given up drugs. I'm not a mean drunk or anything. I enjoy drinking." Jack, with advanced cirrhosis, was unable to utilize the rhetoric of biomedicine to rationalize his drinking. His appeal to pleasure received little validation within the medical encounter, and Jack expressed that he found seeing his hepatitis C specialist frustrating because he invariably had to defend his decision to continue drinking.

Discussion

Alcohol plays an important role in our society as a symbolic marker of leisure time and celebration (Heath, 1999). Public health research, however, tends to remove alcohol use from its social meaning and context, eliding its role as

a social connector and conduit “of pleasure and desire” (Lupton, 1995, p. 150). The narratives of participants in this study illustrate some of the dilemmas inherent in negotiating medical notions of risk with the social and pleasurable roles that alcohol can play. Indeed, through these small narrative snapshots, it can be seen how the ubiquity and normalization of alcohol use in Western culture can present social and psychological barriers to the effective renegotiation of alcohol consumption patterns. The social stigmatization of hepatitis C meant that many participants did not want to disclose their viral status, yet felt that if they altered their drinking patterns they would be open to scrutiny in social situations. For those who did not want to disclose their status or lie about why they were not drinking, it could become easier to avoid social events. For participants who continued to drink, negative judgments from within the medical profession and/or networks of others with hepatitis C could also lead to isolation and a negative self-concept. These tensions remain unresolved, yet represent significant dilemmas for many people living with hepatitis C.

The tensions described above illustrate how practices of abstinence or regular alcohol consumption can both be experienced as excluding in different contexts. Participants such as Claire and Rose spoke of how abstinence could be alienating in social situations, whereas experiences such as Alexis’s show how continued alcohol use could provoke stigmatizing reactions from within particular hepatitis C communities. These experiences of exclusion can, in Foucauldian terms, be seen to stem from larger “circuits of inclusion” that exist alongside surveillance as part of the regulation of conduct in contemporary society (Rose, 2000, p. 325). Rose described surveillance as “designed in” to the flows of everyday existence, with regulation occurring through individuals’ enmeshment in circuits of inclusion or, if slipping out of the inclusionary network, pathologized through circuits of exclusion (p. 325). This surveillance is ultimately that of self-surveillance, as exemplified by Foucault’s (1979) exposition of the panopticon.

Health promotion acts to encourage self-surveillance by focusing on the individual as the locus of change and responsibility rather than on external circumstances or structural barriers (Cheek, 2008). Individuals who fall outside of circuits of inclusion, in Rose’s terms, violate the assumptions of neoliberal subjectivity: those of “responsible morality, self control and self advancement through legitimate consumption” (2000, p. 337). The reference to “legitimate consumption” as a defining attribute of the responsible neoliberal subject is apposite for the topic of this article. Alcohol consumption can be seen as an exercise of freedom; one, however, that is increasingly regulated within specific perimeters of inclusion or exclusion. In Rose’s words, “the exercise of freedom in

regulated societies of consumption . . . generates novel forms of exclusion” (2000, p. 327). Participants’ alcohol-related narratives can therefore be usefully read as situated in a culture in which “novel forms of exclusion” can apply to those who do not drink or those who are seen to drink too much.

An apparent tendency of medical practitioners to focus on clinical markers as an indicator of when to offer alcohol-related advice, accompanied by a reticence to respond to participant-led discussions of alcohol practices, can also be seen as an exclusionary technique. Rebecca’s report that her doctors were not interested in discussing her alcohol consumption was affirmed by McCormick et al. (2006) who, in their study of primary care providers’ interactions with patients, found that providers seldom explored patients’ disclosures of drinking practices. Indeed, the authors found that reticence and discomfort among medical professionals was evident in the majority of alcohol-related discussions (McCormick et al., 2006). What is excluded in this medical focus on clinical markers is the voice of the participants’ lifeworld, or their contextual everyday concerns (Mishler, 1984). Instead, the “voice of medicine” is paramount in these encounters, a defining characteristic of the biomedical model (Mishler, 1984). Despite the ascendancy of patient-centered care as a response to the objectifying tendencies of the biomedical model, it appears that the “voice of the lifeworld” received little space in participant’s interactions with medical professionals (c.f. Jingrot & Rosberg, 2008; Davis, 2008).

Waitzkin and Britt’s (1993) research, although dated, is relevant to the experiences of the participants. Waitzkin and Britt examined medical encounters in which the patient reported a history of self-destructive behaviors, such as heavy alcohol consumption. It was found that physicians paid a marginal amount of attention to contextual issues, tending to view self-destructive behavior as “an objectified disease or habit, amendable to technical intervention” (1993, p. 1134). This pathologizing tendency works to render the contextual, emotive, and meaningful nature of practices such as heavy drinking irrelevant. Such treatment is exclusionary and can be counterproductive, potentially obscuring important aspects of drinking practice as well as alienating patients from their bodies and the medical system.

An aspect of drinking practice that might be obscured by a purely biomedical approach is the relational context of alcohol consumption. Participants’ narratives about alcohol use were generally set in the context of a relationship to another, be it doctor, relative, Web site member, work colleague, or friend. The way participants framed their relationship to alcohol was affected by the power relations and the amount of shared information in that encounter. These relational dynamics were additionally

transformed by the interview process, with the participant in relating his or her story presenting not an unmediated "truth" but an edited, interpretive account, which often imparted a particular version of moral agency (Carter, Jordens, McGrath, & Little, 2008; Riessman, 1990). A narrative framing of the self within an inclusionary discourse might be especially pertinent for a person who is perceived to partake in risky behaviors such as heavy drinking when living with hepatitis C. But the decision to maintain abstinence might also need to be carefully framed, especially in a culture in which alcohol is often used as a marker of celebration and socialization.

Within an inclusionary and exclusionary discursive network, the decisions that people living with hepatitis C make about their alcohol consumption can be interpreted as indicative of the individual's level of commitment to a responsible care of the self. This was evident in the narratives of participants who variously based their claims for low consumption levels on doing the right thing, or conversely, claims for heavy consumption on biomedical markers or notions of personal pleasure and autonomy. The need to justify consumption levels came across strongly in the interviews. Alcohol use is open to many constructions of moral agency; contemporary society abounds with conflicting messages regarding alcohol consumption, indeed consumption in general. Ubiquitous advertising encourages and celebrates consumption, whereas health-promotion discourses exhort personal responsibility, control, and restraint (Szmigin et al., 2008). The burden of these conflicting messages was evident in the narratives of participants such as Claire and Bianca, who struggled with the desire to drink and the guilt that this could then entail. These messages can also be seen to be strategically appropriated by participants. Annie, for example, can be seen to reposition herself from the exclusionary location of "problem drinker," irresponsibly precipitating the progression of her disease, to an inclusionary definition of herself as an informed "expert patient" and rational actor. This narrative repositioning, or resistance, could occur because Annie worked within the logic of biomedicine to adapt it to her own ends.

Narrative resistances such as those evidenced by Annie, Alexis, and Jack are not those of grand stances against "the system," but are centered in the minutia of the everyday, where people make sense of their lives and "struggle along" (Desjarlais, 1994). The space for resistance is often created in the dissonances between the lived experiences of individuals and an "official" discursive interpretation of these experiences (Alcoff, 2000). Alexis and Annie both stated that they felt well, they felt healthy, and they drank, thus leading them to resist official interpretations that their alcohol consumption was unhealthy. The enactment of small resistances, bodily and discursive, is a way participants could be seen to attain self-determination within constraining circumstances.

For example, the decision made by Jack, who had advanced liver damage, to drink alcohol despite the protestations of his doctor, can be understood as an expression of autonomy and a prioritization of pleasure in his last years, rather than as purely irrational and self-defeating behavior. Such an outlook takes into account the meaning-making processes involved in drinking practices and the ways in which often marginalized individuals might practice autonomy.

In conclusion, the reasons people drink are many and varied. Recognition of the real and perceived benefits people receive from drinking would add a needed depth to hepatitis C harm-reduction policy. There appears to be a need for practitioners to provide nonjudgmental, sound advice about the known effects of heavy alcohol consumption on hepatitis C progression, as well as the equivocal evidence regarding moderate drinking. In this way, people living with hepatitis C could make informed decisions regarding the risks and benefits of alcohol in their lives. For some, this might involve the decision to drink. In understanding this decision, it is useful to recognize the contexts and meanings of alcohol use for people living with hepatitis C. Negative judgments, medical and social, can cause drinkers with hepatitis C to hide their drinking habits, become isolated, and limit their opportunities for receiving appropriate medical care. If the meanings of alcohol use are explored and the social barriers to changing consumption patterns acknowledged, then the possibilities open up for the development of more effective models of alcohol-related care and support for people living with hepatitis C.

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Bio

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