WOMEN AND SHAME: STORIES OF RECOVERY FROM ALCOHOL DEPENDENCE

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ABSTRACT

Background: Historically women have been underrepresented in alcohol dependence (AD) research, and gender-sensitive treatment is scarce. Extant literature indicates women have specific pathways into AD and recovery, with shame and stigma as key factors, yet there is a paucity of research exploring shame in AD and recovery from women's perspectives, taking account of their relational and socio-cultural contexts.

Aim: This research aimed to explore how shame features in women's narratives of recovery from AD.

Methodology: Taking a critical realist epistemological position, unstructured life story interviews were analysed via narrative analysis to explore how seven women from the UK storied shame in AD and recovery.

Findings: Shame followed a common trajectory across participants' stories, leading up to AD through to recovery. Participants narrated shame as gendered, contributing to a loss of personal control in defining a valued personal identity. Drinking began as a shame-management strategy to feel 'normal' but later became a source of shame, compounded by fears of being labelled an 'alcoholic woman' constructed within medicalised, disease-based grand narratives of alcohol addiction. Recovery involved reclaiming the self through de-shaming a shame-based identity and developing a positive, non-drinking identity. Positive sobriety narratives offered less-shameful frameworks for sense-making in recovery. By sharing stories and reconstructing their own, participants were able to work through shame, resist pathologising identity labels and internalise esteemed 'sober' identities.

Conclusions: This novel study reveals the significance of shame in women's AD and recovery at the intersection of identity, gender and culture. Dominant medicalised narratives of alcohol addiction were revealed as especially stigmatising for women. The need for gender-sensitive treatments and a more social and relational understanding of AD as a response to gender oppressive experiences is highlighted. Implications for clinical practice, future research and policy are considered.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AD Alcohol dependence
UK United Kingdom
US United States
AA Alcoholics Anonymous
CBT Cognitive Behavioural Therapy
ACT Acceptance and Commitment Therapy
IPA Interpretative phenomenological analysis
DA Discourse analysis
TA Thematic analysis
GT Grounded theory
NHS National Health Service
UEL University of East London
GP General Practitioner
BPS British Psychological Society
NA Narrative analysis

1 INTRODUCTION

1.1 Overview

There is growing scholarly consensus that levels of alcohol dependence (AD) are increasing in women (Grucza et al., 2018; Slade et al., 2016), in some instances, at higher rates than in men (Grant et al., 2017; A. M. White, 2020). Women are more vulnerable to the adverse health, emotional, social and psychological consequences of problematic alcohol use (McHugh et al., 2018; Tuchman, 2010), are more likely to experience numerous barriers in accessing treatment (O'Connor et al., 1994; Tuchman, 2010) and less likely to seek support (Greenfield et al., 2007). More recently, the need for gender-specific support has been highlighted in research and by activists, as evidenced by the proliferation of alternative, women-led sobriety groups in the US and UK (Davey, 2021).

However, knowledge of alcohol-related problems is largely gained from studies using men, which, in turn, inform the basis of mainstream models of addiction and recovery (Brett et al., 1995). Emerging research suggests pathways into AD and recovery are gender-specific, with trauma, histories of abuse, socio-cultural factors, shame and stigma being more relevant to women (Kougiali et al., 2021; Tuchman, 2010). Several authors argue more research into gender differences and women's problematic alcohol use within the socio-cultural specificities of their everyday lives, is needed (Ettorre, 1997, 2015; Tuchman, 2010; Wilsnack et al., 1994). This research seeks to address this gap in the literature by centring the voices of women and their storying of shame in AD and recovery in the UK.

1.2 Definitions and Contextualising Language

A plethora of terms are used to describe alcohol-related problems. Each term reflects its historical, socio-cultural context and a particular view of 'the problem' (Burns, 2021; Kelly et al., 2016). The relative strengths and limitations of terms are debated across research, survivor support groups and clinical practice settings on the basis that 'words matter' (Broyles et al., 2014); they shape how individuals make sense of themselves and others, treatment and policy (Polander & Shalin, 2013). Certain terms (e.g., 'addict', 'substance abuser') have been argued to confer

negative attributions of choice and responsibility, leading to perceptions of blame and reinforcing stigma and shame (Kelly et al., 2016). Therefore, alcohol-related harm can occur both from alcohol consumption, and as a by-product of the marginalisation and treatment of those labelled ‘alcoholics’ (L. E. Frank & Nagel, 2017).

A medicalised perspective is the dominant view of addiction in the West, wherein alcohol-related behaviour is involuntary and ‘alcoholics’ are deemed to suffer from a physical, treatable, if chronic and relapsing disease (Leshner, 1997). Medicalised terms are often presumed less stigmatising, inferring ‘alcoholics’ are not responsible for their addiction and therefore should not be blamed (Broyles et al., 2014; Kelly et al., 2016). Others contest that medicalised terms continue to be morally laden (L. E. Frank & Nagel, 2017; Heather et al., 2022), particularly for women (Beresford, 2015). Not only does the moralisation of addiction, wherein addiction is understood as a character defect or weakness, persist, but ‘addiction as a disease’ is said to invite its own form of moralisation in that people cannot control their alcohol use (L. E. Frank & Nagel, 2017).

Kelly and colleagues (2016) recommend the use of terms like ‘alcohol use disorder’ (American Psychiatric Association, 2013), consistent with diagnostic nomenclature, to aid unambiguous clinical and scientific communication and appraisal of research findings. However, critical psychologists, practitioners and women’s survivor groups have criticised diagnoses for lacking reliability and validity, obscuring the impact of social contexts, causing stigma and reducing perceptions of self-efficacy (e.g., Johnstone, 2017; Wiens & Walker, 2015). In selecting terms for this study, the author faced a considerable dilemma; the term needed to convey the severity of alcohol-related problems it intended to explore to potential participants and audiences, but adopting medicalised terminology risked further stigmatising participants.

Considering the above, the term ‘with AD’, alongside ‘problem drinking’ or ‘problematic alcohol use’, was adopted for this study. AD was considered descriptive, characterising a strong craving for alcohol, continued use despite repeated problems and harmful consequences, an inability to control alcohol

consumption, and/or withdrawal symptoms (Moss & Dyer, 2010). Person-first language separates the individual from the problem or diagnosis, showing a person 'has' rather than 'is' the problem (Broyles et al., 2014). Nevertheless, the author recognises these terms are imperfect, which is reflective of broader issues with definitions in alcohol research. The terms 'addict', 'alcoholic' and 'addiction' are used when referencing literature and participants verbatim.

1.2.1 Recovery

Recovery is operationally problematic and there is no consensus on how to define recovery in the literature. Definitions include abstinence and non-abstinence-based approaches. The Betty Ford Institute Consensus Panel (2007) categorises recovery according to length of time abstinent: early recovery is one month to less than a year, sustained recovery at least a year and stable recovery at least five years. Over time the stability of recovery increases, with the chance of relapse decreasing five to six years into abstinence (Vaillant, 1996). Some approaches, such as Alcoholics Anonymous (AA), argue that the resolution of AD involves the development of a recovery-based identity (Cain, 1991).

In non-abstinence approaches, recovery is 'a state' – a lifelong individual process (Kougiali et al., 2017; Laudet, 2008) contingent on numerous contextual factors and availability of resources (Kaskutas et al., 2014), improved functioning in multiple areas of life (Best et al., 2011; Dekkers et al., 2020) and encompassing personal growth and empowerment (Best & Laudet, 2010). The 'recovery agenda' has been criticised for its focus on wellbeing, which is thought to depoliticise alcohol problems by framing them as a problem with the individual, thereby obscuring the role of social factors and material inequalities (Friedli, 2009). Nonetheless, the study adopted this definition of recovery; it was considered more holistic, centring individual decision-making and recognising recovery as a process with many pathways beyond abstinence (Wright, 2012), thereby challenging some traditional ways of understanding addiction (W. L. White, 2008).

1.3 Literature Search Strategy

The literature search was conducted in three phases. Initially, an extensive search was carried out to identify academic, clinical and grey literature exploring women and 'addiction'. Further research identified through reference list searches of relevant articles and suggested by the researcher's supervisor was read to ensure all relevant outputs were considered. An overview of the literature revealed a convergence of evidence suggesting that although there are gender-specific pathways in the initiation and progression of and recovery from AD, including shame and stigma as key factors (e.g., Kougiali et al., 2021; Tuchman, 2010), women tend to face additional barriers to accessing support and remain underrepresented in 'addiction' research (e.g., Greenfield et al., 2007).

Secondly, a literature search was carried out to explore how shame is conceptualised and theorised in 'addiction' literature, revealing a dearth of research focused on shame and women's experiences of AD and recovery, especially from the perspective of women themselves. It was therefore decided that a formal scoping review would focus on shame, women and AD. A search of relevant academic databases and grey literature was undertaken using a range of search terms for 'shame', 'women' and 'alcohol dependence', yielding only one personal account of shame and guilt in recovery and two studies where shame was included within the secondary research aims (Davis, 1997; Merritt, 1997; Wiechelt & Sales, 2001). It was therefore decided to include research that referenced shame or shame-related constructs in the abstract or findings. Shame was identified as a precursor and response to AD in women; however, no studies focused specifically on shame across women's experiences leading up to AD *and* recovery. The aim of this project is to address this gap in the literature by exploring shame in women's personal stories of recovery from AD in the UK.

1.4 Women and Alcohol Dependence

In the UK, the number of people with AD appears to be growing and recent figures suggest the increase in problematic consumption is not gender specific. It is estimated that 16% of women in England and Wales are drinking in a way that damages their health (NHS Digital, 2016, Table 2) and from 2019 to 2020, there

was a 24% increase in female alcohol-specific mortality rates (Nuffield Trust, 2022).

Research also shows women are less likely to seek help for AD from ‘traditional’ treatment programmes, including disease-model approaches such as Alcoholics Anonymous (AA; Kaskutas, 1994; Rhodes & Johnson, 1994) and more likely to access support through primary care mental health services (Harvard Medical School, 2011) and cognitive behavioural therapy (CBT) models such as SMART recovery (Hester et al., 2013). Recent literature highlights the multiple barriers women face when accessing treatment, including practical barriers (family and work commitments, limited access to childcare, lack of financial, social resource or family support), stigma and shame, fear of social labelling, complex mental health difficulties, and an absence of gender-specific protocols and treatments (Greenfield et al., 2007; McCrady et al., 2020; Tuchman, 2010).

AA, the UK’s largest mutual support group (Public Health England, 2015), utilises a 12-step, self-help philosophy approach developed in the 1930s by upper-middle-class white Protestant US men for ‘male alcoholics’. While a descriptive review found AA can be effective for women, it also highlighted several gender differences (Ullman, 2012). Some feminist researchers postulate that AA might be less applicable (and even shaming) for women due to the emphasis on neutralising ‘egocentric elements’ in the character of the ‘alcoholic’ and powerlessness (in the context of women with significant histories of trauma and victimisation) and the negative implication of the life-long disease model (Kaskutas, 1994; Sered & Norton-Hawk, 2011). While the demand for gender-sensitive support is increasing, provision remains scant, and support is overwhelmingly designed around the needs of men (Holly, 2017).

It is unsurprising then that Western contexts over the last decade have seen a proliferation of alternative recovery modalities in online spaces, spearheaded by women, attempting to distance themselves from more traditional recovery programmes. A conglomerate of online communities (sober media, podcasts,

blogs), web-based support groups[1] and autobiographical 'quit' literature[2] constitute a 'new sobriety', 'positive sobriety' or 'sober curious' movement. These communities tend to reject the use of binary language of 'alcoholic' or 'addict', instead conceptualising alcohol-related problems on a spectrum (Raypole, 2020), and offer information, peer support and recovery coaching to those wanting to 'renegotiate their relationship with alcohol' (Davey, 2021, p. 2).

The prevailing narrative of the movement is predicated on the joy and benefit to personal health and wellbeing of a sober lifestyle, with a view to ameliorating the shame and stigma attached to alcohol refusal (Raypole, 2020). Media reporting suggests the movement has been welcomed as a space to reassess drinking, offering a positive non-drinking identity not premised on the construction of AD as a disease or the stigmatising label of 'alcoholic' (Raypole, 2020). The main criticism is that it minimises the seriousness of alcohol-related problems and challenges in recovery in its commodification and framing of sobriety as a 'lifestyle choice' (Raypole, 2020; Stieg, 2019).

Despite increased attention in the media, there is a paucity of academic research in the area. In a rare study exploring the construction of non-drinking from the UK-based 'Sober Girl's Society' Instagram, Tanskanen (2022), in their master's thesis, identified four dominant discourses in the construction of non-drinking as a radical act, empowering, lifestyle habit and a source of pride: social support, self-improvement, challenge, resistance. Key aspects included: a sense of community, self-improvement and authenticity, managing the challenge of social situations without alcohol and negative reactions to sobriety, resisting drinking as the norm and the pressures of the alcohol industry. This provides evidence for a very different narrative to non-drinking than the traditional disease-based narrative. However, existing research does not explore how and when women traverse and engage with this narrative as opposed to other narratives in recovery.

At the time of writing, based on limited qualitative and quantitative research, Davey (2021) has conducted the only mini review on online sobriety communities for

[1] E.g., Club Soba, LoveSober, Sober Girl Society, Sobriesta, Soberful, Sober Girl Society
[2] Key texts: 'Quit Like a Woman' by Holly Whitaker & 'The Unexpected Joy of Being Sober' by Catherine Gray

women's problematic alcohol use. She found that participants within online sobriety communities are disproportionately female, in employment and have post-graduate qualifications. Many of this treatment pathway's advantages were found to align with the gendered needs of women in recovery, offering solutions to women's barriers to treatment, notably the mitigation of shame and stigma if platform use is anonymous and/or mediated through the written word. However, gendered analysis, for example, into the gendered nature of communication and identity performance within online sobriety communities, was largely absent from these studies.

A lack of gender-sensitive treatment for women with AD is situated in a history of gender bias in addiction research (Greenfield et al., 2007; Waterson, 2000). Until the early 1990s, 'substance abuse' treatment literature was based predominantly on mixed samples without any focus on gender differences or male only samples (Greenfield et al., 2007). Indeed, feminist scholars argue that many of the prevailing theories of 'addiction' are 'gender blind' in that they treat and apply knowledge and research based on male participants as 'universal truths' (Campbell & Ettorre, 2011; Kohn, 2002). In the 'addiction' literature that has focused on women or gender differences, there is emerging consensus that women's pathways into AD and recovery, and therefore treatment needs, are distinct in nature (e.g., Kougiali et al., 2021; McCrady et al., 2020; Tuchman, 2010; Van der Walde et al., 2002).

Gender differences are found in the biological and pharmacological effects of alcohol, and women, when compared to men, are at greater risk of harmful health, physical and social consequences when drinking less over a shorter timeframe (e.g., Tuchman, 2010; Van der Walde et al., 2002; A. M. White, 2020). Prevalence of co-occurring psychiatric diagnoses, including depression, eating disorders, anxiety, and post-traumatic stress disorder, is higher in women than men who meet the diagnostic criteria for AD (Tuchman, 2010; Wilsnack et al., 2013). Consistent with this, women generally attribute their drinking to trauma or stress (Allan & Cooke, 1985; Center for Substance Abuse Treatment, 2009; Lex, 1991).

The self-medication model (Baker et al., 2004; Khantzian, 1997) wherein alcohol is consumed to temporarily relieve emotional pain or stress, including symptoms of posttraumatic stress, is often used to account for the development of drinking problems in women (Reed et al., 2007). In comparison to their male counterparts, women in treatment for AD report higher rates of sexual, emotional and physical abuse and (poly) victimisation, including in childhood or from a spouse (Covington & Kohen 1984). Several studies report strong associations between trauma and increased alcohol misuse (e.g., Langeland & Hartgers, 1998; Ouimette et al., 1996); however, less is known about the factors moderating the relationship between the two.

1.5 Shame and Alcohol Dependence – The Missing Link?

Authors adopting a feminist stance argue that women use substances to numb, conceal or temporarily alleviate feelings of shame related to their own victimisation and that disapproving societal stigma from 'addiction' engenders an intense shame based on negative beliefs about the self that keeps women in 'denial' and 'hiding' (Blume, 1990, p. 299). Shame, as a transdiagnostic process, is implicated in many co-occurring diagnoses found in women with AD, including depression and post-traumatic stress disorder (e.g., Gilbert & Procter, 2006). Shame is also a common consequence of complex trauma (Courtois, 2004; Herman, 1997) and has been identified as a factor contributing to the link between trauma and AD (Wiechelt, 2007). Compared with male counterparts, women with alcohol 'addiction' are more likely to report powerlessness and inadequacy preceding drinking (Beckman, 1980), feelings closely related to shame.

Clinical feminist literature suggests gender differences in AD are rooted in differences in women's psychological development, which increase their vulnerability to problematic levels of shame from dysfunctional or abusive relationships. Theories that focus on female development (e.g., relational theory; J. B. Miller & Stiver, 1997) posit that women are motivated primarily by forming a basic sense of connection to others. When women are disconnected from others (e.g., in abusive relationships or dysfunctional family systems), they experience diminished self-worth, confusion and disempowerment – fertile ground for AD

(Covington & Surrey, 2000). Based on their clinical experience, Covington and Surrey (2000) argue women's disconnection and isolation is experienced as a state of shame. Correspondingly, Lisansky Gomberg (1988) posits that in contrast to men, who tend to act out in an array of aberrant behaviours, women turn negative feelings towards themselves. Internalised shame is thought to be experienced as depression, 'a state of dysphoric discomfort', which leads women to use alcohol in an attempt 'relieve' and 'self-medicate psychic pain' (p. 144).

Feminist scholars argue women remain an oppressed group across cultures and the female role is more conducive to relational trauma, mental health problems, psychological isolation and shame (see Ettorre, 1989). In line with this, irrespective of age, females 'consistently report greater levels of shame than their male counterparts' (Tangney & Dearing, 2002, p. 154) and are found to experience shame as 'a web of layered, conflicting, and competing expectations' about how women are 'supposed to be' (B. Brown, 2006, p. 46). Moreover, qualitative studies on gender and alcohol use find that stresses and pressures attached to gender-role expectations (e.g., motherhood, marriage/family breakdowns, empty-nest syndrome, workplace gender prejudice and male-to-female harassment) are precursors to heavy drinking (Brady & Randall, 1999; Fillmore, 1984; Goldberg, 1995), giving rise to experiences of shame (Sanders, 2018).

Contemporary sociological research shows that the British mass media, general public and governmental institutions continue to pathologise women's alcohol use as a form of transgressive femininity (e.g., Day et al., 2004; de Visser & McDonnell, 2012). Women seen to occupy the position of 'alcoholic' continue to be especially vulnerable to, and more profoundly affected by, stigma due to the perception of their deviation from socially prescribed gender roles as caregivers (wives/mothers) and traditional 'feminine' qualities such as submissiveness, being responsible and caring (Eagly et al., 2000; Lex, 1994).This has led to a pervasive, cultural double-standard regarding alcohol use (de Visser & McDonnell, 2012) that inflicts more shame on women with AD than men (Sanders, 2009).

Motherhood is recognised in the literature as a role that makes women vulnerable to shaming, particularly those with AD. The social construction of the dominant

representation of a good mother (self-sacrificing/nurturing) obscures the actual skills, practices and intense emotional and physical labour of mothering, as these are assumed and therefore devalued and rendered invisible (Banwell & Bammer, 2006; B. Brown, 2006). Not only can this pressure women to live up to these ideals (Banwell & Bammer, 2006), when rendered visible and pathologised through their violation of gendered societal expectations (e.g., use of alcohol), they also are assumed to lack any positive mothering skills, are seen as 'bad mothers' and risk having children taken into custody (Nishimoto & Roberts, 2001).

Shame, as the 'intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging' (M. Brown, 2012, p. 5), therefore cuts across many factors relating to women's AD and recovery, arguably standing out as the main psychosocial issue differentiating females from males. Moreover, literature suggests shame is a 'gender-responsive' phenomenon: the propensity for, sources of, and experience of shame seemingly differ across gender.

1.6 Shame and Addiction Research

1.6.1 Shame and Addiction

Despite the gendered nature of shame, particularly in the context of AD, the majority of research linking shame to 'addiction' uses male-only or mixed-gender samples and therefore continues to be 'gender blind'. According to Wiechelt (2007), 'addiction' research is based on two theoretical definitions of shame. Shame is conceptualised as either an innate affect, internalised when triggered inappropriately or chronically (Cook, 1996), or, as a moral, self-conscious emotion experienced differentially according to one's dispositional proneness and self-evaluation (Tangney & Dearing, 2002), typically when a person evaluates themselves through the eyes of another (M. Lewis, 1995; Tangney & Tracy, 2012).

Quantitative research with male and female participants finds elevated levels of shame in clinical populations in recovery from 'addiction' (Cook, 1987; O'Connor et al., 1994) and that shame-proneness is linked to problematic alcohol use (Dearing et al., 2005), indicating that shame is a risk factor for developing AD and/or that AD

makes people vulnerable to experiencing shame. Due to associations with motivations to hide and escape, avoidance (of the problem) and ruminating self-criticism, shame is generally theorised as leading to an increase, not a decrease, in problematic substance use (Dearing et al., 2005; H. B. Lewis, 1971; Treeby et al., 2020). Shame is often contrasted with guilt (Dearing et al., 2005), which is considered more likely to motivate reparative actions, including taking action to address AD (Baumeister et al., 1995; Treeby et al., 2020).

It has been suggested that, perhaps counterintuitively, the effect of shame on one's global self-image (e.g., 'I'm a bad person') leads them to believe they are damaged beyond repair (Nussbaum, 2006; Tangney & Dearing, 2002), resulting in increased alcohol use. Alcohol has been found to downregulate experiences of anxiety and depression (Treeby & Bruno, 2012) and is thought to offer an especially effective means of coping with shame wherein self-awareness, a precondition for the experience of shame (Tracy & Robins, 2004), is prevented or decreased (Hull et al., 1986). Shame's relationship with 'addiction' is commonly reported in clinical literature as being cyclical, wherein a 'shame-based' individual discovers that substance use facilitates avoidance and escape from painful feelings (of shame) but then feels increasing shame from loss of control, which serves as an antecedent for more substance use, perpetuating a vicious cycle of shame and substance use (Dearing et al., 2005; Wiechelt, 2007).

1.6.2 Shame and Recovery

A significant body of research suggests shame can hinder recovery from 'addiction'. Non-verbal displays of shame (regarding past experiences of drinking) strongly predicted relapse and relapse severity in self-identified newly sober men and women (Randles & Tracy, 2013). Research finds that shame is a major barrier to accessing treatment (Saunders et al., 2006). Luoma and colleagues (2012) argue shame is the 'emotional core' of self-stigma, which is linked to longer stays in residential 'substance use' treatment. Birtel and colleagues (2017) found that perceived stigma of substance use is linked to poorer wellbeing and mental health and that shame mediates the effect of perceived stigma and support. These studies suggest shame is likely to hinder recovery from substance use problems, shaping perceptions of support and help-seeking behaviours.

Further research indicates addressing shame can support recovery from 'addiction'. Findings from a randomised control trial suggest interventions targeting shame, such as acceptance and commitment therapy (ACT), produce superior treatment attendance and reduced substance use (Luoma et al., 2012). One study found that targeting acceptance can lessen the effects of shame and guilt on self-forgiveness in recovery for drug and alcohol problems (McGaffin et al., 2013). In one of few treatment trials, promoting self-forgiveness through group intervention (four hours) successfully decreased levels of shame and increased drink refusal (Scherer et al., 2011). Taken together, these studies suggest promoting acceptance and self-forgiveness helps individuals to manage the effects of shame in recovery.

Conversely, authors from an evolutionary perspective, wherein emotions have evolved because they serve adaptive functions, argue shame motivates individuals to seek help and repair a damaged identity (Cibich et al., 2016; Keltner, 1995; Keltner et al.,1997), and therefore may play a role in facilitating recovery and preventing relapse (e.g., Snoek et al., 2021). Therefore, within 'addiction' research, the role of shame in recovery is ill-defined. For instance, whether or how shame hinders *or* facilitates recovery and if problematic shame is either significant prior to and/or during 'addiction', or seeking treatment triggers such experiences.

1.6.3 Women, Shame and Addiction

In the few quantitative studies comparing shame in men and women in treatment for substance use problems, women with 'addictions' consistently report significantly greater levels of shame than men (e.g., Cook, 1987; O'Connor et al., 1994; Tangney & Dearing, 2002). In their recent systematic and meta-analytic review on shame and substance use, Luoma et al. (2019) identified being a woman or gender minority as the only factor moderating the association between shame and substance use-related problems. Studies with women with substance use problems consistently find that women identify stigma a barrier to accessing treatment (Pinedo, 2019), and this is more significant for women compared to men (e.g., Stringer & Baker, 2018). The only study to explore shame-based interventions with women in treatment for substance abuse problems found that addressing shame, including the gender-based expectations that provoke shame is

an effective treatment modality (Hernandez & Mendoza, 2011). These studies strongly suggest women are disproportionately affected by the stigma and shame from ‘addiction’.

Research indicates shame may be more significant for women with AD than those with dependence on other substances (Sanders, 2011). Arguably, it is important to focus on AD separate from other substances given its unique biological effects and social positioning. While shame has featured prominently in qualitative studies of those with lived experience of AD (e.g., Morck et al., 2020; B. A. Smith, 1998), an extensive search of the literature could only find one recent qualitative study explicitly focused on the lived experiences of shame in recovery from AD, which found that constructing and sharing narratives of shame can support recovery (Sawer et al., 2019). However, this study used a mixed sample of (majority) men and women, precluding a gendered analysis of shame. The following section outlines a scoping review exploring shame in women with or in recovery from AD.

1.7 Scoping Review: Women, Shame and Alcohol Dependence

An extensive search of PsycINFO, PsycARTICLES, CINAHL Plus and Academic Search Complete was conducted using the search terms ‘alcohol dependence’, ‘women’ and ‘shame’, yielding only two studies where shame was included in the research aims. Additional searches of grey literature were conducted using Google Scholar and relevant open-source repositories (Research Gate), yielding one personal account of shame and guilt. Therefore, studies where shame and shame-related concepts were discussed in the abstract or results were included in the review. Key papers were identified, and citation searches carried out by hand. Appendix A includes further details on the inclusion and exclusion criteria, search terms, the limiters applied, studies identified and the relative strengths and weaknesses of snowballing methods.

This section reports on 24 papers published between 1993 and 2021, written in English, using their language, focus, and findings to categorise them. The review summarises the main ways shame has been conceptualised in relation to women’s experience of AD and recovery. The review will highlight UK-based studies given

the culturally and socially situatedness of shame and AD and the UK-specific treatment context.

1.7.1 Pre-alcohol Dependent Stage

1.7.1.1 Shame, Trauma and Childhood Adversity

Six qualitative studies mention shame in relation to early and ongoing trauma and adversity, particularly within family of origin. In these papers, sexual, physical and emotional abuse, neglect, 'alcoholic' parent(s), depression and poverty were identified as sources of shame (Boyd & Mackey, 2000; Brewer, 2006; Jacobs et al., 2012; Jacobs & Jacobs, 2015; Prussing, 2007; Sanders, 2011). A recurring finding across these studies is that women report self-medicating with alcohol to cope with painful emotions and memories attached to experiences of trauma, including shame and guilt. These findings closely relate to central themes – 'trauma and (poly) victimization' as a precursor and perceived causal factor of AD, with AD functioning to 'substitute reality' in this context – within a qualitative meta-synthesis of 23 qualitative studies published between 1998 and 2018 that explored women's pathways into AD and towards recovery (Kougiali et al., 2021).

Participants across nine studies reference neglect and abuse in the context of growing up in alcohol dependent family systems or with alcohol dependent parents. Three of these studies link shame from growing up with AD and trauma as relevant to the development of AD, e.g., because of their potential to normalise dysfunction and alcohol use (Boyd & Mackey, 2000; Jacobs & Jacobs, 2015; Prussing, 2007). Jacobs and Jacobs' (2015) study conducted discourse analysis (DA) on interviews with South African women in recovery and found stories of their childhoods were 'filled with sworn secrecy, silence and shame that infused lies that had to be told to preserve the (alcohol dependent) family system despite its dysfunctional nature' (p. 30). Similarly, women in Boyd and Mackey's (2000) US-based study reported shame from feeling different to their peers in the context of abuse, poverty and parents with 'alcohol addiction', which, alongside other painful feelings, was understood as an expression of and a factor contributing to feelings of 'alienation from others'.

Four studies report links between early experiences of trauma and poly-victimisation (e.g., male-to-female intimate partner abuse and sexual assault) and women's negative self-concept (Boyd & Mackey, 2000; Hanpatchaiyakul et al., 2017), including in Scotland (Lillie, 2002) and Northern Ireland (Long & Mullen, 1994).

These findings suggest shame and trauma, frequently related to exposure to AD in family of origin, play a role in the development of AD in women. However, the samples in three papers were either exclusively or in the majority women who grew up with alcohol dependent parents or family systems, and although this is more prevalent in women with problematic substance use (Tuchman, 2010), it is not necessarily generalisable to all women with AD. While it was common for participants' excerpts to feature shame in their accounts of early trauma and adversity, it was often grouped with other painful feelings without further discussion or elaboration, presumably because shame was not the focus of the studies. Similarly, there was little discussion or explanation of how shame related to low self-esteem or negative self-concept.

1.7.2 Alcohol Dependent Stage

1.7.2.1 Shame and Gendered Stigma

Across 13 papers, heavy or excessive drinking was perceived by participants as incompatible with gender normative behaviours/characteristics and traditionally assigned gender roles (e.g., wife, mother and daughter; Bobbe, 2002; Boreham et al., 2019; Brewer, 2006; Cunningham, 2012; Davis, 1997; Hanpatchaiyakul et al., 2017; Jacobs et al., 2012; Jakobsson et al., 2008; Kougiali et al., 2021; Lillie, 2002; Long & Mullen, 1994; McNally & Finnegan, 1992; Pettinato, 2008). Shame and guilt from the perceived social stigmatisation of identification as an 'alcoholic' or 'drunk' by the participants themselves, significant others or the wider community was a consistent finding across eleven international and UK-based papers (Boreham et al., 2019; Brewer, 2006; Cunningham, 2012; Davis, 1997; Hanpatchaiyakul et al., 2017; Jacobs et al., 2012; Jakobsson et al, 2008; Kougiali et al., 2021; Lillie, 2002; Long & Mullen, 1994; McNally & Finnegan, 1992). The 'alcoholic woman' was perceived to violate traditional feminine qualities of womanly

purity and sexual dignity, being in control and motherhood (Boreham et al., 2019; Cunningham, 2012; Davis, 1997; Hanpatchaiyakul et al., 2017; Jacobs et al., 2012; Jakobsson et al, 2008; Lillie, 2002; Long & Mullen,1994).

In the three studies comparing the perspectives of 'alcoholic' drinking and recovery in men and women, participants reported greater stigmatisation of and shame associated with women's drinking problems (Aaltonen & M Kel , 1994; Cunningham, 2012; Jakobsson et al., 2008). Shame from gender-based expectations shaped women's drinking behaviours, including denial, hiding and hoarding drink, secret and solitary drinking, self-isolation and home-based drinking (Cunningham, 2012; Doty-Sweetnam & Morrissette, 2016; Long & Mullen, 1994).

1.7.2.2 Mothers

Two studies focused on mothers' experiences of AD and recovery (Boreham et al., 2019; Jacobs & Jacobs, 2015), and five papers discussed shame in relation to excessive drinking and the maternal role (Cunningham, 2012; Hanpatchaiyakul et al., 2017; Jacobs et al., 2012; Jakobsson et al. 2008; Long & Mullen,1994). Using a phenomenological approach, Hanpatchaiyakul and colleagues (2017) found that 'feeling inferior and worthless', an essential aspect of Thai women's subjective experience of 'alcohol addiction', was partly rooted in their perceived failure to fulfil the maternal role due to excessive drinking, reinforced by significant others and the wider community. Likewise, Jacobs and colleagues (2012) found participants felt like 'bad mothers' and rejected by society for drinking as mothers. The only UK-based study to focus on the experiences of mothers found identifying as an 'alcoholic' or 'drunk' was 'particularly distressing as it cut right to the very core of women's identities as mothers and as women' (Boreham et al., 2019, p. 191). Participants in this sample, however, may have heightened experiences of shame; they were in proceedings seeking to retain care of, or be reunited with, their children and may have felt shame from having their child removed.

1.7.2.3 Lesbians

Three studies focused on lesbian participants' experiences of AD, suggesting deviation from heteronormative femininity can be a source of shame contributing to

AD. Based on her clinical work, Bobbe (2002) drew on a case study to theorise the vulnerability of lesbians, who may be seen as a threat to the patriarchy due to their lack of dependence on men, to feelings of shame from homophobia and internalised homophobia. She postulated 'unconscious shame', in response to confusion and pain caused by feeling 'different', leads to denial and dissociation from their true selves, resulting in alcohol use as a reaction to shame. Similar themes of shame, stigma and self-hatred from internalised homophobia precipitating excessive alcohol use emerged in two other papers with lesbian participants (McNally & Finnegan, 1993; Pettinato, 2008).

The only study in the sample to include women who had not sought treatment for AD found that participants used several discursive, identity-protection strategies to resist the stigma (and presumably shame) attached to being a woman heavy drinker ('addict') by applying a discourse of self-control, constructing alcohol use as a habit and contrasting their actions and behaviours with younger women (Rolfe et al., 2009). The authors commented on the absence of the discourse of 'addiction' in participants' accounts, which may indicate that it is shaming to take up this discourse or that shame/shame identification is a part of the sequelae of recovery and 'addiction'/recovery narratives.

Taken together, these studies suggest that women experience shame from (highly) gendered moral discourses around drinking; AD remains a site for the propagation of hegemonic discourses around sexuality and femininity, resulting in women feeling shamed for alcohol problems, impacting how they view themselves and their drinking behaviour.

1.7.2.4 Cyclical Shame and Alcohol Dependence

Two studies suggest shame plays a role in escalating alcohol use. Participants describe using alcohol to ameliorate 'internal' shame but that drinking-related behaviours and perceptions of 'being out of control' intensify feelings of shame, guilt and hopelessness, perpetuating a vicious cycle whereby drinking temporarily relieves and amplifies shame (Doty-Sweetnam & Morrissette, 2016; Lillie, 2002).

1.7.3 Recovery Stage

1.7.3.1 Shame as a Barrier to Recovery

In total, 17 studies in the sample covered women's recovery from AD. Four qualitative papers focused specifically on women's pathways to and experiences of recovery, finding that feelings of shame and guilt were most prevalent in early sobriety, initial recovery and during relapse, although they continued to emerge over the course of recovery (Brewer, 2006; Davis, 1997; Doty-Sweetnam & Morrissette, 2016; Merritt, 1997). Kougiali and colleagues' (2021) aforementioned qualitative meta-synthesis reported that shame and stigma hindered the initiation of recovery. This aligns with Jakobsson and colleagues' (2008) Scandinavian study on gendered conceptions in treatment seeking for AD, which found that shame and guilt were barriers to seeking treatment based on participants' perceptions that AD was incompatible with femininity (Jakobsson et al., 2008).

In line keeping with the above, Davis' (1997) US study, as a secondary research aim and using thematic analysis, explored the impact of shame on the recovery process and found that in recovery women were confronted by the awareness of the 'full spectre of societal sanctions against what [they have done]' (p. 165), resulting in painful feelings of shame that persisted into recovery and functioned as a barrier in relationships with non-alcoholics. The gendered aspect of shame in recovery is highlighted in a more recent US study, which found that feeling stigmatised by others for having been an 'alcohol dependent woman' was a factor hindering the process of recovery and the need to hide alcoholism from others out of fear of disapproval and punishment that caused all participants shame (Brewer, 2006).

Merritt's (1997) personal account of recovery using AA distinguishes guilt, a possible healthy catalyst for recovery, from shame, which may trigger responses that stimulate relapse. This observation of the role of shame in relapse is supported by Wiechelt and Sales' (2001) mixed methods study of 53 women attending AA. They predicted that women who had experienced childhood sexual abuse would be more vulnerable to shame; however, no differences in shame between women who had been sexually abused and those who had not were

found. Instead, those with higher levels of shame were more likely to relapse and have social adjustment difficulties, while significantly lower levels of shame were positively associated with longer periods of sobriety. Although the cross-sectional nature of this study meant the direction of causality between shame and relapse rates could not be established and the study lacked power, these findings suggest shame may be a highly pertinent factor in women's recovery from AD.

1.7.3.2 Management of Shame in Recovery

Scant research on shame and treatment for alcohol problems in women has been undertaken. The little research that has been carried out in this area has largely used mixed samples of men and women or samples of women with dependence on a range of substances. The only research in the sample that focuses on shame and women's treatment for AD is from the perspective of women in AA (Merritt, 1997; Sanders, 2011). Sanders (2011) utilised a feminist perspective to compare the experiences of women attending Narcotics Anonymous (NA) and AA, revealing that women in AA exhibited more embarrassment, guilt, and shame over past actions. In line with Merritt (1997), Sanders (2011) found that hearing other women's stories of similar experiences helped women in both fellowships to overcome shame by helping them to recognise they were not alone and to feel accepted and worthy. There is some indication this is not limited to AA as participants in other studies reported that sharing experiences with women in recovery groups or spaces other than AA facilitated belonging and acceptance (Doty-Sweetnam & Morrissette, 2016; Kaskutas 1994; Kougiali et al., 2021).

No other papers in the sample explored the processes and resources women use to heal from, navigate or resist stigma and shame prior to or in recovery, but findings from multiple studies suggest this is highly relevant to women's recovery from AD. For instance, eight other studies exploring women's experiences of recovery found that confronting, understanding, working through or managing painful feelings (including shame) from childhood, about the self and about the alcoholic identity was vital to sustained recovery (e.g., Aaltonen & MäKelä, 1994; Bobbe, 2002; Brewer, 2006; Cunningham et al., 2012; Doty-Sweetnam & Morrissette, 2016; McNally & Finnegan, 1993; Pettinato, 2008; Prussing, 2007).

Five studies note that ‘twelve steps’ and/or spirituality helped participants heal from and become more resilient to shame in recovery (Bond & Csordas, 2014; Brewer, 2006; Doty-Sweetnam & Morrissette, 2016; Jacobs & Jacobs, 2015; Prussing, 2007). For example, one participant in Bond and Csordas’s (2014) study stated that the twelve steps and higher power helped to empower them and ‘unpeel the layers of the patriarchy and expectation and institutional anti-feminist things built into society about women and guilt and shame and sex and motherhood’ (p. 148).

Negative experiences of treatment and help-seeking were reported to compound shame and negative self-perception in two studies. Long & Mullen (1994) found that shame in treatment was rooted in women having to ‘fit into’ programmes designed and facilitated by men for men; a more recent UK-based study noted many women continue to have a negative experience of treatment and professionals (Lillie, 2002). The only paper to compare the experiences of women in AA to another recovery approach, Women for Sobriety, found that the basic complaint with AA was that it was too negative and punitive, increasing women’s shame and guilt (Kaskutas, 1994). Despite this, no studies focused on shame and the experiences of women pursuing alternative pathways to recovery, such as the sober community or online sobriety support groups.

While Kougiali and colleagues’ (2021) meta-synthesis did not explicitly examine the mechanisms with which participants addressed shame, it found that recovery involved regaining control, agency and empowerment and a revision of 'the self' within the wider social structure. This corresponds with seven studies that emphasise the importance of women’s changed self-perception and increased self-esteem in recovery (Brewer, 2006; Kaskutas, 1994; Lillie, 2002; Long & Mullen, 1994; McNally & Finnegan, 1992; Pettinato, 2008; Prussing, 2006). Lillie’s (2002) papers uses grounded theory to focus on the experiences of women who have received person-centred counselling, although it is important to note that these women were also regular users of AA. This study is unique in examining women’s feelings about the self and alcohol use in the context of women’s life trajectories, delineating recovery into two categories: 'breaking the circle’, which describes the processes by which participants found their way out of the vicious circle (of shame), and ‘out and proud’ to encapsulate participants’ feelings of shifting self-

concept, self-love, pride, self-worth and confidence. Factors relating to treatment aiding the process included being seen by someone who was approachable, accepting, non-judgemental and sympathetic and offered support and genuine recognition of achievement and effort.

These findings suggest shame and self-perception are closely linked and that the management of shame in therapy and recovery groups supports recovery by shifting self-perception and identity. However, in Lillie's (2002) study, the researcher was a person-centred counsellor, and participants had received this intervention, which likely influenced the construction of their narratives in relation to the self. Moreover, the majority of these studies did not capture women's experiences across the lifespan, therefore precluding an understanding of how shame, and from what sources, shaped women's sense of self before recovery. The limited studies that do, however, indicate that shame precedes and is felt as a consequence of AD, although none have explored this directly (Kougiali et al., 2021; Lillie, 2002). Indeed, Kougiali and colleague's (2021) aforementioned meta-synthesis found that 'women can experience chronic shame from an early age, which can be further exacerbated by social stigma attached to drinking, reinforcing a destructive 'cycle of shame' which can be a significant barrier to recovery' (p.13). However, this study was based on synthesising qualitative studies rather than looking across individual women's stories, and the study did not have an explicit focus on shame.

1.8 Summary and Justification

The following section summarises the literature review on shame, women and AD, highlighting gaps and methodological issues in the literature and providing a rationale for the present study. 'Addiction' literature has largely focused on the experiences and treatment needs of men. Most research on gender differences is descriptive, centring on risk factors, the epidemiology of alcohol use and its deleterious effects on women, meaning the dynamic relational, psychological and cultural factors that contribute to or hinder women's problematic drinking and recovery pathways have received less attention. Nevertheless, a consistent finding is that women report higher levels of shame and stigma than male counterparts,

suggesting shame is more significant to women's recovery from AD, yet at the same time there is a paucity of research specifically examining shame from women's perspectives and life contexts.

Shame is largely investigated as an intrapsychic variable, divorced from social contexts, resulting in the predominance of quantitative (global self-ratings or scenario-based) measures to determine which groups feel less or more shame. B. Andrews (1998) contends that these measures do not capture chronic or significant shame about one's behaviour or personal characteristics (p. 6), which is significant when studying women (as a personal characteristic) and problem drinking (a behaviour). Reliance on cross-sectional designs means it is impossible to ascertain causality, and measures relying on self-reporting are contingent on participants' ability to recognise and indicate negative feelings about the self; yet characteristics of shame, including the painful and implicit level it is experienced and common strategies used to manage it (e.g., avoiding acknowledging feelings), are thought to hinder individuals' abilities to consciously report or articulate it (Else-Quest et al., 2012; Scheff, 1988; Shaver & Mikulincer, 2005; Zammuner, 1996).

The scoping review of qualitative and quantitative studies revealed that while shame consistently featured in women's accounts of their experiences of AD and recovery, it was only the focus of one paper presented. However, this was a single case study (Merritt, 1997). One mixed-methods (Wiechelt & Sales, 2001) and one thematic qualitative study (Davis, 1997) included a secondary research question on shame. All three studies were US-based and undertaken over 20 years ago. Wiechelt and Sales' (2001) study utilised standardised measures of shame, providing limited understanding of shame from the perspective of women within their socio-relational contexts. Davis' (1997) and Merritt's (1997) studies only explored shame in one or a small number of women's experiences of the recovery stage, precluding exploration of how shame featured across the lifespan. The majority of quantitative studies on shame and AD were excluded from the review as they did not meet the inclusion criteria; they either used mixed gender samples without comparing results across gender or included within female samples those in recovery for dependence on substances other than alcohol.

A strength of the qualitative literature is that a mix of methodologies (interpretive phenomenological, critical discourse, and thematic analysis) provides strong evidence for the presence of shame in women's lives preceding, during and in recovery from AD and includes some descriptions of the phenomenology and culturally-situatedness of shame. Nevertheless, there are some important limitations with the current literature. Quality issues with the existing studies included a high number of papers that did not state their epistemological position and included self-selected samples. Very few studies used samples of women who used alternative methods of recovery to AA, and most of the papers were from North America. Therefore, research examining shame in women's recovery from other parts of the world and with women using alternatives methods of recovery is needed, particularly given the literature suggests cultural and organisational (e.g., AA) contexts are highly influential in shaping women's sense-making of AD and recovery (Cain, 1991). Indeed, no research focused on shame and women using alternative treatment pathways, such as online sobriety groups or communities. Surprisingly few studies in the UK gave voice to women with AD, with none focusing on shame.

Furthermore, most papers did not define shame, resulting in a gap between its theorisation in the clinical literature and empirical research from the perspective of women themselves. In several studies, participants' accounts of themselves and their experiences frequently matched descriptions of shame in the literature (e.g., self as worthless/flawed) but were not identified or categorised as shame by the researchers. Shame was often referenced alongside several different concepts (low self-esteem, negative self-concept, low self-confidence, guilt, embarrassment, depression, anxiety and stigma), with little theoretical or critical elaboration. No studies explored the processes and elements that contribute to shame across women's lives *and* within their relational and cultural contexts, despite evidence to suggest shame is a precursor to and outcome of AD, thereby neglecting the possible cumulative effect of shame and its relationship to AD. While there was clear evidence for shame as a factor hindering recovery, there was little exploration of how shame hinders recovery or women manage, resist or navigate shame in

recovery. Taken together, this suggests shame is overlooked, underexplored and under theorised in the literature.

We know from narrative research with people in recovery from AD that how someone makes sense of, integrates and constructs their experiences and identity appears to be important to recovery and broader psychosocial outcomes (e.g., Bergström, 2017; Hanninen & Koski-Jannes, 1999; McConnell, 2016); however, no studies have explored the ways in which shame impacts this process or how women retain a sense of being morally good actors (in their storytelling) despite how they are positioned by society. Existing research does not explore how women navigate multiple (often shaming) cultural and organisational narratives in recovery. Arguably, our understanding of shame in women's recovery from AD remains partial at best.

1.9 Research Aims and Questions

Gender bias in alcohol research and the results of the scoping review suggest that dominant conceptualisations of shame and AD are culture bound within a cis male-centric, psychiatric heuristic. The predominance of quantitative approaches in the study of shame in this area, given the aforementioned limitations, may therefore silence alternative experiences uncaptured within this frame (Patel, 2003). Thus, a qualitative approach was adopted to centre women's voices and foreground their conceptualisations of shame in their accounts, thereby extending current understandings of the relationship between shame and women's recovery from AD. Not only was this approach considered better suited to capture the interpersonal, social and cultural determinants of shame, but it also recognises women are active social agents engaged in reflexivity, meaning making and identity construction, allowing for exploration of how women may navigate shame. It was hoped the research could somewhat readdress the propensity of traditional (positivist) research to de-contextualise experience.

Papers in the review indicate shame is gendered and temporally and culturally situated, and the 'alcoholic' identity emerged as shameful. Therefore, it was considered necessary to extend the dominant conceptualisation of shame in 'addiction' research by drawing on sociological and feminist perspectives

highlighting that shame occurs in interactions with others and their social worlds (Scheff, 2000). As such, this recognises that shame may be based on restrictive gender roles (M. Brown, 2012) and inflicted onto others, especially marginalised or disempowered identities and communities (Chase & Walker, 2013).

In recognition of shame as a multifaceted and social phenomenon, an intentionally broad definition, borrowed from Leeming and Boyle (2004), was adopted for the current study. Shame is defined as an 'acute emotional experience' felt about 'many aspects of circumstances, behaviour or self which are judged negatively or considered to fall far short of moral, aesthetic or performance standards' and 'may be repeated frequently where someone reaches an understanding of themselves as shamefully inadequate in many areas of life' (p. 2). Not only does this bring into purview shaming practices, it encompasses how women with AD may struggle with shame due to (a) aspects of identity that are stigmatising (Crozier, 1998); (b) perceived failure to perform a long-term social role effectively (e.g., self-sacrificing mothers; Harré, 1990); and (c) shame-avoidance strategies being less accessible to individuals in certain social roles (e.g., P. Gilbert & McGuire, 1998; Goffman, 1967).

This research seeks to address the identified gaps in the literature by exploring the ways in which shame features in women's stories of their experiences of recovery from AD in a UK context.

1.9.1 Research Questions

In what ways does shame feature in the stories of women in recovery from alcohol dependence?

If shame features, in what ways do women navigate shame in their stories?

2 METHODOLOGY

This chapter describes the research approach and epistemological and ethical considerations behind the recruitment strategy, data collection and analysis.

2.1 Epistemological and Ontological Position

Ontology and epistemology are the foundations of research (Carter & Little, 2007), guiding research questions, methodology choice and data interpretation (Haigh et al., 2019). Ontology relates to what can be known and assumed about reality and the world, whereas epistemology concerns the nature and basis of knowledge itself (Willig, 2012). This study uses critical realism as its epistemological position (Bhaskar, 1978; Sayer, 2000). Within critical realist definitions, there is an independently existing reality, but this is neither 'fixed nor stable' and direct access is impossible (O'Mahoney & Vincent, 2014). This position appreciates the role of language in constructing our social realities (e.g., grand narratives of 'addiction') and recognises the material world and how the possibilities and constraints inherent within it (e.g., biology, power) shape these constructions (Sims-Schouten et al., 2007).

Critical realism reflects the central aims of the research: to learn how shame might contribute to women's pathways into and out of AD. It accommodates literature that finds shame to be a fairly stable construct across cultures and, to a certain extent, 'universally experienced' (Keltner, 1995; Syncer et al., 2018). However, it also accounts for the concepts under investigation being socially constructed entities. For instance, perceptions of the nature and determinants of shame vary across time and according to one's personal, historical, economic, political and socio-cultural contexts (Leeming & Boyle, 2004). Likewise, while AD is underpinned by 'real' processes (e.g., biology, power, government policy), it is also subjective and discursively and culturally bound (Selbekk et al., 2015; Stevens, 2020).

2.2 Narrative Inquiry

Narrative inquiry examines the stories individuals construct to make sense of their experiences and lives (Riessman, 2000). This approach allows for exploration of

how participants make meaning of phenomena (e.g., shame and alcohol use) over time and the relational and broader socio-cultural, structural contexts in which they live. Narrative inquiry retains the perspective of the storyteller and their meaning-making (of feelings, people, norms, events, values, organisations, past histories and future possibilities) and subsequent actions, offering insight into how participants might interpret the world (Elliott, 2005; Riessman, 2008). Thus, in analysing stories it may be possible to attend to the duality of social structures and human agency, therefore elucidating the individual *in society* (Plummer, 1983).

2.2.1 Selecting Narrative Inquiry

Before choosing narrative inquiry, alternative qualitative approaches were considered. Interpretative phenomenological analysis (IPA) shares with narrative inquiry a concern with subjectivity and experience, but IPA focuses on uncovering 'the essence' of a phenomenon. Both DA and narrative inquiry are interested in how broader institutional/cultural values and norms are conveyed in language and consider language a kind of action (Potter and Wetherell, 1987); however, DA treats people's verbal and written accounts as actions analysed in accordance with the functions/activities they perform in specific situations. Thematic analysis (TA) and grounded theory (GT) extract a set of themes from the dataset to examine broad issues or develop theories/explanatory-level accounts of a particular phenomenon. All these approaches suffer a subject–object split, which can often produce de-contextualised data.

In contrast, narrative inquiry contextualises data within time and context by focusing on the storyteller (Simms, 2003), not just exploring women's lived experiences (of shame/AD) but also examining how and why they come to understand and narrate their experiences in a certain way from their perspective and socio-cultural contexts. Moreover, it allows for exploration of how broader narratives from the treatment environment and socio-cultural and political structures/contexts imbricate personal stories (as possible sources of shame/resources to resist shame; Loseke, 2007). Finally, narrative inquiry accommodates a view of women as active social agents, engaged in reflexive meaning making (Willig, 2001), centring their voices and resistance (Elliot, 2005), which is important given their historical neglect in the 'addiction' literature.

Narrative inquiry was considered applicable for studying shame. Shame is described as a self-conscious and moral emotion, felt in response to negative self-evaluation, providing feedback on moral and social acceptability (Tangney et al., 2007). Narrative theorists assert that stories, as the building blocks of culture (P. Atkinson & Coffey, 2003), are the primary means by which individuals make sense of themselves, others and the world (Holstein & Gubrium, 2000) and therefore play a crucial role in the transmission of dominant messages of morality or 'goodness' (Crossley, 2000). As such, the exploration of stories is likely to provide insights into self-evaluative and socio-cultural processes involved in the production of shame.

As a central means of sharing and making relatable our emotions and experiences (e.g., shame/AD) (Storr, 2019), stories were considered important in examining how shame features within relationships. Stories can help the storyteller process emotion and make meaning from experiences through the 'sequencing of events' (Polletta et al., 2011, p. 111), including in mutual aid groups, such as AA, and trauma (Crossley, 2000; Kaminer, 2006; Kougiali, 2015). Recent application of narrative inquiry to health and AD has found that storytelling can help narrators heal from or develop resilience against shame (e.g., Sawer et al., 2019; Yue, 2021).

Narrative researchers argue stories are the primary way we communicate and construct our identity (McAdams, 2011; Presser, 2006). Research indicates the identity one adopts in a narrative can inform future behaviour (e.g., Tutenges & Sandberg, 2013). This may be why there has been a proliferation of researchers selecting narrative inquiry when exploring people's experiences of AD (e.g., Etherington, 2008; Kougiali et al., 2017; Sawer et al., 2019). Several studies have highlighted how storytelling, and the construction of sober/recovery identities, might be a possible mechanism of change in recovery (Cain, 1991; Hill & Leeming, 2914). By adopting narrative inquiry, the author hoped to extend this work by considering if and how shame might influence processes of identity construction in women's recovery.

2.2.2 Critical Realism and Narrative Inquiry

The literature divides narrative inquiry into two epistemological strands: naturalist/realist, wherein stories are considered 'windows' into a knowable reality, and 'postmodern' or constructionist, where stories are seen as knowledge constructions (Squire et al., 2014). In practice, it is common for researchers to treat stories as both. This adopted form of 'modified constructionism' (Squire et al., 2014) is consistent with critical realism and the treatment of the narrative in this study: stories are conceptualised as 'social objects', with 'real' mechanisms and effects (Outhwaite, 1987), that are not necessarily universal, material, easily observable nor permanent (Sayer, 2000).

Critical realist epistemology seems not only compatible with but complementary to narrative inquiry in several respects. Both approaches conceptualise people's experience of the world as the artefact of the social construction of meaning within an assemblage of social practices/relations (characterised by power and hierarchies), internalised in the process of self-formation (Bhaskar, 2016). Critical realism lends itself to a complex and dynamic conception of the self and human agency compatible with narrative inquiry. Both emphasise the role of reflexivity and a discursively constituted (to some extent) self that has agency but is not always situated in circumstances of people's own making (e.g., Crossley, 2000; Parker, 1992). This 'constitution of the self' could be understood to bridge the gap between those who see the need to understand the self as relatively stable and those who emphasise a more active, processual view of identity that shifts over time (Somers & Gibson, 1994). Self-reflexivity is a central tenet of both approaches (O'Mahoney, 2011; Riessman, 2015).

2.3 Data

2.3.1 Inclusion Criteria

- Adult women (18+)
- Self-identified as 'in recovery' for AD. No time limit on the length of time sober was stipulated due to the non-linear and discontinuous nature of recovery from AD (Kougiali et al., 2017). Nevertheless, sobriety was a

precondition of interviewing given the ethical implications of intoxication on participants' capacity to consent and possible risks.

- AD typically occurs together with dependence on other substances, especially for women (Sanders, 2018). Informed by prominent studies in the area (e.g., Dearing et al., 2005), drug dependence was not an exclusion criterion, but participants had to deem AD the main problem.
- Sufficiently proficient in English to take part in interview.

2.3.2 Participants

Seven adult women aged between 34 and 57 participated in the study.

Table 1
Participant characteristics table

Chosen Pseudonym	Age	Length of Time Sober
Laura	57	7 months,24 days
Alexa	34	2 months
Lulu	54	6 years
Katie	40	8 years,5 months
Tamzin	54	6 months
Susie	47	1 year,8 months
Linda	45	5 months

Their length of time sober ranged from two months to eight years and five months. Participants were from, and had sought recovery in, various locations across the UK; one had previously lived abroad, and another moved to the US after becoming sober. Participants described varied pathways into recovery, including alternative therapies, psychotherapy, counselling, quit literature, drug and alcohol services, medication, sobriety groups and online platforms, and AA. Four women had attended AA; three attended one to several meetings, and one spent five years in recovery with AA. All participants had read quit literature and accessed support through sobriety groups and online platforms. Four were mothers. One was married, one was in a long-term relationship, three were single, and two were recently separated. All participants were White British and university educated. Six were employed.

2.3.3 Use of Narrative Interview

Narrative life story interviews were chosen as the most suitable approach for data collection. Within this approach, interviewees set the agenda; the interviewer's role is to activate 'narrative production' and facilitate conversation, opposed to relying on a question-answer style (Holstein & Gubrium, 1995, p. 39). A participant-led approach was considered a sensitive and ethical way to explore shame, giving participants greater choice over what they shared, thereby reducing the potential for distress (R. Atkinson, 2012) and allowing unanticipated and novel perspectives to arise. It is considered an effective way to build rapport and trust with marginalised populations (Kougiali, 2015), promoting greater investment in the research (Overcash, 2003) and producing emancipatory outcomes (Parker, 2005).

Participants were asked to tell their life story however they liked and begin wherever they felt comfortable. They were advised that it can be helpful to narrate from the earliest point they remember to the present day. This statement, developed in conjunction with the research supervisor, invited participants to talk about their alcohol use within their socio-cultural contexts and life trajectories (Mishler, 1986). Prompting questions (Appendix B; Etherington; 2014) were used for chronological guidance and to encourage participants to expand on their stories. Specific attention was given to circumstances leading up to, and explanations of, AD and recovery and how participants felt about themselves in relation to events, issues, or times in their life (e.g., 'How did you feel about yourself at that time?').

To support participants to feel comfortable, express themselves and minimise power connotations inferred by the interview context, everyday language and open and non-leading questions were used. Accordingly, participants were not asked about shame directly but to expand on the topic when it arose using the questioning style described above. Given that the literature indicates shame is a significant part of women's experiences of AD and the identification/ becoming cognisant of shame is implicated in the recovery process, there was an expectation shame would feature. This allowed for exploration of the ways in which shame emerged (or not) in participants meaning making at different stages of recovery.

The interview was treated as co-constructed; participants' stories were seen as a product of the narrator, listener, interview context, aims of the research and intended audience (Riessman, 2008). Participant reflexivity was integrated into the interview; participants were asked to reflect on their experience of telling their stories. Supervision and reflexive diaries were used to maintain the boundary of the interviewer's researcher role (versus clinician) (Appendix C; section 5.5.1.).

2.4 Ethics and Procedure

Ethics and procedure are presented together to illustrate how consideration of ethics informed every stage of the research process. Within qualitative research, ethics is understood as something that happens both within (participant ethics) and outside research (operationalisation of research in the 'outside world') (L. S. Brown, 1997). Consequently, the subsequent questions informed the research:

1. In whose interests might the research questions be?
2. How might the findings of the research be used by people and institutions? (Willig, 2001)

Such questions are highly significant if a researcher is to adequately account for the potentially far-reaching implications of their research on both the participants and other impacted parties, e.g., policy makers or service providers.

2.4.1 Consultation

The merits of involvement from service users in healthcare-related research is recognised, particularly in addressing power hierarchies inherent to the research process (Shippee et al., 2015). An NHS expert by experience from the University of East London (UEL)'s 'People's Panel' was consulted on the research project at the planning stage. She expressed enthusiasm about shame as a research topic and made recommendations on how to manage interviewing, which were incorporated into the interview schedule and discussed below (Appendix B).

2.4.2 Ethical Approval

Prior to recruitment, an application for ethics approval was submitted (Appendix D) and granted by the School of Psychology Research Ethics Committee in May 2020 (Appendix E), followed by a minor amendment request (Appendix F) and title

change request (Appendix G), which were approved in March 2021. To ensure the ethical handling of participants' data, a data management plan was approved by UEL (Appendix H).

2.4.3 Recruitment and Sampling

Careful consideration was given to recruitment given that knowledge derived from research is intimately tied up with how the researcher delineates the study population (Karnieli-Miller et al., 2009). Initially, AA or another established third-sector alcohol support service in the UK were the intended avenues for recruitment. However, as most 'addiction' research has been undertaken with women using AA, the recruitment strategy was adjusted to include women who may have chosen not to access traditional services, 'recovered' without formal treatment ('natural recovery') or used online sobriety groups/communities targeting women (Karnieli-Miller et al., 2009). It was hoped this would capture women's stories that might not have otherwise been heard but needed to be (A. W. Frank, 2012), exploring how they came to access one kind of support over another, the role (if any) of shame and how this contributed to how they made sense of and felt about themselves and their recovery.

The study employed a purposive sampling method (Palinkas et al., 2015). I contacted online sober support groups/communities aimed at women, and interviewees were recruited through an online peer-led, grassroots charity for women in, or seeking, recovery from substance use disorders (Appendix I). The organisation founder displayed the recruitment poster on their private Facebook page (Appendix J). Eight women responded expressing interest in participating in the study.

2.4.4 Consent

All prospective participants were emailed an information sheet (Appendix K) and consent form (Appendix L) prior to interviews, invited to ask questions via email or telephone and given a minimum of 24 hours to consider participation. The information sheet described the project, interview process and stated the right to withdraw participation without harm or prejudice.

2.4.5 Interview Procedure

All participants were accepted onto the study and invited to interview; one did not respond after expressing interest. Due to restrictions in the context of the Covid-19 pandemic, interviews were online. Interviews were arranged over email at a time convenient for participants, who were given the option of telephone or video call. Before the interview commenced, the information sheet and consent form were reviewed together; permission was sought to record the interview with a Dictaphone. In line with consultee recommendations, interviewees were asked whether they were in a safe, private, and comfortable place; given the opportunity to ask questions; informed they were welcome to share as little or as much as they wanted and free to take a break, reschedule or withdraw from the interview at any time without penalty; and had the possible benefits of the research explained to them.

To prepare participants for the interview, they were advised that there would be less input from the interviewer than in a regular conversation to give them space to tell their stories without the interviewer's influence and informed that upsetting feelings may arise during the interview. They were advised that if they were under statutory care services and any safeguarding concerns arose, in discussion with the supervisor, the interviewer would adhere to the agency's policies, including requesting permission to share risk concerns with the participant's General Practitioner (GP). All participants were privy to the same information to avoid prejudicing their talk.

Five interviews took place over video call; two participants opted for telephone calls. Interviews were audio recorded and ranged in length from 55 minutes to 96 minutes. An estimated duration of 60 minutes was given to interviewees beforehand. Interviewees were generally encouraged to talk uninterrupted for the first half of the interview, free to construct their stories how they liked. During the interviews, participants were offered regular breaks; only one chose to take a 20-minute break. Given unanticipated topics can arise during conversations (Cutcliffe & Ramcharan, 2002), verbal consent was re-obtained on the conclusion of the interview. Participants were asked to send through written consent if this had not been completed prior to the interview, given the opportunity to reflect upon the

interview, ask any further questions, and informed that a copy of the transcript would be available to change or amend if they wished. The interviews were transcribed verbatim using the transcription convention adopted from Malson (1998; Appendix M).

2.4.6 Participant Debrief

Information on confidentiality and data management, including the plan to use anonymised extracts and disseminate findings across relevant services and academic journals, was made clear to participants in the information sheet prior to asking for consent and in the debriefing letter (Appendix N). The debriefing letter also included contact details of relevant support organisations. Participants were offered £15 Amazon vouchers for participating in the research.

2.4.7 Confidentiality and Data Management

The research complied with the British Psychological Society's (BPS; 2018) Code of Ethics and Conduct. To maintain strict confidentiality of participant data, transcripts and extracts of interviews were anonymised to ensure no names or other identifiable information remained. Participants' identifiable information (e.g., names, contact details) was stored in a password protected folder on the researcher's secure university server. The interview audio recordings were stored in an encrypted folder on the researcher's password protected computer and secure university server. Recordings will be deleted from the researcher's computer on degree conferment. Following this, anonymised transcripts will be deleted from all previous locations and stored solely in a password protected folder on an encrypted external hard drive in a locked cabinet on the researcher's private property and kept for five years in line with UEL data management procedures (University of East London, 2019).

2.5 Analytic Steps

Narrative analysis is described as an 'art rather than science', with no predefined analytic procedure; narrative researchers should be open to what the stories themselves offer and pursue their own approaches to NA (Crossley, 2007). The steps to conduct a systematic narrative analysis outlined by Crossley (2000, 2007)

were used as ‘a loose scaffold’ from which to analyse the data. Specific questions from T. Miller’s (2017) feminist narrative analysis were used to inform an analysis of the wider contexts and gendered aspects of shame and AD found in the literature. A systematic approach, outlined in Appendix O, supported transparency (Tracy, 2010). Each step was taken in order, but movement back and forth between stages ensured the narrative built was grounded in the stories collected.

2.5.1 Step One: Reading and Familiarising

Interviews were transcribed verbatim before reading through each interview transcript multiple times to get a sense of structure and themes. A reflexive diary was used to record emotional responses and impressions.

2.5.2 Step Two: Interpretation of Individual Transcripts

This stage involved identifying narrative tone, key themes and images, presentation of self and grand narratives. Tone was established by reflecting on how something was said (Crossley, 2000) and what was left unsaid (T. Miller, 2017) versus what happened (e.g., whether it was pessimistic or optimistic; McAdams, 1993). Themes and images were looked at together (Crossley, 2000). Themes were understood to summarise key points in the stories, and the personal, socio-cultural context of the imagery was considered. It was noted how participants presented themselves and whether they drew on or rejected grand narratives (T. Miller, 2017).

2.5.3 Step Three: Weaving Together Personal Stories

Following this, images and themes were explored in relation to life chapters, key events, significant people and future scripts, and mapped out (Appendix P); these were used to summarise how shame featured in each participant’s recovery story (Crossley, 2000).

2.5.4 Step Four: Cross-analysis

The final stage involved exploring the commonalities and differences amongst participants by extrapolating and synthesising main themes using mind maps (Appendix P) and comparing and contrasting tone and style (T. Miller, 2017). This

formed the basis of a framework for summarising the stories (Appendix P). Quotes and excerpts were used to demonstrate interpretations throughout.

2.6 A Note on Identifying Shame

Identifying shame in women's stories involved interpretative work; therefore, the results are seen as one of multiple possible interpretations. Nevertheless, a rigorous and systemic approach to the identification of shame was adopted using both extant literature and raw data from the transcripts. Prior literature (e.g., Kasabova, 2017; Leeming & Boyle, 2004; Tangney & Dearing, 2002; Velotti et al., 2017) guided examination of related concepts (e.g., low self-esteem, secrecy, stigma, powerlessness and disconnection) and language (e.g., self as flawed, worthless, inadequate). An inductive approach involved looking for patterns (relating to 'what' and 'how' something was said) within and across the interview transcripts, e.g., naming shame, stories of shame, imagery, non-verbal gestures, pauses, or hesitation.

2.7 Data Quality and Trustworthiness

Qualitative research cannot be evaluated according to the same criteria as quantitative approaches (Yardley, 2007). Trustworthiness is generally considered the basis for assessing the validity of analysis rather than the impossible task of representing the 'truth' (Riessman, 2005; Yardley, 2007). Trustworthiness is approached from a particular position within narrative inquiry, which emphasises fluid boundaries, and is evaluated according to a study's transparency, i.e., the extent to which the process by which the interpretation of the stories has been reached is explicit, rendering reflexivity and methodological integrity crucial (Levitt et al., 2018). Throughout the research, reflexive reviews and a research journal (Section 2.7, Section 5.5) were used to explore and document how the researcher's personal context and characteristics may have shaped the project. A detailed evaluation of the methodology, including data quality and trustworthiness, can be found in Section 5.5.3.

2.7 Researcher Reflexivity

Reflexivity urges us 'to explore the ways in which a researcher's involvement with a particular study 'influences, acts upon and informs such research' (Nightingale & Cromby, 1999a, p. 228). This ranges from choosing the research question to the analysis and presentation of the data (e.g., Harper, 2011). Narrative methodologies recognise that it is impossible for the researcher to stand outside of the subject matter; rather than being positioned as a 'neutral' observer, the researcher 'co-produces' the data (P. Atkinson & Silverman, 1997) and 'co-constructs' the stories (Riessman, 2008). Therefore, it is important to make explicit the external and personal factors, including my theoretical and political orientation, that informed my decisions.

My identification with feminism and interest in women's issues led me to this research and oriented its analysis of how shaming processes are bound up with social inequalities and power, moving away from the tendency in clinical psychology to decontextualise shame by treating it as intrapsychic phenomenon. In line with the feminist dictum 'the personal is the political', women's stories of shame were located within the structural and social power inequalities within societies that disadvantage women. This lens helped me to remain alert both to how shame can be deployed as a means of regulation and control, often serving to regulate gender norms (e.g., Bartky, 1990), and to the productive possibilities of shame as a form of resistance (Shefer & Munt, 2019). Correspondingly, it felt important to choose an epistemological stance that recognised that the events and suffering participants referred to in their stories were real (i.e., victimisation and abuse), as were the wider structural and economic conditions (e.g., social class, power, economic factors) of their alcohol use and shame, whilst also privileging participants' individual meaning-making (Ussher, 1999).

The cornerstone of narrative inquiry is the fundamental belief that the stories people tell about their lives matter. Barbara Dennis (2018) argues for 'praxis as validity' (p. 116), wherein 'praxis is about being interested in the stories, the lives, the personness of the interviewee' (p.112). The criteria from which the reader evaluates the work is not determined by how representative a sample is of a

particular population from which broad generalisations can be inferred, but by ethical sensitivity and the contextualisation of data, borne out of a genuine recognition of the value of stories, the dynamic and messy nature of the 'data' and its temporality (M. Andrews, 2020).

In analysing the data, I was struck by the similarities in participants' narration of shame and its trajectory in their stories of AD and recovery, as well as the richness and unique complexity of their personal stories, which elicited strong emotional reactions in me. This informed my decision to integrate parts of the individual stories into a temporally organised whole with shame as a thematic thread, whilst also striving to maintain the metaphoric richness and 'personness' of these individual stories. I selected excerpts and stories that participants indicated were meaningful to them, representing turning points in their narratives. In selecting and presenting the stories, I also attempted to capture the complexities of shame, AD and recovery so that participants' experiences might be fully appreciated and understood at multiple levels of context. I also considered how these might resonate with the reader and convey the emotions evoked in participants original telling of the story. In line with Riessman's (2008) view that NA should prompt 'the reader to think beyond the surface of a text' (p. 13), I integrated wider literature on shame, AD, recovery, identity and narrative theory (where relevant) in order to bring forth narrative meanings and foreground novel insights.

Throughout the research process, I tried to remain mindful of the influence of my identities as a white, female, middle-class, trainee clinical psychologist in her thirties. Stephens (2007) argues that commonalities and divergences between the characteristics of the researcher and participant can affect the interview process and data collection. Except for age and parenthood status, there were many similarities between the participants and myself, including gender, class and ethnicity. I was mindful that as a female, not only did I have a stake in the research but the participants also might presume shared gendered narratives, leading to the telling of abridged or diminished stories (Dwyer & Buckle, 2009). Indeed, I was surprised by how much of the material I related to in participants' stories. For instance, engagement with said stories led me to reflect on my own experiences of shaming and shame when stepping outside of gender normative behaviours and

expectations as a child, and the long-lasting impact of this on my sense of 'voice entitlement' (Boyd, 2010)[3]. I remained aware of the potential impact of this on the analytic process as, in becoming immersed in participants' experiences, researchers can be unintentionally influenced by personal subjectivity and risk storying their own experiences through participants' narratives. Indeed, Letherby (2002) cautions that in analysing data from their own personal, political and intellectual positions, researchers may make their voice the loudest, which stands in contrast to the aims of narrative inquiry, i.e., centring the voices of participants.

I tried to mitigate the above using a reflexive diary (Appendix C) to maintain awareness of and reflect upon my initial impressions, epistemological position, personal attitude and experiences, aspects of my identity, cultural factors and emotional reactions to the material throughout the research process (Finlay & Gough, 2008). For instance, I tried not to assume knowledge or experience, frequently prompting participants to expand on their stories and experience of storytelling, including by inviting reflection on aspects they considered most significant to them and checking they had the opportunity to share these. Overall, I felt the benefits outweighed the possible dangers highlighted above; the greater feeling of comfort stemming from sharing their story with a female researcher seemed to support the building of rapport, safety and trust, allowing for enough vulnerability to tell stories that were deeply personal, painful and that they considered shameful. Moreover, I felt the analysis benefited from the 'experiential gaze' offered by a researcher with personal experience and knowledge of gendered issues within the research, particularly an understanding of the cultural positioning of participants. Ultimately then, this was thought to provide the context for greater empathy with and fidelity to the participants' stories.

[3] Voice entitlement: 'a narrative about speaking that is deeply embedded in their cultural, gendered, and educational experience' (Boyd, 2010)

3 ANALYSIS

The following section outlines the NA conducted on the transcripts of seven participants' interviews to answer the question 'In what ways does shame feature in the stories of women in recovery from alcohol dependence?' Each participant's story was analysed separately, with reference to length of time sober. Stories were then compared for similarities and differences. Three shared sub-narratives were identified to tell the overarching narrative of shame: the early internalisation of shame, escalating alcohol use and recovery. Each sub-narrative represents a turning point in the story, relating to how participants storied the self, with implications for their broader identities.

The retelling will be presented in chapters by integrating excerpts of participants' stories alongside interpretation and relevant academic literature. Sub-narratives are presented as discrete, self-contained chapters to aid readability and provide an interpretative structure to present the findings. However, in practice, the sub-narratives are overlapping, non-linear and cyclical, recursively feeding into one another. To provide context and retain some of the idiosyncrasies of participants' accounts, further details on their personal stories and backgrounds are presented, where appropriate.

3.1 Cross-analysis of the structure and development of the participants' narratives

In the following section, examples of the cross-analysis of the structure and development of the participants' narratives is presented to aid readability and provide transparency in the analytic process.

Figure 1 represents the shared narrative arc of participants' storying of shame, in relation to their AD and recovery. It divides the overall trajectory of shame in participants' stories into the three main sub-narratives – the early internalisation of shame, escalating alcohol use and recovery – and highlights the related stages of AD development and recovery, as well as prominent turning points under each.

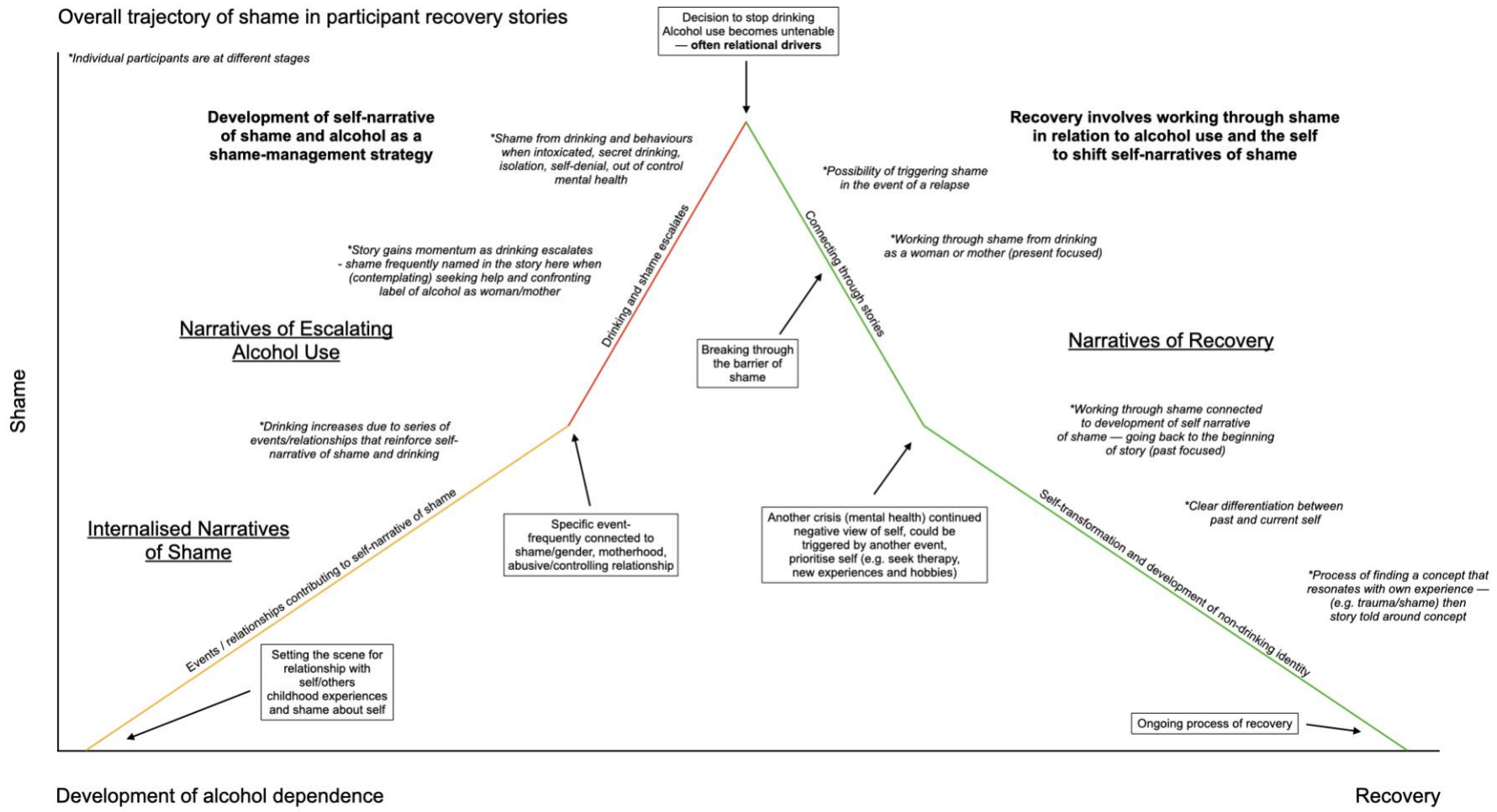

Figure 1: Overall trajectory of shame in participants' recovery stories

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Figure 2 maps out shared themes from participants' recovery narratives, illustrating how storytelling had a de-shaming effect on participants. The figure reveals the central position of storytelling and its relation to other recuperative themes, which recursively feed into one another. The figure also details how increased self-understanding is the mechanism through which storytelling enables participants to shift from shame-based towards positive identities.

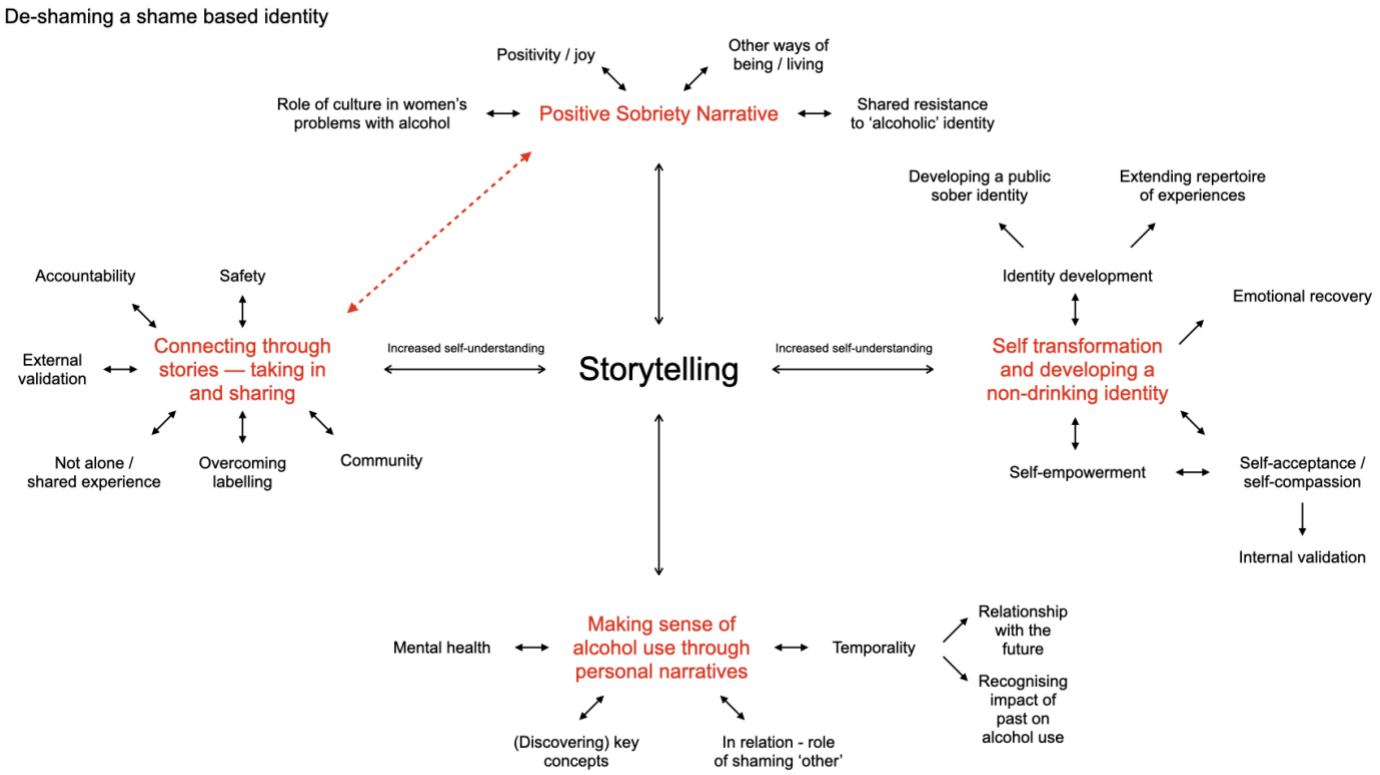


Figure 2: De-shaming effects of storytelling

Figure 3 represents the overall structure of the narrative of shame and its three shared sub-narratives.

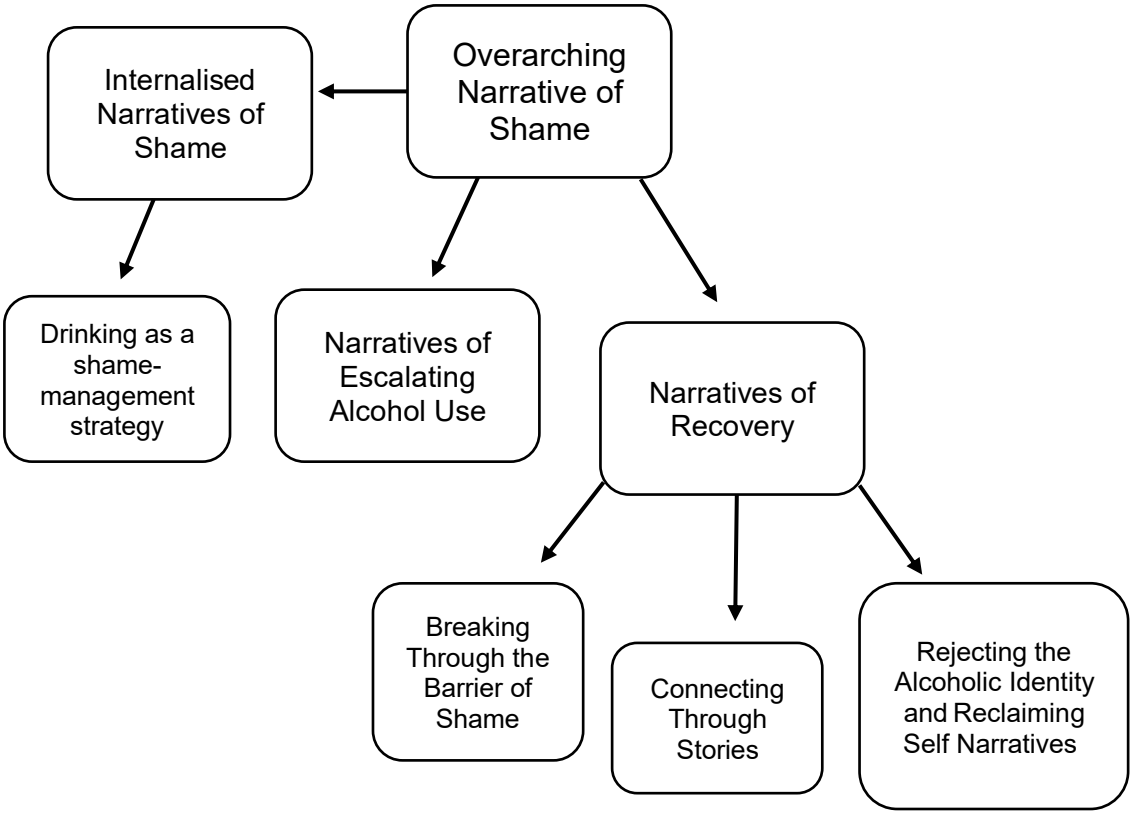


Figure 3: Overall structure of the narrative of shame

3.2 Chapter One: Internalised Narratives of Shame

Participants describe histories of adverse childhood experiences, including sexual and emotional abuse, neglect, parental separation and parents with AD, mental health difficulties and experience of domestic violence. Participants' childhoods are characterised by experiences of disconnection, powerlessness and an absence of emotional nurture. Participants assume devalued or outsider positions within their families and peer groups in their stories, emphasising feeling unwanted, judged or as though they do not measure up to others' standards. Internalisation of early experiences appear to provide the context for a self-narrative of shame, with recounted elements of inadequacy, abnormality or worthlessness becoming the 'dominant story about the self'. Participants narrate employing a range of, ultimately unsuccessful, shame-management strategies to hide their 'real' self and appeal to others, with alcohol being the most effective.

Alexa (34), the youngest participant, has been sober for two months, the shortest length of time in comparison with participants. She is one of five siblings and describes the significant financial hardship her family faced growing up, resulting in frequent house moves. She begins her story by revisiting her childhood, using feelings-based talk, rich detail, and graphic imagery to describe a series of negative events:

> *I always kind of felt socially like an outcast, like I never really fitted in. Erm, errrrm and just, eh, my mum, she was never that, kind of kind to me. She just <intake of breath> there's like video footage of erm...I remember watching video footage of watching us at Christmas and like my mum telling me that I always ruined stuff because I was getting in the way of the camera and <intake of breath> erm, just er, just er, I just never felt like I belonged anywhere from a really early… from really early on my life (Alexa)*

Alexa traces back her '*felt*' sense of herself as an *'outsider'* to being made to feel like she did not belong in her family unit; in her story, she is excluded from a family video, a culturally recognisable symbol of togetherness. Positioning herself outside of the norm seems to allow her to communicate the extent of her emotional impoverishment and isolation, alongside her use of extreme case formulation

(*‘never’, ‘always’*). Her mother is portrayed as a dominant, critical figure; Alexa appears to internalise her mother's negative perception of her as an enduring sense of being unacceptable to others. Though shame is not directly named at this point, her account resembles descriptions of chronic shame, where emotional neglect from parents is identified as a primary source of shame (DeYoung, 2015). When repeated, this leads a child to interpret feelings of chastisement or loneliness as evidence that something is wrong with them, as seen in Alexa’s account of being bullied:

> *Erm, and just because, you know, because of the validation, erm, what you...when people who bully you like that, it kind of reinforces that, that thing in your head that you are worthless and that you are, erm, er, that you're...that you're not...yeah, worthless, but also just like cringey. I felt like a lot cringiness, like embarrassment and shame, like, like, 'Oh, I just...if they don't like me then...' you know...I mean, you know, I...at that point, you don't like yourself anyway so it just reinforces that of feeling like, erm, you know, just not wanting to be in your skin. (Alexa)*

Alexa narrates herself as *‘worthless’*, reinforced by the bullies' negative valuations, which she accepts and internalises. She stories a shift to seeing herself from a critical outsider perspective (Crozier, 1998), wherein shame is depicted as invading her whole sense of self to the extent that she wants to vacate her body and shed her identity. Her description reflects Kasabova’s (2017) metaphor of shame, wherein skin provides a protective veil for an individual's identity, and the experience of being shamed is likened to a form of 'skinning' (p. 107). Such imagery seems to capture the intense discomfort and pain Alexa attaches to the embodied experience of shame. Her use of the second person, generalised 'you' to narrate shameful experiences is consistent throughout her story and may be an attempt to distance herself from the pain of shame in her retelling by depersonalising these experiences (Orvell et al., 2017).

Most participants story emotionally absent/unavailable parents and concomitant early feelings of disconnection as providing the context for internalised self-narratives of shame (e.g., *‘ugly’, ‘boring’, ‘different’, ‘not good enough’, ‘unlikeable’, ‘unlovable’, ‘unworthy’*). These are storied as critical internal monologues, typically

linked to the voice of participants' mothers. Susie (47) captures this process of internalisation: '*I'd had you're not good enough instilled in me from an early age through my mother*.' She repeats the phrase *'not good enough'* throughout her story when describing other people's views confirming her mother's account of who she is. In this way, her mother's voice and judgement seem to become her own. Similarly, Tamzin (54) indicates that being taken to Weightwatchers by her mother aged 15, in conjunction with a lack of emotional nurture or warmth from her, precipitates her view of herself as '*fat*' and '*ugly*'. This reflects Bakhtin's (1984) theory of polyphony, which assumes that the self is continually (re)constructed and (re)positioned in relation to others and the stories people tell about themselves are always in interaction with the stories of others and an imagined audience. As the narrative each person constructs to account for their life needs to be supported by others to be viable (Gergen & Gergen, 1988), it seems likely that participants' self-narratives were maintained, to a certain degree, with their coherence with the narratives of significant others that position them as shameful.

Participants narrate the use of several relational strategies to distance themselves from internalised self-narratives of shame in early life, evidenced by multiple stories of trying to *'fit in'* (Susie), '*be normal'* (Lulu), '*please others'* (Linda, Alexa & Laura), *'pretend everything's okay'* (Linda & Katie), *'not let others come too close'* (Tamzin) and '*keep secrets'* (Lulu, Alexa, Susie, Linda & Laura). In these stories participants dismiss or conceal their feelings (self-silencing), hide 'undesirable' parts of themselves (secrecy) and try to conform to match others' expectations (people-pleasing). Susie links her use of self-silencing to her upbringing:

> *I think I learned very early on to just fit in and (...) not say anything and do as I was told because that was the easiest way to get through life. But it was, it was very apparent that I was never really good enough, but I was never given a chance to, to erm, blossom. Erm, I was never asked what I want. Never given a chance. And sort of… one of the big, the one chance, time, that I did, as an early adult or young adult, to say what I wanted, erm... And that is a really identifying part of my story that (…) I'd always wanted to run away to the circus, and I actually met up with a, a group of trapeze artists who eventually offered me a job (…) I said to my parents, 'I'm not*

> *going to go to university' I'm gonna go back, and I'm going to work with these guys' (…) And my, my dad just said, 'Well, won't bother. Go tomorrow and don't bother coming back'. Erm. And because I've been brought up to fit in and do what I was told, I gave up that chance. And that's stayed with me for a long time too. (Susie)*

Susie describes learning from her parents to self-silence to be accepted. She stories her last attempt to pursue her interests and desires, resulting in rejection and likely abandonment, signifying this as a turning point in her narrative. She points to a loss of agency in defining her own identity and life decisions, speaking with a dejected tone of voice, conveying her apparent frustration and pain around this. Her repetition of the phrase *'never given the chance'*, particularly in reference to her own blossoming, is suggestive of the long-lasting damage this 'assimilation' has on her sense of self.

In speaking out, Susie, in line with other participants, not only appears to risk violating family values and norms but also, as young girls, socio-culturally determined feminine ideals (e.g., cooperative, sensitive and kind; Eagly et al., 2000). This resembles another of Bakhtin's concepts, 'ventriloquation' (Bakhtin et al., 2019); based on the notion that dialogue is present within any thought and voice, Bakhtin argued that in an individual utterance, the voices of groups and institutions are always 'invisibly present' (p. 163). This has been found to constitute a 'powerful strategy of silencing', particularly for young girls, as the individual is inevitably affected by group (cultural and familial) attitudes and beliefs (e.g., J. D. Brown, 1998).

In recovery, participants portray how rather than shift self-narratives of shame, self-silencing and other relational strategies cement them, resulting in an increasing gap between an outward-facing self and whom they believe they really are. In their stories, this 'dual perception of self' disconnects them from themselves and others, depriving them of the ability to form intimate connections and giving rise to power imbalances and feelings of sadness, anger, and isolation. Though employed as protective mechanisms to manage or avoid shame, participants suggest these ultimately limit their capacity to know and articulate their own needs and sense of self outside of other people's perceptions of them.

3.2.1 Drinking as a Shame-management Strategy

All participants tell 'first drink' or 'early drinking' stories. These stories are frequently presented within a liberation and reparation framework, wherein alcohol is narrated as the most effective shame management strategy. Alcohol is framed as reducing inhibitions and offering freedom from painful realities and feelings of shame and anxiety, allowing for temporary character transformation into a preferred, socially acceptable self that can repair early experiences of disconnection and disempowerment:

> *I think drinking came along and I felt normal. And then people made me feel...because they'd say to me, 'Oh, that Lulu. 'he's a right snooty bitch.' Because I would be, I would be too scared to engage with people because if my anxiety came and I couldn't speak, they'd think I was a blithering idiot. So, I would be, nose in the air, just to protect myself. So when I had a drink, I became much more open and they'd be like, 'Oh, you're really nice, really. I thought you were a right snooty bitch.' So, I thought getting drunk was the way to be because that was when people would like me... (Lulu)*

Lulu depicts the transformational capacity of alcohol, allowing her to renegotiate her 'tarnished' social identity (*'snooty bitch'*). Drinking effectively fixes 'the problem' of how she feels at the beginning of her story by reducing anxiety and facilitating interactions with others, rendering her normal. Newly discovered feelings of normality appear to be reinforced when her preferred 'drinking self' is seen to receive positive validation from others. Lulu goes on to narrate how drinking becomes fused with her social identity, stating, '*I could never go anywhere without alcohol'* and she thought *'it wasn't normal'* when others did. Thus, drinking is framed as an act of identity restoration (Killingsworth, 2006), a rational means of seeking acceptance and belonging and, perhaps most importantly, offering the 'seal' of newfound normality, which renders its use essential.

Many of participants' early drinking stories are akin to 'coming of age' stories: drinking is portrayed as customary in the transition to adulthood, facilitating self-exploration and experimentation, and contributing to the formation of participants' social identities (Ettorre, 1997). Drinking is constructed as supporting an identity with power and status, providing a socially acceptable context for individual

expression (‘*I really discovered dancing and a really fun side to going out. Er, it opened my eyes to a lot of things’, Susie)* and, in some instances, the transgression of restrictive gender norms (e.g., feminine virtue; *‘we both got drunk with a couple of boys, which gave us the courage to fool around with them otherwise it was a no, no*’, Lulu). Alexa describes legal drinking as the *‘reward’* for turning 18, signifying a shift from *‘being told they couldn't because of their age and stuff’,* and Laura suggests heavy drinking is a source of pride at university (*‘badge of honour’)*. Participants normalise heavy drinking (*‘we weren’t unusual in that at all’,* Laura; *‘everybody did it’*, Lulu) within British (university) drinking culture. In framing their evaluation of drinking practices as shaped by peers and socio-cultural norms, they suggest that divergence could mean sacrificing normality, which was highly sought after.

Nevertheless, the powers, freedom and connection afforded by drinking are fragile and temporary in their stories and incongruence between the 'real' and 'drinking self' a source of shame. Lulu and Susie tell stories of interactions wherein external validation of their 'drinking selves' is taken as evidence of their inadequacy without drinking, affirming shameful narratives associated with their 'real' selves. When recounting university drinking experiences, Susie recalls a comment made by a student that she was 'fun' when drinking, which she interprets and internalises as *‘without a drink, [she] wasn't any fun’.* Implicit in many of their stories is that, in the context of needing to hide and self-silence their 'real' selves, they do not have a clear sense of who their 'real' selves are and for the majority, drinking comprises a critical part of their social and relational identities.

As their stories unfold, participants narrate a growing chasm between their 'drinking selves' and what they feel about themselves privately. For instance, towards the end of Susie’s story, she reflects on the misattribution of positive qualities to her drinking 'persona' by romantic partners, resulting in them wanting her to be someone different when they discovered the 'real' her. Given that many participants portray the identity claims of their drinking selves to be somewhat inauthentic, it follows that they are likely to be concerned that they will be revealed as frauds. Participants suggest they feel compelled to drink to maintain the performance and minimise the risk of exposure. In recovery, they seem to be

recognising the danger of their perception that all good qualities are concentrated in the 'drinking self'.

3.3 Chapter Two: Narratives of Escalating Alcohol Use: ‘because you’re drinking every day, it’s that shame’

Participants narrate a gradual progression of their drinking, punctuated by one or a series of events, wherein ‘acceptable’ drinking escalates to ‘problematic’ drinking. As participants story drinking more frequently and alone, drinking no longer provides a reparative function but a means to escape increasingly painful and shame-filled realities. Rather than being preferred, their ‘drinking selves’ are now constructed as behaving in ways that frighten or shame them. Their narratives gather momentum as events unfold, resulting in a ‘piling up’ of negative consequences from drinking on participants’ mental and physical health, relationships and work. This culminates in their lives, drinking and drinking selves eventually spiralling ‘out of control’, often portrayed through metaphors (e.g., ‘*train crashing’*, Susie). These narratives often follow the 'and then and then and then' syntax typical of A. W. Frank's (1995) chaos narratives, implying participants perceived loss of control.

Drinking appears to serve as a response to gendered experiences (of shame) in participants’ stories. Self-narratives of shame interact with grand narratives of socially prescribed femininity to further strengthen and reinforce a shameful perception of self. Participants report shame from their perceived inability to fulfil gender roles (mothers, wives), deviation from gender norms (particularly when intoxicated) and the incompatibility of heavy drinking with their identities as women and mothers. For instance, all participants story secret and heavier drinking to cope with and escape from feelings of shame, frustration, anger and sadness from being made to feel ‘inadequate’, ‘inferior’ and powerless in relationships with ‘abusive’ and ‘controlling’ male ex-partners (*‘he'd always made me feel quite inferior in our relationship… I just felt so little and small and stupid’*, Alexa). Katie, the only participant who identifies as non-heterosexual, stories the escalation in her drinking as rooted in the shame associated with the acceptance and disclosure of her bi-sexual identity, locating shame within her deviation from heteronormative

femininity. Within these stories, drinking is also framed as an attempt to regain power by 'not listening' in relationships or contexts where they feel trapped or powerless.

All five self-identified mothers indicate they are the primary caregivers; four describe themselves as '*feeling like'* (Linda, Alexa) or being '*single mothers'* (Laura, Tamzin). The narration of an escalation in drinking to cope with stress and isolation associated with the high demands of motherhood and shrinking social worlds is commonplace. Shame features heavily in stories of motherhood. Lulu traces her escalation in drinking back to shame from a traumatic birth, contrasting this with her *'perfect'* pregnancy, where she feels '*normal'*:

> *I felt <sigh> ashamed again. I felt, 'I fucked this up. I can't even do that. I can't even give birth to a child. What a loser you are'. And I... people were flocking to see me. I was...I could hardly...I couldn't walk, because you can't walk, you can shuffle along. And people were coming to the house bringing me presents and flowers and saying congratulations, and I was honestly thinking, 'What the fuck are you talking about. I didn't even do it. I didn't do it.' (Lulu)*

Lulu narrates a punitive and derogatory inner monologue through which she blames, shames and persecutes herself for a perceived '*failure*' at childbirth. This can be seen as a function of dominant narratives around 'natural childbirth' (Crossley, 2009; Dykes, 2005) and an example of her internalisation of 'self as failure' in relation to grand societal narratives about 'good mothering'. Lulu suggests shame is a repeated experience for her, and the theme of struggling to take up what she perceives as ordinary societal roles is evident across her story. This suggests that those who internalise early shame might be more susceptible to maternal shame. As participants drink more frequently and alone, the shame from heavy drinking appears to interact with their identities as mothers to further escalate their drinking. In Alexa's extract below, shame emerges at the intersection of her self-narrative of shame, grand narratives of 'addiction' and ('bad') mothers:

> *…the easiest way that I've found to kind of like myself was after that kind of that glass of wine. Erm, but then at the same time because you're drinking*

everyday it's that shame and it's that shame that also my daughter deserves better than this because I'm not present and, erm, it's just the easier option to pick up that bottle of wine. To have that drink to make yourself feel better <intake of breath> (…) even when I wasn't drinking, I'd just stare at walls, or just feel lethargic, feel like, er, I couldn't be bothered to do anything. And then I'd feel bad for my daughter because I would do stuff with her, but I wouldn't...I'd go into the actions of doing something that a good mum does, but I wouldn't feel present, or feel engaged, or feel happy to be doing it. And there's shame around that as well (…) I'd find that when I had that glass of wine, I'd loosen up a bit with my daughter and want to play with her so it was just almost like that bit of trying to get back to, to, er, to, er, it felt like I was more happier to be able to play with her after that first glass of wine. (Alexa)

Alexa's vivid and harrowing imagery of *'staring at walls'* captures the depth of her mental anguish and portrays a profound sense of disconnection. She stories a lack of attentiveness or enjoyment in her mothering role as a personal failure, suggesting her internalisation of the unrealistic standards within the grand narratives of 'good mothering'. She narrates a 'stuckness': alcohol offers the only relief from shame, enabling fleeting self-acceptance, yet compounds shame from 'drinking everyday', reminiscent of the vicious cycle of shame in the literature (Wiechelt, 2007), which Laura and Tamzin also narrate. Alexa's identity as mother appears to exacerbate this cycle: drinking supports her temporary enactment of the mothering role (*'happier to play with her'*) but ultimately increases feelings of disconnectedness, reinforcing her perception of failure in the context of grand 'good mother' narratives.

Most mother participants tell highly emotive stories of shame rooted in their perceptions of failure in relation to their mothering role from heavy drinking (disconnectedness, endangering their children), particularly blacking out (e.g., when dropping their children off to school or putting them to bed*).* However, they also resist positions of shame in their retelling. In the above extract, Alexa frames drinking as an understandable response to an unbearable situation and an attempt to fulfil her mothering role. Indeed, for mother participants, their love and concern for their children are presented as a primary motivation for sobriety, and the

inclusion of their children's voices in their stories (reassuring them they are ‘good mothers’) challenge their positioning as 'bad mothers' (Linda, Lulu).

In their narratives of heavy drinking, participants emphasise the loss of control and ego-dystonic nature of the drinking self (e.g., use of ‘not the real/like me’ statements), which is increasingly recognised as causing shame to the 'real' self. Behaviours when intoxicated are framed as inconsistent with traditional femininity, in violation of their caring roles as friends/mothers and personally relevant moral and social standards (e.g., drunk driving), which, in addition to risks attached to drunken behaviour, particularly blacking out, leads them to drink alone and secretly, exacerbating their social isolation and disconnection from others. Susie recounts:

> *Depression was awful. Self-harming was not good, erm. It was a mess. And I knew I had to give up. I knew I had to stop, but I didn't want to (…) because with this whole thing, my isolation became stronger and stronger. It is a form of self-harm in itself. And so, I didn't want to be out when everyone else was out. I didn't want to be looked at. I didn't want to be watched (…) (Susie)*

Susie's narrative implies that her 'real' self carries feelings of shame that are too painful to bear; drinking and associated behaviours are framed as an act of destruction or obliteration of the ‘real’ self (*‘self-harm’*). Living with the 'real' self is constructed as even more difficult to tolerate than earlier in participants’ stories as the ‘real’ self is overloaded with shame from the drinking self; the separation between the two increasingly untenable (Denzin, 1987; Shinebourne & Smith, 2011). At this point, participants convey a sense of being cornered, trapped and out of control; they either face shame from continuing to drink *or* accepting the label of ‘alcoholic’ privately and publicly. By emphasising in recovery that they are taken over by alcohol, not acting as their 'true' selves, participants may be able to distance themselves from the ‘drinking self’, facilitating reintegration of the self without enduring shame. Naming to expunge a ‘bad part’ of self is different from labelling a whole self as bad, as perhaps inferred by the label of alcoholic, thereby precipitating different kinds of action.

A tipping point is eventually reached in their stories (*'hitting rock bottom',* Katie*)*, wherein sustaining the behaviours of the 'drinking self' is untenable. Participants narrate a multitude of (mostly relationally motivated) factors contributing to their decision to stop drinking. Internally focused factors include the worsening impact of alcohol on their physical and mental health, a fear of what they might do to themselves (injuries, self-harm or suicide), and shame from recognising the increasing impact of drinking on their children and significant others. Externally focused factors include: a partner moving out of the home, the threat of losing their children and the impact of drinking on their professional lives.

As participants story recognising their drinking as problematic, alcohol begins to dominate their thinking, namely whether they are 'alcoholics'. Present at this point in their narratives is the stigma attached to the label of being an 'alcoholic woman': participants recount desperate attempts to hide their drinking habits and stop drinking, naming the shame attached to this identity as a hindrance to accepting the problem and seeking help. Laura, one of the few participants who identifies with the label of alcoholic, narrates an internal conflict and turmoil as she tries to navigate and accept this new identity:

> *I think we've all completed forms (…) at hospital you're waiting at A&E and you're completing forms and it's about your alcohol intake, and you know, or gone online and asking the question, 'Am I an alcoholic?' erm, and I think when I found myself lying in these questions, I thought, 'no, this isn't...there's an issue here' (…) It was quite scary because (.) I don't think it's something anybody ever wants to admit to themselves. (…) when I started reading a lot of the quit literature, the quit lit, erm, it was there in black and white (...) it was talking about being a drug addict. And actually, that was something that I hadn't really wanted to consider, but the truth of it was that's exactly what I am <intake of breath> Erm, and so it was scary, but in some ways a relief as well because (…) then I could stop this questioning myself every day and alcohol being the focus for every day. Once I knew, once I knew what I was, then I could move on from there and look at how I dealt with it (…) attending the specialist drugs and alcohol clinic, that felt quite shameful as well, you know walking through of those doors, and I was conscious did anybody see*

me walking through those doors and <sigh> yeah, that, it did, it felt quite erm, it quite felt difficult… (Laura)

Laura stories her acceptance of the label of 'drug addict' as evoking fear and a critical turning point in her recovery. She narrates resistance to the 'addict' identity, framing it as undesirable and unwanted. The 'quit' literature is highlighted as a key factor in her acceptance of this identity – presumably in its legitimisation of grand narratives of 'addiction'. Relief from taking on this identity appears rooted in her reconciliation of this conflict, allowing her to move forward and seek help. McIntosh and McKeganey (2000) found that a crucial part of the decision to cease using is the desire to repair 'a spoiled identity' and taking on this identity, therefore, was a necessary step in order for recovery to commence. For Laura, taking on this label is narrated as the point where she finally accepts drinking as a problem to herself and, later, others, allowing her to seek help through specialist services. Nevertheless, she stories performing this identity publicly to get support as shameful and later resists the language of 'addiction' when discussing her experiences in a sobriety support group, referring to it as a *'common issue'*. Indeed, participants traverse different societal/ treatment narratives to make sense of alcohol problems throughout their stories, including 'addiction', mental health, and sobriety narratives, suggesting that several functions are served by varying narratives.

In contrast to Laura, most participants narrate they do not or cannot take up the 'alcoholic' identity (*'I couldn't get my head around being an alcoholic'*, Lulu), which for many participants impedes them from seeking help and informs their decision to attempt to stop drinking without formal support. Participants story a broader culture of secrecy surrounding women's problematic alcohol use, describing limited support options; either their drinking is not identified as a problem by their GP, or those able to share their concerns are given '*very generic*' advice (Laura) or told alcoholism is '*untreatable*' (Linda). Considering the impact of acquiring a 'spoiled' identity (Goffman, 1963) seems pertinent here. If drinking functions to mask self-unacceptability, taking on a stigmatised identity (to acquire formal or informal support) is likely to be experienced as increasingly shameful. Indeed, participants narrate intense feelings of shame, guilt, anger, fear and sadness from having to

confront the stigmatising label of 'alcoholic' as women and mothers in sobriety, as well as the behaviours of their ‘drinking selves’ and the impact of drinking on loved ones.

3.4 Chapter Three: Narratives of Recovery

Despite the shaming and shame participants experience, participants slowly begin to narrate a form of resistance as crucial turning points in recovery, describing two fundamental processes: breaking through shame by opening up about alcohol problems and working through shame attached to AD as women/mothers and past behaviours when intoxicated through connecting with stories with other recovering women (from the sober community).

3.4.1 Breaking Through the Barrier of Shame: ‘I’ve got to tell her’

Participants narrate opening-up about their drinking to others as a vital step on the road to recovery, allowing them to reconnect with their ‘real’ selves and improve their relationships. The first time acknowledging their drinking with others is storied by Lulu and Linda as a ‘coming-out’, involving breaking through shame, including fears of how they might be perceived by others, and changing lifelong shame management strategies (e.g., secrecy, denial). Lulu links becoming ‘depressed again’ two years into sobriety to feeling too ashamed to speak about her drinking with anyone outside her immediate family:

> *I didn't seek any support until I was nearly two years. I did it myself and there was so much that came up that I didn't really know what to do with so I bottled it all and it made me quite unhappy (…) I was too ashamed to seek any...I went on these things and read things and just thought I can't...I didn't feel I was able to share anything because I felt too ashamed. That was my biggest barrier was my shame (…) But I could just tell her and the world did not...I just felt...I just thought, I've had enough, I've got to speak it, I've got...yeah I just...yeah, I think being sober just...yeah it just gives...it just gave me the...I just had the...my head was clear and I just...I knew I had to do it. I knew I had to work on myself (…) when I walked in, she said to me that I was...that I had like a cloak of shame on me. I was so weighed down*

by it. So then I, I spoke...I actually verbalised...I told her it...I told her everything. (Lulu)

Lulu narrates how shame keeps her stuck with a shaming internal monologue for two years, significantly impacting her mental health. Shame is portrayed as an invisible barrier, preventing her from opening-up and seeking help, the heavy burden of this captured through her use of vivid imagery: '*cloak of shame*'. She frames telling the counsellor out of necessity and desperation rather than a choice (*'I had to do it'/I've got'*), aided by renewed capacity to engage in sense-making in sobriety and the counsellor's identification of shame. Once verbalised, she conveys relief that her worst expectations did not happen ('*the world did not…*') and implies her recovery only begins after she takes off the *'cloak of shame'* (B. Brown, 2006). Like Lulu, Laura narrates that after multiple 'failed' attempts, she can only maintain sobriety after telling her loved ones about her drinking problems. She stories the positive validation and support she receives (opposed to being judged for being 'a stereotypical alcoholic') as alleviating shame and encouraging further honesty and openness, supporting her to reveal her 'true' self, and genuine connection, intimacy and acceptance to occur.

For all participants, opening-up is heavily influenced by how they perceive others will view them in their stories, which fuels shame at all stages. Tamzin and Susie have not disclosed their alcohol problem due to the expectation of being judged as a 'woman alcoholic' ('*But it's a terrible thing, I think women in drinking, you kind of, you have in your imagination of some lush somewhere...', Tamzin).* Opening-up about drinking habits seems to relate to external factors, such as length of time sober and having social networks that include others in recovery from AD and/or are supportive of their sobriety.

3.4.2 Connecting Through Stories: 'I don't think they're a bad person so maybe I'm not a bad person too'

All participants narrate connecting with the stories of other women in sobriety (from the sober community) as a turning point in recovery, facilitating the working through of shame. Comparison and a sense of mutuality seem to normalise drinking and past behaviours when intoxicated, disrupting the totalising (viewing themselves as bad in their entirety) and individualising (directing blame inward) functions of

shame. The sense of community and connection this fosters appears to mirror that which is previously sought through alcohol and is framed as providing the motivation, accountability and support needed to keep sobriety going.

Many participants describe this process as gradual and tentative. All participants report listening to and reading other women's stories in private Facebook groups, podcasts, self-help literature, and women's sobriety support groups in what seems to constitute an active search for a non-shameful, non-drinking identity. Tamzin and Susie in particular story the anonymity afforded by online spaces as offering some protection from judgement and shame. Participants describe moving from reading and listening to other women's stories to sharing their own experiences as a progressive step in their journey towards sobriety. Here, Alexa narrates exchanging stories with women from the sober community as integral to her recovery:

> *I think the thing that's helped me get to where I am now is the sober, the, the LoveSober community, actually. Erm, because it feels like a really safe space and it's, it's women [...] but it's just, erm, having that group where I'd say that I could be having a wobble and, you know, people would be going through the same thing and... or they'd been there and that was really helpful and the, the not having that shame. Erm, because it's not...it's normal, but, you see these women that are really career-driven and they're good mums and it's that kind of thing, 'well, if they're going through, or they have gone through, what I'm going through, that I can't be ...that I'm not that...I don't think they're a bad person so maybe I'm not a bad person too...I'm not a bad person in how I feel in myself. (Alexa)*

Alexa stories her identification with 'sober' women whom she perceives as holding socially valued identities ('*good mothers*', '*career driven*') as helping to break down the stigma attached to the 'alcoholic' stereotype, allowing her to question the basis on which she thinks of herself as 'bad' and reconfigure her self-narrative of shame. Highlighting the absence of shame when sharing 'wobbles' with other sober women suggests the sharing of stories helps Alexa to normalise AD and struggles in sobriety by implying a public normalisation of her personal experiences (Trondsen & Tjora, 2014). The sober community is framed as supportive and dependable in

contrast to how significant others are presented in the rest of her story (i.e., abandoning/rejecting), fostering a sense of connection and acceptance she seeks through alcohol earlier in her story. Belonging to a community therefore may provide a basis from which participants begin to develop more positive social identities (e.g., Dingle et al., 2015). Nevertheless, Alexa and Tamzin's stories suggest the relational context of the sober community presents new opportunities for shaming:

> *Erm, and what I did find when I was trying to stop as well actually was, erm, er, even having that sober community I would kind of go offline a bit because I knew I was drinking and so at the same time there was that there was that shame because the…I was letting these people down, but I know that that was kind of, probably, from my own kind of head. Erm, and also that it was almost like I didn't believe- deserve to be in this group because I was failing miserably at not drinking. Erm, and it'd just become like, you know...I think my drinking, my drinking became quite a secret, err, from everyone really... (Alexa)*

Alexa stories her shaming internal voice as easily re-activated during relapse, triggering existing negative self-perceptions of failure and unworthiness. Although she questions the validity of this voice *'kind of, probably, from my own kind of head'* – perhaps reflecting a lessening of the grip of the self-narrative of shame – she seems to perceive drinking as a violation of the rules of the sober community, resulting in her choosing to drink secretly, possibly intensifying feelings of isolation and shame. Tamzin describes withdrawing from the group after witnessing the response of group members to relapse. Both narratives imply group membership is perceived as tenuous and contingent on sobriety, suggesting that women who relapse or seek non-abstinence recovery paths may find it more challenging to use them (Weston et al., 2018). On the other hand, shame appears to maintain alcohol cessation within the community or group by contributing to a sense of accountability and responsibility to others. Tamzin and Alexa's accounts suggest that when women's self-narratives are saturated with shame, it may be more challenging to benefit from or tolerate the more functional aspects of shame in this context (e.g., Keltner et al.,1997).

3.4.3 Rejecting the Alcoholic Identity and Reclaiming Self Narratives

Participants story the navigation of shame as fundamental to the renegotiation of their drinking identities and the development of positive (sober) identities. All participants narrate their rejection of AA's 'alcoholic identity', framing it as shameful, unrelatable, negative and even dangerous. Participants in early sobriety narrate their internalisation of the sober identity from the positive sobriety movement, constructing this identity as relatable and positive. The language and concepts from the sobriety movement seem to support participants to challenge and resist the stigma and shame associated with dominant medicalised narratives of 'addiction'. At this point in their story, participants begin to actively chose what to incorporate in their stories rather than absorbing others' perceptions of them.

Participants in both early and late sobriety reject the 'alcoholic' identity offered by AA. Tamzin and Susie report finding it too shameful to access AA as they are unable to attend anonymously due to their work or living in the countryside. The rest stop attending AA after one or several meetings, except for Katie, an active member of the AA community for the first five years of sobriety. Lulu describes doubting whether she is 'wrong' for not attending AA or calling herself an 'alcoholic' but reasserts her reasons for doing so:

> *It was a lot of men. A lot of different...there wasn't anybody that I really thought was like me. There was some...there were some younger women there, but it was all higher power stuff, God, which...I mean it doesn't have to be God, but I couldn't, I couldn't get my head round that cus I'm not religious (…) it felt like they were stuck and it, it just felt, 'I'm an alcoholic. I am bad. Everybody else is normal, but I'm shit because I, I can't drink. It's not the drink that's the problem, it's me. I'm, I'm flawed and I'm...yeah.' (…) at the time I was two years...two and a half years sober (…) And I just thought (…) I can't relate to this because I don't feel....yes, I had a drink problem, but I haven't had a drink for x amount of years and if, if, if you don't...with AA, if you drink...you know, I'll have an alcoholic free beer or, you know, and I always have, but to them, they think you're, you're a dry drunk, or if you haven't got a sponsor, you're on the way to relapse. And it's like 'Cor!', it was just too negative for me… (Lulu)*

Lulu emphasises a lack of shared identities with the group (male, religiosity of group members) and situates her rejection of the 'alcoholic' identity, as well as the 'negative' group rituals, rules and behaviours reinforcing and perpetuating this identity (sponsor, 'dry drunk'), with a loss of agency, in the line with majority of participants. She problematises the AA framework, wherein alcoholism is a lifelong, 'progressive disease', and 'addictive characteristics' are enduring psychological traits inherent to the 'addict's personality' (Valverde & White-Mair, 1999). Lulu frames the AA identity as unwanted, shameful ('*I am bad*', '*I'm flawed*'), inauthentic ('*I don't feel like an alcoholic*'), and engendering a 'stuckness', demarcating group members from 'normal' people. She distances herself from the 'alcoholic identity' by emphasising the length of time sober and externalising alcohol as 'the problem', as does Katie.

Participants who are sober for a shorter period draw more heavily on the non-disease framework of the sobriety movement to help structure their narratives, resist the shame attached to the 'spoiled' 'alcoholic' identity (Goffman, 1963) and construct a positive 'sober' identity. The sobriety narrative plays a central role in Susie's story. The tone of much of her story is pessimistic, analytical and sombre. She describes mostly negative enduring traits about the self, with little differentiation between her former and present self, switching to present tense when recounting painful memories. Her narration implies a 'stuckness' in her self-perception and resembles Kougiali et al.'s (2017) findings that the narratives of those using substances are often fixed in the present. However, when Susie discusses the sober community, her tone dramatically shifts to become more hopeful and positive:

> *…when I actually did stop drinking, though, the first time and then this time, it's like having people in your corner. Somebody cheering you on. Er, giving you motivation. Pushing you. Making you question. Telling you you're doing the right thing. Telling you that life can be better. Erm, so it's a lot of positivity around sobriety, rather than society telling you, if you don't drink, you're boring. Here were women, women I could identify with, they were, they're around about my age group, talking about burnout, working too much. Erm, I could identify with them and erm, yeah, I think it was a story*

that I could relate to (...) and these were people as well who weren't calling it alcoholism. They were talking about grey area drinking (…) So, I'm also, I studied biology, so that that does interest me (…) So, she was... also helping me find tools, ways that I could empower myself and keep not drinking, I think. So, it became a secret, but very positive...it became a hidden side to me that nobody else knew about and I loved. I loved the fact that it was mine. Nobody else's… (Susie)

Susie stories her internalisation of the positive sobriety narrative and development of a (private) positive (sober) identity like a motivational mantra – the repetition and short sentences create a rhythm that conveys a momentum that spurs on her sobriety. Her identification with this collective narrative seems to hinge on the relatability of the story *and* the storytellers with whom she has shared experiences and identities (women, age, work). The sobriety narrative seems to facilitate a desirable imagined future and future self, representing a turning point in her story. She suggests messages of positivity and self-empowerment within this narrative are necessary to withstand and counter (dominant) societal narratives that shame women for alcoholism *and* sobriety ('boring'). She emphasises her contentment with this identity is premised on it belonging to her, presumably rather than being defined by a shaming 'other' as earlier in her story. This is the first time Susie narrates ownership over her story, implying an increased sense of agency. Like Susie, in the extracts below Tamzin and Linda draw on language and key concepts in the positive sobriety narrative to resist being positioned as stereotypical 'alcoholics':

And when I'm away with people, absolutely don't drink at all, don't, not interested, they might offer me wine, but I just, you know, so I can go from having a bottle a night, to nothing, with no effects, no longing, when I....So, so that's what I mean, it's not an addiction. It's not an addiction, a physical addiction, I feel it is a...it was, it was a psychological one because now I feel I've broken the habit, it doesn't bother me at all… (Tamzin)

Tamzin distinguishes between a 'psychological' and 'physical' 'addiction' (withdrawal effects). She stories her self-control over alcohol, switching from present to past tense to construct her relationship with alcohol as a 'broken habit',

thereby rejecting being positioned as a 'woman out of control' (Patterson et al., 2016) and connotations of permanence inferred by the ‘alcoholic’ identity. Tamzin, Linda and Susie all frame their alcohol use as a habit, comparing it to their relationship with TV, food and non-alcoholic drinks. Alexa, Linda and Laura describe alcohol use as 'unhealthy' and noting the health benefits of sobriety, thereby presenting themselves as making a positive choice not to drink. In the extract below, Linda discusses the rigidity of imposed labels and highlights how society is complicit in the development of women's problematic alcohol use:

> *…it's (drinking) just like the norm, isn't it? (…) people think that you're either an alcoholic who's sitting on the bench down the park, or you're a normal drinker, and that's not true (…) Erm, I don't think you realise how much it's ingrained in society until, until you start looking at it. Like, there's a pub in every soap, erm, and, and, things like that (…) and then like getting involved, like seeing how the alcohol industry targets women, but also how the tobacco industry targeted women all those years ago… (Linda)*

Like Susie, Linda challenges the false binary of 'alcoholic' vs 'normal drinker' to resist the alcoholic identity (Davey, 2021). The othering of 'true' alcoholics by using narrative 'straw' men and women ('sitting on the bench down the park') may help leave her own identity unspoiled (Goffman, 1963). She also takes up the sobriety narrative in her account of the harm done to women by society, thereby countering assumptions of individual responsibility. This is the first time Linda sits outside her own story to evaluate the role of social institutions (e.g., media, industry) in producing women's alcohol problems. She speaks with authority and conviction, taking up the role of activist/educator to use her knowledge and experience to consciousness-raise and help other women ('getting involved').

Katie also draws on socio-political narratives to highlight how a lack of education and services relating to AD, women and mental health contribute to a downward trajectory in the development of AD and present challenges in recovery. Most participants state their motivation for participating in the research is to help other women. Belonging to a movement and exposing the normative practices of shaming (i.e., harm done by society), therefore, might help women in recovery

defend against, resist or work through feelings of shame, build their self-esteem and facilitate self-empowerment (Drury & Reicher, 2005).

The sober identity is frequently constructed as a source of pride. Some participants are ‘loud and proud’ with this identity, describing attempts to convert friends and family to a ‘sober lifestyle’. However, Susie later narrates struggling to adopt and perform this identity with people outside the sober community. Her narrative implies that she perceives that others will not understand or accept this identity and may still position her as an ‘alcoholic’, suggesting that stepping outside of grand narratives of ‘addiction’ may be extremely challenging.

Participants story the further reclaiming and transformation of their ‘real’ self into sobriety, narrating increased self-understanding through a journey of self-discovery and self-development. Greater evidence of narrative ownership is seen in the stories of Katie and Lulu, participants who have been sober for the longest period, which may be indicative of the further consolidation of their reclaiming of their non-drinking identities. The narrative voice is authoritative throughout, offering up interpretations and clearly differentiating their ‘current (transformed) selves’ in recovery from their past selves. They indicate a process of narrative reconfiguration in line with the discovery of concepts, which they organise their narratives around, allowing them to positively reframe and reinterpret previous feelings and experiences. Trauma is presented as a central element in Katie’s story:

> *I believe that what predates all of my substance use disorder is actually not even depression, I believe it's complex, I have complex PTSD from my move from the States at three years old being taken from my father and, you know, all of these instances are just series of complex trauma throughout my entire life (…) it was really helpful to know that I have complex trauma (...) and once somebody was able to educate me about that, and then I could then educate myself (…)And, you know, I now see that I was trying to escape and cope in the way that I only knew how erm but there was no, you know, there was no, no nurturing, emotional nurturing in my life, erm. So, I just sought escape through drugs and alcohol and weed… (Katie)*

Katie's trauma narrative enables her to present drinking as an understandable response to what happened to her and something she had little choice over (*'that I only knew how'),* rather than as a problem located within her. This seems to support her to take an empathetic, compassionate and forgiving stance towards herself and alcohol use. Medicalised and professional terminology is prevalent throughout her story, which may function to legitimise her position and maintain emotional distance in the retelling of painful and shameful experiences; Katie herself reflects on her 'detachment' at the end of the interview. Katie indicates her story is a re-evaluated 'redemption' (Maruna, 2001) narrative ('I now see that'). She implies complex trauma replaces depression as the explanation for problematic alcohol use. Radzik (2009) notes that an experience needs to be re-evaluated positively for it to be redeemed; Katie suggests trauma resonates with her experiences and empowers her to find her own solutions and move forward ('educate myself'), helping her centre her agency and resilience. Shame plays a similar role in Lulu's narrative:

> *And I just thought, 'That's it. That's what I have felt all my life. Not guilty. I'm ashamed. I'm ashamed of myself. I feel shame about who I am. What I am. Who I am.' So...and that just, yeah, and I think when you can understand yourself...erm, I can understand...I can try and understand my parents for what they are (…) I'll be honest, I didn't know who...I honestly didn't know who I was until I was probably fifty. I didn't have a clue about who I was. I've learnt more about myself in the last four or five years than I've learnt in the...all my life (…) I think I'm still working on myself and I think I always will be. Erm, but I finally I think I know who I am, what I am, and I'm okay with it (…) I'm not doing things to please other people. Erm, erm, I'm sort of...I'm happy, I er I think I'm happy with who I am. I'm a…I used to think I was a really shit person. Really bad. Really bad. But I don't think I am and yeah, I'm not...I still get my moments of, erm, worrying...maybe worrying a little what people think, but I think we all do a little bit, but not really. Not really. (Lulu)*

Lulu stories her relief upon discovering shame as a concept to better understand and forgive herself and others. She frames sobriety as a process of self-discovery

and personal growth, leading to self-acceptance and a newfound sense of agency. In contrast to earlier in her story, her narrative (and self-perception) is no longer dominated by the assumption of others' criticality, and she appears to have discarded the strategies to manage this (‘*I’m not doing thing to please other people’).* Her tone mirrors this shift; rather than critical and shaming, she narrates with self-compassion, tentatively normalising ‘moments’ of worry or self-doubt *(‘I think we all do’).* This is most evident at the end of the interview where Lulu tenderly shares a story about her son, her ‘*biggest supporter’*. He tells her he is grateful for the hardship they endured because it taught him that *‘it is possible to recover from things’.* Here, internalised positive messages (including pride) from her son replace the previous perception of herself as a ‘bad mother’, which may indicate validation from significant others helps to counteract previous negative and shameful self-images. Indeed, for Scheff (2014), pride signifies an intact bond with other human beings, whereas shame implies a severed or threatened bond.

In Lulu and Katie’s narratives of quest-redemption, there is little differentiation between the 'real' self (how they feel about themselves privately) and the self they present to others, which may reflect how, later in sobriety, participants come to see themselves beyond drinking narratives, having worked through shame. Expanding and reshaping their identities beyond 'not drinking' is storied as a gradual and multi-staged but crucial process in recovery. Actively extending their repertoire of experiences, by, for example, seeking out leisure activities and learning new skills, is narrated as fundamental in reclaiming recovery 'for them, rather than others' and identity ‘re-formation’’ (Hood, 2003). A more ‘authentic’ and coherent sense of identity seems to facilitate connection in these stories.

The reworking of narratives in the later stages of sobriety and further reclaiming of their ‘real’ self and self-transformation involves going back to the beginning to make sense of why they drank in the first place, including re-examining (e.g., in therapy) experiences of shaming leading up to the development of the self-narrative shame, shame-management strategies and AD. Katie calls this her ‘*emotional recovery’*. The progression towards newly expanded sober or non-drinking identities seems to depend on the extent to which participants work through shame attached to their drinking and reasons for drinking in the first place

(i.e., shifting their self-narrative of shame). Storytelling – with other sober women or significant others, in therapy and even during the interview – therefore appears to be a key mechanism of change in sobriety by facilitating greater self-understanding and supporting participants to work through shame and alternative, more positive self-narratives to emerge and be validated.

4 DISCUSSION

This study's findings are discussed in the context of broader literature on shame and AD, with implications for research evidence, current clinical practice and services and policy. The section concludes with a critical appraisal of this research.

4.1 Revisiting the Aims of the Research

The research aimed to gain a multi-contextual understanding of shame in women's experiences of recovery from AD in the UK. Three narratives were presented to account for the ways shame featured in seven participants' stories: 'internalised narratives of shame', 'narratives of escalating alcohol use' and 'narratives of recovery'. In contrast to the psychological 'addiction' literature that frames shame as a situational response (Luoma et al., 2018) or an intrapsychic phenomenon (e.g., Kaufman, 1992; Potter-Efron, 2002), shame emerged as a psycho-social-cultural and multidimensional phenomenon in participants' recovery stories, intimately tied to gender norms and identity (Leeming & Boyle, 2004). Participants narrated shame relationally, within their interactions with significant others (family, partners) and broader socio-cultural contexts (e.g., gender norms) (Bronfenbrenner, 1979), contributing to a loss of control in defining a satisfying identity from an early age (e.g., seeing themselves through a critical other) and cumulatively impacting their identity and sense of self over time. Interaction between shaming and critical voices of significant others (mothers, peers, partners) embodied within broader culture appeared to reinforce a self-narrative of shame across the life stages.

In line with most research in the field, shame was storied as exacerbating alcohol use and inhibiting help-seeking and recovery, peaking just prior to and in early sobriety (e.g., Davis, 1997; Sanders, 2011). However, overwhelming shame also appeared to inform participants' decision to stop drinking, suggesting complex and cumulative effects of shame. Quantitative and 'gender-blind' approaches, which do not study shame within the sociocultural realities of women's lives, have largely overlooked this. The methodological approaches traditionally used within psychology to explore shame and 'addiction' appear to have resulted in a partial

and overly reductionist account of shame in women's AD and recovery (Leeming & Boyle, 2004).

The current study suggests recovery involves the de-shaming of shame-based identity, which needs to be supported by others. Participants constructed AD as an understandable response to dysfunctional conditions (trauma, adverse childhood experiences, restrictive gender roles), with varied routes to and methods of recovery, including multiple attempts to stop drinking. The boundaries of recovery were 'fuzzy' and did not map neatly onto the length of time sober, yet a clear commonality across stories was that recovery was staged, involving the reconstructing of identities by working through shame attached to AD *and* participants' sense of self (Biernacki, 1986; Chambers et al., 2017; Hill & Leeming, 2014; McIntosh & McKeganey, 2000). This process was gradual and facilitated by contextual influences, such as social network composition or involvement in sobriety support groups (Best et al., 2016). Therefore, rather than a disorder or disease, these findings most closely align with a social model of AD and recovery (e.g., Best et al., 2016; Staddon, 2005).

Key themes relating to the way shame features and is navigated by women in their stories of recovery follow.

4.1.1 Gendered Shame

Consistent with findings from feminist researchers, AD and shame were rooted in gender oppressive experiences, including victimisation, abusive relationships, restrictive gender norms/role expectations and gendered stigma from AD (see Kougiali et al. 2021 for review).

Participants storied shame from the internalisation of perceptions of failure to fit into the model of a valuable and valued girl, woman and mother in society, within their families and relationships, spurring on alcohol use to cope with shame and feel 'normal'. Interestingly, the literature tends to focus on the negative/disruptive effect of alcohol on women's roles (e.g., parenting) rather than the other way around (Eliason & Skinstad, 1994). Nevertheless, a handful of studies cite the influence that stress and unrealistic expectations placed on women due to their

gender roles (e.g., as caregivers) have on dysfunctional drinking patterns and shame and guilt (Bond & Csordas, 2014; Copeland, 1998; Hood, 2003).

Shame-management strategies were storied as gendered. People pleasing and self-silencing are rooted in unequal distributions of power and gender norms prescribed by culture (e.g., Jack & Ali, 2010). A gender role marked by passivity, niceness and submissiveness may provide women with a particular set of linguistic and behavioural repertoires to respond to, manage and avoid feelings of shame or a shameful identity (Leeming & Boyle, 2004). Angry or assertive behaviours employed to prevent a shamed identity might be less available to those who do not hold a dominant position (e.g., women; P. Gilbert & McGuire, 1998). Self-silencing has been used to account for the gender gap in multiple psychiatric disorders (e.g., depression/ eating disorders) and women's vulnerability to certain diseases (Maji & Dixit, 2018). While placating and prioritising others' needs are highlighted as longstanding patterns of behaviour that need to shift in recovery (e.g., Hood, 2003), this is the first study to highlight the link between shame, people-pleasing/self-silencing and recovery from AD in women.

This study finds support for the cultural double-standard of AD for women (Sanders, 2009; de Visser & McDonnell, 2012). Shame appeared to arise from the interaction between gendered norms and the experience of AD, and perceptions of the 'alcoholic woman' stereotype (e.g., Cunningham, 2012). In line with previous research, participants' accounts of guilt, shame and suffering consequent to their perceived failure as mothers suggest that when the label of 'alcoholic' is layered onto societal narratives of motherhood, the scope of stigmatisation widens (e.g., Boreham et al., 2019). Nevertheless, the value placed upon their identity as 'mother' was highlighted, presenting as turning point in many participants' narratives by informing their decision to stop drinking.

4.1.2 Conceptualising Shame

In line with previous research, the significance of emotionally absent, critical or rejecting parents, namely mothers, was implicated in the emergence of a shamed identity (Widom et al., 1995). Participants narrated their childhood experiences in ways that resembled chronic shame (DeYoung, 2015) or core shame (Sawer et al.,

2019), recently linked to AD (Kougiali et al., 2021; Sawer et al., 2019). Shame is thought to derive from the absence of (emotional) connection, beginning in childhood due to a lack of emotional attunement, with resultant feelings of rejection, isolation, despair and unworthiness interpreted as there being something wrong with them (DeYoung, 2015). However, the current study suggests that any theories of shame and women's AD needs to account for the socio-cultural determinants of a chronically shamed position. Feminist relational-cultural theory posits differences in women's psychological development mean relational connection is especially salient for women's sense of identity and self-worth; therefore, women are more likely to experience shame from relationship disconnection or violation (Covington, 2007; J. B. Miller & Stiver, 1997). B. Brown (2006) developed 'shame resilience theory' to account for the factors supporting women's recovery from shame and in line with the current study, she found the key effects of shame (isolation, being trapped and powerless) emerged from competing demands and unrealistic social expectations on women, and concomitant 'unwanted identities'.

4.1.3 The De-shaming Function of Stories

Exchanging stories of AD and recovery with other women and opening up (for example, in therapy and with loved ones) seemed to help participants normalise past experiences when intoxicated, challenge stigma associated with AD and integrate how they felt about themselves privately with the self they presented to others, allowing for external validation. This appeared to support participants to feel a sense of belonging and connection and build a positive identity. Participants' narration of the benefits of opening up is consistent with 'speaking shame' - the identifying and verbalising of shameful events - in B. Brown's (2006) 'Shame Resilience Theory' (Dayal et al., 2015). Telling stories appeared to disrupt the silence and concealment of shame (R. Richards, 2019; Witham et al., 2018), increasing participants' understanding of the emotion, its antecedents and, in doing so, develop some resilience to it.

These findings link to recent work on recovery capital. Cloud and Granfield (2008) identified internal and external resources necessary to 'initiate and sustain recovery from substance misuse' (Best & Laudet, 2010), including 'social capital':

the amount of support accumulated from relationships (Cloud & Granfield, 2008). Consistent with previous research, this study found that low levels of perceived support (linked to participants' perception of judgement) were a barrier to disclosure and vice versa. Female role models (Hood, 2003) and receiving support from those seen to embody a shared sense of identity (e.g., women/mothers in recovery) was shown to help participants work through shame, supporting their recovery (Haslam et al., 2005; Jetten et al., 2014). However, homogeneous groups (e.g., with strict rules about abstinence) could be experienced as exclusionary for women already holding a shamed identity in the event of relapse (Zmerli, 2010). Despite its significance, a recent systemic review of the recovery capital literature revealed minimal research on women in this area (Hennesssy, 2017).

Narrative theory posits scripts about the self are continuously redefined to make sense of experiences (Morgan, 2000). Findings indicate that a critical mechanism in recovery is identifying and working through shame through storytelling. The narratives participants drew on to construct their personal stories seemed to have the secondary function of helping them navigate and avoid positions of shame and perform, enact and consolidate their sober/non-drinking identities (Hill & Leeming, 2014; Sawer et al., 2019). In this way, participants' stories were more than 'just talk'; they appeared to have 'real' effects both for the narrator and listener.

Participants examined the antecedents of a shamed identity in telling their stories. In doing so, they constructed AD as something 'done to them' rather than an inherent flaw or personal weakness. Through presenting their values and reasons for drinking, they revealed why they made decisions. Framing drinking as one of few survival resources available (e.g., feel normal/connect) may have allowed them to feel less ashamed of past choices. Constructing drinking as a culturally endorsed activity highlighted British society's role in women's alcohol problems and the ongoing challenges participants face in sobriety, perhaps helping them to move beyond a position of self-blame. In eliciting deep empathy, their stories may help participants to feel acceptance rather than judgement (M. Brown, 2012), helping them to overcome shame.

Narratives of recovery included stories of resistance, reclaiming, belonging and acceptance (of self/others), which appeared to help participants take control and reclaim agency. In describing help-seeking behaviours and personal transformation, rather than being objects of shame, they were subjects who actively problem-solved, implemented boundaries in relationships and were accepted by others, in contrast to the disempowered position described earlier in their stories. Self-knowledge and insight were narrated as the basis for personal growth, self-compassion and self-acceptance, which may support a sense of pride, the antithesis of shame (Scheff, 2014). The discovery of key concepts (trauma or shame) appeared to support participants to develop a more compassionate self-narrative, suggesting that being able to develop compassionate narratives may be a factor in alleviating shame and sustaining sobriety (P. Gilbert, 2009).

4.1.4 Societal and Treatment Narratives

Participants' stories included reference to broader societal and treatment narratives pertaining to AD. Participants' internalisation, adoption, and rejection of these narratives (e.g., AA/sobriety) at various stages of recovery appeared to have different implications for shame, self-esteem, self-worth, and sense of identity.

4.1.4.1 AA Narratives

Most research on AD is with participants from AA. Research with AA samples has found that to recover, individuals must internalise and become emotionally attached to an alcoholic identity through attending AA meetings and sharing stories (Cain, 1991). The current study with participants who were not using or had rejected AA challenges this. The internalisation of the AA narrative seemed to generate shame, contributing to participants drinking more, alone and in secret and serving as a barrier to disclosure and seeking help (Corrigan et al., 2017; Hill & Leeming, 2014; Schomerus et al., 2011). Laura's story suggests the internalisation of the alcoholic identity may have helped with problem identification and help-seeking, but this lacked resonance and utility in later recovery.

Participants told their stories with reference to the AA, disease-based narrative, indicating they perceived this as the dominant way of understanding alcohol 'addiction'. Their accounts suggest the AA identity leaves women vulnerable to

hermeneutic injustice[4]. It failed to provide language that reflected their lived experience of AD/recovery and operated to threaten their (already shameful sense of) identity. In line with feminist critiques of AA, participants perceived the concepts/practices embedded within the AA identity as unrelatable (male, old), negative (deficit-based), restrictive/disempowering (associated with lack of agency and punitive) and shameful ('your fault'; Covington, 1994; Kaskutas, 1994; B. A. Miller et al., 1987; Sered & Norton-Hawk, 2011). Their stories imply the stigma attached to the label of 'alcoholic' dominates and interacts with other (gendered) identities, compounding shame and offering impoverished ways of understanding themselves.

4.1.4.2 Sobriety Narratives

The sobriety narrative featured in all participants' stories but was more prominent in the stories of those earlier in sobriety. Participants narrated their internalisation of a 'sober' identity through their engagement with other sober women's stories in quit literature, online platforms and women's sobriety support groups/communities. The sobriety narrative seemed to offer participants an alternative format to AA to make sense of their experiences and an esteemed 'sober' identity.

Participants appeared to value the ability to individually self-define and reframe their relationship with alcohol (‘common issue’, ‘habit’, ‘grey area drinking’, ‘unhealthy relationship’), thereby resisting the shame and stigma associated with the ‘alcoholic' identity (Davey, 2021). Participants described actively searching for a positive sober identity and emphasised aspects such as personal growth and agency, which may have appealed given a loss of agency due to several factors (victimisation, restrictive gender roles, stigma/shame of AD). Belonging to a community may have allowed for a shared sense of identity with other women *while* retaining a sense of autonomy (Chambers et al., 2017).

[4] Hermeneutic injustice is understood as having a significant area of an individual’s social experience obscured from understanding due to prejudicial flaws in shared resources for social interpretation (Fricker, 2007).

The relatability of the sobriety narrative and future-oriented, optimistic and joyful aspects seemed to engender hope, supporting participants to visualise a desirable future sober self (i.e., women with a non-shamed identity). Indeed, previous research has found that the extent to which an imagined future self can inform behaviour change (e.g., abstinence) depends on how realistic and relatable this future self is (Alter & Hershfield, 2014). Although not limited to the sobriety narrative (e.g., Katie's story), the socio-political aspect of this narrative seemed to help participants resist shame by re-situating AD in its social, cultural and political context, redirecting blame or responsibility outwards rather than inwards, and facilitating more powerful positioning (e.g., as an educator or activist) and positive psychological outcomes (Drury et al., 2005; Drury & Reicher, 2005). These are significant findings as, with few exceptions (e.g., Hood, 2003), the 'addiction' literature has neglected the importance of positivity, agency and broader political factors in recovery from AD in women.

Another aspect of the sobriety narrative participants drew on to account for their experiences was their perception of being shamed for sobriety for violating drinking as the norm. Participants indicated that in recovery women not only have to manage the shame associated with their alcohol dependent history, but also in relation to their sobriety. While sober shaming/shame are largely unexplored in the literature, some recent work has begun to explore the paralysing effect of internalised sober phobia and stigma/shame recovery (e.g., Burns, 2021). The sobriety narrative seemed to help participants articulate and challenge this.

Nevertheless, the current study suggests there may be challenges in adopting a narrative different to the dominant one. Susie storied difficulties performing the sober identity outside of the sober community, making navigating new relationships and social situations especially challenging, leading her to question the sustainability of sobriety. Moreover, despite rejecting the 'alcoholic' identity, there were points in their stories where participants drew on medicalised narratives to account for the severity of their alcohol use and why they were not responsible. The sobriety narrative therefore may not convey the harm or severity of AD in its promulgation of choice/wellness narratives (Raypole, 2020).

Several researchers highlight the role of therapeutic discourses/disciplines in the emergence of 'the individual' (Rose, 1989) and the self-help agenda as furthering 'the self' as a primary site of therapeutic transformation (Bellah et al., 1996). The conception of 'a psychologically damaged self' with unbridled agency neglects the wider social determinants of AD and sobriety as a 'choice', may cause women to question the need for sobriety in the first place or lead to shame for not being able to stop drinking as they would consider themselves responsible. Moderation is a viable and sometimes the only recovery option for disadvantaged groups (Collins et al., 2019; Kougiali et al., 2019), in contrast to the sobriety movement and AA (Humphreys & Klaw, 2001; Klaw & Humphreys, 2000). Therefore, sobriety narratives or support contingent on sobriety may exclude certain groups.

4.2 Implications and Recommendations

The following sections bring together the implications and recommendations from the findings to interlinked areas of clinical practice, service delivery and policy and future research (Bronfenbrenner, 1979).

4.2.1 Clinical Practice

4.2.1.1 The Therapeutic Relationship

The study's findings suggest clinicians should remain alert to issues of shame in this population; women's silence around alcohol use might be a form of impression management to save themselves from stigma of the 'alcoholic' identity. While disclosing alcohol problems was narrated as shame-inducing, when participants were supported and validated it relieved shame. Therapy, as a relational context, both carries the potential to shame women or offer relational validation that might help them to work through shame. Given the risks associated with naming alcohol problems for women, a proactive approach may be helpful. Silence from healthcare professionals may be interpreted as shaming. To support relational safety to speak, therapists and healthcare professionals might (tentatively) ask questions about drinking behaviours and re-situate silence as an understandable response to stigma.

The current study points to several factors that might facilitate a supportive, collaborative therapeutic relationship to work through shame and reduce the likelihood of shaming. These include: attending to power imbalances and refusing the role of expert wherever possible (Dearing & Tangney, 2011); naming and formulating service and sociocultural contexts (Afuape, 2011); externalising alcohol as the problem (White & Epston, 1990); asking women what happened, rather than what is wrong with them (Johnstone, 2020); supporting women to self-define their relationship with alcohol (rather than impose an unwanted identity on them; Davey, 2021), and working within women's own value system (Dearing & Tangney, 2011).

It might be helpful for clinicians to be explicit in naming shame and its basis in shaming (as enacted by others and society more broadly) to support women to question or resist it. Demonstrating compassion and empathy for women's experiences and alcohol use might help replace internalised messages of criticism and judgement (P. Gilbert, 2010). Therapist factors, such as lived experience of AD and being a woman, may support relational safety. In particular, the use of personal disclosure may normalise AD.

4.2.1.2 Therapeutic Interventions

Traditional approaches to recovery include detoxification, medication and brief therapeutic interventions that primarily target drinking (CBT, motivational interviewing). Individualised and deficit-based approaches, such as CBT, pay insufficient attention to socio-political contexts (Patel, 2003). Neglecting the broader dehumanising and shaming (e.g., trauma and abuse) experiences that lead to distress and problematic drinking in the first place may shame women by locating the problem of AD in them and disregarding the significant emotional and social upheaval of moving away from a life without alcohol.

Narrative therapy, through collaborative and co-constructed conversations, may support women to verbalise the implicit 'story' behind their distress, which in doing so, becomes open to revision (Polkinghorne, 2004). Re-situating problems outside people (White & Epston, 1990) and questioning internalised, stigmatising (dominant) narratives could support women to make meaning from negative/shameful experiences, making them feel more manageable, and new

meanings and richer 'thicker' narratives of experiences to emerge. By loosening restrictive and negative 'thin' narratives (of shame), women might generate more flexible or alternative accounts of themselves and a 'preferred sense of identity or personhood' (White, 2007). Emergent ‘narratives of recovery' may not only help women to see themselves in a new way but be a resource for navigating a way forward and building a meaningful life.

Targeted interventions designed to increase shame resilience or ameliorate shame might be a helpful adjunct to other interventions (e.g., Hernandez & Mendoza, 2011). Given its relational emphasis, a psychodynamic approach might 'give shame light and air' through attunement, empathetic curiosity and story-making (DeYoung, 2015). Trauma-focused approaches, with a focus on empowerment of the survivor and restoration of relationships, may also have utility with this population (Covington, 2008). Given the centrality of self-forgiveness, acceptance and compassion in recovery narratives, other skills-based, relational approaches designed to build self-compassion or self-acceptance may be helpful, such as compassion-focused therapy (P. Gilbert, 2010) or ACT (Barnes et al., 2017). However, these interventions may need to be adapted to account for the shame in women and girls' lives as lived in a gender-discriminatory society.

4.2.2 Service Level

Despite the emphasis on equality within health care provision (NHS, 2019), the current research suggests a lack of appropriate support for women with AD in the UK. This study’s findings suggest shame is a barrier to accessing traditional alcohol treatment (AA, NHS-funded drug and alcohol support services), often predicated on adopting the ‘alcoholic’ identity. Women‘s needs are distinct (e.g., shame and stigma, trauma, mothering role, mental health difficulties) and are likely to be better addressed in trauma-informed services (Covington, 2008), rather than the generalist ‘one size fits all’ approach of many traditional alcohol treatment services (Salter & Breckenridge, 2014).

Innovation of specialist services is imperative to reduce the shame associated with attending said services and increasing access to women. This might include moving away from medicalised terminology and labels; offering support

anonymously (e.g., online platforms), a range of therapeutic approaches, greater flexibility regarding the number of sessions provided; and delivering services in community and primary care settings. Stronger links between psychological services and specialist services and training (on shame and women's AD) to health professionals (particularly GPs) is indicated.

Consistent with the limited research on online sobriety support groups (Davey, 2021), participants in this study reported online forums and quit literature (from the sober community) helped them to avoid judgement and shame because they could take in other women's stories anonymously before sharing their own (Chambers et al., 2017). For women for whom shame is a barrier to accessing traditional services, online sober groups and the sober community could be safer places to explore their relationship with alcohol, particularly in the early stages of change, and a stepping-stone to further support and viable alternative route to recovery. Clinicians or services might consider signposting to internet-based groups and social media, or adapting standard services based on the ideas and information from sobriety communities and groups. For instance, individual therapy is often prioritised within services; however, findings from this study suggest value in offering 'women-only' groups in clinical settings.

The benefits of mutual aid groups are indicated. This study supports those who postulate that AA may be less accessible for some women and highlight the need for alternatives or modifications to 12-step approaches that are (more) relatable for women (e.g., Hood, 2003; Sered & Norton-Hawk, 2011). Community-based approaches may also help confront the structural inequalities and stigma women face. Clinical psychologists could work alongside women with lived experience to develop and promote services or women-only community spaces (online or face-to-face) where they do not have to feel ashamed and can develop skills and build connections to support them to build a positive sense of identity.

4.2.3 Addressing the Wider Context

Smail (2005) argues psychologists must address the social-environmental powers and contexts that act on the individual to generate distress; reducing problematic shame for the individual would not resolve the relational and cultural role of

shaming in AD. The devalued position of the ‘alcoholic woman’ is continually constructed and promulgated in the media and governmental policies (e.g., McErlain, 2015; Patterson et al., 2016; T. L. Smith et al., 2021), including in public health campaigns that use tropes or stereotypes (pertaining to transgressive femininity) that are likely to perpetuate shame women feel about drinking, resulting in them drinking more, not less. The public telling of personal stories may be a tool to challenge societal narratives that devalue and shame women and increase public awareness of the oppressive contexts that give rise to AD, generating empathy, greater understanding and reducing the barriers to disclosure. This study suggests women are likely to benefit from a diverse range of culturally available narratives about AD and recovery, including narratives of moderation and sobriety. Promoting positive messages about sobriety might help counter sober shaming.

4.2.4 Considerations for Future Research

This study suggests future research should investigate shame and AD within the broader socio-cultural contexts and trajectory of women’s lives, e.g., using narrative, longitudinal or developmental life-course approaches. Participants described a process of restructuring their life stories, supporting them to feel less ashamed and develop a new sober identity. It could be helpful to extend this research by tracking individual participants’ stories as they continue their journey to map how their stories change over time in response to life events and specific interventions/forms of support, with particular attention to how shame features. Further investigation into gendered shame-management strategies (self-silencing) could be fertile ground for research into women and AD.

This study focuses on personal stories, with less attention to the negotiation of shame between stories and comments in, for example, online sober communities or interviews. Conducting future research on narrative interaction is likely to increase knowledge in this field.

How participants drew on 'treatment' or societal narratives (sobriety/’addiction’) to make sense of their own experiences seemed to have implications for shame and identity. Exploring how women in recovery take up and resist societal and treatment narratives or discourses may be fruitful, particularly in the context of

bourgeoning alternative narratives in the sobriety movement. Future research could explore the relative absence of developed ‘stories of moderation’ in British culture and what impact this might have on women pursuing this path to recovery.

Women’s sobriety support groups emerged as a viable, even preferable, recovery pathway. Further research could explore the components identified in this study that seemed to help participants resist shame, namely positivity, future-orientated ways of talking and online forums. Sober shaming emerged in this study and could be a productive area for future research as this has received limited attention in the literature. It might be beneficial to explore the strengths and limitations of women’s sobriety groups and more traditional approaches like AA, and demographic differences between them.

In line with the above, future research could explore shame in the recovery stories of women from minoritised or materially disadvantaged groups. It might be helpful to cross-tabulate how shame features across the stories of women from different backgrounds or men to identify any key differences to inform treatment and support. Alternative research approaches, such as participatory action research might increase opportunities for women’s voices to be heard and give them greater control of the narrative.

‘Recovery capital’ and the development of supportive personal and social relationships feature centrally in UK policy and guidance (HM Government, 2010). Thus far, this has not been translated into the needs of women in research or practice (e.g., Hennessy, 2017). This study’s findings suggest it is a highly relevant concept in women’s recovery; being supported by those with shared identity characteristics was found to facilitate recovery (Haslam et al., 2005; Jetten et al., 2014), and homogeneous groups (e.g., with strict rules about abstinence) could be experienced as exclusionary for women already holding a shamed identity in event of relapse (Zmerli, 2010). Further examination into the link between the quality and quantity of women’s relationships and shame, disclosure and recovery from AD is warranted.

4.3 Critical Review and Limitations

This section will evaluate the research by considering methodological and epistemological limitations and the quality and transferability of the study.

4.3.1 Methodological Reflexivity

4.3.1.1 Recruitment

Recruitment through an online women's sobriety group may have influenced the findings in terms of participant self-selection. Participants encountered barriers and experienced disillusionment with more traditional (male-dominated) support, such as AA. Therefore, issues of shame and gender might have been more pronounced in this sample and the online setting and sobriety community may have been more appealing and accessible. In line with previous research on sobriety-based support groups, participants identified as white, were educated to university level, and the majority were in paid employment (Davey, 2021). Those without access to the internet, computer literacy and proficiency in the English language might not have been able to access the online sober community or the research study.

Marginalised groups face additional stigma and barriers to support (e.g., street homeless, lesbians and women from minoritised ethnic backgrounds, e.g., Kougiali et al., 2019; Pinedo, 2019; Weston et al., 2018). Shame may feature differently or be more prominent in the stories of women experiencing stigma from multiple identities (i.e., possible internalisation of shame from homophobia/racism) or with fewer resources and less privilege (i.e., financial/social). Alternatively, women from more privileged backgrounds by race or class may perceive they have more to protect and, therefore, more to lose, possibly increasing feelings of shame about alcohol use (e.g., Sanders, 2011).

4.3.1.2 Suitability and execution of the narrative method

The literature reports no definitional consensus on shame and limitations with the use of self-report for investigating shame (Wiechelt, 2007). Researchers argue shame is often experienced at an implicit level, the painfulness of the experience and associated behavioural tendencies of hiding make it difficult to acknowledge

and consciously report (Else-Quest et al., 2012; Scheff, 1988). Therefore, it is important to acknowledge the interpretative work in identifying shame. The language of shame featured less in Linda and Katie's stories, offering several possible interpretations – they were not cognizant of experiences of shame, shame was not a significant part of their experience, or they had worked through shame. As a 'fluid form of research' (Craig, 2012, p. 91), NA was considered especially adept at making inferences about shame or absence thereof. Consideration of the 'how' (and 'what') of women's life stories allowed for analysis of shame in participants' socio-cultural, personal and interview contexts.

Nevertheless, the flexibility presented a challenge for a novice narrative researcher (McCormack, 2004). At times, I felt uncomfortable with the lack of clear guidelines and power I held as a researcher in determining shame or a narrative, recognising that my interpretations were inevitably shaped by socio-cultural expectations and position within these. The research context (as a requirement for a clinical psychology doctorate) brought restrictions on time, word count and financial remuneration. NA is an uneasy fit with more traditional research paradigms in clinical psychology (e.g., with predetermined analytic steps) and exceptionally in-depth and time-consuming.

While NA produced rich, varied and individual details of experience, inevitably, given the scope of the research I was unable to use all the data or present individual stories. I was drawn towards keeping the stories as they were rather than dissect them; I worried my search for integrating themes and theory might undermine the idiosyncratic voice of participants (Bute & Jensen, 2011). More participants expressed interest in the study than anticipated, yet I considered, on balance, I had an ethical obligation to honour every request for participation. On reflection, a smaller number of participants may have allowed for the presentation of greater nuance and richness of individual stories and attention to differences. Nevertheless, I tried to weave together individual stories to honour the particularity of each and best answer the research question.

As the interviewer, I will have contributed to what was said with my verbal and non-verbal input and by actively or passively invoking identities that provided the

framework for speech (Mishler, 1986; Ochs, 1997; Pomerantz & Fehr, 1997). The possible impact of my female identity has already been discussed elsewhere (Section 2.7.). My status as a clinician may have influenced participants' deployment of medicalised terminology or exacerbated the power differentials (Oakley, 1981; H. Richards & Emslie, 2000); many participants assumed knowledge (*'as you probably know', 'as you will have heard of'*). However, my professional status may have helped participants feel safe as they described positive experiences of therapy and my student status and visible age may have helped reduce the power differential. I made explicit my role as a researcher and attempted to maintain this boundary during the interviews. While my role in producing stories factored into the analysis, it is less visible in the results given the space limitations and it was not the focus of the research.

The narrative interview method seemed to support participants to share experiences they perceived as shameful. Two participants disclosed specific details (e.g., sexual abuse, drunk driving) at the end of the interview, perhaps due to feeling safer as the interview progressed. Interviews were online (telephone or video call) due to the Covid-19 pandemic. The anonymity of telephone/online interviews may have facilitated participation from those who might otherwise find it too shaming. As participation was not contingent on location, a wide net was cast in terms of potential participants.

While interviewing, I attempted to balance avoiding directing the narrative too much with my interjections while letting participants know I was still present and listening; this was more challenging over the telephone. I was concerned that a lack of visual cues might affect trust building. However, no apparent differences were observed in the stories between the two formats, although I wondered whether the therapeutic benefits for those participants opting for telephone calls might not be as significant. Online interviews allowed participants greater control over their own space and privacy (Holt, 2010): one participant took a comfort break and returned when ready. Several participants lived busy lives (employment/caring responsibilities); the ability to call at a convenient time allowed for greater flexibility, which likely supported participation.

4.3.2 Epistemological Reflexivity

Adopting critical realist positioning involves treating certain aspects of the data as 'real' and others 'relativist' (Burr, 2015). As discussed in Section 2.7, my political orientation influenced how I positioned things as 'real' or 'relativist' (Nightingale & Cromby, 1999b). I treated participants' stories as about 'something happening', but in a complex and non-referential way. I might have inadvertently taken more of a realist position, running the risk of ontological fallacy[5], as I noticed some reluctance to treat participants' accounts with suspicion or extrapolate too far from their intended meanings. I reflected on my position of power imposing labels, using terms like 'alcohol dependence', which participants had to accept, to a certain extent, for their stories to be heard. I tried to mitigate the above through supervision and reflexive logs, using a range of terms (problem drinking, AD)/participants' language in the interview and analysis. In future research I would seek greater collaboration with women with lived experience to consult on the language adopted and analysis.

Narrative theory suggests narratives could help us understand why we continue certain behaviours (e.g., drinking alcohol; Presser & Sandberg, 2015). However, there is not a straightforward relationship between what stories people tell and what they do and not all stories have the same degree of power to generate action (i.e., not drinking; Crossley, 2000; Sayer, 2000). As evident in this study, the constraints of the material world or culturally available narratives determined what stories could be told and the utility of a story at any given time.

Critics of NA argue there is a risk of over-personalising the narrative in reifying the 'interior self' and idealising individual agency (P. Atkinson & Silverman,1997; Bury, 2001). Conversely, relativist approaches can be critiqued for presenting people as mere discursive subject positions, events or assemblages (e.g., Bloomfield & Vurdubakis 1999; Musson et al., 2007), lacking the theoretical basis for 'internal' capabilities such as emotion or reflexivity - from this position, it is difficult to conceptualise how resistance can occur (Fleetwood, 2008). This study highlights the benefits of combining narrative and critical realist understandings of identity.

[5] Ontological fallacy: mistakenly assuming something exists by viewing content in straightforward, referential terms

Identity was not static but situated within culture, time and relationships. However, participants narrated a continuous, authentic sense of self over time in their stories. How they storied ‘the self’ seemed to have implications for sobriety: participants who presented a static, negative sense of self spoke with less hope and certainty about sobriety, suggesting that self-flexibility and the belief that the self can change supports recovery.

4.3.3 Quality in Qualitative Research

The reader is invited to evaluate this as one of many possible readings and a retelling of the participants' stories (Lieblich et al., 1998). Nevertheless, several procedures were put in place to ensure the credibility and trustworthiness of the study (Shenton, 2004). Yardley's (2007) criteria was used as a framework for evaluating the quality of the research (Appendix Q). These criteria and how they were met, are detailed below.

4.3.3.1 Sensitivity to Context

In line with NA, interpretations were made with reference to the findings from an extensive literature review and critical engagement with 'the situated nature of accounts, (...) the ways in which broader structures, contexts or ideologies (...) may shape these accounts' (Chandler, 2020, p. 45; i.e., drinking/gender norms, historical and recent developments in recovery, grand ‘addiction’ narratives). The dialogical nature of data production was factored into the analysis, including the use of a reflexive diary to explore the possible impact of the researcher's characteristics, professional status, and verbal/non-verbal prompts on participants.

4.3.3.2 Commitment and Rigour

NA included a detailed, in-depth and multi-level analysis of ‘what’ was said and ‘how’ the story was told (Riessman, 2005), allowing for exploration of the meaning and function of shame in AD over the lifespan from participants’ perspectives. Therefore, NA was sensitive to the relational, social and cultural aspects of shame, which may partially circumvent the limitations inherent in any single view on the topic. Narratives were identified with the research supervisor – highly experienced in NA. The supervisor was provided with detailed analysed transcripts and checked

the analysis for credibility at multiple points (e.g., coding and narrative development; Huberman & Mile, 1994).

4.3.3.3 Transparency and Coherence

Individual stories, analytic tables, thematic maps (Appendix P) and extracts from the researcher's reflexive diary (Appendix C) are included demonstrating the analytical procedures used. Data collection and details on each step of the narrative method are outlined (Section 2.5.; Appendix O). The presentation of data includes verbatim extracts from a variety of interviews. It is hoped the above facilitates transparency, providing a platform for the reader to assess the credibility of the inferences drawn (Potter, 1996). The researcher had frequent conversations in supervision to balance participants' experiences with the researcher's interpretations and ensure the data told a coherent story. Participant demographics were included to support the reader's understanding of the women interviewed.

4.3.3.4 Impact and Significance

This study intended to focus on the stories of a small number of women in recovery rather than generalising the findings to the whole population. The study's strength is the diversity of the sample in terms of the various methods of recovery/support utilised, age range and parenthood status given the predominance of studies with homogenous groups of women (e.g., lesbians/mothers) and AA samples in the field. The study centres the voices of women who recovered 'naturally' or with the sobriety community, which are mainly absent from the literature. Novel theoretical and clinical insights into shame, AD and recovery were gleaned, which are likely transferable across different groups of women across settings.

4.3.4 Personal Reflexivity and Summarising Comments

Personal reflexivity invites the researcher to consider how the process has changed them (Willig, 2001). I was struck by the participants' courage and desire to help other women and the power of listening to their personal stories, which generated deep empathy and compassion in me. I was humbled by how, in merely having space to tell their story and be heard, they reached their own understandings and solutions, which made me reflect on my role as a psychologist.

In time-limited, oversubscribed and under-resourced services, the emphasis is often on the application of models, skills or techniques offered by the therapist to ‘fix the problem’ in the individual. I wondered how service contexts are likely to be experienced as shaming and risk further silencing the voices of already oppressed groups.

In studying shame, I hope that we can shine a light on injustice, and the empathy cultivated by everyday stories of shame can be a source of resistance: ‘sometimes it [shame] leads to reactionary acts, sometimes it compels close inspection of how we live, and becomes the necessary force to catalyse an ethics of the everyday’ (Probyn, 2004, p. 346).

REFERENCES

Aaltonen, I., & MäKelä, K. (1994). Female and male life stories published in the Finnish Alcoholics Anonymous journal. *International Journal of the Addictions*, *29*(4), 485-495. https://doi.org/10.3109/10826089409047394

Afuape, T. (2011). *Power, resistance and liberation in therapy with survivors of trauma: To have our hearts broken*. Routledge. https://doi.org/10.4324/9780203806401

Allan, C. A., & Cooke, D. J. (1985). Stressful life events and alcohol misuse in women: A critical review. *Journal of Studies on Alcohol, 46*(2), 147–152. https://doi.org/10.15288/jsa.1985.46.147

Alter, A. L., & Hershfield, H. E. (2014). People search for meaning when they approach a new decade in chronological age. In S. T. Fiske (Ed.), *PNAS Proceedings of the National Academy of Sciences of the United States of America* (pp. 17066–17070). United States National Academy of Sciences. https://doi.org/10.1073/pnas.1415086111

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Andrews, B. (1998). Methodological and definitional issues in shame research. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 39–54). Oxford University Press

Andrews, M. (2020). Quality indicators in narrative research. *Qualitative Research in Psychology*, *18*(3), 1–16. https://doi.org/10.1080/14780887.2020.1769241

Atkinson, P., & Coffey, A. (2003). Revisiting the relationship between participant observation and interviewing. In J. F. Gubrium, & J. A. Holstein (Eds.), *Postmodern interviewing* (pp. 108–122). SAGE Publications. https://doi.org/10.4135/9781412985437.n6

Atkinson, P., & Silverman, D. (1997). Kundera's Immortality: The interview society and the invention of the self. *Qualitative Inquiry*, *3*(3), 304–325.

Atkinson, R. (2012). The life story interview as a mutually equitable relationship. In J. F. Gubrium, J. A. Holstein, A. B. Marvasti, & K. D. McKinney (Eds.), *The SAGE handbook of interview research* (2nd ed., pp. 115–128). Sage Publications. https://doi.org/10.4135/9781452218403.n8

Baker, T. B., Piper, M. E., McCarthy, D. E., Majeskie, M. R., & Fiore, M. C. (2004). Addiction motivation reformulated: An affective processing model of negative reinforcement. *Psychological Review*, *111*(1*)*, 33–51. https://doi.org/10.1037/0033-295X.111.1.33

Bakhtin, M. (1984). *Problems of Dostoevsky's poetics*. (C. Emerson, Trans.). University of Minneapolis Press.

Bakhtin, M., Gratchev, S. N. (Ed.), & Marinova, M. (Ed.). (2019). *Mikhail Bakhtin: The Duvakin interviews, 1973*. Bucknell University Press.

Bamberg, M. (2013). Identity and Narration. In P. Hühn (Ed.), *The living handbook of narratology*. Hamburg University. http://www.lhn.uni-hamburg.de/article/identity-and-narration

Banwell, C., & Bammer, G. (2006). Maternal habits: Narratives of mothering, social position and drug use. *International Journal of Drug Policy*, *17*(6), 504–513. https://doi.org/10.1016/j.drugpo.2006.09.005

Barnes, S. M., Smith, G. P., Monteith, L. L., Gerber, H. R., & Bahraini, N. H. (2017). ACT for life: Using Acceptance and Commitment Therapy to understand and prevent suicide. In U. Kumar (Ed.), *Handbook of suicidal behaviour* (pp. 485–504). Springer Nature Singapore Pte Ltd.. https://doi.org/10.1007/978-981-10-4816-6_26

Bartky, S. L. (1990). *Femininity and domination: Studies in the phenomenology of oppression*. New York, NY: Routledge.

Baumeister, R. F., Stillwell, A. M., & Heatherton, T. F. (1995). Personal narratives about guilt: Role in action control and interpersonal relationships. *Basic and Applied Social Psychology*, *17*(1–2), 173–198.

Beckman, L. J. (1980). Perceived antecedents and effects of alcohol consumption in women: June. *Journal of Studies on Alcohol*, *41*(5), 518–530. https://doi.org/10.15288/jsa.1980.41.518

Bellah, R. N., Madsen, R., Sullivan, W. M., Swidler, A., & Tipton, S. M. (1996). *Habits of the heart: Individualism and commitment in American life* (updated edition). University of California Press.

Beresford, P. (2015). The context for a social model of alcohol use. In P. Staddon. (Ed.), *Women and Alcohol: Social Perspectives* (pp. 17–29). Policy Press.

Bergström, M. (2017). ‘‘I could’ve had a better life’’: Reflective life reviews told by late-middle-aged and older women and men with ongoing long-term alcohol problems. *Nordic Studies on Alcohol and Drugs 2017*, *34*(1), 6–17. https://doi.org/10.1177/1455072516682436 journals.sagepub.com/home/nad

Best, D., & Laudet, A. (2010). *The Potential of Recovery Capital*. Royal Society of Arts.

Best, D., Beckwith, M., Haslam, C., Alexander Haslam, S., Jetten, J., Mawson, E., & Lubman, D. I. (2016). Overcoming alcohol and other drug addiction as a process of social identity transition: The social identity model of recovery (SIMOR). *Addiction Research & Theory*, *24*(2), 111–123. https://doi.org/10.3109/16066359.2015.1075980

Best, D., Gow, J., Taylor, A., Knox, A., & White, W. (2011). Recovery from heroin or alcohol dependence: A qualitative account of the recovery experience in Glasgow. *Journal of Drug Issues*, *41*(3), 359–377.

Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*(3), 221–228.

Bhaskar, R., & Hartwig, M. (2016). *Enlightened common sense: The philosophy of critical realism*. Routledge. https://doi.org/10.4324/9781315542942

Bhaskar, R. (1978). On the Possibility of Social Scientific Knowledge and the Limits of Naturalism. *Journal for the Theory of Social Behaviour*, *8*(1), 1–28. https://doi.org/10.1111/j.1468-5914.1978.tb00389.x

Biernacki, P. (1986). *Pathways from heroin addiction: Recovery without treatment*. Temple University Press.

Birtel, M. D., Wood, L., & Kempa, N. J. (2017). Stigma and social support in substance abuse: Implications for mental health and well-being. *Psychiatry Research*, *252*, 1–8. https://doi.org/10.1016/j.psychres.2017.01.097

Bloomfield, B. P., & Vurdubakis, T. (1999). The outer limits: monsters, actor networks and the writing of displacement. *Organization*, *6*(4), 625–647.

Blume, S. (1990). *Secret survivors: Uncovering incest and Its aftereffects in women*. Ballantine Books.

Bobbe, J. (2002). Treatment with lesbian alcoholics: Healing shame and internalized homophobia for ongoing sobriety. *Health & Social Work*, *27*(3), 218.

Bond, L. M., & Csordas, T. J. (2014). The paradox of powerlessness. *Alcoholism Treatment Quarterly, 32*(2–3), 141–156. https://doi.org/10.1080/07347324.2014.907050

Booth, A., Papaioannou, D., & Sutton, A. (2012). *Systematic approaches to a successful literature review*. Sage Publishing.

Boreham, M., Marlow, S., & Gilchrist, G. (2019). "That warm feeling that [alcohol] gave me was what I interpreted love would feel like…": Lived experience of excessive alcohol use and care proceedings by mothers in the family justice system in the UK. *Addictive Behaviors*, *92*, 186–193. https://doi.org/10.1016/j.addbeh.2018.12.032

Boyd, M. R., & Mackey, M. C. (2000). Alienation from self and others: The psychosocial problem of rural alcoholic women. *Archives of Psychiatric Nursing*, *14*(3), 134–141.

Boyd, E. (2010) “Voice entitlement” narratives in supervision: Cultural and gendered influences on speaking and dilemmas in practice. In C. Burck and G. Daniel (Eds.), *Mirrors and Reflections Processes of Systemic Supervision*. Karnac.

Brady, K. T., & Randall, C. L. (1999). Gender differences in substance use disorders. *Psychiatric Clinics of North America*, *22*(2), 241–252.

Brett, P. J., Graham, K., & Smythe, C. (1995). An analysis of specialty journals on alcohol, drugs and addictive behaviors for sex bias in research methods and reporting. *Journal of Studies on Alcohol*, *56*(1), 24–34.

Brewer, M. K. (2006). The contextual factors that foster and hinder the process of recovery for alcohol dependent women. *Journal of Addictions Nursing*, *17*(3), 175–180.

British Psychological Society. (2017). *Ethics guidelines for internet-mediated research*. http://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Ethics%20Guidelines%20for%20Internet-mediated%20Research.pdf

British Psychological Society. (2018). *Code of ethics and conduct*. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

Bronfenbrenner, U. (1979). The ecology of human development: History and perspectives. *Psychology, 19*(5), 537–549.

Brown, B. (2006). Shame Resilience Theory: A Grounded Theory Study on Women and Shame. *Families in Society, 87*(1), 43–52. https://doi.org/10.1606/1044-3894.3483

Brown, J. D. (1998) *The self*. McGraw-Hill.

Brown, J. D. (2006). Working the system: Re-thinking the institutionally organized role of mothers and the reduction of “risk” in child protection work. *Social Problems*, *53*(3), 352–370.

Brown, L. S. (1997). Ethics in psychology: Cui bono?. In D. Fox and I. Prilleltensky (Eds.) *Critical psychology: An introduction* (pp. 51-67). Sage Publications.

Brown, M. (2012). Empathy and punishment. *Punishment & Society*, *14*(4), 383–401. https://doi.org/10.1177/1462474512452507

Broyles, L. M., Binswanger, I. A., Jenkins, J. A., Finnell, D. S., Faseru, B., Cavaiola, A., & Gordon, A. J. (2014). Confronting inadvertent stigma and pejorative language in addiction scholarship: a recognition and response. *Substance Abuse*, *35*(3), 217–221.

Burns, V. F. (2021). The sober professor: Reflections on the sober paradox, sober phobia, and disclosing an alcohol recovery identity in academia. *Contemporary Drug Problems*, *48*(3), 223–240. https://doi.org/10.1177/00914509211031092

Burr, V. (2015). *Social constructionism* (3rd ed.*).* Routledge.

Bury, M. (2001). Illness narratives: Fact or fiction? *Sociology of Health & Illness*, *23*(3), 263–285. https://doi.org/10.1111/1467-9566.00252

Bute, J. J., & Jensen, R. E. (2011). Narrative sensemaking and time lapse: Interviews with low-income women about sex education. *Communication Monographs*, *78*(2), 212–232.

Cain, C. (1991). Personal stories: Identity acquisition and self-understanding in Alcoholics Anonymous**.** *Ethos Journal of the Society for Psychological Anthropology*, *19*(2), 210–253. https://doi.org/10.1525/eth.1991.19.2.02a00040

Campbell, N.D., & Ettorre, E. (2011). *Gendering addiction: The politics of drug treatment in a neurochemical world*. Palgrave MacMillan. https://doi.org/10.1057/9780230314245

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research*, *17*(10), 1316–1328. https://doi.org/10.1177/1049732307306927

Center for Substance Abuse Treatment. (2009). *Substance abuse treatment: Addressing the specific needs of women*. US Substance Abuse and Mental Health Services Administration. https://www.ncbi.nlm.nih.gov/books/NBK83251/

Chambers, S. E., Canvin, K., Baldwin, D. S., & Sinclair, J. (2017). Identity in recovery from problematic alcohol use: A qualitative study of online mutual aid. *Drug and Alcohol Dependence*, *174*, 17–22. https://doi.org/10.1016/j.drugalcdep.2017.01.009

Chandler, A. (2020). Shame as affective injustice: Qualitative, sociological explorations of self-harm, suicide and socioeconomic inequalities. In M. E. Button & I. Marsh (Eds.), *Suicide and social justice: New perspectives on the politics of suicide and suicide prevention* (pp. 32–49). Routledge/Taylor & Francis Group. https://doi.org/10.4324/9780429460494-3

Chase, E., & Walker, R. (2013). The co-construction of shame in the context of poverty: Beyond a threat to the social bond. *Sociology*, *47*(4), 739–754.

Cibich, M., Woodyatt, L., & Wenzel, M. (2016). Moving beyond “shame is bad”: How a functional emotion can become problematic. *Social and Personality Psychology Compass, 10*(9), 471–483. https://doi.org/10.1111/spc3.12263

Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use & Misuse*, *43*(12–13), 1971–1986. https://doi.org/10.1080/10826080802289762

Collins, S. E., Clifasefi, S. L., Nelson, L. A., Stanton, J., Goldstein, S. C., Taylor, E. M., King, V. L., Hatsukami, A. S., & Cunningham, Z. L. (2019). Randomized controlled trial of Harm Reduction Treatment for Alcohol (HaRT-A) for people experiencing homelessness and alcohol use disorder. *International Journal on Drug Policy*, *67*, 24–33.

Cook, D. R. (1987). Measuring shame: The internalized shame scale. *Alcoholism Treatment Quarterly, 4*(2), 197–215. https://doi.org/10.1300/J020v04n02_12

Cook, D. R. (1996). Empirical studies of shame and guilt: The internalized shame scale. In D. L. Nathanson (Ed.), *Knowing feeling: Affect, script, and psychotherapy* (pp. 132–165). W. W. Norton & Company.

Copeland, J. (1998). A qualitative study of self-managed change in substance dependence among women. *Contemporary Drug Problems*, *25*(2), 321–345. https://doi.org/10.1177/009145099802500204

Corrigan, P., Schomerus, G., Shuman, V., Kraus, D., Perlick, D., Harnish, A., Kulesza, M., Kane-Willis, K., Qin, S., & Smelson, D. (2017). Developing a research agenda for understanding the stigma of addictions Part I: Lessons from the mental health stigma literature. *The American Journal on Addictions*, *26*(1), 59–66. https://doi.org/10.1111/ajad.12458

Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training, 41*(4), 412–425. https://doi.org/10.1037/0033-3204.41.4.412

Covington, S. (1994). *A woman's way through the twelve steps*. Hazelden.

Covington, S. S. (2007). Women and the criminal justice system. *Women's health issues: official publication of the Jacobs Institute of Women's Health*, *17*(4), 180–182. https://doi.org/10.1016/j.whi.2007.05.004

Covington, S. S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs*, *5*, 377–385. https://doi.org/10.1080/02791072.2008.10400665

Covington, S. S., & Kohen, J. (1984). Women, alcohol, and sexuality. *Advances in Alcohol & Substance Abuse, 4*(1), 41–56. https://doi.org/10.1300/J251v04n01_05

Covington, S., & Surrey, J. (2000). *The relational model of women's psychological development: Implications for substance abuse*. Stone Center Working Paper Series.

Craig, C. J. (2012). "Butterfly under a pin": An emergent teacher image and mandated curriculum reform. *The Journal of Educational Research*, *105*(2), 90–101.

Crossley, M. L. (2000). *Introducing narrative psychology: Self, trauma and the construction of meaning*. Open University Press.

Crossley, M. L. (2007). Narrative analysis. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 131–144). Sage.

Crossley, M. L. (2009). Breastfeeding as a moral imperative: An autoethnographic study. *Feminism & Psychology*, *19*(1), 71–87. https://doi.org/10.1177/0959353508098620

Crozier, R. (1998). Self-consciousness in shame: The role of the 'other'. *Journal for The Theory of Social Behaviour, 28*(3), 273–286.

Cunningham, J. (2012). A Qualitative Study of Gender-Based Pathways to Problem Drinking in Dublin, Ireland, *Ir J Psych Med*, *29*(3), 163–170

Cutcliffe, J. R., & Ramcharan, P. (2002). Leveling the playing field? Exploring the merits of the ethics-as-process approach for judging qualitative research proposals. *Qualitative Health Research*, *12*(7), 1000–1010. https://doi.org/10.1177/104973202129120313

Davey, C. (2021). Online sobriety communities for women's problematic alcohol use: A mini review of existing qualitative and quantitative research. *Frontiers in Global Women's Health*, *2.* https://doi.org/10.3389/fgwh.2021.773921

Davis, D. R. (1997). Women healing from alcoholism: A qualitative study. *Contemporary Drug Problems*, *24*(1), 147–177. https://doi.org/10.1177/009145099702400108

Day, K., Gough, B., & McFadden, M. (2004). Warning! Alcohol can seriously damage your feminine health: A discourse analysis of recent British newspaper coverage of women and drinking. *Feminist Media Studies*, *4*(2), 165–185.

Dayal, H., Weaver, K., & Domene, J. F. (2015). From shame to shame resilience: Narratives of counselor trainees with eating issues. *Qualitative Health Research*, *25*(2), 153–167. https://doi.org/10.1177/1049732314551988

de Visser, R. O., & McDonnell, E. J. (2012). 'That's OK. He's a guy': A mixed-methods study of gender double-standards for alcohol use. *Psychology & Health*, *27*(5), 618–639. https://doi.org/10.1080/08870446.2011.617444

Dearing, R. L., & Tangney, J. P. (Eds.). (2011). *Shame in the therapy hour*. American Psychological Association.

Dearing, R. L., Stuewig, J., & Tangney, J. P. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use. *Addictive Behaviours*, *30*(7), 1392–1404. https://doi.org/10.1016/j.addbeh.2005.02.002

Dekkers, A., De Ruysscher, C., & Vanderplasschen, W. (2020). Perspectives on addiction recovery: Focus groups with individuals in recovery and family members. *Addiction Research & Theory, 28*(6), 526–536. https://doi.org/10.1080/16066359.2020.1714037

Denzin, N. K. (1987). *The recovering alcoholic*. Sage Publications.

DeYoung, P. A. (2015). *Understanding and treating chronic shame: A relational/neurobiological approach*. Routledge.

Dingle, G. A., Cruwys, T., & Frings, D. (2015). Social identities as pathways into and out of addiction. *Frontiers in Psychology*, *6*, Article 1795.

Doty-Sweetnam, K. & Morrissette, P. (2016). Alcohol abuse recovery through the lens of Manitoban First Nations and Aboriginal women: A qualitative study. *Journal of Ethnicity in Substance Abuse*, *17*(3), 237–254. https://doi.org/10.1080/15332640.2016.1138268

Drury, J., & Reicher, S. (2005). Explaining enduring empowerment: A comparative study of collective action and psychological outcomes. *European Journal of Social Psychology*, *35*(1), 35–58.

Drury, J., Cocking, C., Beale, J., Hanson, C., & Rapley, F. (2005). The phenomenology of empowerment in collective action. *British Journal of Social Psychology*, *44*(3), 309–328.

Dykes, F. (2005). ‘Supply’ and ‘demand’: Breastfeeding as labour. *Social Science & Medicine*, *60*(10), 2283–2293.

Eagly, A. H., Wood, W., & Diekman, A. B. (2000). Social role theory of sex differences and similarities: A current appraisal. In T. Eckes & H. M. Trautner (Eds.), *The developmental social psychology of gender* (pp. 123–174). Lawrence Erlbaum Associates.

Eliason, M. J., & Skinstad, A. H. (1994). Drug/alcohol addictions and mothering. *Alcoholism Treatment Quarterly*, *12*(1), 83–96.

Elliott, J. (2005). *Using narrative in social research: Qualitative and quantitative approaches*. Sage Publications. https://doi.org/10.4135/9780857020246

Else-Quest, N. M., Higgins, A., Allison, C., & Morton, L. C. (2012). Gender differences in self-conscious emotional experience: A meta-analysis. *Psychological Bulletin*, *138*(5), 947.

Etherington, K. (2008) *Trauma, Drug Misuse and Transforming Identities: A Life Story Approach*. Jessica Kingsley Publishers.

Etherington, K. (2014). *A view of narrative recovery* [PowerPoint slides]. SlideServe. https://www.slideserve.com/irisa/a-view-of-narrative-inquiry

Ettorre, B. (1989). Women and substance use/abuse: Towards a feminist perspective or how to 35 make dust fly. *Women's Studies International Forum*, *12*(6), 593–602.

Ettorre, E. (1997). *Women and alcohol: From a private pleasure to a public problem?* Women's Press.

Ettorre, E. (2015). Embodied deviance, gender, and epistemologies of ignorance: Re-visioning drug use in a neurochemical, unjust world. *Substance Use & Misuse*, *50*(6), 794–805. https://doi.org/10.3109/10826084.2015.978649

Fillmore, K. M. (1984). "When angels fall": Women's drinking as cultural preoccupation and as reality. In S. C. Wilsnack & L. J. Beckman (Eds.), *Alcohol problems in women: Antecedents, consequences, and intervention* (pp. 7-36). Guilford Press.

Finlay, L. & Gough, B. (2008). *Reflexivity: A practical guide for researchers in health and social sciences*. Wiley.

Fleetwood, S. (2008). Structure, institution, agency, habit, and reflexive deliberation. *Journal of Institutional Economics*, *4(2), 183-203. https://doi.org/10.1017/S1744137408000957*

Frank, A. W. (1995). *The wounded storyteller: Body, illness, and ethics*. The University of Chicago.

Frank, A. W. (2012). Practicing dialogical narrative analysis. In J. A. Holstein & J. F. Gubrium (Eds.), *Varieties of narrative analysis* (pp.33–52). Sage.

Frank, L. E., & Nagel, S. K. (2017). Addiction and moralization: The role of the underlying model of addiction. *Neuroethics*, *10*(1), 129–139. https://doi.org/10.1007/s12152-017-9307-x

Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press.

Friedli, L. (2009). *Mental health, resilience and inequalities*. WHO Regional Office for Europe. https://apps.who.int/iris/handle/10665/107925

Gergen, K. J., & Gergen, M. M. (1988). Narrative and the self as relationship. *Advances in Experimental Social Psychology*, *21*, 17–56.

Gilbert, K. (2002). Taking narrative approach to grief research: Finding meaning in stories. *Death Studies*, *26*(3), 223–239. https://doi.org/10.1080/07481180211274

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*(3), 199–208.

Gilbert, P. (2010). *Compassion-focused therapy: The CBT-distinctive features series*. Routledge.

Gilbert, P., & McGuire, M. T. (1998). Shame, status, and social roles: Psychobiology and evolution. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 99–125). Oxford University Press.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy*, *13*(6), 353–379. https://doi.org/10.1002/cpp.507

Goffman, E. (1963). Embarrassment and social organization. In N. J. Smelser & W. T. Smelser (Eds.), *Personality and social systems* (pp. 541–548). John Wiley & Sons Inc. https://doi.org/10.1037/11302-050

Goffman, E. (1967). *Interaction ritual: Essays on face-to-face Behavior*. Aldine Publishing Company.

Goldberg, M. E. (1995). Substance-abusing women: False stereotypes and real needs. *Social work*, *40*(6), 789–798.

Grant, B. F., Chou, S. P., Saha, T. D., Pickering, R. P., Kerridge, B. T., Ruan, W. J., Huang, B., Jung, J., Zhang, H., Fan, A., & Hasin, D. S. (2017). Prevalence of 12-Month Alcohol Use, High-Risk Drinking, and DSM-IV Alcohol Use Disorder in the United States, 2001–2002 to 2012–2013: Results From the national epidemiologic survey on alcohol and related conditions. *JAMA psychiatry*, *74*(9), 911–923. https://doi.org/10.1001/jamapsychiatry.2017.2161

Greenfield, S. F., Brooks, A. J., Gordon, S. M., Green, C. A., Kropp, F., McHugh, R. K., & Miele, G. M. (2007). Substance abuse treatment entry, retention, and outcome in women: A review of the literature. *Drug and alcohol dependence*, *86*(1), 1–21.

Grucza, R. A., Sher, K. J., Kerr, W. C., Krauss, M. J., Lui, C. K., McDowell, Y. E., & Bierut, L. J. (2018). Trends in adult alcohol use and binge drinking in the early 21st-century United States: A meta-analysis of 6 National Survey Series. *Alcoholism: Clinical and Experimental Research*, *42*(10), 1939–1950.

Haigh, F., Kemp, L., Bazeley, P. & Haigh, N. (2019). Developing a critical realist informed framework to explain how the human rights and social determinants of health relationship works. *BMC Public Health*, *19*, Article 1571. https://doi.org/10.1186/s12889-019-7760-7

Hanninen, V., & Koski-Jannes, A. (1999). Narratives of recovery from addictive behaviours. *Addiction*, *94*(12), 1837–1848.

Hanpatchaiyakul, K., Eriksson, H., Kijsomporn, J., & stlund, G. (2017). Lived experience of Thai women with alcohol addiction. *Asian Nursing Research*, *11*(4), 304–310.

Harper, D. (2011). Choosing a qualitative research method. In Harper, D. & Thompson, R., A. (Eds.). *Qualitative research methods in mental health and psychotherapy: A Guide for students and practitioners* (pp.83–99). Wiley-Blackwell.

Harré, R. (1990). Embarrassment: A conceptual analysis. In W. R. Crozier (Ed.), *Shyness and embarrassment: Perspectives from social psychology* (pp. 181–204). Cambridge University Press. https://doi.org/10.1017/CBO9780511571183.007

Harvard Medical School (2011). *Alcohol use and abuse: Special report*. Harvard University Press.

Haslam, S. A., O'Brien, A., Jetten, J., Vormedal, K., & Penna, S. (2005). Taking the strain: Social identity, social support, and the experience of stress. *British Journal of Social Psychology, 44*(3), 355–370. https://doi.org/10.1348/014466605X37468

Heather, N., Field, M., Moss, A. C. & Satel, S. (2022). *Evaluating the Brain Disease Model of Addiction* (1st ed.). Routledge.

Hennessy, E. A. (2017). Recovery capital: A systematic review of the literature. *Addiction Research & Theory*, *25*(5), 349–360.

Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror* (2nd ed.). Basic Books.

Hernandez, V. R. & Mendoza, C. T. (2011). Shame resilience: A strategy for empowering women in treatment for substance abuse. *Journal of Social Work Practice in the Addictions*, *11*(4), 375–393. https://doi.org/10.1080/1533256X.2011.622193

Hester R., Lenberg K., Campbell W., & Delaney H. (2013). Overcoming addictions: A web-based application, and SMART recovery: An online and in-person mutual help group for problem drinkers, part 1: three-month outcomes of a randomized controlled trial. *Journal of Medical Internet Research*, *15*(e134). https://doi.org/10.2196/jmir.2565

Hill, J., & Leeming, D. (2014). Reconstructing 'the alcoholic': Recovering from alcohol addiction and the stigma this entails. *International Journal of Mental Health and Addiction, 12*, 759–771. https://doi.org/10.1007/s11469-014-9508-z

HM Government. (2010). Drug strategy 2010 reducing demand, restricting supply, building recovery: Supporting people to live a drug free life. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf

Holly, J. (2017). *Mapping the Maze: Services for women experiencing multiple disadvantage in England and Wales*. Agenda & AVA.

Holstein, J. A., & Gubrium, J. F. (1995). *The active interview.* Sage Publications, Inc. https://doi.org/10.4135/9781412986120

Holstein, J. A., & Gubrium, J. F. (2000). *The self we live by: Narrative identity in a postmodern world*. Oxford University Press.

Holt, A. (2010). Using the telephone for narrative interviewing: a research note. *Qualitative Research*, *10*(1), 113–121. https://doi.org/10.1177/1468794109348686

Hood, C. D. (2003). Women in recovery from alcoholism: The place of leisure. *Leisure Sciences*, *25*(1), 51–79.

Huberman, A. M., & Miles, M. B. (1994). Data management and analysis methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 428–444). Sage Publications.

Hull, J. G., Young, R. D., & Jouriles, E. (1986). Applications of the self-awareness model of alcohol consumption: Predicting patterns of use and abuse. *Journal of Personality and Social Psychology, 51*(4), 790–796. https://doi.org/10.1037/0022-3514.51.4.790

Humphreys, K., & Klaw, E. (2001). Can targeting nondependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the moderation management self-help/mutual aid organization. *Journal of Studies on Alcohol and Drugs*, *62*(4), 528–532. https://doi.org/10.15288/jsa.2001.62.528

Jack, D. C., & Ali, A. (Eds.). (2010). *Silencing the self across cultures: Depression and gender in the social world*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195398090.001.0001

Jacobs, L., & Jacobs, J. (2015). “Fixing” mothers who drink: Family narratives on secrecy, shame and silence. *The Open Family Studies Journal*, *7*(1), 28–33.

Jacobs, L., Naidoo, A., & Reddy, P. (2012). Crossing the invisible line: exploring women's secretive alcohol dependence and barriers to accessing treatment. *Journal of Psychology in Africa*, *22*(3), 441–445.

Jakobsson, A., Hensing, G., & Spak, F. (2008). The role of gendered conceptions in treatment seeking for alcohol problems. *Scandinavian Journal of Caring Sciences*, *22*(2), 196–202. https://doi.org/10.1111/j.1471-6712.2007.00513.x

Jetten, J., Haslam, C., Haslam, S., Dingle, G., & Jones, J. (2014). How groups affect our health and well-being: The path from theory to policy. *Social Issues and Policy Review*, *8*(1), 103–130. https://doi.org/10.1111/sipr.12003

Johnstone, L. (2017). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, *58*(1), 30–46. https://doi.org/10.1177/0022167817722230

Johnstone, L. (2020). General patterns in the power–threat–meaning framework: Principles and practice. *Journal of Constructivist Psychology*, *35*(1), 16–26. https://doi.org/10.1080/10720537.2020.1773358

Kaminer, D. (2006). Healing processes in trauma narratives: A review. *South African Journal of Psychology, 36*(3), 481–499. https://doi.org/10.1177/008124630603600304

Karnieli-Miller, O., Strier, R., & Pessach, L. (2009). Power relations in qualitative research. *Qualitative Health Research*, *19*(2), 279–289. https://doi.org/10.1177/1049732308329306

Kasabova, A. (2017). From shame to shaming: Towards an analysis of shame narratives. *Open Cultural Studies*, *1*(1), 99–112. https://doi.org/10.1515/culture-2017-0010

Kaskutas, L. A. (1994). What do women get out of self-help? Their reasons for attending Women for Sobriety and Alcoholics Anonymous. *Journal of Substance Abuse Treatment*, *11*(3), 185–195. https://doi.org/10.1016/0740-5472(94)90075-2

Kaskutas, L. A., Borkman, T. J., Laudet, A., Ritter, L. A., Witbrodt, J., Subbaraman, M. S., Stunz, A., & Bond, J. (2014). Elements that define recovery: The experiential perspective. *Journal of Studies on Alcohol and Drugs*, *75*(6), 999–1010. https://doi.org/10.15288/jsad.2014.75.999

Kaufman, G. (1992). *Shame: The power of caring*. Schenkman Books Inc.

Kelly, J. F., Saitz, R., & Wakeman, S. (2016). Language, substance use disorders, and policy: The need to reach consensus on an “Addiction-ary”. *Alcoholism Treatment Quarterly*, *34*(1), 116–123. https://doi.org/10.1080/07347324.2016.1113103

Keltner, D. (1995). Signs of appeasement: Evidence for the distinct displays of embarrassment, amusement, and shame. *Journal of Personality and Social Psychology, 68*(3), 441–454. https://doi.org/10.1037/0022-3514.68.3.441

Keltner, D., Young, R. C., & Buswell, B. N. (1997). Appeasement in human emotion, social practice, and personality. *Aggressive Behavior: Official Journal of the International Society for Research on Aggression*, *23*(5), 359–374.

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard Review of Psychiatry*, *4*(5), 231–244. https://doi.org/10.3109/10673229709030550

Killingsworth, B. (2006). ‘Drinking stories’ from a playgroup: Alcohol in the lives of middle-class mothers in Australia. *Ethnography*, *7*(3), 357–384.

Klaw, E., & Humphreys, K. (2000). Life stories of Moderation Management mutual help group members. *Contemporary Drug Problems*, *27*(4), 779–803.

Kohn, C. (2002). Important to recognize that addiction abuse in females is different. *Women’s Health Weekly*, *11*, 8–9.

Kougiali, Z. G. (2015). Reordered narratives and the changes in self-understanding from addiction to recovery. In R. Piazza & A. Fasulo (Eds.), *Marked identities* (pp. 149–169). Palgrave Macmillan.

Kougiali, Z. G., Fasulo, A., Needs, A. & Van Laar, D. (2017). Planting the seeds of change: Directionality in the narrative construction of recovery from addiction. *Psychology & Health*, *32*(6), 639–664.

Kougiali, Z. G., Pytlik, A., & Soar, K. (2021). Mechanisms and processes involved in women's pathways into alcohol dependence and towards recovery: A qualitative meta-synthesis. *Drugs: Education, Prevention and Policy*, *28*(5), 437–453. https://doi.org/10.1080/09687637.2021.1904836

Kougiali, Z., Soar, K., Pytlik, A., Brown, J., Wozniak, K., Nsumba, F., Wilkins, T., Oliva, E., Osunsanya, S., Clarke, C., Casalotti, S., & Pendry, B. (2019). Jigsaw Recovery: The Spatio-temporalities of alcohol abuse and recovery in a non-interventionist, peer-led service. *Alcoholism Treatment Quarterly*, *38*(2), 165–183. https://doi.org/10.1080/07347324.2019.1686960

Langeland, W., & Hartgers, C. (1998). Child sexual and physical abuse and alcoholism: A review. *Journal of Studies on Alcohol, 59*(3), 336–348. https://doi.org/10.15288/jsa.1998.59.336

Laudet, A. B. (2008). The road to recovery: Where are we going and how do we get there? Empirically driven conclusions and future directions for service development and research. *Substance use & misuse*, *43*(12–13), 2001-2020. https://doi.org/10.1080/10826080802293459

Leeming, D. & Boyle, M. (2004). Shame as a social phenomenon: A critical analysis of the concept of dispositional shame. *Psychology and Psychotherapy: Theory, Research & Practice*, *77*(3), 375–396.

Leshner, A. I. (1997). Addiction is a brain disease, and it matters. *Science*, *278*(5335), 45–47. https://doi.org/10.1126/science.278.5335.45

Letherby, G. (2002). Claims and disclaimers: Knowledge, reflexivity and representation in feminist research. *Sociological Research Online*, *6*(4), 81–93. https://doi.org/10.5153/sro.665

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board task force report. *American Psychologist, 73*(1), 26–46. https://doi.org/10.1037/amp0000151

Lewis, H. B. (1971). Shame and guilt in neurosis. *Psychoanalytic Review, 58*(3), 419–438.

Lewis, M. (1995). *Shame: The exposed self*. Simon and Schuster.

Lex, B. W. (1991). Some gender differences in alcohol and polysubstance users. *Health Psychology*, *10*(2), 121.

Lex, B. W. (1994). Alcohol and other drug abuse among women. *Alcohol Health and Research World*, *18*(3), 212.

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis, and interpretation*. Sage.

Lillie, N. (2002). Women, alcohol, self-concept and self-esteem: A qualitative study of the experience of person-centred counselling. *Counselling and Psychotherapy Research*, *2*(2), 99–107.

Lisansky Gomberg, E. S. (1988). Shame and guilt issues among women alcoholics. *Alcoholism Treatment Quarterly*, *4*(2), 139–155. https://doi.org/10.1300/J020v04n02_09

Long, A. & Mullen, B. (1994). An exploration of women's perceptions of the major factors that contributed to their alcohol abuse. *Journal of Advanced Nursing,19*(4), 623–39. https://doi.org/10.1111/j.1365-2648.1994.tb01132.x

Loseke, D. R. (2007). The study of identity as cultural, institutional, organizational, and personal narratives: Theoretical and empirical integrations. *The Sociological Quarterly*, *48*(4), 661–688. https://www.jstor.org/stable/40220047

Luoma, J. B., Chwyl, C., & Kaplan, J. (2019). Substance use and shame: A systematic and meta-analytic review. *Clinical Psychology Review*, *70*, 1–12. https://doi.org/10.1016/j.cpr.2019.03.002

Luoma, J. B., Guinther, P. M., Lawless DesJardins, N. M., & Vilardaga, R. (2018). Is shame a proximal trigger for drinking? A daily process study with a community sample. *Experimental and Clinical Psychopharmacology*, *26*(3), 290–301. https://doi.org/10.1037/pha0000189

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., & Fletcher, L. (2012). Slow and steady wins the race: A randomized clinical trial of acceptance and commitment therapy targeting shame in substance use disorders. *Journal of Consulting and Clinical Psychology*, *80*(1), 43–53. https://doi.org/10.1037/a0026070

Maji, S., & Dixit, S. (2018). Self-silencing and women’s health: A review. *International Journal of Social Psychiatry, 65*(1), 3–13. https://doi.org/10.1177/0020764018814271

Malson, H. (1998). *The thin woman: Feminism, post-structuralism and the social psychology of anorexia nervosa*. Routledge.

Maruna, S. (2001). *Making good*. American Psychological Association.

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. William Morrow & Co.

McAdams, D. P. (2011). Narrative identity. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of identity theory and research* (pp. 99–115). Springer Science + Business Media. https://doi.org/10.1007/978-1-4419-7988-9_5

McConnell, D. (2016). Narrative self-constitution and recovery from addiction. *American Philosophical Quarterly*, *53*(3), 307–322. http://www.jstor.org/stable/44982106

McCormack, C. (2004). Storying stories: a narrative approach to in-depth interview conversations. *International Journal of Social Research Methodology*, *7*(3), 219–236. https://doi.org/10.1080/13645570210166382

McCrady, B. S., Epstein, E. E., & Fokas, K. F. (2020). Treatment interventions for women with alcohol use disorder. *Alcohol Research: Current Reviews, 40*(2), 1–18. https://doi.org/10.35946/arcr.v40.2.08

McErlain, R. (2015). Alcohol and moral regulation in historical context. In P. Staddon. (Ed.), *Women and Alcohol: Social Perspectives* (pp. 17–29). Policy Press.

McGaffin, B. J., Lyons, G. C. B., & Deane, F. P. (2013). Self-forgiveness, shame and guilt in recovery from drug and alcohol problems. *Substance Abuse, 34*(4), 396–404. https://doi.org/10.1080/08897077.2013.781564

McHugh, R. K., Votaw, V. R., Sugarman, D. E., & Greenfield, S. F. (2018). Sex and gender differences in substance use disorders. *Clinical Psychology Review*, *66*, 12–23. https://doi.org/10.1016/j.cpr.2017.10.012

McIntosh, J., & McKeganey, N. (2000). Addicts' narratives of recovery from drug use: Constructing a non-addict identity. *Social Science & Medicine*, *50*(10), 1501–1510.

McNally, E. B., & Finnegan, D. G. (1993). Lesbian recovering alcoholics: A qualitative study of identity transformation: A report on research and applications to treatment. *Journal of Chemical Dependency Treatment*, *5*(1), 93–103.

Merritt, P. (1997). Guilt and shame in recovering addicts: A personal account. *Journal of Psychosocial Nursing & Mental Health Services*, *35*(7), 46–49.

Miller, B. A., Downs, W. R., Gondoli, D. M., & Keil, A. (1987). The role of childhood sexual abuse in the development of alcoholism in women. *Violence and Victims*, *2*(3), 157–172.

Miller, J. B., & Stiver, I. P. (1997). *The healing connection: How women form relationships in therapy and in life.* Beacon Press.

Miller, T. (2017). Doing narrative research? Thinking through the narrative process. In J. Woodiwiss, K. Smith., & K. Lockwood (Eds.), *Feminist narrative research: Opportunities and challenges* (pp. 39–63). Palgrave Macmillan. https://doi.org/10.1057/978-1-137-48568-7_3

Mishler, E. G. (1986). *Research interviewing: Context and narrative.* Harvard University Press.

Mishler, E. G**.** (1996). Missing persons: Recovering developmental stories/histories. In R. Jessor, A. Colby, & R. A. Shweder (Eds.), *Ethnography and human development: Context and meaning in social inquiry* (pp. 74–99). University of Chicago Press.

Morck, C., Kappel, N., & Martinsen, B. (2020). The lived experience of alcohol dependence: A reflective lifeworld research among outpatients in alcohol treatment. *Issues in Mental Health Nursing*, *41*(5), 421–428. https://doi.org/10.1080/01612840.2019.1663569

Morgan, A. (2000). *What is narrative therapy?* Dulwich Centre Publications.

Moss, A. C., & Dyer, K. R. (2010). *Psychology of addictive behaviour*. Bloomsbury Publishing.

Musson, G., Cohen, L., & Tietze, S. (2007). Pedagogy and the ‘linguistic turn’: Developing understanding through semiotics. *Management Learning*, *38*(1), 45–60. http://doi.org/10.1177/1350507607073022

NHS Digital. (2016). *Health survey for England 2015: Adult alcohol consumption*. https://files.digital.nhs.uk/publicationimport/pub22xxx/pub22610/hse2015-adult-alc.pdf

NHS. (2019). *The NHS long term plan*. https://www.longtermplan.nhs.uk/

Nightingale, D. J., & Cromby, J. (1999a). *Social constructionist psychology: A critical analysis of theory and practice.* Open University Press.

Nightingale, D. J., & Cromby, J. (1999b). What's wrong with social constructionism. *Social constructionist psychology: A critical analysis of theory and practice*, 1–19.

Nishimoto, R. H., & Roberts, A. C. (2001). Coercion and drug treatment for postpartum women. *The American Journal of Drug and Alcohol Abuse, 27*(1), 161–181. https://doi.org/10.1081/ADA-100103125

Nuffield Trust. (2022, March 31). *Alcohol-related harm and drinking behaviour*. https://www.nuffieldtrust.org.uk/resource/alcohol-related-harm-and-drinking-behaviour-1

Nussbaum, M. (2006). *Hiding from humanity: Disgust, shame and the law*. Princeton University Press.

O'Connor, L., Berry. J., Inaba, D., & Weiss, J. (1994). Shame, guilt, and depression in men and women in recovery from addiction**.** *Journal of Substance Abuse Treatment*, *11*(6), 503–510. https://doi.org/10.1016/0740-5472(94)90001-9

O'Mahoney, J. (2011). Critical realism and the self. *Journal of Critical Realism*, *10*(1), 122–129. http://doi.org/10.1558/jcr.v10i1.122

O'Mahoney, J. & Vincent, S. (2014). Critical realism as an empirical project: A beginner's guide. In P. Edwards, J. O'Mahoney, & S. Vincent (Eds.), *Putting critical realism into practice: A guide to research methods in organization studies* (pp. 1–20). Oxford University Press.

Oakley, A. (1981). Interviewing women: A contradiction in terms? In H. Roberts (Ed.), *Doing feminist research* (pp. 30–61). Routledge and Kegan Paul.

Ochs, E. (1997). Narrative. In T. A. van Dijk (Ed.), *Discourse as structure and process: Discourse studies: A multidisciplinary introduction* (Vol. 1, pp. 185–207). Sage Publications. https://doi.org/10.4135/9781446221884.n7

Orvell, A., Kroaa, E., & Gelman, S. (2017). How "you" makes meaning. *Science*, *355*(6331), 1299–1302. https://doi.org/10.1126/science.aaj2014

Ouimette, P. C., Wolfe J., & Chrestman, K. R. (1996). Characteristics of posttraumatic stress disorder-alcohol abuse comorbidity in women. *Journal of Substance Abuse, 8*(3), 335–346.

Outhwaite, W. (1993). *New philosophies of social science realism, hermeneutics and critical theory*. Springer.

Overcash, J. A. (2003). Narrative research: A review of methodology and relevance to clinical practice. *Critical Review of Oncology and Hematology*, *48*(2), 179–84.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. Routledge.

Parker, I. (2005). *Qualitative psychology: Introducing radical research*. Open University Press.

Patel, N. (2003). Clinical psychology: Reinforcing inequalities or facilitating empowerment? *The International Journal of Human Rights*, *7*(1),16–39. https://doi.org/10.1080/714003792

Patterson, C., Emslie, C., Mason, O., Fergie, G., & Hilton, S. (2016). Content analysis of UK newspaper and online news representations of women's and men's 'binge' drinking: A challenge for communicating evidence-based messages about single-episodic drinking? *British Medical Journal, 6*, e013124. https://doi.org/10.1136/bmjopen-2016-013124

Pettinato, M. (2008). Nobody was out back then: A grounded theory study of midlife and older lesbians with alcohol problems. *Issues in Mental Health Nursing, 29*(6), 619–638. https://doi.org/10.1080/01612840802048865

Pinedo, M. (2019). A current re-examination of racial/ethnic disparities in the use of substance abuse treatment: Do disparities persist? *Drug and Alcohol Dependence*, *202*, 162–167. https://doi.org/10.1016/j.drugalcdep.2019.05.017

Plummer, K. (1983). *Documents of life: An introduction to the problems and literature of a humanistic method.* Unwin Hyman.

Polander, E. N., & Shalin, V. L. (2013). An analysis of narrative and figurative language within online alcoholism discussion forums. *International Journal of Mental Health and Addiction, 11*(4), 458–473. https://corescholar.libraries.wright.edu/psychology/445

Polkinghorne, D. E. (2004). Narrative therapy and postmodernism. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 53–67). Sage Publications. https://doi.org/10.4135/9781412973496.d5

Polletta, F., Bobby Chen, P. C., Gardner, B. G., & Motes, A. (2011). The sociology of storytelling. *Annual Review of Sociology, 37,* 109–130. https://doi.org/10.1146/annurev-soc-081309-150106

Pomerantz, A., & Fehr, B. J. (1997). Conversation analysis: An approach to the study of social action as sense-making practices, In T. A. van Dijk (Ed.), Discourse as social interaction (pp. 64–91). Sage.

Potter-Efron, R. (2002). *Shame, guilt, and alcoholism: Treatment issues in clinical practice* (2nd ed.). Haworth Press.

Potter, J. (1996). *Discourse analysis and constructionist approaches: Theoretical background.* British Psychological Society.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. Sage.

Presser, L. (2016). Criminology and the narrative turn. *Crime, Media, Culture*, *12*(2), 137–151. https://doi.org/10.1177/1741659015626203

Presser, L., & Sandberg, S. (Eds.). (2015). *Narrative criminology: Understanding stories of crime*. NYU Press.

Probyn, E. (2004). Everyday shame. *Cultural Studies*, *18*(2–3), 328–349.

Prussing, E. (2007). Reconfiguring the empty center: Drinking, sobriety, and identity in Native American women's narratives. *Culture, Medicine and Psychiatry*, *31*(4), 499–526.

Public Health England. (2015). Improving mutual aid engagement: A professional development resource. https://webarchive.nationalarchives.gov.uk/ukgwa/20170807160728mp_/http://www.nta.nhs.uk/improving-mutual-aid-engagement-a-professional-development-resource.aspx

Radzik, L. (2009). *Making amends: Atonement in morality, law, and politics*. Oxford University Press.

Randles, D., & Tracy, J. L. (2013). Nonverbal displays of shame predict relapse and declining health in recovering alcoholics. *Clinical Psychological Science*, *1*(2), 149–155.

Raypole, C. (2020, February 24). *How ‘dry drunk syndrome’ affects recovery*. Healthline. https://www.healthline.com/health/dry-drunk

Reed, P. L., Anthony, J. C., & Breslau, N. (2007). Incidence of drug problems in young adults exposed to trauma and posttraumatic stress disorder: Do early life experiences and predispositions matter? *Archives of General Psychiatry*, *64*(12), 1435–1442. http://doi.org/10.1001/archpsyc.64.12.1435

Rhodes, R., & Johnson, A. D. (1994). Women and alcoholism: A psychosocial approach. *Affilia, 9*(2), 145–156. https://doi.org/10.1177/088610999400900204

Richards, H., & Emslie, C. (2000). The "doctor" or the "girl from the university"? Considering the influence of professional roles on qualitative interviewing. *Family Practice*, *17*(1), 71–75. https://doi.org/10.1093/fampra/17.1.71

Richards, R. (2019). Shame, silence and resistance: How my narratives of academia and kidney disease entwine. *Feminism & Psychology*, *29*(2), 269–285. https://doi.org/10.1177/0959353518786757

Riessman, C. K. (2000). Analysis of personal narratives. In J. F. Gubrium and J. A. Holstein (Eds.), *Handbook of interviewing* (p. 2001). Sage Publications.

Riessman, C. K. (2005). Narrative Analysis. In *Narrative, memory & everyday life* (pp. 1–7). University of Huddersfield.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage.

Riessman, C. K. (2015). Entering the hall of mirrors: Reflexivity and narrative research. In A. De Fina & A. Georgakopoulou (Eds.), *The Handbook of Narrative Analysis* (pp. 219-238). John Wiley & Sons.

Rodham, K., & Gavin, J. (2006). The ethics of using the internet to collect qualitative research data. *Research Ethics*, *2*(3), 92–97. https://doi.org/10.1177/174701610600200303

Rolfe, A., Orford, J., & Dalton, S. (2009). Women, alcohol and femininity: A discourse analysis of women heavy drinkers’ accounts. *Journal of Health Psychology*, *14*(2), 326–335. https://doi.org/10.1177/1359105308100217

Rose, N. (1989). *Governing the soul: Technologies of human subjectivity.* Routledge.

Salter, M., & Breckenridge, J. (2014). Women, trauma and substance abuse: Understanding the experiences of female survivors of childhood abuse in alcohol and drug treatment. *International Journal of Social Welfare*, *23*, 165–173. https://doi.org/10.1111/ijsw.12045

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, *18*(2), 179–183.

Sanders, J. M. (2009). *Women in Alcoholics Anonymous: Recovery and empowerment*. First Forum Press.

Sanders, J. M. (2011). Feminist perspectives on 12-step recovery: A comparative descriptive analysis of women in Alcoholics Anonymous and Narcotics Anonymous. *Alcoholism Treatment Quarterly*, *29*(4), 357–378. https://doi.org/10.1080/07347324.2011.608595

Sanders, J. M. (2018). The sick role: A contemporary analysis of women, alcoholism, and gender ideology. *Alcoholism Treatment Quarterly*, *36*(1), 127–149. https://doi.org/10.1080/07347324.2017.1355225

Saunders, S. M., Zygowicz, K. M., & D'Angelo, B. R. (2006). Person-related and treatment-related barriers to alcohol treatment. *Journal of Substance Abuse Treatment. 30*(3), 261–270. https://doi.org/10.1016/j.jsat.2006.01.003

Sawer, F., Davis, P., & Gleeson, K. (2019). Is shame a barrier to sobriety? A narrative analysis of those in recovery. *Drugs: Education, Prevention and Policy*, *27*(1), 79–85. https://doi.org/10.1080/09687637.2019.1572071

Sayer, A. (2000). *Realism and social science*. Sage.

Scheff, T. (2014). Goffman on emotions: The pride-shame system, symbolic interaction. *Symbolic Interaction*, *37*(1), 108–121. https://doi.org/10.1002/symb.86

Scheff, T. J. (1988). Shame and conformity: The deference-emotion system. *American Sociological Review*, *53*(3), 395–406.

Scheff, T. J. (2000). Shame and the Social Bond: A Sociological Theory. *Sociological Theory*, *18*(1), 84–99. https://doi.org/10.1111/0735-2751.00089

Scherer, M., Worthington, E. L., Hook, J. N., & Campana, K. L. (2011). Forgiveness and the bottle: Promoting self-forgiveness in individuals who abuse alcohol. *Journal of Addictive Disorders, 30*(4), 382–395.

Schomerus, G., Corrigan, P. W., Klauer, T., Kuwert, P., Freyberger, H. J., & Lucht, M. (2011). Self-stigma in alcohol dependence: Consequences for drinking-refusal self-efficacy. *Drug and Alcohol Dependence*, *114*(1), 12–17. https://doi.org/10.1016/j.drugalcdep.2010.08.013

Selbekk, A. S., Sagvaag, H., & Fauske, H. (2015). Addiction, families and treatment: A critical realist search for theories that can improve practice. *Addiction Research & Theory*, *23*(3), 196–204. https://doi.org/10.3109/16066359.2014.954555

Sered, S., & Norton-Hawk, M. (2011). Whose higher power? Criminalized women confront the “Twelve Steps.” *Feminist Criminology*, *6*(4), 308–332. https://doi.org/10.1177/1557085111420557

Shaver, P. R., & Mikulincer, M. (2005). Attachment theory and research: Resurrection of the psychodynamic approach to personality. *Journal of Research in Personality*, *39*(1), 22–45.

Shefer, T., & Munt, S. R. (2019). A feminist politics of shame: Shame and its contested possibilities. *Feminism & Psychology*, *29*(2), 145–156.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63–75.

Shinebourne, P., & Smith, J. A. (2011). 'It is just habitual': An interpretative phenomenological analysis of the experience of long-term recovery from addiction. *International Journal of Mental Health and Addiction*, *9*(3), 282–295.

Shippee, N. D., Domecq Garces, J. P., Prutsky Lopez, G. J., Wang, Z., Elraiyah, T. A., Nabhan, M., Brito, J. P., Boehmer, K., Hasan, R., Firwana, B., Erwin, P. J., Montori, V. M., & Murad, M. H. (2015). Patient and service user engagement in research: A systematic review and synthesized framework. *Health Expectations: An International Journal of Public Participation in Health Care & Health Policy, 18*(5), 1151–1166. https://doi.org/10.1111/hex.12090

Simms, K. (2003). *Paul Ricoeur*. Routledge.

Sims-Schouten, W., Riley, S. C., & Willig, C. (2007). Critical realism in discourse analysis: A presentation of a systematic method of analysis using women's talk of motherhood, childcare and female employment as an example. *Theory & Psychology*, *17*(1), 101–124.

Slade, T., Chapman, C., Swift, W., Keyes, K., Tonks, Z., & Teesson, M. (2016). Birth cohort trends in the global epidemiology of alcohol use and alcohol-related harms in men and women: Systematic review and meta-regression. *British Medical Journal*, *6*(10), e011827. https://doi.org/10.1136/bmjopen-2016-011827

Smail, D. (2005). *Power, interest and psychology: Elements of a social materialist understanding of distress*. PCCS Books.

Smith, B. A. (1998). The problem drinker's lived experience of suffering: an exploration using hermeneutic phenomenology. *Journal of Advanced Nursing*, *27*(1), 213–222

Smith, T. L., Zufferey, C., Bilic, S., Loeser, C. (2021). Questioning policy representations of women's alcohol consumption: Implications for social work. *Qualitative Social Work, 21*(4), 731–747. https://doi.org/10.1177/14733250211025086

Snoek, A., McGeer, V., Brandenburg, D., & Kennett, J. (2021). Managing shame and guilt in addiction: A pathway to recovery. *Addictive Behaviors*, *120,* 106954. https://doi.org/10.1016/j.addbeh.2021.106954

Somers, M. R., & Gibson, G. (1994). *Reclaiming the epistemological other: Narrative and the social constitution of identity* (CSST Working Papers). The University of Michigan.

Squire, C., Andrews, M., & Davis, M. (2014). *What is narrative research?* Bloomsbury Publishing.

Staddon, P. (2005). Labelling out: The personal account of an ex-alcoholic lesbian feminist. *Journal of Lesbian Studies*, *9*(3), 69–78.

Stephens, N. (2007). Collecting data from elites and ultra-elites: Telephone and face-to-face interviews with macroeconomists. *Qualitative Research*, *7*(2), 203–216.

Stevens, A. (2020). Critical realism and the 'ontological politics of drug policy'. *International Journal of Drug Policy*, *84*, 102723. https://doi.org/10.1016/j.drugpo.2020.102723

Stieg, C. (2019). *The problem with calling sobriety a "wellness trend"*. Refinery29. https://www.refinery29.com/en-gb/2019/07/237020/sober-curious-movement-sobriety-trend-problem

Storr, W. (2019). *The Science of storytelling: Why stories make us human, and how to tell them better*. William Collins.

Stringer, K. L., & Baker, E. H. (2018). Stigma as a barrier to substance abuse treatment among those with unmet need: An analysis of parenthood and marital status. *Journal of Family Issues*, *39*(1), 3–27. https://doi.org/10.1177/0192513X15581659.

Sznycer, D., Xygalatas, D., Agey, E., Alami, S., An, X.-F., Ananyeva, K. I., Atkinson, Q. D., Broitman, B. R., Conte, T. J., Flores, C., Fukushima, S., Hitokoto, H., Kharitonov, A. N., Onyishi, C. N., Onyishi, I. E., Romero, P. P., Schrock, J. M., Snodgrass, J. J., Sugiyama, L. S., . . . Tooby, J. (2018). Cross-cultural invariances in the architecture of shame. *PNAS Proceedings of the National Academy of Sciences of the United States of America*, *115*(39), 9702–9707. https://doi.org/10.1073/pnas.1805016115

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt.* The Guilford Press. https://doi.org/10.4135/9781412950664.n388

Tangney, J. P., & Tracy, J. L. (2012). Self-conscious emotions. In M. Leary & J. P. Tangney (Eds.), *Handbook of self and identity* (2nd ed., Vol. 2, pp. 446–478). Guilford Press.

Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual review of psychology*, *58*, 345.

Tanskanen, E. (2022). *"Sober fun is radical and empowering": Discursive construction of non-drinking on Sober Girl Society's Instagram* [Master's Thesis, University of Jyväskylä]. Department of Language and Communication Studies.

Tracy, J. L., & Robins, R. W. (2004). Putting the self into self-conscious emotions: A theoretical model. *Psychological Inquiry*, *15*(2), 103–125.

Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry*, *16*(10), 837–851.

Treeby, M. S., & Bruno, R. (2012). Shame and guilt-proneness: Divergent implications for problematic alcohol use and drinking to cope with anxiety and depression symptomatology. *Personality and Individual Differences*, *53*(5). https://doi.org/10.1080/10826084.2019.1683203

Treeby, M. S., Rice, S. M., Wilson, M., Prado, C. E. & Bruno, R. (2020). Measuring Alcohol Use-Related Shame and Guilt: Development and Validation of the Perception of Drinking Scale, *Substance Use & Misuse*, *55*(3), 441-451. https://doi.org/10.1080/10826084.2019.1683203

Trondsen, M. V., & Tjora, A. (2014). Communal normalization in an online self-help group for adolescents with a mentally ill parent. *Qualitative Health Research*, *24*(10), 1407–1417. https://doi.org/10.1177/1049732314547708

Tuana, N. (2006). The speculum of ignorance: The women’s health movement and epistemologies of ignorance. *Hypatia, 21*(3), 1–19. https://www.jstor.org/stable/3810948

Tuchman, E. (2010). Women and addiction: The importance of gender issues in substance abuse research. *Journal of Addictive Diseases*, *29*(2), 127–138. https://doi.org/10.1080/10550881003684582

Tutenges, S., & Sandberg, S. (2013). Intoxicating stories: The characteristics, contexts and implications of drinking stories among Danish youth. *International Journal of Drug Policy*, *24*(6), 538–544. https://doi.org/10.1016/j.drugpo.2013.03.011

Ullman, S. E., Najdowski, C. J., & Adams, E. B. (2012). Women, Alcoholics Anonymous, and related mutual aid groups: Review and recommendations for research. *Alcoholism Treatment Quarterly*, *30*(4), 443–486. http://doi.org/10.1080/07347324.2012.718969

University of East London. (2019). *Research Data Management Policy.* University of East London. https://repository.uel.ac.uk/item/8448w

Ussher, J. M. (1999). Eclecticism and methodological pluralism: The way forward for feminist research. *Psychology of Women Quarterly*, *23*(1), 41–46. https://doi.org/10.1111/j.1471-6402.1999.tb00339.x

Vaillant, G. E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry*, *53*(3), 243–249. https://doi.org/10.1001/archpsyc.1996.01830030065010

Valverde, M., & White-Mair, K. (1999). One day at a time' and other slogans for everyday life: The ethical practices of Alcoholics Anonymous. *Sociology*, *33*(2), 393–410. https://doi.org/10.1177/S0038038599000231

Van Der Walde, H., Urgenson, F. T., Weltz, S. H., & Hanna, F. J. (2002). Women and alcoholism: A biopsychosocial perspective and treatment approaches. *Journal of Counseling and Development*, *80*(2), 145.

Velotti, P., Garofalo, C., Bottazzi, F., & Caretti, V. (2017). Faces of shame: Implications for self-esteem, emotion regulation, aggression, and well-being. *The Journal of Psychology*, *151*(2), 171–184. https://doi.org/10.1080/00223980.2016.1248809

Waterson, J. (2000). *Women and alcohol in social context: Mother's ruin revisited*. Springer.

Weston, S., Honor, S., & Best, D. (2018). A tale of two towns: A comparative study exploring the possibilities and pitfalls of social capital among people seeking recovery from substance misuse. *Substance Use & Misuse*, *53*(3), 490–500. https://doi.org/10.1080/10826084.2017.1341925

White, A. M. (2020). Gender differences in the epidemiology of alcohol use and related harms in the United States. *Alcohol Research: Current Reviews*, *40*(2), 1. https://doi.org/10.35946/arcr.v40.2.01

White, M. (2007). *Maps of narrative practice*. W. W. Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. W. W. Norton.

White, W. L. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health/Mental Retardation Services.

Widom, C. S., Ireland, T., & Glynn, P. J. (1995). Alcohol abuse in abused and neglected children followed-up: Are they at increased risk? *Journal of Studies on Alcohol*, *56*(2), 207–217.

Wiechelt, S. A. (2007). The specter of shame in substance misuse. *Substance Use & Misuse*, *42*(2–3), 399–409. https://doi.org/10.1080/10826080601142196

Wiechelt, S. A., & Sales, E. (2001). The role of shame in women's recovery from alcoholism: The impact of childhood sexual abuse. *Journal of Social Work Practice in the Addictions, 1*(4), 101–116. https://doi.org/10.1300/J160v01n04_07

Wiens, T. K., & Walker, L. J. (2015). The chronic disease concept of addiction: Helpful or harmful? *Addiction Research & Theory*, *23*(4), 309–321.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Open University Press.

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 1: Foundations, planning, measures, and psychometrics* (pp. 5–21). American Psychological Association. https://doi.org/10.1037/13619-002

Wilsnack, S. C., Wilsnack, R. W., & Hiller-Sturmhöfel, S. (1994). How women drink: Epidemiology of women's drinking and problem drinking. *Alcohol Health and Research World*, *18*(3), 173.

Wilsnack, S. C., Wilsnack, R. W., & Kantor, L. W. (2013). Focus on: Women and the costs of alcohol use. *Alcohol Research: Current Reviews*, *35*(2), 219–228. https://pubmed.ncbi.nlm.nih.gov/24881330/

Witham, G., Haigh, C., Mitchell, D., & Beddow, A. (2018). Carer experience supporting someone with dementia and cancer: A narrative approach. *Qualitative Health Research*, *28*(5), 813–823. https://doi.org/10.1177/1049732317736285

Wright, N. (2012). *The politics of recovery in mental health: A left libertarian policy analysis*. The Institute of Mental Health Blog. https://imhblog.wordpress.com/2012/05/06/dr-nicola-wright-the-politics-of-recovery-in-mental-health-a-left-libertarian-policy-analysis/

Yardley, L. (2007). Demonstrating the validity of qualitative research. *The Journal of Positive Psychology*, *12*(3), 295–296. https://doi.org/10.1080/17439760.2016.1262624

Yue, J. (2021). Speaking shame and laughing it off: Using humorous narrative to conquer the shame of anorectal illness. *Qualitative Health Research*, *31*(5) 847–858. https://doi.org/10.1177/104973232098732

Zammuner, V. L. (1996). Felt emotions and verbally communicated emotions: The case of pride. *European Journal of Social Psychology, 26*(2), 233–245. https://doi.org/10.1002/(SICI)1099-0992(199603)26:2<233::AID-EJSP748>3.0.CO;2-%23

Zmerli, S. (2010). Social capital and norms of citizenship: An ambiguous relationship? *American Behavioral Scientist*, *53*(5), 657–676. https://doi.org/10.1177/0002764209350829

APPENDICES

Appendix A: Scoping review

Booth, Papaioannou and Sutton's (2012) framework for defining the scope of a review was used as follows:

1. Who = women with or in recovery from alcohol dependence (>18)
2. What = shame
3. How (will the study impact on the who) = situate and rationalise the current study aimed at exploring shame in women's narratives of recovery from alcohol dependence

The guiding question in the literature search was: in what ways has shame been investigated in women's alcohol dependence and recovery?
The main aim of the literature was to explore, summarise and disseminate research on shame and women's alcohol dependence and recovery and identify gaps in the evidence base, with particular attention to:

- How shame is conceptualised, what sources of shame are identified and what role shame plays
- Inclusion of women's subjective experiences and meanings of shame
- Qualitative or quantitative methodologies (critical realist)

An initial search included synonyms for shame and related concepts based on the literature, but this yielded too many inappropriate results. The follow search terms were used in searches of CINAHL Plus, Academic Search Complete, PsycINFO, PsycARTICLES:

- alcohol dependence OR alcohol addiction OR alcohol-related problems OR alcoholism OR problematic drinking OR problem drinking OR alcohol problems OR alcohol abuse OR alcohol use disorder OR alcoholic

AND

- Shame

AND

- Women

These key words were searched using the Boolean operators ‘AND’ and ‘OR’

Limiters included:

- English language only
- Adult only (18-65 years)
- Female
- Keyword and abstract only
- Last 30 years only

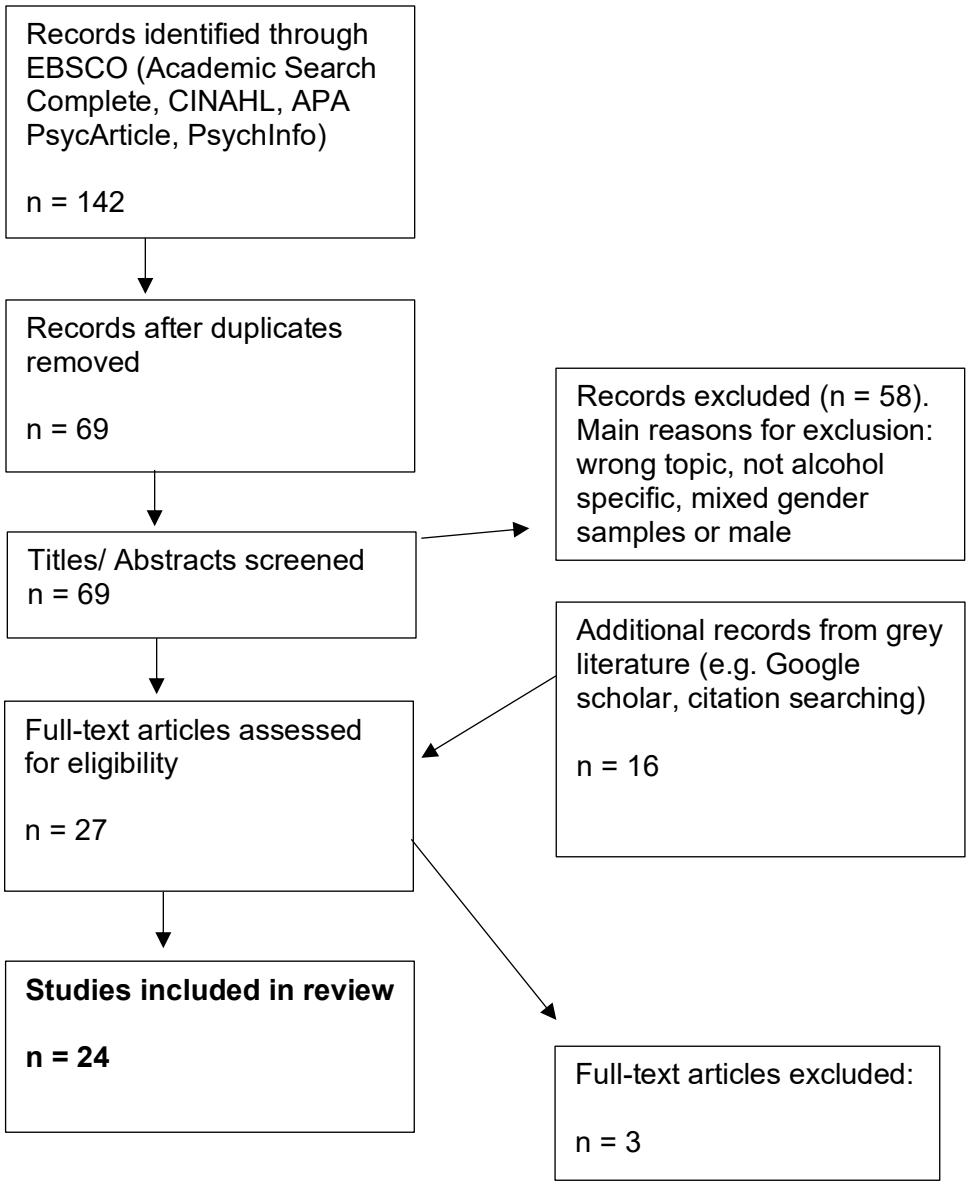
Main reasons discounted:

- Included male only, or male/female with no separate analysis by gender
- Mixed substances, not specific to alcohol dependence
- Wrong topic

I completed the searches throughout the months of July 2020 and July 2021. I undertook a final search in January 2022 for any additional relevant additional literature.

Additional searches of grey literature were conducted using Google Scholar and other open-source repositories. Key papers were identified, and citation searches carried out by hand. Snowballing methods such as tend to be used for niche research areas with a relatively limited number of studies. Any articles not focused specifically on alcohol dependence and women or were not analysed by gender were excluded. This method avoids relying upon key terms/content within specific technology platforms and subjective algorithms that can preserve the under-representation of women’s research. However, limitations with this method include human subjectivity with regards to the selection criterion and a reduced focus on the meta-data (outlined in Davey, 2021).

Figure 1: Scoping review flowchart of results



Appendix B: Interview Schedule and Prompts

- **Introductions –** Robin, Trainee Clinical Psychologist, at UEL and thank participant for taking part

- **Review participant information letter** and check if participant has any questions
    - *Highlight interested in their experiences of alcohol problems and recovery*
    - *All information shared is confidential and private*
        - withdraw at any point/ withdraw data 3 weeks after the data has been collected (from the interview)
    - *How is the data used?*
        - Work with two research supervisors
        - Plan to publish/share findings with alcohol support services
        - Analyse separately and then put women's stories together
        - Use of anonymised extracts – all identifying information is removed and ask participant if they would like to choose the pseudonym
    - *Send documents following interview*
        - Debrief letter
        - Amazon voucher
    - *Check consent*
        - Review consent form and check consent

- **Prepare for narrative interview**
    - Check participant is in a safe and private space
    - Highlight participant can take a break or stop whenever
    - Check how they would like me to check in and advise them of what I will do if I see signs of distress (i.e. ask if they would like to take a break or if they want to proceed with interview)

- Advise them given that this is a research interview I am likely to say less than in usual conversation. Highlight intention to give them the space to talk about what is important to them and let them know I will ask follow-up questions later in the interview
- Discuss and make a a plan for what to do if we encounter IT issues

Main question:

- **Please tell your story at wherever it begins. Please feel free to tell your story in whatever way you wish and begin the story wherever you feel comfortable. It can be helpful to tell your story from the earliest point you remember to the present day.**

General prompt questions include (Etherington, 2014):

1. ***Ways of helping people tell stories***

- *Begin from a 'not knowing' position – rather than 'expert' position.*
- *'Tell me about the/a time when....' rather than 'tell me about your experience of.....' e.g. drinking alcohol*
- *'Who were you with?': invites other characters into story*
- *'What happened then ....?': 'How long did that go on?' invites temporal nature of stories.*
- *'When did you realise that it couldn't go on?' – turning point 'What kind of sense did you make of all that?'- meaning-making*

2. ***Cultural contextual: giving details of values, beliefs, habits etc***

- *'How did you know that...?'*
- *'Why do you think that happened?*
- *'What did you think about that?*
- *'Was that something you usually did?*
- *'Was that OK with you?*

3. ***Embodied nature of the teller and their engagement in the events, their senses, feelings, thoughts, attitudes and ideas; thus locating the narrative in the experience of a real life.***

- *'What could you see/hear?'*
- *'How did it look to you? 'What was your sense of what was going on?'*
- *'How did you cope with that?'*
- *'How did that affect you/make you feel/think?' 'How did you feel about what he did?'*
- *'Did you have any ideas about this at the time?'*

4. ***Significance of other people: how does teller's network of relationships impact on events? Who were the other characters?***

- *'What did your family think of that?'*
- *'Who told you?'*
- *'Did you ask anyone for help?*
- *'Was anybody else aware of what was happening?'*
- *'Where were your friends?'*

5. ***Choices and actions of the teller: the teller is an active participant in events, making choices based on values, beliefs and aims.***

- *'What made you decide to go there?'*
- *'Why did you want to do that?'*
- *'What were you intending?'*
- *'What did you want to happen?'*
- *'When did you decide that?'*

6. ***Historical continuity: we need to understand the teller as coming from somewhere (contextual information) and going somewhere.***

- *'What was happening in the rest of your life at that time?'*

- *'What year was that?'*
  'How old were you?'
  'Were you still at school then?'
- *'Did you get there eventually?'*

7. ***Beginning, middle and an end: a story needs recognisable parameters or it will seem chaotic or meaningless. It starts with an event or decision or some recognisable trigger. The plot then develops toward some form of completion.***

- *'Where does your story begin?'*
- *'How did you get into that situation?'*
- *'What happened after that?'*
  'When did you realise you were safe?'
- *'What do you think about that now?'*

8. ***Metaphors, symbols, and creative, intuitive ways of knowing: these create pictures that capture vivid representations of experiences.***

- *'What was that like?*
- *'Do you have an image of that?*
- *'Did that put you in mind of something?*
- *'Could you draw me a picture of that in words?'*
- *'You say 'it was like falling into a pit...' can you say a bit more about that?***'**

Ending the interview

- Reflecting on telling your story, is there anything that we haven't talked about that you think would be important to share?
- Looking back on the process of telling your story
  - What's it been like for you?
  - Are there any are there any parts that have surprised you or stood out to you?
- Re-check consent

- Re-check if participant wants to choose pseudonym
- Review debrief form

Appendix C: Research Journal Excerpt

Post interview (P1)

Shame prominent in her story – recovery, de-shaming process, moving towards authenticity
Distanced self from image of 'typical' alcohol
Relational nature of 'the problem' – story told in reference to relationship to other
Reluctance to use the word 'problem' when referencing women's sober support group – importance of ability to self-define problem, distancing self from 'alcoholic' or stigmatising terminology ('issue')
Wondered whether I should have asked about certain experiences in more detail? Sexual abuse/ online sober support group – seemed significant. However is it my job to choose what's significant? Is her framing of the topic more important that my follow-up questions? Also ethics of asking about traumatic events in detail? Chose to holdback.
Noticed how the story of sexual abuse came out later on in the story – possibly as P1 became more comfortable
Family/ earlier experiences came through later in the interview – non-linear – in recovery go back to the beginning? Feeling more comfortable?
Elicited immense empathy – the pain of not telling anyone about abuse, shame
Noticed a tendency to want to say more, but held back from making reflections/ interpretations
Awareness of my age (younger), how that might feel for P1 - possibly have daughters a similar age- how did that reflect the dynamic?
Shame linked with process of becoming and unbecoming

Post interview (P6)

Shame in relation to sexuality
Less explicit language of shame due to re-framing of alcohol problems in recovery?
Tangibly different type of story-telling to those in earlier on in sobriety journey

Notably more detached in retelling – found the process of supporting the telling of the story more challenging, should I try to elicit feeling? Ethics? Could be a consequence of having shared story repeatedly compared to some participants who were telling their story for the first time?
Sharing of expertise, professional/psychological language (especially trauma) – intellectualising defence from shame? Establish different positioning interview relative to me as professional (more equal)? Indicative of stage in journey? Useful sense-making tool?
Movement from internal towards external factors – de-shaming? Politicisation of the issue?
Participants narrative of the oppressiveness of the alcoholic identity striking – prison, afraid of self
Therapist factors- from the same city, P6 had negative experiences there, wonder how this may have impacted interview? Familiarity might be positive? Or may have made it more difficult? Noticed some shared cultural references – disparity between resources/ support in the north and south of the UK.

Post all interviews

Powerful experience of listening to stories – wish there was a way of capturing and disseminating them as they are - stories of strength and bravery, elicit empathy and respect
Notable- shaming to shame to shaming – response to gender oppressive experiences and becoming aware of these in sobriety – mothering, abusive relationships, gender stereotypes
Struck by the fact many of these women had never told these stories before – both saddened that society pushes women into hiding, and the pain associated with secrets and silencing – not having needs articulated and met, but privileged to be able to hear them – hoped it was a positive experience for participants
Notable language of the sobriety movement – de-shaming – pick and choose which stories fit with their experiences best, women are individuals – makes me question the applicability of current treatment models

Story development and selecting extracts

Struck by the similarities in women's stories – shared gender oppressive experiences? Shared societal/ treatment narratives as sense-making tools? Only a limited repertoire from which to make sense of these experiences? Dominant understandings not very reflective of their experiences – hermeneutic injustice? Tenative about presenting some aspects of the stories (the centrality of critical mothers in participants' narratives) due to risk of reinforcing disparaging stereotypes. Awareness of history of mother-blaming in psychological research. However, in contrast – indication these relationships are highly significant to see how these women came to see and understand themselves? Not my role to censor an important part of their experience, but to contextualise it. Recognition they shared it with me because it was important to them.

Sanitising stories through academic language - do we as a society do this to make the unthinkable or unbearable more palatable? Whom are we writing for? Maybe we shouldn't be sanitising?

Overwhelmed by amount of content produced from analysis, multiple ways of re-presentating the data, shame constructed as multifaceted and far-reaching in their stories, needs to be contextualised within their lives and whole stories to be fully understood, inevitably emphasising some aspects over others, aware of my role in constructing the stories

Worries maybe I have done some a disservice – some stories don't feature as prominently.

Notice I want to go back to the women and check I am doing their stories justice.

Appendix D: Ethics Application Form

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS (Updated October 2019)

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

1. Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood these codes: [y]

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. It is the responsibility of students to check this has been done.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter [y]
- The participant consent form [y]
- The participant debrief letter [y]

1.6 The following attachments should be included if appropriate:

- Risk assessment forms (see section 6)
- A Disclosure and Barring Service (DBS) certificate (see section 7)
- Ethical clearance or permission from an external organisation (see section 8)
- Original and/or pre-existing questionnaire(s) and test(s) you intend to use
- Interview protocol for qualitative studies
- Visual material(s) you intend showing participants.

2. Your details

2.1 Your name: Robin Lamb

2.2 Your supervisor's name: Dr Zetta Kougiali

2.3 Title of your programme: Professional Doctorate in Clinical Psychology

2.4 UEL assignment submission date (stating both the initial date and the resit date): May 2021 and re-submission TBC (determined by examiner availability)

3. Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

3.1 The title of your study:
Women and shame: stories of recovery from alcohol dependence

3.2 Your research question:

In what ways does shame feature in the stories of women in recovery from alcohol dependence?

If shame features, in what ways do women navigate shame in their stories?

3.3 Design of the research:

The proposed study will utilise a qualitative case series design.

3.4 Participants:

Participants will be UK-based adult women (18+) who identify as in recovery from alcohol dependence

Other inclusion criteria:

- Women to self-identify as in recovery and sober for the interview given the possible effect of intoxication on the construction of narratives, notwithstanding the ethical considerations regarding capacity to consent and risk. This is deemed to be a more useful criterion as the recovery process in addiction is discontinuous, non-linear and long-lasting (e.g. Kougiali et al., 2017).
- Guided by leading studies in the field (e.g., Dearing et al., 2005; Luoma et al., 2012), participants will not be excluded for drug dependency, but they have to consider alcohol a significant component of their addiction.
- The participant will have to be able to speak English fluently for the purposes of the interview.
- The participant will need to have been living in the UK for a substantial period of time (e.g. 5 years) as we are looking for the experiences of women living in the UK.

Sample Size

- Narrative analysis (NA) does not use a 'sampling' procedure (Mishler, 1996) as it is an approach that is interested in the processes by which the 'subject' accounts for and makes sense of their experiences, rather than as a source for generalisations. Nevertheless, NA typically includes samples of 5-6 participants (A. W. Frank, 2012); small sample sizes are thought to allow for in-depth engagement of narratives (K. Gilbert, 2002). Based on this, it is

anticipated a sample of 8-10 will be needed to allow for varying interview quality and unforeseen difficulties with recruitment (e.g. attrition).

3.5 Recruitment:

Recruitment strategy A:

A number of local third sector organisations have been identified and will be invited to participate in the research, including an existing contact of the researcher. The researcher will also explore recruitment through online (e.g. local interest) social media groups and websites.

Steps to be taken include:

- In collaboration with supervisor, the researcher has developed an email and recruitment flyer to invite relevant services to participate in the research (Appendix A).
- The researcher will coordinate with services a recruitment strategy e.g. researcher to attend (online) service user groups to explain the aims of the research and distribute information sheets or service will disseminate information sheets that clearly outline the nature and purpose of the research and the rights of potential participants (Appendix B).
- When pursuing recruitment through online social media groups and websites, the researcher will contact the group moderator for permission to publicise research and distribute information sheets.
- Participants will contact researcher if willing to participant.
- Researcher and participant will arrange a time for the interview and online platform for the interview. In light of the current restrictions on travel and social distancing measures caused by the Covid-19 pandemic, all the interviews will take place over an online platform, such as WhatsApp or Microsoft teams. The researcher will purchase a separate sim for the purposes of research.
- The preliminary organisations identified for recruitment are listed below:
  AA online meetings, specifically Women's only groups
  Change Grow Live (CTL)
  Breaking Free
  SMART Recovery Meetings
  YMCA – explore existing contact of researcher
  Turning Point
  SMART Recovery Meetings

WomenMATTA

Women for sobriety (Advertise for UK women only)

Recruitment Strategy B

Challenges with recruitment are expected: women who experience shame or with victimisation histories may be less open to discussing their experiences, or attending services where recruitment typically takes place. The current circumstances (social isolation measures, impact of Covid-19 on people's mental health) might exacerbate recruitment difficulties in some circumstances. However, many mutual aid groups have moved online and are continuing to support people. This means that recruitment is not limited by geography and there is the potential to access more people from across the country over online platforms, including people were not previously familiar with using online platforms.

Should all the above avenues of recruitment fail, women's posts from open Reddit support groups for alcohol addiction will be used as an alternative source of data. The anonymity afforded by online platforms may allow women to 'express themselves in ways that may be constrained in their real-world interactions' (Rodham & Gavin, 2006, p. 95). The data is considered to be 'in the public domain' and anonymous, which means that it can be accesses without consent (BPS, 2017).

3.6 Measures, materials or equipment:

The resources needed for this study include an audio-recorders, access to Microsoft Teams, a sim for research purposes, an encrypted memory stick and laptop with access to online platforms suitable for online interviews. Participants will be reimbursed for travel costs and will be awarded a £15 voucher for their contribution. This is deemed to be an important as it communicates the value of the participants' contribution.

3.7 Data collection:

Recruitment strategy A:

- Data will be collected via online, individual interviews with women with lived experienced of alcohol dependence.
- The participant will be asked to sign and email a consent form before proceeding with interview (Appendix C).

- A narrative life story approach to interviewing will be employed – which means interviews are participant led. The interviews will be led by the information and the topics the participants provide, as the aim is to create and maintain a conversation, rather than strictly rely on a question-answer style. In order to make the participants feel more at ease to express themselves, as well as minimise the power connotations (and the mistrust) that might come with the role of the researcher and psychologist (and to an extent part of the 'system'), leading questions will be avoided. Instead, prompting words such as 'who', 'when', 'how', 'why' will be used in order to explore in depth events and issues that were presented as important by the participants. This method has been used before and has been considered very effective in creating rapport with marginalised populations, such as our prospective participants (see Kougiali, 2015).
- Interviews will last for approximately one hour, depending on how long the participant wishes to tell their story.
- Interviews will be conducted online via Microsoft Teams or WhatsApp. These are encrypted and secure services. It is anticipated WhatsApp will be more accessible for participants. The researcher will buy a separate sim for research purposes.
- Consent will be sought at the beginning and end of the interview. Participants will be encouraged to raise questions or concerns throughout the interview.
- At the end of the study participants will be given an opportunity to discuss the project and their contributions.

Recruitment strategy B:

- If recruitment strategy A is unsuccessfully, data will be collected via women's posts from open Reddit support groups for alcohol addiction.

3.8 Data analysis:

The data will be subject to Narrative Analysis (e.g., Crossley, 2000; Riessman, 2008). Previous research into addiction suggests that people make sense of the reason they use alcohol by revisiting early experiences (Etherington, 2008). A narrative approach allows for an analysis of how self and identity not only change over time, but how this is influenced by the wider socio-cultural environment. This approach therefore captures both the temporal quality and socio-cultural factors that are bound up with participant's accounts of problems with alcohol.

The approach will be used by focusing on one aspect of participant's lived experience (i.e. problems with alcohol) over the length of a life. In line with qualitative approaches, analysis will be guided by the data. However, the focus of the analysis will be on shame, which has been identified by previous research as significant in the development of and recovery from problems with alcohol (for women in particular), and a barrier to women accessing support/treatment, yet it remains largely unexplored in the literature.

4. Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

4.1 Will participants data be gathered anonymously?

No. The researcher will know the identity of the participant because data will be gathered through qualitative interviews.

4.2 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?

Data analysis

- Only the researcher will know the names and contact details of the participants.
- The researcher will transcribe all the interviews. All identifying information will be redacted in transcripts. Only supervisors and examiners will have access to anonymised transcripts.
- All participant data of a sensitive nature (participant details, recordings and transcripts) will be kept confidential and stored in line with the Data Protection Act (1998). For example, consent forms, transcripts and audio files will be kept in a locked cabinet and saved in secure and separate locations on the researcher's non-networked, password protected laptop and university drives (UEL:H/UEL:ONE).

Dissemination

- Participants will be given pseudonyms and anonymised data will be presented in any extracts, publications or presentations.
- Careful attention will be paid to the selection the extracts chosen to ensure anonymity is preserved.

- Only minimal demographic information about the participants deemed critical to the analysis will be presented (e.g. length of time sober).

4.3 How will you ensure participants details will be kept confidential?

- Only the researcher will know the names and contact details for participants.
- Emails will be sent from the researcher's UEL email account only or separate sim used for research purposes only. sim used
- All interviews will take place online via Microsoft Teams or WhatsApp. These are both secure, encrypted services. There is a minimal risk that hackers may try and access online platforms. Therefore, the researcher will take the following precautions:
    - For use of WhatsApp: the researcher will purchase a separate sim card for research purposes only. WhatsApp cannot work on two phones at the same therefore it is not possible for a hacker to intercept the video call, but they can still try and access messages. In order to ameliorate this risk, the researcher will take extra-precautions, such as enabling two-step verification for WhatsApp, which increases security, and frequently check no other platforms are using WhatsApp.
    - For WhatsApp and Microsoft Teams, the researcher will: only use a secure, password-protected Wifi connection, conduct the interview on their personal, password-protected laptop in a private room and audio- record the interviews on an unencrypted Dictaphone, which will be used to immediately transfer the audio file to the researcher's password-protected, non-networked personal laptop.
- The researcher will transcribe the interviews redacting any identifiable references to participants. Supervisors and examiners will have access to anonymised transcripts.
- All participant data of a sensitive nature (participant details, recordings and transcripts) will be kept confidential and stored in line with the Data Protection Act (1998). For example, consent forms, transcripts and audio files will be kept in a locked cabinet and saved in secure and separate locations on the researcher's non-networked, password protected laptop and university drives (UEL:H/UEL:ONE).
- Participants will be given pseudonyms and only anonymised data will be presented in any extracts, publications or presentations.

4.4 How will the data be securely stored?

- All participant data of a sensitive nature (participant details, recordings and transcripts) will be stored in line with the Data Protection Act (1998). For example, consent forms, transcripts and audio files will be kept in a locked cabinet and saved in secure and separate locations on the researcher's non-networked, password protected laptop and university drives (UEL:H/UEL:ONE).
- Electronic consent forms emailed to the researcher will be saved on the UEL:H drive system as an encrypted file that can only be accessed by the researcher (using the researcher's password).
- Audio recordings and transcriptions will be saved on the researcher's password protected laptop. The laptop is a personal, non-networked laptop with a password only known to the researcher. Audio files and transcripts will be saved in separate folders in storage. Audio files will be backed up and stored on the UEL:H drive system in an encrypted file. Transcripts will be backed up in a different location on the UEL:ONE drive system in an encrypted file.
- Any paper transcripts will be kept in a locked cabinet in the researcher's home.
- All emails will be sent using the researcher's UEL email account.

4.5 Who will have access to the data?

- Only the researcher will have access to personal details of the participant and recordings.
- Supervisors and examiners will have access to anonymised transcripts. Anonymised transcripts will be shared with research supervisors via UEL email. File names will be participant numbers e.g. Participant 1.
- Extracts of transcripts will be provided in the final research and any subsequent publications. Identifiable information will not be included in these extracts.
- Anonymised transcripts will not be deposited via the UEL repository as due to the sensitivity of the data.

4.6 How long will data be retained for?

- Audio recordings and consent forms will be erased once the thesis has been examined and passed.
- Anonymised transcripts will be saved as encrypted files (password-protected) on the researcher's password-protected computer for five years to allow for the publications of the findings. This will not be linked to any personal information and will be saved in an encrypted folder with a non-related name.

5. Informing participants

Please confirm that your information letter includes the following details:

5.1 Your research title: y

5.2 Your research question: y

5.3 The purpose of the research: y

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. invo y

5.5 That participation is strictly voluntary: y

5.6 What are the potential risks to taking part: y

5.7 What are the potential advantages to taking part: y

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked): y

5.9 Their right to withdraw data (usually within a three-week window from the time of their participation): y

5.10 How long their data will be retained for: y

5.11 How their information will be kept confidential: y

5.12 How their data will be securely stored: y

5.13 What will happen to the results/analysis: y

5.14 Your UEL contact details: y

y

5.15 The UEL contact details of your supervisor:

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature.
NO

5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?
NO – see above

- Only the researcher will know the names and contact details for participants.
- Emails will be sent from the researcher's UEL email account only.
- The researcher will transcribe the interviews on password-protected document on Word, redacting any identifiable references to participants.
- Only supervisors and examiners will have access to anonymised transcripts.
- Participants will be given pseudonyms and only anonymised data will be presented in any extracts, publications or presentations.
- Careful attention will be paid to the selection of the extracts chosen to ensure anonymity is preserved.
- Only minimal demographic information about the participants deemed critical to the analysis will be presented (e.g. length of time sober).
- All participant data of sensitive nature (participant details, recordings and transcripts) will be stored in line with the Data Protection Act (1998). For example, consent forms, transcripts and recordings will be stored in separate locations ins separate password-protected folders on the researcher's non-networked laptop, UEL:H or UEL:ONE drive systems that can only be accessed by the researcher (using the researcher's password). Any paper transcripts will be stored in a locked cabinet in the researcher's home.

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth?

YES – Participants will be awarded a £15 redeemable voucher for their contribution. This is deemed to be an important as it communicates the value of the participants' contribution.

6. Risk Assessment

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

The study is not intended to cause any harm or distress to participants; however, given the sensitive nature of the topic of shame or possible experiences of victimisation, participants might be distressed or upset during or after the interviews. It is hoped that a narrative life story approach to interviewing, led by the participant, will reduce the likelihood of distressing the interviewee as it affords participants with greater choice over what they share (R. Atkinson, 2012). A service user was consulted on their views on the implications of interviewing on shame/experiences of victimisation and how to manage this. The service user was enthusiastic the research topic and recommended various ways to safeguard against potential distress to interviewees, which will be implemented. These included: explaining the aims and potential benefits of the research in a clear and transparent way, warning participants that potentially upsetting feelings might arise, inviting participants to share as little or as much as they want, making sure interviews take place in a comfortable and private space and offering the participant regular breaks. In addition to this, the researcher will explain that the participant can stop the interview at any time and monitor for any signs of distress, pausing the interview if needed. Participants will be given a debrief letter, which will include contact details for services they can use to access support at the end of the interview (Appendix D).

There may be increased risk of potential distress to some participants due to the online platform (e.g. if there are technical difficulties). The researcher will try to

reduce this risk by checking their own and the participant's internet connection is stable and devices are charged before undertaking the interview, agree with the participant before starting the interview what actions they should take should technical difficulties occur and raise the possibility of distress caused by this – particularly if the interview has to be terminated early. If technical difficulties do occur, the researcher will look out for any signs of distress from the participant and regularly check in to ensure they are willing to proceed with the interview.

Participants may or may not be under statutory care services. If something is said to indicate harm to self/others the researcher, then, in discussion with the research supervisor, it will be necessary to follow the agency's policies. This could include gaining permission to share risk issues with the participant's GP. Attention will be paid to maintaining a boundary between the researcher's role as a researcher and clinician through supervision and reflexive diaries.

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?
YES – minimal risks to the researcher when interviewing participants. The researcher will be interviewing participants via online platforms so there is no immediate risk to their safety. However, there is a chance the researcher may be distressed by the participant's stories. This will be discussed and managed through regular supervision.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?
YES – Generic support services, such as Samaritans, will be listed in the debrief letter. Participants will also be advised go to their GP if they would like to access mental health support after the interview.

6.4 Does the research take place outside the UEL campus? If so, where?
YES – online (at the researcher's home)

If so, a 'general risk assessment form' must be completed. This is included below as appendix 4. Note: if the research is on campus, or is online only, this appendix

can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been completed:

6.5 Does the research take place outside the UK? If so, where?

If so, in addition to the 'general risk assessment form', a 'country-specific risk assessment form' must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. If that applies here, please tick to confirm that this has been included: ☐

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).
- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).
- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?

YES / **NO**

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: ☐

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: ☐

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead: ☐

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: ☐

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this ☐

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

9. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.

9.1

YES / **NO** If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.
- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

9.2 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

YES / **NO**

9.3 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

NA

9.4 Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.
These organisations have not been approached yet.

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written permission as an appendix: ☐

Please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

10. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): Robin Lamb

Student's number: U1419014@uel.ac.uk Date: 28/05/2020

Supervisor's declaration of support is given upon their electronic submission of the application.

UEL Risk Assessment Form

Name of Assessor:	**Robin Lamb**	**Date of Assessment**	**Between data collection period (June-October 2020)**
Event title:	**Research interviews**	**Date, time and location of activity:**	**Date/time TBC at a time/date that suits participants. Location of interview will be online.**
Signed off by Manager (Print Name)	[redacted] **Dr Zetta G. Kougiali**		

Please describe the activity in as much detail as possible (include nature of activity, estimated number of participants, etc)

If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

Research interviews will take place online via Microsoft Teams or WhatsApp on a sim purchased for research purposes only.

Overview of FIELD TRIP or EVENT:

Event is a research interview with one participant via Microsoft Teams or WhatsApp on a sim purchased for research purposes only.

Guide to risk ratings:

a) Likelihood of Risk	b) Hazard Severity	c) Risk Rating (a x b = c)
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-5 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6-9 = High (Further control measures essential)

Which Activities Carry Risk?

Activity / Task Involved	Describe the potential hazard?	Who is at risk?	Likelihood of risk	Severity of risk	Risk Rating (Likelihood x Severity)	What precautions have been taken to reduce the risk?	State what further action is needed to reduce risk (if any) and state final risk level	Review Date
Research interview	Online platform is hacked and participant	Participant	1	1	1	Use of encrypted online platforms to carry out the interview. This means that the connection is secure and the communication cannot be intercepted.	The researcher will take further precautions to ensure security	21/05/2020

	confidentiality is breached.					While it is still possible for hackers to try and access online platforms, the researcher will take extra precautions, including: WhatsApp- The researcher has purchased a sim card for research purposes only. WhatsApp cannot work on two phones at the same therefore it is not possible for a hacker to intercept the video call. Hackers can still try and access messages. In order to take extra-precautions, the researcher will: - enable two-step verification for WhatsApp, which increases security - frequently check no other platforms are using WhatsApp The researcher has access to Microsoft Teams through the university. This is encrypted at transit and at rest, using industry standard technologies such as TLS and SRTP to encrypt all data in transit between users' devices and Microsoft datacenters, and between Microsoft datacenters.	and confidentiality: WhatsApp: The researcher will: - only use the sim when contacting the participant and undertaking the interview. - Only use a secure, password-protected Wifi connection. Both Microsoft Teams and WhatsApp: - the researcher will record the interview using a separate audio-	

						This includes messages, files, meetings, and other content.	recording device. The interview will be immediately transferred to the researcher's password-protected, non-networked personal laptop. Final risk level = 1	
Research interview	Distress or frustration that might occur if there are technical difficulties when carrying out the interviews	Participant	2	1	2	The researcher will ensure that their own and the participant's internet connection is stable and devices are charged before undertaking the interview. The researcher will agree with the participant before starting the interview what actions they should take should technical difficulties occur and raise the possibility of distress caused by this – particularly if the interview has to be terminated early. E.g. how the researcher should contact the participant If technical difficulties do occur, the researcher will look out for any signs of distress from the	Final risk level = 2	21/05/2020

						participant and regularly check in to ensure they are happy to proceed with the interview.		
Research interview	Managing risk over online platforms. For example, if the researcher observes risks to the participant over the video (e.g. signs of alcohol use) or the participant is distressed.	Participant	1	2	2	The researcher will discuss any risk concerns with their supervisor. The researcher will advise the participant to undertake the interview in a private and safe space. The participant will not be interviewing active users so they should not be intoxicated during the interview. The researcher will look out for any signs of distress/intoxication and if this is indicated, they will not proceed with interview. The researcher will take the time to explain the process of the interview and check for understanding. The researcher will explain that the participant can stop the interview at any time and monitor for any signs of distress, pausing the interview if needed. The researcher will have already provided the participant with a list of services where they can seek therapy or support and will signpost the participant to these at the end of the interview.	Final risk level = 2	21/05/2020
Research interview	Managing confidentiality	Participant	2	1	2	The researcher will be in a private space when conducting the interview. They will advise	Final risk level = 2	21/05/2020

	over online platforms					the participant to undertake the interview in a private and safe space. The researcher will use supervision to explore any issues regarding confidentiality.		

A comprehensive guide to risk assessments and health and safety in general can be found in UEL's Health & Safety handbook at http://www.uel.ac.uk/hrservices/hs/handbook/ and a comprehensive guide to risk assessment is available on the Health & Safety Executive's web site at http://www.hse.gov.uk/risk/casestudies/index.htm. An example risk assessment is also included below.

Appendix E: Letter Confirming Ethical Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Virginia Lam

SUPERVISOR: **Zetta Kougiali**

STUDENT: Robin Lamb

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: Women and shame: stories of recovery in alcohol addiction

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

1. Approved

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)
☑ LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: VL

Date: 2/7/2020

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix F: Ethics Amendment Form

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Trishna Patel (Chair of the School Research Ethics Committee. t.patel@uel.ac.uk).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Trishna Patel at t.patel@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter,

updated consent form etc.

3. A copy of the approval of your initial ethics application.

Name of applicant: Robin Lamb
Programme of study: Professional Doctorate in Clinical Psychology
Title of research: Shame and women: stories of recovery from alcohol dependence
Name of supervisor: Dr Zetta Kougali

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Title change from: 'Women and shame: stories of recovery from alcohol addiction' to 'Women and shame: stories of recovery from alcohol dependence'	Title change to reflect the recruitment strategy used. 'Dependence' is deemed less medicalised terminology.
Change research question from: 'How do women construct their stories of recovery? The stories will be explored in relation to gendered pathways into addiction found in the literature e.g., shame, adverse childhood experiences and victimisation' to the following research questions: 'In what ways does shame feature in the stories of women in recovery from alcohol dependence?' and 'If shame features, in what ways do women navigate shame in their stories?'	Change to research question to reflect the main focus of the research (e.g., shame) and the epistemological stance chosen for this study (e.g., critical realist). This change is consistent with the research proposal and does not reflect a change in the aims of the research, but it allows for a more focused analysis of women's narratives.
Data analysis –I have made slight changes to the analytic method. I have put narrative analysis, rather than being restricted to a life story approach.	I am still using a narrative analysis and looking at the participants' life stories, but following more in-depth reading I felt a more systematic approach to narrative analysis would be more appropriate for addressing the research aims and this better fits with the epistemological stance of the research.

Recruitment- changed the wording from 'alcohol addiction' to 'alcohol dependence'	These terms are often used interchangeably, but I wanted to ensure there is consistency across the ethics form. 'Alcohol dependence' was used in the recruitment materials for participants previously so it does not affect the recruitment strategy as outlined in the original ethics form.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	**X**	

Student's signature (please type your name): Robin Lamb

Date: 30.03.2021

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Trishna Patel

Date: 12/04/2021

Appendix G: Approval of Title Change to Ethics Application

University of East London Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

7. Complete the request form electronically and accurately.
8. Type your name in the 'student's signature' section (page 2).
9. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
10. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

4. A copy of the approval of your initial ethics application.

Name of applicant: Robin Lamb Programme of study: Doctorate in Clinical Psychology Name of supervisor: Dr Zetta Kougiali

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: Women and shame: stories of recovery from alcohol addiction	Title change to reflect the recruitment strategy used. Many of the participants in the study did not identify with the language of addiction. 'Dependence' is also deemed less medicalised terminology.
New Title: Women and shame: stories of recovery from alcohol dependence	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	
Does your change of title impact the process of how you collected your data/conducted your research?		X

Student's signature (please type your name): Robin Lamb

Date: 13.04.2021

TO BE COMPLETED BY REVIEWER		
Title changes approved	YES	
Comments		

Reviewer: Glen Rooney

Date: 14/04/2021

Appendix H: Approved Data Management Plan

UEL Data Management Plan: Full

For review and feedback please send to: researchdata@uel.ac.uk

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	Robin Lamb
PI/Researcher ID (e.g. ORCiD)	(UEL) U1419014 (ORCiD) 0000-0003-2795-0746
PI/Researcher email	U1419014@uel.ac.uk
Research Title	Women and shame in the context of problems with alcohol
Project ID	N/A
Research Duration	February 2020 – October 2021
Research Description	The proposed study aims to increase our understanding of women's experience of shame in the context of problems with alcohol. This is because existing research has found that there could be a link between shame and the development of, and recovery from, alcohol addiction – particularly for women. However, our understanding of why or how shame might relate to addiction to, and recovery from, alcohol addiction is limited. This is because very little research has given women the opportunity to share their stories of shame and alcohol dependency.

	The research questions to be explored are: • How is shame experienced by women with problems with alcohol? • In what ways do these women talk about shame? In order to answer these questions, approximately six to eight women who identify as having, or having had, problems with alcohol will be interviewed.
Funder	N/A
Grant Reference Number (Post-award)	N/A
Date of first version (of DMP)	26 January 2020
Date of last update (of DMP)	5th February 2020
Related Policies	UEL's Research Data Management Policy UEL Data Backup Policy
Does this research follow on from previous research? If so, provide details	N/A
Data Collection	
What data will you collect or create?	Six to eight women who identify as having, or having had, problems with alcohol will be interviewed by the researcher. Interviews will be arranged at a convenient time for participants. Before the interview starts, participants will be asked to read an information sheet describing the research, sign a consent form and complete a demographic form (age, ethnicity, length of time sober). Other personal data (including participant name, telephone number and personal email) will be collected for the purposes of arranging the interview, via the researcher's email. During the interview, participants will be asked to tell their life story, starting at whatever point they feel comfortable. Participants may be asked prompt questions to help them expand on particular parts of their story. The interview is expected to last for approximately 60 minutes, but it may go on longer if the participant wishes.

	All interviews will be audio-recorded and transcribed by the researcher. Each participant will be given a participant number (in chronological order of the interview), participants will be given different names and all identifiable information (e.g. identifiable scenarios, locations) will be anonymised (deleted) from the transcripts. In summary, data collected and created will include: • Research data – audio files and anonymised and pseudonymised transcripts. • Personal data – collected on consent forms (names) and a demographic form prior to the interview (age, ethnicity, gender). No further data will be created in the process of analysing the transcripts. The file of the recordings will be in an MP3 format and will be recording around 8 hours of data. This would be roughly around 480 MB, which is 0.48 GB.
How will the data be collected or created?	Interviews will be recorded on a Dictaphone. Audio files of interviews will be transcribed on a computer as a Word document.
Documentation and Metadata	
What documentation and metadata will accompany the data?	Participant information sheets, consent forms, demographic form (age, ethnicity, length of time sober), list of prompt interview questions, participant ID numbers, list of anonymization techniques, list of transcription techniques and debrief sheet.
Ethics and Intellectual Property	
How will you manage any ethical issues?	• Written and verbal consent will be obtained before all participant interviews. Consent will be re-sought verbally after each interview. • Participants will be advised of their right to withdraw from the research study at any time without being obliged to provide a reason. This will be made clear to participants on the information sheets and consent forms. If a

	participant decides to withdraw from the study, they will be informed their contribution (e.g. any audio recordings and interview transcripts) will be removed and confidentially destroyed up until the point where the data has been analysed. I will notify participants that this will not be possible more than 3 weeks after the interview due to the data having already been analysed. • In order to ensure the confidentiality and safety of the participant, interviews will take place in a private, comfortable and public space. • Given that the interview topic might be experienced as distressing, participants will be warned before the interview that potentially upsetting feelings may arise, they do not have to answer all of the questions and they can stop the interview at any time. If the researcher notices that the participant appears distressed during the interview, they will offer the participant a break or the option to terminate the interview. • If the participant is under statutory care services and the researcher has concerns about the safety of the participant or someone linked to them, they will seek advice from their supervisor and may choose to contact external services to share their concerns (as a result of the discussion with their supervisor). The participant will be warned of this possible eventuality in the information sheet, and the researcher will always try any discuss any break in confidentiality with the participant before contacting external services. • In case of emotional distress during or following the interview, contact details of a relevant support organisation will be made available in a debrief letter. • Transcription will be undertaken by the researcher only to protect the confidentiality of participants. Only the researcher, supervisors and examiners will have access to anonymised transcripts. • Names and all other identifying information (e.g. places) will be anonymised (removed) in transcripts, extracts and any publications. This will be made clear to participants before asking for consent. • Participants will be informed of the plan to disseminate findings (across relevant services and academic journals) and agreement will be made that no names or any other identifiable information will be used.

How will you manage copyright and Intellectual Property Rights issues?	There are no copyright/IP issues.
Storage and Backup	
How will the data be stored and backed up during the research?	• In order to meet with participants, basic contact details, like participant name and phone number, will be acquired. To protect this information, it will be deleted from the researcher's email and saved as an encrypted word file on the researcher's personal, password-protected computer, then transferred to UEL:H drive system via an encrypted memory stick. This file will be deleted on the researcher's computer and then deleted on the UEL shared drive as soon as the interview has taken place. • <u>Audio –recordings will be stored in on the UEL:H drive system</u> - Immediately after the interview, the audio recording from the researcher's unencrypted Dictaphone will be uploaded and saved on the researcher's password protected laptop in a folder with an unrelated name e.g. 'cats' (which only the researcher will have access to). - Once audio files have been uploaded onto the laptop, they will be deleted from the Dictaphone. - These will then be moved onto the H:drive and encrypted. Each audio file will be named with the participants' initials and the date of the interview (e.g. RL 26.01.2020). - All study data on the researcher's personal laptop will be erased once the thesis has been examined and passed.

	• Consent and demographic forms will be stored in PDF format in a different location on the UEL:H drive system. - Consent forms and demographic forms will be scanned and uploaded onto the researcher's laptop immediately after the interview. Demographic forms will not contain identifiable information or the participant ID number. - They will then be transferred to an encrypted storage device and erased from the laptop. The encrypted storage device will be stored in a locked cabinet on the researcher's private property. - Paper versions will then be destroyed, and electronic versions will be transferred from the encrypted storage device onto the researcher's UEL H: Drive (as above) and stored in separate encrypted folders on an encrypted file that can only be accessed by the researcher (using the researcher's password). - Consent forms and demographic forms will then be erased from the encrypted storage device. • Anonymised transcripts will be stored on an encrypted file on the researcher's personal laptop and saved in a different location to personal data on the UEL:ONE drive system - The researcher will transcribe (write up) the audio-recordings using word. The transcriptions will be saved in a folder (with an unrelated name e.g. 'cats') as a password-protected word document. Each participant will be assigned a participant number, in chronological interview order. When writing up the interview, participants will be given pseudonyms (a different name) and any identifiable information will be removed. Transcription files will be named e.g. 'Participant 1'. No list will be kept of participant numbers linked to personal identifying information. - Transcriptions will be saved on the researcher's personal, non-networked, password-protected laptop as an encrypted file. The password for the laptop is only known to the researcher. - All anonymised/pseudonymised research data will be backed up on the researcher's

	personal space on UEL:ONE drive system via an encrypted storage device. - Anonymised/pseudonymised research data will be saved in separate locations to personal data (e.g. scanned consent forms, demographic forms, audio recordings). - Once data has been backed up on UEL servers it will be deleted from the encrypted storage device.
How will you manage access and security?	• As the research study is a part of a University course, two researcher supervisors and course examiners, in addition to the researcher, will have access to anonymised transcripts. Participants will not be identifiable from the transcripts – all personal information will have been removed at the point of transcription. • Recordings from the Dictaphone will be uploaded onto the researcher's password protected personal laptop immediately after the interview has ended. Recordings will then be deleted from the device. Audio recordings and transcriptions will be saved on the researcher's password protected laptop. The laptop is a personal, non-networked laptop with a password only known to the researcher. Audio files and transcripts will be saved in separate folders in storage. Audio files will be backed up and stored on the UEL:H drive system in an encrypted file. Transcripts will be backed up in a different location on the UEL:ONE drive system in an encrypted file. • Consent forms will be scanned and uploaded onto the researcher's laptop immediately after the interview. They will then be transferred to an encrypted storage device and erased from the laptop. The encrypted storage device will be stored in a locked cabinet on the researcher's rented private property. Paper versions will then be destroyed, and electronic versions will be transferred from the encrypted storage device onto the researcher's UEL:H drive system that can only be accessed by the researcher (using the researcher's password) as an encrypted file. Consent forms will then be erased from the encrypted storage device. • The Dictaphone will be stored securely in a lockable storage at the researcher's rented private property.
Data Sharing	

How will you share the data?	• Anonymised transcripts will be shared with research supervisors via UEL email. File names will be participant numbers e.g. Participant 1. • Extracts of transcripts will be provided in the final research and any subsequent publications. Identifiable information will not be included in these extracts. • Anonymised transcripts will not be deposited via the UEL repository as due to the sensitivity of the data.
Are any restrictions on data sharing required?	N/A
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	Audio recordings and consent forms will be erased from the personal laptop once the thesis has been examined and passed. The researcher will erase the anonymised transcripts saved as encrypted files (password-protected) on the researcher's laptop after five years to allow for publication of the findings.
What is the long-term preservation plan for the data?	Anonymised transcripts will be saved as encrypted files (password-protected) on the researcher's password-protected computer for five years to publish the findings of the study for security. This will not be linked to any personal information and will be saved in an encrypted folder with a non-related name (e.g. 'cats').
Responsibilities and Resources	
Who will be responsible for data management?	Robin Lamb
What resources will you require to deliver your plan?	Laptop, audio-recorder, access to UEL OneDrive, access to UEL H: Drive, encrypted memory stick, lockable storage device
Review	Update with file formats of audio-recordings and estimated volume of data in MB/GB

This DMP has been reviewed by:	Penny Jackson Research Data Management Officer
Date: 05/02/2020	Signature: *Penny Jackson*

Guidance

Brief information to help answer each section is below. Aim to be specific and concise.
For assistance in writing your data management plan, or with research data management more generally, please contact: **researchdata@uel.ac.uk**

Administrative Data

Related Policies

List any other relevant funder, institutional, departmental or group policies on data management, data sharing and data security. Some of the information you give in the remainder of the DMP will be determined by the content of other policies. If so, point/link to them here.

Data collection

Describe the data aspects of your research, how you will capture/generate them, the file formats you are using and why. Mention your reasons for choosing particular data standards and approaches. Note the likely volume of data to be created.

Documentation and Metadata

What metadata will be created to describe the data? Consider what other documentation is needed to enable reuse. This may include information on the methodology used to collect the data, analytical and procedural information, definitions of variables, the format and file type of the data and software used to collect and/or process the data. How will this be captured and recorded?

Ethics and Intellectual Property

Detail any ethical and privacy issues, including the consent of participants. Explain the copyright/IPR and whether there are any data licensing issues – either for data you are reusing, or your data which you will make available to others.

Storage and Backup

Give a rough idea of data volume. Say where and on what media you will store data, and how they will be backed-up. Mention security measures to protect data which are sensitive or valuable. Who will have access to the data during the project and how will this be controlled?

Data Sharing

Note who would be interested in your data, and describe how you will make them available (with any restrictions). Detail any reasons not to share, as well as embargo periods or if you want time to exploit your data for publishing.

Selection and Preservation

Consider what data are worth selecting for long-term access and preservation. Say where you intend to deposit the data, such as in UEL's data repository (data.uel.ac.uk) or a subject repository. How long should data be retained?

Appendix I: Email Sent to Prospective Recruitment Organisations

Dear X,

I am conducting research into the stories of women who identify as having experienced problems with alcohol as part of my Doctorate in Clinical Psychology at the University of East London.

Existing research has found gender specific pathways in and out of alcohol dependence, with women more likely to report experiences of victimisation, social stigma and shame. However, women remain underrepresented in research, are more likely to face multiple barriers to accessing treatment and are less likely to seek treatment. We are carrying out this study to better understand women's personal journeys of alcohol addiction, which will be used to inform future research and alcohol support services for women.

I am interviewing women for approximately one hour and asking them to share their story, starting at whatever point they would like. The interviews will be undertaken over the phone, but I can meet face-to-face if this is more convenient. The participant will be reimbursed for travel and all participants will be offered a £15 shopping voucher for their contribution.

I am looking for participants that meet the following criteria:
Adult women (18+) living in the UK who identify as having experienced problems with alcohol.
Must self-identify as in recovery from alcohol dependence and be sober for the interview. Alcohol has to be considered a central component of their dependence, but participants will not be excluded if they identify as having other kinds of drug dependency.
Speak English fluently for the purposes of the interview.

I would be very grateful if you would be willing to discuss the research further and consider supporting the recruitment of people to the study. If you are interested or have any questions, please contact me on the email address below.

Robin Lamb, Trainee Clinical Psychologist, U1419014@uel.ac.uk
Supervised by Dr Zetta Kougiali, Lecturer, z.kougiali@uel.ac.uk

Appendix J: Recruitment Advert

Are you a woman living in the UK who has experienced problems with alcohol?

University of East London

About the Study

If you are over 18 years old, the University of East London would like to hear your story.

This might relate to your experiences leading up to, living or coping with problems with alcohol, as well as the support you have received and/or your recovery.

Existing research suggests women face unique challenges linked to their experiences of alcohol dependency, are more likely to face multiple barriers accessing support and are less likely to seek treatment. However, so far, very little research has focused on the experiences of women and given them the opportunity to share their stories.

If you are interested, we would like to interview you over the phone or online. Interviews should last no longer than 1 hour.

Your experiences will be merged with other people's stories and be used to inform future research and alcohol support services for women.

Make your story count!

Want to take part?

As a token of our appreciation for your time we are offering a £15 Amazon voucher to take part.

If you'd like to hear more about the research please email Robin Lamb:

u1419014@uel.ac.uk

Appendix K: Participant Invitation and Information Letter

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a postgraduate student in the School of Psychology at the University of East London. I am studying for a Professional Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

Existing research suggests that the experiences of and challenges faced by women who identify as having problems with alcohol, as well as the factors supporting recovery, differ from those of men. Moreover, women are likely to face multiple barriers in accessing treatment, but also less likely to seek treatment. However, very little research has given women the opportunity to share their stories. We are carrying out this study to better understand women's personal journeys of alcohol problems and recovery. We are interested in hearing your life story.

This research has been approved by the School of Psychology Research Ethics Committee. This means the research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate as someone who has experiences related to problem drinking/alcohol dependence and recovery. I am looking to interview adult women (18+) currently living in, or from the UK, who identify as in recovery from problems with alcohol. Whilst the focus of this research is on women's experiences of problem drinking/alcohol dependence, you will not be excluded if you identify as having other kinds of drug dependence. You will need to be comfortable enough to communicate in English to tell your story as part of the interview and be sober for the interview.

I want to emphasise that I am not looking for 'experts' on the topic and there are no right answers. You will not be judged or personally analysed in any way and treated with respect and confidentiality. You are free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to take part in an individual interview with me. This will be an informal conversation. The interview will take place online, via Microsoft Teams or WhatsApp, at a time convenient for you. The interview is expected to last one hour, but it may go on for longer if you wish. You will be asked to sign a consent form to confirm you are happy to take part before the interview begins.

During the interview you will be asked to share your story at whatever point you feel comfortable to start. You are welcome to share as little or as much detail as you like. I may ask you some prompt questions over the course of our conversation to help you to tell your story. The interview will be recorded on a digital audio recorder so that I can write-down what you have said and analyse it after the interview has finished.

Some people find the process of telling their story enjoyable or helpful and you will be awarded a £15 redeemable Amazon voucher for your contribution. Your participation would be very valuable in helping to develop knowledge and understanding of women who identify as experiencing problems with alcohol and how to support them.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. During the interview, as you may be talking about difficult experiences, there could be times you feel distressed or uncomfortable. You do not have to answer all the questions asked of you and you can stop your participation at any time.

Part of my role as a researcher is keeping you safe. If I notice you becoming upset, I will check if you are okay. If I am worried that you or someone linked to you might come to some significant harm, I am legally required to inform someone who may be able to help or may need to know. In this case, I will always try and discuss this with you first and will need to discuss this with my supervisors so they can advise. I will provide you with the details of support services at the end of the interview.

All the personal information (personal details, recordings, transcripts) collected during the interview will be kept strictly confidential (please see details below).

What will happen to the information that you provide?

- In order to meet with you, I might need to have some basic contact details. To protect this information, I will record it on my computer and password protected the file. Any contact information will be deleted at the end of the interview.
- When the interview is finished, I will copy the recording onto an audio file, which will be password protected so only I will be able to access the information from the interviews.
- I will type up the information from the recordings. When I write up the interview, I will give you a pseudonym (a different name) and remove (delete) any information that could potentially identify you.

- All data will be stored securely in accordance with government data regulations. For example, any data will be saved in encrypted files so only I can access the data.
- I plan to destroy the audio recordings when I no longer need them (Dec 2021).
- I will hold anonymised transcripts for a maximum of 5 years as I hope to publish the findings of the study.
- As this research study is part of my University qualification, I have two supervisors supporting me with the study and will be discussing information from the transcripts of the interviews with them. My supervisors and the people who examine my papers might ask to see the transcripts. These transcripts will not include any information that could identify you.
- I plan to share the research with relevant services, groups and in academic journals. You will not be identifiable in any written material shared (i.e. presentations, articles).

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, or consequence. Separately, you may also request to withdraw your data even after you have participated data, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible)

Contact Details

If you would like further information about the research or have any questions or concerns, please do not hesitate to contact me.

Name: Robin Lamb Email U1419014@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Zetta Kougiali, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: z.kougiali@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.lomas@uel.ac.uk)

Appendix L: Participant Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Women's stories of problem drinking/alcohol dependence and recovery

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

……

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……

Date: ……..…….

Appendix M: Transcription Conventions

The transcriptions conventions used draw on Malson (1998), and stressed readability of content rather than detailed reproduction of speech features. Punctuation was added to facilitate reading.

Symbols	Description
(.)	Noticeable pauses were denoted by the use of a full stop in brackets (.) although were not timed.
(…)	Text removed, (less than 20 words, in excepts only)
[Inaudible]	Inaudible
<>	Chevrons were also used to provide <clarificatory information>, such as to indicate laughter or non-verbal utterances
…	Three full stops … were used to indicate unfinished utterances
_	An underscore _ was used to indicate an absence of any noticeable gap between two utterances, e.g. when one speaker is interrupted by the other.
Italics	Where words were noticeably stressed they were typed in *italics*

Appendix N: Participant Debrief Letter

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study on women's stories of problem drinking/alcohol dependence and recovery. This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

- In order to meet with you, it is likely I collected some basic contact details. To protect this information, I recorded it on my computer and password protected the file. Any contact information will be deleted at the end of the interview.
- Now the interview has finished, I will copy the recording onto an audio file, which will be password protected so only I will be able to access the information from the interviews.
- I will type up the information from the recordings. When I write up the interview, I will give you a pseudonym (a different name) and remove (delete) any information that could potentially identify you.
- All data will be stored securely in accordance with government data regulations. For example, any data will be saved in encrypted files so only I can access the data.
- I plan to destroy the audio recordings when I no longer need them (Dec 2021).

- I will hold anonymised transcripts for a maximum of 5 years as I hope to publish the findings of the study.
- As this research study is part of my University qualification, I have two supervisors supporting me with the study and will be discussing information from the transcripts of the interviews with them. My supervisors and the people who examine my papers might ask to see the transcripts. These transcripts will not include any information that could identify you.
- I plan to share the research with relevant services, groups and in academic journals. You will not be identifiable in any written material shared (i.e. presentations, articles).

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may find the following resources/services helpful in relation to obtaining information and support:

- Samaritans has a free to call service 24 hours a day, 365 days a year, if you want to talk to someone in confidence. Call them on 116 123.

- The charity Mind provides information on mental health and support. You can access more information online: https://www.mind.org.uk/, or by telephone: 0300 123 3393, or text: 86463

- Visit the NHS website for more information on how to access mental health and alcohol support services online: https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/how-to-access-mental-health-services/

- You can access peer-led alcohol support groups across the UK or online alcohol support groups for women. Please see some examples of these below.
  - Alcoholics Anonymous (https://www.alcoholics-anonymous.org.uk/)

- Change Grow Live (https://www.changegrowlive.org/local-support/find-a-service)
- Women for Sobriety (https://womenforsobriety.org/)
- SheRecovers (https://sherecovers.org/)
- LoveSober (https://www.lovesober.com/)
- Soberistas (https://soberistas.com/).

- Alternatively, you can contact your GP who can signpost you to relevant mental health or alcohol support services.

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Name: Robin Email: U1419014@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Zetta Kougiali, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: z.kougiali@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.lomas@uel.ac.uk)

Appendix O: Narrative Analysis Procedure

Detailed narrative analysis procedures based on Crossley's Systematic Approach (2000) and T. Miller's (2017) feminist narrative analysis.

Detailed Narrative Analysis Procedure	
Step one: Reading and familiarising - Interviews - Transcribing the interviews - Initial coding	- Following each interview, I recorded initial impressions (e.g., triumph? tragedy?) and emotional responses to the participants' stories in my research journal. - I transcribed each participant's interview verbatim, including repetitions, unfinished sentences, silences and pauses, anonymising the information to maintain confidentiality. Punctuation was used to facilitate clarity and readability. - I read through each interview transcript multiple times to familiarise myself with the material, get a general impression of structure and emerging and significant themes, and the storyteller. - Any reflections were recorded in a reflexive diary (Appendix C).
Step two: Interpretation of individual transcripts - Identifying narrative tone - Identifying images and themes - Narrative presentation of self - Identifying grand narratives	I analysed participants' individual transcripts for where and in what ways shame featured in their stories systematically, looking specifically at: - Identifying narrative tone (noted tone, themes and images in coding; Crossley, 2000) Device used to establish the mood or atmosphere of the story. Speaks to narrator's attitude on the subject matter and to the audience and may reflect opinion or attitude of 'other voices'/ characters

	○ I reflected on how something was said, McAdams (1993) recommends looking at what happened versus the narrator's reporting of it. For example, was the tone pessimistic or optimistic? ○ What appears to be left unsaid? How might the silences be read? What appear to be risks of sharing certain revelations? (T. Miller, 2017). ○ Tone of narrator in the present, past, or future (re self, events, other characters), and if there were changes over time (T. Miller, 2017) ○ Identifying images and themes (Crossley, 2000) ○ Crossley (2000) argues that images and themes overlap, and it can be helpful to look at these together. As imagery is both made and discovered, I considered the personal, socio-cultural context of the imagery and the images that were provoked in me. Themes were understood to summarise key points in the stories. Alongside, the identification of themes and images. - Noting narrative presentation of self (noted self in coding; T. Miller, 2017). 'Self' refers to the different ways participants story the self in their narrative (T. Miller, 2017) and identities designate the attempt to differentiate a sense of self along different social and personal dimensions (Bamberg, 2013). Thus, the storying of different selves provides the basis for broader identity formation and development. ○ In the narrative presentation of selves what aspects or features remain constant and what shifts? - Identification of socio-cultural grand narratives and treatment narratives *(italicised in coding)*

	○ In line with Crossley (2000), I recognised stories are told in reference broader social, cultural and political narratives. I drew on T. Miller to consider how grand narratives are apparent, drawn on, rejected as individuals narrate their experiences? (T. Miller, 2017) ○ Grand narratives are socially embedded and broadly shared frameworks of knowledge and experience that are understood and communicated in the forms of stories (T.Miller, 2017)
Step three: Weaving together personal stories	- Next, I explored the images and themes in relation to life chapters, key events, significant people and future scripts using tables and a synopsis of transcript (Appendix P) - I used this to summarise shame in each participants' recovery story (Crossley, 2000), looking at what shifted over time, what was emphasised, different and remained the same? (T. Miller, 2017)
Step four: Cross-analysis	- The final stage involved exploring the commonalities and differences amongst participants by (T. Miller, 2017): o extrapolating and synthesising the main themes using mind maps (Appendix P). o comparing and contrasting tone and style - This allowed me to develop a common plot and build a framework from which to summarise how shame featured across the stories (Appendix P). I considered how the experiences might be mediated by the material conditions participants are living and how participants' stories related to existing grand narratives around alcohol dependence and the addiction/shame literature (T. Miller, 2017) - Quotes and excerpts were used to demonstrate interpretations throughout.

Appendix P: Sample of coding, participant synopsis, cross-analysis narrative development and story construction

Key
Tone
Shame

Structure, chapters	**Transcript**	**Themes, tone, comments on the narrative**
'Traumatic' Childhood: 'Feeling different' in family	So please tell me your story wherever it begins. Please feel free to tell your story in whatever way you wish and begin the story wherever you feel comfortable. It can be helpful to tell your story from the earliest point you remember to the present day. Okay, urgh god. This is the hardest bit because if you'd have asked me this five years ago, four years ago, I would have said, 'Oh yeah, I started drinking, er, it became a problem when I had my son', but now I think actually it goes *right* back to my childhood, which was... nothing *bad* happened, but it was traumatic. There was…there was trauma involved, which I think is a common thread. So, I spent my childhood feeling different, not quite fitting in with any of my family. I was not the black sheep, but more (.) they all went along with my mum and dad with everything and I was always the one saying, 'No, not me. That's not right. I'm not doing that', and I was labelled awkward, or cantankerous, and…so I just felt different. Erm, a lot of childhood anxiety. Erm, that really kind of, not ruined my childhood, I would say my childhood was really good, really happy, but that was a black cloud that followed me around. //So when I discovered alcohol at the age of probably fourteen, it changed the way I felt and I felt normal. And I actually remember the first time I got drunk, me and my best friend who's also in recovery, funnily enough...we both got drunk together with a	**Tone:** Authoritative–narrative reconfiguration and new understanding. Orients listener to key concepts in her story– childhood trauma **Image:** 'Common thread' – in her own story/ reference to link b/w trauma and alcohol dependence in women? **Image:** black sheep – childhood self – different – alienated, isolated? **Theme:** Shaming family narrative *Implicit narratives of gender? Pathologising of speaking out as a girl* **Image:** black cloud – pain of past following her into adulthood?

First drink story: 'I felt normal'
 	
Culturally 'normal' drinking: 'everybody did it'
	couple of boys, which gave us then courage to fool around with them because otherwise it was a no, no. Erm, and we ended up having a fight <laughter> which is really, you know we get on so well just madness, it was just madness. But it just felt, 'Aghh. I can be myself now. I can drink and I can be who I think I should be' and that is confident, sassy, all the things that I feel I am now, but I couldn't be when I was a teenager.
	
	// So it, it was just getting drunk like everybody else. I don't think it was any...I never thought it was problem. I knew I would never…I could never go anywhere without alcohol. I could never go out on a night out without alcohol. It was it...yeah, I used to look at people that…some of my other friends, they wouldn't drink, they'd drive their cars as we were going out of town, and I thought there was something...I just couldn't understand it. I just was like…it's not normal, that's not normal. Erm, so I wouldn't….I still wouldn't have thought it was a problem because everybody does it, everybody did it. Erm, I-I just, I don't know, I just...yeah, everybody did it. And when I met my partner who I'm with now, still with now, we just spent our time getting drunk and, you know, just…but it didn't seem a problem.
	
	// Erm, errr…so, yeah, I mean the anxiety just…that I think that played...the anxiety that I had and the shame I had around that was a big factor. I realise that now. I didn't at the time, but I realise it a lot more now. Erm, and I think yeah, that's kind of quite a short, sort of…of yeah, erm, errr…I'm a bit stuck now <laughter> Oh god.
	
	That's okay. Erm, where do you think...where did you think the anxiety came from? And how did you think of yourself at that time?
	
	Erm, god, it came from school. Erm (.) <crying> Sorry. Oh god. I don't why it makes me upset, it just...<crying>
		Theme: reparative function of drinking – felt 'normal' v. different
		
		Self: Drinking self – preferred/ desirable self – power?
		
		Implicit narratives of gender? Drinking facilitates transgression of traditional femininity
		
		Tone: clear narration of past self v transformed current self,
		
		Theme: Cultural narratives: 'drinking normal' (sobriety as abnormal) – drinking self = social identity
		
		Tone: Narrative reconfiguration – new meanings
		
		Tone: Highly emotive and raw, pain of childhood – still raw and must have been hard to cope with as a child, especially the pain of

Traumatic childhood: anxiety – 'covered in shame'	It's okay. Take your time. It al-it's madness because it just...even though it was forty-odd years ago and it really doesn't get to me now, but it...when I think back to it, it, it just it triggers these feelings and it's just <sigh> I had a lot of anxiety at school. Erm, but nobody would ever have known it. Nobody...my parents never knew. I never said a word to my parents because I was *too* ashamed. I was covered in *shame* that if they found out I had this anxiety, they would…I don't know…I didn't know what...My dad has got quite high standards. Erm, and we...there was never any praise at home. It was always, 'well, well done, but you could have done that', or...and he's still like it to this day, bless him. Erm, and my mum was...I now know is a ball of anxiety, so I couldn't go to her. I didn't know at the time why, but I couldn't go to her and I couldn't tell anybody, so I kept it to myself, but I just…I dreaded going to school. I was, I was always *ill*. I had tonsillitis *all* the time and I know that is...that was my anxiety. I know it was now because if I ever feel anxious, I can feel it in my throat, erm, so oh sorry, I'm just warbling on...<laughter>	keeping it a secret, past + present – embodied shame? **Tone:** extreme case formulation – portray depth of secrecy/ loneliness? **Theme:** Shame and childhood anxiety Secrecy and silence – shame-management strategy **Image:** covered in shame – 'real self' consumed by and hidden by shame **Theme:** Shame and lack of emotional warmth and nurturing from parents **Characters:** father stern, high standards; mother 'ball of anxiety' – unavailable? **Tone:** 'bless him' compassion for father?

Table 1: Sample of Preliminary Coding Following Familiarisation with the Transcript (Lulu)

Key events	• Feeling different/othered (in family) • Childhood anxiety, shame and secrecy --- • Early drinking stories --- • 'Perfect' pregnancy v birth 'failure' • Shame from termination • Sister's shame from cancer diagnosis • Son's anxiety and story of shame from blacking out ('the biggest shame') --- • Son's birthday party ('The best feeling in the fucking world' • Fiftieth birthday ('I was really depressed') • 'Speaking shame' with counsellor • Reaching out to other women on sober platforms • Son's story of pride
Significant people	• Son (He's my biggest supporter') • Husband • Mother ('Nervous ball of anxiety') • Father ('High standards') • Best Friend ('In recovery') • Peers ('Oh, that Lulu. She's a right snooty bitch') • Sister • Counsellor ('She was sober as well, so that helped') • Sober women (understanding) • AA ('negative', 'old', 'mostly men', 'shameful')
Future script	• Continual self-development • Support other women/ mothers

Synopsis of Lulu's story

Lulu is 54 years old and has been sober for 6 years. She is white British, cis female, with one son and is co-Director of company.

Tone: humorous, sad, irreverent, playful, frank, engaging, emotive

Narrative voice:

- Clear narration of present self throughout the narrative – offers up interpretations and understanding. Has the effect of distancing past self with current self who is no longer ashamed and has become all the things she was not or could not be before recovery.
- Takes ownership over her story from the beginning, names that narrative has changed in late recovery (versus early sobriety). Reflects increased understanding of self and the reasons for alcohol use. Uses clear concepts from the beginning – shame and trauma ('common thread') to frame her story and highlight what's important to the listener

How and when is shame talked about (What's missing? Not named or named later? Risks?):
Concept story is organised around shame, lots of emotive imagery about shame, names shame throughout the story, highly emotive/crying when talking about shame memories

- Extreme case formulation - childhood
- Behaviour when drinking (euphemism/ intimating)
- Parenting of son – if teacher had found out about drinking – not named, inferred
- Struggles in early motherhood - (not enjoying it) – qualifying statements (I loved him) – faced with self in relation to another (not meeting expectations)
- Crying indictor of shame? – Childhood anxiety, termination story, story of shame about son
- Drinking self <not me>

Table 2: : Summary of Coding for Weaving Together an Individual Story (Lulu)

Key events	**Themes**	**Imagery**	**Narratives**
'Traumatic' childhood • Being different/othered (in family) • Childhood anxiety, shame and secrecy	Lack of emotional nurturing Disconnection Shame and secrecy Self as different Voicelessness Mental health	*'Black sheep'* *'Covered in shame'* *'Ball of anxiety'* *'Black cloud'* *'Blithering idiot', 'Couldn't speak'* *'Big dark secret'* *'Darting in and out'* *'Shapeshifted'*	Internalised narratives of shame
Early drinking • 'First drink' story ''I felt normal' 'I can drink and be who I think I should be'	Self as normal Empowerment Culturally 'normal' drinking Connection Acceptance		*Grand 'drinking as the norm' narrative* Reparation-liberation narratives

Motherhood and start of problematic drinking • 'Perfect' pregnancy v birth 'failure **Escalating alcohol use** • shame from termination, sister's cancer and son's anxiety • financial difficulties • son finds Lulu blacked out ('the biggest shame') **Early sobriety**	Shame from gender roles Powerlessness Isolation & loneliness Self as ashamed Loss of control Drinking to cope/ escape/ numb Self as ashamed Mental health Shame from drinking (alcoholic label as woman/mother, behaviour when intoxicated) Drinking untenable Shame (barrier to support) Future self	*'I'm stuck here',* *'It just floored me',* *'[breastfeeding] was like knives'* *'Just hanging on', 'Everything was just going to implode',* *'Mental health was shot to pieces'* *'Everything was just a mess',* *'A viscous cycle',* *'I was on the coach fucking comatose'* *'I can't stop drinking, but I tried to imagine myself as a fifty, sixty-year-old woman drinking, and I just thought I can't (…) something's got to give'*	Narratives of escalating alcohol use *Grand 'good/bad mother' narrative* *Grand AA narrative*

Son's birthday party Fiftieth birthday **Recovery and a positive non-drinking identity** Speaking about shame with counsellor Reaching out to other women Son's story of pride	Health benefits of sobriety Improved relationships Identity shift Mental health Shame (barrier to support) Self as ashamed Recovery for others Recovery for self Identity development Extending repertoire of experience Rejection of alcoholic identity and AA (unrelatable, negative, shameful) Comparison Connection (sober platforms, son) Self-compassion and self-acceptance Pride	*'Climbing the walls'* *'A Friday night and I'm drinking pissing coffee'* *'Locked in a lot of shame'* *'I was stuck'* *'I left myself behind'*	Narratives of recovery *Sobriety narrative* Narratives of resistance Reclaiming narratives *Grand AA narrative* *Grand 'good/bad mother' narrative*

Table 3: Cross-analysis sample of narrative structure and development

	Narrative	Shame and management of shame	Positioning of the self/ identity
Childhood	**CORE NARRATIVE** **Internalised narratives of shame** *I am different, flawed, ugly, not good enough, unlovable, unlikeable, I don't fit in, abnormal*	Internalised messages about who they are from critical/ rejecting relationships (parent/mother, peers, partners) Linked to feelings of disconnection, alienation, powerlessness Alongside: Anxiety, appearance eating issues, depression *Strategies:* Secrecy, people pleasing, self-silencing, maintaining distance from others	Seek confirmation of identity from outside the self Distance between externally portrayed self (a performed) in attempt to hide internally felt self as bad
Early drinking	*Reparation – liberation narratives* *I can be who I want to be and people want me to be. I can be normal. People like me.*	*Strategies:* Alcohol temporarily alleviates from shame Reparation/liberation – alcohol facilitates connection, belonging, empowerment, freedom	Drinking facilitates preferred/ desirable drinking self (externally portrayed self) Drinking masks internally felt sense of self as bad Drinking forms the basis of a positive social identity
	Narratives of escalating alcohol use and shame	Internalised messages about who they are from critical/ rejecting relationships with (parent/mother, peers, partners)	Drinking to try to cope with internally felt sense of self as bad/shameful/ stuck

Heavy drinking	Interaction between internalised narrative of shame, gendered grand narratives and shame from drinking	Internalised shaming/stigmatising messages from grand narratives about alcoholism as a disease and gender roles (motherhood, alcoholics) *Alongside:* anxiety, eating issues, depression, self-harm, suicidal ideation *Increase in shame-management strategies the more shame:* drinking, secrecy, distancing self from others	Drinking self no longer desirable, but bad and out of control Navigating stigmatising alcoholic identity
Early sobriety	**Narratives of recovery** *Narratives of resistance* *Positive sobriety narratives*	Gradually working through shame/ involves letting go of strategies used to manage shame – learning that the worst does not happen (e.g., rejection, judgement) Working through shame by connecting through women's stories - comparison with other women normalises drinking and breaks down internalised stigma about 'women alcoholics' - provides possible future self/ women role models – belief can change - sense of connection and belonging Internalising positive/hopeful messages of sobriety movement / from loved ones (e.g., of acceptance, care, support)	Work through shame attached to the drinking self Reduce gap between externally portrayed self and internally felt sense of self – reveal 'authentic' self Provides a basis of a more positive social identity

Late recovery			
	Developing a positive non-drinking identity *Reclaiming narratives* - narrative ownership *Narratives of quest-redemption*	Process of internalising and performing of a positive sober identity Over time leading to a positive non-drinking identity Process of discovery leads to increased understanding, self-compassion, self-acceptance, self-forgiveness	Externally portrayed self and internally felt sense of self more integrated Internally felt sense of self no longer bad – replaced by pride Development of positive sober identity and moving away from a drinking-related identity

Appendix Q: Yardley's criteria for evaluating qualitative research

Yardley's (2007) criteria as a framework for evaluating the quality of the research.

Sensitivity to context	Awareness of the participants' perspectives and setting, the sociocultural and linguistic context of the research, and how these may influence what participants say and how the researcher interprets this.
Commitment and rigour	Demonstrated by in-depth engagement with the topic.
Transparency and coherence	The reader should be able to see clearly how the interpretation was derived from the data.
Impact and significance	The requirement for all research to generate useful knowledge (practical utility, generating hypotheses, or even changing how we think about the world).