The Role of Shame in Alcohol Dependence; Narratives from those in Recovery

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Abstract

A relationship between shame and alcohol dependence has been reported in the literature, however the precise nature of this relationship is largely unexplored. A review of the literature suggested that experiencing shame is considered to be a risk factor of relapse. The drinking of alcohol temporarily relieves the negative feelings of shame therefore reinforcing further drinking and maintaining addictive behaviour. As a consequence, learning how to cope with shame without drinking, may improve recovery. On the other hand, some evidence suggests that experiencing shame may be helpful for developing reasons for stopping drinking and also a necessary protective factor that helps to prevent relapse.

This study sought to explore how shame is experienced and understood by those ‘in recovery’ from alcohol dependence, by looking at the different ways that shame is spoken about in personal narratives. Eight participants were recruited from Alcoholic Anonymous (AA) groups and invited to tell their story of recovery.

Transcripts were analysed using a narrative approach, focusing on how participants narrated their stories and made sense of their experiences, by identifying specific narrative techniques used to talk about shame. An analysis across all transcripts then identified narrative themes in relation to shame and from this a tentative model of shame in alcohol dependence was proposed.

A discussion of the findings evaluated evidence for the model, taking into account the results from this study and those from existing theory and research, whilst identifying areas of further research that are needed. Clinical implications in relation to addressing shame in recovery are also discussed.
Acknowledgements

I would like to express my gratitude to the eight participants who generously gave their time to participate in this research. I have been inspired by your stories and they really have made this research project what it is. I would also like to thank my supervisors, Dr Paul Davis and Dr Kate Gleeson for your guidance and expertise throughout this project. I am also grateful of the support from Martin Weegmann; thank you for introducing to me to some wonderful people and sharing with me your knowledge and wisdom.

As submission of this thesis seals the end of my clinical doctorate training, I look back at how far I have come in my journey to become a clinical psychologist, the amazing memories I have made and the enriching experiences I have had. Thank you to everyone who has been part of that journey with me; to all my past supervisors, work colleagues and fellow trainees.

Thank you finally to my wonderful friends and family. You have supported me through the challenging times and will hopefully get to celebrate with me very soon!
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Major Research Project Empirical Paper

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Introduction

Overview

For over 30 years addictive behaviours have been understood as a method for masking the emotional pain associated with shame (Potter-Efron, 1987). However a literature review suggested that despite the reported link between shame and addiction, our understanding of its impact on recovery is relatively unknown; in particular how those with alcohol dependence experience shame. Whilst generally shame is found to be a hindrance to recovery (Merritt, 1997; Wiechelt & Sales, 2001), it has been found that addressing shame may also enhance recovery (Luoma, Kohlenberg, Hayes & Fletcher, 2012), suggesting that we need to develop a better understanding of people’s experiences of shame in recovery. This research aimed to analyse the stories of those in recovery from alcohol dependence and explore how shame was experienced. I will firstly outline my influences for conducting this research before summarising the literature, demonstrating the rationale for this study.

Influences for this Research

Personal significance

My interest in this research is informed by personal experience, when growing up I witnessed the devastating impact of alcohol dependence. I observed the transformation of a successful individual, to someone crippled by alcohol dependency and the hopelessness of change. I saw the struggles of someone trying and failing to engage in successful recovery, leading me to question- why is recovery so difficult? I acknowledge that my relationship with this research area will have impacted on my
interactions with it and whilst I believe this permitted me to approach the research with empathy and understanding that would allow participants to share their stories with me, I have been mindful throughout the process in considering how this may have impacted on the findings.

Social significance

Alcohol dependence is a stigmatising illness and health campaigns aimed at reducing drinking often portray ‘shaming’ messages (Day, Gough & McFadden, 2004). Despite campaigns, the number of people with alcohol dependence is increasing (SAMHSA, 2013); of the one-million people in England living with alcohol dependence only 6% are believed to be accessing treatment, implying there are serious barriers to recovery (NICE, 2011). Even for those in treatment, relapse rates are high and it is suggested that relapse endorses feelings of failure and shame (Saunders, Zygowicz & D’Angelo, 2006). By developing an improved understanding of shame and its role in recovery, we could better support those with addictions.

Alcohol Dependence

The Diagnostic and Statistical Manual (DSM-5) now uses the term ‘Alcohol Use Disorder’ to place both ‘alcohol abuse’ and ‘alcohol dependence’ into a single category which is defined as the uncontrolled consumption of alcohol in a way that significantly impacts functioning (APA, 2013). Alcohol dependence is characterised by craving and continued drinking despite harmful consequences, with withdrawal symptoms occurring when alcohol is not consumed (Moss & Dyer, 2010).
Psychological theories of alcohol dependence suggest that drinking is a method of self-medicating to cope with negative emotions (Gelkopf, Levitt & Bleich, 2002), with the positive effect of alcohol reinforcing further drinking (West & Brown, 2013). This complements biological (disease) models, that propose that the regular use of substances leads to dependence, with metabolic adjustments meaning that increasing dosages are needed to avoid withdrawal (Hyman & Malenka, 2001).

The public perception of those who drink excessively is often negative. Media campaigns targeting ‘problem-drinking’ frequently have shaming messages; if you drink to a point of no control then you should be ashamed (Day et al., 2004). However a recent study suggested that health campaigns have resulted in people feeling ashamed, causing increased drinking rather than reduction (Watts, Linke, Murray & Barker, 2015). Whilst not everyone who drinks becomes addicted, there is stigma associated with alcohol dependence (Bobbe, 2002; Gray, 2010; Schomerus et al., 2011), perhaps because of the misunderstanding that ‘addicts’ have a choice (Ramsey, 1987). However these negative judgments can be internalised and experienced as shame (Cook, 1987).

**Defining Shame**

Shame is a self-conscious emotion, which typically arises when a person evaluates themselves through the eyes of another (Lewis, 1995). It is recognised to contribute to feelings of inferiority and worthlessness (Flanigan, 1987; Ramsey, 1987).
Guilt is often used interchangeably with shame however important distinctions have been made in the literature (Dearing, Stuewig & Tangney, 2005), particularly with regard to the type of attributions associated with each (Tangney & Dearing, 2002). When a person experiences shame they perceives themselves as bad, thus the attribution is internal and global and the self is judged negatively. In contrast in guilt a person perceives their behaviours as bad and the attribution is unstable and specific and thus the behaviour rather than the self is negatively evaluated (Kim, Thibodeau & Jorgensen, 2011). As such, guilt may motivate reparative actions including seeking support (Baumeister, Stillwell & Heatherton, 1995), whereas shame inhibits help seeking (Gilbert, 2002; 2006).

Little is known about what makes a person attribute situations internally or externally, however adults with insecure attachments have been found to experience more shame (Gross & Hasen, 2000), suggesting that early relationships may impact on proneness for self-conscious emotions.

Shame and Alcohol Dependence

Research suggests that shame increases vulnerability to addictive behaviours (Tangney, Wagner & Gramzow, 1992) and also has been shown to be a risk factor for becoming dependant on substances, rather than using substances recreationally (Dearing et al., 2005). In addition evidence suggests that those who experience shame may also experience anger and depression, in particular self-directed aggression, which can present as substance use (Tangney, Stuewig, & Mashek, 2007). This may negatively impact recovery because drinking is a strategy that relieves shame, which
upon abstinence can become overwhelming, leading to relapse. For example Sanders (2011) found that shame caused distress for women entering recovery and that higher levels of shame were linked to greater chance of relapse. Wiechelt (2007) proposed that relapse triggers feelings of inadequacy and thus intensifies feelings of shame thereby perpetuating a vicious cycle whereby drinking relieves shame but also reinforces it.

Gilbert (2009) suggested that treatments should support people to develop tolerance to shame. Luoma et al (2012) showed sustained reductions in shame at a four-month follow up, when participants were given strategies for managing shame and the perceived judgments of others in an Acceptance and Commitment group.

Therefore, at present there is a paradox in the literature; feelings of shame might be a hindrance to recovery yet evidence also suggests that interventions focussing on shame positively impact on recovery and this warrants further exploration.

Overall, research exploring how those in recovery from alcohol dependence experience shame is severely limited. Generic models of shame suggest that shame is experienced when a person anticipates a negative response from others; this is perceived as threatening because of the possibility of being rejected by others (Gilbert, 2002). This understood to increase vulnerability to many mental health problems. However models are not specific to alcohol dependence, which is concerning given the shame and stigma associated with addiction.
**Alcoholics Anonymous: An Approach to Shame?**

AA is a fellowship of people with alcohol dependences who support fellow sufferers with recovery (Alcoholics Anonymous, 2009). Members are guided by principles called ‘The Twelve-Steps’, however these principles have been criticised for being ‘shaming’. Ramsey (1987) suggests they encourage a person to admit defects of character and anecdotally it is not uncommon for clinicians to report clients leaving an AA meeting feeling more ashamed than when they entered (P. Davis, personal communication, January 11, 2016). Brown (1991) claimed that AA is not effective because people may feel ‘emotionally threatened’ to discuss shame, however these claims were based on a single case study. A more recent, larger study suggested that AA could actually help to remove the ‘veil of shame worn into recovery’ (Sanders, 2011, p.374), implying that acknowledging shame may be helpful. So whilst AA may be experienced as ‘shaming’, a better understanding from those who have been successful in AA may provide further clarity into the processes of addressing shame.

**The Social Construction of Addiction as an Illness**

AA understands alcohol dependence to be ‘an illness’ that you never recover from (Alcoholics Anonymous, 2009). It could be argued that the word ‘illness’ removes blame and therefore shame. MacIntyre (1984) said humans ‘are storytelling animals’, thus the language we use in our stories could be an important method of giving others insight into our worlds (Frank, 1995). AA is likened to storytelling and it is proposed that AA provides a shared vocabulary to create a story from hearing
other people’s stories (Weegamann & Piwowoz-Hjort, 2009; Weegman, 2010). This is a social constructivism position, which suggests that our experiences are jointly constructed through shared language and interaction. Whilst this provides a theory for why people construct stories about themselves, it would be interesting to explore specifically how experiences of shame are narrated, because this might provide further insight into how shame should be addressed in treatment.

**Aims and Research Questions**

In summary there seems to be a relationship between shame and alcohol dependence, however our understanding of this and its impact on recovery is limited. There is mixed opinion on whether shame is unhelpful and linked to relapse, or whether focusing on shame is positive and prevents relapse; this is an important clinical issue that requires further exploration. In particular, exploring how shame is experienced within personal narratives may provide further understanding of how we can work effectively with shame in recovery. This study will address the following questions:

1) In what ways do participants tell their stories of shame?

2) How is shame experienced and/or understood by those in recovery from alcohol dependence?

In answering these questions, it is hoped that themes across narratives can be conceptualised in a tentative framework of shame.
Methodology

Choice of Research Methodology

This study analysed stories of those in recovery from alcohol dependence, to explore how shame was experienced. Recovery is a unique and personal experience; therefore a qualitative methodology was selected because this permitted rich information to emerge from the stories (Barker, Pistrang & Elliot, 2008). Narratives have been claimed as the principal way that humans give meaning to experiences (Murray, 2008; Rowe, 1989), but these are within the context of other stories and situations (Lindy, 1993; Riessman, 2008). Therefore a narrative analysis was selected because this allowed for consideration of how participant stories were likely to have been influenced by other people’s narratives. Furthermore narratives can represent a construction composed jointly between narrator and researcher (Riessman, 2008), therefore my personal experiences and interactions with the participants could also be considered (Plummer, 2001). ‘Quality’ qualitative research postulates researchers to strive for ‘honesty and transparency’ (Tracy, 2010); therefore I have chosen to narrate this thesis in both the first and third person to be open about my reflections.

Methodological Considerations: My Theoretical Position

Narrative Analysis can be conducted in multiple ways therefore it is important to be transparent about my epistemological and ontological position.
Ontology

Two ontologies have influenced Narrative Analysis. The humanistic ontology emphasises a person-centred approach, treating the storyteller and listener as unified. Focus is paid to what is said on an individual basis (Andrews, Squire & Tamboukou, 2004). The post-modern ontology emphasises multiple subjectivities in the construction of narratives and the researcher is interested in the meaning behind narratives. I took a post-modernist position whereby I perceived each narrative as a vehicle for participants to talk about their experiences and language as a medium to do this.

Epistemology

There are two epistemological approaches to shape narrative analysis; the realist (naturalist) and social constructivism (relativist) position. The realist position assumes ‘external reality’ and ‘truth’, taking the premise that an entity ‘exists’ and can be ‘discovered’ (Harper, 2012). The social constructivism position claims that there is no such thing as external reality and instead our language constructs versions of our reality within social contexts (Willig, 2008; 2012). The social constructivism position shares with narrative psychology an emphasis on language as a tool for forming identity (Gergen, 1985). As the literature implied that shame is ‘universally experienced’ (Keltner, 1995) I took the realist position that ‘shame’ is a ‘real’ emotion that ‘exists’ across cultures. However I also understand people as experiencing and interpreting shame in different and unique ways, informed by
personal and social context and available social discourses. As such my position could be understood as ‘middle-ground’ (Esin, 2011; McAdams, 1993).

**Ethical Considerations**

Favourable ethical opinion was granted by University of Surrey Faculty of Health & Medical Sciences Ethics Committee. Information sheets were provided to any potential participant interested, with no obligation to participate. Because the interview had the potential to trigger distress, all participants could make an informed choice based on accurate information of the study, however it was anticipated that distress would be limited due to the open-ended nature of questions, which gave participants control over how they told their story. Those who agreed to be interviewed provided written consent and could withdraw during the interview or immediately after. Interviews were conducted in community locations agreed with the supervisor, permitting privacy and confidentiality in adherence with lone-working policies. For data protection, participants were assigned pseudonyms and identifying information was omitted from transcripts. Furthermore only limited examples of transcripts will be included in this report rather than full narratives. All recordings were stored on an encrypted device and deleted following transcription.

**Participants and Recruitment**

Participants were adults (aged 18+) who defined themselves as being ‘in recovery’ from alcohol dependence. Due to inconsistent definitions of ‘recovery’ it was decided that ‘recovery’ was a personal experience and no minimum length of
sobriety was specified, however the participant must recognise their alcohol dependence and be doing something they considered to be ‘recovery’. It was acknowledged that alcohol dependence often co-occurs with the use of other addictive substances, however participants using other substances were not excluded from the study where alcohol dependence remained a significant issue.

Initially I had hoped to recruit from charities and the probation service, however on discussing the study with them there were concerns about the focus on ‘shame’ and potential associated distress, therefore all recruitment came from AA. I met with a researcher and a professional member of the AA committee to discuss recruitment and was put in contact with fellow committee members who recommended potential participants. A snowball sampling method was used, whereby participants would recommend others. Recruitment took place over a six-month period (March-August 2015); 13 people expressed interest and were provided with further information. Eight participants consented to take part: five males and three females, aged between 27-74, ranging from 21 months to 35 years in sobriety (Table 1).
Table 1.

*Participant demographic information*

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Years in sobriety</th>
</tr>
</thead>
<tbody>
<tr>
<td>James</td>
<td>54</td>
<td>White British</td>
<td>25</td>
</tr>
<tr>
<td>Matthew</td>
<td>41</td>
<td>White British</td>
<td>16</td>
</tr>
<tr>
<td>Gary</td>
<td>74</td>
<td>White British</td>
<td>35</td>
</tr>
<tr>
<td>Raj</td>
<td>48</td>
<td>Black British</td>
<td>17</td>
</tr>
<tr>
<td>Diana</td>
<td>55</td>
<td>White-European</td>
<td>11</td>
</tr>
<tr>
<td>Michelle</td>
<td>27</td>
<td>White British</td>
<td>2.5</td>
</tr>
<tr>
<td>Dean</td>
<td>29</td>
<td>White British</td>
<td>1.75</td>
</tr>
<tr>
<td>Paula</td>
<td>67</td>
<td>White British</td>
<td>19</td>
</tr>
</tbody>
</table>

**Interviews**

Riessman (2008) claims that narrative interviews aim to produce detailed accounts rather than brief answers, therefore an interview schedule was developed which encouraged detailed stories to be told, rather than a question and answer approach. The interview consisted of one main question, which invited participant to ‘*tell their story*’, followed by additional prompt questions for exploring areas of interest. My emphasis was on actively listening, whilst reflecting on how my presence was leading to a joint construction of the narrative (Crossley, 2000). Interviews lasted between 35 -75 minutes (average 47 minutes), each was digitally recorded and transcribed verbatim. I kept a journal of my initial impressions and experience of the interviews.
Data Analysis

There are many approaches to analysis, however I opted for a structured process (Crossley, 2000). In taking this approach I could be transparent during all stages (Tracy, 2010).

Step 1: Reading and familiarising

I transcribed all interviews before familiarising myself by re-reading each transcript multiple times in order to get an overview of the content and structure. Coding notes were then made in relation to general themes, patterns and language.

Step 2: Identifying narrative tone

Narrative tone is the way the story is told and the ‘emotional flavour’ portrayed (Murray, 2008). During this stage I reflected on the manner in which each narrative was told: Was it fast or slow paced? Was it optimistic or pessimistic? White (1973) suggested ‘plot structures’ for making sense of experiences; tragedy, comedy, romance and satire and I used these to consider what genre I could assign each narrative. I also began creating summaries of each narrative.

Step 3: Identifying imagery and themes

Crossley (2000) recommends looking at both images and themes; themes summarise the key points whereas images refer to visual images evoked in the
listener. I looked at themes and images (evoked in me) across the whole narrative to consider changes as the narratives progressed.

**Step 4: Weaving a coherent story**

Having summarised each narrative, I then sought to put the narrative back into a coherent story rather like creating a biography of the participant’s life, which was grounded in the data using excerpts and quotes to demonstrate my interpretations.

**Step 5: Cross-analysis**

Once coherent stories were created for each participant, the final stage involved looking for commonalities and differences across narratives by synthesising salient themes and building a framework to summarise all narratives.

**Credibility**

To ensure credibility I adhered to Yardley’s (2000) principles of quality qualitative research:

1. *Sensitivity to context:* The research question was developed after a substantial review of the literature prior to the study commencing. Reflective diaries were kept throughout the process to ensure that context and wider societal narratives were considered in line with the epistemological position. Quotes from the interviews are provided throughout to illustrate how interpretations were made.
2. *Commitment and rigour*: A detailed process was followed in relation to data collection and analysis over a ten-month period in order to fully engage with the data and reflect between each stage. The researcher transcribed the interviews and took a methodical stepped approach to the analysis to demonstrate academic rigour. All transcripts and analysis were reviewed by the supervisor and discussed, before being reanalysed. Furthermore, peer supervision was attended as a space to reflect on the research. See appendix for further detail on the reflective process.

3. *Transparency and coherence*: Extracts from transcripts and analysis and the reflective journal are included in the appendix to enhance transparency.

4. *Impact and importance*: This study was conducted following an identified gap in our current knowledge, therefore it may make an important contribution to literature with regard to understanding the unique experiences of shame within alcohol dependence. It is also hoped that findings will be disseminated to other professionals in the field through publication.
Results

Overview

In keeping with a narrative inquiry, this section begins by summarising the narratives. Key themes, tone and narrative impression will be offered to provide a context for each participant in which interpretations can be situated (Riessman, 1993). Due to space limitations the exhaustive individual analyses cannot be presented, however detailed examples can be found in the appendix.

I will then present my interpretations of similarities and differences across narratives (Crossley, 2000). Firstly the narrative techniques will be outlined and how these were understood as methods for talking about shame. Secondly a narrative-thematic analysis presents emerging themes and how these relate to shame and recovery. I will finish by proposing a framework to conceptualise the processes of shame identified in the analysis. It is recognised that all ideas presented here should be seen as one version of multiple possibilities (Gilbert & Mulkay, 1984).

Individual Case Analysis

‘Paula’

Paula is age 67 with 19 years sobriety; her parents had drinking problems and her childhood was unpredictable. She explained how there were no conversations at home, they lived ‘in a big house with separate rooms’, where ‘no one passed each other’. Feelings of shame and inferiority started in childhood when she was ashamed to take friends home. She began drinking as a teenager and had alcohol dependence in
her early-twenties. Paula believed this was fate; ‘it’s just the way the cookie crumbles’ and initially saw recovery as outside her control. The tone of her narrative was pessimistic, hopeless and desperate.

Paula married and had two children but believes that she let them down. This was a core theme within her narrative and a source of emotional pain and shame. Another theme related to feeling unworthy (‘I was always less, I don’t deserve to be here’). After 20 years of addiction Paula started recovery by joining AA. Self-acceptance was a fundamental part of her recovery and as she spoke about this the tone shifted to hope and positivity.

‘Diana’

Diana is 55 years old, born in Europe with 11 years sobriety. A theme of shame ran throughout her narrative, starting in childhood when she learnt that she was the result of an affair; she grew up viewing herself as a ‘mistake’. Her single mother had a substance addiction and seemed unable to be emotionally responsive; Diana recalled wearing dirty clothes which made her feel ashamed and different from peers. The narrative tone was initially one of sadness.

Diana moved to the UK in her twenties; her narrative gained momentum and the tone became exciting. Diana found a ‘new lease of life’ and began drinking, which gave her confidence to socialise with others. However Diana made several suicide attempts, lost her job and her shame resurfaced, experiencing shame in who she had become. Diana attended a rehabilitation centre and joined AA. Her recovery involved
acknowledging hatred and blame from childhood and the tone ended as reflection and contemplation.

‘Michelle’

Michelle is age 27 and has 2.5 years sobriety; both her parents had alcohol dependences. The tone of her narrative was frantic, disjointed and lacked structure, giving the impression of disorganisation, perhaps mirroring her childhood experiences. She spoke of instability, seldom seeing her father and being constantly moved, which was a source of shame because Michelle never felt good enough; ‘I just didn’t think I was normal or up to scratch’. She began drinking at age 11 and later started using drugs; her life became moulded around alcohol and drugs, she described taking jobs that she could easily quit. Michelle would usually drink to a point of blackout and her behaviour was another source of shame because she felt greedy and that something was wrong with her for needing to drink.

Fear brought Michelle into recovery, waking up after four days not knowing if it was day or night. She initially attended residential treatment and then joined AA. A theme of fear was salient throughout, particularly fearing relapse. The tone was desperate; wanting to do everything possible to stay well and Michelle attended multiple AA meetings a day. As Michelle spoke of recovery the tone changed to hope and determination.
‘Gary’

Gary is age 74 with 35 years sobriety, his childhood was in the aftermath of World War II and he described it as ‘regimented’ and ‘disciplined’. Gary suggested that his father ‘instilled shame’ by making him feel ashamed of his behaviour unless it was ‘exemplary’. Gary felt inferior and fearful of making mistakes. He started drinking age 15 and described the ‘transforming’ effect of alcohol of removing his feelings of inferiority. Gary did not drink all the time, however when he did it was until blackout; his drinking slowly escalated and the tone was emotional as Gary recounted the negative effects of drinking. He got married and had children but his marriage broke down as a result of becoming abusive when drunk; which was a source of shame. During his second marriage he began to question his drinking and made attempts to stop without success, but finally sought help from AA. During recovery Gary was overwhelmed by shame, however he described overcoming this by building his confidence to share his story with others. The tone of Gary’s narrative was progressive, moving from a place of fear and self-blame, ending in a place of acceptance and positive self-regard.

‘Raj’

Raj is age 48 of Indian origin with 17 years sobriety. He moved from Africa to the UK as a child but described feeling different from his peers. Growing up Raj experienced shame when his mother warned him away from girls, turning the TV off whenever women appeared. Raj felt as though being attracted to women was forbidden and there was something wrong with him; as a result he kept his feelings
secret. During adolescence Raj began drinking, which was a positive experience as it helped him to fit in culturally. Raj experienced similar positive experiences of both drugs and alcohol at university, however it was not until completing university that he identified alcohol dependence. Despite being married with children, he spent little time at home and more time drinking. Apart from childhood, shame was mostly absent from the narrative until Raj described being reprimanded by his four-year-old son, for attending his birthday party drunk. Raj was forced to acknowledge his difficulties and began recovery; he recalled multiple relapses, each time becoming more desperate. Raj started attending AA meetings every day and becoming an active member of the fellowship. Despite the sadness in what was being told, Raj’s narrative had a theatrical and comical tone.

‘James’

James is 54 with 25 years sobriety. Very little was spoken about childhood, but he revealed his father had an alcohol dependence from which he did not recover and died while James was a teenager. James went to boarding school, describing himself as ‘introvert and shy’. When he began drinking it made him confident, ‘it took away the chains and it made me feel free’. He began drinking more frequently and his school performance deteriorated. He dropped out and got a job, which led to a pattern of working, drinking and quitting jobs, which was a source of shame. James moved to Europe where he attempted to create a new identity, however this gave him more opportunities to drink and his dependence on alcohol worsened. On returning to the UK the pattern of working and moving continued. The theme of shame was subtle
throughout James’ narrative, whilst not always named explicitly shame was often described, ‘I felt there was something not quite right with me’; ‘I knew that it was abnormal and it wasn’t what other people did and I was ashamed’. The extent of James’ drinking was eventually revealed on a family holiday and James painted a shameful image of being ‘exposed’ and ‘humiliated’. The tone changed to one of relief; in acknowledging his difficulties James set himself free. James’ story had an abrupt ending; following his first AA meeting he never drank again. James reported that articulating his shame was pivotal in his recovery. The tone was pensive and reflective, giving the impression that James holds his experiences close, but regards them as his past.

‘Matthew’

Matthew is 41 with 16 years sobriety; he grew up in a mining town before moving to London. Alcohol was a ‘normal’ part of his community and many of Matthew’s family had addictions. Matthew started drinking as a teenager, he began having blackouts and feeling terrified frequently. Matthew’s father attended AA and when he died, Matthew too started going to meetings commencing on the day of his funeral. At AA he met someone who recommended attending a rehabilitation centre. Shame was primarily absent from Matthew’s narrative however I learnt that talking about emotions was not part of his upbringing and it seemed that Matthew did not have the language to describe what was happening emotionally. As a result, the tone felt detached and disconnected. It was on becoming sober that Matthew experienced
emotions, primarily anger and shame, which he learnt to manage using alternative methods to drinking.

‘Dean’

Dean is 29 and has 21 months in recovery. The tone was initially sad as he painted an image of a vulnerable child, shy and fearful. He began drinking alcohol at age 11 and described the transforming effect it had on removing his fear. Dean acknowledged that he was addicted to substances by the age of 16 and his behaviour became unpredictable, erratic and criminal; he was frequently arrested and spent time in prison. Many of the events in Dean’s past were shameful and he was still struggling to overcome these (‘the damage that I’ve caused it’s still on-going... it’s like the destruction is still coming’).

His recovery was as part of a rehabilitation programme, however he also joined AA. Dean is new into recovery and spoke of the daily battles in maintaining sobriety. The tone at the end of his narrative was anxious, reflecting the fear he feels about relapsing, however also reflective of the positive changes he has made.

Cross Analysis: How Were Stories Told?

Narrative analysis takes the view that stories are not created in isolation. As all participants had attended AA, it could be suggested that everyone had access to the shared language within this fellowship. This was kept in mind whilst considering similarities because it might have impacted on how stories were told (narrative tools used to tell stories) and what was said (narrative themes).
**Genre**

Genre is a way of categorising stories. It was observed that participants used three main genres as a context for their narratives:(Table 2).

Table 2.

**Genres identified**

<table>
<thead>
<tr>
<th>Genre</th>
<th>Description</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melodrama</td>
<td>These were dramatic narratives with exaggerated characters and exciting events. Mostly high in emotion.</td>
<td>Paula and Diana</td>
</tr>
<tr>
<td>Comedy Theatre</td>
<td>These were humorous narratives, often using dramatic irony to induce laughter.</td>
<td>Raj</td>
</tr>
<tr>
<td>Quest</td>
<td>Narratives that took the listener on a journey in search of something, often becoming lost in the process, but returning triumphant with new knowledge. Usually had a happy ending</td>
<td>Gary, James, Michelle, Dean and Matthew</td>
</tr>
</tbody>
</table>

Diana and Paula’s narratives resembled melodramas; the tone was dramatic and used detailed descriptions. Diana portrayed herself as an emotional drunk similar to the ‘drunk stereotype’ depicted in films and soap operas,

‘...I’d ring his bell. He was not answering, so I rang again...and I just collapsed on the doormat, like nobody loves me’

*(Diana, 248-250)*

Paula used this genre to tell her story of dramatic highs and lows, resembling an emotional rollercoaster,
‘...things got better and then it would all go down hill again, I would be completely out of control. I would be drunk all the time and we would move [to] try a new start’

(Paula, 51-54)

Raj’s narrative was also dramatic; his story was narrated as if an actor was playing his role: a genre I named comedy theatre. Using this genre, Raj could narrate humorous scenes and then pause to invite the listener to laugh,

‘… I ascribed to God, the category of logical fiction. Namely that there had to be a God, because if there wasn’t I was fucked’

(Raj, 134-136)

‘...he looked like Freud and he had a German accent, he had a bow tie and all the rest of it and he said tell me about your mother. I was just like what are you on about [laughs]’

(Raj, 311-314)

In Diana’s, Paula’s and Raj’s narratives, descriptions of the self appeared to be dramatised allowing shame to be externalised; locating it outside themselves and in another character, thus creating distance with the shame.

‘Quest’ was another genre identified. In these narratives the listener was taken on the narrator’s journey through addiction. Michelle’s narrative could be divided into two parts; the first half presenting the journey of her early life and beginnings of her addiction,

‘…I started drinking when I was about 11... both my parents are alcoholics’
The second half presented the ‘return journey’, where she was able to enter recovery and reflect on her relationship with shame,

‘...talking to other people that have been through the same things and done the same things .... takes a lot of the shame out of it, .... I don’t have to let it be a big lead weight anymore.... because that was holding me back from getting sober’

(Michelle, 183-188)

The same two parts were identified for Dean, where the second half of his narrative showed contemplation of the future, armed with knowledge gained from his journey,

‘...maybe I’d not be in recovery now, without all these things’

(Dean, 153-154)

‘ ...but I know that I’ll make everything worse if I drink again’

(Dean, 209-210)

In contrast to highly emotive melodramas, the quest genres maintained a reflective tone throughout, often talking from hindsight,

‘….look[ing] back I realise that I was actually using my knowledge of alcoholism to deny the fact that I had a problem’

(Gary, 56-58)

Whereas the melodramas were emotional, the emotional impact in the quest genres were minimised,

‘...I mean obviously it’s difficult to recollect from that time just how I felt internally, but I probably felt distant’
They were often matter of fact,

‘I just realised that it’s either that or I die, you know, and I didn’t want to die’

(Matthew, 213-214)

**Imagery**

The creation of visual images was interpreted as a narrative tool because this helped the listener to visualise the participant’s shame. It was possible that images also helped to communicate complex experiences:

‘*Out of control train*’

A repeated image conjured for me was visualising the participant on an out of control train. This image was powerful because it removed blame, giving the image of desperation and lack of ability to stop, rather than a lack of desire,

‘... I just tumbled through life like that wing that tumbles with the wind and then I get knocked up against the bush and stay there for a while, and then the wind will blow the other way and I roll off down again’

(Paula, 378-381)

Lack of control over the train (life) was a source of shame for some,

‘... I was ashamed of like my drinking and my behaviour and I didn’t understand that once I had one drink I couldn’t stop’

(Michelle, 173-174)
‘...the most shameful thing is admitting that you can’t deal with life without a
drink... Not being able to do anything unless I’d had a drink’

(Dean, 134-137)

‘Being exposed’

Related to this came an image of people trying to become invisible. However
with this came shame with facing reality when they were exposed,

‘...just awful. I felt ashamed of myself in a big way. I felt as though everyone
was looking at me, criticising me’

(James, 679-681)

The image of a mask falling off and exposing vulnerability underneath was
particularly strong in James’ narrative and a source of shame,

‘... totally gone, totally disappeared.... I was exposed and there was no hiding
from it or pretending that it hadn’t happened. It had happened!’

(James, 598-600)

For Gary and Raj the realisation that someone had discovered their secrets
was shameful,

‘...I didn’t realise that my wife was stood behind me. And I said “gosh I’m
really sorry, I don’t know what came over me”. She said “I do”. I said “what?” She
said “you’re an alcoholic”’

(Gary, 107-109)
‘...when a four-year-old says that, you can’t hide away’

(Raj, 41-42)

How is Shame Experienced? Themes Across Narratives

In exploring the processes of shame in recovery, the themes ‘Addicted Parent’, ‘Inferiority’ and ‘Giving Back’ emerged:

‘Addicted Parent’

Paula, Diana, Michelle, Matthew and James’ parents had addictions. Whilst this shows that not everyone with alcohol dependence will have parents with one (and vice-versa), the processes that occur through having ‘an addicted parent’ could be related to shame. Matthew witnessed how alcohol broke-up his parents’ marriage and alluded to being ashamed of his father’s behaviour,

‘...I never thought that I would follow the same path as him’ [alcoholic father]

(Matthew, 25-26)

Diana and Paula referred to feeling shame as a consequence of having ‘an addicted parent’ and the impact this had on maintaining a ‘normal’ home,

‘...because of her addiction you know, I couldn’t bring people home...we didn’t have the niceties of life’

(Diana, 66-69)
‘I was ashamed of our home, I couldn’t take people home’

(Paula, 523-524)

Seeing a parent experience shame may also contribute to oneself experiencing shame,

‘I had a lot of shame thinking about it….my mother had got divorced because she had an affair with a man and when her husband was away she got pregnant’

(Diana, 31-33)

The child may adopt their parent’s coping strategies,

‘….my mum’s an alcoholic, she’s got an eating disorder…and it’s weird that I developed an eating disorder’

(Michelle, 130-132)

For others, family discourses about ‘inheriting’ the addiction were more explicit,

‘….dad used to say to me it would never surprise me if you and your brother, would end up going to AA meetings’

(Matthew, 34-36).

‘Well my belief is that I was born an alcoholic’

(Paula, 492)

In taking this view it could also be suggested that responsibility for one’s drinking is removed. Such narratives could potentially remove blame, which gives the person permission to carry on drinking.
Having ‘an addicted parent’ may also cause ruptures in relationships with parents,

‘... [Mums’] moods were really unpredictable; she could be really loving and then really aggressive’

(Michelle, 121-123)

‘...My mother didn’t protect me....decisions were not in [my] best interests

(Paula, 357-359)

‘Inferiority’

Inferiority was present across all narratives and referred to the experiences of participants seeing themselves as different. For some, this was about not being ‘worthy’ or ‘up to scratch’,

‘...I had a lot of feelings of inferiority. I thought I was different to other people. I thought that other people were better than me’

(Gary, 36-38)

‘...I thought I was a bad person, I was always less... I don’t deserve to be here I don’t deserve to breathe the air’

(Paula, 210-212)

Feelings of difference and inferiority could be identified as a source of shame,

‘...I just had a sense of shame of who I was, I just didn’t think I was normal or up to scratch, so I think there was an element of shame in all of it’

(Michelle, 177-178)
'I knew that it was abnormal. I knew that it wasn’t what other people did and I was ashamed of it.'

(James, 564-565)

Drinking was therefore identified as a method for ‘transforming’ feelings of inferiority, perhaps a way of managing shame,

‘...I absolutely adored the feelings it gave me. It transformed me, changed me’

(Gary, 26-27)

‘... alcohol just took the edge off of life you know’

(Dean, 30-31)

‘...I saw it [alcohol] as a very positive thing because obviously it was enabling me to do things which I couldn’t normally do. So I looked upon alcohol as very useful’

(James, 47-50)

‘Giving Back’

The final stage (in Twelve-Steps) is called ‘service’, a way of helping others and sharing the messages of AA. Despite the varying lengths of sobriety, all but one of the participants were still attending AA and this seemed to be significant. Participants referred to this as ‘giving back’,
‘...part of my recovery and staying recovered involves passing on and helping others’

(James, 828-829)

‘...I thought I would never get over that, but the years of doing things and I’ve done a lot of service, I’ve given back’

(Paula, 264-266)

‘...I’ve continued to do service. .... I’m constantly doing something within it because it’s important to me to keep on doing it’

(Raj, 152, 158-160)

Whilst the theme was primarily one of giving back and helping others, continued service within AA also seemed to be related to dependency; a fear of what could happen if one left the fellowship,

‘...perhaps I could remain abstinent for the rest of my life, I dunno perhaps I could. But I’m not willing to try’

(Gary, 374-375)

‘...I believe that if I did do [turn my back on AA] I would cut myself off from the supply of whatever it is that is keeping me well’

(James, 837-839)

**Shame in Recovery**

**Core Shame**

Previous research has focused on shameful ‘behaviour’ associated with drinking, however analysis identified that shameful behaviours could be distinguished
from what I interpreted as ‘core shame’. This shame was not about doing something embarrassing but instead feeling as though there was a fault with the self,

‘... I just had a sense of shame of who I was, I just didn’t think I normal or up to scratch’

(Michelle, 177-178)

‘...you’re full of shame aren’t you. I mean I was, about what I’d done, just the fact that I had a problem’

(Matthew, 222-223)

This shame was also constructed through comparison with others,

‘I knew that it was abnormal. I knew that it wasn’t what other people did and I was ashamed of it’

(James, 564-565)

Shame of one’s life emerged across narratives frequently beginning in childhood, sometimes ‘inherited’ from parents,

‘I felt I was ashamed in my life’

(Paula, 136)

‘Shame for me began when I was quite young in regard to my mum, who made me feel ashamed of sex’

(Raj, 355-356)

‘I know that he [father] instilled shame in me... unless your behaviour was exemplary then you should be ashamed of yourself’

(Gary, 221-223)
‘...I had a lot of shame... my mother had got divorced because she had an affair with a man, and when her husband was away she got pregnant

(Diana, 31-33)

Core shame seemed to trigger drinking because of the pain it caused,

‘...it was like bristles in my brain they hurt me so much, I had to drink to take the pain away’

(Paula, 192-193)

Shameful behaviours whilst drunk were mentioned, however these behaviours did not seem to maintain drinking, rather shame seemed to hinder entry into recovery because of the belief that there was something fundamentally wrong with the person that could not be repaired.

*Healing Through Hearing*

All participants experienced AA as pivotal to recovery and it seemed that this was as a result of hearing stories and normalising one’s own experiences through comparison. In hearing stories, participants could make sense of and release their own feelings of shame,

‘There is no shame in AA, everyone has done much worse then anybody else. You can just go and listen and nobody laughs at you’

(Diana, 406-408)

‘I met people who had killed people drunken blackouts, so mine was minor’

(Paula, 259-261)
‘...hearing other people tell their stories...it’s not just me that’s done that. It doesn’t make it right, but it’s suddenly not as shaming it’s more normal’

(Matthew, 257-259)

‘...I’m not the only one you know and it took a lot of the shame out of it’

(Michelle, 193-195)

The process of making relationships seemed to be important for facilitating connections with others,

‘I trusted the people and looking back that was a huge part’

(James, 731-732)

‘I realised that was actually a vital point, having someone to talk to about relationships and to pass something onto somebody’

(Raj, 209-211)

Listening to others provided a forum that started a process of self-discovery,

‘It’s a learning process really. It’s like going back to the beginning, apart from I can talk and walk.... I feel a bit like I’m armed with everything I need in life but I don’t really know how to use it’

(Dean, 249-253)

**Acknowledging and Accepting**

Accepting shame rather than getting rid of it also seemed to be part of the recovery process,

‘Being able to talk about shame and articulate it... what am I ashamed of... and then telling another person. It releases it, it ceases to have power over you’

(James, 753-756)
‘….it’s like bursting a pimple and all this gunk comes out and then you clean it up and you can start healing. But the gunk has got to come out’

(Diana, 687-689)

A narrative within AA is that alcoholism is an illness that cannot be recovered from and this narrative appeared to provide acceptance,

‘I didn’t know that it’s something you’ve got for life’

(Dean, 162-163)

‘ I wasn’t a bad person trying to get good, I was a sick person trying to get well’

(Michelle, 182-183)

**Developing a Model of Shame for Alcohol Dependence**

Following analysis, a tentative model was developed to conceptualise shame (Figure 1). The model is speculative but attempts to link the results from this analysis to existing theory, namely Attachment Theory (see discussion). Put simply, the model suggests ‘layers of shame’ whereby early attachment difficulties (green layer) impact negatively on relationships with others and how oneself is viewed (yellow layer), which can result in ‘core shame’. Drawing on previous theory, alcohol dependence could therefore be understood as a coping strategy for managing shame (Gelkopf et al., 2002).

In recovery, the model suggests that shame needs to be repaired by re-modelling the processes leading to ‘core shame’. This includes developing trusting relationships and safety (green layer), in order to reconstruct a narrative of the self
(yellow layer). Perhaps more controversially, it is proposed that alcohol dependence may be later replaced by dependence on AA.

Whilst addressing shame may promote recovery and prevent relapse, the specific factors that bring a person into recovery are still unknown thus the two parts of the model are tentatively joined.
Figure 1. Proposed Model of Shame

Foundations of Shame

- Insecure Attachment (Absence of secure base)
  - "Inferiority" (Inadequacy/self as not worthy)
  - Disconnection (Not belonging/feeling different)

- "Addicted Parent"
  - "Inherited Shame"
    - "Core Shame"

Maintenance Cycle

- Alcohol Dependence

Recovery Cycle

- Develop a secure base, based on trust and safety
  - "Acknowledging and Accepting"
  - "Healing Through Hearing" (Becoming connected)
  - See self as worthy
  - "Giving Back" (Helping others and the ongoing development of personal narratives)

- Dependency on AA
- Identity based on alcohol dependence
Discussion

This study has explored how participants experienced shame during recovery from alcohol dependence. In presenting the ways that stories were narrated and salient themes to emerge across narratives, a tentative model was proposed to conceptualise ways that those with alcohol dependence may experience shame. In addressing the research question, it was found that those in recovery understand shame to have a role in both the development of alcohol dependence and in recovery. Whilst it was interpreted that shame might maintain dependency because drinking alleviated distress, unlike previous studies, shameful behaviour as a result of drinking did not appear to maintain drinking for participants in this study. Instead it was interpreted that participants experienced ‘core shame’ - a painful, internal experience that developed before drinking began (rather than shame being a consequence of drinking), which the model refers to as ‘Foundations of Shame’. During recovery, participants reported the importance of acknowledging these experiences in a safe space that allowed them to construct an understanding of their shame and subsequently heal this.

Constructing a Shame Narrative

Narrative theory suggests that scripts about the self are continually redefined to make sense of experiences (Morgan, 2000). This study suggested that participants came to develop a personal understanding of their shame by sharing their stories with other people in AA. By analysing how participants told their stories I considered how narratives came to be constructed and whether the creation of a ‘shame-
narrative’ in itself was one way of addressing shame in recovery. It was found that participants used a range of narrative tools for telling stories; genres were a technique for discussing shame. ‘Melodrama’ and ‘comedy theatre’ appeared to help narrators externalise shame, locating it outside of the self and in another character. In doing this, the narrator could control the shame and how it was presented; this was often achieved by turning shaming events into comical ones and it could be suggested that helped remove the pain associated with shame. White and Epston (1990) suggested that externalising emotions removes blame from the individual and makes the emotion less important, therefore perhaps it could be interpreted that shame could be talked about when the emotions associated with it were minimised.

Another genre used by participants was ‘quest’; in these narratives it often seemed like I was accompanying the narrator on their journey, seeing their experiences through their eyes. My personal reflections after these interviews were about the empathy I felt; this made me consider whether this genre was used as a way of evoking empathy in the listener by helping to put the listener in their shoes. Brown (2012) proposed that in experiencing empathy we feel accepted rather than judged, therefore perhaps it could be said that this genre was a method of eliciting empathy, therefore helping a person overcome shame.

**Foundations of Shame**

Participants spoke about shame as a deep-rooted view about themselves, which I labelled as ‘core shame’. Core shame was spoken about in relation to the theme of ‘inferiority’, which emerged in all narratives, capturing participant’s
experiences of feeling unworthy. Participants spoke about their feelings of difference; alcohol being a method whereby feelings of inferiority could be overcome. Therefore it could be interpreted that alcohol provided a means of connecting with another. This would support Gilbert’s (2002) model of shame, who suggests that humans have a desire ‘to belong’, with lack of connection being experienced as rejection and subsequent shame. More recently Brown (2012) also suggested that absence of connections leads to beliefs about being unworthy of belonging. Therefore taken together with the interpretations from this study, it could be suggested that ‘inferiority’ prevents connection with others and also lack of connection increases feelings of inferiority; thus maintaining shame. Alcohol dependence could therefore be maintained in order to manage these deep-rooted feelings of shame (Gelkopf et al., 2002).

Some participants talked about their parent’s addictions and the impact this had on feeling different from peers and the shame of this; the ‘addicted parent’ was therefore presented as another theme. Whilst it is acknowledged that not everyone with alcohol dependence or who experiences shame will have an ‘addicted parent’, these experiences could provide an explanation for how ‘core shame’ develops. Those with ‘addicted parents’ not only felt differences with peers but also had reduced opportunities to connect due to fear and shame of peers finding out about their parent’s addiction. Recently Jacobs and Jacobs (2015) suggested that in avoiding potential shame associated with the ‘addicted’ family member, families become silent. This study also proposes that silence stops peers from discovering
their ‘addicted parent’ and reduces shame, yet in remaining silent, connections with peers cease, which actually reinforces shame.

Furthermore, participants spoke of distress associated with having an ‘addicted parent’ and of not being able to predict their parent’s behaviour. Bowlby’s (1980) Attachment Theory proposes that early attachments with caregivers are critical for developing a sense of safety, for seeking comfort during times of distress and for developing positive relationships with others. Research also suggests that children of parents, who are emotionally unavailable, develop a poorer sense of self and struggle to manage distress (Cooper, Shaver & Collins, 1998). Therefore in drawing upon Attachment Theory it could be implied that ‘addicted parents’ were less able to provide consistent emotional support, leading to attachment difficulties. Cooper et al. (1998) proposed attachment disruptions increase vulnerability for developing a poorer sense of self (i.e. seeing the self as worthless and inferior). Therefore taking this into account, this study could suggest that attachment difficulties increase vulnerability to experiencing shame, whilst also resulting in the lack of development of strategies to manage this.

The model proposed is not the first to link attachment and addiction; Reading (2002) proposed that when attachments are troubled, connections to substances replace connections from humans. Dallos and Vetere (2009) later suggested that people trust alcohol to ‘look after them’ more than others. Crittenden (2006) refers to the development of ‘strategies’ (which could include alcohol) for regulating emotions in the absence of other strategies typically learnt through attentive parenting. Whilst addiction has previously been related to Attachment Theory, this is believed to be the
first model to link attachment theory to *alcohol* dependence specifically. This model goes further by considering how *shame* may modulate early attachment-difficulties and alcohol dependence.

**Maintenance of Alcohol Dependence**

Previous research suggests that shameful behaviours maintain a cycle of dependence (Sanders, 2011; Wiechelt, 2007). Whilst this study also suggests that alcohol alleviates distressing emotions and therefore reinforces drinking, shameful behaviours specifically related to drinking were *not* found to maintain dependence. Nevertheless, painful emotions associated with ‘core shame’ are likely to be a reason why giving up alcohol is challenging (Wiechelt, 2007). In the proposed model, ‘maintenance’ and ‘recovery’ cycles are hinged with a dotted line, symbolising that at present there is no clear understanding of the specific factors that bring a person into recovery.

**Using Shame in Recovery**

The final section of the model conceptualises how participants experienced shame during recovery. A theme to emerge across narratives was in relation to recovery being an opportunity to ‘acknowledge and accept’ shame. This was often about developing a new narrative; moving from a place of seeing oneself as inherently bad, to a narrative about oneself having done ‘bad things’. This can be likened to the processes described by Dearing et al. (2005), whereby shame about the self is changed into guilt about behaviour. It may also indicate the importance of
being able to develop a compassionate narrative about the self during recovery and more specifically how compassionate narratives may help to alleviate shame (Gilbert, 2009).

‘Healing through hearing’ was a theme that captured participants’ experiences of connecting to others during recovery. Listening to others may have provided a template by which participants could talk about their own shame but also facilitated connections through having shared experiences and feeling ‘normal’ (Brown, 2012). Although in this study, these connections were made to AA, it is proposed that connections could also be established through building a relationship with a partner, friend or another service. Bowlby (1980) suggested that responsive and sensitive caregivers who acknowledge distress, assist children to develop secure attachments. Therefore, potentially AA may provide a substitute secure attachment or a forum in which attachment security can be fostered, thus promoting feelings of trust and safety to acknowledge shame and manage the associated distress.

‘Giving back’ was another theme related to recovery. Helping others by telling one’s own story and sharing the messages of AA is an important narrative within AA, therefore it was unsurprising that this was dominant in participants narratives. It was interpreted that ‘giving back’ helped participants to feel worthy of the support that they had received and helped to challenge beliefs of inadequacy and inferiority. It was also considered that ‘giving back’ allowed participants to maintain connections and build new relationships.
A New Dependency?

Participants seemed to fear the consequences of stopping contact with AA and therefore it was questioned whether a dependence on AA had developed in order to maintain sobriety. Even those with significant years of sobriety still identified themselves as ‘an alcoholic’ and whilst it is acknowledged that this narrative is promoted within AA, it could be proposed that such label maintains an ‘alcoholic’ identity and thus a need to attend AA.

Clinical Implications

This study would argue that the assessment and consideration of shame in the treatment of those who enter services is crucial, yet often missing. In providing ‘cost-effective’ services, treatments for alcohol dependence are often time-limited, usually 6-12 sessions (NICE, 2011), yet this only allows for a limited time to develop a trusting therapeutic-relationship. As this study implies that the development of trust and safety is necessary prior to exploring issues of shame, hence it is possible that therapy effectiveness is compromised in time-limited treatments, especially in patients who feel shame. Therefore services could benefit from having a prolonged engagement phase within treatment, enabling the development of trust and safety needed to explore shame issues. It could be argued that the time invested in building relationships could reduce future costs associated with relapse, although this study provides no evidence to support this.

This study further implies that treatment programmes for alcohol dependence could benefit from considering shame. Despite participants in this study benefiting
from AA it is recognised that this approach does not appeal to everyone, therefore patients could be supported to access alternative forms of group therapy, which foster connections with others who have been through similar experiences. NICE guidelines recommend SMART recovery groups as an alternative to AA (NICE, 2011), and potentially these groups could facilitate connection to similar others, thus providing a safe and normalising space to start recovery. This study also demonstrated the importance of developing a personal narrative to help a person make sense of their experiences, therefore it could be suggested that group based interventions could promote this.

Finally, this study implies that for those whom shame is a significant part of their alcohol dependence, may feel threatened by the thought of someone judging them, which will only perpetuate feelings of inferiority. AA was seen as a less judgemental environment; therefore reducing shame and stigma about alcohol dependence within society could help to make accessing alternative treatments easier. For example, recently ‘sobriety tags’ have been introduced in some areas of London. These tags monitor alcohol consumption in those who drink and offend, with the person being brought back to court should they drink whilst wearing the tag. Whilst it is acknowledged that they have been reported to reduce drinking (Lockhart-Mirams, Pickles & Crowhurst, 2015), this study would argue that such interventions are also likely to reinforce shame associated with alcohol dependence within society and make a person feel worse about themselves.
**Appraisal of the Study**

The use of a qualitative methodology is a strength of the study because it enabled detailed data to emerge in an area which until now remained unexplored. The narrative approach allowed unique stories to be told providing an understanding of shame from those who had personal experiences of alcohol dependence. This is of significant value to the literature, which is dominated by self-report measures that do not capture these unique experiences. The use of an open-ended question from which participants could tell their story was also a strength, as this minimised researcher assumptions during the interview. However it is accepted that personal assumptions were inevitable due to the co-creation of narratives, therefore reflexivity and transparency helped to validate the approach (Yardley, 2000). Furthermore I followed a detailed and rigorous analytic approach whereby transcripts were crosschecked with a supervisor and on-going reflective practice through peer-supervision and diaries provided opportunities to challenge personal assumptions. Ricoeur (1976) suggested there is ‘more than one way to interpret text’ (p.76) and because of this I acknowledge that the interpretations offered are one of many different, albeit acceptable, understandings of the data. However it is anticipated that the careful attention to methodological rigor will give credibility to the findings presented (Yardley, 2000).

This study had a specific interest in exploring shame, therefore being explicit about this was important. However this may have dissuaded participants for whom issues of shame may have been too difficult to discuss. Thus the narratives presented in this study are not representative of all those in recovery from alcohol dependence.
and only illustrative of those for whom shame could be talked about. It was initially hoped to recruit from a range of organisations, to present narratives from a variety of recovery approaches, however when organisations were contacted they were unsupportive of the study because of concerns that talking about shame may impede recovery. On reflection, I realise that this may indicate how different people/organisations construct understandings of shame. AA may conceptualise shame in a very particular way and therefore it is recognised that the experiences of participants in this study were based on their specific understanding of the term shame, which may not be meaningful to everyone in recovery.

**Suggestions for Further Research**

This study has proposed a model that may be useful for conceptualising shame in alcohol dependence. However the proposals are tentative and further research is required. It would be beneficial to explore how shame is experienced during various points in recovery and therefore a larger quantitative study that correlates measures of shame against time in recovery could provide further understanding about the levels of shame experienced in recovery. Additionally a longitudinal study that followed participants through recovery, whilst tracking measures relating to self-concept, self-worth and relationships would offer further knowledge about the way that shame is experienced at different stages in recovery, either contesting or lending support for the explanation proposed.

This study was based only on those currently in recovery and therefore not able to offer further explanations about what factors maintain alcohol dependence or
the role shame has in this. As such, a similar study in a sample of people with alcohol
dependence not currently in treatment could potentially provide further insight into
what maintains dependence and also what hinders entry into recovery.

Further research may also wish to explore alternative ways that shame can be
approached outside of AA. Initial studies have suggested the use of Acceptance and
Commitment Approaches for addressing shame in addiction (Luoma et al., 2012),
however there is limited research into their effectiveness at present. Given the
potential benefits of addressing shame in recovery, further research into treatments
that can assist with this is warranted.

Conclusion

This study explored how those in recovery from alcohol dependence
experienced shame and how these experiences were narrated. In addressing the
research questions, this study proposed a tentative model that suggests how shame
can be understood to contribute to the development of alcohol dependence and also
used in recovery from it; the model is believed to be the first within the literature.
Further research is now needed to explore the processes outlined in the model to
inform treatment in the future.
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Major Research Project Empirical Paper: Appendices

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Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

**Computer Code**

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code. In Online Supplemental Material we request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article if you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

**Tables**

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

**Submitting Supplemental Materials**

APA can place supplemental materials online, available via the published article in the PsycARTICLES database. Please see Supplementing Your Article With Online Material for more details.

**Abstract and Keywords**

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

**References**

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

**Figures**

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file. The minimum line weight for line art is 0.5 point for optimal printing. For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side. APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

**Permissions**
Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments). On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

**Publication Policies**

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

**Ethical Principles**

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

Appendix B: Participant Information Sheet

Participant Information Sheet
(January 2015, Version 2)

PROJECT TITLE: A Narrative Analysis of the Experiences of Shame in the Recovery of Alcohol Addiction

Introduction
I am a Trainee Clinical Psychologist from the University of Surrey and I am conducting a research study as part of my professional clinical doctorate qualification. You are being invited to take part in this research study.

Before you decide whether you wish to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Please ask me if there is anything that is not clear or if you would like any further information.

What is the purpose of the study?
This study is being carried out to help us better understand some of the factors which both help and hinder recovery from addictions. I would like to hear your personal story in relation to your journey into recovery. I am especially interested in some of the negative emotions that you may have experienced during this journey, in particular shame. This is because at the present time, there is very limited research, which has given people the opportunity to share their experience of shame and how these experiences may affect recovery from addiction.

Why have I been invited to take part in the study?
You are being asked to take part because I am interested in hearing your story and how negative emotions, including shame have affected you and impacted on your recovery.

Do I have to take part?
No, you do not have to participate and it is your choice if you want to be involved. You are also free to withdraw at any time without giving a reason.

What will my involvement require?
If you agree to take part, you will take part in an interview with the researcher. This interview will take place at a convenient location for you. You will be asked to sign a consent form before the interview starts. You will also be asked for the details of your current GP. The interviews are completely confidential and no information from the interviews will be shared with your GP, unless a significant risk is identified.

During the interview you will be asked some questions, which will give you the opportunity to tell your story to the researcher. The interview could last any length of
time, depending on how long you want to talk for. It is imagined that the interview will last about an hour, however it may go on longer than this if you wish.

The interview will be recorded on a digital audio recorder, so that the researcher can transcribe (write-down) what you have said and analyse it after the interview has finished.

**Will I be paid my expenses?**
You will be reimbursed for reasonable travel expenses you incur to attend the interview. These will be paid on production of a receipt or a reasonable mileage given, and paid at a standard mileage rate.

**What are the possible disadvantages or risks of taking part?**
Because you will be talking about some potentially difficult emotions, you may become upset during the interview. Your welfare is our priority and therefore if you do become distressed the interview can be stopped.

**What are the possible benefits of taking part?**
Some people think that the process of telling your story on a 1:1 basis can be therapeutic and therefore the interview could be a nice experience for you.

It is hoped that the research and the information collected from the study will provide some valuable information about how to support people who have addictions. Every piece of research can put us one step closer to fully understanding addiction and how to treat it.

**What happens when the research study stops?**
The study will be running for a number of months (March to November 2015), so that lots of people have the opportunity to participate. Once the study stops, all the data will be analysed and written up as part of the researcher's doctoral thesis. If you take part, you can ask the researcher to be informed of the results once it is completed in 2016.

**What if there is a problem?**
It is not anticipated that you will suffer any harm because of your participation in this study, however if you have any concerns or complaints about the way in which you have been treated during the research, you can contact:

Francesca Sawer (Principle Investigator); Dr Paul Davis (Supervisor);
Below is a list of organisations that can also provide you with further support:

**Samaritans**  
24/7 helpline for advice and support  
Website: [www.samaritans.org](http://www.samaritans.org)  
Tel: 08457 90 90 90

**Mind**  
Mind runs drop in sessions twice a week  
Website: [xxxxxx]  
Tel: 01483 766998 (local)  
Tel: 020 8221 9666 (national)

In addition to the organisations listed above, you can also contact your GP or use your AA sponsor for further advice and support.

**Will my taking part in the study be kept confidential?**  
All information that is collected, including information from the interviews will be kept confidential. What you say during the interview will be recorded and transcribed. However any personal identifiable information will be removed, for example your name will be deleted from the transcripts, as will any information, which could potentially identify you. Data will be stored securely in accordance with the Data Protection Act 1998. Recordings will be kept in a secure storage facility until they have been transcribed and anonymised. Anonymised transcripts may be included within the researchers final thesis and retained for 10 years in line with university policy.

Information would only be shared in an instance where the researcher believes you or another person could be at significant risk of harm. This would always be discussed with you first.

**Who has reviewed the project?**  
The study has been reviewed and received a Favourable Ethical Opinion from the University of Surrey Ethics Committee.

Thank you for taking the time to read this Information Sheet
Appendix C: Consent Form

Consent Form
(January 2015, Version 1)

- I the undersigned voluntarily agree to take part in this interview, which is exploring experiences of shame in recovery from addiction.

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I agree to comply with any instruction given to me during the study and to cooperate fully with the investigators. I shall inform them immediately if I suffer any deterioration of any kind in my health or well being.

- I consent to my personal data, as outlined in the accompanying information sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I understand that confidentiality will only be broken in the event of a significant risk and that this would be discussed with me.

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I acknowledge that in consideration for completing the study I shall receive reasonable reimbursement of travel costs.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of participant (BLOCK CAPITALS) ......................................................

Signed ......................................................

Date ......................................................

Name of researcher/person taking consent (BLOCK CAPITALS) ......................................................

Signed ......................................................

Date ......................................................
## Appendix D: Risk Assessment

<table>
<thead>
<tr>
<th>Potential identified risk</th>
<th>Risk to who</th>
<th>Method for reducing risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant becoming distressed during the interview.</td>
<td>Participant</td>
<td>Participants will be briefed prior to taking part in the study. Through discussion prior to the interview the researcher will be able to assess, identify and discuss with the participant any potential concerns. The researcher will be alert to potential distress throughout the interview and questions will be designed to be as sensitive as possible. The participant can also refuse to answer questions and the interview can be stopped at any time. The participant will be informed of their rights to withdraw their results.</td>
</tr>
<tr>
<td>Participant disclosing information, which could indicate that harm could come to either them or another person.</td>
<td>Participant</td>
<td>The participant will be informed of confidentiality before taking part in the interview. This will include instances where confidentiality would be broken (i.e. in the event of harm). If this did come up in the course of the interview, the researcher would inform the participant of the concerns they had and would remind the participant of their duty to share the relevant information, which may include the participants GP. The researcher will be supervised throughout the process and any concerns will be discussed in supervision.</td>
</tr>
<tr>
<td>Safety of the researcher when conducting interviews alone in community locations.</td>
<td>Student researcher</td>
<td>The researcher will ensure that interviews are conducted in a private yet public place, where there is a method of escape if necessary. These places will include libraries, university rooms and clinic rooms at the relevant community site. The researcher will inform someone of their whereabouts and will agree to call that person following the interview to confirm that they are safe.</td>
</tr>
<tr>
<td>Participant being dissatisfied with the research and making a complaint to the university.</td>
<td>Organisation</td>
<td>The participant will be informed of their rights to complain and will be given the details of the researcher and the supervisor. However it is anticipated that the researcher will be able to reduce this happening by being professional and transparent throughout the research process. Any concerns can also be discussed with the researcher (supported in supervision) and aimed to be resolved prior to the participant needing to make a complaint.</td>
</tr>
</tbody>
</table>
Appendix E: Interview Schedule

Interview Guide

Thank you for agreeing to take part in this interview today. As we have already discussed, I am completing this research as part of my Doctorate in Clinical Psychology at the University of Surrey. This interview is being recorded and will be later transcribed; any personal or identifiable information in these transcriptions will be anonymised. In a moment I will be asking you to tell your story of how you developed an addiction and your process of entering recovery. There will also be a series of prompt questions that I may use throughout the interview to guide the process.

I would like to remind you that you have the right to withdraw from this research at any point and if there are any questions that you would prefer not to answer, please say so.

Main question:

• I would like you to start by telling me about your personal story of recovery? Please feel free to tell your story in whatever way you wish and begin the story wherever you feel comfortable.

Prompt questions:

• What was life like for you before you developed a problem with alcohol?
• What were the circumstances that contributed to you developing your addiction to alcohol?
• How did you come to realise that you had a problem?
• How and when did you decide to access help/support/treatment?
• You mentioned that you felt (e.g. a particular emotion). Would you be willing to tell me more about that? At what point did you feel this emotion?
• (If a particularly good/bad part of recovery is mentioned). Could you tell me more about that time during your recovery?
• How has (e.g. the emotion described) affected/impacted upon your recovery?
• Has/how has shame
• Looking back, is there anything which you think helped or hindered your recovery?
• I am particularly interested in hearing about any feelings of shame that you may have in relation to your alcohol addiction, would you feel comfortable telling me more about that?
  o Could you tell me more about that?
  o How did that make you feel?

Shame; guilt; abashment; humiliation; remorse; contempt; self-disgust
Appendix F: Evidence of Ethical Approval

Faculty of Arts and Human Sciences
Ethics Committee

Chair’s Action

Proposal Ref: 1081-PSY-15
Name of Student/Trainee: FRANCESCA SAWER
Title of Project: A help or hindrance? A narrative analysis of the experience of shame in recovery from alcohol addiction
Supervisor: Dr Paul Davis
Date of submission: 05th January 2015
Date of confirmation email:

The above Research Project has been submitted to the FAHS Ethics Committee and has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee with minor conditions. Confirmation has been received that the conditions stipulated after ethical review have now been addressed and compliance with these conditions has been documented.

The final list of documents reviewed by the Committee is as follows:

Protocol Cover sheet
Summary of the project
Detailed protocol for the project
Participant Information sheet
Consent Form

This documentation should be retained by the student/trainee in case this project is audited by the Faculty Ethics Committee.

Digitally signed by Bertram Opitz
DN: cn=Bertram Opitz,c=University of Surrey, ou=School of Psychology, email=b.opitz@surrey.ac.uk, c=GB
Date: 2015.01.26 18:48:15 Z

Signed: Professor Bertram Opitz
Chair

Dated:

Please note:
If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.
Appendix G: Examples of Coded Transcripts

‘Paula’

<table>
<thead>
<tr>
<th>Paula</th>
</tr>
</thead>
<tbody>
<tr>
<td>149 I'd sober up a bit, go to meetings couldn't get it, I was very very _____</td>
</tr>
<tr>
<td>150 angry they all seemed snug, but there was this link that I knew</td>
</tr>
<tr>
<td>151 they had been where I was, this thing about if you don't take a</td>
</tr>
<tr>
<td>152 drink you are a success, that's good enough, you don't have to do</td>
</tr>
<tr>
<td>153 anything else. And all my meaning about my life, the mess in my</td>
</tr>
<tr>
<td>154 life, my life situation which was not good at that time. Hmm (.)</td>
</tr>
<tr>
<td>155 they would just say don't pick up a drink and it will get better</td>
</tr>
<tr>
<td>156 (//yeah). And the other thing that had a big impact on me was what</td>
</tr>
<tr>
<td>157 they said about it being an illness, was that you, when you were</td>
</tr>
<tr>
<td>158 drinking you were sick and you were in the grip of an illness. You</td>
</tr>
<tr>
<td>159 have now come here and learned a little and been given the</td>
</tr>
<tr>
<td>160 opportunity from now on you are responsible. For every that has</td>
</tr>
<tr>
<td>161 happened up to that point, if you walk into AA, it is not your fault.</td>
</tr>
<tr>
<td>162 Some people say that's a copout, but that saved my life. That I was</td>
</tr>
<tr>
<td>163 not responsible I was in the last chance saloon of an addiction, so</td>
</tr>
<tr>
<td>164 the result of my drinking was the things I had done and the fact</td>
</tr>
<tr>
<td>165 that I thought I was a bad person, was not really my fault. I didn't</td>
</tr>
<tr>
<td>166 ask to be an alcoholic. And I hung onto that with my fingernails. It</td>
</tr>
<tr>
<td>167 was an illness. I mean I kept drinking and then I made my mind</td>
</tr>
<tr>
<td>168 up, one guy who came down from _____ why that's made a</td>
</tr>
<tr>
<td>169 difference everybody else was saying all the same things he just</td>
</tr>
<tr>
<td>170 said to me beautiful place you all live in here ________</td>
</tr>
<tr>
<td>171 _____ lots of lovely bars but why don't you try it the AA way and</td>
</tr>
<tr>
<td>172 not have a drink. I know you have probably paid a lot over the bars</td>
</tr>
<tr>
<td>173 but those bars will still be there after 6 months if you think I'll wait</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Themes, tone, comments on the narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning to be &quot;good enough&quot; acceptance</td>
</tr>
<tr>
<td>Illness narrative</td>
</tr>
<tr>
<td><strong>Theme</strong>: Illness</td>
</tr>
<tr>
<td>Not to blame; but can be responsible for getting better (compassion)</td>
</tr>
<tr>
<td><strong>Theme</strong>: Being saved (by AA)</td>
</tr>
<tr>
<td><strong>Character</strong>: A hero that came to save her</td>
</tr>
<tr>
<td>Being persuaded to do things the AA way (entering the AA narrative)</td>
</tr>
</tbody>
</table>
it's not what you want, anyway he was such a funny man the way he said it, and I did I laughed. Anyway I did, I made the decision to try it the AA way. And I really struggled, some people go on to what they call a pink cloud, I didn't. I found the pain was enormous dealing with life, my past, but this thing being an illness. Up to that point I had had no choice, now I had choice, a lot of people say well it's a copout that it's an illness but what I got was that cut off thing, up to there you are not responsible but from that moment on you put the drink down you are responsible, now you had to take responsibility. And I got that and I got the support but ( ) around the guilt and shame, when I moved on I struggled with that a lot and it's taken a long time.

**Interviewer,** Did you struggle with that once you had stopped the drinking? Was that what came up?

**Paula:** Yes! And when I moved on far enough to see it, I could see that that was probably something without the support of other people who had followed the same road as me. When I tried to not drink I would try to not drink on my own, and hmm it was like my head, visually it was like bristles in my brain they hurt me so much, I had to drink to take the pain away. It was the strain and the guilt that were a big part. So you took more drink to get rid of it. So I could see moving on, and I hear other people now and I try to be helpful in some way (/yeah). But that was something that kept me from being able to deal with my drinking.
Appendix H: Examples of In-Depth Individual Case Analysis

‘Paula’

Background context
Text omitted to protect participant identity

Summary of the story
Paula’s Biography: Weaving a coherent story, bringing together what was said in the interview into a coherent story. FACTUAL, what was said in the interview

Text omitted to protect participant identity

Core narrative
How was the narrative told (order, structure, tone what was told and how)
How does shame weave throughout the narrative?

Text omitted to protect participant identity

Chapter 1-Starting to drink, recognising an addiction
Text omitted to protect participant identity

Chapter 2-Dipping the foot into the water of recovery
Text omitted to protect participant identity

Chapter 3-Maintaining sobriety and repairing shame
Text omitted to protect participant identity

Chapter 4-The story of shame
Text omitted to protect participant identity

Chapter 5-The happy ending
Text omitted to protect participant identity

Narrative episode
Narrative tone-form and manner in which it is told

The initial chapters of the narrative were quite chaotic and lacked a clear and coherent structure and order. This is likely to mirror what was happening at the time and the fact that these memories may not have been formed clearly.

Throughout the initial stages of Paula’s narrative there never seemed to be any resolution the chaos. Paula coping strategies were alcohol and moving from place to place, as if to escape, or Perhaps...

Whilst there were times that Paula did manage to regain some control, for example while pregnant, it seemed that alcohol was always around to trip her up whenever things seemed to be going okay: “I think I never made plans or I just...”
tumbled through life like that wing that tumbles with the wind and then I get knocked up against the bush and stay there for a while, and then the wind will blow the other way and I roll off down again”

Whilst her life had little direction for many years, help was found in the form of AA, and despite further set backs, it was AA that helped Paula to change direction.

Paula told her story using humour, often laughing at herself. However there were also many sad parts to her story and as a listener I felt that there were times when Paula could cry. Humour may have been a defence for protecting against from the painful emotions in her story.

Overall the narrative had an optimistic and upbeat tone (despite the sad content) however this is likely to be as a result of hindsight and reflection. Paula was [blank] years sober when she spoke to me, which put significant distance between her and her addiction. As she knew the end of her story she could be optimistic about recalling what happened, knowing that the ending was a positive one.

**Thematic analysis**

- **Illness, alcohol as a disease**
  Throughout the narrative alcohol addiction was talked about as a disease and an illness; something that happens to the person, that they have no control over and which they are powerless over preventing.

  When ‘constructing’ alcohol as a disease, this gives a particular image. For example when you think of other diseases such as cancer all blame is removed and there is lots of sympathy for the individual. This construction of alcoholism may be reflective of the fact that within society there is often little sympathy for those with alcohol addiction, which is stigmatising for those who have lived with addiction.

  Paula’s narrative is also situated within the wider narrative and rhetoric of Alcoholics Anonymous. As such her construction and understandings of alcoholism as an illness will have been influenced by the stories she has heard from others. Paula said that she has slowly learnt that she was entirely powerless over alcohol, which is now her understanding of how she came to develop an addiction. However, others who also hold this understanding have informed this construction of her internal world.

- **Social Comparison/ minimising**
  There are many examples in Paula’s narrative where she compares herself to others who also drank.

  Later in the narrative Paula talks about her feelings of abnormality as a child growing up: [highlighted text] growing up around people who drank heavily and did not communicate with each other. Comparing herself with friends growing up contributed to her feeling different and not like others.
Learning that her behaviour was not all bad and there were others with similar experiences was a key theme in Paula’s successful recovery.

- **Moving**
  In the early chapters Paula’s story was full of frequent moves, which was a repeated theme that followed her through her addiction, this seemed to mirror the chaos of her own life, which it seems she felt she had no control over.

  Moving seemed to be a way of managing her alcohol addiction. However with this physical moving, came the movement of the addiction, images are conjured of the alcohol following her. Alongside this the image of help is also presented as following her around as she moves and it is only when she enters recovery that her life becomes less chaotic and her movement much less frequent. At the end of her story, Paula is settled and no longer moving.

- **Being saved**
  Paula attributes her recovery to others ‘saving her’, and there are many examples throughout her narrative of being saved by ‘hero-type’ characters. Firstly she is saved from her [redacted] husband by her future husband, and despite [redacted], and as she called it his own problems, she still attributes him to saving her life.

  The theme of being saved is also repeated as she enters recovery. On reflection she sees AA as having saved her life, in addition to a number of other ‘hero’ characters, who had a significant impact on her life, particularly how she saw herself.

- **Fate**
  Being saved is also linked to the theme of fate; the idea that help found her/was sent to her. In some respects she is attributing her entry into recovery and AA as down to chance, that external events worked together to make it possible. In this construction she is dismissing any input that she personally had in this process. The idea of fate could also be linked to the idea of a “Higher Power” which is again highly dominant within the AA narrative, and since being part of AA, Paula’s understanding and memory of how she entered recovery may have been informed by this.

- **Faith and religion**
  The same is likely to apply to Paula’s understanding of religion, which features throughout her narrative. Whilst initially she was an atheist (“I came in an atheist, allegedly”), her faith has changed over the course of her story. She attributes this to there always being an underlying faith, however the narrative approach would also suggest that this understanding has been co-constructed by those she recovered with.

- **Death**
  There several occasions where Paula mentioned attempts to commit suicide. Death seemed like it could have been a way out for her and the intensity of what she was feeling. Perhaps a way of her controlling her end, in a world where she felt very out of control.
Paula felt very much as though she had let people down and suicide attempts were included in this. While suicide and death could end the shame, it was also a cause of shame for her.

- **Relationships**
  Alcohol allows her to maintain a relationship that wouldn’t exist otherwise. Convenient for her husband, who subsequently left when she got sober.

- **Powerlessness**
  Paula mentioned that she was unable to stand up for herself on a number of occasions, this was scary but also a source of shame that she did not have the skills to manage her life. An image that life was happening to her and not knowing what was going on….. ‘I feel shame that I was not a human being who recognised what was going on around me and stood up for myself’.

- **Parenting**
  Feeling as thought she ‘damaged’ her sons and let them down through her drinking. Making decisions that were not in their best interests.

Repeated pattern, not being protected by her own mother and then not protecting her own children.

‘A lot of shame about my children. Not that I did bad things to them but I wasn’t there for them. I was physically always there but I was mentally and emotionally shut off with alcohol you know. I thought I would never get over that, but the years if doing things and I’ve done a lot of service, I’ve given back’.

‘So I can see that I’m not the bad person I thought I was and I can come on a good day and I could say that I am just an ordinary person who has done bad things. On a bad day I can go into I’m hopeless, I’m a bad person and I’m not good enough…but as it does on it gets less and less’

‘My youngest son when he was 11 he had lived in places. As a mother I should not have allowed that to happen, but I had no way of not letting it happen’.

**Genre**

Listening to Paula’s narrative, I got the sense of there being triumph in the face of adversity, when the odds seemed to be stacked against her. Rather like a **drama with some comical elements in it. Melodrama.**

It was a story of personal growth, learning to manage on her own, very much how I would view a drama, with ups and downs, elements of excitement, followed by disappointing lows. It reminded me of a **soap opera** at times.
# Images and themes

<table>
<thead>
<tr>
<th>Life Chapters</th>
<th>Images</th>
<th>Themes</th>
</tr>
</thead>
</table>
| Chapter 1: Starting to drink, recognising an addiction | Confused and chaotic teenager-off the rails Falling in love with a* (destruction falling down a hole) but being saved from this relationship (offered a way out) Alcohol always finding her wherever she went. Alcohol creeping up on her. | • Rebellion  
• Alcohol as an illness  
• Being saved  
• Never being settled, always moving  
• Relationships  
• Powerlessness  
• Being parented  
• Being let down  
• Fear  
• Not being good enough/failure  
• Suicide  |
| Chapter 2: Dipping foot into the water of recovery | Alcohol chasing her  
Arrival of AA; AA falling into her life as though also following her  
Being surrounded by alcohol, out of control-“pissed as a parrot” “drunk as a skunk” | • Moving and running away from problems  
• Shame, fear  
• Acknowledgement of a problem  
• Chaos  
• Parenting  
• Letting others down  
• Not being good enough  
• |
| Chapter 3: Maintaining sobriety and repairing shame | Drip by drip- the slow process of recovery during recovery-although quite the opposite to what it felt like | • AA as the saviour  
• Fate  
• Managing shame  
• Alcohol as an illness  |
| Chapter 4: The story of shame | Hurried speech, list of events, images of pain  
Being ‘walked all over’  
Tumbling through life, bouncing from one thing to another | • Seeking resolution  
• Chaos and instability  
• Relationships  
• Parenting  |
| Chapter 5: The happy ending | Calm and peace | • Living life rather than letting it happen  
• Self reflection  
• Finding faith  
• Spreading wisdom and her story to others  
• AA as a saviour  
• Feeling normal  |
<table>
<thead>
<tr>
<th><strong>Key events</strong></th>
<th><strong>Images</strong></th>
<th><strong>Themes</strong></th>
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| Teenage drinking | Vulnerability, Chaos, Being lost, Core sense of shame and worthless, image of lost child and a empty body | • Illness  
• Chaos  
• Parenting templates  
• Letting people down |
| Being saved for the first time-meeting husband and having children | Being rescued by knight in shining armour | • Being saved  
• Suicide |
| Constant moving | Running away, Tumbling around from one place to another, lack of direction | • Moving, instability  
• Letting people down  
• Being controlled  
• Lack of control |
| Finding AA | Relief at finding people she can relate to, following by frustrations at not being able to stick to recovery | • Finding faith  
• Fate  
• Shame |
| Recovering | Emotional rollercoaster, Being let down by knight in shining armour | • Finding faith  
• Chaos  
• Shame |
| Life after alcoholism | Self-reflection | • Managing shame  
• Faith |

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<th><strong>Significant people</strong></th>
<th><strong>Images</strong></th>
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<td>Husband (father of children)</td>
<td>Saviour, warrior</td>
<td>• Being saved</td>
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<td>Lady in AA</td>
<td>Funny</td>
<td>• Being saved</td>
</tr>
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<td>Man</td>
<td>Funny</td>
<td>• Being saved</td>
</tr>
<tr>
<td>Lady with the same name at AA convention</td>
<td>Funny</td>
<td>• Being saved</td>
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<td>Future script</td>
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<td>To spread the message about AA and help others going through the same problems</td>
<td>To become someone’s angel/saviour, like she was saved</td>
<td>Alcohol as an illness</td>
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<td>Finding a better life</td>
<td>Strong, independent women, no longer reliant on others</td>
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<td>Good enough mother</td>
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<td>Make amends</td>
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<td></td>
<td></td>
<td>Give back through service</td>
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<td>To heal</td>
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</table>
Appendix I: Initial Stages of Developing Themes

- **HEALING/HEARING?**
  - Removes blame/shame

- **Alcohol as an ILLNESS**
  - Control – feeling out of control, and learning to gain control

- **Powerlessness**
  - Early experiences, shame felt early in life, prior to alcohol dependence

- **Shame**
  - Overcoming, labelling, accepting emotions in recovery

- **Feeling INFERIOR**

- **Fear**

- **Anger**

- **Building Relationships**
  - with others in the AA fellowship, hearing how other people recovered

- **Comparison with others**
  - normalising, minimising, learning from others

- **Connection**
  - Being saved by another person, locating success outside of oneself, turning point in recovery
  - Getting Answers
  - Finding an identity
  - Developing a narrative to make sense of experiences

- **Parenting**
  - Difficult relationships with own parents. Feeling as though let own children down

- **Attachment**
  - Guardian Angel character, hero
  - ‘Alcoholic’ identity, maintained by AA?

- **Acceptance and Acknowledgement of shame**

- **Giving back**
  - Helping others
  - Sharing narrative

- **Helping others**

- **Finding an identity**

- **Getting Answers**

- **Acceptance and Acknowledgement of shame**
Appendix J: Extracts from Reflective Journal

21st March 2015

I had the first of my interviews this afternoon. I was a little nervous and wondered whether this might come across and impact the interview. As I listened to the participants story I realised how privileged I was to be hearing it. I thought about the stigma in relation to those with alcohol dependence and even some of the backhanded jokes that are made by people when I mention I am researching it. If people could hear what I was hearing, I think they would think so much differently. Would this somehow make me more invested in this research? Would this make me perhaps more prone to present stories in a particular way to remove this stigma? I must be mindful of this and focus on what is said, trying to keep my personal emotions separate whilst also recognising that peoples responses (including my own in this interview) all play a part in how people view themselves and how they construct personal narratives.

This participant was very talkative and told his story without the need for much use of the prompt questions. As such I was able to sit back and listen and really concentrate on what was being said during the interview. I found myself having lots questions going around my head as his spoke. I think I struggled switching from my usual position of therapist to that of researcher because I was consciously holding back from interrupting speech to explore further. Sometime I did find myself drifting into my ‘therapist’ habits; nodding and in encouragement and I wondered whether this had an impact on how long the participant talked for. He kept going for about 45 minutes in answer the first question and told me his
whole story in a way that seemed perfectly scripted. This made me think I was not the first person he had told this too. Was this exactly what had happened or was this the version he had learnt to tell people? I guess this matter; it was how he had come to make sense of his past.

Overall I was struck by his strength and resilience in managing alcohol dependence. I found myself wanting to tell him this, but again held back, reminding myself I was in researcher-mode not therapist. I felt a lot of respect and empathy for him and I left feeling hopeful that anyone with alcohol dependence can change and ‘recover’ just like he did.

16th July 2015

I’ve done a few interviews now and I’ve been invited to attend AA meetings by some of the people I’ve met. I thought about these offers and what it meant to be invited to a group that usually prides itself on being quite secret and separate from professional organisations. I realised that in all my reading and conversations with other professionals during this research process, I had come to make particular assumptions about AA, in particular that AA might be a very shaming environment. Therefore I thought it would be useful for me to challenge these assumptions by experiencing what it was actually like to be an AA meeting. I believed it would be important for my analysis not to make comments about a group which I had not ever been to.

In attending the meeting this afternoon I have completely changed my perception of what AA meetings are. The people were incredibly friendly and inviting and all
very normal. I realised that I had assumed that you might be able to tell that people attending had alcohol dependences- that they might stand out in some way. I think back to my personal experiences of witnessing this and how obvious it was, however this was really not the case. There were people at all different stages of recovery, some who had been sober longer than I have been alive.

I got to hear lots more stories at the meeting today, all of them shorter than the interviews I have done, but snippets of story none the less. I wonder whether every time someone speaks and tells a short bit of their story, whether they are adding that to the larger narrative they have about themselves. It made me realise that personal narratives don’t just form overnight; they are a work of art, on-going and developing all the time. AA is a fantastic forum to do that (for some people), what other places like that are there? I also reflected on shame while I was there. The environment didn’t feel shaming and in fact very welcoming and supportive, even though people did not have conversations and just simply listened. It made me consider whether there is something very powerful and healing just in being listened too, no one speaks back so you cannot feel judged but equally everyone is talking about the same difficult things, which brings a sense of connection to the room. On reflecting after the meeting, I reconsidered shame; does this have to be something that is either helpful or unhelpful but instead perhaps it is just something that connects people in AA.

24th September 2015

I’m in the middle of transcription at the moment, listening back through recent interviews has made me aware of how much I missed at the time, despite the fact I
believed I had been actively listening. I’m definitely starting to notice common
themes and patterns across narratives, but also feeling overwhelmed at the
quantity of data that is in these narratives and how I can possibly do it all justice
by incorporating everything that I think is important.

Its interesting hearing interviews for a second and third time, although the
emotion is still there and some powerful images arise as I listen, I think I feel less
connected than I did on the day of the interviews. This made me reflect on the
power of hearing these stories first hand and being able to put a face to the story.
Again, perhaps this is something powerful about the AA setup.

10th October 2015

I revisited my transcripts after a short break and have really got into the analysis
now. I am finding using the structured narrative approach beneficial, as it is
giving me a process to follow and I am cautious that with so much rich data, I
want to be rigorous and methodical, to make sure bits aren’t missed. On speaking
in supervision about whether I might be unconsciously drawn to parts of the
narratives about shame, I have started being clear about whether shame is
explicitly mentioned and whether it is mentioned implicitly. When it is mentioned
implicitly, I am taking time to think about why I am interpreting that particular
passage as ‘shame’, linking back to other definitions of shame and reviewing with
my supervisors. I’m also considering the different sections of the narratives where
shame is mentioned to see how it is interspersed with other things, as ultimately
these are all important parts of the narrative that I must consider.
16th January 2016

I revisited some of my analysis today in preparation for beginning my results and took some time to reflect on my initial analysis. I was definitely surprised looking back at some of the repeated phrases used across transcripts, which made me consider where these have come from; AA groups or wider societal/cultural messages? It’s definitely shown me the value of the narrative approach in not only considering what has been said, but also being able to think about the context in which this can be situated. Interestingly, none of the participants I interviewed seemed to challenge the stigma of their illness and many seemed to accept terms such as ‘addict’ and ‘drunk as a skunk’. I think I have been struck by how much ownership and responsibility participants have taken for their recovery and the strength I personally believe it must take to accept some of the difficult experiences of their past; knowing that they cannot be changed. I wonder whether some of the more comical parts of the narrative are in relation to knowing that things cannot be changed, so perhaps instead they can be laughed about. Certainly it seems that sharing shameful experiences and talking about them, makes them much easier to talk about.

In writing my results I am trying to get a balance between presenting descriptions are they arise from the data, against personal interpretations. I am sticking firmly to the data and using quotes for every point to be sure that my interpretations are grounded in the data as I think this will add credibility to my analysis.
Appendix K: Examples of How Supervision and Personal Reflections Informed the Analytic Process

**Supervision**

After my transcription and initial analysis of each participant, both were read by my supervisors and then discussed within supervision. In particular my supervisors would ask me to consider my personal use of language, in order to help me reflect on whether I was using my own language (and thus potentially my own assumptions of what was said), or whether I was using the participants language. This was particularly important given the significance of language within the creation of a narrative. Following such discussions I would then revisit the analysis, paying attention to exactly what had been said by the participant and adding in additional detail to make it clear how I had made the interpretation I had, from specifically what the participant had said. I would also ensure that I provided quotes at every opportunity in order to be transparent about every interpretation I made.

Furthermore my supervisors would help me to reflect on what was missing from my analysis and why this was. For example in one of the narratives, I had not made reference to the fact that the participant was a mother and we reflected on how my personal experiences and personal narratives were informing which part I may have paid attention to and which parts I neglected. In this example I wondered whether the fact I was not a mother myself, had made me overlook this. After each supervision session I would then revisit the analysis and re-analyse...
based on our conversations from supervision. This resulted in me being over-inclusive in my analysis, in order to represent everything that was said. However ultimately I believe it gave me a very thorough case-by-case analysis.

**Reflective Journal**

I made entries in my journal after every interview and also after every transcription/initial analysis. This helped me to consider my assumptions prior to the interview and during the interview and what had particularly stood out for me during the interviews. When I transcribed I would then compare this to my memory of the interview would consider the parts that I hadn’t remembered so well and reflected about why this was. Doing this allowed me to consider my personal assumptions and biases and whether this had made me remember some parts of the narratives more than others. For example, in my first few interviews I recognise that I was particularly focused on listening out for any explicit talk of ‘shame’ and missing the more implicit references to it. This was also the case in my initial case-by-case analysis where I focused the occasions where shame was talked about, rather than the other, equally important parts of the narrative. It was through this reflection that I then was able to realise this and start focusing on the whole narrative, the participant’s journey and how shame weaved throughout the whole narrative. This ultimately helped to understand shame differently and understand that although not labelling explicitly shame was often spoke about.
Appendix L: Extended analysis

In addition to the analysis presented in the main paper, the way that participants spoke about other character was recognised as a narrative tool and is presented here as an extended part of the analysis.

Characters

Characters were another narrative tool for story-telling. Many narratives included a ‘guardian angel’ who was a character perceived to be someone who saved them. ‘Being saved’ was a theme within Paula’s narrative and her ‘guardian angel’ was her ex-partner who then betrayed her. Despite this, her sense of loyalty remained,

‘...I always feel that in retrospect, that he kind of saved my life’

(Paula, 45-46)

Similarly for Diana her ‘guardian angel’ was her boss who had sacked her and whom initially was the person who gave up on her,

‘...after sacking me...he insisted on meeting me.... when he saw what I looked like, you know he said, what’s happened to you...and he just took me straight to hospital

(Diana 254-260)

One reason for using a ‘guardian angel’ could be to locate success in another person, perhaps related to beliefs of ‘not being good enough’ (to take credit).

‘I’m not good enough, why have I got the right to be here?’
Or perhaps relating to another person served as a catalyst for seeing one’s own problems.

‘...I could just relate to everything he said. Everything he said I really identified with’

(Matthew, 68-69)

Furthermore participants attributed the AA fellowship as a ‘guardian angel’ figure whom they located their successes,

‘I mean it’s the support of other people really, because I, I couldn’t have done any of this on my own’

(Gary, 367-368)

AA sponsors were also a ‘guardian angel’ character to locate hope in,

‘...I was prepared to do what I was told, if he told me to do something’

(Raj, 146-147)
Major Research Project Proposal

Shame Stories: A Narrative Analysis of the Experience of Shame in Persons Recovering from Alcohol Addiction
1.0 Introduction

1.1 Background and Theoretical Rationale

Alcohol addiction has been named as one of the biggest preventable causes of death in the UK (Lifestyle Statistics, Health & Social Care Information Centre, 2013). However recovery is still a challenge for those living with an addiction and for mental health services. Our knowledge of addiction is primarily driven by a biological understanding (Jofee, Grueter & Grueter, 2014), however psychological constructs are also considered to play a role in recovery (Moss & Dyer, 2010).

Shame is one psychological construct suggested to contribute to a range of mental health problems (Gilbert, 2006), including drug addiction (Meehan et al., 1996). Shame can be understood a ‘self-conscious emotion’, caused by a ‘conscious’ sense of wrongdoing (Tangney & Fisher, 1995), and treatment specifically focussing on shame, e.g. Compassion Focussed Therapy (Gilbert, 2009), has been found to help with depression and trauma symptoms. Due to the stigma, blame (Gray, 2010), and loss of control associated with alcohol dependence (Weegmann & Piwowoz-Hjort, 2009), it could be argued that shame should be part of our understanding of addiction and subsequent treatment models. However a review of the literature identified that there is a dearth of research exploring the role that shame may have in the development of, and recovery from alcohol dependence.

In particular it is unclear whether shame is a ‘help’ or a ‘hindrance’ in recovery. Literature from Twelve Steps implies that shame is a necessary
component of the recovery process. The approach uses shaming language to encourage a person with alcohol dependence to acknowledge and address shame in order to make amends (Ramsey, 1987); thus implying that shame is necessary for recovery. Despite Twelve Steps being a widely recognised treatment with successful outcomes (Kelly, Magill & Stout, 2009), little is known on the precise mechanisms of change in Twelve Steps at the present time. In contrast, other literature implies that shame can start a perpetuating cycle whereby alcohol provides temporary relief from shame, however in turn the behaviour associated with drinking causes further shame (Cook, 1987; Randles & Tracy, 2013; Wiechelt, 2007). Therefore we are still unsure as to whether shame is a hindrance to recovery or a helpful and facilitative mechanism in preventing relapse.

A review of the literature also identified that there is limited research from service user perspectives. If we are to broaden our understanding of shame, it seems imperative to offer those living with alcohol dependence an opportunity to share their subjective experiences and to consider personal understandings of what is a help and hindrance in recovery. Furthermore, it has been suggested that self-report questionnaire measures of shame lack validity and are not appropriate for people to disclose feelings (Randles & Tracy, 2013). If we are to progress in our assessment (including the use of questionnaire measures) and treatment of shame in alcohol dependence, in a way which is service user led (BPS, 2009), it seems essential to ensure that we have an understanding about the experience of shame, in particular how it relates to peoples personal recovery journeys from alcohol dependence.

Understanding more about what role shame may have in the development
of, and recovery from alcohol dependence could have significant implications for both prevention and the role of psychology within treatment. In an illness with much stigma, more needs to be done to challenge this, which may be better achieved with a more rounded understanding, informed directly from those with living with alcohol dependence. Therefore, the aim of the proposed study is to explore how shame is experienced in a sample of people who have lived experience of alcohol dependence. The findings from the literature review suggest that at present there is little known in this area, therefore there is a strong rationale for using qualitative methodology in order to explore shame from an individual perspective. ‘In order to learn about people, it makes good sense to explore their lives and narrative’ (Freeman, 2013). The research outlined in this proposal will provide a foundation for future research on shame in alcohol dependence.

1.2 Research Questions

The study will address the following research questions:

1) How is the experience of shame understood by those in recovery from alcohol dependence?

2) In what ways do participants tell their stories of shame?

2.0 Method

2.1 Design

The proposed design will utilise a qualitative case series design. Interviews will be undertaken with a small sample of adults with lived experience of alcohol dependence. Interviews will then be transcribed and analysed using
Narrative Analysis. The study will use an iterative design process, which will facilitate a back and forward process between the interviews and the analysis, making the assumption that interviews will be informed by the knowledge gained from interviews and subsequently questions may change between interviews.

2.2 Participants

Sample size. Studies using Narrative Analysis typically include samples of 5-6 participants (Frank, 2012). Gilbert (2002) argues that Narrative Analysis requires in-depth explorations of interview data using samples of 1-10 participants because small sample sizes allow for in-depth engagement of narratives. Narrative Analysis is an idiographic method that aims to gain insight of personal experiences, therefore it is not aiming to provide neutral, objective, generalizable data and instead each interview will provide an individual narrative.

Based on the narrative literature, it is therefore anticipated that an initial sample of 8-10 will be needed. This will allow for varying interview quality and unforeseeable consequences that could arise during recruitment, for example dropouts or withdrawals. The ideal number of narratives included in this research will be 5-6 (Frank, 2012) and therefore being over-inclusive in target sampling numbers should help to ensure that the final narratives included are of good quality.

Inclusion criteria. Participants will be adults (over 18) who define themselves as being ‘in recovery’ from alcohol addiction. The definitions of recovered and recovery are complicated and it is argued that recovery is an ongoing life process. For the purpose of this study it is acknowledged that ‘recovery’
is a personal experience and the period of time in sobriety will be different for every person. Individuals know what ‘recovery’ means to them (The Betty Ford Institute Consensus Panel, 2007); therefore the definition of ‘recovery’ will be as it is understood by each participant. However it will be a requirement that participants recognise that they have alcohol dependence problem and are doing something that they consider to be ‘recovery’.

It is acknowledged that alcohol addiction is often synonymous with the use of other addictive substances such as drugs. In line with the key studies identified in the literature review (e.g. Dearing, Stuewig & Tangney, 2005; Luoma, Kohlenberg, Hayes & Fletcher, 2012; McGaffin, Lyons, & Deane, 2013), participants will not be excluded if they also have drug dependence, however participants will be asked whether they consider alcohol to be a significant component of their addiction and it will be a requirement that participants are sober during the interview. This will be self-reported, however the researcher will also use their clinical skills to identify this. Finally it will be a requirement that participants are willing to talk about their feelings of shame and this will be discussed before arranging the interview.

**Recruitment.** A challenge for this study is that it is not known how to access the ‘target sample’. People who may experience high shame may not be currently able to access services or be in contact with organisations where recruitment would characteristically take place. A snowball sampling method will be used in order to try and access participants who may not typically be involved in research projects, however in order to begin this process a number of avenues of recruitment will be considered as a starting point (see below). One site has
already given agreement in principle for recruitment:

- Services running SMART Recovery groups; **Surrey Drug and Alcohol Service**
- **Hampshire Operational Model for Effective Recovery (HOMER)**
- **Safe Haven** (crisis service)
- **Kent, Surrey and Sussex Community Rehabilitation Company (Probation Service)**

The researcher will meet with staff from the agreed services to discuss the research and provide information sheets. The researcher will remain in contact with the services throughout the project and if there is any person whom staff believe could be suitable, then staff will provide that person with information about the research and the contact details of the researcher. Alternatively staff (with the permission of the client) can directly contact the researcher with the details of interested participants.

All eligible participants will firstly be offered an informal discussion about the research, with no obligation to commit. The researcher will provide information about what can be expected from the interview and answer any questions. The participant can then choose not to participate but if agreed, interviews will be arranged at the participant’s convenience. In line with the snowball sampling method, participants will be asked if they know of any further potential participants.

* Services approached for initial consultation regarding recruitment
** Service has given agreement in principle to recruit
2.3 Measures/Interviews/Stimuli

In line with the narrative approach, participants will be asked to tell their story in whatever way they feel comfortable, however there will be a series of semi-structured interview prompt questions to facilitate this process. The interview guide will be developed in consultation with service users and professionals as part of the process of preparing an ethics application, therefore this initial guide should be considered as work-in-progress. The integrative design process may mean that the schedule will also change as the research progresses.

2.4 Procedure

Below is an outline of the stages involved in the proposed study. Further details on the timings are indicated in the Gantt chart.

1) MRP proposal submitted and passed.

2) Consult with local organisations (see above) about recruitment.

3) Development of interview schedule and participant information sheets in consultation with service users and professionals.

4) Complete/submit Surrey University Faculty of Arts and Human Sciences (FAHS) Ethics form.

Following ethical approval

5) Recruitment process (in collaboration with services, as detailed above):
   a. Pilot interview (to practice questioning style, managing the interview situation and timings).\(^1\)
   b. Screening and recruitment of eligible participants.

\(^1\) Pilot interview may be included in the analysis with the participant’s permission.
c. Conduct interviews (on-going throughout the stages below).

6) Transcription of interviews.

7) Analysis of the data including re-analysis.

8) Write up (see Gantt chart for timings throughout the process).

2.5 Ethical Considerations

As indicated, this study plans to use a people from a non-clinical population who have alcohol dependence problems and therefore participants will not be recruited from NHS services; NHS ethical approval and R&D will therefore not be applied for. However other local support services will be used and ethical issues will be carefully considered as part of an ethics application made to the University of Surrey (FAHS).

A major ethical consideration is in relation to confidentiality and management of the data. All participant data of sensitive nature (participant details, recordings and transcripts) will be stored in line with the Data Protection Act (1998). All participants will provide written informed consent and will have the right to withdraw from the interview or remove their data at any point up until the analysis is completed. It will also be necessary to consider how risk will be identified and managed if needed. As participants may not be under statutory care services, if something is said which may indicate the participant or another person were at harm then it will be necessary to follow the agency’s policies, which could include gaining permission to speak with each participants’ GP in order to share risk issues. A full debrief will take place after each interview and a formal procedure will be developed for managing distress.

2 There will be approximately a one-month timeframe to conduct each interview.
Steps will be taken to ensure that the researcher is not placed in a vulnerable position. Safe places for interviews will be arranged and emergency contacts put in place, so that another person knows where the researcher is at all times. A further ethical consideration will be with regard to maintaining a professional boundary between the research and clinical role. Participants are not entering into therapy, however due to the training and clinical role of the researcher, there will need to be a clear distinction between the roles. The use of reflexive diaries and regular supervision will help with this process and ensure that reflectivity is recorded throughout the process. The researcher will take opportunities to enrol upon interview training and reflective support spaces will take place within the trainee’s peer group.

Finally, due to the sensitive nature of the interviews, all participants will be informed of the potentially upsetting feelings that may arise. A discussion will take place about this before the interview is arranged, so that the participant is able to make an informed choice about their participation. Interviews can be stopped at anytime if needed.

2.6 R&D Considerations

NHS R & D considerations are not applicable for this study.

3.0 Project Costing

Participants will be reimbursed for all travel expenses incurred to attend any interview. However as the researcher will aim to travel to the participant it is not envisaged that these costs would be more than £15 per person. The printing of posters and information sheets is estimated to cost no more than £30. Recording
equipment will be borrowed from the university at no cost and the researcher will transcribe the data, which again will be at no financial cost. Any remaining monies will go towards any specialist training and binding of the trainee’s thesis on completion of the project, however these costs will be subsidised by the trainee if needed.

4.0 Proposed Data Analysis

The interviews will be analysed using Narrative Analysis, to examine what is said, how it is communicated and why it might have been expressed in a particular way (Murray, 2003; Riessman, 2008). It is proposed that each participant’s narrative will be analysed separately, before ‘narrative’ and ‘process’ themes are collated across the case series. This will allow the exploration of the meaning-making process that individuals undergo during recovery from alcohol dependence.

Narrative Analysis is based upon social constructivist epistemology, which suggests that our use of language can construct versions of our reality with social contexts (Burr, 2003; Willig, 2008; 2012). Under this epistemology, ‘shame’ would be understood, as being constructed for a specific purpose, in contrast to a realist epistemology would imply that shame is a construct that exists in our reality. As researcher, I will be approaching the analysis from a position of ‘middle ground’, taking the position that shame exists as a construct, however people will construct shame in different ways in order to tell a personal story, which will be based on unique social contexts. By taking this position I am acknowledging that narratives will be affected by my presence as a researcher, and what I may represent to each of the participants. This position will allow me
to explore both the process of the individual narratives but also look at any repeated ideas across narratives.

During the research, I will be keeping a reflexive journal to reflect on my reactions before, during and after interviews. I will consider my feelings and understanding of the topic and how this may develop through the process and what influence this could have on the interview and my analysis of transcripts. Extracts from my dairies will be included in the analysis in order to be transparent and credible.

The analysis procedure will start with a transcription of the interviews to allow the researcher to become familiar with the data. Transcripts will then be re-read for further familiarisation. Description and coding will then take place to look for how the personal narratives are talked about, including ‘plot type’ (Gergen & Gergen, 1988). Coding will inform further questions if necessary in line with the iterative design. This back and forth process will continue until all the interviews are completed. Common themes across the narratives will be explored as well as any differences; this will include reflections from the researcher on how the narratives will have been influenced by their role as interviewer.

5.0 Involving/Consulting Interested Parties

Due to the sensitive nature of the interviews, it was important to gain feedback from service users who represent the participants who will be interviewed. Therefore the researcher consulted with service users\(^3\) about the nature of the study and feasibility and willingness of participants to contribute. As

\(^3\) Service User Consultation Workshop run by the PsychD Clinical Programme
a result further consideration was given to recruitment and accessibility of participants, in addition to thinking about the pre-briefing of interviews and preparing participants for what they would talk about.

Experts within the field were also consulted regarding the methods of recruitment and analysis. This was to make use of the experience of professionals who work in the field and who could potentially signpost participants into the study, and to get the opinion from someone who is experienced in using narrative approaches.

6.0 Contingency Plan

As a contingency against equipment failure, two recorders will be used during interviews. Timings have been over-estimated to account for more interviews needing to be completed in the event of lack of appropriate data. A specialist practitioner and researcher has also been involved in the consultation process of this proposal and has agreed to provide participants who have already been involved in research and consented to being contacted again, should other avenues of recruitment fail.

7.0 Dissemination Strategy

It is planned that the final research findings will be written up and submitted to a relevant peer review journal (for example The Journal of Psychology and Psychotherapy; Health Psychology Review) in order to share the findings within the field. It is also hoped that the study will be presented at the University of Surrey Postgraduate Research Conference, during the trainee’s final year, as a way of getting feedback from peers. All results will be presented to the services where recruitment took place.
References


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Literature Review

Help or Hindrance?

The Role of Shame in the Recovery from Alcohol Dependence
Abstract

Shame is an emotion that has been shown to play an important role in psychopathology. However, to date, the role it plays in recovery from alcohol dependence is relatively unknown. Leading models (Gilbert, 2002), suggest that shame is an evolutionary construct and an experience, which may make a person vulnerable to developing a range of mental health problems. However, one of the leading treatment approaches for alcohol dependence, Alcoholics Anonymous, appears to actively encourage a person to experience shame. Therefore, it is unclear whether shame is a help or hindrance to recovery from alcohol dependence. This paper reviews the literature on shame in alcohol dependence, in an attempt to answer this question. A systematic search strategy was initially conducted which led to 14 papers being identified for the review. Overall, shame was generally regarded as a risk factor for relapse in alcohol dependence and experiencing shame was often shown to be a hindrance to a successful recovery. However it was also suggested that successful recovery might involve treating shame. More specifically, ‘acceptance’ has been highlighted as a useful mechanism in treatment. Research into effective treatment interventions is severely lacking at present. Just two studies examined the treatment of shame but both showed promising results. Areas of future research are identified.

Key Words: Shame, Alcohol Dependence, Addiction, Recovery, Relapse
Statement of Journal Choice

This literature review is written with the view of submitting to a peer-reviewed journal. The journal of choice for this review is *The Psychology of Addictive Behaviors*. This journal has an impact factor of 2.3 and is published quarterly. It accepts manuscripts on a range of addictive behaviours including alcohol dependence and also publishes literature reviews.

Much of the research into alcohol dependence has been focused on the biological mechanisms of tolerance and dependence, however this literature review is specifically focusing on the role of a psychological construct, shame. Shame is a transdiagnostic construct and may be applicable to a range of addictive behaviour (Gilbert, 2006). The specific focus on psychological aspects of addiction therefore meets the requirements of *The Psychology of Addictive Behaviors* and makes it an appropriate journal choice.
Introduction

Alcohol dependence is a mental health condition, which is affecting an ever-increasing percentage of the population (Lifestyle Statistics, Health & Social Care Information Centre, 2013); alcohol is considered the biggest preventable killer in the UK. The biological basis of addiction currently forms a large part of our understanding of addiction (Joffe, Grueter & Grueter, 2014), however research shows that psychological constructs are also important (McMurran, 1994; Moss & Dyer, 2010). This literature review will examine a psychological construct that might be less well understood; the role of shame.

How is Alcohol Addiction Understood?

Alcohol addiction refers to the uncontrolled consumption of alcohol. It implies physical dependency; that is, there are physiological changes, which means when alcohol is not used, withdrawal symptoms are experienced (Moss & Dyer, 2010).

The DSM IV (APA, 1994) used the terms Alcohol Dependence and Alcohol Abuse to refer to individuals who had problems with alcohol. The difference between ‘dependence’ and ‘abuse’ referred to severity, however they were often used interchangeably. The DSM 5 (APA, 2013) now uses the single term ‘Alcohol Use Disorder’ and no longer distinguishes between dependence and abuse. The wider term ‘Substance Use Disorder’ places alcohol and drug use under the same overarching criteria (APA, 2013). This review it is written at a time where the DSM 5 has been used clinically for one year; subsequently most
published research will use DSM IV terminology. As such, Alcohol Use Disorder will be used interchangeably with Alcohol Dependence.

Despite addiction being understood as a mental illness, research suggests greater stigma associated with alcohol dependence than other mental health conditions (Gray, 2010; Schomerus et al., 2011), and this may be more pronounced for women (Bobbe, 2002; Lisanksy Gomberg, 1987). There is often a misunderstanding that ‘addicts’ have choice over their drinking and are therefore unworthy of sympathy and deserving of punishment (Ramsey, 1987). If judgments such as these are internalised, this can be understood as shame (Cook, 1987).

What is Shame?

Shame is a ‘self-conscious emotion’ (Tangney & Fisher, 1995), caused by a ‘conscious’ sense of wrongdoing. It forms a major part of ‘Affect Theory’ (Tomkins, 1962; 1963), an evolutionary theory that views shame as part of an innate affective system, suggesting humans are hard-wired to experience shame. Tomkins proposed that shame is one of the most painful human emotions because it serves to diminish positive emotions, namely enjoyment and excitement.

Formally, shame has been defined as ‘an emotion produced by dishonour, disgrace or censure’ (Merriam-Webster’s 1993). Shame is associated with being negatively evaluated (by self or others) because one has failed to meet appropriate standards (Lewis, 1974). Shame can be understood as a judgment of the whole self, which leaves a person feeling worthless, vulnerable, visible and powerless (Flanigan, 1987; Ramsey, 1987). It is often considered as stemming from a belief that the self is defective, flawed or no good (Brown, 1991).
Shame is recognised to be a universal emotion (Darwin, 1872; Keltner, 1995). However, in contrast to theories that suggest shame is innate (Darwin, 1872; Tompkins, 1962, 1963), it was recently proposed that shame is culturally dependent. Wong and Tsai (2013) suggest individualistic societies (ones which promote independence and focus on self needs) promote the experience of shame. In these societies, shame is associated as a stable part of the self. In contrast, in collectivist societies (ones which emphasise cohesion and community needs) self-improvement is explicitly valued. Feeling bad about the self is normal and expected. Scheff (1997) found in western cultures, shame tends to be kept hidden and Gilbert (1998) suggests that shame makes a person feel ‘rejectable’ and ‘vulnerable’ therefore secrecy serves as a defence, which protects the individual.

Shame is often used interchangeably with guilt, however there are important differences to consider (Dearing, Stuewig & Tangney, 2005). Shame is about ones core-self being bad whereas guilt labels behaviours or actions as bad. As such, feelings of guilt may be less painful and more likely to motivate reparative behaviours (Baumeister, Stillwell & Heatherton, 1995).

Evidence suggests that shame-prone individuals might be vulnerable to psychological problems (Tangney, Burggraf & Wagner, 1995) and interpersonal difficulties (Leith & Baumeister, 1998), whereas shame-free guilt is positively correlated with enhanced coping.

**The Role of Shame in the Etiology of Psychopathology**

Shame is recognised to contribute to many mental health problems (Gilbert, 2006; Tangney, Wagner & Gramzow, 1992). This includes depression (Glibert, 1997), anxiety (Irons & Gilbert, 2005), Post Traumatic Stress Disorder
(Lee, Scragg & Turner, 2001), obesity (Conradt et al., 2008) and eating disorders (Sanftner, Barlow & Tangney, 1995). Higher shame levels have also been reported in those with drug addictions (Meehan et al., 1996; O’Connor & Weiss, 1993). More recently, higher shame levels have been found in people who drink as a method of coping with their depression and anxiety (Treeby & Bruno, 2012).

People may risk injury and death to avoid experiencing shame (Gilbert, 2003), and in addition to effecting vulnerability to mental illness shame is proposed to contribute to avoidance, which inhibits seeking help and support (Gilbert, Pehl & Allan, 1994). Hook and Andrews (2005) found people who experienced shame were less likely to disclose information to their therapists, which reduced therapy benefits. Cheung, Gilbert and Irons (2004) found that feelings of shame were associated with depressive rumination, suggesting that shame has a ‘stickiness’ that pulls individuals into a self-critical style, increasing vulnerability to illness.

Gilbert (2002) has developed a biopsychosocial model of shame. Underlying this model is a person’s innate desire ‘to belong’. If a person experiences stigmatisation or rejection then this can then lead to shame and a person viewing themselves as undesirable. Gilbert proposes that a person copes via defence mechanisms: becoming self-blaming and submissive, or by externalising anger and seeking revenge. This model implies that shame precedes illness, but shame (rather than the symptoms of the disorder) should be the focus of treatment (Gilbert, 2006). Nevertheless, it is likely in alcohol dependence, that uncontrolled drinking (and the stigma attached to this) is also a source of shame. Gilbert’s model suggests that shame is central to psychopathology but as yet, this has not extended to alcohol dependence.
The role of shame in drinking psychopathology has been recognised in literature since the 1980’s. Literature developed from psychoanalytic thinking; shame was central to Freud’s model of psychological development (Potter-Efron, 1987, 2013). A special edition journal ‘The Treatment of Shame and Guilt in Alcoholism Counselling’ (1987) gave early indication to the importance of shame. The papers were primarily clinical discussions and observations and there was a lack of empirical evidence. However, this early literature indicated that shame might have an important role in addiction. We now need to know how the role of shame in alcohol dependence has developed.

Alcoholics Anonymous and The Twelve Steps: A Role of Shame?

Alcoholics Anonymous (AA) is a non-professional fellowship of people who support recovery and on-going sobriety (Alcoholics Anonymous, 1981). Established in the USA, it is a widely recognised treatment across the world (NICE, 2011; Tirbutt & Tirbutt, 2008).

AA is the largest support organisation for people with alcohol dependence and research suggests that participation in AA has positive effects on alcohol-related outcomes (McCready, 1994; McKellar, Stewart & Humphreys, 2003; Snow, Prochaska & Rossi, 1994). In the United Kingdom (UK), the NICE Guidelines (NICE, 2011) recommend clients access AA in addition to treatment offered by provider agencies such as the National Health Service (NHS).

The premise of AA is based upon guiding principles known as The Twelve Steps. The Twelve Steps have a spiritual underpinning and the language reflects this e.g.
Step 1. Admitting one is powerless

Step 3. Turning ones life over to the care of God

Step 6. Ready for God to remove defects of character

This central part of AA has received limited research and it is not known how spiritual components facilitate change (Kelly, Magill & Stout, 2009). The core principles in Twelve Steps are based around the concept of shame (Ramsey, 1987), with a person being taken through a process of acknowledging and feeling shame, to a place where they can attempt to heal shame e.g.

Step 6. Ready for God to remove defects of character

Step 7. Humbly ask Him to remove shortcomings

Step 8. Make a list of the persons harmed

Step 9. Make direct amends to all people

Evidence suggests that AA can be helpful; it can improve chances of sobriety and is a widely-recognised treatment (Kelly et al., 2009; McKellar et al., 2003), however at present, little is known on the mechanisms of change in AA. Whilst Twelve Steps uses language that is both religious and shaming, the question about whether shame has a role to play in the recovery of alcohol dependence remains largely unanswered.

Rationale

In order to understand psychopathology it seems essential to understand the role of shame. Over the past decade, research has begun to explore this.
Perhaps more importantly, the role of shame needs to be investigated in disorders that hold stigma and perception that the individual is to blame, in illnesses such as addiction.

Knowing what role shame plays in the development and recovery of alcohol dependence could have implications for both treatment and prevention of alcohol use disorders. Particularly in the UK, there are increasing demands upon services to provide cost-effective, as well as evidence-based treatments. Models (such as shame) that may be understood transdiagnostically could be an important step in providing packages of care where treatment addresses underlying cause rather than symptoms, especially in co-morbid disorders,

There is an emphasis on shame in the Twelve Steps and the success of this approach implies this is helpful; perhaps shame serves as a motivator for change. In contrast, Gilbert’s model suggests that experiencing shame makes a person vulnerable [to drink], implying that shame could be a hindrance. This aim of this literature review is to investigate what, if any, the role of shame has in recovery from alcohol dependence.

**Research Questions**

1) How has shame been researched in alcohol use disorders?

2) What is the quality of this research?

3) What role does shame have in recovery from alcohol use disorders?

4) Where is further research needed?
Method

Aim

This review aims to answer the research questions by ensuring a systematic search is conducted to provide confidence that all relevant literature is identified, subsequently appraised and the chance of omissions are limited.

Scoping

An initial scoping of the literature was conducted using combinations of words that the author thought would generate appropriate search results. The scoping revealed that searching for ‘shame, relapse or recovery and alcohol’ returned limited results, therefore the search criteria were broadened. This was achieved by removing ‘relapse or recovery’, (which made the search too specific) and by adding additional synonyms for shame (guilt, embarrass and remorse).

‘Substance’ was not used as a search term. Until the revision of the DSM the term ‘substance’ was not used to refer to alcohol dependence unless other substances were also involved. Using generic terms ‘substance’ and ‘chemical dependence’ made the search parameters significantly wider. On scanning these papers, relevant articles also used ‘alcohol’ as a search term. Therefore it was decided the search term ‘alcohol*’ was sufficient.

Database Searching

In the first three weeks of February 2014, the major psychological, social science and nursing electronic databases were searched: PsychINFO, Medline, Scopus and Web of Science and CINAHL, using the finalised key search terms
“shame* OR guilt* OR remorse* OR embarrass* AND alcohol*”. Searches were run on ‘subjects’ (SU), with the exception of Web of Science, which does not index papers using subject’s terms. For this database the search was run on the title. All searches excluded results unavailable in English. Grey literature, book chapters and manuscripts were included, however theses and dissertations which were unpublished, were excluded due to access restrictions. All literature is inclusive of anything published until February 2014. Furthermore, a search was run on the Cochrane Collaboration Registers of Randomised Controlled Trials.

**Inclusion Criteria**

All search results were exported into bibliographic software (RefWorks), where duplicate records were removed, leaving 421 potentially eligible records. The title and abstract of these records was read for eligibility. The inclusion criteria at screening was:

1) Shame or guilt mentioned as having a role in development, recovery or the treatment or access to treatment. Non-clinical samples were included provided a measure of alcohol use was collected.

2) An adult population sample should be used (rather than children, adolescents or adult children of alcoholics).

3) Alcohol must be the primary problem (rather than other addictive substances). This was so not to contaminate the review with other illicit drugs, which may carry different types of shame, for example illegality.
If all of the inclusion criteria were not identified in the abstract, papers were included providing the first inclusion point was met. It was decided to be over inclusive to enable a thorough reading to take place.

Forty-one articles were found to meet the inclusion criteria at screening. The reference lists of these articles were hand-searched, revealing five further potential records. Each of these 46 articles was accessed in full. On instances where full access could not be gained, papers were sourced using Inter Library Loans and by emailing authors.

Further Screening

The 46 articles were then read and scrutinised using a stricter criterion. It was decided that shame must have a predominant focus and therefore articles that included a measure of shame as part of a larger battery of measures were excluded, unless there was reference to the role of shame in the results. ‘Guilt’ was a term included in both the initial search and screening to account for literature that might have used the terms interchangeably, however at this stage more attention was given to the definition; only papers with a primary focus on shame were included. This included shame as both a positive and negative construct, however it is acknowledged that this review could not include research that may have found shame to be irrelevant and selectively not discussed.

In addition, the quality of information gained from the paper was assessed. Non peer-reviewed articles, including letters, book chapters, treatment manuals were excluded. Papers more than 30 years old (N=2) were omitted because they were not considered to be up to date with developments of this field.
and these papers also lacked sufficient detail. Figure 1 shows reasons for exclusions.

This left 14 articles to be included in the literature review, this included a mixture of quantitative and qualitative papers, in addition to personal accounts from both client and clinician perspectives.

**Health Technology Assessment Tool**

Given the limited number of papers that met criteria, it was not possible to exclude papers that only used ‘gold-standard’ research methodology. Each of the remaining 14 articles was reread and assessed for quality using the Health Technology Assessment (HTA) framework (Kmet, Lee & Cook, 2004). This tool was not applied for exclusion purposes, but so that the quality of relevant papers could be considered. The HTA is a well-recognised tool, endorsed by the National Institute for Health Research (NIHR). The tool bridges evidence and decision-making, ensuring better synthesis and dissemination of information and assesses quantitative and qualitative papers. This was beneficial because the qualitative papers included, were not detailed enough to use a specific qualitative research guidelines such as Yardley (2000).

The broad nature of studies identified also meant that this framework was preferable over a traditional hierarchical ordering system. The HTA framework was designed for considering diverse study designs (Kmet et al., 2004), whilst assessing quality in terms of the extent to which papers minimised errors and biases. Each criteria marker was scored as; 2=met in full, 1=partially met criteria, 0=failed to meet criteria and not applicable. The maximum score for quantitative
papers was 28 and 20 for qualitative papers. Scores were totalled and a percentage quality mark was given to each paper. The first few papers were discussed with the supervisor to establish inter-rater reliability, although this was not possible for every paper. Three papers could not be assessed using the HTA framework because they were commentaries, reviews or personal accounts.

The range of quality was 50%-90%, with an average quality score of 75%. Kmet et al., (2004) considered 75% to be a ‘conservative’ cut-off and 55% to be a ‘liberal’ cut off, therefore the quality ranges from modest to very good. Eight papers would be considered good quality (above 75%); two papers would fall below the conservative cut-off but would meet a less stringent quality (above 55%). One paper would fall below the liberal cut off and may suggest that this paper is not as valid as the other articles.
Results

Potentially eligible records identified through database searches \( N = 580 \)

- PsychINFO \( N = 107 \)
- Medline \( N = 104 \)
- CINAHL \( N = 37 \)
- Scopus \( N = 305 \)
- Web of Science \( N = 27 \)
- The Cochrane Collaboration Register \( N = 0 \)

Exclusion of duplicate records using bibliographic software \( N = 159 \)

Potentially eligible records \( N = 421 \)

Additional potentially relevant records \( N = 5 \)

Excluded—did not meet screening criteria \( N = 380 \)

Full text articles accessed and read in full \( N = 46 \)

Exclusions after reading \( N = 32 \)
- Reasons:
  - Duplicate records (not picked up by bibliographic software) \( N = 2 \)
  - Book chapters, treatment manuals, letters (not peer reviewed) \( N = 3 \)
  - Not an adult sample \( N = 3 \)
  - Paper older than 30 years \( N = 2 \)
  - Alcohol not the primary problem or measure \( N = 4 \)
  - Shame not a significant focus of the paper \( N = 8 \)
  - Measure of shame in families or health care professional rather than the client \( N = 2 \)
  - Commentary paper with no empirical evidence included \( N = 8 \)

Articles included in the literature review \( N = 14 \)

Quality criteria applied to remaining articles using Health Technology Assessment Tool

**Figure 1.** Flow chart of search methodology
Overview of Literature in this Review

Fourteen relevant papers were identified; these were mostly published in the last ten years (figure 2). Of papers meeting criteria, few met a ‘gold standard’ of academic rigor meaning it was not possible to discount articles solely on quality; subsequently papers are not equal in quality. The contributions of each paper will be discussed whilst considering the worth of the conclusions that can be made. A summary of the findings, including detail of quality is included in table 1.

Figure 2. The year of publication for articles included this review
<table>
<thead>
<tr>
<th>Paper</th>
<th>Quality rating</th>
<th>Country</th>
<th>Method and design</th>
<th>Sample</th>
<th>Summary</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown, H.M. (1991). Shame and relapse issues with a chemically dependent client.</td>
<td>N/A</td>
<td>America</td>
<td>Clinician account, critical commentary</td>
<td>N/A, but includes a case example</td>
<td>12 Steps programme is a safe, protective setting to reveal shame. Healing of shame occurs when a person is accepted by others.</td>
<td>Little evidence for claims made, based on single case study.</td>
</tr>
<tr>
<td>Cook, D.R. (1987). Measuring shame: The internalized shame scale.</td>
<td>15/20 75%</td>
<td>America</td>
<td>Quantitative, factor analysis</td>
<td>Undergraduate sample, N=603, Adult sample, N=198, Clinical sample (from chemical dependency programme), N=64</td>
<td>First paper to empirically test shame. Developed reliable and valid shame scale. Higher levels of shame correlated to alcohol dependence.</td>
<td>Used a smaller clinical sample. The shame measure was in its experiential stage for this study.</td>
</tr>
<tr>
<td>Dearing, R.L., Stuewig, J., &amp; Tangney, J.P. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use.</td>
<td>17/22 77%</td>
<td>America</td>
<td>Quantitative 3 x studies, correlational</td>
<td>Undergraduates, N=235, Undergraduates, N=249, Jail inmates, N=332</td>
<td>Positive link between shame-proneness and problematic alcoholic and drug use. Shame associated with dependence of substance rather than frequency of taking the substance.</td>
<td>The undergraduate sample did not meet criteria for addiction. Included drug use, however alcohol was primary problem.</td>
</tr>
<tr>
<td>Houts, S. (1995). Explaining alcoholism treatment efficacy with the theory of reintegrative shaming.</td>
<td>12/20 60%</td>
<td>America</td>
<td>Qualitative, interviews, data analysed and grouped into themes</td>
<td>Clinical, members of 12 Steps, N=59</td>
<td>54% of those interviewed socialised exclusively with persons in recovery, important to consider for reintegration.75% claimed they trust others in their recovery. 89% viewed the recovering community as a safe place.</td>
<td>Unclear on the validity of measures. Non-random, snowball sample was used.</td>
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</table>
Many described addictions are ‘shame-based’ diseases.

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Country</th>
<th>Study Design</th>
<th>Sample</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ianni, P.A., Hart, K.E., Hibbard, S., &amp; Carroll, M.</td>
<td>2010</td>
<td>Canada</td>
<td>Quantitative. Cross-sectional correlation design. ANOVA, interaction</td>
<td>College students, N=567</td>
<td>Shame found to be a significant independent predictor of alcohol abuse. Shame moderated the association between alcohol and self-forgiveness. Drinkers who displayed self-forgiveness and had high shame were less likely to misuse alcohol.</td>
</tr>
<tr>
<td>Luoma, J.B., Kohlenberg, B.S., Hayes, S.C., &amp; Fletcher, L.</td>
<td>2012</td>
<td>America</td>
<td>Quantitative. RCT</td>
<td>Clinical sample, from residential treatment programme for addiction. Substance abuse sample, but primary problem was alcohol. N=133 allocated to ACT group or TAU.</td>
<td>First Randomised Control Trial (RCT) to look at treating shame in substance use using ACT. No effect for treatment condition on measures of shame, both groups improved. However only those in the treatment group sustained and improved on measures of shame at 4 month follow up.</td>
</tr>
<tr>
<td>Merritt, P.</td>
<td>1997</td>
<td>Unknown</td>
<td>Personal account</td>
<td>N/A</td>
<td>Since achieving sobriety the author has attempted to differentiate between guilt and shame. Commented on the importance of shame in their recovery.</td>
</tr>
</tbody>
</table>

Potential confounding variables such as personality disorder and being reared in alcoholic family environment. Non-clinical sample.

Some missing data. Lack of blinding for participants. Included drug dependence although alcohol was main problem. In the ACT group, expectation might have had an affect.

No formal measures, account could be biased. Limited generalisability.

Cross-sectional design limits causality. Bias sample; religiously
<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
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<th>Study Design</th>
<th>Sample Details</th>
<th>Findings</th>
<th>Notes</th>
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<tr>
<td></td>
<td>Randles, D., &amp; Tracy, J.L.</td>
<td>2013</td>
<td>Canada</td>
<td>Quantitative, repeated measures design</td>
<td>Clinical sample (AA) N=105, 6 months sober</td>
<td>First study to look at non-verbal measures of shame (though video recordings). Non-verbal behaviours of shame were found to be predictive of relapse.</td>
<td>Bias effects of being videoed (desirability bias).</td>
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<tr>
<td></td>
<td>Sanders, J.M.</td>
<td>2011</td>
<td>America</td>
<td>Quantitative, survey design with some selective qualitative data to provide supporting illustrations. Descriptive analysis.</td>
<td>Clinical sample: AA, N=167 NA, N=92</td>
<td>Feminist approach. Differences found between AA and NA in race, class status, and occupation. AA Women in AA did not speak of their ‘lifestyle’ as often as NA. Stories causes for embarrassment, guilt and shame.</td>
<td>Potentially biased sample, demographics of the sample not representative of AA and NA demographics. Not all results were reported and ‘selected’ qualitative data may be subject to author bias.</td>
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<td></td>
<td>Saunders, S.M., Zygowicz, K.M., &amp; D’Angelo, B.R.</td>
<td>2006</td>
<td>America</td>
<td>Quantitative, independent measures design</td>
<td>Clinical sample: Treatment seekers (persons in treatment) N=80 Comparison controls (persons with problem drinking but not seeking treatment) N=65</td>
<td>Self-stigma found to be a bigger barrier to seeking help than public stigma. Embarrassment about having a problem was one of the most frequently endorsed barriers for seeking treatment.</td>
<td>Females underrepresented in the sample (22%), gender comparison not possible due to insufficient power. Volunteer sampling.</td>
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<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Country</td>
<td>Study Type</td>
<td>Sample</td>
<td>Results</td>
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<tr>
<td>Wiechelt, S.A. (2007). The specter of shame in substance misuse.</td>
<td>N/A</td>
<td>America</td>
<td>Critical summary</td>
<td>N/A</td>
<td>Reviews the empirical literature on shame as it relates to substance misuse.</td>
<td></td>
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</tr>
<tr>
<td>Wiechelt, S.A., &amp; Sales, E. (2001). The role of shame in women’s recovery from alcoholism: The impact of childhood sexual abuse.</td>
<td>13/20</td>
<td>America</td>
<td>Mixed methods: Semi-structured interviews and a range of self-reported measures</td>
<td>Clinical sample Women from AA, N=53</td>
<td>Childhood sexual abuse did not make a difference on the levels of shame. Shame had a significant impact on both measures of difficulty to recover. Significant correlation between shame and recovery time. Lower levels of shame linked with longer periods of sobriety.</td>
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</table>

Sample; lack of diversity, low percentage of female. High drop out in the TAU. Possible confounding variables. The review includes all addictions (drug and alcohol), but the author clearly differentiates between different substances. Lack of generalisability due to potentially biased sample: Convenience sampling, small and only consisted of women. Correlational design precludes causal inference.
Articles not based on empirical evidence were excluded from this review, however there were three non-empirical studies that were included because they met the inclusion criteria and made important contributions to the evidence.

One article was a personal account (Merritt, 1997); the only article written from the service-user perspective. Despite the paper being written as a narrative, specific reference was made to shame in the author’s recovery from alcohol addiction. This perspective should be considered and can supplement findings from empirical research.

A second article was a clinician’s account (Brown, 1991), which included case examples. This was one of the first professional accounts in the literature and shows that shame has been considered clinically for many years, however it is only in recent years that empirical research has supported these observations.

The third article was a critical summary of shame (Wiechelt, 2007). This paper indicated the areas needed in future research and inclusion of this paper ensured a historical account of the shame literature was considered.

Two papers included in this review used primarily qualitative methodology (Houts 1995; Wiechelt & Sales, 2001). The remaining nine papers used a quantitative methodology (Cook, 1987; Dearing et al., 2005; Luoma et al., 2012; Ianni et al., 2010; McGaffin et al., 2013; Randles & Tracy, 2013; Sanders, 2011; Saunders et al., 2006; Scherer et al., 2011). Two of these papers were randomised controlled treatment trials (RCT’s) (Luoma et al., 2012; Scherer et al., 2011).

There was limited literature using alcohol dependent samples; nine used clinical samples (Cook, 1987; Houts, 1995; Luoma et al., 2012; McGaffin et al.,
What is the Role of Shame in Recovery from Alcohol Dependence?

Papers using a range of methodological approaches suggest that shame has a role in the recovery from alcohol dependence. In Merritt’s (1997) personal account, shame was reported to contribute to relapse. Similarly in Brown’s (1991) professional account, it was observed that clients with ‘shame-based’ issues tended to relapse. It was suggested that ‘chronic shame’ increases the chance of ‘being attracted’ to addictive substances. Both of these accounts were based on personal experience and other relapse factors were not considered. The accounts may also have been subject to observer-expectancy bias however, similar reports were found in a qualitative study; (Houts, 1995) found many interviewees described their addiction as a ‘shame-based disease’. Empirical research further supports these claims; shame has been found to be a positive predictor of alcohol use in both clinical (Cook et al., 1987; Randles & Tracy, 2013) and non-clinical samples (Dearing et al., 2005; Ianni et al., 2010).

Together these papers provide credible evidence that shame may contribute to the development and relapse of alcohol dependence and ‘anecdotal’ observations have been supported empirically. However, whether shame is a help or hindrance to recovery was not consistent. Four key themes emerged:

**The cycle of shame.** Five papers referred to shame as a ‘cycle’. In the first empirical study investigating shame and alcohol dependence, Cook (1987) found shame was related to vulnerability to drink, with alcohol dependence then
deepening shame-based identity. Thus an individual gets caught in a cycle where they may drink to relieve shame; behaviour that triggers further shame.

Brown (1991) and Wiechelt (2007) both observed that alcohol was used as a short-term relief from ‘shaming emotions’; however, long term drinking exacerbated shame. Dearing et al., (2005) went further to suggest that any negative emotions may be a motivator for drinking, but if drinking evolves into dependency then the primary emotion may become shame, which can lead to increased drinking to manage the shame. It was also suggested that shame motivates escape and hiding behaviours, which serves to increase, rather than decrease problematic behaviours (Randles & Tracy, 2013). Collectively these papers suggest that shame has a specific role in maintaining alcohol dependence; the experience of shame reinforces drinking. If shame is a vicious cycle that maintains alcohol dependence, then shame can be considered a hindrance to recovery. It implies that recovery will involve breaking this cycle.

Help or hindrance. Merritt (1997) reported that shame stimulated relapse. Their personal experience was that drinking helped to deny shame, but wanting to heal shame prompted recovery. During recovery shame was described as an ‘overwhelming burden’, implying that shame is not a helpful in recovery but at the same time shame may be needed to initiate the recovery process. As this was a personal account the results are not generalisable, however it provides preliminary evidence, that from a personal perspective, experiencing shame is a hindrance but may also be necessary for successful recovery.

Cook (1987) found higher levels of shame were correlated with greater number of addictions for both males and females, suggesting that there is a relationship between alcohol dependence and recovery, suggesting that shame is
the risk factor for developing alcohol dependence and/or alcohol dependence makes a person vulnerable to experiencing shame. Empirical findings reported by Wiechelt and Sales (2001) found that shame, regardless of its origin, put women at greater risk of relapse and lowered quality of life. They found higher levels of shame in women who relapsed and lower shame in women with longer sobriety, suggesting that shame might be a hindrance to recovery because it increases chance of relapse. More recently, Dearing et al., (2005) found that shame was positively correlated with alcohol dependence rather than the frequency of drinking, suggesting that being unable to resist drinking is experienced as shameful, rather than the act of drinking itself. The correlational nature of these studies means that whilst shame might be a hindrance to relapse, we do not know whether this is because shame leads to relapse or whether relapse leads to feelings of shame. The studies by Cook (1987) and Dearing et al., (2005) used non-clinical samples with only a subset of those with alcohol problems. Drinking was measured on a spectrum with higher levels of drinking implying dependence, however formal diagnosis was not provided. Despite this, these papers suggest that shame might play an early role in the development of drinking before a disorder develops and further support shame as being a hindrance to recovery from alcohol dependence.

Ianni et al., (2010) found that shame was a significant predictor of alcohol consumption, suggesting that shame makes a person vulnerable to relapse. However the paper also suggested that reducing shame could decrease the need for alcohol. This implies that whilst shame is unhelpful, successful recovery may need to involve experiencing shame, giving empirical support to Merritt’s (1997) personal account.
In a mixed methods study, Sanders (2011) indicated that shame might have a role in maintaining alcohol dependence. They quoted a respondent who spoke about ‘shame deep inside that all they knew how to do was to use’ (p.368). It was limiting that the author chose one quote to support the conclusions and could indicate that the data was under-analysed (Antaki, Billig, Edwards & Potter. 2003). This may suggest that the experience of shame is not as pronounced for everyone, however this study benefited from using an alcohol dependent sample. Sanders (2011) further found that women attending AA reported embarrassment and shame, and as a consequence they were reluctant to share their shame. This suggests that shame is an emotion, which causes distress and that the first steps of recovery is being aware of shame and accepting it. For the women in this study, the experience of shame was an initial barrier to recovery but once they started to acknowledge shame it was helpful for their recovery. Sanders (2011) also supported Merritt (1997) using a larger sample; whilst shame is unhelpful, it may be needed for recovery.

A difficulty in researching shame is that it relies on participants being open. Shame can promote avoidance and therefore self-reported shame measures may not fully capture the shame experience as some shame may be experienced implicitly. Randle and Tracy (2013) conducted a well-designed study to address these issues. Their research looked at both verbal and non-verbal measures of shame. Non-verbal measures of shame were ‘chest narrowing’ and ‘slumped shoulders’ which are behaviours found to signify shame (see Tracy & Matsumoto, 2008). Respondents from AA provided self-reported measures of shame but participants were also video-recorded, from which body language was coded. It was found that non-verbal displays of shame predicted relapse, but self-reported
measures of shame did not. This study reinforces that shame is a core emotion in alcohol dependence and might be a hindrance to recovery. It also suggests that self-reported measures of shame may not be completely reliable. Most importantly this study (of higher quality design) supports the results of lower quality studies, indicating that shame can be a hindrance to recovery and a risk factor for relapse.

**Internalised shame.** Many papers specified ‘internalised’ shame as being unhelpful. Internalised shame is where the shame has been ‘taken on’ by the person and become part of them. Cook (1987) first identified that shame consisted of multiple internalised feelings and found that the constructs he labelled as ‘fragile and out of control’ and ‘empty and lonely’ were factors which accounted for the largest variance in alcohol dependence. In Wiechelt’s (2007) review paper, shame was discussed as problematic in recovery from alcohol dependence only when shame was internalised. Following interviews with women attending AA, Wiechelt and Sales (2001) differentiated internalised shame as ‘trait shame’ (part of the person) and ‘state shame’ (a shameful event). They suggested relapse causes a ‘state shame’ which reinforces internalised ‘trait shame’, but that ‘state shame’ alone may not be sufficient for relapse. The differentiation between ‘trait’ and ‘state’ shame appears to mirror the separation made between shame and guilt (Dearing et al., 2005).

Papers by Cook (1987), Wiechelt and Sales (2001) and Wiechelt (2007) propose different types of shame. Internalised shame is described as a personality characteristic that seems to be a hindrance to recovery from alcohol dependence. However individuals without internalised shame might be protected from the
shameful experiences of drinking and for these people, shame may not be such a significant factor for relapse.

**Stigma and self-esteem.** The shameful experience of drinking can be reinforced by the reactions of others. Houts (1995) found that most interviewees viewed changing self-identity and self-esteem as the most essential aspect of recovery. This was later supported by Saunders et al., (2006), who found that shame was a barrier to seeking help for alcohol dependence and that ‘self-stigma’ was a greater barrier than ‘public-stigma’. Public stigma may lead to avoidance of treatment in order to avoid a harmful reaction from society whereas self-stigma may lead to avoiding treatment to prevent diminished self-esteem. Combined, these papers suggest that shame is a construct related to self-esteem, which further puts a person at risk of relapse. However there is limited research into shame and self-esteem and at present the nature of this relationship is unknown.

**Shame and Guilt: Differing Roles in Recovery**

Differences between shame and guilt are well reported in the literature; therefore it was unsurprising that many of the papers reviewed reported shame and guilt have differing roles in recovery.

Merritt (1997) suggested that guilt is an emotion that stimulates a person to show remorse thus triggering entry to treatment. The author described guilt a ‘catalyst to change’. Wiechelt (2007) suggested that guilt is an emotion to label bad behaviour, which can be repaired, in contrast to shame, which is based on the self as being bad and not repairable. These findings were further supported in a correlational study; Dearing et al., (2005) found that shame-proneness was associated with alcohol dependence whereas guilt-proneness was found to have a
protective effect against the development of problematic alcohol patterns. So far in this review it has been suggested that reducing shame is important for recovery, but mutually these papers imply that increasing guilt is also important for successful recovery.

Most recently, McGaffin et al., (2013) found that guilt-proneness positively predicted acceptance whereas shame-proneness negatively predicted acceptance. This study goes beyond previous studies by suggesting that the relationship between shame and recovery is mediated by empathy and reparative actions, which then promote acceptance and recovery. This study used a substance dependence sample and whilst the primary substance use was alcohol, the authors did not differentiate between those with alcohol and drug dependence and therefore the results may be limited in their generalisability.

**Gender Differences**

There was a consensus in the literature that gender differences are important to consider in alcohol dependence. Typically females are underrepresented in research and at present, knowledge about women with alcohol dependence lags behind males (Wiechelt & Sales, 2001). However, despite this recognition, many of the studies could not report gender difference due to uneven sample sizes and an underrepresentation of females in research (e.g. Saunders et al., 2006; Scherer et al., 2011).

Some papers specifically chose to take a feminist perspective. Wiechelt and Sales (2001) interviewed women attending AA, predicting that women who had experienced childhood sexual abuse would be more vulnerable to shame. Their results did not support this; instead they found no differences in shame
between women who had been sexually abused and those who had not, however they did find high levels of relapse in women with high levels of shame. Sanders (2011) also used a feminist perspective to compare the experiences of women attending AA with women attending Narcotics Anonymous (NA), finding higher levels of shame in women attending AA. Both of these studies propose the differing needs of women in understanding shame and treating alcohol dependence treatment and that further research is needed in this area.

The Treatment of Shame

Wiechelt (2007) identified a lack of research into interventions designed to alleviate shame, which was confirmed in this review. Aside from the Twelve Steps approach, just two of the papers examined interventions for shame.

Twelve Steps. One paper argued that Twelve Steps does not work (Brown, 1991). In this professional account the author suggested that some people are too emotionally threatened to discuss shame, particularly those who have been sexually abused, neglected or subject to shaming parental messages. This paper was based on anecdotal accounts and was not supported by any other papers. Overall, Twelve Steps was reported as an effective intervention and beneficial in addressing shame.

Merritt’s (1997) personal experience of Twelve Steps was that it helped to make amends, to share responsibility and suffering. Merritt (1997) described ‘fitting in’ while the rest of the world can feel blaming and stigmatising. This was also supported in a qualitative study of people attending AA (Houts, 1995). A key theme was Twelve Steps being a safe place where one experiences ‘connectedness’. Interviewees believed that upon being ‘de-labelled’, they could
envisage reintegration with society. Sanders (2011) suggested “what is shared across women in the twelve steps movement is the veil of shame that is worn into recovery…the twelve steps program, women begin to shed this cloak” (p.374).

Acceptance and Commitment Therapy (ACT). Luoma et al., (2012) is the only RCT (to date) to evaluate ACT for shame in substance misusers with a primary alcohol problem. An ACT group was compared to treatment as usual (TAU) and ACT reduced levels of shame post group and at follow up. In comparison for clients in the TAU group, reductions in shame during treatment were predictive of higher substance use at follow up. It was proposed that gradual reductions in shame are protective against relapse. A limitation of this study was that some participants in the study had other substance use (for example tobacco and methamphetamines), although alcohol was the most prevalent problem. This means that we must be cautious in generalising specifically to alcohol addiction, however it shows a benefit of ACT in treating addiction and implies that acceptance may be important for recovery. As this was the only study examining the treatment of shame, it is apparent that more research is needed. At present, our understanding of how shame can be treated in alcohol dependence is limited.

The Role of Acceptance

Self-forgiveness is a way of coming to terms with, or accepting shame. It seems that Twelve Steps can promote self-forgiveness by providing a safe and protective setting where it is safe to reveal shame; healing occurs through acceptance of the person by others (Houts, 1995; Sanders, 2011). Acceptance was a common theme reported across research methodologies. Merritt (1997) wrote that recovery was helped once they accepted emotions. Brown (1991) identified
that once clients were able to speak about shame they became accepting, which promoted recovery.

Ianni et al., (2010) used a non-clinical student sample to explore relationships between alcohol consumption with levels of shame and self-forgiveness, finding that self-forgiveness can be protective in those with high shame. Drinkers who had high shame but who also displayed self-forgiveness were less likely to misuse alcohol. McGaffin et al., (2013) used statistical mediation analysis to explore possible mechanisms underlying the relationship between guilt and self-forgiveness. They demonstrated that guilt-proneness positively predicted self-forgiveness and this was mediated by acceptance. This implies that acceptance may play an important role in governing the relationship between guilt and self-forgiveness and suggests that guilt promotes acceptance. In contrast, the authors found that shame negatively predicts self-forgiveness. In comparison to Ianni at al., (2010), a large clinical sample (where alcohol was the main problem) was used by McGaffin et al., (2013), which strengthens initial conclusions. This study emphasised the importance of targeting acceptance in treatment of alcohol dependence, whilst trying to reduce the effects of shame and guilt on self-forgiveness. However this study is limited by the cross-sectional design used; it prevents causality from being established and indicates that prospective studies are needed in this area. Additionally the data was drawn from a religiously affiliated treatment centre, which might limit the generalisability of the study, specifically to treatment, which does not have a religious focus.

In one of the few treatment trials carried out (Scherer et al., 2011), it was found that a four-hour group intervention promoting self-forgiveness was successful in increasing self-forgiveness and decreasing levels of shame.
Furthermore this study found participants attending the group intervention demonstrated increased drinking refusal, maintained at a three-week follow up. Longer-term follow up results were not collected and therefore further research into the longer-term benefits is needed. Furthermore the sample included participants who were subject to court-mandated treatment. This is important to consider because feelings of shame might have arisen from being caught by the police for an alcohol offence, rather than feeling shame for drinking. Despite these limitations, this study suggests that the shame-cycle can be broken. When shame is addressed in treatment indirectly it may not have to be a hindrance to recovery.

As already discussed, Luoma et al., (2012) showed benefits that an ACT group can have on reducing shame long term. The main idea behind ACT is to notice shame rather than to eliminate it. Therefore the benefits found in this trial also suggest the importance of ‘acceptance’ in managing shame and reducing the likelihood of relapse.

**Methodological Considerations of the Literature**

All of the studies in this review were conducted outside of the UK, indicating that there is a need for research within the UK and the extent to which findings can be generalised to UK populations is limited.

Sample is also important to consider. Four papers recruited from AA, which is based on Twelve Steps, which has a spiritual underpinning. Approximately 75% of the American population identifies with Christianity compared to 60% of the UK population and it is possible that American samples may find it easier to relate to the language of Twelve Steps than persons from the UK.
Using samples of people attending AA is advantageous because it captures individuals who have alcohol dependence, however it can also be argued that a particular profile of person will be suited to AA and attendance implies motivation to recover. If, as the literature implies, shame is a hindrance to recovery then it could be that people with alcohol dependence who experience most shame are excluded from samples because they are not known by services or will be in more specialist residential services; only two papers used inpatient samples. It should also be considered that residential treatment is expensive and without a health service such as the UK, wealth may be an important factor in the quality and length of treatment received, which again may further bias the participants in the samples.

Diversity and access to treatment was also something that was not overtly considered in the papers reviewed. There are areas of varying wealth and diversity in America and it is difficult to assess what role social and cultural factors may have on shame. Finally, as already mentioned there was a lack of high quality research in this review and only two RCT’s were identified. RCT’s are not the only indication of quality; the range of methodologies, samples and approaches to researching shame to date, means that interesting conclusions are emerging from the literature.

**Discussion**

**Is Shame a Help or Hindrance?**

This literature review explored whether shame is a help or hindrance in recovery from alcohol dependence. Unfortunately the answer is not straightforward and seems to be ‘it depends’.
There was general agreement that shame is a painful emotion that seems to increase vulnerability to relapse in people with alcohol dependence (Houts, 1995; Merritt, 1997; Sanders, 2011). After critiquing the literature, the majority of evidence (although there is limited good quality research), suggested that shame is a hindrance to recovery. Shame may arise from perceived stigma (Saunders et al., 2006), compelling the person to keep their illness hidden and inhibit help-seeking behaviour, which acts as a barrier to accessing treatment.

However, even on entering treatment shame has been shown to be problematic. In studies using both clinical and non-clinical samples, shame was consistently associated with increased drinking (Cook, 1987; Dearing et al., 2005). Relapse then intensified feelings of shame (Wiechelt, 2007). Whilst the behaviour of drinking is believed to be something that reinforces feelings of shame, the relationship between shame and drinking is not simple. Research suggests that ‘trait shame’ (shame which is part of a persons personality) and ‘internalised shame’ (when a person has taken on the identity of having shame) are most significant to relapse (Cook, 1987; Wiechelt & Sales, 2001). Trait shame and internalised shame are fundamentally about the individual being in some way bad and it may be this that makes a person vulnerable to developing alcohol dependence and have difficulty in recovery. In contrast, people who experience their behaviour (rather than themselves) as shameful may be less vulnerable to relapse (Dearing et al., 2005), because this experience might make them feel guilt rather than shame. Although ultimately this comes downs to ‘definitions’, the literature seems to indicate that ‘guilt’ is distinct from ‘shame’ and promotes help-seeking behaviour rather than avoidance, which can be helpful in overcoming addiction.
Differentiating ‘trait shame’ from the ‘shame of drinking’ in this way supports Gilbert’s (2002) biopsychosocial theory of shame and implies that shame (or the personality characteristic of shame) may precede illness, which could have important implications for clinical practice. It suggests that drinking is not the fault of the individual and when understood this way, blame and subsequent stigma associated with alcohol use disorder could be removed. The increase in media attention around the consequences of increased alcohol consumption has improved in recent years (Lifestyle Statistics, Health & Social Care Information Centre, 2013), however improved information about alcohol dependence as an illness, could start to challenge stigmatising assumptions about alcohol dependence. Furthermore, when viewed using this model, shame can be understood transdiagnostically. This could be of particular relevance when working with comorbid disorders, where shame is an underlying factor to all. It may imply treatment should be focussed specifically on shame in these instances.

Where there was some disparity in the literature was with regard to role of shame in recovery. Whilst it was agreed that shame contributes to relapse, shame was also identified as being important for recovery. Many papers found that addressing shame in treatment led to increased chance of recovery. More specifically, a key theme for successful recovery came from the process of accepting shame in treatment rather than trying to eradicate or ignore shame (Ianni et al., 2010; Sanders, 2011). This is an important consideration for clinical practice. Professionals should be aware that shame can be important to the recovery process, but there is a fine line between addressing shame and being so overwhelmed by shame that it causes relapse. Managing this balance will be important skill for clinicians working with alcohol dependence.
Treatment of Shame

Addressing this balance is where the role of treatment comes into play. The search indicated that treatment of shame is poorly researched; just two papers examined treatment options for shame (Luoma et al., 2012; Scherer et al., 2011). Both an ACT group and a group promoting self-forgiveness were found to be beneficial in reducing shame and preventing relapse. These papers were published in the last few years, which may indicate that this is an area that is slowly being recognised. However questions need to be asked about why these results have not been expanded. Of course it is recognised that despite a lack of published research, interventions such as these could be being used in services. Having said this, it is generally acknowledged by the British Psychology Society Faculty of Addiction, that interventions of this type are not happening (P.Davis, personal communication, May 1, 2014). At present, the treatment of alcohol use disorder is primarily focused on improving motivation, reducing the effects of withdrawal and relapse prevention. This review suggests that targeting shame could also be component part of treatment, but there is a clear need for further expansion of research in this area before the full benefits can be assessed.

Twelve Steps: Bridging the Gap

The paradox between shame being a hindrance but also essential to recovery, may be bridged by understanding the Twelve Steps approach. Whilst this literature review was not focused on Twelve Steps, many papers made reference to it (Houts, 1995; Sanders 2011), which perhaps reflects the impetus that this model has in recovery from alcohol dependence. As identified in the
introduction, the language of the approach is shaming and given that shame has been identified as a risk factor for relapse, understanding the mechanisms of Twelve Steps may help us understand how shame might be helpful for recovery.

What seems to be essential in Twelve Steps is the supportive environment and the shared experience, which acts as a safe space in which an individual can reveal their shame (Kelly et al., 2009; Ramsey, 1987). There also seems to be some evidence to suggest that being in a group with others who share the same experience is normalising, thus potentially protecting from stigma (Houts, 1996). This may indicate that it is the process of Twelve Steps, rather than the content that has therapeutic benefit. It should also be considered that those with lived experience of alcohol dependence developed this approach as an anti-professional standpoint and it is not based on theory. Successes of this treatment highlight the need for clinicians to incorporate lived experiences into any future theory.

The Next Steps in Understanding Shame: Future Research

Whilst stronger conclusions can be drawn from studies that have large randomised samples, this literature review found that accounts by service users showed similar findings to larger scale projects, suggesting that these papers have a place in this review. As the empirical study of shame in alcohol is in its infancy, considering such range of literature was necessary. This literature review has identified many gaps that could benefit from further research.

Firstly there is a lack of research in alcohol dependent samples; as yet there has been no research that directly compares the experiences of shame in those with and without alcohol dependence. Secondly there has been no research conducted within the UK meaning the extent to which findings are generalisable
is limited. There is need for research in the UK; a country that is unique in the health care it provides. Thirdly there is a distinct lack of research looking at the treatment of shame in alcohol dependence. Some treatment approaches targeting shame in other areas of mental health are emerging such as Compassion Focused Therapy (Gilbert, 2009), and this could be explored within the addiction field. Fourthly, shame is difficult to measure and some research has shown that using implicit measures of shame may be more valid. Methodological improvements in measuring shame in alternative ways could enhance the quality of the literature. Finally, although this literature review has focused on the role of shame, it might also be helpful in exploring how the role of shame compares with other factors associated with relapse and recovery such as negative life events and family factors (Birmingham, 1986; Dyson, 2007). It would be helpful to explore this from a service user perspective because this literature review has shown that their viewpoint is relatively lacking in the literature.

Limitations

It is recognised within science, that there can be a bias to publish positive results (Rosenthal, 1979). This paper acknowledges that it is only representative of published research. Additionally, papers where shame did not have a significant focus would not have been considered. This review has shown that there is a lack of research in this area and this might be because of publication bias (Scargle, 2000). Nonetheless this review is representative of the literature within the search parameters, checking of additional literature cited by authors of papers also minimised the likelihood of overlooking important articles.
Summary and Conclusions

This literature review has examined the role of shame in the recovery from alcohol dependence and has shown that research is relatively limited, despite clinicians noting the concept of shame as being important for over 30 years. Research is in its infancy, but conclusions drawn from the limited research initially indicates that shame may be a hindrance to recovery from alcohol dependence. Drinking is a behaviour that can relieve shameful feelings and therefore during periods of abstinence feelings of shame become overwhelming, contributing to relapse. However it also seems that for individuals who experience shame, the most successful recovery involves addressing shame. The very nature feeling shame can to lead to relapse, but for recovery, shame must be acknowledged.

The Twelve Steps approach uses shame as a fundamental principle in its practice, making persons feel shame. On the surface, this may suggest shame could function as a relapse trigger for some people. However evidence suggests that this approach can help people to use shame to recover alcohol dependence. More recently, treatment approaches which specifically target shame have been found to be beneficial however more research is needed in order to get closer to understanding the role of the shame in alcohol dependence.
References


with a special focus on shame. In N. Tarrier (Eds.), *Case formulation in CBT. The treatment of challenging and complex cases* (pp.81-112). East Sussex: Routledge.


Clinical Experience on Training

Adult Placement (1 year)
I spent my first year of clinical training working within an adult mental health outpatient community team. I gained extensive experience of delivering evidence-based psychological interventions, primarily Cognitive Behavioural Therapy (CBT) with adults presenting with a range of complex problems. This included psychosis, bipolar, depression, social anxiety, generalized anxiety disorder, panic and acrophobia. I worked with clients who had physical health difficulties including pain, HIV and also with a gentleman who was selectively mute. I was also involved in developing and facilitating an eight-week education and support group for those who had received a diagnosis of Bipolar Disorder. I formally evacuated this group and wrote this up as my service evaluation project.

In addition to therapeutic intervention I was also involved in conducting initial multi-disciplinary assessments, alongside mental health nurses, psychiatrists and other psychologists. These would often involve the use of standardized assessment measures and screening questionnaires as well as formal cognitive tests including the WAIS. I delivered training to the team on how work with clients who have distressing voices and gave a presentation to psychologists on the updated NICE guidelines for psychosis, which had recently been published.

Older Adult Placement (6 months)
My older adult placement was split between a memory assessment clinic, older adult community mental health team and physical health rehabilitation service. I had a major role in the completing dementia assessments using a comprehensive battery of neuropsychological tests, observations and family interviews. My therapeutic work included the facilitation of groups for older people including a Mindfulness-Based Cognitive Therapy (MBCT) group, falls prevention groups and an eight-week cognitive stimulation group for those in the early stages dementia along with their carers. I provided consultation regarding the management of challenging behaviour and delivered staff training and workshops.
to residential care homes. I also worked 1:1 with older people; using CBT life review and narrative approaches and was invited by the local Age-UK group to deliver a mindfulness workshop to 70 people.

**Learning Disability Placement (6 months)**

In my learning disability place I worked within a community service, which was a joint ‘health’ and ‘social’ care team. I delivered 1:1 therapy, which was always adapted in order to make it accessible and used range of approaches including CBT, family and narrative for clients with anger, depression, psychosis and anxiety. Approaches were flexible in order to make therapy as accessible and meaningful as possible for the clients. I completed formal assessments for ASD and dementia using adapted measures suitable for those with learning disabilities. In addition to formal reports I wrote client accessible reports. I was often asked to work the team to manage issues of capacity and consent and completed assessments related to the capacity to consent to sexual relationships. I offered systemic consultations to families and residential care homes for managing challenging behaviour and would use integrative assessments and observations to develop Positive Behavioural Support (PBS) plans.

**Child Placement (6 months)**

My child placement was split between a community Child and Adolescent Mental Health Team (CAMHS) and a Specialist Services-Looked After Children Service based at the Local Authority. I had opportunity to work with young people using CBT, Interpersonal Psychotherapy (IPT) and family approaches, presenting with a range of difficulties including eating disorders, complex bereavement and depression and a delivered therapy through interpreters for some families. As I started this placement in my third year, I was also able to take more clinical responsibility and acted as case manager for my clients. I was involved in a comprehensive risk assessment of a young boy within care who had a forensic history and this assessment was used to help place the boy within a new children’s home, suitable for his needs.

I was involved in neurodevelopmental assessments of ADHD, ASD and
completed multiple cognitive assessments using the WISC. I ran therapeutic consultation clinics and supervision for social workers and foster carers with the aim of reducing placement breakdowns and consulted to children's homes, foster cares and schools, offering interventions and strategies based on attachment, solution focused and metalization models. I attended training on Adolescent Metalization-Based Integrative Treatment (AMBIT) which is a framework used to address the chaotic and complex systems and to reduce anxiety within these systems. I also developed and delivered a training day to 30 multi-agency professionals on ‘responding to complex developmental trauma’.

**Specialist Placement (6 months) Pediatric Neuropsychology**

My final and specialist placement was based within a rehabilitation centre for children with acquired brain injury. As part of a large MDT (including physiotherapists, speech and language therapists, occupational therapists, music therapists and educational psychologists) I was involved in providing assessment, rehabilitation, education and therapy to young people and families who had been affected by severe brain injury. Many of the young people I worked with had life-changing injuries, therefore therapy is often focused around reducing distress associated with trauma of the injury, improving quality of life and adapting to life with a brain injury. I was involved in completing neuropsychology assessment using formal standardized measures including the WAIS, WISC, WIAT, BADs, BADs-C, CMS, WMS and NEPSY and also informal assessment which involved dynamic observations, play-based assessments and gathering information from clinical notes. Assessments would often inform Education Health Care Plans (EHCP) and I would present findings to families, schools and local commissioners in order to support the young person with their transition back home and to get access to the additional extra support that they needed.

I ran a group for siblings, which included providing accessible brain injury education and also a narrative beading approach to encourage the siblings to tell their personal story and think about their future narrative as a sibling of a child with a brain injury. I also offered consultation to the residential houses, to help care staff manage challenging behaviour using PBS approaches.
## Assessments

### Year I Assessments

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<td>Professional Issues Essay</td>
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<td>Child and Family/People with Learning Disabilities/Older People/Specialist – Case Report</td>
<td>Interpersonal Psychotherapy (IPT) for Depression (Grief Focus) with an Adolescent Girl</td>
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</tbody>
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