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Women and shame: narratives of recovery from alcohol dependence

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ABSTRACT

Objective: Existing literature indicates distinct pathways and the key role of shame and stigma into alcohol dependence (AD) and recovery for women. Internationally, there is a paucity of research exploring these factors from women's perspectives.

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

Results: Shame followed a common trajectory across participants' stories, appearing as a reoccurring factor throughout AD and recovery. Participants narrated shame as gendered, contributing to a loss of personal control in defining a valued personal identity. Drinking began as a shame-management strategy but evolved into a source of shame, compounded by fears of being labelled an 'alcoholic woman'. Recovery involved reclaiming the self through de-shaming a shame-based identity and developing a positive, non-drinking identity. By evaluating 'shaming' recovery frameworks, sharing stories and reconstructing their own, participants were able to work through shame, resist pathologising identity labels and internalise esteemed 'sober' identities.

Conclusion: This research provides important insights into the intersection between shame, identity, gender and culture in women's recovery from AD. Implications for clinical practice, future research and policy are considered.

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Introduction

There is growing scholarly consensus that levels of alcohol dependence (AD) are increasing in women (Grucza et al., 2018; Slade et al., 2016), in some instances, at higher rates than in men (White, 2020). Women, generally, are more vulnerable to the adverse health, emotional, social and psychological consequences of problematic alcohol use (McHugh et al., 2018; Tuchman, 2010), are more likely to experience

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numerous barriers in accessing treatment (O'Connor et al., 1994; Tuchman, 2010) and are significantly less likely to seek support (Greenfield et al., 2007). More recently, the need for gender-specific support has been highlighted in research and by activists, as evidenced by the proliferation of alternative, women-led sobriety groups in the US and UK (Davey, 2021). However, knowledge on alcohol-related problems and interventions is primarily gained from studies with male samples, an issue commonly encountered in other areas of health research and has been noted to contribute to wider gender inequality (Fitzgerald et al., 2016; Sen & Ostlin, 2008).

It is estimated that 16% of women in England and Wales drink in a way that damages their health (NHS Digital, 2016) while from 2019 to 2020, there was a 24% increase in female alcohol-specific mortality rates (Nuffield Trust, 2022). Research also shows women are significantly less likely to seek help for AD from 'traditional' treatment programmes, including disease-model approaches such as Alcoholics Anonymous (AA) (Kaskutas, 1994; Rhodes & Johnson, 1994). Instead, they are more likely to seek support from primary care and mental health services (Harvard Medical School, 2011). Emerging research suggests pathways into AD and recovery are gender-specific, with women presenting with experiences of trauma, and histories of abuse, situated within socio-cultural contexts that allow for shame and stigma (Kougiali et al., 2021; Tuchman, 2010). Several authors argue that more research into underlying gender differences, exploring women's problematic alcohol use within the socio-cultural specificities of their everyday lives, is needed (Ettorre, 1997, 2015; Tuchman, 2010). The present research seeks to address this gap in the literature by centring on the voices of women and their experiences of shame and AD in the UK.

Recent literature highlights the multiple barriers women face when accessing treatment, including practical barriers (family and work commitments, limited access to childcare, lack of financial, social resource or family support), stigma and shame, fear of social labelling, complex mental health difficulties, and the absence of gender-specific protocols and treatments (Greenfield et al., 2007; Tuchman, 2010). AA, the UK's largest mutual support group (Public Health England, 2015), utilises a 12-step, self-help approach developed in the 1930s by upper-middle-class white Protestant US men for 'male alcoholics'. While a descriptive review found AA can be effective for women, it also noted gender differences (Ullman et al., 2012). Some researchers postulate that AA might be less applicable for women due to the emphasis on neutralising 'egocentric elements' in the character of the 'alcoholic', powerlessness (in the context of victimisation histories), and the life-long disease model (Davey, 2021; Kaskutas, 1994; Sered & Norton-Hawk, 2011). Therefore, while the demand for gender-sensitive support is increasing, support is overwhelmingly designed around men, and gender-responsive provision remains scant.

There is emerging consensus in the 'addiction' literature that women's pathways into and recovery from AD, and therefore treatment needs, are distinct (e.g. Kougiali et al., 2021; Tuchman, 2010; Van Der Walde et al., 2002). A lack of gender-specific treatment for women with AD is situated in a history of gender bias in addiction research (Greenfield et al., 2007; Waterson, 2000). Until the early 1990s, 'substance abuse' treatment literature was based predominantly on mixed samples without any focus on gender differences or male samples (Greenfield et al., 2007). Feminist scholars argue

that many prevailing theories of 'addiction' are 'gender blind' in that they treat and apply knowledge and research based on male participants as 'universal truths' (e.g. Campbell & Ettorre, 2011). Authors adopting a feminist stance argue that women use substances to numb, conceal or temporarily alleviate feelings of shame related to their own victimisation and that disapproving societal stigma from 'addiction' engenders an intense shame based on negative beliefs about the self that keeps women in 'denial' and 'hiding' (Blume, 1990, p. 299). As a transdiagnostic process, shame is implicated in many co-occurring diagnoses in women with AD, including depression and post-traumatic stress disorder (e.g. Gilbert & Procter, 2006). Shame, a common consequence of complex trauma (Courtois, 2004; Herman, 1997), is a contributing factor to the link between trauma and AD (Wiechelt, 2007). Compared with their male counterparts, women with alcohol 'addiction' are more likely to report powerlessness and inadequacy preceding drinking (Beckman, 1980), feelings closely related to shame.

Clinical feminist literature suggests gender differences in AD are rooted in differences in women's psychological development, increasing vulnerability to problematic levels of shame from dysfunctional or abusive relationships. Theories that focus on female development (e.g. relational theory; Miller & Stiver, 1997) posit that women are motivated primarily by forming a basic sense of connection to others. When women are disconnected from others, they experience diminished self-worth, confusion and disempowerment; a fertile ground for AD (Covington & Surrey, 2000). Based on their clinical experience, Covington and Surrey (2000) argue that women's disconnection and isolation are experienced as a state of shame. In line with this, Lisansky Gomberg (1988) posits that in contrast to men—who tend to act out in an array of aberrant behaviours—women turn negative feelings towards themselves. Internalised shame is thought to be experienced as depression, 'a state of dysphoric discomfort', which leads women to use alcohol in an attempt to 'relieve' and 'self-medicate psychic pain' (p. 144). Despite the gendered nature of shame, particularly in the context of AD, the majority of research linking shame to 'addiction' uses male-only or mixed-gender samples highlighting the need for further consideration of gendered aspects of shame in alcohol and broader addiction research.

According to Wiechelt (2007), 'addiction' research is based on two theoretical definitions of shame. Shame is conceptualised as either an innate affect, internalised when triggered inappropriately or chronically (Cook, 1996) or as a moral, self-conscious emotion experienced differentially according to one's dispositional proneness and self-evaluation (Tangney & Dearing, 2002), typically when a person evaluates themselves through the eyes of another (Lewis, 1995; Tangney & Tracy, 2012). Quantitative research with male and female participants finds elevated levels of shame in clinical populations in recovery from 'addiction' (Cook, 1987; O'Connor et al., 1994) and that shame-proneness is linked to problematic alcohol use (Dearing et al., 2005), indicating that shame is a risk factor for developing AD and/or that AD makes people vulnerable to experiencing shame. Due to associations with motivations to hide and escape, avoidance (of the problem) and ruminating self-criticism, shame is generally theorised as leading to an increase in problematic substance use (Dearing et al., 2005; Treeby et al., 2020). Shame is often contrasted with guilt (Dearing et al., 2005), which is considered more likely to motivate reparative actions, including taking action to address AD (Baumeister et al., 1995; Treeby et al., 2020).

It has been suggested that, perhaps counterintuitively, the effect of shame on one's global self-image (e.g. 'I'm a bad person') leads them to believe they are damaged beyond repair (Nussbaum, 2006; Tangney & Dearing, 2002), resulting in increased drinking. Alcohol has been found to deregulate experiences of anxiety and depression (Treeby & Bruno, 2012) and is thought to offer an especially effective means of coping with shame wherein self-awareness, a precondition for the experience of shame (Tracy & Robins, 2004), is prevented or decreased (Hull et al., 1986). DeYoung (2015) characterizes shame as a protective barrier arising from repeated failures in early childhood development, particularly in relation to a dysregulated other. This chronic misattunement leads to defensive adaptations and various pathological behaviours, including addiction. DeYoung emphasizes that shame is not merely an emotion or cognition; rather, it encompasses a complete 'world of experience' involving affect, emotion, thought, and self-image, all aimed at preventing self-disintegration. Shame's relationship with 'addiction' is commonly reported in clinical literature as being cyclical, wherein a 'shame-based' individual discovers that substance use facilitates avoidance and escape from painful feelings (of shame) but then feels increasing shame from loss of control, which serves as an antecedent for more substance use, perpetuating a vicious cycle of shame and substance use (Dearing et al., 2005; Kougiali et al., 2021; Wiechelt, 2007).

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

In the few quantitative studies comparing shame in men and women in treatment for substance use problems, women with 'addictions' consistently report significantly greater levels of shame than men (e.g. Cook, 1987; O'Connor et al., 1994; Tangney & Dearing, 2002). In their recent systematic and meta-analytic review on shame and substance use, Luoma et al. (2019) identified being a woman or gender minority as the only factor moderating the association between shame and substance use-related problems. Studies with women with substance use problems consistently indicate that women identify stigma as a barrier to accessing treatment (Pinedo, 2019), and are more likely to report perceived stigma as the reason for not seeking treatment when compared to men (e.g. Stringer & Baker, 2018). The only study to explore shame-based interventions with women in treatment for substance abuse problems found that addressing shame, including the gender-based expectations that provoke shame, is an effective treatment modality (Hernandez & Mendoza, 2011).

It is necessary to situate the position of women with AD within the preexisting models of addiction and broader historical framework. The UK's temperance movement (see more in Berridge, 2005) rooted in moral values, framed problematic drinking as

a personal failing, linking abstinence to self-improvement (Batho, 2017). The movement located responsibility and moral flaws within the drug/alcohol-consuming individual and was succeeded by the disease model, employing a deterministic approach to argue that addiction is a 'chronic, relapsing brain disease characterised by compulsive drug seeking and use, despite harmful consequences' (NIDA, 2024). Traces of both approaches can be located in the philosophy of AA, who approach problematic drinking as a disease and simultaneously as a moral flaw, defining 'alcoholism' as a permanent, incurable illness that, at the same time indicates 'the kind of person one is' (Yeung, 2007). Critics of the disease model argue that although pathological neuropsychological dysfunction is involved in addiction, a biological causal explanation disregards social structures, and allocates blame to individuals, leading to further stigma, social exclusion and marginalisation (Heather et al., 2018; Levy, 2013).

Masculinities and femininities, as argued by Lyons and Willott (2008) through a social constructionist lens, are better understood as emerging from cultural concepts that are further constructed and enacted in specific social contexts. This continuously negotiated and tenuous identity is fluid, localised and shaped by power dynamics. While gender norms can determine alcohol consumption (for example lower drinking rates for women in communities where drinking is not socially acceptable, see Montemurro & McClure, 2005), drinking alcohol can also be seen as a way of 'doing gender', a means of expressing and embodying traditional and non-traditional gender identities (Lyons and Willott (2008; Peralta, 2007). More recent research, highlights that while women's drinking might be more widely accepted, however it is still performed within the boundaries of certain gendered expectations, whereby 'a "drinking femininity" is acceptable but a "drunken femininity" is not' (Hutton et al., 2016, p. 85). Contemporary sociological research highlights how the British mass media, general public and governmental institutions continue to pathologise women's alcohol use as a form of transgressive femininity (e.g. Day et al., 2004; de Visser & McDonnell, 2012). Women seen to occupy the position of 'alcoholic' remain especially vulnerable to, and more profoundly affected by, stigma due to the perception of their deviation from socially prescribed gender roles as caregivers (wives/mothers) and traditional 'feminine' qualities such as submissiveness, being responsible and caring (Eagly et al., 2000; Lex, 1994). This is said to have led to a pervasive, cultural double standard regarding alcohol use (de Visser & McDonnell, 2012) that inflicts more shame on women with AD than men (Sanders, 2009).

Stigma has been identified as a central concern for those who use illegal drugs, who are heavily stigmatised due to associations with crime, affecting willingness to seek treatment and harm reduction services (Gibson & Hutton, 2021; Meyerson et al., 2021). The stigmatisation can be experienced more intensely by women who inject drugs, who can be regarded as violating societal gender expectations (Gisbson & Hutton, 2021). Importantly, stigma has been noted as influenced by factors such as gender, citizenship, race and ethnicity, resulting in feelings of shame, exclusion, secondary stigma and discriminatory treatment (Douglass et al., 2023), while internalised stigma can exacerbate guilt and shame, deterring help-seeking, especially from gender-blind services (EMCDDA, 2023). A similar mechanism in the cycle of internalised stigma and shame has been previously noted in a recent meta-synthesis focusing on

women dependent on alcohol (Kougiali et al., 2021). Participants noted social perceptions of promiscuity, lack of adherence to gender roles and generalised social stigma, which led to feelings of worthlessness and, in turn, to intensification of shame, social isolation, feelings of being 'dirty' and tainted' and significant reluctance in seeking help.

Research indicates that shame may be more significant for women with AD than those with dependence on other substances (Sanders, 2011). Indeed, a consistent finding across research with women on their experiences of alcohol dependence and recovery is the reporting of shame and guilt from perceived social stigmatisation from being identified as an 'alcoholic' or 'drunk' by the women themselves, significant others or the wider community (Boreham et al., 2019; Brewer, 2006; Cunningham, 2012; Davis, 1997; Hanpatchaiyakul et al., 2017; Jacobs et al., 2012; Jakobsson et al, 2008; Kougiali et al., 2021; Lillie, 2002; Long & Mullen, 1994; McNally & Finnegan, 1993). Within these studies, the 'alcoholic woman' was constructed as violating traditional feminine qualities of womanly purity and sexual dignity, being in control and motherhood (Boreham et al., 2019; Cunningham, 2012; Davis, 1997; Hanpatchaiyakul et al., 2017; Jacobs et al., 2012; Jakobsson et al, 2008; Lillie, 2002; Long & Mullen, 1994). Shame from gender-based expectations was also found to shape women's drinking behaviours, including denial, hiding and hoarding drink, secret and solitary drinking, self-isolation and home-based drinking (Cunningham, 2012; Doty-Sweetnam & Morrissette, 2018; Long & Mullen, 1994).

Over the last decade, sobriety has been gradually presented within alternative recovery modalities surfacing in online spaces, spearheaded by women, attempting to distance themselves from more traditional recovery programmes (Davey, 2021). Narratives of 'positive sobriety' share similarities with historical temperance movements, however, today's sobriety advocates focus more on consumer choice, identity construction, and well-being, rather than religious moralizing (Morris et al., 2023). A conglomerate of online communities (sober media, podcasts, blogs), web-based support groups[1] and autobiographical 'quit' literature[2] constitute a 'new sobriety', 'positive sobriety' or 'sober curious' movement, promoting abstinence and moderation (Nicholls, 2021; Yeoman, 2019). These communities tend to reject the use of binary language of 'alcoholic' or 'addict' and instead conceptualise alcohol-related problems on a spectrum (Raypole, 2020), offering information, peer support and recovery coaching to those wanting to 'renegotiate their relationship with alcohol' (Davey, 2021, p. 2).

The limited academic research in alternative recovery provision has found that this treatment pathway's advantages appear to align with the gendered needs of women in recovery. At the time of writing, Davey (2021) had conducted the only mini-review on online sobriety communities for women's problematic alcohol use based on qualitative and quantitative research. She found that participants within online sobriety communities are disproportionately female, in employment and have post-graduate qualifications and this treatment pathway offered solutions to women's barriers to treatment, notably the mitigation of shame and stigma, particularly if platform use is anonymous and/or mediated through the written word. More recently, Atkinson et al. (2023) noted that despite the distinct

differences between recent online communities and traditional, abstinent-focused programmes, and although these spaces appear to be inclusive of a broader range of drinking practices, full abstinence was often presented as the only option. This stance may indicate potential tensions in the way women navigate such spaces and the perpetuation of gendered shaming practices. A more nuanced gendered analysis, especially for example, into the gendered nature of communication and identity performance within online sobriety communities, has been largely absent from these studies. Given the predominance of disease-based and medicalised addiction narratives, such as those propagated by AA, the lack of exploration of how and when women traverse and engage with sobriety narratives vis a vis other narratives in recovery is a significant gap in the recovery literature.

While shame has featured prominently in qualitative studies of women's experiences of alcohol dependence highlighted above and men and women with lived experience of AD (e.g. Morck et al., 2020; Smith, 1998), an extensive search of the literature could only locate one recent qualitative study explicitly focused on the lived experiences of shame in recovery from AD, which found that constructing and sharing narratives of shame in AA can support recovery (Sawer et al., 2019). However, this study used a mixed sample of (majority) men and women, precluding a gendered analysis of shame from the perspective of women.

Narrative research with people in recovery from AD demonstrates that sense-making, integrating and constructing individual experiences and identity appears to be important to recovery and broader positive psychosocial outcomes (e.g. Bergström, 2017; Hanninen & Koski-Jannes, 1999; McConnell, 2016). However, no studies have explored the ways in which shame impacts this process for women, how, in their storytelling, women retain a sense of being morally good actors despite any differential societal positioning, or how women navigate multiple (often shaming) cultural and organisational narratives in recovery. Arguably, our understanding of shame in women's recovery from AD remains partial at best.

In recognition of shame as a multifaceted and social phenomenon, an intentionally broad definition, borrowed from Leeming and Boyle (2004), was adopted for the current study. Shame is defined as an 'acute emotional experience' felt about 'many aspects of circumstances, behaviour or self which are judged negatively or considered to fall far short of moral, aesthetic or performance standards' and 'may be repeated frequently where someone reaches an understanding of themselves as shamefully inadequate in many areas of life' (p. 2). The conceptual elements of this definition bring into purview shaming practices, and encompass how women with AD may struggle with shame due to aspects of identity that are stigmatising (Crozier, 1998), such as perceived failure to perform a long-term social role effectively (e.g. self-sacrificing mothers; Harré, 1990) and inaccessibility of shame-avoidance strategies (e.g. Gilbert & McGuire, 1998; Goffman, 1967).

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

Materials and methods

This study employs a critical realist epistemological position (Bhaskar, 1978; Sayer, 2000). Within critical realist definitions, there is an independently existing reality, but this is neither 'fixed nor stable', and direct access is impossible (O'Mahoney & Vincent, 2014). This position appreciates the role of language in constructing our social realities and recognises the material world and how the possibilities and constraints inherent within it (e.g. biology, power) shape these constructions (Sims-Schouten et al., 2007) Critical realism reflects the central aims of the research: to understand how shame might contribute to women's pathways into and out of problematic alcohol use, by incorporating literature that finds shame to be a fairly stable construct across cultures and, to a certain extent, 'universally experienced' (Keltner, 1995; Sznycer et al., 2018) while accounting for the socially constructed elements of the experience. For instance, perceptions of the nature and determinants of shame vary across time and according to personal, historical, economic, political and socio-cultural contexts (Leeming & Boyle, 2004). Likewise, while 'alcohol dependence' is underpinned by 'real' processes (e.g. biology, power, government policy) it is also subjective, discursively and culturally bound (Selbekk et al., 2015; Stevens, 2020).

Narrative inquiry was employed as the analytical framework for the examination of shame in this study. Shame is described as a self-conscious and morally constructed emotion felt in response to negative self-evaluation, providing feedback on moral and social acceptability (Tangney et al., 2007). Narrative theorists assert that stories, as the building blocks of culture (Atkinson & Coffey, 2003), are the primary means by which individuals make sense of themselves, others and the world (Holstein & Gubrium, 2000) and therefore play a crucial role in the transmission and incorporation of dominant messages of morality or 'goodness' (Crossley, 2000). Grand narratives are socially embedded and broadly shared frameworks of knowledge and experience that are understood and communicated in the forms of stories (Miller, 2017). Grand narratives of addiction, in turn, can be considered as the accumulated, culturally embedded plots that define public perceptions of the characteristics and causal factors (as influenced, for example by the disease, moral or criminal justice approaches) of those who engage with alcohol and drug consumption. As such, the exploration of stories is likely to provide insights into self-evaluative and socio-cultural processes involved in the production of shame.

As a central means of sharing and making relatable our emotions and experiences (e.g. shame/AD) (Storr, 2019), stories were considered essential in examining how shame features within relationships. Stories can help the storyteller process emotion and create meaning from experiences through the 'sequencing of events' (Polletta et al., 2011, p. 111). Such processes have been widely reported in the research analysing narratives and storytelling in mutual aid groups, such as AA, (Crossley, 2000; Kaminer, 2006; Kougiali, 2015) while more recent studies indicate that storytelling can help narrators heal from or develop resilience against shame (e.g. Sawer et al., 2019; Yue, 2021).

Procedures

Input from service users in healthcare-related research has been documented as valuable, particularly in addressing power hierarchies inherent to the process (Shippee

et al., 2015). During the planning phase, a member of the host University's 'People's Panel', a panel comprised of NHS experts by experience and carers, was consulted on the research project. They expressed enthusiasm about shame as a research topic and made several recommendations on ways to manage interviewing on shame and alcohol use, which were incorporated into the interview schedule. Prior to recruitment, ethical approval was granted by the host University's Research Ethics Committee. All prospective participants were sent an Information sheet and consent form before interviews took place and were invited to ask any questions *via* email or telephone. The information sheet included a description of the project aims, what the interview would entail and the right to withdraw participation without harm or prejudice.

Sampling and recruitment

Narrative analysis generally uses small sample sizes (e.g. Frank, 2012) to examine the stories individuals construct to make sense of their experiences and lives (Riessman, 2000). In line with the exploratory aims of this study, this approach allows for a deeper exploration of how participants make meaning of phenomena (e.g. shame and alcohol use) over time and the relational and broader socio-cultural, and structural contexts in which they live. The study employed a purposive sampling method (Palinkas et al., 2015). Online sober support groups/communities aimed at women were contacted, and interviewees were recruited through an online peer-led, grassroots charity for women in, or seeking, recovery from substance use disorders through a recruitment poster the organisation's founder displayed on their private Facebook page. Eight cisgender women responded, expressing interest in participating in the study.

Seven women aged between 34 and 54 participated in the study. The average length of time sober was 2.4 years, ranging between two months to eight years and five months. Three participants talked about using substances other than alcohol in the past, but all considered alcohol to be the main substance of concern. Participants were from, and had sought recovery, in various locations across the UK; one had previously lived abroad, and another moved to the US after becoming sober. The women described varied pathways into recovery, including informal support, alternative therapies, counselling, quit literature, drug and alcohol services, medication, social media (the sobriety movement), and mutual aid groups, including AA and women's online sober groups. Four women had attended AA; three attended one to several meetings only and one spent five years in recovery with AA. Four were mothers, all participants were university-educated and five were employed.

Narrative interview

Narrative life story interviews were chosen as the most suitable approach for data collection. In this approach, interviewees set the agenda; the interviewer's role is to activate 'narrative production' and facilitate conversation instead of relying on a question-answer style (Holstein & Gubrium, 1995, p. 39). A participant-led approach

was considered a sensitive and ethical way to explore shame, giving participants greater choice over what they shared, thereby reducing the potential for distress (Atkinson, 2012) and allowing unanticipated and novel perspectives to arise. Such approaches are considered an effective way to build rapport and trust with marginalised populations (Kougiali, 2015), promoting greater investment in the research (Overcash, 2003) and producing emancipatory outcomes (Parker, 2005).

Analytical steps

The steps outlined by Crossley (2000, 2007) were used as 'a loose scaffold' from which to analyse the data and facilitate transparency in the analytical process (Tracy, 2010) (1) Reading and familiarising with the data, (2) Identifying narrative tone: This step involved a reflection on how something was said (Crossley, 2000) and what was left unsaid (Miller, 2017), the storied events and the chronological positioning of the participants by taking note of whether this was the narrator in the present, past, or future, and if there were changes over time (Miller, 2017: (3), identifying images and themes: Crossley (2000) argues that images and themes overlap, and it can be helpful to look at these together. As imagery is both made and discovered, the personal, socio-cultural context of the imagery and the images that were provoked were explored. Themes were understood to summarise key points in the stories. Alongside the identification of themes and images, the ways in which women presented themselves, with reference both to themselves and in relation to others, events over time, and whether women seemed to draw on, or reject dominant narratives, were reflected upon (Miller, 2017) (4) Weaving a coherent story: The images and themes were mapped in relation to life chapters, key events, significant people and future scripts; these summaries were used to build a coherent story (Crossley, 2000) (5) Cross-analysis: The final stage involved exploring the commonalities and differences amongst participants by extrapolating and synthesising the main themes and comparing and contrasting tone and style (Fraser, 2004) (Table 1).

Analysis

Early internalisation of shame and shame management practices

Participants described histories of adverse childhood experiences, including sexual and emotional abuse, neglect, mental health difficulties, parental separation and parents with alcohol problems, mental health problems and experience of domestic violence. Women's childhoods were characterised by experiences of disconnection, powerlessness and absence of emotional nurture. Most participants assumed occupying devalued or outsider positions within their families and peer groups, emphasising feeling unwanted, judged or like they did not measure up to others' standards. The internalisation of early experiences appeared to provide the context for a self-narrative of shame, with recounted elements of inadequacy, abnormality or worthlessness becoming the dominant story about the self. In line with DeYoung's (2015) approach towards shame, participants storied emotionally absent/unavailable parents and concomitant early feelings of disconnection as providing the context for internalised

Table 1. Illustrative example of the analytical process based on one participant's life story.

Key events	Themes	Imagery	Narratives (Personal and grand)
'Traumatic' childhood Being different/othered (in family) Childhood anxiety, shame and secrecy	Lack of emotional nurturing Disconnection Shame and secrecy Self as different Voicelessness Mental health	*'Black sheep'* *'Covered in shame'* *'Ball of anxiety'* *'Black cloud'* *'Blithering idiot', 'Couldn't speak'* *'Big dark secret'* *'Darting in and out'* *'Shapeshifted'*	Internalised narratives of shame
Early drinking 'First drink' story "I felt normal' 'I can drink and be who I think I should be'	Self as normal Empowerment Culturally 'normal' drinking Connection Acceptance		Reparation-liberation narratives *Grand 'drinking as the norm' narrative*
Motherhood and start of problematic drinking 'Perfect' pregnancy v birth 'failure	Shame from perceived failure at gender roles Powerlessness Isolation & loneliness Self as ashamed	*'I'm stuck here', 'It just floored me', '[breastfeeding] was like knives'*	*Grand 'good/bad mother' narrative*
Escalating alcohol use Shame from health concerns (self, sibling, child) Financial difficulties Child finds Lulu blacked out (*'the biggest shame'*)	Loss of control Drinking to cope/ escape/ numb Self as ashamed Mental health Shame from drinking (label of alcoholic woman/mother, behaviour when intoxicated) Drinking untenable Shame (barrier to support) Shame (turning point for recovery) Future self	*'Just hanging on', 'Everything was just going to implode', 'Mental health was shot to pieces'* *'Everything was just a mess', 'A vicious cycle', 'I was on the coach fucking comatose'* *'I can't stop drinking, but I tried to imagine myself as a fifty, sixty-year-old woman drinking, and I just thought I can't (…) something's got to give*	Narratives of escalating alcohol use *Grand 'good/bad mother' narrative* *Grand AA narrative*
Early sobriety Child's birthday party Milestone/birthday	Health benefits of sobriety Improved relationships Identity shift Mental health Shame (barrier to support) Self as ashamed Recovery for others	*'Climbing the walls'* *'A Friday night and I'm drinking pissing coffee'* *'Locked in a lot of shame'* *'I was stuck'* *'I left myself behind'*	Narratives of recovery *Grand AA narrative*
Recovery and a positive non-drinking identity Speaking about shame with counsellor Reaching out to other women Child's story of pride	Recovery for self Identity development Extending repertoire of experience Rejection of alcoholic identity and AA (unrelatable, negative, shameful) Comparison Connection (sober platforms, son) Self-compassion and self-acceptance Pride		Narratives of resistance Reclaiming narratives*Sobriety narrative* *Grand AA narrative* *Grand 'good/bad mother' narrative*

self-narratives of shame (e.g. *'ugly', 'boring', 'different', 'not good enough', 'unlikeable', 'unlovable', 'unworthy'*). These were storied as critical internal monologues, typically linked to the voice of participants' mothers. Susie captures this process of internalisation: '*I'd had you're not good enough instilled in me from an early age through my mother.*' She repeats the phrase *'not good enough'* throughout her story when describing other people's views confirming her mother's account of who she is. In this way, her mother's voice and judgement seem to become her own. As the individual life narrative constructs need to be supported by others to be viable (Gergen & Gergen, 1988), it seems likely that participants' self-narratives were maintained in coherence with narratives of significant others, particularly their mothers, that appeared to have initiated a shameful positioning.

Participants traced shame management strategies back to their childhoods as they narrated the use of several relational strategies to distance themselves from the internalised self-narratives of shame, constructed through stories of trying to *'fit in'* (Susie), '*be normal'* (Lulu), '*please others'* (Linda, Alexa & Laura), *'pretend everything's okay'* (Linda & Katie), *'not let others come too close'* (Tamzin) and '*keep secrets'* (Lulu, Alexa, Susie, Linda & Laura). Within these stories, participants dismissed or concealed their feelings (self-silencing), hid 'undesirable' parts of themselves (secrecy) and attempted to conform to match others' expectations (people-pleasing). Rather than shifting self-narratives of shame, these strategies cemented them, resulting in an increasing gap between an outward-facing self and who they believed they really were.

This dual perception of self ultimately appeared to disconnect participants from themselves and others, depriving them of the ability to form intimate connections. In recovery, participants portrayed these shame management strategies as engendering a divided self, giving rise to power imbalances in relationships and feelings of sadness, anger, and isolation. Though employed as protective mechanisms to manage or avoid shame, participants convey that these strategies ultimately limited their capacity to know and articulate their own needs and sense of self outside other people's perceptions of them.

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

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

Lulu depicts the transformational capacity of alcohol, allowing her to renegotiate her 'tarnished' social identity (*'snooty bitch'*). Drinking effectively fixed 'the problem'

of how she felt at the beginning of her story by reducing anxiety and facilitating interactions with others, rendering her normal, which she goes on to suggest is *'really nice'*. Newly discovered feelings of normality appear to be situated in Lulu's perception of alcohol as supporting her to better perform the gender role expectation of 'niceness', which is reinforced when her preferred 'drinking self' is seen to receive positive validation from others. Later in her story, Lulu narrates how drinking became fused with her social identity, stating, '*I could never go anywhere without alcohol*' and that she thought *'it wasn't normal'* when others did. Thus, drinking is framed as an act of identity restoration (Killingsworth, 2006), a rational means of seeking acceptance and belonging and, perhaps most importantly, offering the 'seal' of newfound normality, which rendered its use essential.

Nevertheless, the powers, freedom and connection afforded by drinking were fragile and temporary in participants' stories and the incongruence between the 'real' and 'drinking self' developed into a source of shame. Lulu and Susie told stories of interactions wherein external validation of their 'drinking selves' was taken as evidence of their inadequacy without drinking, which affirmed shameful narratives associated with their 'real' selves. When recounting university drinking experiences, Susie recalls a comment made by a student that she was 'fun' when drinking, which she interpreted and internalised as *'without a drink, [she] wasn't any fun'*. Implicit in many of their stories was that, in the context of needing to hide and self-silence their 'real' selves, the women did not have a clear sense of who their 'real' selves were and for the majority, drinking comprised a critical part of their social and relational identities.

Narratives of drinking escalation: 'because you're drinking every day, it's that shame'

Participants narrated a gradual progression of their drinking, punctuated by one or a series of events, wherein 'acceptable' drinking escalated to 'problematic' drinking. As participants narrated drinking more frequently and alone, drinking no longer provided a reparative function but a means to escape increasingly painful and shame-filled realities. Rather than being preferred, their 'drinking selves' were now constructed as deviating from socially acceptable behaviours in ways that frightened or shamed them. Their narratives gathered momentum as events unfolded, resulting in a 'piling up' of negative consequences and eventually spiralling 'out of control', often portrayed through metaphors (e.g. '*train crashing*', Susie). These narratives often followed the 'and then and then and then' syntax typical of Frank's (1995) chaos narratives, indicating participants' perceived loss of control. Drinking escalation appeared to serve as a response to gendered experiences of shame in participants' stories. Self-narratives of shame appeared to interact with grand narratives of traditional femininity to further strengthen and reinforce a shameful perception of self. Participants reported shame from their perceived inability to fulfil gender roles (mothers, wives), deviation from gender norms (particularly when intoxicated) and stigma from heavy drinking as women and mothers.

All participants storied secret and heavier drinking to cope with and escape from feelings of shame, frustration, anger and sadness from being made to feel 'inadequate', 'inferior' and powerless in relationships with 'abusive' and 'controlling' male ex-partners

(*'he'd always made me feel quite inferior in our relationship… I just felt so little and small and stupid'*, Alexa). Katie, the only participant who disclosed a non-heterosexual identity, storied the escalation in her drinking as rooted in the shame associated with acceptance and disclosure of her bi-sexual identity. Within these stories, drinking was also framed as an attempt to regain power by 'not listening' in relationships or contexts where they felt trapped or powerless.

The four participants who self-identified as mothers indicated they were the primary caregivers; four described themselves as '*feeling like*' (Linda, Alexa) or being '*single mothers*' (Laura, Tamzin). The narration of an escalation in drinking to cope with stress and isolation from the high demands of motherhood and shrinking social worlds was commonplace. Shame featured heavily in stories of motherhood and drinking. Lulu traces her escalation in drinking back to shame from a traumatic birth, contrasting this with her *'perfect'* pregnancy, where she felt '*normal*':

> I felt < sigh > ashamed again. I felt, 'I fucked this up. I can't even do that. I can't even give birth to a child. What a loser you are. And I… people were flocking to see me. I was…I could hardly…I couldn't walk, because you can't walk, you can shuffle along. And people were coming to the house bringing me presents and flowers and saying congratulations, and I was honestly thinking, 'What the fuck are you talking about. I didn't even do it. I didn't do it'…I think I put myself under an enormous amount of pressure because I wasn't enjoying it. It wasn't what I thought it would be…I was left on my own… it was really difficult…and I'd started having a drink every evening (Lulu)

Lulu narrates a self-punitive and derogatory inner monologue through which she blames, shames and persecutes herself for a perceived '*failure*' at childbirth. This can be seen as a function of dominant narratives around 'natural childbirth' (Crossley, 2009; Dykes, 2005) and an example of her internalisation of 'self as failure' in relation to grand societal narratives of 'good mothering'. Lulu indicates shame is a repeated experience for her, and the theme of struggling to take up what she perceives as ordinary gender roles is evident across her story. Fulfilling the collectively shared image of the 'perfect' pregnancy, seemed to be perceived as the minimum precondition (I can't even do that/I didn't even do) necessary for fulfilling the expectations of the maternal role in Lulu's narration, followed by repeated expressions of self-judgement and shame Her account suggests those who have internalised early shame might be more susceptible to maternal shame. Lulu goes on to the shift in identity, recounting the loss of agency and independence

As they drank more frequently and alone, the shame from heavy drinking appeared to interact with participants' identities as mothers to further escalate their drinking. Alexa states:

> …the easiest way that I've found to kind of like myself was after that kind of that glass of wine. Erm, but then at the same time because you're drinking everyday it's that shame and it's that shame that also my daughter deserves better than this because I'm not present and, erm, it's just the easier option to pick up that bottle of wine (…) even when I wasn't drinking… I'd feel bad for my daughter because I would do stuff with her, but I wouldn't…I'd go into the actions of doing something that a good mum does, but I wouldn't feel present, or feel engaged, or feel happy to be doing it. And there's shame around that as well (…) (Alexa)

Alexa links the lack of attentiveness or enjoyment in her mothering role, establishing links with negative self-perception. She suggests that drinking rectifies this by allowing her to temporarily like herself, despite it ultimately increasing feelings of shame and disconnectedness from her daughter. Both Lulu and Alexa narrate their 'stuckness': alcohol offers relief from shame and shame-filled realities, enabling fleeting self-acceptance, yet compounds shame from 'drinking everyday', reminiscent of the vicious cycle of shame in the literature (Wiechelt, 2007).

In their narratives of heavy drinking, participants often emphasised the loss of control and the ego-dystonic nature of the drinking self. For example, Linda describes getting into 'fights' when drunk as 'completely out of character for [her]' and as the 'quieter one' compared to her sisters. Alexa narrates shame in relation to specific drunken behaviours that violated personally relevant moral and social standards:

> So I got a call at one o'clock in the morning, erm I was like, 'well that wine will be out of my system' so I drove to this guy's house. Erm, and then obviously the shame that happened from waking up from that and that feeling of like, 'I've never driven drunk in my life.' And that was kind of like…this is a whole fucking different thing now (Alexa)

Alexa and Linda's stories were typical of participants in emphasising how inconsistent behaviours when intoxicated were with who they really are and how they typically behave. By highlighting they were taken over by alcohol, and not acting as their 'true' selves, participants may be able to distance themselves from the 'drinking self', facilitating reintegration without enduring shame. In their stories of drinking heavily, participants describe their enactment of more traditionally masculine behaviours (fighting) and transgression of traditional feminine qualities and characteristics (niceness, responsibility, caring, selflessness), which appears to load on more shame. In addition to risks attached to drunken behaviour, particularly from blacking out, this is storied as contributing to participants' decisions to drink alone and in secret, exacerbating social isolations, as well as supporting them to recognise their drinking as problematic. Shame is constructed as cumulative in its effects, and while it is generally reported to exacerbate alcohol use, the impact of intolerable levels of shame from drunken behaviour was also identified as informing some participants' decision to stop drinking. Susie recounts the impact of this on her mental health and isolation:

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

Susie makes associations between her mental health, drinking as a form of self-medication and describes how the escalation of her drinking led to increasing attempts of self-isolation. Alcohol is positioned as both a causal and alleviating factor of worsening mental health symptoms. At this stage in their stories, participants conveyed a sense of being stuck and out of control; they either faced shame from continuing to drink *or* being forced to accept the label of alcoholic privately and publicly. During stages of escalating alcohol consumption, previous literature notes that a rupture whereby the 'drinking self' exacerbated shame and the negative feelings

alcohol helped mask in earlier drinking stages, gradually overpowering women's lives (Kougiali et al., 2021).

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

As participants storied gradually alcohol exerted dominance over their thinking and decision-making, signalling potential problem severity with implications for self-identity. Laura, one of the few participants who identified with the label of alcoholic, narrates internal conflict and turmoil as she tries to navigate and accept this new identity:

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

Laura stories her acceptance of the label of 'drug addict' as evoking fear and a critical turning point in her recovery. She narrates resistance to the 'addict' identity, framing it as undesirable and unwanted. The 'quit' literature is highlighted as a key factor in her acceptance of this identity—presumably, in this case, in its legitimisation of grand narratives of addiction. Relief from taking on this identity appears rooted in her reconciliation of this conflict, allowing her to move forward and seek help. The recognition of individual characteristics that might be contributing to addictive behaviours and acceptance of this 'spoiled identity' has been argued as a crucial part of the initiation of the process of change (McIntosh & McKeganey, 2000)

For Laura, taking on this label was narrated as the point where she accepts drinking as a problem to herself and, later, others, allowing her to seek help through specialist services. Nevertheless, she stories performing this identity publicly to get support as shameful and later resists the language of addiction when discussing her experiences in a sobriety support group, referring to it as a *'common issue'*. Indeed, participants traversed different treatment and societal narratives to make sense of alcohol

problems throughout their stories, including addiction, mental health, and sobriety narratives, suggesting that several functions are served by varying narratives.

In contrast to Laura, most participants narrated that they did or could not take up the alcoholic identity (*'I couldn't get my head around being an alcoholic'*, Lulu), and storied attempts to stop drinking without formal support, sharing their reluctance to seek help from AA. The stigma attached to being labelled an 'alcoholic woman', predicated on the social construction of gender that continues to position women who drink heavily as deviant, was present in their narratives at this point. When an individual is 'discreditable' (Lloyd, 201) or 'passing' (Goffman, cited in Lloyd, 201), they regularly engage in self-management to avoid revealing their stigma to others. Indeed, participants recounted going to great lengths to hide their drinking habits and telling themselves not to drink, identifying the shame attached to this identity as a barrier to accepting the problem and seeking help.

Participants storied a broader culture of secrecy surrounding women's problematic alcohol use, describing limited support options and that their drinking was either not identified as a problem by their GP despite reporting they were drinking heavily or those who felt able to share their concerns were either given '*very generic*' advice (Laura) or told 'alcoholism' was '*untreatable*' (Linda). Considering the impact of acquiring a 'spoiled' identity (Goffman, 1963) seems pertinent here. If drinking functions to mask self-unacceptability, taking on a stigmatised identity (to acquire formal or informal support) is likely to be experienced as a shaming process. Indeed, participants narrated intense feelings of shame, guilt, anger, fear and sadness from having to confront the stigmatising label of 'alcoholic' as women and mothers in sobriety, as well as the behaviours of their 'drinking selves' and the impact of drinking on loved ones.

Narratives of recovery

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

Breaking through the barrier of shame: 'I've got to tell her'

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

> I didn't seek any support until I was nearly two years. I did it myself and there was so much that came up that I didn't really know what to do with so I bottled it all and it

> made me quite unhappy (…) I was too ashamed to seek any…I went on these things and read things and just thought I can't…I didn't feel I was able to share anything because I felt too ashamed. That was my biggest barrier was my shame (…) But I could just tell her and the world did not…I just felt…I just thought, I've had enough, I've got to speak it, I've got…yeah I just…yeah, I think being sober just…yeah it just gives…it just gave me the…I just had the…my head was clear and I just…I knew I had to do it. I knew I had to work on myself (…) when I walked in, she said to me that I was…that I had like a cloak of shame on me. I was so weighed down by it. So then I, I spoke…I actually verbalised…I told her it…I told her everything. (Lulu)

Lulu narrates how shame kept her stuck with a self-critical internal monologue for two years, significantly impacting her mental health. Shame is portrayed as an overwhelming weight, preventing her from opening up and seeking help, the heavy burden of this captured through her use of vivid imagery: '*cloak of shame*'. She frames telling the counsellor out of necessity and desperation rather than a choice ('*I had to do it'/I've got'*), aided by a renewed capacity to engage in sense-making in sobriety and the counsellor's identification of shame. Once verbalised, she conveys relief that her worst expectations did not happen ('*the world did not…'*) and implies her recovery only begins after she takes off the *'cloak of shame'* (Brown, 2006).

Like Lulu, Laura narrates shame in the process of telling loved ones/others about her drinking problem and that after multiple 'failed' attempts, she has been only able to maintain her sobriety after doing so:

> …the first time that I told my daughters that this was the problem that I had, it was, I felt ashamed (…) but you know, having told my family and my friends, the support from them has just been like you know incredible really. And allowed me to feel less shameful about it (…) Erm, and that people weren't judging me for being, you know, the typical alcoholic that they tend to think of when they talk about an alcoholic or a drug addict. Erm, so maybe having told one person, the sense of relief that I got from that allowed me to tell others as well (Laura)

Laura stories the positive validation and support she receives (as opposed to being judged for being 'a stereotypical alcoholic') as alleviating shame and encouraging further openness, supporting her to reveal her 'true' and 'honest' self, and genuine connection, intimacy and acceptance to occur. For all participants, opening up in their stories was heavily influenced by their preconceptions of how others would view them, which fuelled shame at all stages.

Connecting through stories: 'I don't think they're a bad person so maybe I'm not a bad person too'

All participants narrated connecting with the stories of other women in positive sobriety communities as a turning point in recovery, facilitating the working through of shameful feelings. Comparison and a sense of mutuality seemed to normalise drinking and past behaviours when intoxicated, disrupting the totalising (viewing themselves as bad in their entirety) and individualising (directing blame inward) functions of shame. The sense of community and connection this fostered appeared to mirror that which had previously been sought through alcohol and was framed as providing the motivation, accountability and support needed to keep going.

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

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

Alexa recounts an identification with 'sober' women whom she perceives as holding socially valued identities ('*good mothers*', '*career driven*') as helping to break down the stigma attached to the 'alcoholic' stereotype, allowing her to question the basis on which she thought of herself as 'bad' and reconfigure her self-narrative of shame. Highlighting the absence of shame when sharing 'wobbles' with other sober women suggests exchanging stories helps to normalise AD and struggles in sobriety by implying a public normalisation of her personal experiences (Trondsen & Tjora, 2014). The sober community is framed as supportive and dependable in contrast to how significant others are presented in the rest of her story (abandoning/rejecting), appearing to foster a sense of connection and acceptance she sought through alcohol earlier in her story. The sober community may have provided a basis from which participants began to develop more positive social identities (e.g. Dingle et al., 2015). Nevertheless, in Alexa and Tamzin's stories, the sober community could also be a context that made them vulnerable to shame:

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

Alexa's stories her shaming internal voice as easily re-activated during relapse, triggering existing negative self-perceptions of failure and unworthiness. Although she questions the validity of this voice *'kind of, probably, from my own kind of head'*, perhaps reflecting a lessening of the grip of the self-narrative of shame in early sobriety, she constructs drinking as a violation of the rules of the sober community, resulting in her choosing to drink secretly, possibly intensifying feelings of isolation and shame. Tamzin describes the impact of witnessing the response of the group facilitator/organisation founder to relapse.

> …there are some people that come on there [sober community facebook/online group]… that are struggling and she [organisation founder]…the last time she said to them, 'you know, if, if you're wanting to talk about having a drink, you're not to do it here'. This is for people who are true… And I just found that the way she was talking about this poor woman who is reaching out to people was terrible (Tamzin)

Both narratives imply group and community membership was perceived as tenuous and contingent on sobriety, suggesting that women who relapse or seek non-abstinence recovery paths may find it more challenging to use them (Weston et al., 2018). While participants' stories indicated shame maintains alcohol cessation within the community or group by contributing to a sense of accountability and responsibility to others, Tamzin and Alexa's accounts suggest that when women's self-narratives are saturated with shame, it may be more challenging to benefit from or tolerate the more functional aspects of shame in this context (e.g. Keltner et al., 1997).

Rejecting the 'alcoholic' identity and reclaiming self-narratives

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

Participants in both early and late sobriety rejected the 'alcoholic' identity offered by AA. Tamzin and Susie reported finding it too shameful to attend AA, contextualising this with their inability to attend anonymously due to their work or living in the countryside. The rest attended one or several AA meetings, except for Katie, an active member of the AA community for the first five years of sobriety. Lulu narrated doubting whether she was 'wrong' for not attending AA or calling herself an alcoholic but reasserts her reasons for doing so:

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

Lulu emphasises a lack of shared identities with the group (male, religiosity of group members) and situates her rejection of the 'alcoholic' identity, as well as the

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

Lulu's and the participants' accounts of AA are reminiscent of feminist critiques of AA. Indeed, in Kaskutas (1994) study comparing AA and Women for Sobriety, participants perceived the concepts and practices embedded within the AA identity as unrelatable (male, old), negative (deficit-based), restrictive (associated with lack of agency and punitive) and shameful (Covington, 1994; Kaskutas, 1994; Miller et al., 1987; Sered & Norton-Hawk, 2011; Wilkie, 1994). Participants narrated their stories with an assumption that the disease-based, medicalised AA narrative was the primary lens through which audiences would be making sense of them and their relationship with alcohol, suggesting its continued dominance in participants' individual meaning-making. The AA narrative and identity therefore appear to fail to provide them with linguistic resources reflective of the nuances of their lived experiences of alcohol dependence. What is more, it is suggested that being positioned as an 'alcoholic' further threatened their (already shameful sense of) identity as women.

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

> …when I actually did stop drinking, though, the first time and then this time, it's like having people in your corner. Somebody cheering you on. Er, giving you motivation. Pushing you. Making you question. Telling you you're doing the right thing. Telling you that life can be better. Erm, so it's a lot of positivity around sobriety, rather than society telling you, if you don't drink, you're boring. Here were women, women I could identify with, they were, they're around about my age group, talking about burnout, working too much. Erm, I could identify with them and erm, yeah, I think it was a story that I could relate to (…) and these were people as well who weren't calling it alcoholism. They were talking about grey area drinking (…) So, I'm also, I studied biology, so that that does interest me (…) So, she was… also helping me find tools, ways that I could empower myself and keep not drinking, I think. So, it became a secret, but very positive…it became a hidden side to me that nobody else knew about and I loved. I loved the fact that it was mine. Nobody else's… (Susie)

Susie stories her internalisation of the positive sobriety narrative and development of a (private) positive (sober) identity like a motivational mantra: the repetition and short sentences create a rhythm that conveys momentum spurring on her sobriety. Her identification with this collective narrative seems to hinge on the relatability of the story *and* the storytellers with whom she has shared experiences and identities (women, age, work). The sobriety narrative seems to facilitate a desirable imagined future and future self, representing a turning point in her story. She suggests the messages of positivity and self-empowerment within this narrative are necessary to withstand and counter (dominant) societal narratives that shame women for alcoholism *and* sobriety ('boring'). She emphasises her contentment with this identity is premised on it belonging to her, presumably rather than being defined by a shaming 'other' as earlier in her story. This is the first time Susie narrates ownership over her story, implying an increased sense of agency. Linda, below, discusses the rigidity of imposed labels and highlights how society is complicit in the development of women's drinking problems when resisting the label of 'alcoholic':

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

Like Susie, Linda draws on the sobriety narrative to resist the alcoholic identity by challenging the false binary of 'alcoholic' vs 'normal drinker' (Davey, 2021). In distancing herself from 'true' alcoholics ('sitting on the bench down the park'), it may, as a form of impression management, help leave her own identity 'unspoiled' (Goffman, 1963). Hutton et al. (2016) terms this 'positioned othering', whereby women distance themselves from expressions of femininity that are seen as inappropriate or 'other', such as 'the alcoholic woman' presumably to resist the intense stigma and shame associated with this labelling and retain a sense of respectability.

Linda also takes up the sobriety narrative in her account of the harm done to women by society, thereby countering assumptions of individual responsibility. This is the first time Linda sits outside her own story to evaluate the role of social institutions (e.g. media, industry) in producing women's alcohol problems. Linda speaks with authority and conviction, taking up the role of activist/educator to use her knowledge and experience to consciousness-raise and help other women ('getting involved'). Most participants stated that their motivation for participating in the research was to help other women. Belonging to a movement and exposing the normative practices of shaming (i.e. harm done by society) might help women in recovery defend against, resist or work through feelings of shame, build their self-esteem and facilitate self-empowerment (Drury & Reicher, 2005).

Participants storied sobriety as a journey of self-discovery and self-development, leading to increased self-understanding. Greater evidence of narrative ownership is seen in the stories of Katie and Lulu, participants who were sober for the longest period, which may be indicative of the further consolidation of their reclaiming of their non-drinking identities. Their narrative voice was authoritative throughout,

offering up interpretations and clearly differentiating their current '(transformed) selves' in recovery from their past selves. They indicate a process of narrative reconfiguration in line with the discovery of key concepts, which they organised their narratives around, allowing them to positively reframe and reinterpret previous feelings and experiences. Trauma is presented as a central element in Katie's story:

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

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

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

Lulu stories her relief upon discovering shame as a concept to better understand and forgive herself and others. She frames sobriety as a process of self-discovery and personal growth, leading to self-acceptance and a newfound sense of agency. In contrast to earlier in her story, her narrative (and self-perception) is no longer dominated by the assumption of others' criticality, and she appears to have discarded the

strategies to manage this (*'I'm not doing things to please other people'*). Her tone mirrors this shift; rather than critical and shaming, she narrates with self-compassion, tentatively normalising 'moments' of worry or self-doubt *('I think we all do')*. This is most evident at the end of the interview, where Lulu tenderly shares a story about her son, her '*biggest supporter*'. He tells her he is grateful for the hardship they endured because it taught him that *'it is possible to recover from things'.* Her internalisation of positive messages (including pride) from her son seems to help her shift her negative self-perception (as a bad mother in particular), which may indicate that validation from significant others helps to counteract previous negative/shameful self-narratives. For Scheff (2014), pride signifies an intact bond with other human beings, whereas shame implies a severed or threatened bond.

The progression toward newly expanded 'non-drinking' identities seemed to depend on the extent to which participants worked through shame attached to their drinking and their reasons for drinking in the first place (i.e. shifting their self-narrative of shame). Narratives were reworked as participants progressed into the later stages of sobriety, reflecting the further reclaiming of their 'real' self and self-transformation. This involved going back to the beginning to make sense of why they drank in the first place, including the closer examination (e.g. in therapy) of experiences of shaming that led to the development of the self-narrative of shame and shame-management strategies. Katie called this her '*emotional recovery*'. Storytelling—with other sober women or significant others, in therapy and even during the interview—appeared to be a key mechanism of change in sobriety, facilitating greater self-understanding, allowing participants to work through shame and alternative and more positive self-narratives to emerge and be validated.

Discussion

The research aimed to gain a multi-contextual understanding of women's experiences of shame in recovery from alcohol dependence in the UK. Narratives were presented to account for the ways in which shame featured in seven participants' stories: 'internalised narratives of shame and liberation-reparative narratives of early drinking', 'narratives of escalating alcohol use' and 'recovery narratives', which included themes of resistance, reclaiming and redemption. Narratives were non-linear and cyclical, recursively feeding into one another. Participants not only described multiple attempts to stop drinking, but recovery involved going back to the beginning of their story and re-examining their early lives to explore the factors leading up to alcohol dependence.

In contrast to the psychological addiction literature, which frames shame as a situational response (Luoma et al., 2018) or an intrapsychic phenomenon (e.g. Kaufman, 1992; Potter-Efron, 2002), shame emerged as a psycho-social-cultural and multidimensional phenomenon in participants' recovery stories, intimately tied to gender norms and identity (Leeming & Boyle, 2004). Participants narrated shame relationally, within their interactions with significant others (family, partners) and broader social and cultural contexts (e.g. gender norms) (Bronfenbrenner, 1979), cumulatively impacting their sense of self and identity over time. Interaction between shaming and critical

voices of significant others (mothers, peers, then partners) and embodied within broader culture appeared to reinforce a self-narrative of shame across the life stages.

In line with the majority of the research in the field, shame was storied as exacerbating alcohol use and inhibiting help-seeking and recovery, peaking just prior to and in early sobriety (e.g. Davis, 1997; Doty-Sweetnam & Morrissette, 2018;; Kougiali et al., 2021; Sanders, 2011). However, participants indicated that unbearable levels of shame informed their decision to stop drinking. Quantitative and 'gender-blind' approaches, which do not study shame within the sociocultural realities of women's lives, have largely overlooked the cumulative impact of shame. A partial and overly reductionist account of the role of shame in women's alcohol dependence and recovery appears to be an artefact of the methodological approaches traditionally used within psychology to explore shame and addiction (Leeming & Boyle, 2004).

Participants constructed alcohol dependence as an understandable response, in contexts that lack other resources or coping skills, to dysfunctional conditions, including trauma, adverse childhood experiences, restrictive gender roles. Rather than a disorder or disease, participants' narratives most closely reflected a social model of alcohol dependence and recovery (e.g. Best et al., 2016; Staddon, 2005). While recovery emerged as staged and gradual in their accounts, intimately linked to participants' identity and sense of self, the boundaries of recovery were 'fuzzy' and did not map neatly onto the length of time sober. These findings support Formiatti, Moore and Fraser's (2017) critique of social identity theory for creating a binary understanding of recovery or not without in-between space. While the methods and routes to recovery varied across participants, a clear commonality in their stories was that recovery involved working through the shame attached to alcohol dependence *and* their sense of self to reconstruct their identity (Biernacki, 1986; McIntosh & McKeganey, 2000). This process was gradual and facilitated by contextual influences, such as social network composition or involvement in sobriety support groups (Best et al., 2016).

Consistent with the qualitative feminist research with women, alcohol dependence and shame were rooted in gender-oppressive experiences, including victimisation experiences, abusive relationships, restrictive gender norms/role expectations and gendered stigma from alcohol dependence (e.g. Boreham et al., 2019; Covington, 2008 and Kougiali et al., 2021 for a review; Davis, 1997). Participants storied shame *via* their internalisation of failure to fit into the model of a valuable and valued girl, woman and mother in society; their families and relationships spurred on the use of alcohol to cope with shame and feel 'normal'. However, as women, they were especially vulnerable to shame from the stigma of 'drinking too much'. Interestingly, relevant literature tends to focus on the negative and disruptive effect of alcohol use on women's roles and parenting rather than the other way around (Eliason & Skinstad, 1994).

Shame-management strategies, such as people-pleasing and self-silencing, were storied as gendered. Emotional suppression is a more common response to women's shame than men's (Velotti et al., 2017). People-pleasing and self-silencing are rooted in gendered norms prescribed by culture and power (e.g. Jack & Ali, 2010). A gender role marked by 'passivity, niceness and submissiveness' may provide women with a particular set of linguistic and behavioural repertoires to respond to, manage and avoid feelings of shame or a shameful identity (Leeming & Boyle, 2004). Angry or

assertive behaviours employed to prevent a shamed identity might be less available to those who do not hold a dominant position (e.g. women) (Gilbert & McGuire, 1998). People-pleasing and self-silencing have been used to account for the gender gap in multiple psychiatric disorders (e.g. depression and eating disorders) and women's vulnerability to certain diseases (Maji & Dixit, 2018). Placating and prioritising the needs of others have been identified in limited studies with women as longstanding patterns of behaviour that need to shift in recovery (Hood, 2003). However, this is the first study to focus on the link between shame, people-pleasing and self-silencing, and recovery from alcohol dependence in women.

The current study suggests a fundamental process in recovery is the de-shaming of shame-based identity, which needs to be supported by others (Best et al., 2016). Participants narrated shame as contributing to a loss of personal control in defining a satisfying identity from an early age (e.g. seeing themselves through a critical other), resulting in a gap between an externally portrayed self and an authentic self. The experience of 'a divided self' precedes and likely contributes to the development of alcohol dependence, resulting in instability and fragmentation, extending its conceptualisation in previous research (e.g. Denzin, 1987; Shinebourne & Smith, 2011). Instead, drinking may have widened this division by helping to conceal the 'real' self and, for many, their social identity and drinking identity appeared synonymous. Women were then subject to shame from the polarised positions within societal narratives of addiction (e.g. bad mother, alcoholic). In line with other qualitative research in the field, recovery involved working through shame attached to the alcoholic identity and the earlier shameful sense of self, and the emergence of a positive sense of identity and integrated sense of self (Hill & Leeming, 2014; Sawer et al., 2019).

Narratives of resistance and reclaiming, linked to broader narratives of belonging and acceptance (self/others), seemed to help narrators assert control and regain agency. For example, in describing help-seeking behaviours and personal transformation, they were no longer objects of shame, but subjects who actively problem-solved, reached out to and supported others and implemented boundaries in relationships, in contrast to earlier in their stories where they described a lack of power or control over their lives. Within these narratives, Katie and Lulu, sober over a more extended period, drew on 'redemption-discovery' narratives. Through an active process of self-exploration and self-discovery (in therapy, quit literature), they found vital concepts (shame and trauma) that resonated with their experiences and provided the basis for a positive re-evaluation of their experiences. Self-knowledge and insight were narrated as the basis for personal growth and increased self-compassion and self-acceptance, which may support a sense of pride, the antithesis of shame (Scheff, 2014). In these narratives, there was greater evidence of re-biographing their life stories and ownership of their narratives (a solid authoritative/interpretative narrative voice, clear organisation of their narratives around crucial concepts and differentiation between the present and past selves), which may be indicative of their further consolidation of reclaiming of their non-drinking identities.

These findings suggest concepts such as trauma or shame may not only support women to develop a more compassionate self-narrative but that being able to develop compassionate self-narratives may be an essential factor in alleviating shame and sustaining sobriety (Gilbert, 2009). Many of the participants were well versed in and

adopted professional discourses (e.g. mental health diagnoses), which may have supported them to legitimise their position and make sense of and create distance from their experiences. Nevertheless, developing expertise in dominant discourses can be a survival strategy as professionals hold epistemic privilege over clients; women may have to adopt specific language to be heard in the current system. It has been suggested that this strategy can be costly in terms of identity and sense-making - for example, it may lead to 'thin' narratives that attribute everything to diagnoses (White, 1980).

Most research on alcohol dependence involves participants from AA. This research suggests that to recover, individuals must internalise and become emotionally attached to an alcoholic identity through attending AA meetings and sharing stories (Cain, 1991). However, the current study, undertaken with participants who were not using or had rejected AA, challenges this. The internalisation of the AA narrative seemed to generate shame, contributing to participants drinking more, alone and in secret and serving as a barrier to disclosing alcohol problems and seeking help (Corrigan et al., 2017; Hill & Leeming, 2014; Schomerus et al., 2011). Findings also indicate that while internalisation of the alcoholic identity may have helped with problem identification and help-seeking for some and in earlier stages of recovery, however, it lacked resonance and utility in later recovery.

Participants appeared to value the ability to individually self-define and reframe their relationship with alcohol and resist the shame and stigma associated with the 'addict or alcoholic' identity (Davey, 2021). Terms from the sober community were more prevalent in the stories of those sober for less time. One explanation might be that participants sober for longer had alternative ways to reject this identity (e.g. temporally, emphasising distance from their drinking experiences), or it might be an artefact of the sober movement being less well established when they stopped drinking. The emphasis on personal growth and agency seemed to appeal to participants who narrated a loss of agency due to several factors (victimisation experiences, restrictive gender roles, the experience/stigma of alcohol dependence itself and early shame/shame management strategies). Participants described actively searching for this identity; belonging to a community may have allowed them to embody a shared sense of identity with other women *and* retain a sense of themselves as autonomous individuals (Chambers et al., 2017).

Implications

Findings from the study suggest that women's silence around their alcohol use is a form of impression management to save themselves from stigma and shame (from the alcoholic identity). While disclosing alcohol problems was narrated as shame-inducing, it was also crucial in relieving shame when participants were supported and validated. Therapy, as a relational context, both carries the risk of further shaming and has the potential to offer relational validation that might help women to work through shame.

Given the risks associated with naming alcohol problems for women, a proactive approach may be helpful. Indeed, silence from healthcare professionals may be interpreted as shaming. To support relational safety, therapists and healthcare professionals

could (tentatively) ask questions about drinking behaviours and re-situate silence as an understandable response to stigma. Nevertheless, questions and language adopted in therapy are not neutral, and each position holds consequences for the speaker, hearer and dialogue (Freedman & Combs, 1996).

The current study points to several factors that might facilitate a supportive, empathetic and collaborative therapeutic relationship, reducing the likelihood of shaming women and supporting them to work through shame. These include: attending to power imbalances and refusing the role of expert wherever possible (Dearing & Tangney, 2011); naming and formulating service and socio-cultural contexts (Afuape, 2011); sharing intentions in asking questions (Afuape, 2011), externalising alcohol as the problem (White & Epson, 1990); asking women what happened to them, rather than what is wrong with them (Johnstone & Boyle, 2018); helping women to identify and amplify subjugated narratives (White, 2007); supporting women to self-define their relationship with alcohol (rather than impose an unwanted identity on them) (Davey, 2021), and working within women's own value system (Dearing & Tangney, 2011).

Clinicians should remain alert to issues of shame in this population. It might be helpful to be explicit in naming shame and its basis in shaming (as enacted by others and broader society), as this may support women to question or resist it. Demonstrating compassion and empathy for women's experiences and alcohol use might help to replace internalised messages of criticism and judgment (Gilbert, 2010). Clinicians should attend to recognise, acknowledge their own potential shame, familiarise themselves with literature on shame and aim to create a shame-free frame for therapy (DeYoung, 2015). Therapist factors, such as the lived experience of alcohol dependence and identifying as a woman, may support relational safety. The use of personal disclosure might help women normalise past behaviours when intoxicated.

Narrative therapy, through collaborative and co-constructed conversations, may support women to articulate the implicit 'story' behind their sufferings, which through doing so, becomes open to revision (Polkinghorne, 2004). Re-situating problems outside people (White & Epston, 1990) and noticing and questioning internalised and stigmatising dominant narratives could support women to make meaning from negative and shameful experiences. In turn, past experiences may feel more manageable, and new meanings and richer 'thicker' narratives of experiences might emerge. By loosening restrictive/negative 'thin' narratives (of shame), women might generate more flexible or alternative accounts of themselves and 'the preferred sense of identity or personhood' (White, 2007). Emergent' narratives of recovery' may not only help women to see themselves in a new way but be a resource for figuring a way forward and constructing a meaningful life. Targeted interventions designed to develop shame resilience or reduce shame might be a helpful adjunct to other interventions. A programme tailored to women to increase shame resilience has already had positive outcomes for women recovering from substance issues (Hernandez & Mendoza, 2011). Given its relational emphasis, a psychodynamic approach might 'give shame light and air' through 'attunement, empathetic curiosity and story-making (DeYoung, 2015). Supporting women to explore their childhood and ongoing relationships might help them work through negative feelings about themselves. The mother-daughter relationship may be significant to explore, given the participants' narration of the

significance of this relationship in the development and maintenance of self-narratives of shame (Reed, 1985).

Despite the significant attention placed on equity and equal access within health care provision (NHS, 2019), the current research suggests a lack of appropriate support for women with alcohol dependence in the UK. Shame may be a significant barrier to accessing traditional alcohol treatment (AA, NHS-funded drug and alcohol support services), often predicated on adopting the 'alcoholic' identity. Most participants sought therapy in services for general mental health problems; a pattern observed more widely (Harvard Medical School, 201). This study found women have unique needs and experiences (re: shame and stigma, trauma, mothering role, mental health difficulties) that may be overlooked in the generalist 'one size fits all' approach of many Specialist- Drug and Alcohol Services (Salter & Breckenridge, 2014) and highlights the need for trauma-informed services (Covington, 2008).

Consistent with the limited research on online sobriety support groups (Davey, 2021), this study suggests that online spaces and quit literature from the sobriety community help women experiencing shame because it allows them to avoid judgement and shame by taking in other women's stories anonymously, before sharing their own (Chambers et al., 2017). For women for whom shame is a barrier to accessing traditional services, online sobriety support groups and the broader sobriety community appeared to provide a viable alternative or a stepping-stone to further support as safe places to explore their relationship with alcohol in the early stages of change. Clinicians or services might consider signposting to internet-based groups or social media that are known to be safe spaces.

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

This study suggests that to increase our understanding of why and how women stop and resume drinking over the long term and unpack the multifaceted and complex underlying mechanisms and factors involved in lasting changes in recovery, future research should investigate shame and alcohol dependence within the broader socio-cultural contexts and trajectory of women's lives, e.g. using narrative, longitudinal or developmental life-course approaches. It is important to note that the stories of women explored in this study are situated within their educational, professional and social context which might have influenced their access, negotiation and resistance of grand narratives and shameful strategies; expanding alcohol and shame research to broader populations, including women underrepresented in health research and those facing multiple disadvantage, is essential.

Notes

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

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