Recovery from Alcohol and the Relationship with the Self: Insights from Long-Term Counselling Clients

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Statement of authorship

This dissertation is written by Manos Christodoulakis and has ethical clearance from the Faculty Research Ethics Committee of the University of the West of England. It is submitted in partial fulfilment of the requirements of the University of the West of England for the Doctorate of Counselling Psychology. The author is alone responsible for the content and writing of the dissertation

Research title:

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Abstract

The present study explores the experience of recovering from alcohol dependence from the perspectives of people who have received long-term therapeutic work. Diverting from the existing literature that focuses solely on the perspective of AA members, the study is interested in how counselling clients make sense of themselves throughout their efforts to recover from problematic alcohol use. The research design was developed through the prism of critical realism and follows the qualitative methodology of IPA. Semi-structured interviews were employed as the instrument for data collection, and five participants were interviewed. For all participants the engagement with counselling was a big part of their journey, while for three of them recovery also entailed their engagement with the AA fellowship.

The interpretative-phenomenological analysis yielded three superordinate themes. The first draws from participants' narratives of conceptualising alcohol as an abusive partner that was initially relied on for soothing of pre-existing struggles with anxiety and low-self worth, only to eventually exacerbate those issues further. The second pertained to the participants' differential response to the alcoholic label. The third and final superordinate theme explores the shift towards a new, more compassionate way of relating with the self that emerged as a key process that promoted recovery, and reflects on the distinct yet complimentary ways in which counselling and AA have facilitated that shift.

The study's findings could have useful implications in the way that we conceptualise and treat alcohol dependence. Most prominent among them is the conceptualisation of alcohol dependence as the symptom of underlying causes that might necessitate a paradigm shift towards longer-term therapy as opposed to short-term, outcome-focused interventions. It is further proposed that insights from this study could inform future qualitative research to explore the potential of integrative synergies between counselling and AA whereby the two approaches can be seen complementary rather than oppositional. A critical evaluation of the study offers an account of the author's reflective process and the challenges and rewards of utilising an IPA methodology.

Literature review

Alcohol Dependence: Definition and Risks

Alcohol dependence, more recently known as alcohol use disorder, is defined by the DSM-V as the unrestrained use of alcohol that severely inhibits functioning (APA, 2013), and is marked by lack of control with regards to alcohol use, negative affect in the absence of alcohol intake, and a chronic, compulsive use in spite of severe physical and psychological repercussions (Carvalho et al., 2019). The phenomenon is a major concern in modern societies with an annual figure of 3.3 million deaths being attributed to alcohol misuse across the globe (WHO, 2014).

Various theories have attempted to provide a framework within which the experience of alcohol dependence can be better understood. From a neurobiological perspective, the Opponent-Process theory proposes that alcohol use becomes alcohol dependence due to maladaptive shift in the mechanisms that would aim to revert us back from a hedonic state to homeostasis (e.g. withdrawal symptoms) (Koob & Le Moal, 2008). As a result the individual stays at a prolonged state of discomfort that can only be lifted through further alcohol use (Koob & Le Moal, 2008). Similarly, according to the incentive-sensitisation theory, chronic alcohol use leads to brain changes that favour substance-related cues (Townshend & Duka, 2001), ultimately resulting to an attentional bias that compels the individual towards alcohol, even if that is not motivated by conscious craving (Volkow et al., 2011; Robinson & Berridge, 2008). Furthermore, it has been shown that prolonged heavy use of alcohol is associated with an overactivation of the endogenous opioid system, and therefore greater release of endorphins and dopamine (Gianoulakis, 2001). The overactivation of those reward pathways results to alcohol experienced as more euphoric, which in turn further fuels excessive drinking (Mitchell et al., 2012)

Alcohol expectancy theory can be seen as an attempt to further contextualise our neurobiological understanding of alcohol dependence with insights from cognitive psychology. According to the model, individuals are more likely to become entrenched in the abuse of alcohol if they hold positive expectations about the substance capacity to induce positive or alleviate negative affect (Jones, Corbin, & Fromme, 2001). Indeed, there has been a substantial body of empirical evidence in support of this hypothesis (Waddell et al., 2022; Lee et al., 2020; Ramirez et al., 2020), as well as its predictive value for the efficacy of treatment (Patrick et al., 2021). However it has been further suggested that the degree to which alcohol expectancies influences the individual's alcohol

consumption is also mediated by the extent to which they perceive themselves as capable of refusing alcohol use, with lower self-efficacy for refusal being associated with increased alcohol use (Oei & Morawska, 2004).

Finally, a psychodynamic perspective can offer further value in understanding the individual differences that are observed in the development of alcohol dependence. Through this lens, alcohol dependence could be seen as indicative of a fragile Ego, which when confronted with environmental challenges is unable to effect self-regulation (Khantzian, 1994), thus caving in to the Id's persistent urge for immediate gratification and the soothing from emotional suffering (Fonagy, 2018). According to Object-Relations theory this can be further understood as a consequence of a failure to internalise both "good" and "bad" qualities of a caregiver within a cohesive internal object (Waska, 2006). As a result, the primary caregiver's failings might lead the infant to seek soothing externally in the form of self-medication through substances, something that can follow the individual throughout adulthood (Johnson, 2013; Waska, 2006). This is very much in line with insights from attachment theory, and the suggestion that individuals who have not formed a secure attachment to their primary caregivers are much more at risk of developing substance abuse disorders later in life, a notion that is indeed well-supported through empirical findings (Lawrence et al., 2023; Schindler, 2019; Maté, 2012; Dixon et al., 2009). There is also evidence to suggest that trauma in early childhood can have a disruptive effect on the person's ability to identify and engage with their emotional processes, with alexithymia and dissociation being well-documented post-traumatic responses (Craparo et al., 2014). According to Khantzian's self-medication hypothesis, such affective disturbances can be conceptualized as adaptive responses that aim to shield individual from intolerable pain by severing the link with their emotion (Khantzian, 2021). The soothing appeal of alcohol in such cases is theorised as stemming from its sedative properties (Dodgen & Shea, 2000), which allow the individual to relax their overly rigid emotional defenses and soothe the feelings that would otherwise be too overwhelming to experience (Maté, 2022; Maté, 2012; Suh et al., 2008).

The disruptive effects of alcohol abuse are well-documented both for the user and the broader society (Taylor et al, 2009), and it's problematic use has been shown to have a severe impact for the individual's wellbeing on a psychological, physiological, and social level (Goodwin, 2000). With regards to its psychological repercussions, alcohol has been found to correlate positively with the development of other substance use disorders (Grant et al., 2015), the development of alcohol-related psychosis (Stankewicz, Richards, & Salen, 2017), and has been shown to be highly

comorbid with antisocial and borderline personality disorders (Guy et al., 2018), ADHD (van Emmerik-van Oortmerssen et al., 2012), bipolar disorder (Balanzá-Martínez et al., 2015), and schizophrenia (Koskinen et al., 2009). Furthermore, there is strong evidence to suggest that due to the overreliance on alcohol for symptom alleviation (Khantzian, 1997) it could function as a maintenance factor for major depressive disorder (Boden & Fergusson, 2011; Sullivan et al., 2005), anxiety disorders (Oliveira et al., 2018; Turner et al., 2018), and PTSD (Jacobsen; 2001), while it has also been argued that problematic alcohol use could be a risk factor for the development of such disorders (Strunin et al., 2015; Agosti & Levin, 2006; Quello, Brady & Sonne, 2005; Kushner et al., 2000).

Equally detrimental are the physiological implications of alcohol dependence, with alcohol being considered one of the most prevalent causes of death globally (Grant et al., 2015), and the greatest risk factor for death in men between 15 and 59 years of age (WHO, 2000). Chronic dependence has been shown to raise the risk for the development of more than 200 somatic afflictions and diseases (Rehm et al., 2010), including liver failure and pancreatitis (Schoepf & Heun, 2015), cardiomyopathy (Fernández-Solà & Nicolás-Arfelis, 2002), as well as different forms of cancer (Corrao et al., 2000). Furthermore, alcohol abuse can impact the brain at a cellular level, and chronic dependence has been linked to the atrophy of brain regions and reduction in overall brain weight (Zahr, Kaufman & Harper, 2011), impaired motor skills (Brust, 2010), learning and memory deficiencies (Brust, 2010), and alcohol-related dementia (Ridley, Draper, & Withall, 2013)

Finally, there is extensive literature that indicates the severe impact of alcohol dependence on a person's social connectedness. Specifically alcohol abuse is shown to be a major risk factor for domestic abuse and family disruptions (Klingemann & Gmel, 2001), rise in criminality rates and loss of productivity (Rehm, 2011). The negative socio-economic consequences of alcohol misuse have been especially prevalent in the UK where alcohol related loss in productivity, illness and violence has been estimated to require a government expenditure of up to £21 billion per annum (Obuna, Hayes, & Fulton, 2016).

Alcohol and stigma

Given the severity of alcohol's social impact it comes as no surprise that there is significant stigma surrounding alcoholism (Hill & Leeming, 2014). Indeed alcohol and substance abuse is being socially perceived as signs of a person's laziness, weakness and proneness to crime (Tatarsky & Marlatt, 2010). Additionally, it is not uncommon for alcohol addicts to be perceived as coming from a lower educational, social, and economic background and of possessing inherent character flaws such as being deviant, immoral, and unhygienic (Hill & Leeming, 2014).

Research on people's views of alcoholism in the UK revealed such perceptions as alcoholics being unpredictable and highly likely to cause harm to others (Crisp, Cowan, & Hart, 2004). Furthermore the same study reports that people who suffer from alcohol addiction are viewed by the general public as responsible for their affliction and thus the distress they experience is their own fault (Crisp, Cowan, & Hart, 2004). This negative perception of alcoholics as the ones to blame for their condition goes back to the early conceptions of alcohol abuse as something entirely deliberate that the individual engages with on their own volition (Schomerus, 2014). This notion has found further support through the years with some dismissing concepts such as tolerance to alcohol and withdrawal symptoms as being a myth and suggesting that a life of alcoholism is one that the individual has chosen for themselves (Romo, Dinsmore & Watterson, 2016). Davies (2013) furthers this argument by suggesting that the concept of alcohol dependence being a condition beyond a person's willpower is a false excuse to not attribute alcoholics the blame they deserve.

According to Romo and Obiol (2021), the views presented above are still represented in modern societies. They further posit that the penal system's lack of leniency in situations involving alcohol abuse as indicative of a generalised negative view of people who suffer from alcohol addiction (Romo & Obiol, 2021). What makes the relationship between alcohol abuse and stigmatisation even more complicated is the romanticisation of alcohol that is being observed in the UK society as well as other parts of the western world (Pincock, 2003; Szmigin et al., 2008), leading many to regard the western society's relationship with drinking as a culture of intoxication (Measham & Brain, 2005). It could be argued that this idealisation of alcohol, combined with the social stigma it entails, creates a problematic social stance of ambivalence towards alcohol which could undermine even further an individual's efforts to recover from alcohol dependence. Indeed according to De Visser (2007), alcohol consumption and binge drinking is, especially for younger males, regarded as a fundamental part of the masculine identity, and thus a person's failure to conform socially can be met with unfavourable reactions and social exclusion by their peers (De

Visser, 2007). This has also been supported by qualitative findings where recovering alcoholics reported increased perceived stigma about not drinking and fear that they would be regarded as faulty human beings who lack in self-control and willpower (Hill & Leeming, 2014)

Self-stigmatisation and negative self-concept

Given the aforementioned negative perceptions around alcoholism it comes as no surprise that people who suffer from alcohol addiction are often met with intense disapproval and ostracism by their surrounding communities (Gray, 2010). Being at the receiving end of such social discrimination is likely to negatively affect the individuals' views of themselves who will internalise society's views of their condition (Hill & Leeming, 2014).

What is particularly important to note is that people do not necessarily need to have experienced discriminatory behaviours from their social environment to assume a negative view of themselves (Morris et al., 2022). A qualitative study of AA members perceptions of self and identity has shown that even though participants felt highly stigmatised by their social environment, they could not recall or give particular examples of situations or behaviours that communicated such stigma (Hill & Leeming, 2014). An explanation for this could be the notion that once people subscribe to a generalised negative view about certain situations it is almost unavoidable that they will adopt a negative self-image if they would happen to find themselves in those situations. (Johnson, Schaller, & Mullen, 2000). According to Link et al. (2001) the perceived stigmatisation, or felt stigma (Scambler, 1998), can have just as corrosive a psychological impact on the individual as actual experiences of marginalisation and discrimination. Gilbert and Procter (2006) further argue that the perception of oneself to be worthy of other people's discrimination and disapproval can make the person experience a profound sense of invalidation that severely damages their sense of identity. Ultimately the emotional consequences of this internalised stigma will be that individuals who suffer from alcohol dependence will often experience feelings of intense shame which is suggested to be the emotional core of their self-stigmatisation (Gray, 2009).

The role of shame for the development and maintenance of addiction.

Out of all the negative emotions that a negative self-concept might entail, shame is arguably the most powerful and disruptive for the individual's sense of self (Kaufman, 2004). Specifically when it comes to the issue of addiction it has been argued that the emotion of shame is profoundly

connected with alcohol and substance dependence (Khantzian, 2014), and has been reported as more prevalent for individuals who struggle with substance abuse when compared to general population (Dearing et al., 2005). Furthermore, the experience of shame has been shown to intensify the use of substances (Mohr et al., 2008), while also having a hindering impact for recovery (Gray, 2010).

The relationship between shame and alcohol dependence can often be identified early in the development of substance misuse. Khantzian (2012) proposes that substance misuse is in many instances a self-comforting behavioural strategy that develops as a result of early experiences of disorganised attachment. Unfortunately, such coping mechanism can follow the individual into adulthood and impair their ability to relate with others, thereby leading to the opting of substances over intimacy (Sanderson, 2015). However, shame can also manifest as a consequence of dependence. According to Khantzian (2014), one of the main functions of substance abuse is to comfort the individual by alleviating shame and internalised stigma. Sanderson (2015) posits that as the self-soothing effect of alcohol abuse is short-lived, the individual is likely to increase the use of the addictive substance. Ultimately, as the dependency to the substance is intensified, the person becomes entangled in a vicious cycle where the loss of control over alcohol induces shame which in turn further fuels alcohol abuse (Sanderson, 2015).

Shame and negative self-concept as a barrier for recovery.

Existing literature on alcohol dependence has provided ample evidence that the negative self-image that emerges through shame and perceived self-stigmatisation has severe implications on the individual's recovery (Keyes et al., 2010). Indeed based on the aforementioned, it can be argued that unless the feelings of shame are regulated, the individual will remain at risk of using alcohol for self-soothing (Khantzian (2014). This alone makes shame a significant maintaining factor for a person's dependence on alcohol (Gray, 2010). However there are also other ways in which shame can hinder the recovery process.

According to Rüsch, Angermeyer & Corrigan (2005), individuals that experience intense shame are less likely to seek help in managing their dependency over substances. This is also confirmed by a more recent US-based interview study by Keyes et al. (2010) which collected data from a large sample of 34,653 adults residing in the United States. The findings of the study was that individuals who were diagnosed by alcohol addiction would be more reluctant to seek professional support in recovering from their addiction if they considered themselves to be stigmatised by their respective

communities (Keyes et al., 2010). According to King et al. (2007) this relationship between reluctance to seek help and self-stigma can be explained by the individual wishing to protect themselves from further stigmatisation. Furthermore Schomerus et al. (2011) in a study that particularly explores the emotional impact of self-stigma have concluded that it correlates positively with a decreased belief that change is possible, and thus lower self-efficacy about one's capacity to maintain abstinence from alcohol. Consequently it is being suggested that felt stigma can be threatening even for people in recovery as it is being considered to be a major risk factor for the possibility of a re-lapse (Schomerus et al., 2011). Indeed literature on shame indicates that highly shame-prone individuals are often internalising a narrative of a "negative self" as opposed of that of a "negative behaviour" (Nicolosi, 2009). This could translate to lack of effort towards change as there is little belief that such change is possible (Potter-Efron, 2002).

It is important to note that, apart from discouraging people to seek support for combating their dependence, the experience of intense shame can also prompt the individual to withdraw from their social surroundings and avoid social interactions, opting for isolation instead (Leeming & Boyle, 2013). This is particularly alarming when considering that emotional nourishment by a supportive social environment has been consistently emerging by research findings as a vital and indispensable tool for the individual's success in achieving and maintaining recovery over alcohol dependence (Kaskutas, Bond, & Humphreys, 2002; Kubicek, Morgan, & Morrison, 2002).

Finally this association between shame and withdrawal can also be observed after a person's decision to engage with the recovery process. Particularly with regards to the therapeutic setting, shame is regarded as an obstructing element for the client's growth (Van Vliet, 2008). This is due to a profound unwillingness from the part of the client to fully disclose themselves, opting for concealment instead (Pattison, 2000). Such reluctance can physically manifest in the form of prolonged periods of silence, or sensations of somatic numbness (Gray, 2009). Even in cases where the client engages, they are likely to evade discussions on areas that are shame inducing, thereby limiting the therapeutic dialogue and reducing its capacity to promote change (Pattison, 2000).

A shift in identity as an important part of change

The negative self-concept that results from self-stigmatisation and shame is often powerful enough to cause a fundamental shift in the person's sense of identity. According to Dingle et al. (2015), it is common for individuals that have grappled with alcohol dependence to experience the loss of their earlier identity, as this becomes replaced with the 'spoiled' identity of an addict (Cain, 1991).

This compromised view of the self not only is corrosive for their self-worth but has been also shown to be a factor that further fuels their alcohol abuse (Dingle et al., 2015). Consequently it has been posited that recovery from alcohol abuse should not be conceptualised as the simple cessation of drinking, but rather viewed as a broader process of change that encompasses the whole of a person's life as well as the way in which they make sense of themselves (Laudet, 2007). Indeed, according to Cain (1991) one of the major changes that a person will be experiencing during recovery is also the shift in their self-concept and the emergence of a new identity.

Several authors have proposed that recovering from problematic alcohol is most successful when the individual undergoes a re-definition of the concept of self as well as the way in which they conceptualise the world around them (Morris et al., 2022; Best et al., 2016; Weegmann & Piwowoz-Hjort, 2009). It has been further argued that this redefining of the self needs to extend further back in time, allowing the individual to reach a deeper understanding and appreciation of the people that they were before alcohol dependence (McIntosh & McKeganey, 2000). As the researchers point out, it is often the case in addiction that the person's self-image becomes corroded due to the emergence of the 'addict identity', a highly unflattering version of themselves as it encompasses the social stigma they have internalised. For a new non-addict identity to be constructed the individual needs to integrate their re-conceptualisation of the earlier self with their hopes and aspirations of themselves in a post-alcohol future (McIntosh & McKeganey, 2000).

Biernacki (1990) has proposed 3 major ways in which a person's identity is transformed throughout their journey towards abstinence. The first would be to reconnect with a former conceptualisation of the self that has been frozen in time throughout the years of addiction. The second would be to shift to an identity that has existed in parallel with the identity of the 'addict' and has managed to remain relatively unscathed throughout the person's struggles with alcohol and substance abuse. Finally Biernacki suggests that there is a third process, one of constructing a brand new concept of identity that has no connection to the individual's past and has no ties with their experience of addiction. It is proposed that this would be the case particularly for those individuals whose concept of identity has become irreparably wounded due to their struggles with addiction (Biernacki, 1990). Similarly Dingle, Cruwys, & Frings (2015) posit that it is important for the individual to undergo a movement away from the addict identity towards a new "recovery" identity. The findings from their interview study with individuals of a therapeutic community shown that most people underwent a loss of their earlier identity throughout their alcohol abuse, with which they were able to reconnect during their recovery. The study further shown that

individuals who identified more strongly with the "recovery" identity are likely to exhibit better results in their abstinence from alcohol (Dingle et al., 2015).

The shift towards a new identity of a 'recovered' person as opposed to that of an addict has also been highlighted numerous times by the existing literature on the experiences of AA members (Swora, 2004). More specifically as the individual AA member becomes increasingly more integrated to the fellowship group, they gradually shed the stigmatised identity of an addict, and replace it with the new collective identity of a 'recovering alcoholic' (Medina, 2013). It is within this new social identity that they reframe and reconceptualise their past experiences and begin a process of healing for the wounds to their self-worth caused by self-stigmatisation and shame (Medina, 2013).

Counselling and alcohol dependence

Psychological therapies have been shown to be effective as an intervention for the treatment of alcohol dependence (Luoma et al., 2012). Existing research has mostly focused in brief interventions and demonstrated that models such as Cognitive Behavioural Therapy and Motivational Interviewing can achieve reduction in alcohol consumption (Vasilaki, Hosier, & Cox, 2006; Watt et al., 2006). Nevertheless, literature that sought to compare the two modalities has not reported significant differences in their efficacy (Cutler & Fishbain, 2005).

Attempting to explore the determinants of therapeutic change, research has pointed to the quality of the therapeutic relationship as being a major predictor for treatment attendance and treatment success (Connors, 1997; Cook, Heather, & McCambridge, 2015). Another factor is the client's motivation for change (DiClemente, Bellino, & Neavins, 1999), which is directly influenced by the social support that is available to them (Hunter-Reel et al., 2010). Finally, it is important to note that the client's capacity for regulating challenging emotions has been shown to correlate positively with the efficacy of treatments for alcohol dependency (Berking et al., 2011). Again, particular attention is given to shame which is recognised as one of the most highly distressing emotions (Brown, 2008).

The aforementioned correlation between emotion regulation and treatment efficacy is further advocating to the necessity of regulating shame as part of addictions treatment (Berking et al., 2011). Indeed there is a growing body of literature that aims to understand shame in the therapeutic context, with recent studies pointing to self-compassion as an effective way of regulating shame

(Neff, 2011; Goss and Allan, 2012). According to Neff (2011), self-compassion can be understood as the relational bond with the self that acknowledges one's imperfections and promotes kindness and nurturing behaviours as opposed to shaming and self-criticism. Two therapeutic models that have put an extensive focus on self-compassion as a response to shame are Acceptance and Commitment Therapy and Compassion Focused Therapy. Both ACT and CFT have been shown to be efficacious treatments for shame in alcohol dependence, as randomised control trials reported decreased alcohol use and less shame for interventions when compared to controls (Brooks et al., 2012; Luoma et al., 2012).

Recovery as a long-term process

Even though the insights presented above indicate that the aforementioned therapeutic models can produce positive outcomes for alcohol dependence, attempts to compare between them has shown that those outcomes are the same across therapies with significant theoretical differences (Project MATCH Research Group, 1997). Even more interesting is the finding that even the control condition of waiting to be assigned for therapy can produce therapeutic outcomes equal to those of the detox process. (Vaillant, 2009).

Such findings cast a shadow of doubt with regards to the actual usefulness of studies that focus exclusively on the therapeutic outcomes of certain interventions. Yet what is even more concerning is the fact that the vast majority of studies on therapeutic interventions are solely focused on the cessation of alcohol use as a therapeutic outcome, effectively disregarding the stabilisation of those outcomes and the challenges of maintaining one's recovery (Laudet & White, 2008). The literature's focus on short-term outcomes has been particularly limiting when taking into consideration that in the issue of alcohol dependence, maintenance of recovery for long-term has been shown to be a rare phenomenon (McGovern & White, 2014; Harris, 2011; Laudet & White, 2008). Indeed our current understanding of recovery from alcohol views that as a long-term process where the cessation of problematic use is just the first step and should followed by the improvement of the person's overall well-being and their eventual integration back to society (Laudet, 2007). This view is also echoed in qualitative empirical findings where participants with experience of alcohol dependence perceived their recovery as lengthy or even life-long process (Swora, 2004). Furthermore interviews with former alcoholics who have achieved long-term recovery show that, irrespectively of their recovery pathway, people perceive this process as comprising of 3 stages: achieving, stabilising, and maintaining recovery (Flaherty et al., 2014).

Taken from the aforementioned it can be argued that focusing exclusively on the short-term efficacy of therapeutic models fails to address the issue in a holistic manner. This endangers the risk of missing out on a better understanding of alcohol dependence and thus limits our capacity to treat in an effective way that truly promotes the individual's wellbeing (Laudet, Savage & Mahmood, 2011). This risk is exemplified particularly well in the case of an earlier study by Sobell and Sobell (1976), which examined the efficacy of cognitive behavioural interventions for learning to drink in a controlled way. Even though the researchers reported positive results, a 10-year follow up on the same participants demonstrated that most have ended up resuming their unhealthy drinking patterns which for some of them had destructive consequences (Pendery, Maltzman, & West, 1982).

Yet, if we look beyond the setting of 1:1 counselling and psychotherapy interventions, we would find that alcohol dependence has been for decades now treated effectively and with long-term results in the meeting rooms of Alcoholic Anonymous (Straussner & Byrne, 2009). Additionally, AA has been proven to be either just as effective, or indeed more efficacious to therapeutic interventions like CBT and motivational interviewing (Vaillant, 2005), whereas it has demonstrated a proven effectiveness at maintaining those positive results in the long run (Kelly, 2003). What is even more is the fact that the treatment outcomes of AA and the 12 step model have been consistent throughout the years and they have spanned different nationalities, ethnic backgrounds, social backgrounds and age groups (Kelly, Magill, & Stout, 2009). Despite this historically proven track-record of helping to achieve and maintain recovery, AA has for years now been regarded with scepticism and even hostility by the counselling world (Medina, 2013), with many criticising its religious beginnings and the spiritual overtones that run through the 12 step model (Swora, 2004).

The AA model

In recent years there has been a growing number of researchers who showed interest in the AA model of recovery, resulting to different theories that attempt to elucidate process of change that is being experienced in the fellowship rooms (Straussner & Byrne, 2009). McKellar, Stewart & Humphreys (2003) attempted to explore the criticism that AA positive outcomes might be just a result of its members' initial motivation to change. If that were indeed true then the perceived efficacy of AA would be just the product of coincidence as highly motivated individuals are more likely to achieve recovery as they are to commit in keep attending AA meetings (Morgenstern et al., 1997). The researchers have invalidated this argument by demonstrating that even when

controlling for AA members' initial level of motivation, this did not have an impact on AA's positive recovery outcomes. Furthermore, the researchers suggested that it is more plausible to argue that AA participation helps with building and maintaining the motivation to change (McKellar, Stewart & Humphreys, 2003).

Other researchers have suggested that AA employs the same approaches and techniques that are common in psychological therapies such as supporting people's motivation to change, building self-efficacy and the belief that such a change is possible and teaching practical coping skills and techniques (Kelly, Magill, & Stout, 2009). McCrady (1994) suggests that the structure of the 12 steps model promote a shift in people's perceptions of alcohol as well as provide support with attitudinal and behavioural changes, and further notes that the same process of change is in line with a cognitive behavioural therapeutic approach. Similarly, Vaillant (2005) proposes that AA is, perhaps unknowingly, following a CBT framework of managing and preventing relapse (Vaillant, 2005). While there may be some merit to the aforementioned hypotheses, they still do not explain the superiority of AA and twelve-step facilitation over CBT and other therapeutic approaches for stabilising and maintaining change (Kelly, 2003). An alternative explanation is provided by the hypothesis that the positive benefits of attending AA are in very big part due to its social element. (Kaskutas, Bond, & Humphreys, 2002). Vaillant (2005) further posits that AA's effectiveness might be ought to 4 major factors: supervision by another, a healthier substitute dependency to the group rather than the substance, new emotionally nourishing relationships, and being prompted to engage with one's sense of spirituality. The importance of a supportive community has been echoed by other studies that underline the significance of social and emotional nourishment for overcoming addiction (Groh, Jason, & Keys, 2008). It is also worth noting that Jung himself pointed out the importance of AA's social support in a correspondence with the co-founder of Alcoholics Anonymous (Thomsen, 2010).

Additional interpretations of AA's efficacy have been its capacity to manage and reduce negative affect. Kelly et al. (2010) proposes that the long-term participation in mutual support group is helping the individual to manage their emotional distress, cope with depression and work towards an overall higher level of emotional and psychological wellbeing. Streifel and Servanty-Seib (2006) further suggest that AA allows the person the time and space to manage and receive support for feelings of loss and grief that will very often emerge as the person engages with and tries to maintain recovery. Finally there has been a growing body of qualitative research on AA members' experiences of recovery which shows that AA participation is instrumental in managing the self-

stigmatisation and shame that come with issue of alcohol abuse (Flores, 2001; Hill & Leeming, 2014; Zakrzewski & Hector, 2004). A consistent finding of such studies is that of a holistic transformation of people's identity as they move towards a new positive self-schema (Koski-Jannes, 2002; Kubicek, Morgan, & Morrison, 2002; McKeganey, 2001). Participants have often discussed the themes of overcoming shame and building self-acceptance and self-worth (Shinebourne & Smith, 2011), as well as the struggle between two conflicting identities, one yearning for a chaotic life of liberated expression that comes with being intoxicated, while the other is looking forward to a life of emotional balance and genuine sense of self that is found through abstinence (de Visser & Smith, 2007; Orford et al., 2002; Shinebourne & Smith, 2011). Consistent in the literature is also the notion of abstinence as a life-long journey which unless the individual is vigilant about maintaining could easily lead back to the suffering of alcohol abuse (Swora, 2004).

As a final note it is worth mentioning that there is also a number of studies which report that the process of recovery in AA can be particularly challenging for its members (Zakrzewski & Hector, 2004). This is mainly due to the emotional difficulties that come with having to embrace the stigmatising identity of an alcoholic (Hill & Leeming, 2014; Shinebourne & Smith, 2011; Zakrzewski & Hector, 2004), something that is a fundamental part for the recovery journey through AA. Furthermore, those are challenges that follow the individual even after achieving abstinence due to the fear of other people perceiving the label "recovering alcoholic" in a negative light (Hill & Leeming, 2014).

Critique of the literature & rationale of present study

As has been shown above there is evidence to suggest that fostering self-compassion can produce therapeutic results of less shame and decreased alcohol use (Luoma & Platt, 2015). However, the majority of existing literature on counselling for alcohol dependence is mostly comprised of short-term studies that aim specifically to determine the efficacy of certain therapeutic models (Laudet, Savage & Mahmood, 2011). This is particularly limiting when considering that many of the findings and hypotheses on why AA produces positive long-term outcomes are related to issues that go beyond the decrease or cessation of problematic drinking and are rather focused on the individual's overall wellbeing (Vaillant, 2005). Improving the individual's emotional and psychological health is of course at the very heart of the therapeutic process, however this does not necessarily apply to short-term interventions with a particular focus on drinking outcomes. Furthermore, even though research on therapeutic efficacy of interventions is undoubtedly valuable for the acquisition

of new knowledge, and promotes evidence-based practice (Clay, 2010), it is at the same time restricted in its focus on therapeutic outcomes and provides limited insight as to the process through which such outcomes were produced (Gordon, 2015). In the context of the relationship with the self in alcohol abuse, this limitation effectively marginalises the experiences of participants, whose internal process is only reflected in self reporting scales of alcohol use and shame before and after the intervention (Laudet, Savage & Mahmood, 2011).

White (2005) argues the knowledge that is acquired from the client's own perspective is especially valuable for psychotherapy research as it can elucidate the determinants for therapeutic change. Focusing on the client's own perspective is particularly significant when considering the divergence that is reported between clients' and counsellors' views as to their perceptions of helpful or hindering elements in the therapeutic process (Gatt, 2005). Considering the aforementioned, there is a limited number of studies that explore the way in which people who struggle with alcohol abuse relate with themselves from the perspective of counselling clients (Gordon, 2015). Instead, the majority of studies in this area have approached this topic from the point of view of AA members (Gubi, & Marsden-Hughes, 2013; Hill & Leeming, 2014).

As has been examined earlier, this literature is consistent in reporting that the negative self-image of people with addiction issues is regulated as the person pursues a new healthy identity, and is tied to the perception of recovery as a long-term ongoing process that requires a holistic life transformation (Hill & Leeming, 2014). However, when reflecting on the distinct philosophical framework of AA, it is worth noting that it differs substantially from the ethos of counselling and psychotherapy (Le, Ingvarson, & Page, 1995). More specifically, psychological therapies, regardless of their model or theoretical background, seek to empower the individual and assist in the actualisation of their abilities and potential, whereas AA encourages their submission to a greater power than themselves in order to remove their flaws (Le, Ingvarson, & Page, 1995).
Furthermore, and with regards to the particular emotion of shame, it has been argued that the AA model is inherently shame-based due to its focus on personal shortcomings and the admission of one's powerlessness (Peele, 2015). Taking into account the dissonance between the two approaches to recovery, it would not be unreasonable to assume that the insights of existing research might differ to the experiences of individuals whose recovery involved long-term counselling. Nevertheless, AA's conceptualisation of recovery as a long-term, holistic transformation is in line with the argument for long-term therapeutic work as most suited for addiction (Aaronson, 2006; Maté, 2008; Swora, 2004), as working with addiction in a longer time-

frame allows the client to address the underlying issues that fuel alcohol abuse, something that could not be possibly addressed within the time restraints of short-term work.

At the moment of writing, I am not aware of existing literature that explores the relationship with the self in alcohol dependency from the perspective of people that have received long-term therapeutic work. As the majority of relevant literature is quantitative, recovery is not regarded as a process but rather as an outcome that can be measured based on the decrease or cessation of drinking (Gordon, 2015). Furthermore, as the existing literature on counselling is focused on short-term interventions there is limited insight as to how counselling affects the person over a longer time-frame (Hill & Leeming, 2014).

Aims of the study

The present study aims to contribute to our understanding of how people who have struggled with alcohol issues relate with themselves by giving voice to people who have experienced this issue and whose journey towards recovery has included long-term therapeutic work. In focusing on individuals that have recovered from alcohol dependence the present study will tap to their own experiences, thereby illuminating the process in which difficult feelings can be regulated (White, 2005). Furthermore it allows for an exploration of this topic from the perspective of counselling clients thereby complementing the existing literature which has been solely focused on the AA model. Finally it will enable for a greater understanding of long-term therapeutic work in relation to alcohol dependence, something that has been largely overlooked in the literature. Such knowledge can then inform counselling practice by pointing to adjustments that can be made to existing interventions towards a more tailored and targeted approach for individuals that struggle with alcohol and substance dependence (Hill & Leeming, 2014). In order to acquire such knowledge the present study aims to explore the following questions:

- What is it like to experience of alcohol dependence and recovery from problematic alcohol use?
- How did participants make sense of their sense of "self" and what feelings might have fed into this hermeneutic process?
- What has been the role of counselling in promoting the participants' recovery?

METHODOLOGY

Ontology & epistemology

The present research is informed by the ontological stance of critical realism. Critical realism stands between the realist and relativist paradigms and posits the existence of an objective reality, while also allowing the possibility for its different interpretations (Larkin, Watts, & Clifton, 2006). With regards to the acquisition of knowledge critical realism proposes that the objective reality of phenomena can only be approximated through exploring people's experiences and subjective views of such phenomena (Willig, 2008). This epistemological standpoint is in line with the idiographic and phenomenological nature of counselling which aims to facilitate the individual in making sense of their own subjective meanings (Woolfe et al., 2009).

Research design

The study follows a qualitative phenomenological design and specifically the methodological framework of Interpretive Phenomenological Analysis (Smith et al., 2009). A phenomenological standpoint is considering the reality of the observed phenomenon to be emerging through people's own experiences, perceptions and understanding of the issue that is being studied (Larkin, Watts, and Clifton 2006). With regards to the particular issue of alcohol dependence, McIntosh & McKeganey (2000) suggest that the experience of being an alcoholic is continuously re-structured as the person is experiencing themselves in relation to the world that surrounds them, and argued that the reality of being an alcoholic is best understood through a phenomenological exploration of people's subjective understanding of that condition and what is means for them personally (McIntosh & McKeganey, 2000).

It is my opinion that the journey of overcoming addiction is unique for every individual, as it is arguably tied to the specific emotional and psychological challenges that have historically necessitated the use of substances for self-soothing (Khantzian, 2003; LeTendre & Reed, 2017; Maté, 2008). Furthermore, the emotion of shame that has been shown to be prevalent in the experience of this stigmatised population, is similarly unique for different people, as it is shaped by their previous experiences and background (Bradshaw, 2005; Gray, 2009). Phenomenology was therefore considered to be the appropriate stance for exploring the reality of overcoming alcohol dependence, as it allowed for an idiographic exploration of different people's journeys towards overcoming problematic alcohol use. Being a methodological approach that is firmly rooted in

phenomenology, Interpretive Phenomenological Analysis serves well the study's aim to acquire rich insights into the participants' own world, allowing for an in-depth understanding of the participants' own meanings. (Smith, Flowers, & Larkin, 2009; Creswell, 2013).

Aiming to investigate the participants' personal realities and their understanding of the world that surrounds them, IPA regards the participant as being the expert on the phenomenon that is being researched and strives to provide a rich, deep account of their subjective process of sense-making (Smith, Flowers & Larkin, 2009). However, as the approach has its theoretical foundations in both phenomenology and hermeneutics, IPA also acknowledges that the researcher's interpretive stance is inevitably a part of the research process (Spinelli, 1989; Smith & Osborn, 2003). Therefore it suggests that the understanding of a certain phenomenon emerges within a process of double hermeneutics where the researcher makes sense of the participants as they are making sense of their own experiences (Smith & Osborn, 2003).

It is IPA's marriage of phenomenology and hermeneutics that I found personally appealing in opting for this methodological approach over other qualitative methods. Thematic analysis, though unique in its flexibility, would not have encouraged me to tap into my own experience of my participants sense-making to such an extent (Braun & Clarke, 2013), whereas the interpretative paradigm of IPA was a constant reminder to remain inquisitive for hidden meanings beyond what was being said (Alase, 2017; Larkin, Watts, & Clifton, 2006). On the other hand, even though I initially considered the possibility of employing Grounded Theory, I was weary of the temptation to deviate from my participants' unique experiences in favour of constructing a theoretical framework within which their narratives would neatly converge (Mazzei & Jackson, 2012). However my aspiration about this study was to steer away from nomothetic sensibilities, but rather to fully hone into the phenomenology of my participants' unique experiences and honour the subjectivity of their sense-making process (Giorgi, 2010; Urcia, 2021).

Reflexivity and bracketing

In interpreting the participants' process of sense-making, it was paramount that I would exercise caution about not projecting my own pre-conceived understanding and assumptions onto the participant's narrative (Giorgi, 2010). Doing so required that I would engage in an honest process of self-exploration so as to identify my own presuppositions (Finlay, 2011). This process of bracketing was in turn facilitative in my capacity to discern what parts of the emerging insights corresponded to the participant's own process of sense making, and what is the possibility that

certain meanings could have been filtered through the lens of my presuppositions (Finlay, 2011; Gearing, 2004).

Nevertheless, as has been pointed out by DeRobertis (1996), it is not realistically feasible to identify and bracket all of one's prior assumptions. In order to facilitate this process I have discussed extensively the concept of recovery from alcohol dependence in personal therapy while also bringing it as a topic of discussion to a peer support group comprised by both academic colleagues and fellow practitioners in the SWAN project. It was particularly useful that some of those individuals had prior experiences of alcohol dependence and others have cared for family members who struggled with this condition. Having had those conversations offered great value to my process of self-exploration and assisted me in further illuminating a pre-conceived understanding of both the phenomenon of shame and the condition of alcohol dependence.

I have had no prior personal experience of alcohol dependence but have nevertheless familiarized myself with this issue through clinical practice with alcohol clients at the SWAN project. Furthermore, I have had some experience with the 12 step model of recovery through my own brief engagement in a similar fellowship focused on food addiction. Having experienced the value of both counselling and a 12 step fellowship I am deeply respectful to both approaches. However, I was aware of my own inclination in favour of long-term process of recovery from addiction that treats the client in a holistic manner, as opposed to short term, outcome-focused counselling interventions. Even though this inclination is partly supported by existing literature (Flaherty et al., 2014; Laudet, Savage & Mahmood, 2011; Maté, 2008; Swora, 2004), I have sought to remain vigilant about the possibility of personal bias.

Data collection

The study made use of semi-structured interviews for the needs of collecting data. Being an interactive tool, the interview allows the researcher to observe both the verbal and non-verbal responses of the participant and probe for further exploration when necessary (Braun & Clarke, 2013). According to Smith et al. (2009), the semi-structured interview can be a particularly useful format for phenomenological research as it allows the researcher to have a conversation with the participants, while also probing them to discuss particular topics. Furthermore, the loose format of semi-structured interviews enables the emergence of unanticipated insights as participants are encouraged to share their thoughts, feelings, and experiences without being too confined by specific questions (Turner, 2010).

As has been suggested by Rubin and Rubin (2011), the course of the interviews should start by aiming to encourage participants to bring their own understanding of the phenomenon that is being studied. As the interview unfolds the researcher would steer the conversation towards particular points of interest while remaining vigilant about not allowing the structure of the interview to overshadow the participants' own process of sense-making (Rubin and Rubin, 2011). At the same time, the authors further suggest that the structure of the interview should be dynamic in nature and be constantly re-designed in accordance to the meaning that is being emerged through the participant's narrative (Rubin & Rubin, 2011). For that reason the interview structure was not comprised by a rigidly pre-formatted set of questions but rather by broader topics of discussion that aimed to allow the structure to be co-constructed through the discourse that is taking place between participant and researcher. The interviews' duration was approximately 1 hour. Throughout the interview process I was mindful of striking a balance between probing for answers and creating rapport that would allow the participants to feel safe enough to disclose their experiences in greater depth (DiCicco-Bloom & Crabtree, 2006). In building such rapport I sought to offer the participants a space of empathetic listening and unconditional acceptance (Rogers, 2012), elements that have been argued to facilitate the interview process (Paterson, 1997). The broad topics of discussion are presented in the appendix section (*Appendix E: Sample interview questions*).

Recruitment

As the study employs an IPA research paradigm the sample size focused on the quality rather than the quantity of data, therefore a small number size of 3 to 6 was considered to be more appropriate in order for individual cases to be analysed in depth (Smith, Flowers, & Larkin, 2009). According to Finlay (2011), the sole requirement for participation in phenomenological research was for people to have had personal experience of the issue that is being researched and to be willing to share that experience with the researcher.

A total of 5 participants were recruited who all fulfilled the requirements of having had experience of alcohol dependency, having achieved recovery from problematic alcohol use, and having had completed a minimum of 1 year of counselling. Even though all 5 participants made use of counselling sessions throughout their recovery from alcohol, 2 participants (Matt and Simon) only relied on counselling as the main vehicle that promoted their recovery, although they did have a brief experience of group-based recovery programs (AA or SMART meetings). Conversely, the

remaining 3 participants (Sharon, Carol, and Barry) have had experience of both counselling and a long-term engagement with the AA fellowship, with Carol and Sharon in particular identifying AA as having been the primary force that assisted them in recovering from alcohol use, with 1 to 1 counselling having played a secondary, supportive role.

Table of participants' demographics

Alias	**Age**	**Gender**	**Ethnicity**	**Sexuality**	**Faith**	**Relationship Status**	**Employment Status**
Matt	30s	Male	White British	Heterosexual	None	Single (divorced)	Full-time
Simon	30s	Male	White British	Gay	None	Single	Full-time
Carol	40s	Female	White British	Heterosexual	Not Stated	Single	Full-time
Sharon	40s	Female	White British	Heterosexual	Christian	Single (divorced)	Unemployed (ESA)
Barry	30s	Male	White British	Heterosexual	None	Single	Not Stated

Setting: The SWAN Project

Participants have been sourced by advertising the study in the facilities of the SWAN Project, a South West-based charity that provides long-term counselling for people with alcohol dependence. The centre was established with the aim of offering affordable long-term counselling to people with alcohol-dependence issues.

The promotion of the study was conducted by placing posters at the walls and doors of the SWAN building, as well as distributing information leaflets. Both posters and leaflets communicated the aims of the study and the criteria for participation. The leaflets also featured a space for interested clients to complete with their names and contact information. Furthermore, a ballot box has been installed for the interested individuals to place completed leaflets into. Upon collecting the completed leaflets, I have contacted the interested individuals via email, providing them electronic copies of the information sheet and the consent form. Having provided agreement and consent of participation, I agreed with the participants about the time and date of interviews. Clients that have provided their consent to participate were met by the researcher at the SWAN facilities where the interviews were conducted.

It is the ethos of the organization that made it a suitable match for the original contribution of this study. More specifically the SWAN ethos does not align itself with the AA disease model for alcohol, while also advocating for long-term therapeutic work as a means of addressing the underlying issues of alcohol dependency (Aaronson, 2006). The SWAN employs volunteer counselling practitioners of various training backgrounds and therapeutic orientations. However it is also expecting from the practitioners to adhere to the organisation's particular ethos of understanding and working with alcohol and substances addiction. The SWAN understands the phenomenon of addiction to be a problematic form of self-soothing and thus it regards it as having a place in a broader self-care/self-harm continuum (Turp, 2002). Furthermore it posits that in order to effectively treat alcohol dependence it is important to address the underlying issues that caused it to manifest as a form of self-soothing (Maté, 2008). In doing so it allows for long-term therapeutic work that can last up to or more than 2 years.

With regards to the process of recovery, the SWAN is inspired by the concept of the cycle of change as this has been articulated by Prochaska et al. (1997). Consequently recovery is regarded as a series of cycles of recoveries and potential relapses from which the client can learn and grow until they are capable to maintain long-term recovery from the substance (Prochaska, DiClemente, & Norcross, 1997). Regarding its therapeutic orientation, the SWAN's integrative ethos employs concepts and techniques from CBT relapse management, Compassion Focused Therapy and Motivational Interviewing, however those are all integrated to a strong Person-Centered foundation that regards the therapeutic relationship and the Rogerian core conditions as being the fundamental agents of therapeutic change (Rogers, 2012). Finally the SWAN pays particular attention to the feeling of shame that regards as potentially prevalent part of the clients' experience both pre and post recovery (Aaronson, 2006), and it promotes fostering self-compassion as a way of working with shame. (Gilbert, P., & Procter, S. (2006). To ensure that practitioners are adhering to the aforementioned philosophy and ethos, the SWAN requires that its volunteers will attend compulsory training days that cover topics related to understanding and working with alcohol dependence. Furthermore, all practitioners are required to attend internal clinical supervision twice per month which delivered by supervisors trained on the ethos and philosophy of the SWAN. I have discussed the aims and design of the research with the director of the SWAN, and received written confirmation about SWAN's agreement for collaboration (*Appendix D*).

Ethical considerations

Ethical approval for this study has been granted from the University of the West of England, Faculty Research Ethics Committee (FREC). In line with the BPS code of human research ethics, consent for participation was sought only after the participants were informed about the aims of the study and the content of the interviews (BPS, 2021). I have also confirmed with SWAN's clinical supervisors that clients have the capacity to provide informed consent and that it was safe for them to participate in this study. The study respected the participants' right for self-determination. It was communicated to the participants that they could withdraw from the study at any time if they so choose and that they could request for the destruction of their data, and they were also made aware that the researcher reserved the right to terminate the interviews if there were concerns about their wellbeing (BPS, 2021). Crucially, participants were assured that the study was not related in any way with their therapy at the SWAN and their participation or withdrawal from the study will not influence their counselling in any way.

Participants were informed that the transcribed data would feature aliases in the place of participants' names and any demographic or contextual information that could potentially lead to their identification will be changed or omitted. However they were also made aware that part of the anonymised transcript might be included in the data analysis section of this study, and thus potentially published. They were assured that their confidentiality will be respected at all stages of the research process, however the information sheet also communicated that in certain situations it would be necessary that confidentiality should be breached. The need to breach confidentiality would have risen in a situation where participants disclose an intention of inflicting harm upon themselves or another, or to engage in any form of offending/illegal behaviour, however such a situation has not emerged in any of the interviews.

Risk management and prevention of harm

It has been determined that if a situation rose that made it necessary for confidentiality to be breached this would have taken place in the following steps:

In the case that a participant were to disclose a suicidal intent, this would be further explored to determine whether they had a plan to take their own lives. In such case it would be made known to the participant that their confidentiality must be breached and that this information will be shared with their respective counsellor at the SWAN as well as the GP that they are registered with. The interview would be terminated and the focus of our interaction would be to de-escalate

the emotional distress of the participant. Following the departure of the participant this information would be shared with their respective counsellors at the SWAN. The information would also be disclosed to the project leader of the SWAN project and the contact details of the participants' GP would be requested to also inform them about the participant's suicidal intent. The same procedure was to be followed in the case that the participant was to disclose the intent to harm another adult or minor, or to engage in some form of offending behavior. In such case the information would also be disclosed to the police in order to take immediate action to prevent the cause of harm.

Given that recovery from alcohol dependence is a basic requirement for participation in the present study, the risk of relapse was something that needed to be taken into consideration. It was therefore important that appropriate safeguarding measures were taken so that participants' wellbeing would be ensured throughout the study. For this reason, potential participants were only considered eligible if they had achieved recovery from alcohol dependence. Furthermore, it was important for them to be working therapeutically with a counsellor at the SWAN Alcohol Project at the time of the recruitment. This would offer them a containing space for the exploration and sense-making of their thoughts, emotions, and experiences served to explore and contain the potential emotional distress that might have risen during the interviews. As an additional safeguarding measure, participants were informed that if during the process of the interview they were to show signs of acute emotional distress, it might have been important to pause the recording, and focus on de-escalating the emotional distress.

At the end of the interview, participants were offered with up to 30 minutes of non-recorded conversation which aimed to contain and de-escalate the challenging emotions that could have risen during the interview and thus safeguarding the their emotional well-being. Furthermore, in the case that I was concerned that the interview process has been particularly challenging for the client, I would be asking the clients' permission to feedback those concerns to the supervisors at the SWAN. This would have allowed for the aforementioned emotional challenges to be further explored in the containing space of the client's counselling sessions. Finally, in the case that the participant presented themselves intoxicated they would be referred to the inclusion criteria for participation and explained that interviewing them at those circumstances would not be useful for the needs of the study. They would also be advised that their recent lapse is something that would be more appropriate to discuss with their respective counsellor. They would then be escorted out

of the SWAN building. In the case that they were driving they would be advised the use of a taxi, and in case they could not afford one SWAN funds would be used to call a taxi for them.

Apart from the aforementioned, the safeguarding of participants drew from my experience of working with service users concerned with alcohol dependence in a variety of settings (community centre, mental health clinic, IAPT, counselling agencies). This experience combined with my training in person-centered counselling served to provide my interviewees with a safe space of empathetic understanding, within which I sought to encouraged them to openly discuss their own experiences while also being attuned to their emotional state and mindful of their wellbeing.

Analysis

The interview data were recorded with the use of an audio recording device. They were then transcribed in word document and anonymized. The transcription process was orthographic and produced a verbatim account of all verbal information (Braun & Clarke, 2013). I made sure that the transcript was faithful to the content of the interviews by carefully considering the participants' punctuation and including bracketed notes about non-verbal communication (Braun & Clarke, 2006). Upon transcription the audio files were destroyed and word documents stored in an encrypted flash drive, accessible only to the researcher.

Being an explorative phenomenological approach IPA does not seek to test a prior hypothesis. As such it does not need adhere to a rigid analytic structure (Hein & Austin, 2001), but rather lends itself to be used flexibly by the researcher and fit their research goals (Smith et al., 2009). Nevertheless, According to Finlay (2011), any phenomenological design should follow the 3 basic processes of bracketing, intuiting, and describing. In bracketing the researcher is attentive to the meaning that emerges through the data while also being aware of their own presuppositions (Gearing, 2004). Intuiting and describing refer to the processes of discerning themes and presenting them in a way that reveals the thread of meaning with which they are connected (Finlay, 2011; Finlay, 2008).

The study followed the aforementioned processes by adhering to the stages of Interpretive Phenomenological Analysis as those have been suggested by Smith, Flowers & Larkin (2009). I have familiarised myself with the data by reading each participant's transcript multiple times, while also making initial exploratory notes (Smith et al., 2009). Upon familiarisation with data I proceeded to the coding stage by making notes on each data item and commenting on the

descriptive, linguistic, and conceptual content of each data item (Smith et al., 2009). At this stage I also kept reflective notes on my own understanding of the participants' reflections, seeking to look beyond what was being said for hidden meanings. Indeed, the IPA framework requires the researcher to not aim only at the description of the participants' views but also seek to interpret and make sense of the participants as they are making sense of their own experiences (Larkin et al., 2006; Smith & Osborn, 2003; Spinelli, 1989). Doing so required me to be careful in bracketing my preconceptions and make constant use of reflexivity exercises both before and throughout the data analysis (Biggerstaff & Thompson, 2008; Clarke & Braun, 2013). This process was further facilitated by the keeping of a reflective journal throughout the analytical process. I found it interesting that my experience of this process was not too dissimilar with the therapeutic interaction, as I was aiming to empathically attune to my participants' experiences, while also being congruent in noticing my own experience of them while feeding my observations in my reflective journal. Subsequently I collected the codes from the previous stage while searched for emerging patterns and connections across themes. This search for patterns was informed by strategies proposed by Smith et al. (2009) such as abstraction, polarisation, contextualisation and numeration.

After applying the above steps for each transcript, I then proceeded to search for overarching themes across all transcripts, developing a master table with all super-ordinate themes (Smith et al., 2009). I found this stage to be the most challenging part of the analysis, as I have experienced the temptation of "shoehorning" my participants individual realities to fit a straightforward and compelling narrative, that would however be making a disservice to the nuances of their individual realities. I found my supervisor's input most helpful during that stage, as it was invaluable to have this temptation highlighted to me, while also being encouraged to keep harnessing my reflexivity in order to properly honour the phenomenology of their individual journeys. As a result the table of super-ordinate themes has changed shape several times, and it was important to go back to early stages of the analytic process, so as to make sure that the final super-ordinate and sub-ordinate themes were indeed representative of the participants' own meanings (Eatough and Smith, 2006).

RESULTS

Table of themes:

1. Alcohol as an abusive relationship	1.1 A gremlin, a rock-star, and a toxic friend: Personifications of Alcohol. 1.2 The seduction: Alcohol's false promises of safety and confidence. 1.3 The abuse: The harmfulness of alcohol on the participants' relationship with themselves
2. The label of the "alcoholic"	2.1 Embracing the label: Finding meaning in alcohol as a disease. 2.2 "You can't call someone an alcoholic": Initial resistance towards the label. 2.3 Rejecting the label: "We are more than our addictions".
3. Reacquainting with the self: Recovery as a transformative process	3.1 An experience of unravelling. 3.2 Trust and unconditional acceptance as pre-requisites for self-exploration. 3.3 Understanding the self leads to self-acceptance. 3.4 Befriending the inner critic. 3.5 Self-compassion through being held

1. Alcohol as an abusive relationship

It was the case for all participants that alcohol's presence in their lives was initially benign. Alcohol would be shielding them from negative feelings that they harboured towards themselves and made it possible for them to connect socially with others. However it was a common pattern among participants that this initially benign presence would become increasingly more possessive of them. It would slowly corrode their self-worth and gradually isolate them from important relationships until they would completely surrender to it.

1.1 "A gremlin, a rock-star, and a toxic friend": Personifications of Alcohol.

For some participants alcohol was visualised as toxic presence in their lives, a seductive friend who would become increasingly possessive and abusive as they would become more dependent on it.

For Carol that entity would take the shape of a *"gremlin",* that would seek to sabotage all her efforts towards recovery and push her back into drinking: *"No matter how much I wanted it, in my mind I was still going to meetings, I was trying to connect, but that gremlin – I call it the gremlin – he had got big, and he was starting to take control over"*

For Simon it was described as a charming friend that was fun to be spending time with but eventually he would always regret having done so.

"I would say like a friend that's bad for you. You're fond of them, and they're familiar and you like seeing them, but never do you leave seeing them feeling the better for it. I mean you feel like they've kind of encouraged the worst parts of you … so a bit like a relationship with like a drug dealer or something"

For Barry, alcohol seems to have been tied to cultural influences of rock stars with an unhealthy lifestyle.

"It was quite bad, but I remember looking in the mirror … I couldn't grow a beard or anything, but I remember … and I'd look unwell and I would like it because that's what musicians look like".

1.2 The seduction: Alcohol's false promises of safety and confidence

The main appeal of alcohol has been the boost in confidence that the participants would experience while intoxicated, as well as the ability to detach from themselves and the negative feelings and thoughts that they were experiencing.

A vulnerable victim: Wounded self-worth due to early life experiences

Most participants have disclosed varying degrees of traumatic early-life experiences that have shaped negatively the way in which they viewed themselves. Those early wounds to their self-worth seems to have played a crucial role in the appeal of alcohol as a means of comfort later in their lives.

For Matt, early childhood didn't seem to hold many positive memories. Instead of the holding, nurturing space of a stable family environment, what he has experienced was the uncaring neglect of his parents. When reflecting on the main challenge in his experience of life, Matt was very clear:

"I can't put it plainer than that, loss and abandonment, I think the things I've probably had to deal with the most out of all of that".

As a result of those difficult formative experiences, Matt has eventually come to internalise a self-defeating narrative of him not being a good enough person to deserve being cared for. Reflecting further of this narrative of a "bad person" Matt shared with me the following passage:

"You see, I think the reason why I don't, the reason why I don't see myself as a very good person is because I don't, from quite an early on age, I've never really had much kind of like stability or hope in anything. So it's kind of hard to know, without feedback whether you are doing a relatively good job at anything."

Listening to Matt I could feel his anger coming forth. My experience of him was that of anger born of injustice, for having to bear the burden of this skewed appreciation of himself from very early on. No stability, no hope in anything, no feedback, there doesn't seem to have ever been a safe base for him to return to, therefore he had to create one for himself while growing up. It is no wonder that he got attracted to the easy path for safety that alcohol promised. No one was there for him to offer a better alternative.

Neglect has also been part of Carol's childhood, which contributed in her alcohol dependence having grown in secrecy without her parents being there to safeguard her from its disastrous consequences: *"Yeah my sister was quite ill from that age, and I've got a little sister who was young … so much of the focus from my mum and dad was on them. Which meant that I could very easily slip through the radar"*

Carol never specifically articulated this, but throughout our interview I got the sense of a person that has never really experienced the validation or approval for who she is. Reflecting on her relationship with herself she shared: *"My brain has a tendency to beat myself up a lot, like tell myself that I'm worthless, I'm a piece of shit, I should just die. Like all these like really negative thoughts – you know I go over and over, and over and over in my mind when I'm alone – that's where my head goes, and that has been just throughout my life."*

Later on while she was recalling her long journey of trying and failing to achieve abstinence, she mentioned one particular encounter with her parents which in my eyes provided some insight as to how this self-defeating regard of herself came to be:

"I'd met up with my mum and dad, because they lived up that way, and I told them … and again I just felt so ashamed. And their reaction when I said to them you know 'I've done it again' they were just like … they didn't have a go at me, they didn't … you know but they were just so sort of … they'd just had enough"

Simon did not take much time to disclose information about his formative years. However his struggles with self-worth and the attachment to alcohol in order to avoid being overly conscious of himself seem to indicate the possibility of prior wounding that predated alcohol abuse. Indeed in his own words: *"An alcohol problem which has lasted for years doesn't come out of nowhere".*

Intoxication as a confidence boost to manage anxiety in social settings

According to most participants, the main "promise" of alcohol was that it would help them to function better in social settings, making them less self-conscious and more confident.

For Matt in particular when reflecting about what has been difficult about life, social interactions was immediately the first thing that came to mind: *"People I guess.., yeah people.., socialising.., yeah I find it difficult, I find it really difficult, social anxiety"*

It therefore made sense for him that the boost in confidence that he was able to experience while intoxicated would eventually become invaluable:

"Once you've had been, like between say three to six beers, you can, you feel like you can go and tackle and talk to anyone, you don't care, you just, you don't.., you don't care at all basically, it gives, it gives you.., it just gives you heightened confidence (…) having a heightened confidence, for me meant everything."

Barry's experience very much echoes the boost in confidence that Matt described. In his own words: *"I used to say I was at my best after half a pint or one pint of alcohol. I don't know why – I felt quick, I was confident, no anxiety"*. Similarly with Matt, alcohol enabled Barry to manifest an aspect of himself that he approved more of. The word "quick" feels particularly important, as it indicates a heightened capacity to deal with people in real time without being held back by feelings of self-doubt.

Simon's experiences of the relationship between alcohol and social confidence have also been along these lines. He has acknowledged that one of the main functions of drinking was to provide a boost to his confidence when he had to be *"doing things where I felt uneasy or would provoke anxiety"*. Alcohol was for him a way in which he could *"take those feelings away for a while"*.

Sharon also found social interactions difficult since a very young age. Reflecting back in her childhood years she shared:

"I'd grown up in a Welsh village, but I was always feeling awkward, always nervous going anywhere, (…) so I found a drink … especially before I went anywhere as I got older, you know a drink or two would give me that confidence to go"

Sharon recalled her understanding of how she was first introduced to alcohol, and unsurprisingly this took place in her own family environment: *"My nanna when I was small used to make elderflower wine, and in those days they used to give children little drops you know (…) and I think it did used to warm me and it felt quite nice you know (…) And then I think it became a thing of … more and more as I got older it was a thing of I knew that if I had alcohol before I went anywhere I would have the confidence"*

I remember noticing my own perception of Sharon at this point, in front of me is sitting a woman in her 50s and yet the way she articulates the word "nanna" made me visualise the little girl in her that seeks the reassuring, nourishing embrace of her grandmother.

Alcohol as a safe haven to hide from the self.

It was a common theme across participants that alcohol was experienced as a safe haven that enabled them to disconnect from life and avoid engaging with difficult thoughts and feelings that they would have found intolerable to connect with.

Matt considers the escape from reality to have been the main reason why he remained attached to alcohol:

"It was an escape, it was an escape from actually having to deal with all of the things that I had to deal with. (…) Everything that I didn't like, or everything that I didn't want to deal with, everything that I didn't want to listen to, everything that I didn't want to have to.., see you know, like just stay at home and just get drunk and forget everything, you know when you just kind of close the doors and throw the curtains and just forget about the world".

Matt's words brought to mind a stasis cocoon. Within that space time would have stood still as the responsibilities and challenges of life remained outside of its walls. All the aspects of life that would have been too difficult to deal were comfortably pushed to the side as Matt surrendered himself to an alcohol-induced oblivion, a state of hibernation where he would stay safe at the expense of living his own life.

In line with Matt's experience, Carol too has used alcohol as a way of pushing life's difficulties to the side:

"I think it's like escapism, and you become so used to being in that frame of mind that reality seems really scary. You don't want to be with yourself at any cost".

There is something profoundly challenging about the self that made it intolerable to remain self-aware. Carol's primary directive was to achieve that disconnect and the need was so urgent that it had to be met at any cost. It seems that Carol has identified in herself the vicious cycle that was also part of Matt's experience. In her own words: *"I was just in this self perpetuating cycle of trying … it feels like I was sort of running away all the time from being in my own head"*

The theme of not liking the self was also present in Simon's narrative. Indeed being alone with the self was for him an unpleasant experience, and one that alcohol had the capacity to soothe. In his own words:

"And maybe those feelings of low self-worth. (…) I would be being alone and being sad, and maybe feeling boredom - so a way of pushing those feelings away for a bit anyway is to drink"

1.3 The abuse: The harmfulness of alcohol on the participants' relationship with themselves

Overtime alcohol would systematically betray all its promises of a safe haven, instead causing the participants intense shame that would progressively confine them in isolation from others.

Alcohol causes shame and undermines self-worth

Even though one of the major functions of alcohol was to help the participants manage their negative feelings towards themselves, the escape that it provided was short-lived. Overtime the participants would be gradually pushed to a place of intense shame that would eventually become intolerable. Indeed as Barry shared: *"It took a long time for that to change, it took a few years, you know I was very anxious and very ashamed and very doubtful of myself"*

This effectively formed a vicious cycle in which the alcohol created the very same difficult feelings that it was supposed to relieve the participants from. This in turn made it necessary for them to intensify their drinking in a futile desperate effort to escape from them.

Alcohol would effectively exacerbate Matt's already wounded self-image due to the fact that he was failing his own expectations of himself. This dissonance between the person that he was witnessing himself to be as opposed to what he aspired to be further fuelled the intense feelings of shame that Matt was already experiencing, therefore driving more and more into drinking:

"It wouldn't have made me feel any better, it would have made me feel worse because feeling worse with not doing what I needed to be doing would have made me drink more"

Shame has also been expressed by Simon as the prevalent feeling that he had to grapple with throughout his alcohol dependence:

"It's trying to forget those negative feelings. You know these feelings of sort of shame and stuff around drinking too much, those kind of things."

However, in line with Matt he would find that the relief was only momentary and one that he would have to pay a price for soon after: *"For that period of time the alcohol is elating you, is certainly moving your mood - but then the next day you are in the same place, but you are feeling worse obviously"*

Carol has been experiencing the emotion of shame in such a profound intensity that it would often lead her to self-destructing thoughts of life not worth living. I recall the depth of sadness that I felt while listening to her words in the passage below:

"I remember hiding in a bush in the morning drinking this can of Strongbow, and I felt so ashamed. And I didn't even know who I was hiding from, it felt like I was hiding from … something was watching me – the universe or something was watching me, I felt so ashamed".

Isolation and disruption of relationships

As was mentioned before, one of the main functions of alcohol was to make it easier to connect with people. Yet it was a common experience among participants that in longer term it would exacerbate their anxiety in social settings, corrode their important relationships, and increasingly push them to a place of isolation.

Matt's reflections provided valuable insight into this gradual shift:

"Over a prolonged period of time, through drinking, that became less laughing, less people, less going out, less socialising, as you see all of that happening yet you are still drinking, you then begin to kind of question and ask yourself why is like, why, why is it like all become, you know why is it all kind of narrowing down, why is there, yeah why is there less and less of it, and you kind of wonder whether it is because of you, because of how you are behaving, because you are under the influence of alcohol".

Matt's wording and his tone of voice made me feel a sense of betrayal. Matt has put his trust in alcohol to be his wingman, his brother in arms to carry him through the battlefield of socialising and dodge the bullets of self-consciousness. At some point he came to the realisation that his companion stopped having his back, and he was alone again as anxiety was storming the gates of his fragile self-worth.

This worry about how one is being perceived when intoxicated was also shared by Barry and Simon. For Barry in particular, the state of intoxication was the main driver for his anxiety, which he would experience in a debilitating intensity:

"I remember I'd be paying for things and I'd see someone I knew you know at the top of my vision and I'd go 'Oh God' – I feel bad or hung over or look bad … and the anxiety would just completely stop me functioning, you know (…) And I'd be there and I'd have my hat on, my hood up, and I used to feel 'Oh God' cos I'd see them, you know (…) There was a lot of kind of shame with it I remember. I remember feeling quite alone"

According to Barry, for him to be seen, to be connected with people would have felt intolerable back then, and there was comfort in hiding away. Similarly to Matt and Simon, his experience of anxiety seems to be tightly connected to shame.

The insidious effect that alcohol had on relationships was particularly prevalent in Carol's story. In her case alcohol dependence would gradually sever her ties with her family, and thus deprive her of what could have been a lifeline in her times of need:

"Yeah it would affect relationships, become very volatile … relationships with my parents, because I was always hiding everything - like I had like this secret life that they didn't know about. Yeah I had some traumatic experiences which were created from my out of control drinking, which were suppressed you know – don't tell anyone, carry on."

In her case alcohol can really be visualised as a predatory presence who would seek to isolate Carol in a life of secrecy. I can't help but bringing to mind harrowing accounts from survivors of child abuse, who would suffer years in silence due to the threats of their abuser were they to reveal the truth.

The destructive impact of alcohol for Carol's relationships would progressively exacerbate to the point of ultimately making her feel unworthy of being connected to her family: *"I just reached the lowest part of my life where I was like I really didn't want to live any more, I just did not care, like I didn't care. And my mind was saying your family don't care about you, you know all this like lies … it's lies as what I see now"*.

2. The label of the alcoholic.

It was a common theme across participants that 'pulling the self apart' was a process that they had to go through in their pursuit of understanding themselves better. It makes sense that this stage of deconstruction would be going hand in hand with the need to find answers that would provide a new meaning to their past experiences. One such answer comes in the form of the term "alcoholic" which is predominantly used in the AA fellowship to conceptualise the person's suffering as a consequence of a disease that they are powerless against. However, participants varied considerably on the degree that they identified themselves with this label.

2.1. Embracing the label: Finding meaning in alcohol as a disease

Sharon made it clear from the very start of our interview that the term "alcoholic" was part of the new identity that she embraced for herself in her new life of sobriety

"*My experience has been that I cannot touch the first drink because if I drink one of anything alcoholic I will not stop at that – it'll set off a train of reaction, and I know that it's a disease, an illness you know of mind, body and spirit."*.

The way in which she used the term did not seem to indicate any negative connotations. Rather it felt like a comforting term through which she experienced a sense of belongingness and connection with her fellow AA members: *"Working the Steps, going to AA meetings, talking to other alcoholics, having a sponsor, having a home group, doing service, sponsoring now myself, and doing service in the phone office when other alcoholics ring up"*.

This feeling of comfort was echoed by Carol who has also conceptualised her experience of alcohol dependence in the same terms. This has been pivotal in alleviating Carol's shame and helping her to make peace with her past suffering:

"I think where I carried around so much guilt all my life for the way that I was and the way that I acted (…) you know I knew that that was not the right thing to be doing and that brought a lot of shame (…) But you know I look at my life and I can see that actually I tried my hardest through like so many different points, I haven't just been living in ignorance all my life … so I do see it, you know I do see it as an illness, like a mental illness in a way, because how else could you explain it? Like how else could you explain that someone gets into so much trouble, has organ failure, like ruins relationship with their family, loses all this stuff – and they still carry on and go 'Oh it wasn't the drink'. Well yes it bloody was, you know"

For Carol, being able to identify with the collective identity of the "alcoholic" produced a normalising effect for her struggles that helped with mending her wounded self-worth: *"I think being told like look you have this problem, you identify with all these other people that I meet in the meetings that tell their stories and … yeah, do you know what, that is me – that is me, and so it just feels like okay'"*.

It is perhaps this aspect of a collective identity that further explains their eagerness for subscribing to the alcoholic label, as doing so gave them the experience of belongingness to a supporting group which on some level might have replaced alcohol as a comforting mechanism.

For Sharon in particular the importance of feeling that she belonged was invaluable, as this was something that she has been profoundly deprived of throughout her adult life: *"I was somebody who had never really felt part of … and even the family when I married my husband you know – certainly didn't feel part of his family"*

The normalising effect that Carol and Sharon pointed out has also been experienced by Barry when he first engaged with AA: *"I mean it helped me with my confidence (…) Knowing that it was okay to have a problem I guess. I remember when I first … because before those meetings I'd never met anyone else who had a problem."*

2.2. "You can't call someone an alcoholic": Initial resistance to the label

Nevertheless this alignment with the term "alcoholic" was not an easy one and it was something that both Carol and Sharon have initially resisted to. Carol recalled a point earlier in her life when her parents have suggested that her alcohol consumption was problematic and that she should attend AA meetings. Her reaction to that suggestion was one of anger:

"If other people are trying to tell you you have a problem, but if you're not ready to admit that or face up to it, (…) it made me angry, you know it pushed me further away from them because I'm like 'Hey I don't have a problem' you know 'Screw you' … I really couldn't face up to it"

Sharon's experience was remarkably similar. She recalls an exchange with a nurse during her hospitalisation for alcohol overdose: *"The first thing I said to her was 'I'm not an alcoholic' you know 'Before we start, I'm not an alcoholic'. And she said 'I'm not calling you an alcoholic'. I've realised since that's quite clever because you can't call another person an alcoholic, they have to see it for themselves, you know it can make people rebel can't it and do a lot of damage really by saying that"*.

Sharon's initial aversion to the term alcoholic could be explained by her not being ready to admit the severity of harm that alcohol had in her life. However later in our interview she offers an additional insight on that reluctance to identify with the term:

"I thought well I can go and then I know then I'm not an alcoholic. Because if I go and I see all these smelly men and … you know men and whatever you know"

As Sharon points out, the term alcoholic seems to have been carrying with it a particularly negative image of a group of "smelly men". Her internalisation of the social stigma surrounding alcohol has likely played a big part in her not wanting to associate herself with such an unflattering image.

2.3. Rejecting the label: "We are more than our addictions"

Contrary to Carol and Sharon, the other 3 participants have made a point of distancing themselves from the term alcoholic. Barry's account was particularly interesting as it was within the AA fellowship that his recovery became consolidated. However, Barry felt that he was *"forced"* to identify himself as an "alcoholic" as part of this social context, which was something "*so difficult to say"*. At different times in our interview Barry has reflected on his frustration with AA, due to what he experienced as a stifling of his individuality: *"I don't know where that need came from to be such an individual in a place full of people you know that were quite happily defining themselves as someone with an issue"*. It was clear listening to Barry that this label was imposed on him, almost like a membership card without which he could not have a place in the fellowship.

Matt also made it clear that he distances himself from the term "alcoholic", even though he was not shy of admitting how all-encompassing alcohol's influence has been for him: *"Alcohol was mine, alcohol was my total escape, and I just used to, I used to use it all the time, for every reason, the one thing that I, I mean I wasn't, the thing is that I wasn't dependant, I wasn't like a dependant alcoholic, but I used to drink to tackle most situations"*

Simon also considered that "alcoholic" was a loaded term that he did not wish to have an association with. Simon never attempted to engage with AA but participated in "AA adjacent programs" which were group-based but *"didn't have the language of AA, and they were quite keen to avoid for example calling someone an addict, and that kind of labelling"*. In his eyes the fact that those groups seek to distance themselves from the language of AA serves to *"alleviate a lot of the monologue of guilt"*.

Reflecting further on his rejection of the term, Simon explained:

"Saying 'I've got an alcohol problem' is a much less weighted term than 'alcoholic'. But also having a problem – well you can fix a problem, manage a problem … if you're an alcoholic that is something which you are … and also we are more than just our vices, we are more than our addictions."

Perhaps their aversion to the label is also explained through the fact that contrary to Sharon and Carol, Simon and Matt never really found the social grouping that this label entailed as appealing.

Matt has experienced the context of AA as particularly unpleasant, and found that listening to other people's struggles not only was not helpful but was actually a trigger that further exacerbated his alcohol use:

"I would go and sit there and do that for an hour, but even after that I'd feel so kind of.. I kind of felt so depressed through listening to other people's stories of alcoholism that it would just make me want to drink to kind of forget about it"

My understanding of the reason why listening to other AA members was so challenging, is the possibility that identifying with them would have further undermined his self-worth. It makes sense that Matt would have sought to escape from this through numbing himself with alcohol.

For Simon the dynamics of social comparison had the exact same effect of further fuelling alcohol use. However there were further reasons as to why the group setting was unhelpful for Simon, such as a difficulty to reveal his genuine self to the group caused by feelings of anxiety with regards to the actual safety of that social space:

"Their behaviour is often very very unboundaried, and that can be quite an unnerving thing to be around, it can make … it made me anyway feel quite unsafe in terms of speaking honestly at length"

Ultimately all those elements combined to create an environment that was not conducive to Simon connecting with and sharing his personal struggles, or as Simon puts it: *"It's very hard to feel that you can own a space"*

Conversely, both Matt and Simon appreciated much more the one to one context of the counselling interaction within which they could fully focus on making sense of themselves and make their own individual choices with regards to how recovery should look like.

Simon articulates this very poignantly when he says *"The answer we find for ourselves is much more likely to be the answer we believe"*. This was a stark contrast to his experience in recovery groups, as Simon often felt that he was often being pushed towards complete abstinence:

"Well should I be like the not drinking at all people, or am I okay because I do have a day a week where I don't drink?' And actually you know I think the goal sort of implicitly is not drinking at all"

Finally Barry disclosed that even though his membership to AA yielded the initial benefits of normalisation and alleviation of shame, those would slowly give way to feelings of being constrained and the stifling of his individuality. Eventually Barry felt that he has *"outgrown"* all the benefits that AA could offer, and had to leave the fellowship and rely solely on counselling for safeguarding his abstinence.

In response to what he felt that was missing from AA, Barry's answer was immediate and clear: *"Individuality, yeah. I quite like counselling because I was the expert about how the session was going, I could talk about whatever I wanted to talk about. Whereas in meetings and AA and stuff it was very 'We're all the same' you know – everyone's the same. And some of the talk amongst the people I was living with, they would be saying 'We're all the same, we all think the same' and I was saying 'No we don't'."*

3. Reacquainting with the self: Recovery as a transformation process

For all participants, alcohol has been a major and constant presence that dominated their experience of life since early adulthood. It was the place they would go to in order to find comfort from distress, and confidence in dealing with others. More importantly, however, in alcohol they would achieve a state of oblivion which kept any distressing thoughts and feelings at bay. As a result, when they finally commited to not drinking, they also had to grapple with the fact that life without alcohol was a novel experience, and one that necessitated that they should engage with and establish a new relationship with themselves.

This was not an easy process and was initially experienced as an "unravelling" of the self, during which they became confronted by the self-deprecating inner monologue and negative self-concept that alcohol used to mask. Ultimately, however, this process yielded a shift towards a more compassionate way of relating with themselves which manifested in increased self-acceptance, a renegotiation of their critical inner monologue, and the internalisation of a compassionate "other", whether that was the supporting network of the fellowship or a non-judgemental therapist.

3.1 An experience of "unravelling"

It was a common experience among participants that putting the alcohol to the side essentially exposed them to their own selves. Until that point the concept of the self has been something largely unexplored as due to the years of intoxication people have become disconnected from their own thoughts and emotions.

According to Barry: *"I came out of this kind of 10 year, 13, 14 year intoxication… You know it can cover up a lot – a lot of emotion. And that's still quite new"*. Similarly for Carol intoxication has been her default state for more than 20 years, starting at the age of 13. It has dominated so many different areas of her life that eventually it *"became the norm"* with her sense of self has gradually becoming so tightly intertwined to alcohol to the point that she *"don't know how to be without substances"*.

For Sharon the concept of the self has not been particularly important for most of her life, and therefore not one that she has spent time exploring. In her own words *"I didn't know myself, I used to say in my head 'It's only me, it's only me' you know. Well it doesn't matter what's happening to me cos it's only me basically"*. As a result, the notion of the self being something important enough to dedicate time and effort in understanding better was unprecedented for Sharon.

In the process of learning to live a life without alcohol, participants have effectively gone through a re-acquaintance with themselves, and that experience that has been portrayed as a deconstruction or "unravelling" of the self. For Carol this took place as part of her working on the 12 steps of the AA fellowship. Working on step 4 in particular, which asks members to 'make a searching and fearless inventory of themselves', Carol has had the opportunity to look back at her life and confront her fears, her resentments and also to understand what were the ways in which she has contributed to her past suffering:

"I think by pulling that all apart and not delving into it, not … you know just literally writing it down in very simple like brief things of what it was, you know and going through that, and looking at my part in things."

The wording *"pulling apart"* echoes the experiences of other participants. For Matt this endeavour for a greater awareness and understanding of himself was a process of *"picking away"* at himself, as he admitted that for most of his life he had *"a more comfortable, yet uncomfortable relationship with alcohol than I had with my actual self"*. For him the process of recovery required that he should make an effort to meet himself, and counselling was the way in which he sought to accomplish this: *"The reason why I came here, basically, was to try and get a better understanding of myself"*. I find it poetic that in the same way that alcohol was the knife that Matt used to cut ties from himself, counselling was the "glue" that allowed him to reconnect with himself again. In that sense alcohol and counselling for him have been experienced as antithetical entities, the former standing for the yearning for oblivion whereas the latter being a gateway to self-knowledge.

Barry's engagement with counselling as part of his recovery initially aimed at providing an answer to his anxiety of having been irreparably damaged or in his own words: *"I kind of started it to make sure I wasn't insane"*.

Throughout his recovery, Barry sought to delve deeper into himself, to understand and make sense of himself in a new world where alcohol is no longer present. Doing so wasn't easy as the many years of intoxication have severed Barry's connection to his thoughts and emotions, and part of his process of recovery was to find a way to repair that connection: *"I'd got all my thoughts from my head from all these years, and just week by week spoke through them, talked"*. At another point in our discussion he reflects on the novelty of engaging with his feelings again, and expressing his surprise at realising the depth of his emotional world: *"I've not really noticed I have emotion as much as I do"*. Engaging with himself was a novel experience for Barry and, as was the case with Matt and Carol, Barry too had to slowly deconstruct himself in a process that he referred to as an *"unravelling"*. His experience was that he *"pulled apart and had a look, you know a good look at what it was. And I'm still finding out"*.

3.2 Trust and non-judgemental listening as pre-requisites for self-exploration.

Matt, Simon, and Barry have all considered their engagement with therapy as instrumental in holding them through this process of unravelling and self-exploration. When asked to reflect on what was it about the counselling interaction that made it useful to them, all participants pointed out to the therapeutic relationship itself. More specifically it was the trust and rapport that has been achieved with their therapists that was identified as key in allowing them to fully disclose themselves and confront difficult aspects of their experience of life.

For Matt, it was the trust that he experienced in the counselling relationship that made it possible to use the therapeutic space the way he needed to, which was to challenge and confront all the aspects of life and of himself that has historically found intolerable to engage with. It was heartwarming listening to him reflecting on his relationship with his therapist in a laughing, playful manner:

"She definitely gives me a run for her money, I'll say that much. In other words, she does make me sit through some of the most uncomfortable things ever. But that's good. You know?"

Trust seems to also have been at the heart of Simon's experience of therapy:

"I think because trust takes a while to build up, you know, so you can like someone, you can get a good feeling of them, but to really like let your defences down and to give your real self you know the truth of yourself to someone, for me … and obviously I can only talk about myself … does take an amount of time"

He went on to elaborate further on what he considers to have made the counselling interaction effective for him:

"It is the therapeutic process by its very nature. I think that it is rare in life that we get someone's undivided attention, and it's rare that we ourselves are able to talk at length about our feelings without there being a sense in which people are going to tell you what to do, or are telling you to dismiss those feelings".

The value of therapy for Simon seems to have been derived from his experience of being truly witnessed, and it was through experiencing that as part of his interaction with another person, that he was also able to witness himself. In contrast to the groups with which Simon has engaged in the past, the aim of the therapy was not to *"fix"* him, but rather to get to know the *"brokenness*" in him. He did not have to be conscious as to how he is perceived by his social group, nor was there a need to project an idealised self that was purged from what he perceived as blemishes. The wholeness of himself was welcome in the therapy room and that in turn allowed Simon to gradually become more welcoming of himself.

This was very much in line with Barry's experience of therapy:

"*Learning to kind of … building a relationship with a counsellor one on one, and knowing that it's not going to go anywhere else, and trusting them. Which can be a rare thing if it's not … if it's a person that's not related to you … it's something that's quite powerful about just being sat in like a position like this and just talking about your life – it's a very rare opportunity nowadays. And that's why … that's why it's worth doing. You don't get a chance to talk through what's going on in your head, you know, and I think that's quite unique to counselling, what's going on in your head, not someone on the bus or … you know, it's very individual, it's very unique. There's no judgement in it.*"

It seems that what Barry needed and valued in therapy was the experience of a space that was truly devoid of judgement, where he could afford to be really and completely seen by another without any fear of shame or embarrassment. I am reminded of the aversion towards AA that Barry has expressed earlier. Contrary to the social environment of the fellowship, counselling was a space where he was not expected to act or to be in a certain way, and consequently there was no fear of being judged unfavourably if he failed to conform to such demands. As Barry puts it: "*The counsellor barely had to say anything you know I was just like 'chat chat chat', because it was okay, no shame, no embarrassment, nothing*".

Perhaps it was even more interesting to note that even those participants that contributed their recovery to AA, still benefitted from the qualities of trust and acceptance that Barry, Simon, and Matt discussed.

For Sharon in particular, the relationship with her therapist was one of complete trust*: "It's very very good. I could talk about anything with my counsellor, I felt I could trust … you know I could trust her, and developed a good rapport with her really."*

In her experience there were often issues which for her felt either not safe or not appropriate to disclose to an AA setting. A particular example for her was traumatic experiences earlier in her life which, even though they were important due to having shaped the way she would relate with herself and others, Sharon felt that there was no place in AA to discuss about and work through them:

"And there's things that I just didn't want to talk to my sponsor about. So things like (…) my music teacher, I had some abuse from him as a child, about 5 or 6. It was sexual … not serious sexual abuse, but it was sexual abuse"

Conversely, the therapeutic relationship felt safe and appropriate for her to disclose the more sensitive and vulnerable aspects of her experience:

But I think it's just the fact that counsellor is not a friend, not a sponsor, you know nothing to do with the alcohol side of it, so once you put the drinking down, you know, you're left with yourself. And it helped me in a non-judgemental, not with other people … and I didn't 100% trust to talk to, that's the people in the dry house basically … helped me talk

Carol's words very much echo Sharon, as she too have found that AA was not enough to completely hold her during her work on step 4, a difficult time in which she was being "*pulled apart*". In her own words:

"Yeah. It played a very important part in this. I feel like especially with stuff that came up from my Step 4, you know where I did need to talk about things more in depth – that was really useful because I could go to the counsellor and talk to her more openly about things which I couldn't with the sponsor"

Perhaps what has been the most important way in which counselling would complement AA is once again derived by the sense of trust that was experienced in the therapeutic interaction. Having this safe space where they could feel confident in revealing the whole of themselves has played an important role in helping them to manage the challenging aspects of being part of the fellowship, thereby enabling them to make the most of what AA had to offer.

For Carol and Barry in particular engaging with AA was initially not easy, as they were both very resistant of the demands that were imposed on them:

Carol paints a very clear picture of her frustration during that time:

"When you're first finding out about the 12 Steps and how it works and stuff, you've got to do all these crazy things, you know it seems crazy to you … counselling was a place where I could go and be like normal and offload and say like … you know because you can't say to people who are doing the 12 steps, you can't be like 'This is fucking crazy, I don't want to do this'. You know so I could go to my counsellor and tell her all the stuff how I was finding you know my recovery I guess."

As has been shown previously, frustration has been a constant element of Barry's experience in AA and contrary to Carol it has never gone away, ultimately resulting to Barry leaving the fellowship. Nevertheless he was able to stay with his discomfort for two whole years before he decided to move on. Similarly to Carol he considers counselling to have been the reason he was able to manage his frustration during that time:

"*Yeah, I used to badmouth it a lot, to the counsellor. Because I couldn't say it to anyone. I couldn't say it to a sponsor, I couldn't say it in the meetings, I couldn't say it to a support worker, you know. But I'd come into the counselling session and I was like 'I hate everything you've got to do' and they would*

say 'Why is that?' and I'd go 'Cos you've got to do this and that and that and that' – and it was such a release to be able to say that."

The words "I couldn't say it to anyone" are powerful. Pressured within the confines of AA, Barry felt that there was no outlet for the internal tension he was experiencing. He needed counselling to tear a rupture into the walls that were smothering him so that his emotions could breathe.

There are strong similarities between Barry's and Sharon's accounts, as she too have felt the need for an external outlet when the tensions between her and her fellow AA members became too much:

"*Because there was usually things … although with my sponsor I'd try and tell her everything, sometimes maybe about my sponsor I wouldn't want to be telling my sponsor about my sponsor*."

3.3 Understanding the self leads to self-acceptance

Simon perceived that the improved way in which he relates to himself was the outcome of understanding himself better: "*It's a little bit better now … uh … I think what I have now which I didn't have is more self-knowledge*".

Simon attributed this greater self-knowledge to therapy and the fact that he was provided with the space and time to reflect on the whole of himself and not just his problematic behaviours:

"*But I think if you are in the pattern of regularly having a space where you're allowed to have your feelings whether they be happiness or depression or jealousy or whatever they are – at least you are having them, you aren't constantly moving them away through drinking or whatever, and it does give you a greater sense of feeling that you are aligned within yourself*."

The importance of self-knowledge was also articulated by Barry as a crucial for him becoming more accepting of himself:

"*I'm still learning about myself, I think we all learn about ourselves more and more, and we get to a point … as we grow older we kind of reach more self-acceptance, (…) some days I get up and look in a mirror and I go 'Am I normal?' – and I laugh – I don't know, maybe not, maybe I am what's normal, you know … and I don't care, which is a big thing*."

Similarly for Matt, his gradual movements towards self-understanding have been in his eyes the building blocks from which his self-acceptance was forged:

"*To be able to kind of come in and analyse myself in the small amount of time that I get. And then to bring, not always bring something good, but to bring something back the following week. And to have recognised what you've worked on is kind of an achievement in itself."*

Carol also reported that connecting with and understanding herself has played a part in her reaching a place of self-acceptance, although it is important to note that this came primarily through her engagement with AA and the fact that she was forced to examine herself and her life more closely:

"I was quite reluctant doing it, it took me quite a while to write it all down and talk it through with some you know new person in my life … but … I don't know what happened … I just felt like I'd let

go of … I've managed to let go of things, like I've managed to … not let go of them but accept them, accept for what it is."

3.4 Befriending the inner critic

As mentioned above, for all participants the shift towards self-compassion and self-acceptance was a gradual one that required time. This is understandable when considering that all participants have been carrying for many years a powerful negative self-image which manifested in a highly critical inner monologue. It was interesting to observe how their relationship with their inner critic has gradually shifted from a disempowering persecutory voice, to something much kinder which fuelled and encouraged their aspirations for a healthier future.

Simon has also been acutely aware of the way his inner critical voice functioned and the role that it played in fuelling his problematic alcohol use. In his own words: *"I think that I am more inclined to notice that inner critic – I notice when it's helpful and when it's not helpful, and I'm more resilient than I was".*

Throughout therapy it was possible for Simon to realise the unrealistic expectations he placed on himself which was instrumental in nullifying the harmful effects of that critical voice:

"I think some of the dissonance originally would be … I would have a version of myself which would not drink, not use drugs, not be promiscuous, whatever it is - and then be so hard on myself if I ever let that version down. And then there's a realisation of well who am I trying to impress the whole time – and ultimately shame is just a feeling … it's a powerful one, but it is just a feeling"

According to Simon, it was his engagement with therapy that produced this shift towards self-compassion. For him it was the very act of investing in himself that helped to reduce the intensity of his toxic inner monologue as he was witnessing in real time the fact that he was actually valuing himself:

"I think the very action of paying for it has an effect too, because you know by paying for something which you know is good for you you are saying 'I think I am worth investing in' – as a way of saying to yourself 'I care enough to pay for this'"

Similarly to Simon, Matt has also found that at the very core of his inner-critic was the notion that he was constantly failing to meet his own standards. Contrary to Simon however, Matt's process of befriending this voice required him to actually move towards it in order to be aligned with his own standards:

"The resentment that I've already had for myself would be much greater if I was to start drinking again. Because it would be, I would be giving myself the feeling of letting myself down".

Overtime and throughout his recovery Matt has managed to forge a new relationship with his critical voice which instead of chastising and persecuting him, it now empowered his movement towards a healthier life:

"*Despite the social anxiety, I made sure that if my friends wanted to go for a drink and they were like, come meet me at the pub for a drink, I'd be like, OK, and I'd still go there. And I might hate being there because I'd be totally clear headed… I'd just try and deal with it. (…) I basically just made myself tackle everything that I don't want to deal with".*

This was also exemplified by his reflections on the kind of person he needed to be in order to be a healthy role model for his daughter:

"I was also kind of doing this for her because the older she gets, the less I want to see her.. the way that I was. You know, I'd rather be a bit more of a stronger kind of person or figure for her, I guess, as she gets older".

What emerged from Matt's narrative as a new, more functional relationship with the inner critic was also present in Barry's narrative. His self-defeating monologue of having been fundamentally damaged as a person was replaced by a new voice that urged him towards self-development and growth. As Barry reflects: "*Now it's just about progressing, I need to be progressing – that's what it's turned into. And because of that, when I feel I'm not progressing I feel like guilty because of it."*

3.5 Self-compassion through being held

A shift towards self-acceptance and self-compassion has also been reported by Carol and Sharon. However since those participants' recovery relied heavily on their long-time engagement with AA, it was no surprise that this shift was also tied to their experience of being held by the fellowship.

Carol considered that framing her struggles with alcohol in terms of having a disease has been instrumental in relieving feelings of shame. However it was her experience of feeling part of a group and being surrounded by people who shared similar experiences that has made it possible for this re-framing to occur:

"*I am so glad that I've met other people who can be honest enough to share like their journeys and their shame. And so I think yeah, kind of like seeing it like that lifted some of the shame in my mind now, which really helps me to move on*"

Indeed throughout our interview it very much felt that Carol has found in AA a new family, one that would be there for her to embrace and to comfort her even at the times that she felt unworthy of receiving such warmth. Undoubtedly this must have been a profoundly liberating experience for Carol, especially considering the shame and secrecy in which she lived in order to spare herself from the disappointment and judgement of her parents.

This experience of being held by a new family has also been instrumental in enabling Sharon to connect with herself in a more compassionate way. Perhaps it was particularly her that benefitted the most from experiencing herself as part of a loving collective, as Sharon's whole life's journey has been a search for the loving comfort of her childhood parenting:

I was somebody who had never really felt part of … and even the family when I married my husband you know – certainly didn't feel part of his family"

Sharon's need to feel like she is part of something was so fundamentally crucial that when this need was finally met it automatically erased all her prior negative preconceptions of AA:

"*It was just totally different you know.. It was back to probably when I was a little girl and I didn't have to work at it, because they were coming to me, you know, and couldn't do enough for me.*"

Indeed as Sharon herself articulated when referring to the value of AA for her: "*Yeah, I belonged, I was home you know*".

Within the holding social space of the fellowship, Sharon has been receiving consistent positive reinforcement which encouraged to reflect on herself and her life in a positive way:

"*I mean within AA we're encouraged to do affirmations and gratitude lists. Well the affirmations I've learnt to say you know 'I'm kind, caring' - and I do believe it, because I've been told it by other people as well.*"

Finally, it is important to notice that it was not only her relationship with other people that produced those positive effects in self-compassion. Through her engagement with AA Sharon has also been able to establish a nourishing bond with her Higher Power which further promoted her shift towards self-compassion:

"*Well I'm Christian, so I believe in God, and you know God created me. And by not valuing me I'm actually going against God really, so that's helped me do that.*"

Ultimately this sense of belongingness and of being held and carried by the love of her group, by the love of her God resulted in the gradual repairing of her self-worth and a greater capacity for self-acceptance: "*Knowing that I can't be perfect, because I do suffer from a bit of perfectionism – and nobody's perfect.*"

DISCUSSION

The present study employed the qualitative methodology of Interpretative Phenomenological Analysis to explore people's experiences of recovery from chronic problematic alcohol use. Contrary to the existing literature which seems to be focused solely on the experience of AA members, the focus of the present study is people whose recovery included long-term engagement with counselling. Several important insights have emerged through the analysis which were clustered in 3 super-ordinate themes: "*Alcohol as an abusive relationship*" includes reflections on the gradual development of the participants' problematic relationship with alcohol, the pain that it initially soothed, and the disruptions that it eventually caused for their quality of life. The theme "*The label of the alcoholic*" aims to make sense of the participants' differential response to the alcoholic identity. The last theme "*Reacquainting with the self: Recovery as a transformative process*" goes further into the participants shift towards a healthier, more compassionate way of relating with themselves and the ways in which change materialised in the contexts of counselling and AA. Reflections on the limitations and strengths of the study are being discussed, and concluding remarks are offered about the implications of the study and the merits of a conceptualising recovery as a long-term process.

Discussion of themes

Alcohol as an abusive relationship

The first super-ordinate theme is concerned with the onset and gradual development of participant's problematic alcohol use. All participants have spent a considerable part of their interviews reflecting and making sense of their relationship alcohol which at various times in their narratives was personified as a deceitful and trickster companion that was both alluring and destructive.

The personification of alcohol as a trickster entity can be traced back to Ancient Greek theology in the form of Dionysus, the Greek God of wine and pleasure, but also madness and ritual ecstasy, who out of all Olympians was the one best associated with the Jungian "trickster" archetype, as he embodied the instinctual, primal energies that live outside the realm of reason and civility (Kerényi, 1976). Nietzsche would argue that the deity stands as a stark contrast to Apollo, as two parts of a duality that is inherent in us all, with the God of the sun standing for order, reason, and logic, whilst the wine God representing chaos, instinctual drives, and emotions (Nietzsche, 2017). Dionysus would be revered as much as feared by the people of Ancient Greece, and was regarded

as a conduit through which we can access our internal capacity for chaos which when liberated from the confines of reason could bless the individual with blissful joy, but also damn them to a state of bestial madness (Hatfield, 2019). This ambivalence towards alcohol was an integral part of my participants' experiences, as all of them initially experienced alcohol as a benign presence that would deceive them with false promises of soothing from long-standing emotional difficulties, but which they grew to loathe as it was progressively becoming the very cause of their suffering.

Participants disclosed varying degrees of trauma going back to their early childhood. This would come in the form of problematic relationship with primary caregivers, as was especially the case with Matt and Carol, the difficulty to integrate in early social settings, and in Sharon's case the trauma of child abuse. It was not the scope of the study to delve deeper into such traumatic experiences, but it was made clear that those formative wounds have shaped the way in which they related with themselves. It is likely the case that such adverse early life experiences would have planted the seeds of a diminished sense of self-worth that would follow them throughout adulthood (Derin et al., 2022), giving rise to alcohol as an unhealthy means of self-soothing (LeTendre & Reed, 2017).

Indeed, and very much in line with Khantzian's (2003) self-medication hypothesis, participants of this study have unanimously disclosed that, at an early stage in their lives, alcohol wooed them by presenting itself as a soothing friend. It ultimately went on to become an indispensable safe shelter, and it was only within it that they could find solace from life's adversities, and the harshly critical inner voice that has accompanied them from childhood. What has also been unanimously the case, was the participants' lifelong struggles with anxiety, which could be linked to their aforementioned wounded sense of self-worth (Iancu, Bodner, & Ben-Zion, 2015). Alcohol has also played an important role in modulating the effects of social anxiety, which has been well documented as a major risk factor for the development of alcohol and substance abuse (Crum & Pratt, 2001). It was my participants' experience that when faced with anxiety-provoking social settings, alcohol used to play the role of the "wingman". It cloaked them from other peoples' perceived criticisms by dampening their own intense self-awareness, effectively allowing them to integrate more effortlessly in their social surroundings.

However, as is well documented in alcohol literature, the soothing effects of alcohol tend to last little, while this short-term relief carries with it a heavy price for the individual's physical and emotional well-being. This has been very much the case with the participants of this study. Not

too dissimilar to the relationship with an abusive partner, they too have overtime witnessed what was once a benevolent presence gradually becoming more and more insidious, ultimately growing into the source of the very suffering that they initially sought to shelter themselves from. All five participants reported that their heavy alcohol use has further compromised their self-worth, and had a severe impact on their capacity to form and maintain nourishing social bonds. Those experiences are corroborated by a large body of existing research into the psychological impact of alcohol, which has been shown to be a major risk factor for the development of anxiety and depression (Kushner, Abrams & Borchardt, 2000; Lloyd & Turner, 2008), as well as having a corrosive impact on people's sense of self-worth (Chaudhury, Prakash, Walia, Seby, Sukumaran & Kumari, 2010).

Perhaps, it is the wounding to self-worth that has been most prevalent in my participants' narratives, with all 5 disclosing intense levels of shame emerging as a result of their problematic alcohol use. The disastrous impact of shame in the context of alcohol abuse has been extensively documented, and has shown to be a major perpetuating factor for problematic drinking as a means of self-soothing (Khantzian (2014), as well as an obstructing element for the efficacy of therapeutic interventions (Van Vliet, 2008). Furthermore, shame has been shown to be particularly corrosive for people's sense of self-worth, promoting the internalisation of their suffering as proof of their inherent and fundamental unworthiness as human beings (Nicolosi, 2009).

Taking into consideration the early traumatic experiences that the participants disclosed in their narratives, it could be argued that the shame response they experienced as tied to their disruptive alcohol use, could function as an emotional link to their earlier wounding (Wiechelt, 2007). As such, the role of shame in perpetuating my participants' problematic alcohol use could be placed within a broader context of re-enacting their traumatic past (Wiechelt, 2007). It has been shown that the stress response due to re-visiting past trauma is marked by the release of high levels of dopamine, b-endorphin and other stress hormones (Nicolaides et al., 2015), in a way that has been suggested to mirror the opiate response to alcohol (Berlin & Montgomery, 2017). Placing this in the context of the psychodynamic notion of repetition-compulsion (Freud, 1920), it could be argued that my participants' persistent resorting to alcohol for the soothing of shame can be seen as an attempt to bring a quick resolution to the perpetually resurfacing previous trauma, with shame being at the very centre of this vicious feedback loop.

Ultimately the re-activation of such prior wounding and the consequent decreased sense of self-worth can manifest socially in withdrawal from supportive social settings and the severing of emotionally nourishing bonds (Leeming & Boyle, 2013). Indeed, isolation has very much been the experience of the study's participants, who once used alcohol to help them cope with social anxiety, only to find themselves progressively more anxious, to the point where social connectedness would eventually become intolerable. Literature into drinking motives provides interesting insights into this gradual progression. It has been suggested that people's motivations for drinking can fall into 3 distinct categories: coping with emotional adversity, enhancing positive affect, and improving socialisation (Cooper et al., 2016; Kuntsche et al., 2005). Out of those 3 motives, coping with difficult emotions has been shown to predict problematic drinking behaviours to the point of compromising social functioning, whereas enhancing positive affect is associated with heavy and frequent alcohol abuse (Buckner, Eggleston & Schmidt, 2006). Conversely, social motives are thought to be associated with less disruptive behaviours (Buckner, Eggleston & Schmidt, 2006). Nevertheless, it has been suggested that social anxiety can play a mediating role to those associations, as social contexts would trigger severe emotional distress that needs to be alleviated (Stewart, Morris, Mellings & Komar, 2006). As a result, social situations become triggering of coping and enhancement motives for socially anxious individuals thereby locking the person in a perpetuating vicious cycle of problematic alcohol behaviours that keep intensifying the social distress they aim to alleviate (Sanderson, 2015).

It is chilling to reflect that those findings have been so faithfully replicated in the experiences of this study's participants, with every single one of them reporting that the wounding to their self-worth would deepen, and they would become increasingly more anxious and isolated from important others, as alcohol would steadily become the single most important relationship of their lives. By the end of this analysis it was difficult not to see clear parallels between the relationship with alcohol and an abusive relationship. Both would become increasingly more possessive and seek to become established in their victims lives through damaging their self-worth and isolating them from supportive relationships (Bostock, Plumpton & Pratt, 2009). Having dived into my participants experiences and sense-making, I am left concerned as to whether the notion "abuse of alcohol" would need reframing. In the same way that it would be ill-advised to assign blame to a victim of domestic abuse for the suffering that they are experiencing in the hands of their abuser, I wonder if it would be therapeutically more valuable to conceptualise this as "abuse <u>from</u> alcohol" so as to avoid colluding with their chronic disempowerment and systematic wounding to their self-worth.

The label of the alcoholic

From the 5 participants of this study, 2 have considered the AA fellowship to have been the main pillar that supported their recovery from problematic alcohol use, with their therapy at the SWAN playing a supporting role. Conversely another 2 participants had minimal experience of AA which they regarded as "not right" for them, instead attributing their recovery entirely to their engagement with therapy. Perhaps the most intriguing case was that of Barry who has experienced both AA and counselling and considered both to be significant at different parts of his journey.

The label of the alcoholic has been a major point of divergence between participants' experiences, as those whose recovery was AA-driven have found it helpful and empowering, whereas the remaining participants made a point of disidentifying with the term. For Sharon and Carol, the "alcoholic" label was experienced as empowering, validating, and reassuring. They were not the ones to blame for their misfortunes, as their suffering had a cause and a name. It was largely through that label that their experiences were normalised and their feelings of shame and guilt soothened. This brings to mind the often empowering impact of diagnostic labels, which are often reported to relieve mental health patients from blaming themselves about the challenges they face (Ruscio, 2004). It could be argued that AA provides its members with an interpretative framework through which they can make sense of their prior suffering. However, in contrast to the interpretations that are offered within a therapeutic context which should always be offered tentatively and with the aim of promoting the client's self-exploration (Stukenbrock, Deppermann & Scheidt, 2021), the alcoholic label is imposed with an almost religious confidence of the one definite truth, and its acceptance often becomes a crucial pre-requisite for belonging to AA's social context (Hoffmann, 2006). Perhaps this lack of tentativity could provide some explanation for the aversion that half of this study's participants expressed for this term.

And yet, it is important to underline that even those participants that would now identify with the term "alcoholic" have initially resisted it, and sometimes vehemently so. However, looking a bit closer at those participants' eventual acceptance and identification with this term, it is important to notice that those were also the people that have more gravely impacted by the disruptive effects of alcohol dependence. It was interesting to observe that for those participants who were later attracted to the AA model, for change to be initiated it had to be experienced as a choice between life and death. Indeed, Sharon, Carol, and Barry have all witnessed their lives unravelling to the point where life in alcohol was simply not sustainable anymore. Alcohol has been physically and psychologically disruptive to such a degree that they have come dangerously close to death or

permanent, irreparable damage. This is a stark contrast to Matt's and Simon's experiences who have transitioned more smoothly the different stages of the cycle of change (Prochaska, DiClemente & Norcross, 1997), culminating with their taking action in seeking counselling.

For Sharon, Carol, and Barry the transition from pre-contemplation to action was abrupt, violent, and forceful; Life itself has backed them to a corner, making recovery the only alternative to death. Interestingly this is an identifiable pattern in the context of AA recovery, as members would often refer to those violent events that precipitated change as "the gift of despair", and would view it as a blessing in disguise, without which change would not have been possible (Rowen, 2003). In that sense it could be argued that it was not possible for Carol, Sharon, and Barry to be in denial of alcohol's disruptive impact anymore, which in itself has helped with overcoming their previous ambivalence towards change. All of them have experienced their agency being stripped away in restricting detox settings where they were forced to make the right choices for the benefit of their health and wellbeing. It could be argued that the alcoholic label, and the AA doctrine to which this is embedded, came as a natural continuation of those restricting environments, as for a self-identified alcoholic in AA abstinence is regarded as the singular and only alternative to the perpetuation of their suffering (Vaillant, 2005). This black & white conceptualisation of recovery must have felt familiar to the life or death dilemma that initiated their journey towards change, and by eliminating any other potential choices and making abstinence the only "right" choice to be making seems to have felt re-assuring and containing for those participants (Schwartz & Ward, 2004).

In attempting to make further sense of the different ways in which this study's participants have conceptualised this label, it is important to also consider that the term itself carries different meanings depending on the context within which it is communicated (Tkach, 2018). It has been well-documented that the prevalent social narrative around the term "alcoholic" is linked with powerful negative connotations and is regarded as a moral failing of the individual (Hill & Leeming, 2014; Tatarsky & Marlatt, 2010). And yet, something interesting happens when this term is re-contextualised within the AA environment. As Bradshaw (2005) points out there is a paradoxical shift in meaning where a term that was once loaded with self-stigmatisation becomes the very vehicle for alleviating shame. Tkach (2018) notes that different people have been shown to internalise the "alcoholic" label in different ways, with some experiencing it as a catalyst for their empowerment (Critcher & Zayas, 2014), whereas others focusing on the negative connotations and the social stigma that it evokes (Tkach, 2018).

According to Critcher & Zayas (2014), the empowering impact of identifying as an alcoholic is very often due to the members' prior experiences of stigmatisation and exclusion becoming replaced by their new experience of belongingness and validation by the social group of the fellowship. In that sense what was before a term that encapsulated ostracism becomes re-framed as a symbol of inclusion. This resonates strongly with Sharon's and Carol's experiences as it was them out of all 5 participants that have experienced social ostracism as a result of their problematic alcohol use. According to Kurtz (2002), in admitting their powerlessness over alcohol, the AA member is letting go of the intense critical narratives of a moral failure, instead adopting an attitude acceptance, ultimately allowing themselves to be imperfect. At the same time, by subscribing to the notion of an alcoholic self, they concurrently and inevitably invite in the parallel identity of the "recovering alcoholic" (Pollner & Stein, 2001). This parallel identity serves as an extension and perhaps a transcendence of the alcoholic label, founded on the belief that a new, healthy way of being is indeed achievable and within their grasp (Pollner & Stein, 2001). What is perhaps more important to note here, and that was particularly evident within Carol's and Sharon's narratives, is that this conceptual shift was not an abstract play of ideas, but rather the product of actual experiencing as those notions would become manifest in their fellow members' presentation and narratives (Borkman, 2008). Carol and Sharon have experienced the attitude of self-acceptance as this was being enacted by their fellow members attitudes towards themselves, they have witnessed the identity of the recovering alcoholic and the hope that this represents, as this was embodied in their more experienced fellow AA members (Bradshaw, 2005).

It is then worth considering that for Carol and Sharon, engaging with the term alcoholic was more than just wearing a label. Rather it was an act of submission to a collective identity which served as a gateway, a "membership card" to a benevolent and supportive microsociety (Vaillant, 2005). Embracing the notion of the alcoholic was also being embraced by a new surrogate family whose acceptance, inclusion and hope were catalysts for an experiential reframing of their previous unhelpful narratives of shame and self-stigmatisation (Buckingham, Frings & Albery, 2013; Rice & Tonigan, 2012). It is perhaps this social linking implicit to the alcoholic label that could further explain the other participant's aversion to the term. Sharon herself expressed the preconception of alcoholics as a "group of smelly men". Unlike Sharon however, it is arguably the case that Matt and Simon never really allowed those pre-conceptions to be re-framed, and as such their conceptualisation of this term would likely be in line with the unfavourable social narrative around alcoholism (Hill & Leeming, 2014). Furthermore, as those three participants have not experienced

social stigma and ostracism to the extend that Sharon and Carol did, it makes sense that to identify with the alcoholic label would not come as a relief from a toxic self-narrative but rather them giving in to one. This is perhaps most observable in Matt's case, whose brief engagement with AA burdened him with feelings of depression, further fuelling his alcohol abuse. Such a response to the term is likely an example of what Bateson (1971) has suggested as "an alcoholic pride", the individual's escalation of alcohol use in a self-destructive attempt to negate the alcoholic label by proving themselves capable of controlling their alcohol use.

Reacquainting with the self: Recovery as a transformative process.

The 3rd super-ordinate theme involves discussions where the participants went into further depth in what has been their experience of recovery, with a particular focus on the ways in which their relationship with themselves was gradually shaped through that process. As has been mentioned above, the participants of this study had to grapple with intense shame and self-criticism, for which alcohol was a means of soothing. It was a common experience that in the absence of this comforting mechanism they all had to confront those difficult thoughts and feelings and find different ways to navigate them.

What seems to have emerged through all participants narratives was a distinct movement towards a more compassionate way of relating to themselves. Even though this was a common experience, it was interesting to observe the different ways in which this movement materialised for different people. Given the differences between the ethos of psychological therapies and the AA tradition (Le, Ingvarson, & Page, 1995), it was expected that the shift towards a compassionate inner-voice would manifest in different ways in those settings. This was indeed the case. Attempting to make sense of the participants' individual experiences it was helpful to consider what have been theorised as being the individual components of self-compassion. According to Neff (2011), those components would be a shift away from criticism and towards self-kindness, the realisation of common humanity as opposed to suffering in solitude, and the increased capacity for mindfulness when dealing with challenging situations. Listening to their narratives, it becomes apparent that the shift towards self-kindness was an important element to all participants' journeys. However it could be argued that the element of common humanity was much more integral for those participants whose recovery was mainly driven by AA. Carol, Sharon, and to some extent Barry, considered that being part of a group with which they shared similar experiences has effectively normalised their struggles, making it easier to move away from the toxic notion that they were somehow uniquely flawed as human beings.

This is something well documented in literature around AA, where the supportive social network of the fellowship was considered by its members as the key factor for promoting and safeguarding recovery (Cohen, Tracy, Rodriguez, & Bowers, 2020). It also brings to mind Bruce Alexander's infamous "rat-park" experiment and the resulting hypothesis that the "cure" for addiction might not be sobriety, but connectedness (Alexander, 2012). It might be important here to also keep into consideration the deep relational wounding that Carol and Sharon experienced in their formative years, which has inarguably played an important role for their compromised capacity to form nourishing bonds as adults (Erozkan, 2016). According to both, prior to entering the social context of the fellowship they were deeply fearful and mistrusting of others, and considered themselves as being profoundly undeserving of others' love and acceptance. As a result, and perhaps more than the other participants of this study, their lives prior to the fellowship were marked by social and emotional starvation. It could be argued that their engagement with the social element of the fellowship has been a reparative experience that might have facilitated the shift towards a more secure attachment style (Dark-Freudeman, Pond Jr, Paschall, & Greskovich, 2020). Consequently it would enable them to gradually internalise the care and acceptance they received by their new friendships and become more capable to channel those qualities in the way they related with their own selves.

Even though it could be argued that this reparative process can also be experienced within the therapeutic interaction, listening to Sharon and Carol, I would become increasingly doubtful as to whether this would have really been sufficient for them. I am reminded of the proposed determinants of therapeutic efficacy (Duncan, Miller, Wampold & Hubble, 2010), where 40% of therapeutic efficacy is attributed to extra-therapeutic factors such as changes in client's circumstances, and 30% being ought to the quality of the therapeutic relationship. Given the wealth of evidence regarding social support as a key extra-therapeutic factor that promotes positive therapeutic outcomes (Roehrle & Strouse, 2008), particularly so in the domains of addiction and depression (Litt, Kadden, Kabela-Cormier & Petry, 2009; Delaney, 2017; Ioannou, Kassianos, & Symeou, 2019), I suggest that the fundamental relational shift that Carol and Sharon experienced in being part of a supportive social network might not have been substituted by their engagement with therapy alone.

In contrast to the previous participants, Matt and Simon, whose recovery has been almost exclusively supported by their engagement with 1 to 1 therapy, seem to have been benefited much

more from the suggested mindfulness component of self-compassion (Neff, 2011). It appears that Matt, Simon, and Barry would become increasingly more lenient towards themselves as their understanding of their emotional processes progressively deepened. They all talked about an experience of "unravelling" or "picking away" at themselves, a painful but enlightening process through which they graduated with an increased awareness of their triggers and a realisation that the function of alcohol in their lives was indeed one of self-soothing.

The way they made sense of their experiences in their therapy very much echoes the fundamental notions of the Compassion Focused model which conceptualises addiction to substances as an adaptive response to trauma (Phelps, Paniagua, Willcockson & Potter, 2018). The participants' narratives were in line with the basic tenets of the model which aims to increase the client's understanding of how they respond to environmental threats, while also reprogramming their self-defeating inner monologue to one of warmth and acceptance of the self (Gilbert, 2014). Indeed CFT has been proven effective in managing addiction issues, with studies reporting a lasting decrease in substance use (Brooks, Kay-Lambkin, Bowman & Childs, 2012), reduced feelings of shame (Matos & Steindl, 2020), and greater capacity for mindfulness and self-compassion (Frostadottir & Dorjee, 2019).

Nevertheless, this transformative process has indeed been shown to be emotionally challenging (Carlyle et al., 2019). A recent study of CFT for opioid use yielded seemingly paradoxical results, with the treated group exhibiting both greater capacity for resisting opiate use, but also increased craving for it when compared to untreated controls. The researchers interpreted the apparent antithesis in those findings as indicative of the CFT group engaging and working through their resurfacing trauma, something that escalated their comfort-seeking drive, yet ultimately resulted to increased robustness in tolerating distress (Carlyle et al., 2019). This is very much in accordance with my participants' experience of "picking away" or becoming "unravelled" due to confronting parts of their experience that was initially thought of as intolerable. And yet being mindful of those internal processes ultimately awarded them with the capacity to say no to this toxic way of comforting themselves, to endure the surge of emotional distress, and seek to comfort themselves in ways that would not compromise their emotional well-being.

As I would listen to the participants describing their experiences of their therapy I was very aware of how well those fit to an Internal Family Systems paradigm. I conceptualised their acceptance of deeper emotional issues as them extending an olive branch to their "exiled" wounded selves (Smith, Hayes & Smock Jordan, 2019), an understanding that alcohol was a means of "firefighting"

the distress that they would experience every time their past trauma was resurfaced due to challenging life circumstances. To accomplish this, however, it was necessary for the therapeutic interaction to allow them space and time for self-reflection, and to unearth the previous wounding that would become triggered each time they turned to alcohol for self-soothing. Ultimately, it became clear to me that both AA and the SWAN's integrative therapeutic approach had one important thing in common, that they both prioritised a holistic view of my participants' experience of life. They both approached recovery as a lengthy, transformative process, which cannot be possibly reduced to short-term interventions of alcohol reduction goals (Aaronson, 2006). For Carol and Sharon this self-exploration took place within the context of their accepting, supportive fellowship group, whereas for Matt, Barry, and Simon it emerged through discussions within a therapeutic relationship where they could feel safe and held enough to fully reveal themselves. In both cases, however, participants have come to internalise a compassionate "other" that saw and embraced their vulnerability and responded with kindness as opposed to condemnation.

Implications and suggestions for future research

The present study aimed to explore the experience of recovering from alcohol dependence through the lens of counselling clients who have engaged in therapy for at least 1 year. Through their individual narratives several crucial points emerged that seem to indicate that despite the variety in their experiences, there are certain aspects of their journeys that could be perceived as common. I consider that several of those points merit further reflection due to their implications for our conceptualisation and treatment of alcohol dependence.

One such point is the view of alcohol abuse as not the heart of their problem, but rather as a problematic response to much deeper issues of anxiety and low self-worth that preceded it. Alcohol was conceptualised by my participants as a "toxic friend" that came in their hour of need to numb and comfort them from painful thoughts and feelings, only to progressively lure them deeper in a quicksand of shame and self-loathing, while cutting them off from any other source of emotional nourishment. I consider this personification of alcohol as an abusive partner to be a useful re-conceptualisation of alcohol dependence, as it serves to point out unhelpful social narratives around alcoholism. More specifically, even though it is well documented that alcohol has a tremendous disruptive impact in our societies (Obuna, Hayes, & Fulton, 2016; Rehm, 2011),

we live in a culture that celebrates intoxication and systematically encourages alcohol use (Ahern et al., 2008; Measham & Brain, 2005). And yet we are seemingly quick to turn our backs to the people that fall victims to this culture, we criticise, shame, and marginalise them as pariahs (Tatarsky & Marlatt, 2010). In viewing alcohol through the lens of an abusive relationship, the attitude of our societies becomes eerily resemblant to blaming the victim of the abuse, while the perpetrator keeps being exonerated.

With this into consideration, I suggest that the notion "abuse of alcohol" might be inherently problematic, as it paints a picture of them as willing participants in a life of suffering. This fails to encapsulate the experiences of shame, isolation, and consistent undermining of their sense of self, that have disempowered them to the point of seeing life outside of alcohol as something to be feared and avoided at all costs. I would suggest that a perceptual reframing to "abuse from alcohol", would also imply an attitudinal shift towards support and compassion, as opposed to the stigma and ostracisation that is sadly too often the experience of this population (Hill & Leeming, 2014). I would further argue that AA's conceptualisation of alcohol as a disease could be seen as an example of such perceptual reframing, as it has the potential of shielding the individual from the toxic monologue of shame and internalised stigma (Sawer, 2016).

However, this brings me to a second point worth raising, which is that, as the experiences of my participants illustrate, AA is not an answer that appeals to everyone. For some participants the encouragement and acceptance that they received through being part of AA's supportive social network was key in normalising their struggles and shifting their inner monologues towards acceptance and self-compassion. Nevertheless, what seems to be a crucial limitation of AA is the demand to submit to the collective identity of the alcoholic, which suggests that the aforementioned benefits of belongingness might be dependent on the person's willingness and capacity to integrate to the AA identity and worldview (Hoffmann, 2006; Vaillant, 2005). For some of my participants this was an insurmountable barrier that prevented them from pursuing a deeper engagement with the fellowship, as doing so was seen as a surrendering of their individuality in favour of a label that they perceived as stigmatizing or unhelpful at that particular time. For them it was the context of 1 to 1 therapy that they regarded as instrumental for promoting recovery, and that was specifically attributed to the experience of being received without judgement by an empathetic other, as they were encouraged to unfold, explore, and compassionately re-integrate aspects of themselves that had been disowned. Furthermore, even those participants like Sharon and Carol that came to fully embrace the AA narrative, found it useful to use the counselling space

in order to work through their initial resistance to aspects of the fellowship that they found challenging, as well as to contain interpersonal tensions that could otherwise threaten to making them feel disconnected from the group. Additionally, therapy offered them the opportunity to reflect on and make sense of past trauma, as doing so was regarded as risky or inappropriate in the context of the fellowship.

And yet, in spite of AA's limitations, it is undoubtable that the belongingness that this study's participants experienced as a result of conforming and integrating with the group yielded important benefits, and was considered by them as the cornerstone of their recovery process. My experience of those participants was that this element of social support could not possibly be substituted by 1 to 1 therapy, and there is indeed literature to suggest that for this stigmatised population, the degree to which they feel socially valued and supported can be a crucial factor in achieving and maintaining recovery (Rapier, McKernan & Stauffer, 2019). With this in mind, it is important to consider that in cases that recovery from alcohol is AA-driven, there might be some value in flexibly reframing the therapeutic encounter as not the centre of the recovery process, but rather as an additional layer of containment that is facilitative to the AA engagement and can support the person with negotiating the tensions and challenges that could emerge from it.

The value of such synergies seem to has been recognised at a policy level, with national clinical guidelines for alcohol dependence acknowledging the importance of the social context in both the attainment and maintenance of recovery (Department of Health and Social Care, 2017). To this end, it is suggested that clinicians will not only be aware of peer support schemes and mutual aid programmes such as Alcoholics Anonymous, but also demonstrate a positive attitude towards them, a factor that is considered to be influencing the service user's own attitudes and engagement with such groups (Department of Health and Social Care, 2017). Furthermore, it is also suggested that recovery navigators will adopt an active stance when it comes to linking service users with Alcoholics Anonymous, and thus go beyond passive signposting but consider co-attending initial meetings along with the service user in order to encourage their future engagement (Department of Health and Social Care, 2017). It is also important to note that similar considerations are observed at a local authority level around the UK, with initiatives such as Birmingham's "Reach Out Recovery" a programme that places particular emphasis in the social support that is available for service users and their linking with peer support schemes (Local Government Association, 2018), or Liverpool's holistic drop-in service, an initiative that provides service users with a space

of connection and social nourishment in spite of initial resistance by the local community (Local Government Association, 2018).

And yet despite the aforementioned, it is my experience that when it comes to the attitudes of counselling and psychotherapy practitioners, there is widespread scepticism regarding the value and merits of AA participation (Peele, 2015; Wiens & Walker, 2015). I have too often encountered colleagues from a variety of training backgrounds and therapeutic modalities expressing condemning views of the AA model as being inherently disempowering and shame-inducing (Gray, 2010; Peele, 2015; Wiens & Walker, 2015). I can sympathise with those views, as I too believe that the AA ethos is not without its problems, principal among which I would consider the pathologising of the individual that could be argued as inherent in the doctrine of "alcohol as a disease" (Peele, 2015). It is conceivable that such a conceptualisation of alcohol dependence could indeed have a disempowering effect on some people, as it would be reasonable to suggest that it fails to address the social determinants that contribute to this phenomenon (LaMarre et al., 2019). In practice, however, it is very often the case for many AA members to experience their participation as empowering and shame-alleviating (Bond & Csordas, 2014), a phenomenon that has been theorised to be tightly linked with them becoming integrated in a new social context which acknowledges their suffering and responds with compassion to their struggle of overcoming it (Kaskutas, Bond, & Humphreys, 2002).

As this study's small sample was able to demonstrate, there can be significant variance between client's attitudes and perceptions of AA, which leads me to suggest that it would be wise for psychological therapies to seek working alongside AA rather than in opposition to it. Some research has already been done in this area, which seems to be acknowledging the paradoxical empowerment that comes through AA's narratives of powerlessness and surrendering (Bond & Csordas, 2014). Yet it might be worth taking this one step further and consider the possible merits of broadening the integrative ethos that underpins most modern counselling, psychotherapy, and counselling psychology programmes, so that it would also encompass insights from approaches that do not sit with any established therapeutic modality, but like AA, they might have something valuable to contribute to our clients' wellbeing. Some steps towards this direction that could be implemented at a training level could be inviting AA members to share their experiences, thus giving the opportunity to trainee psychotherapists, psychologists and CBT practitioners to become aware and reflect on the possibility that counselling and psychotherapy might not be the singular answer to supporting this population.

The final, but no less crucial, point that emerges from this study's findings comes from my realisation that despite the obvious differences between AA and the SWAN's integrative ethos of long-term therapy, there was one key concept that those two approaches shared; That is the view of recovery as something dynamic - a process, rather than a destination to be arrived at. This key notion permeated through all participants' narratives, as they all saw alcohol not as the root cause of their suffering but as a symptom of a deeper malaise, that has social as well as individual determinants. In fact, the identified themes all come together to illustrate that recovery was experienced by my participants as a lengthy process that went beyond the simple cessation of drinking. Rather, it encompassed the exploration of the past trauma that made drinking necessary, as well as facilitated the gradual transformation of their inner monologue, so that their own self-compassion would in part take the place of alcohol for self-soothing. To quote Sharon: *"Once you put the drinking down, you know, you're left with yourself"*.

Indeed the conceptualisation of recovery from alcohol as a lengthy transformational process has long been voiced by the AA fellowship since its very inception (Schaberg, 2019), and the notion of addiction as a symptom and by-product of deeper trauma has been the focus of much deliberation in the academic community (Aaronson, 2006; Maté, 2008; Padykula & Conklin, 2010).

It appears that in recent years there has been a growing consideration of trauma in alcohol treatment. Services are encouraged to provide trauma-informed care by being mindful of service users that consume alcohol for self-medication, identifying trauma at the assessment stage, and prioritising recovery from trauma when assigning service users to clinical treatment (Department of Health and Social Care, 2017). And yet, I would argue that the extent to which trauma-informed care is implemented in the context of the UK-prevalent IAPT model is subject to debate.

An issue of major concern is the fact that assessments are often conducted by low intensity Psychological Wellbeing Practitioners (Binnie, 2015), whose limited expertise and brief, low-intensity training cannot account for cases of greater complexity. Furthermore, the IAPT practitioners' training in a prescriptive, manualised version of CBT has been heavily criticised for colluding with a medicalisation of the human experience that fails to acknowledge the nuance of unique individuality of the client (Williams, 2015; Conrad, 2007), being of limited efficacy in complex cases that don't neatly fit a straightforward diagnostic and prescription-based treatment

(Goodman, 2016; Strawbridge & Woolfe, 2010), and overlooking the importance of the therapeutic relationship (Leahy, 2008; Easterbrook & Meehan, 2017), but reducing this to its basic working alliance component, which is regarded as a vehicle for the effective administering of technique (Turner, Brown & Carpenter, 2018).

With the above criticisms in mind, it is worth considering that there is a real possibility for service users with more complex treatment needs could find themselves assigned to short-term goal-oriented programs, whose focus on improving alcohol outcomes, would fail to address whether such outcomes would be sustainable for people that have been effectively been deprived of the only way they have known to deal with distress (Laudet, Savage & Mahmood, 2011). My concern is that by approaching and treating alcohol in this manner, mental health services would be to some extend colluding with the aforementioned notion of blaming, as opposed to supporting, the victim of alcohol's abuse, and it is not unreasonable to suggest that by disregarding the underlying issues that necessitated alcohol use for self-soothing, many individuals would be effectively set up for failure. Indeed, there has been some indication that within the context of IAPT treatments, problematic alcohol use is associated with high drop-out rates from psychological therapies (Buckman et al., 2018), poor outcomes in the treatment of comorbid anxiety and depression (Boschloo et al., 2012), and there is some evidence to suggest that comorbid PTSD could further undermine post-treatment outcomes (Giebel, Clarkson & Challis, 2014; Van Minnen, Arntz & Keijsers, 2002). What is even worse, is that due to the social stigma around alcohol dependence, it is very likely that the failure of the system will become internalised as a failure of the self (Wachtel, 1999), thereby further fuelling feelings of shame that alcohol is always too eager to soothe.

Taking the aforemenntioned into consideration, I find myself firmly aligned with the view proposed by Gabor Mate that in order to heal alcohol dependence we need to address the underlying trauma (Maté, 2008), and shift from the question "why the addiction" to "why the pain" (Melnyk, 2008). In line with this view, Wanigaratne and Keaney (2002) have proposed an integrative stepped care approach to treating alcohol dependence. Their model suggests that the first step should indeed be to stabilise the disruptive alcohol use. However according to them this is only the beginning of a much lengthier process, as once stabilisation has been achieved then counselling and psychotherapy can and should move deeper towards the underlying issues of alcohol abuse (Wanigaratne & Keaney, 2002). Despite its limitations, I find myself admitting that the fellowship of Alcoholics Anonymous does indeed operate from an ethos of respect and appreciation towards the level of effort that is required in order to achieve in giving up this toxic

way of self-soothing in favour of healthier more fulfilling lives. With this in mind, I suggest that an integrative way of treating alcohol would be benefitted by incorporating this aspect of the AA ethos, and therefore move towards providing treatments that look beyond the condition but embrace the person in a holistic manner.

To this end, I recommend that the findings of the present study could inform future qualitative research that will seek to delve deeper into the experiences of individuals that have experienced both AA and counselling/psychotherapy as part of their recovery from alcohol dependence. As this was not the initial aim of this study, only a fragment of the already small sample has experienced and was able to provide insights of both approaches. I would suggest that a grounded theory methodology that will be specifically focusing on this population, will be able to build on or challenge the present findings, while also being in a better standing to propose ways that the two approaches can complement one another in an integrative manner. Future qualitative research could also provide additional insights on the concept of individuality, the surrendering of which was unappealing for some of this study's participants, but instrumental for others. Finally, and in addition to the above, it would be worth encouraging counselling, psychotherapy, and counselling psyhology trainees that have had been members of 12 step fellowships to engage with self-investigative methodologies such as autoethnography (Adams, Holman Jones & Ellis, 2002; Ellis & Bochner, 2000; Fixsen, 2021; Parker, 2020), and reflect further on this experience in the context of their foray into the counselling world. The reflections and insights that would emerge through such research projects would be invaluable in delineating further the tensions of opposition, as well as the opportunities for integration that can emerge through the marriage of those two worlds.

Evaluation & critical reflection

The present study is subject to the same limitations that are inherent in idiographic qualitative research, namely the conscious sacrifice of breadth in favour of depth. The small number of 5 participants sits within the suggested sample size for an IPA research (Smith, Flowers & Larkin, 2009), and indeed allowed for a nuanced exploration of their experiences by going beyond what was being directly communicated, instead querying their narratives in search for additional meanings that those could be conveying (Smith & Shinebourne, 2012). Nevertheless, it can be argued that a larger sample would have allowed for a greater range of participants' experiences, that would have better contextualised the phenomenon of recovery from alcohol addiction. The difficulty in recruitment is perhaps suggestive of a population that was hard to reach. Indeed, the

dominant model of treating alcohol addiction seems to fall within the confines of short-term, outcome-focused interventions, making long-term therapy somewhat of a rarity (McKay & Hiller-Sturmhöfel, 2011). Limiting my pool of recruitment to a single counselling organisation was in itself a recruitment challenge, but one that was deemed necessary as a means of securing a level of sample homogeneity (Larkin, Shaw & Flowers, 2019).

Still, despite the narrow criteria for recruitment, it was surprising to realise the extent to which my participants' experiences varied. An example of such diversity was the my participant's differential experiences of therapy and AA. More specifically, even though all participants had issues with alcohol since childhood, and despite long-term therapy having been a major part of their recovery, some of them considered AA to have been the main pillar that supported their journey, with counselling playing a secondary, facilitative role. Initially I considered this crucial difference as a compromising factor for the homogeneity of my sample, worrying as to whether my sample was effectively telling the story of 2 different life experiences as opposed to the exploration of a singular phenomenon. However as my analysis progressed I have come to cherish the variety of perspectives that my study was able to encompass. In doing so it effectively safeguarded me from presenting an oversimplified understanding of this phenomenon, instead enabling me to highlight the complexities and intricacies of addiction and recovery. This has very much influenced my outlook throughout the analysis, making me more sensitive to the notion that life is rarely as neat and tidy as academic manuscripts are often guilty of representing.

Perhaps another more crucial limitation stems from my own dual role as both a researcher and a volunteer therapist for the SWAN Alcohol Project, which could have contributed to problematic biases. This was my biggest concern about undertaking this study; to not allow my passion for therapy and my allegiance to the long-term therapeutic approach of the SWAN unwittingly transforming this research to an echo chamber of my own convictions, as opposed to an interpretation of my participants' sense-making. The use of my reflexive journal has been particularly valuable in helping me to remain aware and to bracket my internal processes throughout the data analysis stage. I found that the best way to make use of my journal was at times that I would either identify too strongly with the participant's words, or at times that I would feel particularly distant from their reality. In that sense my reflective notes mirrored my use of clinical supervision in which I would seek to explore my over-identification with my clients or my inability to connect with them.

It was through this constant exercise in reflexivity that I became vigilant about my own strong feelings and held values about alcohol counselling influencing even before commencing with the interviewing process. Having worked with this population in therapy since the beginning of my doctoral training 6 years ago, I have come to form my own opinions and ethos with regards to the recovery process and the role of counselling/psychotherapy in promoting that. I was aware, for example, of my strong resentment towards the manualisation of therapy that the IAPT model has been promoting in the UK (Goodman, 2016).). I consider this categorically incompatible with my own existential and phenomenological ethos of bringing the client to the forefront of the therapeutic interaction, as opposed to shoehorning their experience of life in uniform, one-size-fits-all prescriptive brackets. And yet, it was this very resentment that made me sensitive to the temptation of "herding" my participants narratives to walk the narrow path of my own understanding and values for the sake of producing a compelling and uncomplicated narrative of their experiences (Mazzei & Jackson, 2012), thereby committing the very same "sin" that I see as condemnable. In opting for the utilisation of Interpretative Phenomenological Analysis, I sought to mitigate that risk, by approaching the interview process not too dissimilarly than that of the therapeutic interaction. I sought to fully embrace my participant's phenomenology, attempting to park my own preconceptions to the side, in the same way that I would strive to do when receiving my client's realities as a holding, empathic vessel. Still, the interpretative element of the analysis has always been a firm reminder that such bracketing would not only be unrealistic, but also undesirable. The naive conviction that such a feat can be truly accomplished nearly rendered me oblivious to the subtle (and sometimes not so subtle) ways in which I actively contributed to the co-construction of my participants' meanings during the interview process and the subsequent analysis of their narratives (Jackson & Mazzei, 2009).

Nevertheless, my own anxiety to not overly "contaminate" my participants' responses with my own presuppositions, has manifested in a reluctance to be as present during the interview process. Consequently I admit having adopted a perhaps too passive stance of receiving their process as opposed to engaging in a more active dialogue that might have been facilitative in some of them (Simon would be a good example), unfolding their experiences in greater depth (Ellis & Berger, 2003). Even though my passive stance as an interviewer was predicated on the notion that the participants are the most credible sources of their lived experiences, it can be argued that this otherwise desirable phenomenological view is not unproblematic. As has been suggested by Rosenwald (1992) interview participants are unavoidably colouring the narrative of their respective life stories as they attempt to approximate the experiences of an earlier self that is no longer here

to tell their side of the story. It is therefore conceivable that in their process of sense-making they would punctuate, or omit facets of their experience in an attempt to forge a narrative that would be consistent with their present identities (Järvinen, 2000), as people who have successfully managed to liberate themselves from the chains of addiction.

Perhaps if I allowed myself to adopt a more active stance in co-creating this narrative alongside them during the interviews, I would have challenged their narratives a bit more in an attempt to dive further into the past and give voice to the self that once was. A clear example of such an opportunity was Matt's initial conviction that alcohol abuse was a completely pleasure-less experience. It fortunate that Matt himself challenged this towards the end of our interview, admitting to us both that there were indeed times where there was nothing else he would rather do but getting lost in the oblivion of intoxication. Another example was Sharon and Carol's internalisation of the AA doctrine and the almost religious fervour in which they surrendered their individual identity to the collective label of the alcoholic. It was clear to me that certain aspects of their experience were interpreted in such a way as to conform with AA narratives of the archetypal alcoholic's journey of powerlessness, surrendering, and hope through shared experience (Weegmann & Piwowoz-Hjort, 2009). However I still feel that in this instance it would have been inappropriate for me to challenge this script as it was very much instrumental to their process of recovery. I therefore strived to accept and embrace as part of their experience as opposed to challenging it with my own views of the individual as something to be celebrated and empowered through the self-exploration and self-understanding that individual therapy promotes.

However, even though I was able to respectfully embrace their experiences during the interview stage, it was not until the analysis of their narratives that I became fully aware of the limiting impact of my own process. I found myself bound to a conceptualisation of recovery as an intrapersonal phenomenon, which exerted a gravitational pull towards the aspects of my participants' narratives that pertained to shifts in their concept of self, effectively dismissing the interpersonal facets of their journey. It took many discussions with my supervisor and a great deal of patience from their part for me to eventually detach from this overzealous focus on the concept of self and open up to the ways in which my participants shaped and were shaped by their environment. In doing so I have in turn allowed myself to also be shaped by their narratives, thereby experiencing an "unravelling" of my own. I distinctly recall my discomfort in contemplating on the limitations of 1 to 1 therapy, as it was evident from some of my participants' experiences that this might not

have been enough to substitute the healing effect of belonging in the supportive social context that AA has offered.

My difficulty in flexibly broadening my focus to what lied outside the concept of the "self" is perhaps indicative of social narratives around happiness as an individual responsibility, a neoliberal notion that many have argued the world of psychotherapy is inadvertently guilty of perpetuating (Rustin, 2015). Indeed, it is too often the case that personal therapy, in seeking to hone in on the individual client's cognitive and emotional processes, does so at the risk of failing to appropriately position their distress within the systemic context of their environment (LaMarre et al., 2019). It is clear to me that this narrative has taken roots in the way that I approach and manage my own experience of distress. I consider the notion that the attainment of emotional health is within my control to have been a soothing port where I could weather my own struggles with depression. It has been empowering to be able to focus on the few things that I could influence with my own limited power when surrendering to hopelessness felt alluringly convincing. And yet, in the same way that compulsive rituals are often both the relief from but also the perpetuation of distress, so too a compulsive adherence to divorcing the individual's mental health struggles from the context within which those are generated serves to perpetuate this context in remaining unexamined and unchanged. In my case I was fortunate and privileged enough to be raised in a stable, loving family environment, and to be surrounded by empathic, supportive friends and colleagues with whom my distress could be shared and soothed. It is clear to me that the same cannot be said about my participants, whose suffering has largely been experienced in isolation and complete disconnect from a nourishing social context. As soon as I allowed myself to expand the scope of my analysis beyond the concept of the self, I found myself sinking in the same powerlessness they might have experienced, witnessing that much of their distress stemmed through aspects of life they had no control over. And scary though this place was, I could also see how liberating it must have been for them to admit that they were indeed powerless to affect change on their own. It was through this admission that they were motivated to seek support from something that was external to them, and indeed for some of them the non-judgmental environment of the 1:1 therapeutic interaction seems to have been insufficient. Some of them needed the radical transformation of their whole social network, and it's replacement by the supportive embrace of the AA fellowship, in order to feel validated, valued, and accepted.

Finally, it is important to note that the data analysis took place throughout the global crisis of the Covid19 pandemic. The unprecedented physical and emotional disconnect of a quarantined society has impacted me in ways that I had not anticipated, as I found myself regressing to an earlier time of emotional starvation due to revisiting past trauma of bullying and social exclusion. This was arguably the time when engaging with my reflective journal has been most useful, as I could see very clearly how my own behaviours started mirroring my participants' narratives. In a similar way to them I would find it progressively more difficult to contain my own distress without resorting to my own past maladaptive coping mechanisms such as comfort-eating. In that way I would opt for a dampening of my self-awareness while at the same time withdrawing from emotionally nourishing social bonds. Eventually I had to accept that my capacity to detach myself emotionally from my participants' narratives was severely compromised. However, it was perhaps due to those narratives of self-compassion through belongingness that I was motivated to eventually halt my research, instead seeking to become emotionally nourished by spending 6 months in my hometown, Athens, connecting with my family. I have only allowed myself to re-engage with the analysis process when I could feel that I was psychologically robust enough to reflect on, bracket, but also harness my own processes again.

Conclusion

It is broadly acknowledged that the issue of alcohol dependence has a severe negative impact on both the individual and society as a whole. Nevertheless, I am concerned that the short-term, outcome-focused interventions that seem to dominate it's treatment fail to consider the complexity of this phenomenon. It is my hope that the insights that emerged through this IPA study will offer a small contribution towards a greater appreciation of the underlying mental health concerns, as well as the social determinants that give rise to and perpetuate problematic alcohol use.

My participants' experiences of both long-term 1:1 therapy and AA participation have, in spite of the differences between the two settings, converged in suggesting that overcoming this issue is a lengthy process that requires a fundamental shift in the individual's self-concept, and a movement towards a self-compassionate inner monologue. Both psychological therapies and AA have been identified as having distinct strengths and limitations, which made the two approaches be more or less suitable and appealing for different people. However, in contemplating ways in which alcohol dependence could be better understood and treated, it is worth exploring the possibility of synergies that could emerge through integrating their respective strengths.

In providing a concluding reflection, I acknowledge that even though I made a conscious effort to resist the pull towards oversimplifying my participants' narratives to fall in line with my own understanding of addiction and recovery, it is inevitable that my experiences, convictions, and preconceptions have inadvertently formed lenses through which my participants' accounts were viewed, and this has at some level played a role in the generation of the study's themes. I realise that seeing alcohol as an abuser, emerges partly from my own experiences as a therapist where I found beneficial to parallel the experiences of client-survivors of domestic abuse, with the experience of breaking away from the clutches of addiction. The time that I spent reflecting on the alcoholic label, is undoubtedly the result of having personally grappled with this aspect of the AA experience when working with clients that attended 12 step meetings. I gravitated towards the concept of self-compassion as this has been one of the key notions that supported my own journey in managing depression and the self-harming comforting behaviours I would employ to escape my own inner critic.

There is no doubt that had the same participants been interviewed by a different researcher, both the emerging themes but also the interviews through which those emerged would have been

different, thereby giving birth to a different manuscript than the one that I was able to produce. And yet I embrace the unique and individual nature of this work, as the product of IPA's double hermeneutics that was made possible through the honesty and genuine interest that both I and my participants shared in collaborating together to make sense of their journey. It do not regard the findings of this study to comprise the one definite truth of my participants' experiences, but rather a truth, perhaps one of many, which doesn't make it any less valid or indeed valuable in contributing to our understanding of recovery from alcohol dependence.

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References

Aaronson, R. (2006). *Addiction-This being human: A New Perspective*. AuthorHouse.

Adams, T. E., Holman Jones, S., & Ellis, C. (2022). Introduction – making sense and taking action: Creating a caring community of Autoethnographers. In Adams, T. E., Holman Jones, S., & Ellis, C. (Eds.). *Handbook of Autoethnography* (2nd ed, pp. 1-20). Routledge.

Agosti, V., & Levin, F. R. (2006). The effects of alcohol and drug dependence on the course of depression. *American Journal on Addictions*, *15*(1), 71-75.

Ahern, J., Galea, S., Hubbard, A., Midanik, L., & Syme, S. L. (2008). "Culture of drinking" and individual problems with alcohol use. *American journal of epidemiology*, *167*(9), 1041-1049.

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies*, *5*(2), 9-19.

Alexander, B. K. (2012). Addiction: The urgent need for a paradigm shift. *Substance Use & Misuse*, *47*(13-14), 1475-1482.

American Psychiatric Association (APA). (2013). *Diagnostic and statisticalmanual of mental disorders* (5th ed.). Washington, DC: Author.

Balanzá-Martínez, V., Crespo-Facorro, B., González-Pinto, A., & Vieta, E. (2015). Bipolar disorder comorbid with alcohol use disorder: focus on neurocognitive correlates. *Frontiers in physiology*, *6*, 108.

Bateson, G. (1971). The cybernetics of "self": A theory of alcoholism. *Psychiatry*, *34*(1), 1-18.

Berking, M., Margraf, M., Ebert, D., Wupperman, P., Hofmann, S. G., & Junghanns, K. (2011). Deficits in emotion-regulation skills predict alcohol use during and after cognitive–behavioral therapy for alcohol dependence. *Journal of consulting and clinical psychology*, *79*(3), 307.

Berlin, H. A., & Montgomery, J. (2017). Neural basis of intrapsychic and unconscious conflict and repetition compulsion. In *Psychoanalytic Perspectives on Conflict* (pp. 260-277). Routledge.

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

Biernacki, P. (1990). Recovery from opiate addiction without treatment: A summary. *The collection and interpretation of data from hidden populations*, *98*, 113.

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative research in psychology*, *5*(3), 214-224.

Binnie, J. (2015). Do you want therapy with that? A critical account of working within IAPT. *Mental Health Review Journal*, *20*(2), 79-83.

Boden, J. M., & Fergusson, D. M. (2011). Alcohol and depression. *Addiction*, *106*(5), 906-914.

Bond, L. M., & Csordas, T. J. (2014). The paradox of powerlessness. *Alcoholism Treatment Quarterly*, *32*(2-3), 141-156.

Boschloo, L., Vogelzangs, N., van den Brink, W., Smit, J. H., Veltman, D. J., Beekman, A. T., & Penninx, B. W. (2012). Alcohol use disorders and the course of depressive and anxiety disorders. *The British Journal of Psychiatry*, *200*(6), 476-484.

Bostock, J. A. N., Plumpton, M., & Pratt, R. (2009). Domestic violence against women: Understanding social processes and women's experiences. *Journal of Community & Applied Social Psychology*, *19*(2), 95-110.

Borkman T. (2008). The Twelve-Step recovery model of AA: A voluntary mutual help association. In: L. Kaskutas & M. Galanter (Eds.), *Recent developments in alcoholism* (18th Vol., pp. 9-35). New York: Springer. doi: 10.1007/978-0-387-77725-2_2

Bradshaw, J. (2005). *Healing the shame that binds you.* Florida: Health Communications, Inc.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

British Psychological Society (2021). Code of Human Research Ethics. Retrieved from https://www.bps.org.uk/guideline/bps-code-human-research-ethics-0

Brooks, M., Kay-Lambkin, F., Bowman, J., & Childs, S. (2012). Self-compassion amongst clients with problematic alcohol use. *Mindfulness*, *3*(4), 308-317.

Brown, B. (2008). *I thought it was just me (but it isn't): telling the truth about perfectionism, inadequacy, and power*. New York: Gotham Books.

Brust, J. C. (2010). Ethanol and cognition: indirect effects, neurotoxicity and neuroprotection: a review. *International journal of environmental research and public health*, *7*(4), 1540-1557.

Buckman, J. E. J., Naismith, I., Saunders, R., Morrison, T., Linke, S., Leibowitz, J., & Pilling, S. (2018). The impact of alcohol use on drop-out and psychological treatment outcomes in improving access to psychological therapies services: an audit. *Behavioural and cognitive psychotherapy*, *46*(5), 513-527.

Buckner, J. D., Eggleston, A. M., & Schmidt, N. B. (2006). Social anxiety and problematic alcohol consumption: The mediating role of drinking motives and situations. *Behavior therapy*, *37*(4), 381-391.

Buckingham, S. A., Frings, D., & Albery, I. P. (2013). Group membership and social identity in addiction recovery. *Psychology of Addictive Behaviors*, *27*(4), 1132.

Cain, C. (1991). Personal Stories: Identity acquisition and self-understanding in Alcoholics Anonymous. *Ethos*, *19*(2), 210-253.

Carlyle, M., Rockliff, H., Edwards, R., Ene, C., Karl, A., Marsh, B., ... & Morgan, C. J. (2019). Investigating the feasibility of brief compassion focused therapy in individuals in treatment for opioid use disorder. *Substance Abuse: Research and Treatment*, *13*, 1178221819836726.

Carvalho, A. F., Heilig, M., Perez, A., Probst, C., & Rehm, J. (2019). Alcohol use disorders. *The Lancet*, *394*(10200), 781-792.

Chaudhury, S., Prakash, J., Walia, T. S., Seby, K., Sukumaran, S., & Kumari, D. (2010). Psychological distress in alcohol dependence syndrome. Journal of Projective Psychology & Mental Health, 17(1), 38–44.

Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The psychologist*, *26*(2), 120-123.

Clay, R. A. (2010). More than one way to measure. *Monitor on Psychology*, *41*(8), 52-55.

Cohen, J., Tracy, S., Rodriguez, F., & Bowers, R. (2020). Therapeutic Change Factors in Alcoholics Anonymous. *The Person Centered Journal,* Vol. 25, No. 1-2

Connors, G. J., Carroll, K. M., DiClemente, C. C., Longabaugh, R., & Donovan, D. M. (1997). The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. *Journal of consulting and clinical psychology*, *65*(4), 588.

Conrad, P. (2007). *The medicalization of society: on the transformation of human conditions into treatable disorders* (Vol. 14). Baltimore: Johns Hopkins University Press.

Cook, S., Heather, N., & McCambridge, J. (2015). The role of the working alliance in treatment for alcohol problems. *Psychology of addictive behaviors*, *29*(2), 371.

Cooper, M. L., Kuntsche, E., Levitt, A., Barber, L. L., & Wolf, S. (2016). Motivational models of substance use: A review of theory and research on motives for using alcohol, marijuana, and tobacco.

Corrao, G., Rubbiati, L., Bagnardi, V., Zambon, A., & Poikolainen, K. (2000). Alcohol and coronary heart disease: a meta-analysis. *Addiction*, *95*(10), 1505-1523.

Craparo, G., Ardino, V., Gori, A., & Caretti, V. (2014). The relationships between early trauma, dissociation, and alexithymia in alcohol addiction. *Psychiatry investigation*, *11*(3), 330.

Creswell, J. W. (2013). Qualitative inquiry and research design: Choosing among five approaches (3rd ed.). Thousand Oaks, CA: Sage.

Crisp, A., Cowan, L., & Hart, D. (2004). The College's anti-stigma campaign, 1998–2003: a shortened version of the concluding report. *Psychiatric Bulletin*, *28*(4), 133-136.

Crum, R. M.,&Pratt, L. A. (2001). Risk of heavy drinking and alcohol use disorders in social phobia: A prospective analysis. American Journal of Psychiatry, 158, 1693–1700.

Cutler, R. B., & Fishbain, D. A. (2005). Are alcoholism treatments effective? The Project MATCH data. *BMC Public Health*, *5*(1), 1.

Davies, J. B. (2013). *Myth of addiction*. Routledge.

Dark-Freudeman, A., Pond Jr, R. S., Paschall, R. E., & Greskovich, L. (2020). Attachment style in adulthood: Attachment style moderates the impact of social support on depressive symptoms. *Journal of Social and Personal Relationships*, *37*(10-11), 2871-2889.

Dearing, R. L., Stuewig, J., & Tangney, J. P. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use. *Addictive behaviors*, *30*(7), 1392-1404.

Delaney, M. E. (2017). The relationship between counseling, social support, and depression in mothers of fragile families. *Journal of Mental Health Counseling*, *39*(4), 320-334.

Department of Health and Social Care. (2017, July 14). *Drug misuse and dependence: UK guidelines on clinical management*. https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

Derin, S., Selman, S. B., Alyanak, B., & Soylu, N. (2022). The role of adverse childhood experiences and attachment styles in social anxiety disorder in adolescents. *Clinical child psychology and psychiatry*, 13591045221078085.

DeRobertis, E. M. (1996) *Phenomenological Psychology: A Text for Beginners*. Lanham, MD: University Press of America

De Visser, R. O., & Smith, J. A. (2007). Alcohol consumption and masculine identity among young men. *Psychology and health*, *22*(5), 595-614.

De Visser, R. O., & Smith, J. A. (2007). Young men's ambivalence toward alcohol. *Social Science & Medicine*, *64*(2), 350-362.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical education*, *40*(4), 314-321.

DiClemente, C. C., Bellino, L. E., & Neavins, T. M. (1999). Motivation for change and alcoholism treatment. *Alcohol Research and Health*, *23*(2), 87-92.

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

Dixon, L. J., Leen-Feldner, E. W., Ham, L. S., Feldner, M. T., & Lewis, S. F. (2009). Alcohol use motives among traumatic event-exposed, treatment-seeking adolescents: Associations with posttraumatic stress. *Addictive behaviors*, *34*(12), 1065-1068.

Dodgen, C. E., & Shea, W. M. (2000). *Substance use disorders: Assessment and treatment*. Elsevier.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works in therapy*. American Psychological Association.

Easterbrook, C. J., & Meehan, T. (2017). The therapeutic relationship and cognitive behavioural therapy: A case study of an adolescent girl with depression. *The European Journal of Counselling Psychology*, *6*(1).

Eatough, V., & Smith, J. (2006). I was like a wild wild person: Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology*, *97*(4), 483-498.

Ellis, C., & Berger, L. (2003). Their story/my story/our story: Including the researcher's experience in interview research. *Postmodern interviewing*, 157-183.

Ellis, C., & Bochner, A. P. (2000). Autoethnography, personal narrative, reflexivity. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage Handbook of qualitative research* (2nd ed., pp. 733-768). Sage.

van Emmerik-van Oortmerssen, K., van de Glind, G., van den Brink, W., Smit, F., Crunelle, C. L., Swets, M., & Schoevers, R. A. (2012). Prevalence of attention-deficit hyperactivity disorder in substance use disorder patients: a meta-analysis and meta-regression analysis. *Drug and alcohol dependence*, *122*(1-2), 11-19.

Erozkan, A. (2016). The Link between Types of Attachment and Childhood Trauma. *Universal journal of educational research*, *4*(5), 1071-1079.

Fernández-Solà, J., & Nicolás-Arfelis, J. M. (2002). Gender differences in alcoholic cardiomyopathy. *The journal of gender-specific medicine: JGSM: the official journal of the Partnership for Women's Health at Columbia*, *5*(1), 41-47.

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the" phenomenological psychological attitude". *Journal of phenomenological psychology*, *39*(1), 1-32.

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. John Wiley & Sons.

Fixsen, A. (2021). Fragile minds, porous selves: Shining a light on Autoethnography of mental illness. *Qualitative Social Work*, *0*(0), 1–19.

Flaherty, M. T., Kurtz, E., White, W. L., & Larson, A. (2014). An interpretive phenomenological analysis of secular, spiritual, and religious pathways of long-term addiction recovery. *Alcoholism Treatment Quarterly*, *32*(4), 337-356.

Flores, P. J. (2001). Addiction as an attachment disorder: Implications for group therapy. *International Journal of Group Psychotherapy*, *51*(1: Special issue), 63-81.

Fonagy, P. (2018). Attachment, trauma, and psychoanalysis: Where psychoanalysis meets neuroscience. In *Early development and its disturbances* (pp. 53-75). Routledge.

Freud, S. (1920). Beyond the pleasure principle. *SE*, *18*, 7-66.

Frostadottir, A. D., & Dorjee, D. (2019). Effects of mindfulness based cognitive therapy (MBCT) and compassion focused therapy (CFT) on symptom change, mindfulness, self-compassion, and rumination in clients with depression, anxiety, and stress. *Frontiers in psychology*, *10*, 1099.

Gatt, A. (2005). *Clients' and counsellors' perceptions of helpful and hindering events in outpatient drug addiction counselling* (Doctoral dissertation, University of British Columbia).

Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative health research*, *14*(10), 1429-1452.

Gianoulakis, C. (2001). Influence of the endogenous opioid system on high alcohol consumption and genetic predisposition to alcoholism. *Journal of psychiatry & neuroscience*.

Giebel, C. M., Clarkson, P., & Challis, D. (2014). Demographic and clinical characteristics of UK military veterans attending a psychological therapies service. *The psychiatric bulletin*, *38*(6), 270-275.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6-41.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *13*(6), 353-379.

Giorgi, A. (2010). Phenomenology and the practice of science. *Existential Analysis: Journal of the Society for Existential Analysis*, *21*(1).

Goodman, D. M. (2016). The McDonaldization of psychotherapy: Processed foods, processed therapies, and economic class. *Theory & Psychology*, *26*(1), 77-95.

Goodwin, D. W. (2000). *Alcoholism, the facts*. Oxford University Press, USA.

Gordon, K. (2015). Understanding Compassion-Focused Therapy from a Participant's Perspective.

Goss, K., & Allan, S. (2012). An Introduction to Compassion-Focused Therapy for Eating Disorders (CFT-E). *Eating and its disorders*, 303-314.

Grant, B. F., Goldstein, R. B., Saha, T. D., Chou, S. P., Jung, J., Zhang, H., ... & Hasin, D. S. (2015). Epidemiology of DSM-5 alcohol use disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions III. *JAMA psychiatry*, *72*(8), 757-766.

Gray, R. (2009). The dynamics of shame: Implications for counsellors working in alcohol and other drug settings. *Psychotherapy in Australia*, *16*(1), 30.

Gray, R. (2010). Shame, labeling and stigma: Challenges to counseling clients in alcohol and other drug settings. *Contemporary drug problems*, *37*(4), 685-703.

Groh, D. R., Jason, L. A., & Keys, C. B. (2008). Social network variables in alcoholics anonymous: A literature review. *Clinical psychology review*, *28*(3), 430-450.

Gubi, P. M., & Marsden-Hughes, H. (2013). Exploring the processes involved in long-term recovery from chronic alcohol addiction within an abstinence-based model: Implications for practice. *Counselling and Psychotherapy Research*, *13*(3), 201-209.

Guy, N., Newton-Howes, G., Ford, H., Williman, J., & Foulds, J. (2018). The prevalence of comorbid alcohol use disorder in the presence of personality disorder: systematic review and explanatory modelling. *Personality and Mental Health*, *12*(3), 216-228.

Harris Jr, J. D. (2011). *Maintaining abstinence from substance use: A grounded theory investigation* (Doctoral dissertation, Capella University).

Hatfield, F. (2019). Caught in the Net of the Divine: Archetypal Roots of Alcoholics Anonymous in Euripides's Bacchae. *Jung Journal*, *13*(4), 53-71.

Hein, S. F., & Austin, W. J. (2001). Empirical and hermeneutic approaches to phenomenological research in psychology: A comparison. *Psychological methods*, *6*(1), 3.

Hill, J. V., & Leeming, D. (2014). Reconstructing 'the alcoholic': recovering from alcohol addiction and the stigma this entails. *International Journal of Mental Health and Addiction*, *12*(6), 759-771.

Hoffmann, H. C. (2006). Criticism as deviance and social control in Alcoholics Anonymous. *Journal of Contemporary Ethnography*, *35*(6), 669-695.

Hunter-Reel, D., McCrady, B. S., Hildebrandt, T., & Epstein, E. E. (2010). Indirect Effect of Social Support for Drinking on Drinking Outcomes: The Role of Motivation. *Journal of studies on alcohol and drugs*, *71*(6), 930-937.

Iancu, I., Bodner, E., & Ben-Zion, I. Z. (2015). Self esteem, dependency, self-efficacy and self-criticism in social anxiety disorder. *Comprehensive psychiatry*, *58*, 165-171.

Ioannou, M., Kassianos, A. P., & Symeou, M. (2019). Coping with depressive symptoms in young adults: perceived social support protects against depressive symptoms only under moderate levels of stress. *Frontiers in psychology*, 2780.

Jackson, A. Y., & Mazzei, L. A. (2009). Voice in qualitative inquiry. *Challenging conventional, interpretive, and critical conceptions in qualitative research*.

Jacobsen, L. K., Southwick, S. M., & Kosten, T. R. (2001). Substance use disorders in patients with posttraumatic stress disorder: a review of the literature. *American Journal of Psychiatry*, *158*(8), 1184-1190.

Järvinen, M. (2000). The biographical illusion: Constructing meaning in qualitative interviews. *Qualitative inquiry*, *6*(3), 370-391.

Johnson, C., Schaller, M., & Mullen, B. (2000). Social categorization and stereotyping:'You mean I'm one of "them"?'. *British Journal of Social Psychology*, *39*(1), 1-25.

Johnson, B. (2013). Addiction and will. *Frontiers in human neuroscience*, *7*, 545.

Jones, B. T., Corbin, W., & Fromme, K. (2001). A review of expectancy theory and alcohol consumption. *Addiction*, *96*(1), 57-72.

Kaskutas, L. A., Bond, J., & Humphreys, K. (2002). Social networks as mediators of the effect of Alcoholics Anonymous. *Addiction*, *97*(7), 891-900.

Kaufman, G. (2004). *The psychology of shame: Theory and treatment of shame-based syndromes*. Springer Publishing Company.

Kelly, J. F. (2003). Self-help for substance-use disorders: History, effectiveness, knowledge gaps, and research opportunities. *Clinical psychology review*, *23*(5), 639-663.

Kelly, J. F., Magill, M., & Stout, R. L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. *Addiction Research & Theory*, *17*(3), 236-259.

Kelly, J. F., Stout, R. L., Magill, M., Tonigan, J. S., & Pagano, M. E. (2010). Mechanisms of behavior change in alcoholics anonymous: does Alcoholics Anonymous lead to better alcohol use outcomes by reducing depression symptoms?. *Addiction*, *105*(4), 626-636.

Kerenyi, C. (1976). Dionysos: Archetypal image of indestructible life, trans. *Ralph Manheim. New Jersey*.

Keyes, K. M., Hatzenbuehler, M. L., McLaughlin, K. A., Link, B., Olfson, M., Grant, B. F., & Hasin, D. (2010). Stigma and treatment for alcohol disorders in the United States. *American Journal of Epidemiology*, *172*(12), 1364-1372.

Khantzian, E. J. (1994). Some treatment implications of the ego and self disturbances in alcoholism.

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard review of psychiatry*, *4*(5), 231-244.

Khantzian, E. J. (2003). The self-medication hypothesis revisited: the dually diagnosed patient. Primary Psychiatry, 10(9), 47–54.

Khantzian, E. J. (2012). Reflections on treating addictive disorders: A psychodynamic perspective. *The American journal on addictions*, *21*(3), 274-279.

Khantzian, E. J. (2014). The Self-Medication Hypothesis and attachment theory: pathways for understanding and ameliorating addictive suffering. *Addictions From an Attachment Perspective: Do Broken Bonds and Early Trauma Lead to Addictive Behaviours?*, 33.

Khantzian, E. J. (2021). Commentary: It Is Not About Supply, It Is About Demand: Why the Self-Medication Hypotheses Is Still So Important. *The American Journal on Addictions*, *30*(4), 301-304.

King, M., Dinos, S., Shaw, J., Watson, R., Stevens, S., Passetti, F., Weich, S., & Serfaty, M. (2007). The stigma scale: Development of a standardised measure of stigma and mental illness. *British Journal of Psychiatry, 190*, 248-254.

Klingemann, H., & Gmel, G. (Eds.). (2001). *Mapping the social consequences of alcohol consumption*. Dordrecht: Kluwer Academic Publishers.

Koob, G. F., & Le Moal, M. (2008). Neurobiological mechanisms for opponent motivational processes in addiction. *Philosophical Transactions of the Royal Society B: Biological Sciences*, *363*(1507), 3113-3123.

Koski-Jannes, A. (2002). Social and personal identity projects in the recovery from addictive behaviours. *Addiction Research and Theory*, *10*(2), 183-202.

Koskinen, J., Löhönen, J., Koponen, H., Isohanni, M., & Miettunen, J. (2009). Prevalence of alcohol use disorders in schizophrenia–a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, *120*(2), 85-96.

Kubicek, K. R., Morgan, O. J., & Morrison, N. C. (2002). Pathways to long-term recovery from alcohol dependence: Comparison of spontaneous remitters and AA members. *Alcoholism Treatment Quarterly*, *20*(2), 71-81.

Kuntsche, E., Knibbe, R., Gmel, G., & Engels, R. (2005). Why do young people drink? A review of drinking motives. *Clinical psychology review*, *25*(7), 841-861.

Kushner, M. G., Abrams, K., & Borchardt, C. (2000). The relationship between anxiety disorders and alcohol use disorders: a review of major perspectives and findings. Clinical Psychology Review, 20(2), 149–171.

Kurtz, E. (2002). Alcoholics Anonymous and the disease concept of alcoholism. *Alcoholism Treatment Quarterly*, *20*(3-4), 5-3.

LaMarre, A., Smoliak, O., Cool, C., Kinavey, H., & Hardt, L. (2019). The normal, improving, and productive self: Unpacking neoliberal governmentality in therapeutic interactions. *Journal of Constructivist Psychology*, *32*(3), 236-253.

Larkin, M., Shaw, R., & Flowers, P. (2019). Multiperspectival designs and processes in interpretative phenomenological analysis research. *Qualitative Research in Psychology*, *16*(2), 182-198.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative research in psychology*, *3*(2), 102-120.

Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of substance abuse treatment*, *33*(3), 243-256.

Laudet, A. B., Savage, R., & Mahmood, D. (2011). Pathways to long-term recovery: A preliminary investigation. *Journal of Psychoactive Drugs, 34*, 305-311.

Laudet, A. B., & White, W. L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction, and stress among former poly-substance users. *Substance use & misuse*, *43*(1), 27-54.

Lawrence, T. I., Mcfield, A. A., Byrne, M. M., S. Tarver, S., & Stewart, T. K. (2023). Depression and substance use as consequences of exposure to family violence: a moderation mediation and self-medication hypothesis study. *Journal of Child & Adolescent Trauma*, *16*(1), 69-79.

Leahy, R. L. (2008). The therapeutic relationship in cognitive-behavioral therapy. *Behavioural and Cognitive Psychotherapy*, *36*(6), 769-777.

Leeming, D., & Boyle, M. (2013). Managing shame: An interpersonal perspective. *British journal of social psychology*, *52*(1), 140-160.

Le, C., Ingvarson, E. P., & Page, R. C. (1995). Alcoholics Anonymous and the counseling profession: Philosophies in conflict. *Journal of Counseling and Development: JCD*, *73*(6), 603.

Lee, C. M., Fairlie, A. M., Ramirez, J. J., Patrick, M. E., Luk, J. W., & Lewis, M. A. (2020). Self-fulfilling prophecies: Documentation of real-world daily alcohol expectancy effects on the experience of specific positive and negative alcohol-related consequences. *Psychology of Addictive Behaviors*, *34*(2), 327.

LeTendre, M. L., & Reed, M. B. (2017). The effect of adverse childhood experience on clinical diagnosis of a substance use disorder: Results of a nationally representative study. *Substance use & misuse*, *52*(6), 689-697.

Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric services*, *52*(12), 1621-1626.

Litt, M. D., Kadden, R. M., Kabela-Cormier, E., & Petry, N. M. (2009). Changing network support for drinking: network support project 2-year follow-up. *Journal of consulting and clinical psychology*, *77*(2), 229.

Lloyd, D. A., & Turner, R. J. (2008). Cumulative lifetime adversities and alcohol dependence in adolescence and young adulthood. Drug and Alcohol Dependence, 93(3), 217–226.

Local Government Association. (2018, August 29). *Working Together. Helping to support and transform the lives of people affected by drug and alcohol problems.* Local Government Association. https://www.local.gov.uk/sites/default/files/documents/22%2029%20Substance%20Misuse%20Case%20Studies_05WEB.pdf

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., & Fletcher, L. (2012). Slow and steady wins the race: a randomized clinical trial of acceptance and commitment therapy targeting shame in substance use disorders. *Journal of consulting and clinical psychology*, *80*(1), 43.

Maté, G. (2008). *In the realm of hungry ghosts: Close encounters with addiction*. Random House Digital, Inc.

Maté, G. (2012). Addiction: Childhood trauma, stress and the biology of addiction. *Journal of Restorative Medicine*, *1*(1), 56-63.

Maté, G. (2022). Beyond the medical model: Addiction as a response to trauma and stress. In *Evaluating the brain disease model of addiction* (pp. 431-443). Routledge.

Matos, M., & Steindl, S. R. (2020). "You are already all you need to be": A case illustration of compassion-focused therapy for shame and perfectionism. *Journal of Clinical Psychology*, *76*(11), 2079-2096.

Mazzei, L. A., & Jackson, A. Y. (2012). Complicating voice in a refusal to "let participants speak for themselves". *Qualitative inquiry*, *18*(9), 745-751.

McCrady, B. S. (1994). Alcoholics Anonymous and behavior therapy: Can habits be treated as diseases? Can diseases be treated as habits?. *Journal of Consulting and Clinical Psychology*, *62*(6), 1159.

McGovern, T. F., & White, W. (2014). *Alcohol problems in the United States: Twenty years of treatment perspective*. Routledge.

McIntosh, J. and McKeganey, N. (2000). 'Addicts' narratives of recovery from drug-use: constructing a non-addict identity'. Social Science and Medicine. 50, p1501-1510.

McKay, J. R., & Hiller-Sturmhöfel, S. (2011). Treating alcoholism as a chronic disease: approaches to long-term continuing care. *Alcohol Research & Health*, *33*(4), 356.

McKeganey, J. M. N. (2001). Identity and recovery from dependent drug use: The addict's perspective. *Drugs: education, prevention and policy*, *8*(1), 47-59.

McKellar, J., Stewart, E., & Humphreys, K. (2003). Alcoholics Anonymous involvement and positive alcohol-related outcomes: Cause, consequence, or just a correlate? A prospective 2-year study of 2,319 alcohol-dependent men. *Journal of Consulting and Clinical Psychology*, *71*(2), 302.

Measham, F., & Brain, K. (2005). 'Binge'drinking, British alcohol policy and the new culture of intoxication. *Crime, media, culture*, *1*(3), 262-283.

Melnyk, S. (2008, March 19). *Gabor Maté on Addiction and Love.* The Tyee. Retrieved from: https://thetyee.ca/Books/2008/03/19/HungryGhosts/

Medina, M. (2013). *The paradox of self surrender and self empowerment: an interpretative phenomenological investigation of the individual's understanding of the higher power in Alcoholics Anonymous* (Doctoral dissertation, Middlesex University/New School of Psychotherapy and Counselling).

Mitchell, J. M., O'Neil, J. P., Janabi, M., Marks, S. M., Jagust, W. J., & Fields, H. L. (2012). Alcohol consumption induces endogenous opioid release in the human orbitofrontal cortex and nucleus accumbens. *Science translational medicine*, *4*(116), 116ra6-116ra6.

Mohr, C. D., Brannan, D., Mohr, J., Armeli, S., & Tennen, H. (2008). Evidence for positive mood buffering among college student drinkers. *Personality and Social Psychology Bulletin*, *34*(9), 1249-1259.

Morgenstern, J., Labouvie, E., McCrady, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of consulting and clinical psychology*, *65*(5), 768.

Morris, J., Moss, A. C., Albery, I. P., & Heather, N. (2022). The "alcoholic other": Harmful drinkers resist problem recognition to manage identity threat. *Addictive behaviors*, *124*, 107093.

Neff, Kristin D. 2011. "Self-Compassion, Self-Esteem, and Well-Being." *Social and Personality Psychology Compass* 5(1): 1-12.

Nicolaides, N. C., Kyratzi, E., Lamprokostopoulou, A., Chrousos, G. P., & Charmandari, E. (2015). Stress, the stress system and the role of glucocorticoids. *Neuroimmunomodulation*, *22*(1-2), 6-19.

Nicolosi, J. J. (2009) *Shame and attachment loss: the practical work of reparative therapy*. Downers Grove, Illinois: IVP Academic.

Nietzsche, F. (2017). The birth of tragedy. In *Aesthetics* (pp. 330-334). Routledge.

Obuna, B. C., Hayes, C., & Fulton, J. (2016). Factors Influencing Levels of Alcohol Misuse in UK Adolescents; A Systematic Literature Review. *International Journal of Current Research*, *8*(10).

Oei, T. P., & Morawska, A. (2004). A cognitive model of binge drinking: The influence of alcohol expectancies and drinking refusal self-efficacy. *Addictive behaviors*, *29*(1), 159-179.

Oliveira, L. M., Bermudez, M. B., de Amorim Macedo, M. J., & Passos, I. C. (2018). Comorbid social anxiety disorder in patients with alcohol use disorder: a systematic review. *Journal of psychiatric research*, *106*, 8-14.

Orford, J., Dalton, S., Hartney, E., Ferrins-Brown, M., Kerr, C., & Maslin, J. (2002). How is excessive drinking maintained? Untreated heavy drinkers' experiences of the personal benefits and drawbacks of their drinking. *Addiction Research & Theory*, *10*(4), 347-372.

Padykula, N. L., & Conklin, P. (2010). The self regulation model of attachment trauma and addiction. *Clinical Social Work Journal*, *38*(4), 351-360.

Parker, I. (2020). Psychology through critical Auto-ethnography: Instituting education. *AWRY: Journal of Critical Psychology, 1*(1), 3-13.

Paterson, A.S. (1997). *A humanistic framework for interviewer skills*. Paper presented at the British Educational Research Association Annual Conference 11-14th September 1997

Pattison, S. (2000). *Shame: Theory, therapy, theology*. Cambridge University Press.

Patrick, M. E., Terry-McElrath, Y. M., & Bonar, E. E. (2021). Patterns and predictors of high-intensity drinking and implications for intervention. *Psychology of addictive behaviors*.

Peele, S. (2015, January 02). American addiction treatment is shame-based. *Psychology Today*. Retrieved from https://www.psychologytoday.com/blog/addiction-in-society/201501/american-addiction-treatment-is-shame-based

Pendery, M. L., Maltzman, I. M., & West, L. J. (1982). Controlled drinking by alcoholics? New findings and a reevaluation of a major affirmative study. *Science*, *217*(4555), 169-175.

Phelps, C. L., Paniagua, S. M., Willcockson, I. U., & Potter, J. S. (2018). The relationship between self-compassion and the risk for substance use disorder. *Drug and alcohol dependence*, *183*, 78-81

Pincock, S. (2003). Binge drinking on rise in UK and elsewhere. *The Lancet*, *362*(9390), 1126-1127.

Pollner, M., & Stein, J. (2001). Doubled over in laughter: Humour and the construction of selves in Alcoholics Anonymous. In J. F. Gubrium & J. A. Holstein (Eds.), *Institutional selves: Troubled identities in a postmodern world* (pp. 46-63). New York: Oxford University Press

Potter-Efron, R. (2002). *Shame, guilt, and alcoholism* (2nd ed.). New York: Haworth Press..

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1997). In search of how people change: Applications to addictive behaviors. *Addictions Nursing Network*, *5*(1), 2-16.

Project MATCH Research Group. (1997). Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH Posttreatment drinking outcomes. *J. stud. alcohol*, *58*, 7-29.

Quello, S. B., Brady, K. T., & Sonne, S. C. (2005). Mood disorders and substance use disorder: a complex comorbidity. *Science & Practice Perspectives*, *3*(1), 13.

Ramirez, J. J., Rhew, I. C., Patrick, M. E., Larimer, M. E., & Lee, C. M. (2020). A daily-level analysis of moderators of the association between alcohol expectancies and alcohol use among college student drinkers. *Substance use & misuse*, *55*(6), 973-982.

Rapier, R., McKernan, S., & Stauffer, C. S. (2019). An inverse relationship between perceived social support and substance use frequency in socially stigmatized populations. *Addictive behaviors reports*, *10*, 100188.

Rehm, J., Baliunas, D., Borges, G. L., Graham, K., Irving, H., Kehoe, T., ... & Taylor, B. (2010). The relation between different dimensions of alcohol consumption and burden of disease: an overview. *Addiction*, *105*(5), 817-843.

Rehm, J. (2011). The risks associated with alcohol use and alcoholism. *Alcohol research & health: the journal of the National Institute on Alcohol Abuse and Alcoholism*, *34*(2), 135.

Rice, S. L., & Tonigan, J. S. (2012). Impressions of Alcoholics Anonymous (AA) group cohesion: A case for a nonspecific factor predicting later AA attendance. *Alcoholism treatment quarterly*, *30*(1), 40-51.

Ridley, N. J., Draper, B., & Withall, A. (2013). Alcohol-related dementia: an update of the evidence. *Alzheimer's research & therapy*, *5*, 1-8.

Robinson, T. E., & Berridge, K. C. (2008). The incentive sensitization theory of addiction: some current issues. *Philosophical Transactions of the Royal Society B: Biological Sciences*, *363*(1507), 3137-3146.

Roehrle, B. and Strouse, J. (2008). Influence of social support on success of therapeutic interventions: A meta-analytic review. Psychotherapy: Theory, Research, Practice, Training, 45(4), 464-476

Rogers, C. (2012). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin Harcourt.

Romo, L. K., Dinsmore, D. R., & Watterson, T. C. (2016). "Coming out" as an alcoholic: How former problem drinkers negotiate disclosure of their nondrinking identity. *Health Communication*, *31*(3), 336-345.

Romo, L. K., & Obiol, M. E. (2021). How People in Recovery Manage the Stigma of Being an Alcoholic. *Health Communication*, 1-11.

Rosenwald, G. C. (1992). Conclusion: Reflections on narrative self-understanding. *Storied lives: The cultural politics of self-understanding*, 265-289.

Rowen, S. L. (2003). The Treatment of Alcohol Dependence in Ireland. *Studies: An Irish Quarterly Review*, *92*(367), 243-247.

Rubin, H. J., & Rubin, I. S. (2011). *Qualitative interviewing: The art of hearing data*. Sage.

Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences and initiatives to reduce stigma. *European Psychiatry, 20*, 529-539.

Ruscio, J. (2004). Diagnoses and the Behaviors They Denote: A Critical Evaluation of the Labeling Theory of Mental Illness. *The Scientific Review of Mental Health Practice: Objective Investigations of Controversial and Unorthodox Claims in Clinical Psychology, Psychiatry, and Social Work*.

Rustin, M. (2015). Psychotherapy in a neoliberal world. *European Journal of Psychotherapy & Counselling*, *17*(3), 225-239.

Sanderson, C. (2015). *Counselling Skills for Working with Shame*. Jessica Kingsley Publishers.

Sawer, F. (2016). *The Role of Shame in Alcohol Dependence: Narratives from Those in Recovery*. University of Surrey (United Kingdom).

Schaberg, W. H. (2019). *Writing the big book: The creation of AA*. Central Recovery Press.

Schindler, A. (2019). Attachment and substance use disorders—theoretical models, empirical evidence, and implications for treatment. *Frontiers in psychiatry*, *10*, 727.

Schoepf, D., & Heun, R. (2015). Alcohol dependence and physical comorbidity: Increased prevalence but reduced relevance of individual comorbidities for hospital-based mortality during a 12.5-year observation period in general hospital admissions in urban North-West England. *European Psychiatry*, *30*(4), 459-468.

Schomerus, G., Corrigan, P. W., Klauer, T., Kuwert, P., Freyberger, H. J., & Lucht, M. (2011). Self-stigma in alcohol dependence: consequences for drinking-refusal self-efficacy. *Drug and alcohol dependence*, *114*(1), 12-17.

Schomerus, G. (2014). The stigma of alcohol and other substance abuse.

Schwartz, B., & Ward, A. (2004). Doing better but feeling worse: The paradox of choice. *Positive psychology in practice*, 86-104.

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

Smith, J., Flowers, P., & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. London: Sage

Smith, J. A., Hayes, N. D., & Smock Jordan, S. (2019). Systemic integration of IFS therapy and 12-step facilitation for substance use: A theoretical discussion. *Alcoholism Treatment Quarterly*, *37*(1), 60-74.

Smith, J.A. & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), Qualitative psychology: A practical guide to research methods (pp.51–80). London: Sage

Smith, J. A., & Shinebourne, P. (2012). *Interpretative phenomenological analysis*. American Psychological Association.

Sobell, M. B., & Sobell, L. C. (1976). Second year treatment outcome of alcoholics treated by individualized behavior therapy: Results. *Behaviour Research and Therapy*, *14*(3), 195-215.

Spinelli, E. (1989). *The Interpreted World: An Introduction to Phenomenological Psychology*. London: Sage

Stankewicz H. A., Richards, J.R., & Salen, P. (2022, July 12) Alcohol Related Psychosis. *Treasure Island (FL): StatPearls Publishing*. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK459134/

Stewart, S. H., Morris, E., Mellings, T., & Komar, J. (2006). Relations of social anxiety variables to drinking motives, drinking quantity and frequency, and alcohol-related problems in undergraduates. *Journal of mental health*, *15*(6), 671-682.

Straussner, S. L. A., & Byrne, H. (2009). Alcoholics Anonymous: Key research findings from 2002–2007. *Alcoholism Treatment Quarterly*, *27*(4), 349-367.

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. *Handbook of counselling psychology*, *3*, 3-22.

Streifel, C., & Servanty-Seib, H. (2006). Alcoholics anonymous: Novel applications of two theories. *Alcoholism Treatment Quarterly*, *24*(3), 71-91.

Stukenbrock, A., Deppermann, A., & Scheidt, C. E. (2021). The art of tentativity: Delivering interpretations in psychodynamic psychotherapy. *Journal of Pragmatics*, *176*, 76-96.

Strunin, L., Díaz-Martínez, L. R., Díaz-Martínez, A., Heeren, T., Winter, M., Kuranz, S., ... & Solís-Torres, C. (2015). Drinking patterns and victimization among male and female students in Mexico. *Alcohol and alcoholism*, *50*(2), 226-235.

Suh, J. J., Ruffins, S., Robins, C. E., Albanese, M. J., & Khantzian, E. J. (2008). Self-medication hypothesis: Connecting affective experience and drug choice. *Psychoanalytic psychology*, *25*(3), 518.

Sullivan, L. E., Fiellin, D. A., & O'Connor, P. G. (2005). The prevalence and impact of alcohol problems in major depression: a systematic review. *The American journal of medicine*, *118*(4), 330-341.

Swora, M. G. (2004). The rhetoric of transformation in the healing of alcoholism: The twelve steps of Alcoholics Anonymous. *Mental health, religion & culture*, *7*(3), 187-209.

Szmigin, I., Griffin, C., Mistral, W., Bengry-Howell, A., Weale, L., & Hackley, C. (2008). Re-framing 'binge drinking'as calculated hedonism: Empirical evidence from the UK. *International journal of drug policy*, *19*(5), 359-366.

Tatarsky, A., & Marlatt, G. A. (2010). State of the art in harm reduction psychotherapy: An emerging treatment for substance misuse. *Journal of clinical psychology*, *66*(2), 117-122.

Taylor, B., Irving, H. M., Baliunas, D., Roerecke, M., Patra, J., Mohapatra, S., &

Rehm, J. (2009). Alcohol and hypertension: gender differences in dose–response relationships determined through systematic review and meta-analysis. *Addiction*, *104*(12), 1981-1990.

Thomsen, R. (2010). *Bill W: The absorbing and deeply moving life story of Bill Wilson, co-founder of Alcoholics Anonymous*. Simon and Schuster.

Townshend, J., & Duka, T. (2001). Attentional bias associated with alcohol cues: differences between heavy and occasional social drinkers. *Psychopharmacology*, *157*, 67-74.

Turner, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *The qualitative report*, *15*(3), 754-760.

Turner, J., Brown, J. C., & Carpenter, D. T. (2018). Telephone-based CBT and the therapeutic relationship: The views and experiences of IAPT practitioners in a low-intensity service. *Journal of psychiatric and mental health nursing*, *25*(5-6), 285-296.

Turner, S., Mota, N., Bolton, J., & Sareen, J. (2018). Self-medication with alcohol or drugs for mood and anxiety disorders: A narrative review of the epidemiological literature. *Depression and anxiety*, *35*(9), 851-860.

Turp, M. (2002). *Hidden self-harm: narratives from psychotherapy*. Jessica Kingsley Publishers.

Urcia, I. A. (2021). Comparisons of Adaptations in Grounded Theory and Phenomenology: Selecting the Specific Qualitative Research Methodology. *International Journal of Qualitative Methods*, *20*, 16094069211045474.

Vaillant, G. E. (2005). Alcoholics Anonymous: cult or cure?. *Australian and New Zealand Journal of Psychiatry*, *39*(6), 431-436.

Vaillant, G. E. (2009). *The natural history of alcoholism revisited*. Harvard University Press.

Van Minnen, A., Arntz, A., & Keijsers, G. P. J. (2002). Prolonged exposure in patients with chronic PTSD: Predictors of treatment outcome and dropout. *Behaviour research and therapy*, *40*(4), 439-457.

Van Vliet, K. J. (2008). Shame and resilience in adulthood: A grounded theory study. *Journal of Counseling Psychology*, *55*(2), 233.

Vasilaki, E. I., Hosier, S. G., & Cox, W. M. (2006). The efficacy of motivational interviewing as a brief intervention for excessive drinking: a meta-analytic review. *Alcohol and Alcoholism*, *41*(3), 328-335.

Volkow, N. D., Wang, G. J., Fowler, J. S., Tomasi, D., & Telang, F. (2011). Addiction: beyond dopamine reward circuitry. *Proceedings of the National Academy of Sciences*, *108*(37), 15037-15042.

Wachtel, P. L. (1999). Resistance as a problem for practice and theory. *Journal of Psychotherapy Integration*, *9*(1), 103-117.

Waddell, J. T., Corbin, W. R., Chassin, L., & Anderson, S. F. (2022). The prospective interactive effects of alcohol expectancies and subjective response on future drinking behavior. *Experimental and clinical psychopharmacology*, *30*(3), 300.

Wanigaratne, S., & Keaney, F. (2002). Psychodynamic aspects of relapse prevention in the treatment of addictive behaviours. *The psychodynamics of addiction*, 117-132.

Waska, R. (2006). Addictions and the quest to control the object. *The American journal of psychoanalysis*, *66*(1), 43-62.

Watt, M., Stewart, S., Birch, C., & Bernier, D. (2006). Brief CBT for high anxiety sensitivity decreases drinking problems, relief alcohol outcome expectancies, and conformity drinking motives: Evidence from a randomized controlled trial. *Journal of Mental Health*, *15*(6), 683-695.

Weegmann, M., & Piwowoz-Hjort, E. (2009). 'Naught but a story': Narratives of successful AA recovery. *Health Sociology Review*, *18*(3), 273-283.

Wiechelt, S. A. (2007). The specter of shame in substance misuse. *Substance Use & Misuse*, *42*(2-3), 399-409.

Williams, C. H. J. (2015). Improving Access to Psychological Therapies (IAPT) and treatment outcomes: Epistemological Assumptions and Controversies. *Journal of psychiatric and mental health nursing*, *22*(5), 344-351.

White, W. L. (2005). Recovery. *Alcoholism Treatment Quarterly, 23*, 3-15.

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

Willig, C. (2008) Introducing qualitative research methods in psychology: Adventures in theory and method. 2nd ed. Maidenhead: McGrawHill/ Open University Press.

Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. (2009). Handbook of counselling psychology (3rd ed.). London: Sage

World Health Organization. (2000). *International guide for monitoring alcohol consumption and related harm* (No. WHO/MSD/MSB/00.4). Geneva: World Health Organization.

World Health Organization. 2014. Global status report on alcohol and health. World Health Organization.

Zahr, N. M., Kaufman, K. L., & Harper, C. G. (2011). Clinical and pathological features of alcohol-related brain damage. *Nature Reviews Neurology*, *7*(5), 284-294.

Zakrzewski, R. F., & Hector, M. A. (2004). The lived experiences of alcohol addiction: Men of alcoholics anonymous. *Issues in Mental Health Nursing*, *25*(1), 61-77.

Appendices

APPENDIX A: Information sheet

INFORMATION SHEET
Counselling and Alcohol Dependence: The Journey to Recovery

The study
You are being invited to take part in this research study about counselling clients' experiences of recovery from alcohol dependence. You are being asked to participate in this study as a counselling client with a minimum of 1 year of counselling and experience of and recovery from problematic alcohol use. Your e-mail address was retrieved through the SWAN Project upon your expressing your interest in taking part to this study. Please take the time to read the following information carefully in order to understand why the research is being done and what it will involve. Please ask the researcher if there is anything that is not clear or if you need more information.

The procedure
The aim of the study is to explore counselling clients' experiences of recovery from alcohol dependence. The research will require around 60 to 90 minutes of your time. During this time you will be encouraged to discuss about your experiences with alcohol dependence, your personal journey towards recovery, and your experience of counselling as a part of this journey. The study will take place at the facilities of the SWAN Project at a day and time that is convenient for you. The interview will be recorded and then transcribed into text form. Upon transcription the recordings will be destroyed.

Voluntary participation
Your participation in this study is voluntary. If you do decide to take part in this study, please respond to this email to arrange the date and time interview. If you decide to take part in this study, you are still free to withdraw at any time and without giving a reason. If you withdraw from the study, every attempt will be made to remove your data from the study, and have it destroyed. However please note that your data will be difficult to be removed after a period of 6 months from the date of the interview as the study will potentially have been handed for publication by that time. Please note that the present study is not related to your counselling with the SWAN in any way and your decision to participate or not participate in this study will not influence your ongoing therapeutic work.

Anonymity & Confidentiality
Throughout the project, several steps will be taken to protect your anonymity and confidentiality. While the interviews will be recorded, the vocal files will be destroyed upon the end of the study. The typed interviews will not contain any mention of your name and any identifying information from the interview will be removed. Consent forms and transcribed interviews will be stored under password protection and be accessible only to the researcher. When no longer necessary for research, all materials will be destroyed. Also, the information you give during the interview will be completely anonymised and a numerical ID will be used to conceal your identity. The findings of the

study will be presented in a conference and potentially published but your name will not be disclosed. *Please note that the only exception to maintaining your confidentiality is the disclosure of intention to inflict considerable harm to oneself or another or engaging in offending behaviour. In such case it is required by law to disclose such information to appropriate third parties such as your SWAN counsellor, your GP, or in case of concerns regarding offending behaviour the police, in order to reduce the possibility of harm.*

Data protection.

The personal information collected in this research project will be processed by the University (data controller) in accordance with the terms and conditions of the Data Protection legislation. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used/processed as described on this participant information sheet. The interview data will be destroyed when the final award is conferred and the final output is accepted for publication. You have a number of rights in relation to your personal data. For data protection queries, please write to the Data Protection Officer, dataprotection@uwe.ac.uk

Contacts for further information

If you have questions at any time about the study or the procedures or face any kind of problem, you may contact the researcher. You can find the contact details at the bottom of this letter. This project has been reviewed and approved by the ethics committee of the University of West of England as well as Dr Tony Ward, Associate Professor of Health and Counselling Psychology at the University of West of England. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr Tony Ward (Tony.Ward@uwe.ac.uk).

Researcher's contact details: Manos Christodoulakis (Manolis2.Christodoulakis@live.uwe.ac.uk)

APPENDIX B: Consent Form

CONSENT FORM
Counselling and Alcohol Dependence: The Journey to Recovery

Name of Researcher: Manos Christodoulakis.

initial box	**Please**
1. I confirm that I have read and understand the information letter for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that this research is not related to my counselling at the SWAN and my participation will not influence my ongoing therapy in any way.	☐
3. I understand that my participation is voluntary and that I am free to withdraw from the interview at any time, without giving any reason.	☐
4. I understand that the content of the interview may be used in future reports, presentations, or publications by the researcher.	☐
5. I understand that my identity will remain confidential and my name or any identifying information about my person will not appear in any reports, presentations, or publications	☐
6. I understand that my anonymity and confidentiality will be respected at all stages of the research, unless a breach of confidentiality is required by law.	☐
7. I agree to the interview being recorded.	☐
8. I understand that any audiotape material of me will be used solely for research purposes and will be destroyed on completion of your research.	☐
9. I agree to take part in the above study.	☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Researcher	Date	Signature

When completed, please return in to the researcher. One copy will be given to the participant and the original to be kept in the file of the researcher.

APPENDIX C: Promotional leaflet/poster

Counselling and Alcohol Dependence:

The Journey to Recovery

An interview study

UWE Bristol | University of the West of England

YOU ARE NEEDED!!

To participate in study investigating the journey of recovery from alcohol misuse!

YOUR EXPERIENCE MATTERS!!

Insights from your personal journey to change your relationship with alcohol can help us to better help others!

This is an opportunity to make your voice heard and help light the way towards recovery for the people who are still struggling.

"When you quit drinking, you stop waiting for life to begin"

- Caroline Knapp

WHAT IS REQUIRED?

- 60 minutes of your time!
- Participating in an interview that will focus on your personal experiences of alcohol misuse, counselling, and recovery.

WHO CAN ENTER?

To participate you have to:

- Have had experience with alcohol misuse
- Have been in counselling with the SWAN for at least 1 year
- Be currently sober.

If you are interested in participating or learning more about this study please provide your name and email below and place the leaflet in the green box!

Name: **Email Address:**

*Please note that the present study is not related in any way with your counselling at the SWAN and your decision or not to participate will not affect your ongoing therapeutic work.

APPENDIX D: Letter of consent by the SWAN Project

The SWAN Project
Registered Charity No: 1122634

Manos Christodoulakis

Dear Manos

Re: Approval for a Research Project

I am pleased to approve your application to undertake a research project at The Swan Project with the title:

"Shame in Alcohol Dependence: Insights from Recovering Alcoholics with Experience in Long-Term Counselling".

I will be emailing the Supervisors of the Project to look at the recruitment of clients for your interviews in the next week. I hope that you and I can meet again to finalise the timescales involved and to further discuss the process of recruitment and interviews, with a view to ensuring that the experience is a valuable one both for your research, but also for our clients in their ongoing recovery. I also look forward to continuing as your supervisor whilst we take this research forwards.

Yours sincerely

Hannah Duncan
Project Leader

APPENDIX E: Sample interview questions

- *What has been your personal experience of alcohol dependence?*

- *How did they make sense of yourself and what have been the feelings that you were experiencing during this time?*

- *How did those feelings affect your journey towards recovery, and how were they regulated?*

- *What has been other people's perceptions of you and how did this impact your recovery?*

- *What has been your experience of long-term therapeutic work with regards to alcohol dependency?*

- *What has been the role of therapeutic work in the regulation of difficult feelings?*

- *What has been your experience with the AA 12-step model, how did this influence your recovery and your engagement with therapy?*

APPENDIX F: Sample transcript (Matt)

- Me: When did you realise that alcohol was becoming problematic, what was the.. if you can recall, the time when this became clear?

Matt 1: (Long pause) I don't know.., I think it would be.., it would be a very long time ago but I think it would kind of become relationship based.

- Me: Right.

Matt 1: I mean I wouldn't say it was.., I wouldn't say it was based off of family stuff, I think it would have to have been like a relationship of mine that have kind of fallen apart, you know like a break-up in a relationship, that kind of thing.

- Me: Sure

Matt 1: Which one I don't know, d'you know what I mean? Like I don't, I can't, it wou.. it would have been fairly early on but I'm not too sure, but I know that that would have been something that I would have used to get through, but..

- Me: So there is a certain sense that loss had something to do with it.

Matt 1: Yeah, yeah I guess so, (exhales), it's quite a tough question cause the, the, like for me.., my alcoholism was kind of based around issues I also had with myself, kind of self-worth, and I would say I drank a lot to kind of deal with anxiety and depression as well, I guess you can kind of add the depression into the back of loss of relationships because they kind of go hand in hand, but I don't know when the anxiety came in, when that would come in to all of it, I mean I guess that's something I have kind of recently like started to discover.

- Me: Hmm, right, I see

PAUSE for 8 seconds.

- Me: So when, when you were experiencing those difficult times

Matt 1: Yeah

- Me: I understand that alcohol, umm, came, came into play as a source of relief. Is that, would you say that this is correct?

Matt 1: Yeah, yeah, (nodding emphatically), of course, it was an escape, it was an escape from actually having to deal with all of the things that I had to deal with. Every problem that I was kind of faced with, I never actually took to dealing with, like I never, even if, if it was like a person or, or a place that I had to go or something like that, rather than go and do those things I would basically then go and use my alcohol as an excuse and, and an escape to avoid doing those things, you know

- Me: Yeah, yeah,

Matt 1: Like so, so (5 second pause), well like take, take the relationship for example, if the relationship kinda broken down rather than actually finding a way of processing that and having to go and approach that person and deal with sorting out what have gone wrong, the easiest thing for me to do would have been to have gone and got drunk and try to forget about all of that, knowing that that would have been the best thing for me to have done would have gone to have seen that person and sorted out what needed sorting out, I would just have gone and got drunk because it was easier

- Me: (reluctantly) maybe it was less painful, as well?

Matt 1: Yeah, yeah, yeah, it would have been that, it would have been less to deal with. But umm, it wouldn't have made me feel any better, it would have made me feel worse because feeling worse with not doing what I needed to be doing would have made me drink more (looking slightly amused), does that make sense?

- Me: Right, right

Matt 1: You know when, you know when you know that you should have done something

- Me: Sure, sure

Matt 1: And you haven't done it and it leaves you with that kind of element of, I guess it kinda leaves you with the element of anxiety, knowing that there was something that you should have done

- Me: I see, I see. So what seems to be the case is that this was not a decision that you were making whole-heartedly, that I will not be dealing with this. It sounds like a part of you didn't want to deal with this, but a part of you was critical about that, a part of you was saying that you should be dealing with this.

Matt 1: I think the part of me that would have said I should have been dealing with it came afterwards

- Me: Right, right

Matt 1: I don't think I would have dealt with it there and then. Umm, no it's much easier for me to kinda just ignore every problem that ever was and just use alcohol as my escape.

- Me: And when did this other, let's say other voice kicked in, the more finger-pointing "you should be doing something else"?

Matt 1: (Long pause) I am not sure it kind of ever kicked in, I think it may have always been there, but I just don't think I have ever listened to it

- Me: Right, yeah

Matt 1: It's so much easier to not listen to something like that when you have an easier escape, d'you know what I mean

- And perhaps some things are, when things are unpleasant, umm, we tend to want to pay a bit less attention to them

Matt 1: Yeah, of course, yeah

- *Me:* Almost like somebody calling you names, you wouldn't want to hang out with this person (I am aware of contributing my own interpretation to Matt's account of his experiences, I am conscious of my empathy and feelings of warmth towards Matt's at this point. It feels to me that this narrative is quite strict and I feel the need to introduce some warmth)

Matt 1: Yeah, no

- *Me:* What, how would you, reflecting back on those times, how would you say it was your relationship with yourself during those times?

Matt 1: Bad (readily spoken), I have always had self-worth issues, like I have always had, like I've always had to deal with how I kind of felt or how I come across to other people, I've always umm, (long pause) I've just struggled with myself, like feeling like I am, feeling like I'm a good person, d'you know what I mean?

- Me: Ok (still experiencing heightened empathy towards Matt's vulnerability)

Matt 1: (Long pause, the discussion feels difficult for Matt at this point) And I think when you feel like that, and when you are borderlining being depressed, then you would gonna want to use something to not think about it, you'd gonna use something to not kind of wanna, (pause) I guess.. (long pause, Matt is obviously welling up at this point and looks particularly tender), yeah, if you don't like yourself, if you don't like yourself then it's really easy to kind of just turn to something else to get rid of that, you know what I mean?

- Me: Yeah (I am very conscious that I know exactly what Matt means, his emotional tenderness at this point is very touching for me)

Matt 1: And I know that in this, in this what we are discussing is alcohol and I used a lot of that to cover that up,

- Me: Yeah

Matt 1: But at the same time, just as I would have used alcohol, I mean people would have used recreational drugs and all that kind of stuff, d'you know what I mean? It's just, just depends on whichever you will turn to first

- Me: Yeah

Matt 1: But alcohol was mine, alcohol was my total escape, and I just used to, I used to use it all the time, for every reason, the one thing that I, I mean I wasn't, the thing is that I wasn't dependent, I wasn't like a dependent alcoholic, but I used to drink to tackle most situations, d'you know what I mean? Like the only, the only situation, yeah the only situation that I never, I would never drink was in work, d'you know what I mean, like it that was the only thing, the only thing in my life that I tackled without alcohol was going to work (seems amused), it's as simple as that. But when I wasn't at work, Christ I would be drinking loads.

- Me: Right, umm, how, how do you understand this, how do you make sense of that?

Matt 1: How do I understand it?

- Me: Hmm, because it is quite an interesting observation. (Matt sighs appearing puzzled). Was it that work didn't feel as difficult/

Matt 1: No, I hated my job, I HATED my job (said passionately and emphatically), like all of the jobs that I've, except for one, one job that I had which I really liked, but every job that I ever had I've never enjoyed.

- Me: Right

Matt 1: But I think it's.. (long pause), it was kind of having something to focus on, it was the one thing I had to focus on that took me away from everything else that I was feeling, does that make sense?

- Me: I see, that makes perfect sense. In a way even though the object of the work was not very appealing, you were able to be in the zone and isolate yourself from everything else

Matt 1: Completely isolate myself from everything else (said with particular emphasis), and not have to think about myself and how I was feeling and the things that were surrounding that, which made me want to use alcohol as my form of escape, d'you know?

- Me: Sure

Matt 1: Umm, but outside of work, it was a completely different story, because it was a case that the moment I would finish work I'd go straight to the shop and I would go and get some beer and drink (pause) and that could, that could go on for quite some time depending on how, depending on what the days where or the hours were before I had to either come off a shift or go back to work, I could drink for ages.

- *Me:* Hmm.. (long silence), until the next time that you had to go back to work

Matt 1: Yeah, well.., yeah sometimes I would, sometimes I could.., sometimes I'd finish work I'd say 8 o'clock in the evening and I could have a few drinks until 12, but I would make sure I would get a decent enough night's sleep in order to get back up and go to work, I can't, I wouldn't.., I wouldn't go to work and would have like a hangover, but I kind of, like.., If I were.., talking about it now, I did a four-on, four-off shift, so I would have, I would work for four days and I would have four days off, like work for four days and have four days off, I would finish work on the last night of my shift, or on the last day, depending on whether I was in a day-shift or a nightshift, for those four days I'be drinking (pause) purely out of self-worth and boredom.

- Me: Right.., (pause). It sounds like, umm, this was a shelter, coming out of work, having to be exposed to difficult feelings, alcohol was a shelter

Matt 1: Yeah, (Matt's breath becomes noticeably heavier), yeah it was my, it was my total go to, that's what exactly where I would run to, every single time.

- Hmm, what was the, if you like.., can you remember what were the things that you were gaining during that time? Or what made this appealing or enjoyable?

Matt 1: Nothing (Emphatically), there wasn't anything that was, there's nothing that was kind of appealing about it, there's nothing that I did enjoy about it, it wasn't enjoyable, it was.., (long pause), no there wasn't anything enjoyable. Enjoyable for me, enjoyable drinking for me is.., that sounds, that feels like a distant memory (looking amused), of when I used to kind of go out with my friends and socialise and have a few drinks, and, and have a good time..

- Me: I see

Matt 1: And it felt like it been.., so many years since that had happened

- Me: It sounds very similar to your relationship with work. Work's something that's not enjoyable but it allows you to not think about difficult things, not feel difficult things. It sounds like there's a similarity there with alcohol.

Matt 1: Yeah, (lauhingly), yeah probably, yeah it's funny you say that, because even I wouldn't have thought that hearing myself say that.

- Me: Which means that something was much more unappealing, much more difficult, much more..,

Matt 1: Yeah, probably my.., probably my life outside of work I think.

APPENDIX G: Transcript with process notes (Sharon)

Submitting to AA - Using AA terminology, personal meaning merges with AA narrative.	I	Yeah, it's recording now, so I'll put this out of sight. Yeah, thanks very much again for being here.	Even though I am asking for Sharon's individual understanding and experience of alcohol dependence, the narrative that I am getting from her is essentially the doctrine of AA. The terms "disease" and "illness" are very much an integral part of how the fellowship conceptualises alcohol dependence. The notion of complete abstinence from alcohol is a fundamental principle of AA recovery, but what is even more worth noting for me is Sharon's wording of "cannot touch the first drink" is exactly the same wording that I have heard being said in AA meetings. This also applies to the wording "an illness of mind, body and spirit". I remember noting to myself that this very much sets the tone about the content of the interview, and I already formed an expectation that Sharon's reflections and understanding of her experiences would not be deviating too much from the AA narrative. I was conscious of being slightly annoyed with Sharon. Even though I was grateful to her for generously accepting to participate in the study and share with me her experiences, a part of me now wanted to say to her "Please do not recite AA principles as if reading from the big book. I did not ask you what is the meaning that AA assigns to your experiences, what I want to know is your unique, individual understanding of your unique and individual journey". This was a strong emotional reaction from my part and thankfully I became conscious of those feelings that I was
	R	No problem.	
	I	So let us start with me asking you what is your understanding of the term 'alcohol dependence' and what has your experience been of it?	
	R	My experience has been that I cannot touch the first drink because if I drink one of anything alcoholic I will not stop at that – it'll set off a train of reaction, and I know that it's a disease, an illness you know of mind, body and spirit.	

		experiencing a few seconds after they emerged. Becoming aware of my reaction almost automatically diffused it. I felt ashamed and embarrassed about how quickly I became dismissive of Sharon's process. Obviously the conceptual framework of AA was one that Sharon subscribed to, but who am I to say that this is not right, or that invalidates her reflections? Quite ironically, it is I at that very moment that is invalidating Sharon, and it is even more ironic for me to be doing so in the name of validating her unique and individual self. Looking back to this moment it reminds me of the infighting between different sub-sects of the same religion, each one considering itself to be the "right" path, while condemning the other as being a "cult". AA sometimes can indeed be reminiscent of a religious group as its principles and traditions can often be adopted in a dogmatic way. However at that moment I was also being too dogmatically attached to the phenomenological uniqueness of a person's lived experience, to the point of dismissing the unique and deeply personal connection that Sharon has established with AA, and the meaning that was clearly resonating so strongly with her as person. I am grateful for realising my emotional process in real time. Doing so allowed me to bracket it so as not to inhibit my capacity to be a receptive vessel for Sharon's narrative.
A troubled history of recovery attempts. Submitting to AA	Having done day programmes, two day programmes … it's the same day programme but <u>I didn't listen the first time</u> so I went back … I relapsed and then I got back onto the day programme	Sharon's words "I didn't listen the first time" are interesting to me. There is something ever so slightly submissive to this wording. She "didn't listen" to the programme the first time, in the same way that a child does not listen to their parents, usually with regrettable consequences. Submission is in itself an interesting word for me to be using. I am perhaps

	again and listened … having lived in a dry house with a very effective system for nearly two years I think that was, for two years – something like that	influenced by the 3rd step of 12-step programmes "Made a decision to turn our will and our lives over to the care of God". It seems that Sharon had to come back to the programme as the first time her own understanding of what she was experiencing was not yet fully aligned with the AA narrative.
Submission to AA: Identifying as an alcoholic	… and working the Steps, going to AA meetings, talking to other alcoholics, having a sponsor, having a home group, doing service, sponsoring now myself, and	"Talking to other alcoholics" – Sharon clearly identifies herself as being an alcoholic. There definitely feels to be a sense of group identity here, perhaps a sense of belongingness?
Submission to AA. A fully committed AA member	doing service in the phone office when other alcoholics ring up you know and things like that … um yeah, so lots of things. Literature, you know specially the AA recommended books like Alcoholics Anonymous book 'As Bill Sees It – 12 steps and 12 traditions' which is very good – lots of books like that really.	"Working the steps, going to meetings, having a home group, doing service, having a sponsor and being a sponsor, reading AA literature" Sharon is indeed an exemplary AA member, I can imagine her being the kind of presence in meetings that new members look up to.
Spirituality through AA	And then I do a daily routine now which is a morning reading and prayers, going through the day … I upset my friend this morning … something came out of my mouth that shouldn't have, she took it the wrong way, so I had to explain myself to her and apologise. Then I spoke to my sponsor afterwards and I told my	"Morning reading and prayers". Sharon also aligns herself to the spiritual dimension of AA.
Spirituality through AA: Constantly connected	sponsor what had happened, and you know I'm going to pray … pray about it as well … so that's working you know Step 10, which we do … I expect you	Sharon upset her friend which is clearly something distressing for her. She talked about it to her sponsor who sounds like they are a constant presence in Sharon's life. She would be also praying about this incident, so perhaps the same notion of

	understand, have a knowledge of the Steps, I don't know. But yeah … so try and work the programme in my everyday life, you know. So watching for things throughout the day, you know. And I still suffer with you know … things like fear of financial insecurity came up because of my heating bills - well as it was now I've got a warm heating discount, so that's wonderful, that's sort of taken the pressure off,	constant connectedness can be said about her relationship with her Higher Power.
A shelter from the hardships of life.		Financial insecurity. Listening to Sharon saying that I felt a warm feeling inside me. This is perhaps also due to her presence. I notice in myself experiencing Sharon as a gentle and delicate human being. She is softly-spoken and humble and there is a distinct sense of fragility about her which makes me want to shield and protect from the fear and the hardships of life. At this point I feel in myself a sense of relief that Sharon does find strength in her engagement with AA. I am happy that this works so well for her.
Spirituality through AA – Submission	but it's a lack of faith and trust in my higher power. I've got to know me …	"A lack of faith and trust in my Higher Power". This triggers another strong reaction in me. Once again I feel Sharon's submissiveness. The notion that a person's suffering is the result of not having completely surrendered themselves to their God is one that makes me feel uncomfortable. There is a sense of submissiveness there that to me invokes a feeling of despair. In my mind what Sharon is communicating is: "nothing else works, I am unable to affect change in my life. If I am to survive, I have to resign myself at the mercy of something that is more powerful than me". Perhaps this might not be too far off from the truth, considering that AA prompts its members to admit their powerlessness and surrender their will and their life to the care of God. I am conscious of the fact that what Sharon is communicating here is clashing with my own personal values. I have always had deep respect for spirituality and religious practices and have always been attracted to people that are more religious than me, as if there is something about their peacefulness and sense of reassurance

		about life that I would like to be rubbed off on me. And yet, no matter the spiritual discipline I would be involved with, I would always encounter the same obstacle when it comes to notions of submission and surrender, as if the price for this reassurance is too high for me to pay. At the same time I am also taking into consideration my role as a therapist: I am there for people, receiving their struggles and caring for their happiness, being a Winnicotian "good enough mother" for them. However under no situation would I even dream of encouraging dynamics of submission. I would never want my clients to surrender their will to my care and I am always actively discouraging dynamics of dependency as soon as I become aware of them. Quite on the contrary, my wish for my clients is for them to become confident in their own capacity to endure the hardships of life, to become more competent and more capable about pursuing happiness, and therefore the ultimate success for me would be to eventually become obsolete. I realise that perhaps my reaction towards Sharon's surrender to a power greater than her might be reflecting the broader tension between AA and counselling when it comes to their ethos and values.
Submitting to AA. The problem is me – submissiveness, disempowerment	I put the drink down and I've realised that the bottles are only a symbol – as it says in the Big Book, you know the problem is me, and I had to change … and that's how my sponsor was 'nothing changes and nothing changes'.	"The problem is me, and I had to change". Once again I feel a tension in me with this wording. I can appreciate how this could be perceived as empowering, a sense of taking responsibility for one's life and actively pursue to improve one's quality of life instead of drowning in a ruminating stuckness feeling incapable to be anything more than what we are. And yet something about Sharon's phrasing and the way her words are articulated makes me perceive this sentence as self-punishing, defeatist and disempowering. I don't like Sharon referring to herself as "the problem", I would ideally

		have liked her to say "I know that the responsibility towards my life lies within me, and I owe it to myself to try harder".
Disempowerment. Surviving domestic abuse. Possible cause of disempowerment?	So I was living with my husband, I left him twice, a year last November I could see … it was a slippery slope … I think I was going to contemplate overdosing basically, and it could have got to … from overdosing could have got to alcohol as well. So I thought I've got to get out, so I did get out – I went over to my friend's, I got stuck into … was that the first time? … no last November I went back into a safe house actually, and then went on from there and got my own flat. Because before that you know I'd ended up in crisis houses, I was in a terrible mess basically – mainly alcohol fuelled, because I couldn't cope with life, I couldn't cope with anything, you know I was scared of everything, everybody, you know real fear.	Domestic issues. Within the 5 minutes that we have been talking with Sharon, I am not surprised to learn that there have been domestic issues with her husband. Her presentation and particularly the fragility that I was noticing earlier is very reminiscent to the presentation of domestic abuse survivors that I have worked with in the past. I am wondering as to which extent her experiences of domestic abuse have shaped her self-narrative. That would explain such wording as "the problem is me" and perhaps also might have facilitated her admission of Powerlessness within the AA context.
Disempowerment. – Surviving domestic abuse. Real fear of everything.	I Sounds like a lot of anxiety. R Yeah. My husband's behaviour of late … this is why I had to leave … and one of the reasons why I got so depressed … his behaviour was extremely controlling and he gets very angry very quickly you know. He was suddenly getting … he was shouting in your ear, or stuff like that going on … and name calling,	Sharon could not cope with life, she was scared of everything and everybody. When she says real fear I absolutely believe her, I hear in my mind REAL fear and that pains me. I really feel for Sharon, and once again I am overcome with a need to protect her. This need very often manifests when I work with domestic abuse clients. I feel pain at the thought that a person has been so consistently, so systematically devalued by another, that this sank in and shaped their own appreciation of themselves.
Surviving domestic abuse. Disempowerment and wound to self-esteem.		Indeed Sharon is confirming my suspicions about the domestic problems that she has encountered. It is dreadful listening to

Surviving domestic abuse. Guilt is the chains. Domestic abuse and dependency	belittling … my self esteem was on the floor – you know all of that. So I seem to have gone back each time when I was told … everybody was saying 'Don't' but I took no notice and I went back. But this time something changed, like it did when I … you know before when I got to a stage where I can't … I'd relapsed, I did about a fortnight when I was on spirits all the time then, the progression had gone from red wine to spirits. So I was drinking the spirits, and after about a fortnight … and I can't tell you precisely, but one morning I woke up and I thought 'I can't do this anymore, I've got to get out' you know. So I did, and for some reason I'd always been wracked with guilt you know … that's why I'd gone back, I went back the first time because my husband had cancer – first stage cancer, I went back.	her recounting her experiences of a systematic corrosion to her self-worth and self-esteem. It makes so much sense to me that having suffered and survived the toxicity of her abusive marriage, her need would now would be for safety and containment. I can see how it would have been possible to meet those needs within the safe boundaries and group camaraderie of AA. There is a parallel process in which Sharon's dependence on alcohol is coinciding with dependence in her abusive partner. She one day decided that she had enough of being hurt, that she would be claiming a new, better life for herself. Nevertheless the hook of guilt kept her attached to the abuser. My fantasy of Sharon's process is that despite her husband's hurtful behaviour, she could still see the brokenness in him. This is a brokenness that she empathised with, she felt guilt about abandoning, perhaps because she too has come to identify herself as being broken? As is often the case with victims of abuse, I am wondering as to whether she did indeed believe that she was worth of a better life at that point.
Surviving domestic abuse. Domestic abuse and dependency	The second time because I had cancer, and I thought 'I'm in a dry flat' I'd gone	Interestingly Sharon had to battle with cancer soon after her husband did. I fantasise the connecting link between them becoming physically manifest, almost like they are both

Surviving domestic abuse. Domestic abuse and dependency – better the devil you know	through three stages, done really really well, but I was faced with this and in a dry flat with all men around me, and I thought I can't go through bowel cancer … the thought of going through with men all around … even though they were very nice and helpful, I thought if I go back home there's neighbours that are very good and like my church is up there and they're very supportive as well, so I would have that support. So against the advice of my support worker there, who was brilliant, and the owner of the dry house system there, I went back and lasted … I actually lasted 2 years, but it wasn't great, I had to keep defending myself … do-do-do-do … you know … and he got worse anyway.	conjoined, merged in a symbiotic coexistence in which one person's suffering is doomed to afflict the other. Having to confront the discomforting symptoms of bowel cancer, Sharon felt more comfortable going back to her husband rather than staying in the dry flat, despite being surrounded by nice and helpful people. What is particularly intolerable for Sharon was being surrounded by men, the fact that men would be witnessing the impact of bowel cancer in her body. I can appreciate the state of embarrassment that Sharon would have been feeling. I am getting a sense of nakedness that is just too much to endure. My fantasy is that Sharon just did not want to endure any more suffering, any more humiliation anymore. Her husband might have been horrible to her, but at least him being hurtful is something that she has been accustomed to. I imagine that since she has already decided to leave him and start a new life, whatever abuse she might have to endure upon coming back must have been perceived as more of a reflection of him and his horribleness as a person, and therefore it would not have any further devaluing impact on Sharon. Furthermore, her husband has already seen her in her "nakedness". He has already witnessed her darker, more embarrassing, more unflattering aspects of her, Sharon must be feeling more comfortable about him now witnessing the brokenness of her body, much more so than the men she only met recently in the dry house. Once again I am visualising their symbiotic bond of their relationship, after all he only recently had to grapple with cancer himself. It feels like brokenness is a connecting link, and the struggle of her body feels more comfortable in that context, almost like it belongs there. It would have felt infinitely more exposing and embarrassing if her present struggles were to be witnessed by those new men that were

		now surrounding her, because nice and helpful though they were, they were also part of a new life, one that she might have preferred to keep unspoiled. There is comfort in what is already familiar, even when it is toxic, after all, better the devil you know.
Surviving domestic abuse The social network of AA – a substitute to alcohol The need for containment. A place to feel safe A life of suffering	Then he went into stage 2 cancer, but still when I left him he was pretty independent. So the guilt by that point had gone, you know I didn't have that guilt with him, so … and that maintained, thank goodness, and I was able to … as I say, I went back up to my friend's, went to meetings over there, I built up … I'm getting confused now … but I'd already built up friendships within AA, and one friend in particular, very close to her over there, and she … we sat down and had coffee one day and she told me her story, and it was identical as far as the abuse and safe house. And then going back and being able to look after her husband as he got worse, but having her own space, her own flat to come back to – so that was the difference for me, I had my own flat to come back to. So I thought right … that really spurred me on, and I thought that's what I need, you know I need that. So … unfortunately my son, who's got a brain injury, bipolar disorder and non	It seems like for Sharon fleeing has been a gradual process. She begrudgingly had to go back to her husband to go through her battling with bowel cancer, however when this has been worked through, she was now ready to be free again. My mind conjures an image of a wounded bird that allows itself to be captured so as to shield itself from the wind and the rain, but once its wings are healed it is now time to break free, to fly away and be free again! AA seems to have definitely played a big part in Sharon's empowerment to break free from the shackles of her abusive relationship. She has built a social circle that she could be a part of. Especially her friend with whom she shared common experiences must have been a massive boost to her self-worth. Her past suffering was something that she could share with another person and know that she would be understood, and by empathising and being supportive towards her friend's past hurt she must have also experienced some of this warmth towards her own self. Sharon's flat, a space that she could come back to. Indeed it sounds so important for Sharon, a shelter in which she can be safe.

Surviving domestic abuse. Guilt is the chains	epileptic attack disorder, which is the most crippling thing for him, he then decided to come out of supported living where he was and … because a chap who had autism was kicking him. And it was fine when he was conscious because he could block him, but when he was unconscious he was out of it so he was vulnerable, and he didn't feel they were on top of it enough – so he decided to go back to his father. So Social Services immediately put Safeguarding in because he gets abuse as well, and he's had some physical abuse from his father, and he's been back as well. So that happened. I think he expected me to go back if he went there I'd go back, but I said I can't, I said I told you this before, and I'm not coming back, you know … I'll obviously see you but I won't come back to live there. And anyway he went back to live with his father, they've arranged now he's got 56 hours support a week coming in – 10 till 8 – which doesn't cover the 8 till … husband's now in the third stage of cancer, he's very prone to falls, he's got cancer in the backbone, hip, and now onto the lungs … but he is there and they're sort of supporting each other from 8pm to 10am the following	Sharon's history of suffering keeps being expanded more and more. Her boy with a brain injury, bipolar disorder, and non-epileptic attack disorder. It almost feels surreal to hear how much pain life had in store for Sharon. That must have been a difficult decision for Sharon to make. Her vulnerable son would have to now live with his father who has also been abusive to him. Even though he asks her to be there for him, Sharon remains firm on her boundaries and refuses to allow herself to be tortured again, she refuses to turn her back on her safety and well-being. Sharon's gentleness of character, her prone-ness to self-deprecation and guilt make it hard to believe that she was able to be so firm with her boundaries of self-care at that time. I wonder as to whether this would have been possible if it was not for the firm boundaries and the social cycle of support that were given to her by AA.

A life of suffering	morning when they come. So it's not great because my son gets a lot of these attacks in the evening. And he was in the hospital the other day because the ambulance decided to take him in, because he's gone into one of these, and it took him 2 hours … well after 2 hours he was still not right. So they tried to bring him round but they couldn't, so they said well we'll take him … they'd take him in, so he goes in overnight. They level him, they get him stable, and then he's discharged you know. So all that's going on as well … and the fact that this year because of debts and things we've got a huge mortgage on the house. So the house has to be sold just after … well his birthday,… has to be sold to repay the mortgage, and it's about half … we get just over half between us again. So that's got to be sold in the next … or go on the market in the next few months … so all that's going on. So there's a heck of a lot happening really, but because I think I've got my own flat … you know I do go back to the house … Next Link would have a fit, because I was with Next Link … they'd have a fit probably … but I can cope with that, because now you know when I get in the	Domestic abuse, alcohol dependence, bowel cancer, a boy crippled by a collection of medical conditions, and now financial troubles. Indeed, a heck of a lot that Sharon had to go through. I reflect back on my initial reaction towards Sharon's attachment to AA and I just take it all back. I am so grateful that AA has been there for that woman at the times that she must have felt truly alone in the world. I am grateful that within that context she found a place to belong, a group of people that have cared for wellbeing and supported her to keep supporting herself. I imagine that her attachment to the AA ethos and values must have borne out of her own gratitude towards the holding that she has received during the years.

The need for containment - A place to feel safe Submission to AA. The social network of AA – A substitute for Alcohol	car if things get too much I can get in the car and come back to my flat. Before I've got in the car, driven round, and thought 'Where can I go?' and I thought 'I can't be bothering so and so because it's this time of night' and all the rest of it – so I've ended up at a fast food place for a while and then I've thought well I've got to go back, so I've gone back you know, so there's been that. So but I haven't … in the last 5 years … I think it's down to the programme, I think it's down to the programme … and having built relationships I've got	Sharon's words paint a vivid picture of the despair that she has endured. I try to visualise a person running away from a hostile home in the middle of the night, having no-one to turn to, ending up at a fast food restaurant, only to realise that there can be no escape, that ultimately she has to return to what must have felt as a perpetual torture. Her flat has changed all that, she now had a place to call home, a place to return to where she could be safe and shielded from the hurt and the pain of life. "I think it's down to the programme". That is Sharon's honest appreciation of her experiences, this is how she makes sense of the positive changes that have happened in her life. I can see it. In a way the social context of AA, the releationships that she built there are very much akin to her flat. The walls of her house were holding and protecting her physically, but the people that comprise AA have been holding her emotionally, psychologically and spiritually. AA for Sharon is a place she could call home.

APPENDIX H: Ethical approval

(Redacted due to Personal Information)

APPENDIX H: Ethical approval (continued)

(Redacted due to Personal Information)

APPENDIX I: Risk assessment form

University of the West of England BRISTOL

GENERAL RISK ASSESSMENT FORM

Ref:

Describe the activity being assessed: Interviews with clients of the SWAN Alcohol Project with prior experience of alcohol dependence who have achieved recovery from problematic alcohol use. Sample will be comprised of 3 to 6 participants. Interviews will be taking place at the facilities of the SWAN project in one of the counselling rooms.	**Assessed by:** Manos Christodoulakis and Tony Ward	**Endorsed by:** Zoe Thomas
Who might be harmed: Participants, Researcher **How many exposed to risk:** 4-7	**Date of Assessment:** **19/01/2018**	**Review date(s):** **8-2-2019**

Hazards Identified *(state the potential harm)*	**Existing Control Measures**	**S**	**L**	**Risk Level**	**Additional Control Measures**	**S**	**L**	**Risk Level**	**By whom and by when**	**Date completed**
The content of interview process might be emotionally distressing thereby triggering relapse to problematic alcohol use.	Recovery from alcohol use is a basic criterion for inclusion. Assessment by SWAN supervisors as to the likelihood of this risk will exclude participants that are at the risk of relapsing.	1	3	3	Interview will be terminated in the case of acute emotional distress. Participants will be offered 30 minutes of debriefing that will aim to de-escalate potential emotional distress. Participants will be currently attending therapy with the SWAN where the potential emotional distress will be further explored and contained. Participants will be asked their permission to feedback any further concerns to the SWAN supervisors.	1	2	2		

Participant presenting themselves intoxicated.	Assessment by SWAN will exclude participants that are currently engaged in problematic alcohol use.	1	1	1	Interview will not take place. Participants will be advised to discuss their recent relapse with their SWAN counsellor. In case they are driving they will be offered a taxi.	1	1	1		
Participant becoming a risk to themselves or to the researcher.	Assessment by SWAN supervisors will serve to exclude participants that might demonstrate such behaviours.	3	1	3	Interview will be immediately terminated and the focus will be to de-escalate participant's distress. I will sign in the SWAN's room diary so that SWAN personnel will be aware of my presence in the room/building at the date/time of interviews. I will sound personal alarm in case of perceived considerable danger to my wellbeing. An ambulance will be called in case of considerable concern for participants' physical health.	2	1	2		
Fire emergency	SWAN's Health and Safety processes and procedures and regular checks of the premises eliminate the likelihood of such a risk.	3	1	3	Interview will be immediately terminated. SWAN building will be evacuated and participant will be escorted to safety.	1	1	1		

RISK MATRIX: (To generate the risk level).

Very likely 5	**5**	**10**	**15**	**20**	**25**
Likely 4	**4**	**8**	**12**	**16**	**20**

Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Extremely unlikely 1	1	2	3	4	5
Likelihood (L) Severity (S)	Minor injury – No first aid treatment required 1	Minor injury – Requires First Aid Treatment 2	Injury - requires GP treatment or Hospital attendance 3	Major Injury 4	Fatality 5

ACTION LEVEL: (To identify what action needs to be taken).

POINTS:	RISK LEVEL:	ACTION:
1 – 2	NEGLIGIBLE	No further action is necessary.
3 – 5	TOLERABLE	Where possible, reduce the risk further
6 - 12	MODERATE	Additional control measures are required
15 – 16	HIGH	Immediate action is necessary
20 - 25	INTOLERABLE	Stop the activity/ do not start the activity

APPENDIX J: Journal Article

Recovery from Alcohol and the Relationship with the Self: Insights from Long-Term Counselling Clients

Manos Christodoulakis

Abstract

The present study explores the experience of recovering from alcohol dependence from the perspectives of people who have received long-term therapeutic work. Diverting from the existing literature that focuses solely on the perspective of AA members, the study is interested in how counselling clients make sense of themselves throughout their efforts to recover from problematic alcohol use. The research design was developed through the prism of critical realism and follows the qualitative methodology of IPA. Semi-structured interviews were employed as the instrument for data collection, and five participants were interviewed. For all participants the engagement with counselling was a big part of their journey, while for three of them recovery also entailed their engagement with the AA fellowship.

The interpretative-phenomenological analysis yielded three superordinate themes. The first draws from participants' narratives of conceptualising alcohol as an abusive partner that was initially relied on for soothing of pre-existing struggles with anxiety and low-self worth, only to eventually exacerbate those issues further. The second pertained to the participants' differential response to the alcoholic label. The third and final superordinate theme explores the shift towards self-compassion that emerged as a key process that promoted recovery and reflects on the distinct yet complimentary ways in which counselling and AA have facilitated that shift.

The study's findings could have useful implications in the way that we conceptualise and treat alcohol dependence. Most prominent among them is the conceptualisation of alcohol dependence as the symptom of underlying causes that might necessitate a paradigm shift towards longer-term therapy as opposed to short-term, outcome-focused interventions. It is further proposed that insights from this study could inform future qualitative research to explore the potential of integrative synergies between counselling and AA whereby the two approaches can be seen complementary rather than oppositional.

Literature review.

Alcohol dependence, is defined by the DSM-V as the unrestrained use of alcohol that severely inhibits functioning (APA, 2013). The phenomenon is a major concern in modern societies with an annual figure of 3.3 million deaths being attributed to alcohol misuse across the globe (WHO, 2014). Due to the severity its impact it comes as no surprise that there is significant stigma surrounding alcoholism (Hill & Leeming, 2014). Indeed alcohol and substance abuse is being socially perceived as signs of a person's laziness, weakness and proneness to crime (Tatarsky & Marlatt, 2010). Given the aforementioned negative perceptions around alcoholism, people who suffer from alcohol addiction are often met with intense disapproval and ostracism by their surrounding communities (Gray, 2010). Being at the receiving end of such social discrimination is likely to negatively affect the individuals' views of themselves who will internalise society's views of their condition (Hill & Leeming, 2014)

Ultimately the emotional consequences of this internalised stigma will be that individuals who suffer from alcohol dependence will often experience feelings of intense shame which is the emotional core of their self-stigmatisation (Gray, 2009). Khantzian (2014) further posits that it is often the need to alleviate from shame and internalised stigma that drives substance abuse. However, as the dependency to the substance is intensified, the person becomes entangled in a vicious cycle where the loss of control over alcohol induces shame which in turn further fuels alcohol abuse (Sanderson, 2015). It has further been argued that unless the feelings of shame are regulated, the individual will remain at risk of using alcohol for self-soothing (Khantzian (2014). This alone makes shame a significant maintaining factor for a person's dependence on alcohol (Gray, 2010).

Counselling and alcohol dependence.

Psychological therapies have been shown to be effective as an intervention for the treatment of alcohol dependence (Luoma et al., 2012). Existing research has mostly focused in brief interventions and demonstrated that models such as Cognitive Behavioural Therapy and Motivational Interviewing can achieve reduction in alcohol consumption (Vasilaki, Hosier, & Cox, 2006; Watt et al., 2006). Nevertheless, literature that sought to compare the two modalities has not reported significant differences in their efficacy (Cutler & Fishbain, 2005), but has shown that those outcomes are the same across therapies with significant theoretical differences (Project MATCH Research Group, 1997). Even more interesting is the finding that even the

control condition of waiting to be assigned for therapy can produce therapeutic outcomes equal to those of the detox process. (Vaillant, 2009).

Such findings cast a shadow of doubt with regards to the actual usefulness of studies that focus exclusively on the therapeutic outcomes of certain interventions. Yet what is even more concerning is the fact that the vast majority of studies on therapeutic interventions are solely focused on the cessation of alcohol use as a therapeutic outcome, effectively disregarding the stabilisation of those outcomes and the challenges of maintaining one's recovery (Laudet & White, 2008).

The literature's focus on short-term outcomes has been particularly limiting when taking into consideration that in the issue of alcohol dependence, maintenance of recovery for long-term has been shown to be a rare phenomenon (McGovern & White, 2014; Harris, 2011).

Indeed our current understanding of recovery from alcohol views that as a long-term process where the cessation of problematic use is just the first step and should followed by the improvement of the person's overall well-being and their eventual integration back to society (Laudet, 2007; Maté, 2008). Taken from the aforementioned it can be argued that focusing exclusively on the short-term efficacy of therapeutic models fails to address the issue in a holistic manner. This endangers the risk of missing out on a better understanding of alcohol dependence and thus limits our capacity to treat in an effective way that truly promotes the individual's wellbeing (Laudet, Savage & Mahmood, 2011).

The role of AA

Yet, if we look beyond 1:1 counselling and psychotherapy interventions, we would find that alcohol dependence has been for decades now treated effectively and with long-term results in the meeting rooms of Alcoholic Anonymous (Straussner & Byrne, 2009).

Research on the effectiveness of AA has suggested the hypothesis that the positive benefits of attending AA are in very big part due to its social element. (Kaskutas, Bond, & Humphreys, 2002). The importance of a supportive community has been echoed by other studies that underline the significance of social and emotional nourishment for overcoming addiction (Groh, Jason, & Keys, 2008).

There has also been a growing body of qualitative research on AA members' experiences of recovery which points to a holistic transformation of people's identity as they move towards a new positive self-schema (Koski-Jannes, 2002; Kubicek, Morgan, & Morrison, 2002;

McKeganey, 2001). Consistent in the literature is also the notion of abstinence as a life-long journey which unless the individual is vigilant about maintaining could easily lead back to the suffering of alcohol abuse (Swora, 2004).

However, it is also worth mentioning that there is a number of studies which report that the process of recovery in AA can be particularly challenging for its members (Zakrzewski & Hector, 2004). This is mainly due to the emotional difficulties that come with having to embrace the stigmatising identity of an alcoholic (Hill & Leeming, 2014; Shinebourne & Smith, 2011; Zakrzewski & Hector, 2004), something that is a fundamental part for the recovery journey through AA. Furthermore, those are challenges that follow the individual even after achieving abstinence due to the fear of other people perceiving the label "recovering alcoholic" in a negative light (Hill & Leeming, 2014).

Critique of the literature & rationale of present study.

There is a limited number of studies that explore the way in which people who struggle with alcohol abuse relate with themselves from the perspective of counselling clients (Gordon, 2015). Instead, the majority of studies in this area have approached this topic from the point of view of AA members (Gubi, & Marsden-Hughes, 2013; Hill & Leeming, 2014).

However, when reflecting on the distinct philosophical framework of AA, it is worth noting that it differs substantially from the ethos of counselling and psychotherapy (Le, Ingvarson, & Page, 1995). Furthermore, and with regards to the particular emotion of shame, it has been argued that the AA model is inherently shame-based due to its focus on personal shortcomings and the admission of one's powerlessness (Peele, 2015).

The present study aims to contribute to our understanding of how people who have struggled with alcohol issues relate with themselves by giving voice to people who have experienced this issue and whose journey towards recovery has included long-term therapeutic work.

In focusing on individuals that have recovered from alcohol dependence the present study will tap to their own experiences of shame and negative self-image thereby illuminating the process in which such feelings can be regulated (White, 2005). Furthermore it will allow for an exploration of this topic from the perspective of counselling clients thereby complementing the existing literature which has been solely focused on the AA model. Finally it will enable for a

greater understanding of long-term therapeutic work in relation to alcohol dependence, something that has been largely overlooked in the literature.

In order to acquire such knowledge the study aimed to explore the following questions:

- What has been the participants' experiences of alcohol dependency and recovery from problematic alcohol use?
- How did they make sense of themselves and what have been the feelings that they experienced during this time?
- What has been the role of counselling in promoting the participants' recovery?

METHODOLOGY

Ontology, epistemology & research design

The research is informed by the ontological orientation of critical realism which posits the existence of an objective reality, while also allowing the possibility for its different interpretations (Larkin, Watts, & Clifton, 2006). This epistemological standpoint is in line with the idiographic and phenomenological nature of counselling which aims to facilitate the individual in making sense of their own subjective meanings (Woolfe et al., 2009).

The study follows a qualitative phenomenological design and specifically the methodological framework of Interpretive Phenomenological Analysis (Smith et al., 2009). A phenomenological standpoint is considering the reality of the observed phenomenon to be emerging through people's own experiences, perceptions and understanding of the issue that is being studied (Larkin, Watts, and Clifton 2006).

With regards to the particular issue of alcohol dependence, McIntosh & McKeganey (2000) suggest that the experience of being an alcoholic is continuously re-structured as the person is experiencing themselves in relation to the world that surrounds them, and argued that the reality of being an alcoholic is best understood through a phenomenological exploration of people's subjective understanding of that condition and what is means for them personally (McIntosh & McKeganey, 2000).

Aiming to investigate the participants personal reality and their understanding of the world that surrounds them (Smith, Flowers & Larkin, 2009), IPA regards the participant as being the expert on the phenomenon that is being researched and strives to provide a rich, deep account of their subjective process of sense-making (Smith, Flowers & Larkin, 2009).

However, as the approach has its theoretical foundations in both phenomenology and hermeneutics, IPA also acknowledges that the researcher's interpretive stance is inevitably a part of the research process (Spinelli, 1989; Smith & Osborn, 2003). Therefore it suggests that the understanding of a certain phenomenon emerges within a process of double hermeneutics where the researcher makes sense of the participants as they are making sense of their own experiences (Smith & Osborn, 2003).

Data collection

The study made use of semi-structured interviews for the needs of collecting data. According to Smith et al. (2009), the semi-structured interview can be a particularly useful format for phenomenological research as it allows researcher to have a conversation with the participants, while also probing them to discuss particular topics. Furthermore, the loose format of semi-structured interviews enables the emergence of unanticipated findings as participants are encouraged to share their thoughts, feelings, and experiences without being too confined by specific questions (Turner, 2010). The interviews' duration was approximately 1 hour. Throughout the interview process I was mindful of striking a balance between probing for answers and creating rapport that would allow the participants to feel safe enough to disclose their experiences in greater depth (DiCicco-Bloom & Crabtree, 2006). In building such rapport I sought to offer the participants a space of empathetic listening and unconditional acceptance (Rogers, 2012), elements that have been argued to facilitate the interview process (Paterson, 1997).

Recruitment

As the study employs an IPA research paradigm the sample size focused on the quality rather than the quantity of data, therefore a small number size of 3 to 6 was considered to be more appropriate in order for individual cases to be analysed in depth (Smith, Flowers, & Larkin, 2009). According to Finlay (2011), the sole requirement for participation in phenomenological

research was for people to have had personal experience of the issue that is being researched and to be willing to share that experience with the researcher.

A total of 5 participants were recruited who all fulfilled the requirements of having had experience of alcohol dependency, having achieved recovery from problematic alcohol use, and having had completed a minimum of 1 year of counselling.

Even though all 5 participants made use of counselling sessions throughout their recovery from alcohol, 2 participants (Matt and Simon) only relied in counselling as the main vehicle that promoted their recovery, although they did have a brief experience of group-based recovery programs (AA or SMART meetings). Conversely, the remaining 3 participants (Sharon, Carol, and Barry) have had experience of both counselling and a long-term engagement with the AA fellowship, with Carol and Sharon in particular identifying AA as having been the primary force that assisted them in recovering from alcohol use, with 1 to 1 counselling having played a secondary, supportive role..

Table of participants' demographics

Alias	**Age**	**Gender**	**Ethnicity**	**Sexuality**	**Faith**	**Relationship Status**	**Employment Status**
Matt	30s	Male	White British	Heterosexual	None	Single (divorced)	Full-time
Simon	30s	Male	White British	Gay	None	Single	Full-time
Carol	40s	Female	White British	Heterosexual	Not Stated	Single	Full-time
Sharon	40s	Female	White British	Heterosexual	Christian	Single (divorced)	Unemployed (ESA)
Barry	30s	Male	White British	Heterosexual	None	Single	Not Stated

Participants have been sourced by advertising the study in the facilities of the SWAN Alcohol Project, a South West-based charity that provides long-term counselling for people with alcohol dependence. The centre was established with the aim of offering affordable long-term counselling to people with alcohol-dependence issues. It is the ethos of the organization that makes it a suitable match for the original contribution of this study. More specifically the SWAN ethos does not align itself with the AA disease model for alcohol, while also advocating for long-term therapeutic work as a means of addressing the underlying issues of alcohol dependency (Aaronson (2006).

Ethical considerations

Ethical approval for this study has been granted from the University of the West of England, Faculty Research Ethics Committee (FREC).

In line with the BPS code of ethics and conduct, consent for participation was sought only after the participants were informed about the aims of the study and the content of the interviews (BPS, 2021). The author has also confirmed with SWAN's practitioners that clients have the capacity to provide informed consent and that it was safe for them to participate in this study.

The study respected the participants' right for self-determination. Participants were made aware that they could withdraw from the study at any time and that they could request for the destruction of their data. Participants were also made aware that the researcher reserved the right to terminate the interviews if there were concerns about the participants' wellbeing (BPS, 2021). Participants were assured that the study was not related in any way with their counselling at the SWAN and their participation or withdrawal from the study will not influence their counselling in any way.

Participants were reassured that their confidentiality will be respected at all stages of the research process. However the information sheet also communicated that in certain situations it would be necessary that confidentiality should be breached.

Analysis

The interview data were recorded with the use of an audio recording device. They were then transcribed in word document and anonymized. The transcription process was orthographic and produced a verbatim account of all verbal information (Braun & Clarke, 2013).

I ensured that the transcript was faithful to the content of the interviews by carefully considering the participants' punctuation and including bracketed notes about non-verbal communication (Braun & Clarke, 2006). The analysis was conducted following the 3 basic processes of bracketing, intuiting, and describing (Finlay, 2011), and adhered to the stages of Interpretive Phenomenological Analysis as those have been suggested by Smith, Flowers & Larkin (2009).

Furthermore, the IPA framework required the researcher to not aim only at the description of the participants' views but also seek to interpret and make sense of the participants as they are

making sense of their own experiences (Larkin et al., 2006; Smith & Osborn, 2003; Spinelli, 1989).

Doing so required careful bracketing of the my preconceptions and constant reflexivity exercises both before and throughout the data analysis (Biggerstaff & Thompson, 2008; Clarke & Braun, 2013). This process was further facilitated by the keeping of a reflective journal throughout the analytical process.

RESULTS

A shift towards self-compassion

For all participants, alcohol has been a major and constant presence that dominated their experience of life since early adulthood. It was the place they would go to in order to find comfort from distress, and confidence in dealing with others. More importantly, however, in alcohol they would achieve a state of oblivion which kept any distressing thoughts and feelings at bay. As a result, when they would finally commit to not drinking, they also had to grapple with the fact that life without alcohol was a novel experience, and one that necessitated that they should engage with and establish a new relationship with themselves.

This was not an easy process and was initially experiencing as an "unravelling" of the self, during which they became confronted by the self-deprecating inner monologue and negative self-concept that alcohol used to mask. Ultimately, however it yielded a shift towards a more compassionate way of relating with themselves which manifested in increased self-acceptance, a renegotiation of their critical inner monologue, and the internalisation of a compassionate "other" whether that was the supporting network of the fellowship or an unconditionally accepting therapist.

1. Trust and unconditional acceptance as pre-requisites for self-exploration.

Matt, Simon, and Barry have all considered their engagement with therapy as instrumental in holding them through this process of unravelling and self-exploration. When asked to reflect on what was it about the counselling interaction that made it useful to them, all participants pointed out to the therapeutic relationship itself. More specifically it was the trust and rapport

that is achieved with their therapists that was identified as having been key in allowing them to fully disclose themselves and confront difficult aspects of their experience of life.

For Matt, it was the trust that he experienced in the counselling relationship that made it possible to use the therapeutic space the way he needed to, which was to challenge and confront all the aspects of life and of himself that has historically found intolerable to engage with. The value of therapy for Simon seems to have been derived from his experience of being truly witnessed, and it was through experiencing that through his interaction with another person, that he was also able to witness himself. In contrast to the groups with which Simon has engaged in the past, the aim of the therapy was not to "fix" him, but rather to get to know the "brokenness" in him. He did not have to be conscious as to how he is perceived by his social group, nor was there a need to project an idealized self that was purged from what he perceived as blemishes. The wholeness of himself was welcome in the therapy room and that in turn allowed Simon to gradually become more welcoming of himself.

This was in line with Barry's experience who reports that what he needed and valued in therapy was the experience of a space that was truly devoid of judgement, where he could afford to be really and completely seen by another without any fear of shame or embarrassment. Perhaps it was even more interesting to note that even those participants that contributed their recovery to AA, still benefitted from qualities of trust and acceptance that Barry, Simon, and Matt discussed.

For Sharon, there were often issues which for her felt either not safe or not appropriate to disclose to an AA setting. A particular example for her was traumatic experiences earlier in her life which even though they were important due to having shaped the way she would relate with herself and others, Sharon felt that there was no place in AA to discuss about and work through them. Conversely, the therapeutic relationship felt safe and appropriate for her to disclose the more sensitive areas of her life:

Carol's words very much echo Sharon, as she too have found that AA was not enough to completely hold her during her work on step 4, a difficult time in which she was being "*pulled apart*". Perhaps what has been the most important ways in which counselling would complement AA is once again derived by the sense of trust that is inherent to the therapeutic interaction. Having this safe space where they could feel confident in revealing the whole of themselves has played an important role in helping them to manage some challenging aspects

of being part of the fellowship, thereby enabling them to make the most of what AA had to offer. For Carol and Barry in particular engaging with AA was initially not easy, as they were both very resistant of the demands that were imposed on them. Pressured within the confines of AA, Barry felt that there was no outlet for the internal tension he was experiencing. He needed counselling to tear a rupture into the walls that were smothering him so that his emotions could breathe.

2. Understanding the self and befriending the inner critic

Simon perceived that the improved way in which he relates to himself was the outcome of understanding himself better. He attributed this greater self-knowledge to therapy and the fact that he was provided with the space and time to reflect on the whole of himself and not just his problematic behaviours. Similarly, Matt and Barry viewed their gradual movements towards self-understanding as the building blocks from which self-acceptance was forged.

In reaching that greater understanding of himself, Simon had to also become aware of the way his inner critical voice functioned and the role that it played in fuelling his problematic alcohol use. Throughout therapy it was possible for him to realise the unrealistic expectations he placed on himself which was instrumental in nullifying the harmful effects of that critical voice.

Similarly to Simon, Matt has also found that at the very core of his inner-critic was the notion that he was constantly failing to meet his own standards. Contrary to Simon however, Matt's process of befriending this voice required him to actually move towards it in order to be aligned with his own standards. Overtime and throughout his recovery Matt has managed to forge a new relationship with his critical voice which instead of chastising and persecuting him, it now empowered his movement towards a healthier life. What emerged from Matt's narrative as a new, more functional relationship with the inner critic was also present in Barry's narrative. His self-defeating monologue of having been fundamentally damaged as a person was replaced by a new voice that urged him towards self-development and growth.

3. Self-compassion through being held

A shift towards self-acceptance and self-compassion has also been reported by Carol and Sharon. However since those participants' recovery relied heavily on their long-time engagement with AA, it was no surprise that this shift was also tied to their experience of being held by the fellowship.

Carol considered that framing her struggles with alcohol in terms of having a disease has been instrumental in relieving feelings of shame. However it was her experience of feeling part of a group and being surrounded by people who shared similar experiences that has made it possible for this re-framing to occur.

Indeed throughout our interview it very much felt that Carol has found in AA a new family, one that would be there for her to embrace and to comfort her even at the times that she felt unworthy of receiving such warmth. Undoubtedly this must have been a profoundly liberating experience for Carol, especially considering the shame and secrecy in which she lived in order to spare herself from the disappointment and judgement of her parents.

This experience of being held by a new family has also been instrumental in enabling Sharon to connect with herself in a more compassionate way. Perhaps it was particularly her that benefitted the most from experiencing herself as part of a loving collective, as Sharon's whole life's journey has been a search for the loving comfort of her childhood parenting. Within the holding social space of the fellowship, Sharon has been receiving consistent positive reinforcement which encouraged to reflect on herself and her life in a positive way. Ultimately this sense of belongingness and of being held and carried by the love of her group resulted in the gradual repairing of her self-worth and a greater capacity for self-acceptance.

DISCUSSION

The participants of this study had to grapple with intense shame and self-criticism, for which alcohol was a means of soothing. It was a common experience that in the absence of this comforting mechanism they all had to confront those difficult thoughts and feelings and find different ways to navigate them. Given the differences between the ethos of psychological therapies and the AA tradition, it was expected that the shift towards a compassionate inner-voice would manifest in different ways in those settings. This was indeed the case.

Listening to their narratives, it could be argued that what has been suggested by Neff (2011) as the common humanity element of self-compassion was much more integral for those people whose recovery was mainly driven by AA. Carol, Sharon, and to some extent Barry, considered

that being part of a group with which they shared similar experiences has effectively normalised their struggles. This is something well documented in literature around AA, where the supportive social network of the fellowship was considered by its members as the key factor for promoting and safeguarding recovery (Cohen, Tracy, Rodriguez, & Bowers, 2020). It also brings to mind Bruce Alexander's infamous "rat-park" experiment and the resulting hypothesis that the "cure" for addiction might not be sobriety, but connectedness (Alexander, 2012). It might be important here to also keep into consideration the deep relational wounding that Carol and Sharon experienced in their formative years, which has inarguably played an important role for their compromised capacity to form nourishing bonds as adults (Erozkan, 2016). It could be argued that their engagement with the social element of the fellowship has been a reparative experience that might have facilitated the shift towards a more secure attachment style (Dark-Freudeman, Pond Jr, Paschall, & Greskovich, 2020). Consequently they gradually became more capable of internalising the care and acceptance they received by their new friendships and became more capable to channel those qualities in the way they related with their own selves.

Even though it could be argued that this reparative process can also be experienced within the therapeutic interaction, listening to Sharon and Carol, I would become increasingly doubtful as to whether this would have really been sufficient for them. I am reminded of the proposed determinants of therapeutic efficacy (Duncan, Miller, Wampold & Hubble, 2010), where 40% of therapeutic efficacy is attributed to extra-therapeutic factors such as changes in client's circumstances, and 30% being ought to the quality of the therapeutic relationship. Given the wealth of evidence regarding social support as a key extra-therapeutic factor that promotes positive therapeutic outcomes (Roehrle & Strouse, 2008), particularly so in the domains of addiction and depression (Litt, Kadden, Kabela-Cormier & Petry, 2009; Delaney, 2017; Ioannou, Kassianos, & Symeou, 2019), I suggest that the fundamental relational shift that Carol and Sharon experienced in being part of a supportive social network might not have been substituted by their engagement with therapy alone.

In contrast to the previous participants, Matt and Simon, whose recovery has been almost exclusively supported by their engagement with 1 to 1 therapy, seem to have been benefited much more from the suggested mindfulness component of self-compassion (Neff, 2011). It appears that Matt, Simon, and Barry would become increasingly more lenient towards themselves as their understanding of their emotional processes progressively deepened. They

all talked about an experience of "unravelling" or "picking away" at themselves, a painful but enlightening process through which they graduated with an increased awareness of their triggers and a realisation that the function of alcohol in their lives was indeed one of self-soothing.

The way they made sense of their experiences in therapy very much echoes the fundamental notions of the Compassion Focused model which conceptualises addiction to substances as an adaptive response to trauma (Phelps, Paniagua, Willcockson & Potter, 2018). The participants' narratives were in line with the basic tenets of the model which aims to increase the client's understanding of how they respond to environmental threats, while also reprogramming their self-defeating inner monologue to one of warmth and acceptance of the self (Gilbert, 2014). Indeed CFT has been proven effective in managing addiction issues, with studies reporting a lasting decrease in substance use (Brooks, Kay-Lambkin, Bowman & Childs, 2012), reduced feelings of shame (Matos & Steindl, 2020), and greater capacity for mindfulness and self-compassion (Frostadottir & Dorjee, 2019). Nevertheless, this transformative process has indeed been shown to be emotionally challenging (Carlyle et al., 2019). A recent study of CFT for opioid use yielded seemingly paradoxical results, with the treated group exhibiting both greater capacity for resisting opiate use, but also increased craving for it when compared to untreated controls. The researchers interpreted the apparent antithesis in those findings as indicative of the CFT group engaging and working through their resurfacing trauma, something that escalated their comfort-seeking drive, yet ultimately resulted to increased robustness in tolerating distress (Carlyle et al., 2019). This is very much in accordance with my participants' experience of "picking away" or becoming "unravelled" due to confronting parts of their experience that was initially thought of as intolerable. And yet being mindful of those internal processes ultimately awarded them with the capacity to say no to this toxic way of comforting themselves, to endure the surge of emotional distress, and seek to comfort themselves in ways that would not compromise their emotional well-being.

To accomplish this, however, it was necessary for the therapeutic interaction to allow them space and time for self-reflection, and to unearth the previous wounding that would become triggered each time they turned to alcohol for self-soothing. Ultimately, it became clear to me that both AA and the SWAN's integrative therapeutic approach had one important thing in common, that they both prioritised a holistic view of my participants' experience of life. They both approached recovery as a lengthy, transformative process, which cannot be possibly

reduced to short-term interventions of alcohol reduction goals (Aaronson, 2006). For Carol and Sharon this self-exploration took place within the context of their accepting, supportive fellowship group, whereas for Matt, Barry, and Simon it emerged through discussions within a therapeutic relationship where they could feel safe and held enough to fully reveal themselves. In both cases, however, participants have come to internalise a compassionate "other" that saw and embraced their vulnerability and responded with kindness as opposed to condemnation.

Implications

Through their individual narratives several crucial points emerged that seem to indicate that despite the variety in their experiences, there are certain aspects of their journeys that have been identified as common. I consider that several of those points merit further reflection due to their implications for our conceptualisation and treatment of alcohol dependence.

For some participants the encouragement and acceptance that they received through being part of AA's supportive social network was key in normalising their struggles and shifting their inner monologues towards acceptance and self-compassion. Nevertheless, what seems to be a crucial limitation of AA is the demand to submit to the collective identity of the alcoholic, which suggests that the aforementioned benefits of belongingness might be dependent on the person's willingness and capacity to integrate to the AA identity and worldview (Hoffmann, 2006; Vaillant, 2005). Indeed, for some of my participants this was an insurmountable barrier that obstructed them from pursuing a deeper engagement with the fellowship, whereas they found that it was within the non-judgemental space of 1 to 1 therapy that they were encouraged to unfold, explore, and compassionately re-integrate aspects of themselves that had been disowned.

And yet, in spite of AA's limitations, it is undoubtable that the belongingness that some of this study's participants experienced as a result of conforming and integrating with the group yielded important benefits, and was considered by them as the cornerstone of their recovery process. My experience of those participants was that this element of social support could not possibly be substituted by 1 to 1 therapy, and there is indeed literature to suggest that for this stigmatised population, the degree to which they feel socially valued and supported can be a crucial factor in achieving and maintaining recovery (Rapier, McKernan & Stauffer, 2019). With this in mind, it is important to consider that in cases that recovery from alcohol is AA-

driven, there might be some value in flexibly reframing the therapeutic encounter as not the centre of the recovery process, but rather as an additional layer of containment that is facilitative to the AA engagement and can support the person with negotiating the tensions and challenges that could emerge from it. Furthermore it might be worth considering the possible merits of broadening the integrative ethos that underpins most modern psychotherapy programmes, so that it would also encompass insights from approaches that do not sit with any established therapeutic modality, but like AA, they might have something valuable to contribute to our clients' wellbeing.

Another crucial, point emerges from the realisation that despite the obvious differences between AA and long-term therapy, there was one key concept that those two approaches shared; That is the view of recovery as something dynamic - a process, rather than a destination to be arrived at. This key notion permeated through all participants' narratives, as they all saw alcohol not as the root cause of their suffering but as a symptom of a deeper malaise. Recovery was seen as going beyond the simple cessation of drinking, but encompassing the exploration of the past trauma that made drinking necessary, as well as facilitating the emergence of a new self-compassion would in part take the place of alcohol for self-soothing. To quote Sharon: "*once you put the drinking down, you know, you're left with yourself*".

And yet, it is important to point out here that this view of recovery comes in direct opposition to the way that alcohol dependence is understood and treated in our society. Most interventions seem to be taking the form of short-term goal-oriented programs that aim to improve alcohol outcomes, while failing to address whether those would be sustainable for people that have been effectively been deprived of the only way they have known to deal with distress (Laudet, Savage & Mahmood, 2011).

My concern is that by approaching and treating alcohol in this manner, mental health services are to some extend colluding with the aforementioned notion of blaming, as opposed to supporting, the victim of alcohol's abuse. It is not unreasonable to suggest that by disregarding the underlying issues that necessitated alcohol use for self-soothing, many individuals would be effectively set up for failure. What is even worse, is that due to the social stigma around alcohol dependence, it is very likely that the failure of the system will become internalised as a failure of the self (Wachtel, 1999), thereby further fuelling feelings of shame that alcohol is always too eager to soothe.

It is not without some regret that I find myself admitting that the fellowship of Alcoholics Anonymous, with all its limitations, seems much more respectful than our current mental health services towards the level of effort that is required in order to achieve in giving up this toxic way of self-soothing in favour of healthier more fulfilling lives. With this in mind, I suggest that an integrative way of treating alcohol would be benefitted by incorporating this aspect of the AA ethos, and therefore move towards providing treatments that look beyond the condition but embrace the person in a holistic manner.

To this end, I recommend that the findings of the present study could inform future qualitative research that will seek to delve deeper into the experiences of individuals that have experienced both AA and counselling as part of their recovery from alcohol dependence. As this was not the initial aim of this study, only a fragment of the already small sample has experienced and was able to provide insights of both approaches. I would suggest that a grounded theory methodology that will be specifically focusing on this population, will be able to build on or challenge the present findings, while also being in a better standing to propose ways that the two approaches can complement one another in an integrative manner. In addition to the above, it would be worth encouraging counselling trainees that have had been members of 12 step fellowships to engage with self-investigative methodologies such as autoethnography, and reflect further on this experience in the context of their foray into the counselling world. The reflections and insights that would emerge through such research projects would be invaluable in delineating further the tensions of opposition, as well as the opportunities for integration that can emerge through the marriage of those two worlds.

Limitations

The present study is subject to the same limitations that are inherent in idiographic qualitative research, namely the conscious sacrifice of breadth in favour of depth. The small number of 5 participants sits within the suggested sample size for an IPA research (Smith, Flowers & Larkin, 2009), and indeed allowed for a nuanced exploration of their experiences by going beyond what was being directly communicated, instead querying their narratives in search for additional meanings that those could be conveying (Smith & Shinebourne, 2012). Nevertheless, it can be argued that a larger sample would have allowed for a greater range of participants' experiences, that would have better contextualised the phenomenon of recovery from alcohol addiction. The difficulty in recruitment is perhaps suggestive of a population that was hard to reach. Indeed, the dominant model of treating alcohol addiction seems to fall within

the confines of short-term, outcome-focused interventions, making long-term therapy somewhat of a rarity (McKay & Hiller-Sturmhöfel, 2011). Limiting my pool of recruitment to a single counselling organisation was in itself a recruitment challenge, but one that was deemed necessary as a means of securing a level of sample homogeneity (Larkin, Shaw & Flowers, 2019).

Still, despite the narrow criteria for recruitment, it was surprising to realise the extent to which my participants' experiences varied. An example of such diversity was the differential experiences of Counselling and AA. More specifically, even though all participants had issues with alcohol since childhood, and despite long-term therapy having been a major part of their recovery, some of them considered AA to have been the main pillar that supported their journey, with counselling playing a secondary, facilitative role. Initially I considered this crucial difference as a compromising factor for the homogeneity of my sample, worrying as to whether my sample was effectively telling the story of 2 different life experiences as opposed to the exploration of a singular phenomenon. However as my analysis progressed I have come to cherish the variety of perspectives that my study was able to encompass. In doing so it effectively safeguarded me from presenting an oversimplified understanding of this phenomenon, instead enabling me to highlight the complexities and intricacies of addiction and recovery. This has very much influenced my outlook throughout the analysis, making me more sensitive to the notion that life is rarely as neat and tidy as academic manuscripts are often guilty of representing.

Even though I strived to respectfully embrace my participants' experiences, it was not until the analysis of their narratives that I became fully aware of the limiting impact of my own process. I found myself bound to a conceptualisation of recovery as an intrapersonal phenomenon, which exerted a gravitational pull towards the aspects of my participants' narratives that pertained to shifts in their concept of self, effectively dismissing the interpersonal facets of their journey. My difficulty in flexibly broadening my focus to what lied outside the concept of the "self" is perhaps indicative of social narratives around happiness as an individual responsibility, a neoliberal notion that many have argued the world of psychotherapy is inadvertently guilty of perpetuating (Rustin, 2015). Indeed, it is too often the case that personal therapy seeking to hone in on the individual client's cognitive and emotional processes, does so at the risk of failing to appropriately position their distress within the systemic context of their environment (LaMarre et al., 2019).

Conclusion

It is broadly acknowledged that the issue of alcohol dependence has a severe negative impact on both the individual and society as a whole. Nevertheless, I am concerned that the short-term, outcome-focused interventions that seem to dominate it's treatment fail to consider the complexity of this phenomenon. It is my hope that the insights that emerged through this IPA study will offer a small contribution towards a greater appreciation of the underlying mental health concerns, as well as the social determinants that give rise to and perpetuate problematic alcohol use.

My participants' experiences of both long-term therapy and AA participation have, in spite of the differences between the two settings, converged in suggesting that overcoming this issue is a lengthy process that requires a fundamental shift in the individual's self-concept, and a movement towards a self-compassionate inner monologue. Both Counselling and AA have been identified as having distinct strengths and limitations, which made the two approaches be more or less suitable and appealing for different people. However, in contemplating ways in which alcohol dependence could be better understood and treated, it is worth exploring the possibility of synergies that could emerge through integrating the respective strengths of the two approaches.

In providing a concluding reflection, I acknowledge that even though I made a conscious effort to resist the pull towards oversimplifying my participants' narratives to fall in line with my own understanding of addiction and recovery, it is inevitable that my experiences, convictions, and preconceptions have inadvertently formed lenses through which my participants' accounts were viewed, and this has at some level played a role in the generation of the study's themes. There is no doubt that had the same participants been interviewed by a different researcher, both the emerging themes but also the interviews through which those emerged would have been different, thereby giving birth to a different manuscript than the one that I was able to produce. And yet I embrace the unique and individual nature of this work, as the product of IPA's double hermeneutics that was made possible through the honesty and genuine interest that both I and my participants shared in collaborating together to make sense of their journey. It do not regard the findings of this study to comprise the one definite truth of my participants' experiences, but rather a truth, perhaps one of many, which doesn't make it any less valid or indeed valuable in contributing to our understanding of recovery from alcohol dependence.

References

Aaronson, R. (2006). *Addiction-This being human: A New Perspective*. AuthorHouse.

Alexander, B. K. (2012). Addiction: The urgent need for a paradigm shift. *Substance Use & Misuse*, *47*(13-14), 1475-1482.

American Psychiatric Association (APA). (2013). *Diagnostic and statisticalmanual of mental disorders* (5th ed.). Washington, DC: Author.

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative research in psychology*, *5*(3), 214-224.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

British Psychological Society (2021). Code of Human Research Ethics. Retrieved from https://www.bps.org.uk/guideline/bps-code-human-research-ethics-0

Brooks, M., Kay-Lambkin, F., Bowman, J., & Childs, S. (2012). Self-compassion amongst clients with problematic alcohol use. *Mindfulness*, *3*(4), 308-317.

Carlyle, M., Rockliff, H., Edwards, R., Ene, C., Karl, A., Marsh, B., ... & Morgan, C. J. (2019). Investigating the feasibility of brief compassion focused therapy in individuals in treatment for opioid use disorder. *Substance Abuse: Research and Treatment*, *13*, 1178221819836726.

Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The psychologist*, *26*(2), 120-123.

Cohen, J., Tracy, S., Rodriguez, F., & Bowers, R. (2020). Therapeutic Change Factors in Alcoholics Anonymous. *The Person Centered Journal*, Vol. 25, No. 1-2

Cutler, R. B., & Fishbain, D. A. (2005). Are alcoholism treatments effective? The Project MATCH data. *BMC Public Health*, *5*(1), 1.

Dark-Freudeman, A., Pond Jr, R. S., Paschall, R. E., & Greskovich, L. (2020). Attachment style in adulthood: Attachment style moderates the impact of social support on depressive symptoms. *Journal of Social and Personal Relationships*, *37*(10-11), 2871-2889.

Delaney, M. E. (2017). The relationship between counseling, social support, and depression in mothers of fragile families. *Journal of Mental Health Counseling*, *39*(4), 320-334.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical education*, *40*(4), 314-321.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works in therapy*. American Psychological Association.

Erozkan, A. (2016). The Link between Types of Attachment and Childhood Trauma. *Universal journal of educational research*, *4*(5), 1071-1079.

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. John Wiley & Sons.

Frostadottir, A. D., & Dorjee, D. (2019). Effects of mindfulness based cognitive therapy (MBCT) and compassion focused therapy (CFT) on symptom change, mindfulness, self-compassion, and rumination in clients with depression, anxiety, and stress. *Frontiers in psychology*, *10*, 1099.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6-41.

Gordon, K. (2015). Understanding Compassion-Focused Therapy from a Participant's Perspective.

Gray, R. (2009). The dynamics of shame: Implications for counsellors working in alcohol and other drug settings. *Psychotherapy in Australia*, *16*(1), 30.

Gray, R. (2010). Shame, labeling and stigma: Challenges to counseling clients in alcohol and other drug settings. *Contemporary drug problems*, *37*(4), 685-703.

Groh, D. R., Jason, L. A., & Keys, C. B. (2008). Social network variables in alcoholics anonymous: A literature review. *Clinical psychology review*, *28*(3), 430-450.

Gubi, P. M., & Marsden-Hughes, H. (2013). Exploring the processes involved in long-term recovery from chronic alcohol addiction within an abstinence-based model: Implications for practice. *Counselling and Psychotherapy Research*, *13*(3), 201-209.

Harris Jr, J. D. (2011). *Maintaining abstinence from substance use: A grounded theory investigation* (Doctoral dissertation, Capella University).

Hill, J. V., & Leeming, D. (2014). Reconstructing 'the alcoholic': recovering from alcohol addiction and the stigma this entails. *International Journal of Mental Health and Addiction*, *12*(6), 759-771.

Hoffmann, H. C. (2006). Criticism as deviance and social control in Alcoholics Anonymous. *Journal of Contemporary Ethnography*, *35*(6), 669-695.

Ioannou, M., Kassianos, A. P., & Symeou, M. (2019). Coping with depressive symptoms in young adults: perceived social support protects against depressive symptoms only under moderate levels of stress. *Frontiers in psychology*, 2780.

Kaskutas, L. A., Bond, J., & Humphreys, K. (2002). Social networks as mediators of the effect of Alcoholics Anonymous. *Addiction*, *97*(7), 891-900.

Khantzian, E. J. (2014). The Self-Medication Hypothesis and attachment theory: pathways for understanding and ameliorating addictive suffering. *Addictions From an Attachment Perspective: Do Broken Bonds and Early Trauma Lead to Addictive Behaviours?*, 33.

Koski-Jannes, A. (2002). Social and personal identity projects in the recovery from addictive behaviours. *Addiction Research and Theory*, *10*(2), 183-202.

Kubicek, K. R., Morgan, O. J., & Morrison, N. C. (2002). Pathways to long-term recovery from alcohol dependence: Comparison of spontaneous remitters and AA members. *Alcoholism Treatment Quarterly*, *20*(2), 71-81.

LaMarre, A., Smoliak, O., Cool, C., Kinavey, H., & Hardt, L. (2019). The normal, improving, and productive self: Unpacking neoliberal governmentality in therapeutic interactions. *Journal of Constructivist Psychology*, *32*(3), 236-253.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative research in psychology*, *3*(2), 102-120.

Laudet, A. B., Savage, R., & Mahmood, D. (2011). Pathways to long-term recovery: A preliminary investigation. *Journal of Psychoactive Drugs*, *34*, 305-311.

Laudet, A. B., & White, W. L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction, and stress among former poly-substance users. *Substance use & misuse*, *43*(1), 27-54.

Le, C., Ingvarson, E. P., & Page, R. C. (1995). Alcoholics Anonymous and the counseling profession: Philosophies in conflict. *Journal of Counseling and Development: JCD*, *73*(6), 603.

Litt, M. D., Kadden, R. M., Kabela-Cormier, E., & Petry, N. M. (2009). Changing network support for drinking: network support project 2-year follow-up. *Journal of consulting and clinical psychology*, *77*(2), 229.

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., & Fletcher, L. (2012). Slow and steady wins the race: a randomized clinical trial of acceptance and commitment therapy targeting shame in substance use disorders. *Journal of consulting and clinical psychology*, *80*(1), 43.

Maté, G. (2008). *In the realm of hungry ghosts: Close encounters with addiction*. Random House Digital, Inc.

Matos, M., & Steindl, S. R. (2020). "You are already all you need to be": A case illustration of compassion-focused therapy for shame and perfectionism. *Journal of Clinical Psychology*, *76*(11), 2079-2096.

McGovern, T. F., & White, W. (2014). *Alcohol problems in the United States: Twenty years of treatment perspective*. Routledge.

McIntosh, J. and McKeganey, N. (2000). 'Addicts' narratives of recovery from drug-use: constructing a non-addict identity'. Social Science and Medicine. 50, p1501-1510.

McKay, J. R., & Hiller-Sturmhöfel, S. (2011). Treating alcoholism as a chronic disease: approaches to long-term continuing care. *Alcohol Research & Health*, *33*(4), 356.

McKeganey, J. M. N. (2001). Identity and recovery from dependent drug use: The addict's perspective. *Drugs: education, prevention and policy*, *8*(1), 47-59.

Neff, Kristin D. 2011. "Self-Compassion, Self-Esteem, and Well-Being." *Social and Personality Psychology Compass* 5(1): 1-12.

Paterson, A.S. (1997). *A humanistic framework for interviewer skills*. Paper presented at the British Educational Research Association Annual Conference 11-14th September 1997

Peele, S. (2015, January 02). American addiction treatment is shame-based. *Psychology Today*. Retrieved from https://www.psychologytoday.com/blog/addiction-in-society/201501/american-addiction-treatment-is-shame-based

Phelps, C. L., Paniagua, S. M., Willcockson, I. U., & Potter, J. S. (2018). The relationship between self-compassion and the risk for substance use disorder. *Drug and alcohol dependence*, *183*, 78-81

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1993). In search of how people change: Applications to addictive behaviors. *Addictions Nursing Network*, *5*(1), 2-16.

Project MATCH Research Group. (1997). Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH Posttreatment drinking outcomes. *J. stud. alcohol*, *58*, 7-29.

Rapier, R., McKernan, S., & Stauffer, C. S. (2019). An inverse relationship between perceived social support and substance use frequency in socially stigmatized populations. *Addictive behaviors reports*, *10*, 100188.

Roehrle, B. and Strouse, J. (2008). Influence of social support on success of therapeutic interventions: A meta-analytic review. Psychotherapy: Theory, Research, Practice, Training, 45(4), 464-476

Rogers, C. (2012). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin Harcourt.

Rustin, M. (2015). Psychotherapy in a neoliberal world. *European Journal of Psychotherapy & Counselling*, *17*(3), 225-239.

Sanderson, C. (2015). *Counselling Skills for Working with Shame*. Jessica Kingsley Publishers.

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

Smith, J., Flowers, P., & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. London: Sage

Smith, J.A. & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), Qualitative psychology: A practical guide to research methods (pp.51–80). London: Sage

Smith, J. A., & Shinebourne, P. (2012). *Interpretative phenomenological analysis*. American Psychological Association.

Spinelli, E. (1989). *The Interpreted World: An Introduction to Phenomenological Psychology*. London: Sage

Straussner, S. L. A., & Byrne, H. (2009). Alcoholics Anonymous: Key research findings from 2002–2007. *Alcoholism Treatment Quarterly*, *27*(4), 349-367.

Swora, M. G. (2004). The rhetoric of transformation in the healing of alcoholism: The twelve steps of Alcoholics Anonymous. *Mental health, religion & culture*, *7*(3), 187-209.

Tatarsky, A., & Marlatt, G. A. (2010). State of the art in harm reduction psychotherapy: An emerging treatment for substance misuse. *Journal of clinical psychology*, *66*(2), 117-122.

Turner, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *The qualitative report*, *15*(3), 754-760.

Vaillant, G. E. (2005). Alcoholics Anonymous: cult or cure?. *Australian and New Zealand Journal of Psychiatry*, *39*(6), 431-436.

Vaillant, G. E. (2009). *The natural history of alcoholism revisited*. Harvard University Press.

Vasilaki, E. I., Hosier, S. G., & Cox, W. M. (2006). The efficacy of motivational interviewing as a brief intervention for excessive drinking: a meta-analytic review. *Alcohol and Alcoholism*, *41*(3), 328-335.

Wachtel, P. L. (1999). Resistance as a problem for practice and theory. *Journal of Psychotherapy Integration*, *9*(1), 103-117.

Watt, M., Stewart, S., Birch, C., & Bernier, D. (2006). Brief CBT for high anxiety sensitivity decreases drinking problems, relief alcohol outcome expectancies, and conformity drinking motives: Evidence from a randomized controlled trial. *Journal of Mental Health*, *15*(6), 683-695.

White, W. L. (2005). Recovery. *Alcoholism Treatment Quarterly*, *23*, 3-15.

Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. (2009). Handbook of counselling psychology (3rd ed.). London: Sage

World Health Organization. (1992). World Health Organization Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death. *Geneva, Switzerland: World Health Organization*.

Zakrzewski, R. F., & Hector, M. A. (2004). The lived experiences of alcohol addiction: Men of alcoholics anonymous. *Issues in Mental Health Nursing*, *25*(1), 61-77.