

Understanding Compassion-Focused Therapy from a Participant's Perspective

Author: Kristin Gordon

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Understanding Compassion-Focused Therapy from a Participant's Perspective

Kristin Gordon

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Boston College Sociology Department

Advised by Professor Paul Gray

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Introduction

Alcohol dependence produces social, economic, and health consequences. When this harm reaches beyond the dependent, he or she is labeled as a deviant and subsequently faces stigmatized perception and treatment from his or her family, friends, and larger society. This stigma may be internalized as shame and self-stigma in the mind of the dependent, serving to perpetuate harmful alcohol use. While research about the internalization of stigma and its consequences is readily available, little is known about the reasons why labels are more strongly internalized and felt by some and not by others (Corrigan, Watson, and Barr 2006; Shaw 2002).

Clinical studies show that an ability to practice self-compassion may mitigate and counter self-stigma, thereby suggesting a potential to decrease harmful alcohol use (Goss and Allan 2012; Hedman et al. 2013; Livingston et al. 2010; Neff 2011). However, there is minimal research about whether self-compassion may be increased among those suffering from alcohol dependence. Additionally, the factors that may facilitate the development of this capability have not been explored in the existing clinical studies.

In this study, alcohol dependents are defined as those who are reliant upon alcohol, continue drinking regardless of the health, social, and economic consequences of this dependence, and have sought intervention. In particular, this study explores the perceptions and experiences of participants in “compassion-focused therapy” (CFT) in Ireland. Through first-hand narrative accounts, it is apparent that CFT enables modifications in the self-labeling and self-concept of alcohol dependents. Such modifications lead to decreased shame and self-hate amongst participants, as well as improvements in self-compassion. When combined with spirituality and mindfulness, this capability grants alcohol dependents cautious optimism for a life of sobriety.

Background

Experience, Rapport, and Validity

In February of 2013, an Irish nun visited Boston College to host a discussion on a series of rehabilitation centers for drug, alcohol, and gambling addictions that she founded throughout Ireland and Northern Ireland. After the presentation, I approached her and told her that I was interested in pursuing a future in social services. Upon hearing this, she immediately extended an invitation to me to visit one of her centers. She said that I could come whenever and for however long I pleased. On a gut instinct, I booked a flight to Ireland, where I spent six weeks participating in an internship during the summer of 2013. Throughout this study, I will refer to the center using the pseudonym “Fáilte.” My internship allowed me to attend, participate in, and lead group therapy meetings in the detox unit and the women’s residence unit of the center. During these weeks, I lived on-site and I spent a majority of my free time with the women going through therapy. I attended occupational therapy sessions, ate in the dining hall, and participated in recreational activities including meditation, singing workshops, and fundraising events alongside the participants.

Before my arrival, I was aware that my opinion of alcohol dependents was solely derived from what I had heard other people say about them. As society views alcohol dependence with stigma, the things that I heard others say about alcohol dependents were often not positive. Aware that such views would affect my ability to gain an understanding of alcohol dependence directly from those suffering from the condition, I made a significant effort to leave my bias and preconceived views of alcohol dependents behind me when I arrived in Ireland. In doing so, I made no claims to have an understanding of alcohol dependence or its impact on those it touches. As such, I entered Fáilte both acknowledging my ignorance and seeking to remedy it.

My initial interactions with the women at the center were marked with a degree of distrust and hostility. During one interaction I was asked whether I, too, was dependent on alcohol. When I replied that I was not, the woman responded, “Why do you have a right to be here then?” For a long time, any sort of answer to this question evaded me. Later I would begin to respond to such inquiries with the simple reason I had decided to travel to Fáilte – to understand. The women seemed receptive to this response, and over the course of my six weeks they began to share their stories with me. When women spoke to me, my response was nothing more than to listen. When I was particularly troubled by something a woman told me, I would turn to the counselors at the center and they would help me understand the wider connotations of what I was hearing.

Over time, it became apparent to me that I had gained acceptance from the group of women participating in therapy regardless of the fact that I do not suffer from alcohol dependence. This acceptance was exemplified in one particular instance when I was sitting outside knitting with the women. Several women were discussing whether they should break the rules and take a smoke break outside of the designated smoking time. In the discussion, one woman said, “Oh no, we can’t do that... Kristin is here.” Here, she viewed me as a figure with authority relative to that of a staff member at the center. However, the other women quickly responded, “No, no. Kristin is one of us.” This comment and similar anecdotes solidify my belief that the women were presenting their authentic and honest selves to me while I stayed at the center. By the time I left my internship, I had developed close relationships with those who lived and worked at Fáilte. With the development of these relationships, any preconceived views of alcohol dependents that I had unintentionally brought with me were completely dismantled. The women who had originally looked at me with apprehension were the same ones to organize my

goodbye party, where heartfelt wishes and gratitude for our time together were shared between all of us. I will never forget the moment when I walked out of the residence hall for the final time, only to be chased after by one woman who yelled after me, “Kristin, we love you!” It was in that moment that I knew I could not allow their stories to continue to be told by others who were outsiders to their experience. I wanted the women at Fáilte to be able to share their stories, using their own words to explain their most private beliefs and experiences. While I did not know it at the time of my internship, the time spent at Fáilte served to be a source of participant observation for this study. In total, the time I shared with the women and staff members during the summer of 2013 amounted to approximately 200 hours of participant observation and granted me privileged knowledge and understanding of the rehabilitation program at Fáilte.

I returned to Fáilte for a week in November of 2014 with a goal of more formally recording the experiences of those who were going through therapy. When I arrived, I was grateful to see that several of the women who had been in the program during my initial visit were still involved with the center. I reached out to them about participating in interviews and they graciously accepted my invitation. Several of the same staff members were also working at the center and they, too, agreed to participate in my study. Having these established networks allowed other women at the center to look at me with less hostility than my initial interactions with participants had been during my first visit. One of the staff members, Laura, who I had grown close to during my previous stay was also well-liked by many participants. Laura gave me recommendations about women she believed would be willing to participate in an interview and would also be likely to provide honest answers and narratives of their experiences. She volunteered to facilitate my introduction to women I had not met, which further assisted in the development of rapport and trust and therefore increased the validity of my interviews. While it

is impossible to tell the degree to which Laura's selection of participants resulted in bias, I believe that the rapport that was developed with her assistance is invaluable to this study.

When I was not conducting interviews, I found time to conduct an additional 20 hours of participant observation to supplement fifteen in-person interviews of counselors as well as current and past participants. I started all of these interviews by asking the woman to briefly explain her story. This introduction allowed me to highlight the themes that each participant deemed most important to her journey. I made certain that I asked additional questions that would draw out more information about these themes in particular. I also encouraged all of my interviewees to skip any questions that they did not feel comfortable answering. However, I found that those I interviewed were generally willing to answer all of my questions. I believe that this willingness may have been facilitated by their participation in therapy. The fact that many of the women I interviewed were participating in therapy may have increased their willingness to and comfort in discussing their personal life stories, which they had grown accustomed to doing in therapy sessions. Furthermore, the program at Fáilte encourages women to be honest in their interactions, and many of the participants agreed that this was an important part of their recovery. As Cameron (Week 6) explained, "But this program is a lot different in that you have to get honest or you're just wasting your time." It is my hope that the honesty advocated for in therapy was carried over to my interviews. Although it is impossible to know the true degree of honesty that each woman exhibited in the course of her interview, based on my past experience at the center, I believe that the responses were genuine.

At the conclusion of each interview, I asked participants if they felt that I was understanding and capturing their experience in an accurate way. During this time, I asked them if there was anything else they would like to share with me about their experience. Several

interviewees took this opportunity to voice their gratitude for participating in the interview. Many also said that they found the questions insightful and helped them to better understand their journey in addiction and recovery.

The Center

Fáilte is located in a remote region of Northern Ireland. Participation in the rehabilitation program at the center costs sixty euros per week. However, the government may provide these expenses for those that qualify for government assistance. A majority of individuals receiving treatment suffer from alcohol dependency, although there are a few participants with gambling addictions as well. Participants in the program must self-refer themselves to participate in rehabilitation. While they are free to leave the program at any time and for any reason, they must wait a period of six months in order to re-enter treatment if they leave early. While participating in the program, men and women may not leave the premises unless accompanied by a staff member for purposes deemed legitimate, such as a doctor's appointment.

The property owned by Fáilte is divided into five buildings – the detox and assessment unit, the men's residence unit, the women's residence unit, the building for occupational therapy, and a house for on-site staff members and volunteers. The women's unit holds approximately thirty residents while the men's unit holds up to forty residents. Five support workers, three group therapy facilitators, and one counselor rotate shifts in the women's unit on a daily basis.

The detox and assessment unit is located in the same building as reception. Here, participants stay in dorms with up to four other participants. Women in this unit are required to attend mass once per day, as well as group meetings and meditation twice per day. Although men and women reside simultaneously in the detox unit, the building is L-shaped and the two genders

may only come in contact with one another at the nurse's station which separates the two sides of the building. Throughout the program, men and women encounter one another daily at mass, but participants are not permitted to socialize with the opposite gender.

As interviews were solely conducted with women, the experience of women in the program will be primarily examined. The women's residence unit consists of a dining hall, living room, smoking area, kitchen, and bedrooms. Each bedroom has a set of two beds and a private bathroom, which the residents are responsible for keeping clean and tidy. In this unit, the schedule is much more rigorous than in the detox and assessment building. During the weekdays, residents are expected to attend two group meetings, participate in meditation, complete chores, and listen to an evening educational program. Significant time during the day is also spent participating in occupational therapy in rooms monitored by staff members. Of these, the women have a choice between participating in knitting, sewing, pottery, and art.

Saturdays are considered free days at Fáilte and participants are granted time to visit the on-site hair salon and run supervised errands to the local convenience store. On Sundays, women with children are allowed a scheduled visit. Once a month, these Sundays are used for larger family visits for all of the participants. The center believes that family members of those in addiction suffer as much as those with an addiction. For this reason, during Family Sundays, families are encouraged to attend family meetings in which they may learn more about addiction and receive support, advice, and coping strategies. On top of this monthly contact, each participant is permitted one fifteen minute phone call per week with an individual of her choice.

The Program

The first two weeks of the rehabilitation program are spent in the detox and assessment unit, where staff members seek to stabilize residents physically, mentally, and emotionally. To handle the severe symptoms associated with alcohol withdrawal, the women are asked to begin taking a prescription medication such as Librium a few days prior to their entry into the program. They may continue taking the medication as needed while in detox. However, the center encourages all women to adopt a substance-free lifestyle during and following the program and therefore commits to reducing each resident's intake of alcohol and prescription drugs.

On most weeks, approximately three to five women enter the center's program. The group meetings for the first two weeks offer a brief introduction to the topics that will be explored in the ten-week group program. Participants may participate in the full two weeks of detox, move on early, or remain for an additional week depending on the recommendation and evaluation of the support staff in the detox unit.

The ten-week program therefore begins at week three, although some women may not be at the center for that length of time. The program officially begins when participants are moved from the detox unit to the adjacent women's residence unit. There, the women are divided into three different groups according to the stage of the program that they have most recently completed. At times, this system requires residents to complete the sequence of the program out of order, but all participants are eventually exposed to the content of each week. Groups include up to ten women, but the number tends to decline as the course of the program goes on and some participants choose to leave the program early. A woman may be allowed to remain at the center longer than the ten weeks if staff members agree that it would be beneficial to her recovery to repeat a week of the program. However, particular care is made to ensure that participants do not

become dependent on the safety and shelter offered by the center, and a woman may therefore be required to leave after an extended stay of several weeks is completed.

Each week of group therapy has a theme and learning objectives for the participants, which are discussed in more depth below. At the beginning of the week, the group is given a binder with a short summary of the topic for the week and its importance to those going through recovery. Questions for each group meeting are then listed and are to be answered by each participant in a journal that is provided to her when she arrives at the center. Interestingly, alcohol is mentioned only twice in the program material and the program is therefore commonly referred to by staff members and participants as a “program for living.” In week six, participants may choose to begin participating in one-on-one counseling. This component of therapy is not offered until the second half of the program to ensure that the women are emotionally strong enough to handle the often traumatic events that emerge during more intensive counseling.

The ten-week program was created with the overarching and intersecting goals of helping participants accept themselves and their addiction by practicing unconditional love, understanding the importance of attentiveness, and acknowledging the value of a higher power. The following summary and in-depth exploration of weekly themes provides a narrative of the journey that participants take in the center.

Summary

Pervasive throughout the program is the notion that participants must separate their inner goodness from their addictive and harmful behavior. The women are encouraged to come to this understanding by accepting God’s love for them and working to incorporate such acceptance into their subconscious. With this understanding, those in the program may be able to find self-love.

The development of self-love, or self-compassion, is regarded as one of the most relevant predictions of whether a participant will be successful in maintaining sobriety after leaving the center.

Week 3: The Blindness of Addiction

Individuals in the program begin the process of overcoming the total lack of awareness and distorted views that they have of their lives. Participants are encouraged to examine how addiction causes their lives to become a fantasy that serves to hide, defend, and justify their addiction. As such, life in addiction is presented as one of non-reality and isolation. Early in the week, the women are asked to respond to the prompt “Can you see that you were living a double life? That the goals you professed to have were opposite to those that guided your life?” Later, the material calls on group members to confirm that they are committed to making positive steps towards recovery by being willing to listen and put into practice suggestions made throughout the program. In doing so, participants reflect on the question “Have you suffered enough to want to recover?”

Week 4: Recovery is the Choice

Residents are encouraged to have the humility to accept that their beliefs have been affected by addiction, that alcohol is no longer a way to cope with situations, and that they must surround themselves with positive influences. This is the first time that each woman is presented with the idea that she should work to accept herself as the person she is deep down, as “the beautiful person God has created you to be.” To do this, the material asks participants to begin saying the phrase “I am good, I was always good, God made me good” daily to begin to allow

the concept of goodness to make its way into their subconscious. Such an acceptance also requires each woman to acknowledge the fact that she has a problem with alcohol. It is suggested that the participants ask God for help in maintaining their sobriety, even if they do not have a notion of spirituality at this early stage in the program.

Week 5: Unconditional Love, The Way Forward

The program introduces the concept of unconditional love. Here, the concept of the head level versus the soul level is presented to participants. The head level is one filled with the symptoms of addiction – self-centeredness, anxiety, self-criticism, and chaos. Conversely, at the soul level, individuals are able to practice unconditional love towards others and themselves. In order to reach this soul level, participants are encouraged to be attentive to the present moment during their chores and meditation. Practicing unconditional love towards oneself is particularly important because it ensures that a woman does not set unrealistic expectations for herself or feel negatively towards herself in challenging situations. An ability to practice this unconditional love is said to grant participants a sense of peace and enable them to safely deal with pain that may be brought up in future therapy sessions.

Week 6: Listening, The Key to Recovery

Listening is presented as a key to recovery because it enables participants to be fully present and attentive to the present. Active listening to the well-intentioned advice of others is difficult to do when caught in addiction because alcohol dependence takes over one's will, energy, and attention. It is therefore challenging, but essential, for those in addiction to learn how to listen. Facilitators are provided as an example of good listeners; they listen without judging

and accept the goodness in all people while helping them to see it in themselves. The women are encouraged to model their behaviors in order to increase their attentiveness and maintain sobriety. Here, the participants are also reminded of the support offered by others and are asked to reflect on the questions, “What difference would it have made for your life if you had listened?” and “Have you come to understand that you will gain a lot of insights and help by listening to what others have learned through their experiences?”

Week 7: Spirituality, The Answer

The program discusses the importance of spirituality in recovery and states that God and Our Lady are always present in participants’ lives, whether the moment is one of celebration or of hardship. The material provided to participants particularly states that it is not important to identify with a specific religion or set of beliefs, but to experience the unconditional companionship of a higher power. This higher power loves each individual and will ultimately lead him or her to become the beautiful person he or she was created to be. It is suggested that the women begin the journey to accept their own powerlessness by turning their will over to a power greater than themselves. These are modeled after the first three steps of A.A. Although participants may not accept these claims, they are nevertheless encouraged to participate in prayer and meditation to enhance their ability to accept what is and let go of their own “self-run will.”

Week 8: Imaginative Functioning, A Major Obstacle to Recovery

Participants begin to examine their tendency to participate in imaginative functioning, a form of negative thinking. This thinking is a coping mechanism because it allows people to run

away from their problems by living in a world of non-reality filled with constant worry and distrust. Imaginative functioning consumes individuals by always presenting the possibility of what should have been, rather than how things are. Such a pattern of thinking is an addiction in itself, and the fear of “having to face reality and actually do something with one’s life can appear to be worse than staying with the familiar.” In order to overcome imaginative functioning and obtain peace, participants are encouraged to live in the present by being attentive to the moment. As the program explains, living in the past or present is a world of non-reality and unnecessary worry, as “the present well-lived takes care of yesterday and every tomorrow.”

Week 9: Self-Discipline, The Backbone of Recovery

The program examines self-discipline and its necessity in recovery. It goes on to encourage participants to practice self-discipline out of unconditional self-love. Self-discipline is practiced by following the guidelines and being attentive to tasks within the daily schedule, which help the residents gain freedom from the self-will that fueled their addiction. A devotion to one’s self-will is presented to be a life of slavery and self-contempt because it ultimately leads to self-centeredness and self-destruction. The program says that, with the practice of self-discipline, “You will discover how to make choices; you will experience great inner freedom and a feeling of self-worth.” In this way, self-discipline is framed as a freedom to be oneself without being controlled by one’s addiction and therefore must be practiced in order to maintain sobriety.

Week 10: Without Change There is No Recovery

Participants are reminded of the idea that recovery is a lifelong journey of acceptance, and one that does not come easily. Those who think that they will one day have a drink will

likely have that drink, and acceptance of never being able to drink again is therefore essential to maintaining sobriety. In order to begin this journey, the women are encouraged to make the choice to not drink “one day at a time.” The program states that many alcohol dependents have developed drinking to cope with the behaviors of other people in their lives. Such behaviors may have made them feel unseen, unheard, or unaccepted. While the women cannot change the behaviors of others, they may change their own reactions to situations and are encouraged to do so by refraining from drinking alcohol. On the last day of the week, participants are asked to reflect on the phrase “Until I accepted myself as I really am, no change happens” and to begin to introduce the declaration “I accept myself as I am” into their subconscious. This introduction can be practiced through a daily statement to oneself or through prayer.

Week 11: Healing the Hurts of the Past

In order to recover, the women are encouraged to examine and work through pains from their past. Pains of the past may include instances in which participants did not feel recognized, secure, or valued as a good person. As explained by the program, “We have to do for ourselves what the people who were significant to us for one reason or another did not manage to do. We need to begin to see ourselves as the beautiful people we are.” While in the past, these experiences continue to influence an individual’s self-concept and behaviors. Midway through the week, the women are encouraged to explore this idea by reflecting on the question “Are you beginning to become aware [that] the real problem in these situations is not the situation or the person who touched off your anger, that the real problem is within you?” The process of healing past pains is one that takes a lifetime and should not be rushed, as it may lead to relapse. When

such pain arises, participants are encouraged to practice unconditional love towards themselves and others.

Week 12: Gratitude, the Hinge on Which Recovery Swings

The program concludes by stating that gratitude is the key to continuing recovery and maintaining sobriety after leaving the center. Gratitude is again modeled by the staff, as they show their gratitude by being committed to the recovery of women going through the program. The material states that those who are grateful for their recovery and maintain such gratitude are more likely to remain sober because they take active steps to show their appreciation by going to A.A. and helping others in their journey to sobriety. Recovery is reiterated to be a lifelong journey that brings infinitely increasing rewards of peace, joy, and freedom.

Methodology

In this study, twelve one-on-one interviews were conducted with alcohol dependents that were currently completing or had completed compassion-focused therapy at Fáilte. I made a particular effort to interview women at different stages of their recovery in order to gain a better understanding of the effects of CFT over time. After conferring with counselors, it was decided that it would not be possible to interview women during their first week of the program. This decision was made because I believe that the interview questions may have brought up topics that the women were not prepared to deal with immediately upon their arrival at Fáilte. Therefore, I interviewed participants in week 2-12, as well as women who were 3 months to 3 years sober. The ages of those interviewed ranged from 21 to 50. One of the interviewees was a

former participant in therapy at Fáilte and was working at the center as a counselor at the time of her interview. In a similar fashion, one former participant remained volunteering as a companion to residents at Fáilte. Depending on the availability of the interviewee, these interviews ranged from thirty minutes to two hours.

The interviews were based on a semi-structured interview guide (Appendix A). The questions were developed from the themes that emerged during the literature review. As such, the first part of the interview focused on the degree to which a participant's self-concept and ability to practice self-compassion was or has been modified during therapy. The second part of the interview subsequently focused on the factors that the participant believed enabled this change to occur. However, the interviews were conducted to privilege the experiences of those being interviewed and therefore space was left for the introduction of new themes.

Additionally, four counselors at Fáilte were interviewed. Their experience working at Fáilte ranged from 5 months to 30 years. These interviews lasted from twenty-five minutes to one hour. The interviews were also based off of a semi-structured interview guide (Appendix B). The purpose of these interviews was to gain a better understanding of the degree to which a participant's perception of labeling or shaming treatment by counselors was intentional or did not exist in the realm of compassion-focused therapy. It is probable that the experiences and perceptions of participants and therapists differ. Nevertheless, "Regardless of whether things happened the way people said they did, what interests is that people chose to tell us that they happened that way" (Luker 2008:167). As such, these differences shed light on factors that contribute to stigmatizing behavior, self-stigma, and self-compassion and are therefore a valuable part of this study.

Justification of Methodology

The interview methodology has been chosen for several reasons. On a fundamental basis, interviews are beneficial due to the sensitive nature of addiction and treatment, even amongst those going through treatment. Interviews also enable the exploration of subjugated knowledge related to a participant's perception of labeling, self-stigma, and self-compassion. As explained by Shaw (2002:215):

Only interview[s] can find out whether labeling acts upon the subject positively, negatively, or neutrally. In other words, only the subject can tell whether he or she takes pride in a label, becoming motivated to enhance his or her newly obtained fame with more use, or labeling takes a negative toll, punishing him or her further into severe use.

The reality perceived and experienced by an individual has implications for his or her subsequent feelings and behaviors. This is especially true for the marginalized, whose voices and narratives are often overlooked in favor of the opinions of those with more power – in this case counselors, doctors, and policy makers (Karp and Birk 2013). Interviews grant the researcher a privileged understanding of the subjective interpretation, experience, and implications of stigmatization. Thus, it is only possible to explore this study's research question by looking at the way in which alcohol dependents themselves perceive their health, self-stigma, relationships with others, and self-concept.

Coding and Analysis

An inductive approach was used to code and analyze the data. While the literature review assisted in the construction of the interview guide, a codebook was developed from the data itself (Appendix C). I conducted coding according to this list, which minimized the risk that any preconceived notions and bias affected the interpretation of the data. Notes were also taken regarding non-verbal cues such as gestures and body language that occurred during the

interviews directly following each interview itself. Based on the model of grounded theory analysis proposed by Charmaz (2008), further analysis of the data simultaneously allowed new themes to emerge and allowed me to identify patterns and correlations between the experiences of those that were interviewed. When similar thoughts were expressed by multiple participants, a social statement was constructed about the experiences of participants in the program (Luker 2008).

Protection of Subjects

Every effort has been made to protect the subjects of this study. Informed consent was obtained from each participant, which ensured that the interviewee understood the procedure of the study prior to being interviewed (Appendix B). In order to protect the confidentiality of the participants in this study, I have used a pseudonym for each individual and I have also changed the name of the center at which research was conducted. The entire research study has been approved by the IRB under the case number 15.039.01.

Bias and Limitations

I did not arrive at Fáilte in the summer of 2013 with any knowledge or conceptions about the treatment program offered at the center. Over the course of my stay I witnessed the transformative impact of the program on the lives of the women I came to know. By the time I left, I had developed a strong belief that compassion-focused therapy not only worked, but was accepted by the women and staff members in a unique way. With this belief, I was motivated to better understand how such a transformation was able to occur by exploring participants' perspectives of their own experience while in therapy. It is therefore important to acknowledge

that I approached this study with a personal bias in favor of the therapy methods practiced at Fáilte. However, I took several steps in order to minimize the influence of this bias. For example, I told the women that I interviewed that I sought to understand their experience with therapy, whether such an experience was positive or negative. In this introduction, I acknowledged that the program had its strengths and weaknesses and that I simply wished to listen to her thoughts on the program. The fact that my research focuses on how participants perceive, accept, and reject various aspects of CFT allows for a well-rounded analysis of the therapy. Finally, I minimized my bias by coding the interviews using a codebook (Appendix C), which allowed for a more objective presentation of the data.

There are also several limitations in this study that must be accounted for and acknowledged. First, I am not an alcohol dependent and I have not gone through treatment. This creates a potential for limited understanding and analysis of data collected from interviews. The sample size is also relatively small and is limited to female participants at one treatment center in Northern Ireland. Additionally, as mentioned previously, much of the sample was selected based on counselor recommendations. This makes generalizations to wider populations, both within Ireland and beyond, problematic and provides the potential for bias. Furthermore, the interviews were only conducted with participants who were enrolled in the program or had been able to maintain their sobriety upon leaving the program. The data collected is therefore limited to treatment-seeking alcohol dependents and lacks the perceptions and experiences of those who did not enter therapy, those who dropped out of the program early, and those who did not choose to return to the program relapsing upon leaving the center.

Literature Review

Addiction

According to the World Health Organization (2014), alcohol dependence is defined as:

[A] cluster of behavioural, cognitive, and physiological phenomena that develop after repeated alcohol use and that typically include a strong desire to consume alcohol, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to alcohol use than to other activities and obligations, increased tolerance, and sometimes a physiological withdrawal state.

Similar to the way in which children are reliant on their parents for existence, survival, and functioning, those with alcohol dependence are physically and psychologically dependent upon alcohol for their day-to-day functioning. In essence, they are under its control. When this control becomes unbearable, individuals may seek an intervention in an attempt to regain control of their lives (Centers for Disease Control and Prevention 2014). Therefore, individuals who admit themselves to treatment will be defined as having alcohol dependence and will be referred to as “alcohol dependents” in this study. This terminology is important because it mitigates the stigmatization associated with negative labels of “alcoholic” and “addict.”

Health and Socioeconomic Effects

According to the World Health Organization (2014) approximately 5.9% of deaths globally in 2012 were due to harmful alcohol use. Furthermore, alcohol consumption is closely tied to more than sixty diseases, negatively affects almost every organ in the human body, and leads to mental and behavioral problems (Health Service Executive 2008; World Health Organization 2014). Harmful alcohol use causes damage to one’s physical and mental health. More specifically, its use may lead to frequent episodes of depression, liver disease, cardiac conditions, and respiratory infections (Lyons et al. 2011; World Health Organization 2014).

Harmful alcohol use is a burden not only to the dependent, but also to the dependent's family and society at large (Ipsos 2012). As such, "The burden of alcohol harm to the drinker can be seen in hospitals, on the streets, on the roads, in families, and in lost and damaged lives in every community" (Health Service Executive 2008:5). For example, studies have found that harmful alcohol use is associated with marital problems, suicide, violence, poverty, and decreases in productivity and public safety (Health Service Executive 2008). Alcohol dependence is also associated with socioeconomic consequences including unemployment and loss of financial earnings (World Health Organization 2014). While these consequences immediately impact the dependent, they also manifest themselves in society. For example, society must bear the increased costs of health facilities; police and justice systems; and welfare and unemployment benefits used to treat, punish, and provide assistance for alcohol dependents (North South Inter-Parliamentary Association 2014; World Health Organization 2014). Dependence incurs social consequences on society, as those with dependence on alcohol are unable to contribute to the production and workforce of the nation (Health Service Executive 2008; Long and Mongan 2014; World Health Organization 2014). Further, alcohol dependence places "intangible" harm upon members of society due to its role in suffering worldwide (World Health Organization 2014).

Addiction and Treatment in the Context of Ireland and Northern Ireland

While it is difficult to accurately measure rates of alcohol dependence, there is a strong drinking culture in Ireland, and its harm has been increasing since the early 1990s (Health Service Executive 2008; Walsh and Walsh 1973). In 2010, the World Health Organization (2014) estimated that 5.8% of the male population and 1.8% of the female population in Ireland

suffered from alcohol dependence. Other studies report an estimated 1.4 million people engage in harmful alcohol use and more than 200,000 are considered alcohol dependents (Long and Mongan 2014). The National Drug Treatment Reporting System found 8,000 new cases of alcohol dependence between 2008 and 2012, with the number of return cases increasing 16.8% (Health Research Board 2014). The high rate of such dependence produces serious economic consequences for the country and negatively impacts families (Ipsos 2012). Relatedly, research shows that more than 50% of the population has experienced negative consequences from somebody else's drinking, is concerned with another person's alcohol use, and knows somebody that they think drinks too much (Health Service Executive 2008; Ipsos 2012).

Harmful alcohol use is also problematic in Northern Ireland, and an estimated 170,000 adults in the country engage in harmful or dependent drinking, as defined by standards set by the National Institute for Health and Care Excellence (Central Survey Unit 2012; Gilbert 2014; Northern Ireland Executive 2012). Hospital admissions with an alcohol-related diagnosis increased more than 60% between 2000 and 2010 (Institute of Alcohol Studies 2013). This parallels studies that report alcohol use in Northern Ireland has increased almost 150% between 1960 and 2010 (North South Inter-Parliamentary Association 2014). However, it is estimated that only 9% of those who need treatment for alcohol dependence are able to receive it in Northern Ireland (Gilbert 2014).

Deviance of Alcohol Dependence in Ireland and Northern Ireland

Although a majority of this literature review is comprised of sources and studies from the United States, these theories of deviance are widely applicable to Ireland and Northern Ireland. Walsh and Walsh (1973) found that the stereotype of the "drunken Irishman" is prevalent in Irish

society. They go on to say that the stereotype results in a high tolerance for excessive drinking in Irish society and that it is not viewed as a form of deviance to the degree that it is in other countries. However, this argument is outdated, and recent studies show a more accurate picture of the way in which alcohol dependence is viewed in Ireland. A study by the Road Safety Authority (2007) of Ireland found that 80% of drivers found drinking and driving extremely shameful, and in 2008 67% believed that penalties for drinking and driving should be more severe. These figures are significant because the frequency of drunkenness in a society is strongly associated with the degree to which individuals believe they will face punishment for acts committed while under the influence (Field 1991). Although the legal punishment for alcohol-induced harmful behavior may not be as significant as desired in Ireland, the association of shame with such behavior suggests that individuals inflict some sort of self-punishment for the act. This self-punishment suggests that individuals in Ireland believe that alcohol use may be deviant under some conditions.

Bales (1991) contends that, when looking at cultural contexts for alcohol consumption, it is important to examine whether a culture encourages drinking as a way for individuals to deal with stress and tension. He goes on to state that alcohol consumption has been consistent throughout Irish culture and acts as a cultural symbol to confirm solidarity, equality, and acceptance. As such, Bales (1991) argues that those who consume large amounts of alcohol are looked at with sympathy, jealousy, and approval by Irish society. However, it is evident that societal attitudes in Ireland towards drinking have changed since Bales' writing and have come to constitute alcohol dependence as deviance. Such an argument is supported by Iposos (2012), who found that 85% of individuals surveyed think that the level of alcohol consumption in Ireland is too high. This figure represents an ongoing symbolic transformation in Ireland from

seeing harmful alcohol use as acceptable to deviant. Therefore, while the majority of literature presented in this discussion is from the United States, its theoretical basis and general applicability to the context of Ireland remain relevant.

Compassion-Focused Therapy at Fáilte

Fáilte has several locations throughout Ireland and Northern Ireland and has treated over 75,000 people for alcohol, drug, and gambling addictions. The treatment offered at Fáilte stands in contrast to many programs offered throughout Ireland because it practices “compassion-focused therapy.”

Confrontational therapy offers a particular point of comparison by which to showcase the duality of treatment modalities in Ireland. Confrontational therapies were created and enforced throughout the world based on the belief that individuals with addictions have personality disorders that make them unable to understand or see reality. As a result, confrontational therapies aim to break down the inherent denial and dishonesty of participants through ridicule, humiliation, and ultimatums (Rose and Cherpitel 2011; White and Miller 2007). Scholars and researchers alike voice concerns regarding the potential harm that confrontational programs cause to vulnerable participants (Rose and Cherpitel 2011; White and Miller 2007). However, stories of their prevalence are often talked about in therapy sessions at Fáilte, as some participants come to the center after failing to recover at a confrontational program. A cultural shift in the beliefs regarding those with alcohol dependence has led to the creation and increased availability of compassion-focused therapy.

Compassion-focused therapy is defined as a therapy that seeks to increase the self-compassion of participants in an effort to decrease self-stigma. It is specifically aimed at

improving the self-compassion of those with high levels of shame, self-criticism, and depression (Gilber and Procter 2006; Neff 2011). During therapy, participants learn how to approach experiences and feelings (whether positive or negative) with a mindset permeated in compassion for themselves and others. For this change to occur, Germer and Neff (2013) argue that group leaders must model such compassion. Additionally, therapy sessions help participants identify fears and beliefs that inhibit him or her from accepting the compassion of others and feeling self-compassion (Goss and Allan 2012). These barriers are overcome by training participants to accept their fears and reframe these fears with compassion and positivity instead of developing coping strategies that often result in self-criticism and self-isolating behavior (Gilbert and Procter 2006). Therefore, the result of such a therapy does not just create a positive self-concept, but affects how participants relate to themselves (Neff 2011).

Women and Substance Abuse

This study will focus on the experience of women participating in compassion-focused therapy. Therefore, particular attention must be paid to the gendered concerns of this population of alcohol dependents. Although research shows that men engage in harmful substance use at high rates, women have recently been closing the gap and represent approximately one of every four substance abusers (Greenfield, Back, Lawson, and Brady 2010). For females, harmful substance use is more likely to affect family life, be related to a traumatic experience such as sexual or physical abuse in childhood or adulthood, and involve the internalization of problems (Brady and Randall 1999; Women's Health Council 2009). Women are more stigmatized than men for their engagement in harmful substance use and suffer from more serious health consequences (Brady and Randall 1999). In specific regard to harmful alcohol use, women

develop problematic drinking and seek treatment at faster rates than their male counterparts (Brady and Randall 1999). Women are also more likely to drink to cope with negative emotions such as stress (Greenfield, Back, Lawson, and Brady 2010). Bridge (2001) argues that providing single-sex treatment is not enough to increase retention and completion of a treatment program for harmful substance use and that these gendered experiences must be taken into account by treatment programs.

Deviance, Labeling, and Stigma

Theoretical Beginnings

According to symbolic interactionism, society is made up of an infinite number of interactions between individuals and groups of people. On an individual level, when two people interact, each places the other into a category that exists in his or her mind (Goffman 1959). This notion forms the basis of labeling theory, in which labels are ascribed to individuals and, with these labels, come subsequent assumptions about the nature and morality of each individual (Cooley 1922).

To maintain order, society and the individuals within it must define acceptable and unacceptable behaviors for its members (Becker 1963). In this study, deviance is defined as an inability to adjust one's behaviors to actions deemed normal and acceptable by society. When individuals deviate, society reacts towards them in a certain way, and this reaction is felt and interpreted by the individual (Lemert 1951). The societal reaction to a deviant behavior may result in the application of a certain label to the offender, which is readily applied in social interactions. Tannenbaum (1938:20) argues that the immorality of deviant acts subtly shifts from being applied to the act to being applied to the actor and "The person becomes the thing he is

described as being.” As such, when negative labeling occurs, the individual becomes directly identified with the harmful effects of his or her behaviors, essentially embodying the harm itself, and is therefore labeled to be a harmful person (Shaw 2002).

Societal labels carry meaning and serve to define expected behavior of the labeled individual (Lemert 1951). Therefore, regardless of whether the individual labeled is actively participating in deviant behavior at the time of an interaction, labels influence how members of society interact with the one being labeled. A deviant label, such as one of an “alcoholic,” often carries a stigma with it. As explained by Lemert (1951:64), “if the deviant behavior persists for any length of time, stereotyped stigmas tend to be attached to the deviant along with societal definitions of the deviant.” Stigmatized behavior towards a deviant implicitly works to show that the individual is neither normal nor accepted in a particular context. In doing so, it often attempts to motivate an individual to return to non-deviant behavior and regain acceptance from society. Therefore, stigma impacts the treatment of an individual with a stigmatizing label and may be enacted through ostracization, isolation, and marginalization. A deviant may therefore choose to hide the components of himself or herself that elicit stigma in certain settings (Goffman 1963). However, a stigma is often tied to behaviors that are so intricately linked to a component of oneself that the act of suppression proves to be difficult.

Application to Alcohol Dependence and Implications for Therapy

Drinking excessively is commonly viewed as deviance because it causes harm to society. For example, drinking is correlated with traffic accidents, violent crime, disrupted relationships, and aggressive behavior (World Health Organization 2004). Therefore, the labeling of an “alcoholic” may be based on many behaviors, including drinking excessive amounts of alcohol,

as well as committing offenses following the consumption of alcohol. With this label, the view of alcohol as a dangerous substance that leads people to behave in ways that cause pain is transformed to identify the alcohol dependent as the source of pain (Tannenbaum 1938). It is important to recognize that many alcohol dependents do not begin drinking with the intention of being labeled or with the belief that they will ever develop dependency to alcohol. Instead, the act of labeling an individual to be an “alcoholic” is a lengthy process (Shaw 2002). With the labeling of “abuser,” “addict,” or “alcoholic,” alcoholism is seen as a voluntary condition with significant, if not sole, personal responsibility (Schomerus et al. 2011). As a result of this perception, unique stigmatized beliefs and behaviors are enforced against those with alcohol dependence and serve to affect the placement of blame, punishment, and assistance to those suffering from the condition (Kelly and Westerhoff 2010).

Social control agents and societal reactions to alcohol dependency work to bring an end to the destruction that deviant patterns of alcohol consumption cause. In these efforts, society may attempt to ostracize a dependent through labeling and subsequent isolation and punishment. However, stigmatizing labels for alcohol dependents may not invoke abstinence and conformity to normal patterns of drinking. In this situation, instead of successfully punishing dependents to correct their behavior, they may instead strengthen their attachment to the community that approves of them (i.e. other drinkers) (Tannenbaum 1938).

By spending time with other people who accept and reinforce their drinking, alcohol dependents are able to maintain a barrier between society’s expectations and the expectations of the few that are similar to them. The reaffirming and positive feedback given to an alcohol dependent by fellow substance abusers will further reinforce an alcohol dependent’s desire to gain approval from those he or she values (Tannenbaum 1938). It is not until a dependent is

forced to confront the expectations of broader society outside of this small group that the stigma is felt and his or her self-concept may be changed (Crocker and Major 1989). Therefore, many therapies stress the need for alcohol dependents to distance themselves from former social groups that drink excessively. This distance creates a new reality by which an alcohol dependent may measure his or her behaviors. Such a reality inhibits the individual from rationalizing his or her deviant behavior and motivates entry into therapy (Jellink 1991). Although Jellink (1991) argues that an inability to rationalize may be “induced” by others, little evidence is provided as to how this may occur. Therefore, this study attempts to identify the self-concept of participants that served to motivate their entry to therapy. Particular attention is paid to the point at which a participant evaluated herself to be a deviant and whether this self-perception had an impact on her decision to enter therapy. This original measure of self-concept also provides a starting point by which to measure improvements in self-compassion.

Self-Labeling, Self-Concept, and Shame

Theoretical Beginnings

One is acutely aware of the labeling process that occurs in the mind of the other because it is a process that all human beings engage in on a daily basis. As such, in social interactions, one will imagine how the other is reacting to his or her behaviors and act accordingly. Cooley (1922) explains this process by saying that it is as if one is viewing oneself through a “looking glass,” perceiving oneself from the standpoint of the other. He terms this phenomenon the “looking glass self” (Cooley 1922). By imagining oneself in the mind of the other, an individual is therefore able to modify his or her behaviors to confirm or challenge the labeling done by the

other. Often, his or her actions serve to confirm the label that was placed upon him or her during the labeling process, and labels therefore act as a self-fulfilling prophecy (Merton 1948).

By relying on a “looking glass” to interpret and modify one’s behaviors, it is evident that an individual’s self-concept is based on how that person believes others are interpreting his or her actions. Cooley (1922:184) explains this concept, saying, “A self-idea of this sort seems to have three principal elements: the imagination of the appearance to the other person; the imagination of his judgment of that appearance, and some sort of self-feeling such as pride or mortification.”

As a result, a label does not need to be applied for an individual to act according to a label. So long as the individual subjectively interprets an interaction to be one of stigma and blame, the interpretation acts as a reality (Thomas and Thomas 1928). In this way, “If men define situations as real, they are real in their consequences,” and the perception of labeling is enough for one to feel stigmatized against and act accordingly.

Over time, individuals learn to accept that they are worthy of the perceived and actual treatment and judgment placed on them by others (Memmi 1965). As a result of this acceptance, people begin to adopt self-images and behaviors towards themselves that are modeled after the way they perceive others to be viewing and treating them (William, Strupp, and Schacht 1990). With this phenomenon, a person may begin to adopt the label he or she is given (or perceives to be given) by another. When an individual accepts the label placed on him or her by society, self-labeling occurs. When one self-labels, one’s feelings towards oneself become the feelings that society has towards the deviant act that the label represents (Becker 1963; Lemert 1951). As such, self-labeling is believed to be more powerful in the formation of one’s self-concept and identity than the labeling of oneself by others (Shaw 2002).

Although it is evident that one's self-concept is based on the imagined and constructed attitudes of the others, the awareness of labeling and subsequent stigma against oneself is not enough to affect one's self-concept or self-identity. Instead, an individual must not only perceive stigma, but also agree that the stigmatization is valid and applies to him or herself. As Mead (1943:194) explains, "One attains self-consciousness only as he takes, or finds himself stimulated to take, the attitude of the other. Then he is in a position of reacting in himself to that attitude of the other." In this instance, the way in which society reacts to the individual becomes true and justified for that individual based solely on his or her modified self-concept. Self-stigma therefore occurs when an individual internalizes the stigma of others, resulting in decreased self-esteem and self-efficacy (Corrigan, Watson, and Barr 2006). Self-stigma manifests itself within an individual as shame and may lead to increases in the behaviors that originally led to stigmatization. Decreasing such shame therefore requires an altering of the individual's self-concept (Gray 2010).

Application to Alcohol Dependence and Implications for Therapy

For alcohol dependents, Lemert (1951) detailed the differences between primary and secondary deviance in order to explain the moment at which one applies the label given by others to an internal self-label of oneself. Primary deviation occurs when one drinks in excess, but does so for a socially acceptable reason. For example, it is acceptable to drink after work with one's colleagues following a particularly stressful day. However, secondary deviation marks a change in one's own self-concept. This occurs when one drinks for a reason that is "motivated by the conception the drinker has of the self as that of a drunkard, a sot, an inebriate, an alcoholic, or a

drunken bum” (Lemert 1951:371). One’s act is a physical manifestation of a self-label and self-stigma (Corrigan, Watson, and Barr 2006).

Becker (1963) critiques this idea, saying that the motivation to use drugs may not solely be a result of a desire to cope with pain or trauma, nor an act to confirm a deviant self-label. Instead, the act is first completed and then must be learned to be associated with a way to cope with self-stigma. Shaw (2002) also complicates this theory by arguing that drinking may be a fulfillment of a label that does not have to do with an “alcoholic” identity. For example, a man may turn to alcohol after being fired from his job. The termination may have labeled him as failure to his colleagues or he may have interpreted the termination as such. Nevertheless, the interpretation of the situation changed the self-concept of the man and caused him to drink. Therefore, a fulfillment of a self-label occurs when one views oneself according to a label and feels a sort of shame or guilt about living up to the label. Drinking then becomes the punishment for fulfilling a label that one ascribes to oneself.

The stigmatization of alcoholism results in negative self-labeling, shame, and self-stigma that fuel the onset and continuation of harmful drinking and minimize the likelihood for alcohol dependents to seek treatment (Lemert 1951; Shaw 2002). Research shows that drug and alcohol counselors find shame to be a common theme in their interactions with participants (Gray 2010; Randles and Tracy 2013). Furthermore, shame displayed by Alcoholics Anonymous (A.A.) members through nonverbal bodily representations was found to predict the likelihood of relapse within 3 to 11 months (Randles and Tracy 2013). The existence and perception of shame regarding alcohol dependence have also been cited amongst factors that decrease the likelihood of individuals to seek treatment (Andréasson, Danielson, and Wallhed-Fin 2013; Keyes et al. 2010). These findings offer insight into the relationship between self-concept and self-stigma and

reinforce the necessity of decreasing shame in order to mitigate harmful alcohol use. The implications for therapy and the research of this study will be discussed in the context of delabeling.

Delabeling

Theoretical Beginnings

Delabeling is the process of removing a label and imposing a new one (Shaw 2002). It is difficult to retract a label once it is applied because a label becomes an unconscious judgment against an individual (Tannenbaum 1938). The assumption that such deviant labels are permanent helps to explain the lack of research into the removal of society-enforced and self-enforced labels.

Trice and Roman (1970) outline three ways in which successful delabeling by society may theoretically occur. First, a deviant act may become acceptable to society. Second, a ceremony during which professionals deem a deviant to be reformed and cured may allow the deviant to return to a socially acceptable standing and status in society. This ceremony involves a complete re-altering of the deviant's behavior. Third, society may create a socially accepted label that is attached to deviant behavior. The use of a new label does not change the acceptance of the deviant act or the application of the initial label, but allows a deviant to acquire new behavior that conforms to societal norms. Despite the usefulness of such a theory, it remains essential to understand the construction and deconstruction of a self-label. How this may occur is not explored in this theoretical framework. However, based on earlier discussions of the relationship between self-concept, self-labeling, and self-stigma, this study focuses on the potential for change offered in the dynamic and flexible construction of one's self-concept.

Application to Alcohol Dependence and Implications for Therapy

Due to the challenge of removing a label and its associated stigma, research regarding the delabeling of alcohol dependents is limited. Much research focuses on the importance of modifying society's labeling of alcohol dependents. These strategies argue that delabeling "alcoholics" with new terminology and conscious efforts to practice anti-stigmatizing behavior will lead to a modifications in self-concept and produce a decrease in self-labeling, self-stigma, and harmful alcohol use.

Medicalization is a common framework promoted in delabeling theories and serves to frame alcohol dependence as an illness instead of a consciously chosen form of deviance. Furthermore, medicalization aims to decrease the stigma associated with having alcohol dependence in the hope that it will modify society's treatment of the condition. These goals are supported by studies that find that those labeled as suffering from a "substance use disorder" invoke different responses and perceptions of fault as well as obligations of assistance than those referred to as "substance abusers" (Kelly and Westerhoff 2010). Its roots may be found in Alcoholics Anonymous, which has obtained widespread support in its campaign to frame alcohol dependence as a disease (Conrad, Schneider, and Gusfield 1980; Roman and Blum 1991; Trice and Roman 1970). With modifications in society's perception and treatment of alcohol dependence, supporters of medicalization rely on labeling theory to contend that self-stigma will be decreased for those with dependence. Such decreases are argued to increase the likelihood of individuals to seek treatment, facilitate the modification of one's self-concept, and ultimately decrease harmful alcohol use.

There is an ongoing debate about whether deviant drinking should be defined by medicalization. Some scholars argue that medicalization lacks scientific evidence and was created by individuals outside of medical professions who wished to serve their own interests (Conrad, Schneider, and Gusfield 1980). They also contend that that medicalization is no longer necessary because moral views associated with deviant drinking have been loosened so that alcohol dependence is no longer stigmatized (Conrad, Schneider, and Gusfield 1980). This argument is supported by research that shows various degrees of agreement about whether the labeling of those with alcohol dependence results in increased drinking levels or self-labeling (Combs-Orme, Helzer, and Miller 1998; Shaw 2002). Furthermore, while Fingarette (1991) acknowledges that the medicalization of alcohol dependence has implications for public policy and the treatment of dependents, he argues that the framework does not encourage individuals to enter treatment. Instead, Fingarette (1991) believes that the medicalization model validates an individual's desire to drink and, by framing his or her actions as involuntary, provides an excuse for an alcohol dependent to continue to drink. This is supported by evidence that the introduction of the medicalization model to Ireland increased the normalization of drinking in the country and placed the responsibility for alcohol-related harm on an individual's predisposition to the substance instead of on the nature of alcohol itself (Butler 2002).

It is evident that recent research contradicts all of these claims. For example, many studies show that alcohol dependence is widely stigmatized and that it remains stigmatized even when placed within a medical framework (Livington et al. 2011; Schomerus et al. 2011; Williamson 2012). Additionally, such claims stand in contrast to previous discussions about the way in which perceived stigma inhibits alcohol dependents from seeking treatment (Keyes et al. 2010). Nevertheless, recent scholars have sought to address these critiques by advocating for a

“Medicoethical Approach” to alcohol dependence. Such an approach would acknowledge the plural responsibility that the individual and society share for perpetuating and combatting alcohol dependence (Williamson 2012).

Delabeling theories also advocate for the importance of practicing anti-stigmatizing behavior towards alcohol dependents. In a therapeutic setting, research finds that there is a direct relationship between the way in which therapists interact with participants and how the same participants view themselves (William, Strupp, and Schacht 1990). While this research did not conclude that the absence of such behaviors may lead to a positive change in self-concept, it does show that the presence of shaming and blaming interactions may be enough to inhibit change altogether. As a result, many scholars argue that it is essential for counselors to avoid labeling or enacting stigmatizing treatment towards participants that may result in feelings of self-stigma or shame (Gray 2010).

It is important to note that a removal of harmful labels against alcohol dependents by society may not result in a modified self-concept. Additionally, the efforts of counselors to avoid the enactment of stigmatized treatment on participants may not result in such a change. This is because, as discussed previously, the mere perception of stigma or judgment may elicit self-stigma. Therefore, the conscious delabeling of alcohol dependents by society and therapists will not result in self-concept modification until the alcohol dependent delabels him or herself. As explained by Shaw (2002:212), “No matter what pressure they may receive from their surroundings in the labeling process, it is in the end the users who decide what course of action to take in their own reaction.” Thus, self-labeling remains the primary motivation for behavior confirmation or modification. When one self-labels oneself as a good person, one may modify one’s behaviors towards oneself in an effort to correspond with this new self-label. Such a

process may result in decreased levels of drinking that once fulfilled the self-applied label of an alcohol dependent. This can be done by increasing an individual's ability to practice self-compassion and is the focus of this study.

In its framework, compassion-focused therapy does not enforce stigma or induce self-stigma and shame. At Fáilte in particular, efforts are made to label participants as “good people” separate from all notions of the “alcoholic” and other negative labels. As such, the compassion-focused therapeutic setting has been proven to provide the grounds for a reduction in self-stigma and shame amongst individuals with substance use and anxiety disorders (Hedman et al. 2013; Livingston et al. 2010). However, these studies do not explore whether participants perceived the modified labeling and anti-stigmatizing treatment to be significant factors in modifying their own self-labeling. Additionally, the fact that participants may subjectively interpret therapist interactions to be stigmatizing, and therefore unintentionally produce shame, is not examined. This study fills these gaps by examining the experience of participants in compassion-focused therapy, participants' perceptions of the attitudes of therapists towards alcohol dependents, and the factors that participants themselves believe assisted in modifying their self-concept.

Self-Compassion

Theoretical Beginnings

Self-compassion is an emerging measure of overall well-being. It enables one to treat oneself with kindness, even in negative moments. The capability is also closely tied to feelings of self-worth, as increases in self-compassion are theorized to motivate one to make positive change in one's life because it symbolizes a care for oneself (Neff 2011). Studies cite that self-compassion is generally lower amongst women, with mixed results when looking for differences

between age groups (Neff 2011). Scholars argue the measure is more stable than traditional measurements of self-esteem.

Whereas self-esteem entails evaluating oneself positively and often involves the need to be special and above average, self-compassion does not entail self-evaluation or comparisons with others. Rather, it is a kind, connected, and clear-sighted way of relating to ourselves even in instances of failure, perceived inadequacy, and imperfection. (Neff 2011:1)

For this reason, this study makes particular efforts to focus on self-compassion rather than self-esteem or self-confidence. Nevertheless, an important relationship exists between the two.

Individuals suffering from low self-esteem have been found to engage in higher rates of self-criticism than those with high levels of self-esteem (Gilbert and Procter 2006). Therefore, both self-compassion and self-esteem are intricately related and not mutually exclusive concepts.

According to Neff (2011), there are several components of self-compassion. The first encompasses an individual's acceptance of the fact that he or she is imperfect. This does not require overlooking one's flaws, but requires one to refrain from being overly critical of these flaws. Secondly, an individual must be aware that such imperfection is part of being human, a condition that Neff (2011) terms "common humanity." With this understanding, when suffering, an individual should feel interconnected to those around him or her, and not isolated and ostracized by such suffering. Group solidarity through social networks or group therapy enable this to occur, but an individual with high degrees of self-compassion will be able to feel such solidarity even when not in a group of individuals voicing similar suffering (Gilbert and Procter 2006; Goss and Allan 2012). Finally, mindfulness enables an individual to observe an experience with a proper degree of attention, neither letting it pass by nor fixating on it. It is an ability to accept one's emotions, both positive and negative, as components of life and not as feelings that must be held for extended periods of time (Shorey et al. 2014).

There has recently been an increase in the study of CFT. CFT has been shown to increase self-compassion, mindfulness, and well-being and to sustain these increases for more than one year following therapy (Neff and Germer 2013). Increases in self-compassion have also been found to be correlated with reductions in perceived feelings of marginalization, depression, feelings of inferiority, and shame (Braehler et al. 2012; Neff 2011; Gilbert and Procter 2006; Goss and Allan 2012).

Application to Alcohol Dependence and Implications for Therapy

Self-compassion is a relatively stable measure of self-concept and well-being and therefore offers a reliable capability to target for lasting change. A study by Shorey et al. (2014) found that individuals with substance-abuse problems who sought treatment had lower levels of mindfulness when compared to healthy adults. More specifically, alcohol dependents have been found to have higher rates of depression and anxiety, and lower rates of self-compassion than the general public (Brooks et al. 2012).

High levels of self-compassion are correlated with a decrease in self-criticism, shame, and depression (Goss and Allan 2012; Neff 2011). Therefore, studies contend that compassion-focused therapy, which is specifically designed for individuals with such measures of low self-esteem and high self-criticism, is appropriate and effective in treating alcohol dependents. However, there are few studies that seek to measure the way in which compassion-focused treatment may be applied, or must be modified, for alcohol dependents.

Interventions to increase mindfulness prove to be clinically successful and result in decreased substance use (Brooks et al. 2012; Shorey et al. 2014). In a study of compassion-focused therapy methods, Brooks et al. (2012) found that increases in self-compassion following

treatment remained significantly correlated with decreases in alcohol use 15 months later. The results supported Rendon (2007), who found that increases in self-compassion led to reductions in anxiety and depression, followed by subsequent reductions in drinking behavior. While this research supports a correlation between self-compassion and decreases in alcohol consumption, it does so in a clinical and outcome-focused manner. Thus, such studies measure the before and after rates of self-compassion and alcohol use, but not how modifications in the two occurred. It is significant to examine the nature of these modifications because alcohol dependents have a particularly stigmatizing and shame-inducing label to confront, which may affect how compassion-focused therapy may be applied and interpreted. More specifically, which components of compassion-focused therapy had the most impact on the clinical improvement is not explored. The studies may leave some readers satisfied, but sociologists are left questioning whether such improvements are due to therapist interactions, group dynamics, a change in self-labeling, or some other concept unexplored in this literature review.

Measuring Success

Regaining Socioeconomic Status

Alcohol dependence affects one's employment, economic security, marriage and family stability, connection to community, and health (Westermeyer 1982). Therefore, successful treatment for an individual with alcohol dependence must not solely address his or her consumption of alcohol. Instead, it can only be considered effective if it also addresses and improves the socioeconomic losses that result from addiction. Shaw (2002) argues that re-entering society as a self-sufficient member suggests a successful delabeling of an alcohol dependent. He says the fact that the individual is employed demonstrates two things. First, it

shows that the individual has reoriented his or her priorities from alcohol to productivity, a decision that was previously inconceivable while in addiction. Secondly, his or her hiring suggests that society is accepting of this delabeling. Additional improvements that mark the success of therapy can be found by looking at the socioeconomic impacts of treatment. For example, improvements in family relationships, civic participation, and non-violent behavior may all demonstrate outcomes of a successful therapeutic intervention. In this study, such improvements are measured by the way in which the participant believes he or she has improved. This is done in an effort to maintain the value placed on the subjective experience of the participant throughout the study.

Spirituality

Several studies provide evidence of a positive relationship between spirituality and recovery amongst alcohol dependents. In these studies, an important differentiation between religion and spirituality is made. As Murray, Malcarne, and Groggin (2003:26) explain, “Spirituality has been differentiated from religiosity, with spirituality defined as focused on an individual’s direct personal experiences of the sacred, in contrast to religion’s focus on specific belief systems and dogma.” In this study, spirituality will therefore not be confined to a specific religion or set of beliefs. Instead, the participant’s experiences and understanding of spirituality will be valued.

Polcin and Zengmore (2004), Robinson et al. (2011), and Zengmore and Kaskutas (2004) found that those who reported higher levels of spirituality were able to maintain longer periods of sobriety following treatment. Additional research theorizes that levels of spirituality may play a role in an individual’s willingness to seek treatment for addiction because it affects an

individual's openness to and acceptance of change (Galanter et al. 2007). However, some researchers find no such relationship between a belief in a higher power and abstinence. Murray, Malcarne and Goggin (2003) did not find evidence to support the argument that spirituality acts as a motivation to stop drinking, or that it has a positive influence on length of sobriety for alcohol dependents. There is also debate about whether such increases in spirituality aid in maintaining sobriety, or are a result of it (Jarusiewicz 2008). Martin et al. (2015) contend the former, as their study found that religious coping (embodied in statements such as "I put my problems in God's hands," "I ask for God's forgiveness," "I pray for strength," and "I pray for help") is associated with maintaining abstinence. Furthermore, the study found that women used such religious coping mechanisms more than men.

Self-Efficacy

Self-efficacy is the belief that one will be able to use new behaviors to produce a desired effect (Kadden and Litt 2011). In the realm of addiction, this means that individuals leave treatment with a conviction that they will be able to transition their newly learned behaviors into the real world and remain abstinent. Kadden and Litt (2011) cite numerous studies that report a correlation between an individual's belief that he or will be able to remain sober and his or her actual abstinence following treatment (see e.g., Ilgen, McKellar, and Tiet 2005; Moos and Moos 2006), as well as ones that do not support such a relationship (see e.g., Demmel, Nicolai, and Jenko 2006). Self-efficacy has also been found to increase the longer abstinence is maintained (Romo et al. 2009). Due to its potential benefits, this study relies on the argument that it is important for effective therapies to increase participants' feelings of self-efficacy. However, a literature review by Kadden and Litt (2011) failed to produce conclusive evidence on whether

and how self-efficacy may be improved in therapy for substance abuse. Therefore, this study examines the way in which participants wrestle with such optimism while maintaining an awareness of the difficult reality of upholding their sobriety.

The Potential for Relapse

While abstinence is commonly used to suggest success in recovering from addiction, it is often inevitable that an alcohol dependent will drink again at some point during his or her recovery. During this relapse, an individual may fall back into his or her old label. This process is termed relabeling (Shaw 2002). A relapse reinforces the need for self-compassion. Self-esteem is dependent upon both outcomes and societal approval and is therefore absent from one's self-concept during relapse. Conversely, self-compassion may be drawn upon even in times of failure when a sense of self-esteem may be absent. Therefore, if an individual has the ability to practice self-compassion, it may enable him or her to better plan for and manage a relapse and work toward recovery (Goss and Allan 2012).

Increases in Self-Compassion

As discussed previously, studies showcase marked clinical improvement in self-compassion, but are vague about the “tools” and “exercises” used. Few clinical studies detail the methods used in therapy as well as the ways in which participants interpret therapy and the process of such a change in their self-perception throughout the course of treatment. Furthermore, they shed limited light on how and why a participant's self-concept, self-labeling, and self-stigma – all concepts related to self-compassion – may change. Therefore, this study pays particular attention to the way in which participants evaluate their own ability to practice

self-compassion and the factors that they believe contributed to or inhibited the development of this capability.

Data Analysis

A Life of Addiction

“Alcohol [...] brings them to hell and back”

The life of alcohol dependents while in the throes of their addiction is one riddled with negativity and loss. The wide impact of such loss was described by Brianna (Week 3), who said, “I think everything goes out the window when you drink. Everything. Even your appearance, your morality, your sense of being.” Four women directly associated the life of addiction as living a life of hell. This hell manifested itself in many forms, including physical discomfort, a loss of financial resources, and disownment from one’s family.

Health Effects

More than half of those interviewed spoke of the negative effect of their alcohol dependence on their health. Many times, these experiences did not make reference to a woman’s own physical health, but were in regards to the death of a close family member due to alcohol addiction. As women spoke of the passing of their siblings and parents, their narratives served to confirm the high rates of death attributable to alcohol dependence on a global scale (World Health Organization 2014). Even more significantly, such close personal encounters with others suffering from alcohol dependence supports the statement that harmful drinking behaviors are

widely prevalent in Ireland and Northern Ireland (Health Service Executive 2008; Northern Ireland Executive 2012).

Three women also described experiences in which their drinking led to their own physical pain. This often occurred when the participants did not have access to alcohol to treat their withdrawal symptoms after long periods of excessive drinking. Nicole (Week 4) explained that whenever she refrained from drinking, “I was just like a 70 year old woman – couldn’t even get a shower without a chair. The shaking and the physical pain. Just horrible, really not very nice.”

As suggested in the literature review, the health effects of alcohol dependence were not limited to physical experiences of discomfort or pain. The way in which dependence affects one’s mental health was supported in the interviews of women within this study (Lyons et al. 2011; World Health Organization 2014). Most significantly, participants described their addictions to be ones of intense negativity towards themselves, which will be discussed in more depth.

Financial Impacts

Although a few participants were able to remain consistently employed, a majority of those interviewed said they were unable to hold a job while in addiction. As supported by the review of relevant literature, this resulted in severe economic consequences, as these women struggled to survive while financing their addictions with a limited income (World Health Organization 2014). As a result of financial constraints, approximately fifteen percent of women said that they were forced to sell their material possessions. Cameron (Week 6) explained the result of her dependence, saying, “I’d lost everything. I sold all of my jewelry, my TV, my

laptop. I had sold everything.” In Cameron’s experience, the loss of these material possessions was only one loss in a series of consequences that she suffered during addiction. Over the course of her interview, it became clear that the immense feeling of loss and failure that was caused by her addiction subsequently fueled its continuation. Later, she went on to say, “I had let everybody down. Mainly my family. It’s hard to describe that guilty feeling. You can’t cope with it. You just drink to take it away.” Here, it is evident that loss does not solely affect dependents emotionally or financially, but may serve to encourage the continuation of harmful drinking.

Loss of Family

Women described their interactions with their families during addiction to be marked by a lack of involvement, dishonesty, and on the verge of complete loss. Many women viewed their dependence as one that caused selfishness because it took all of their time and energy away from social interactions. These experiences confirm the negative effects of alcohol dependence on family and marital relations (Health Service Executive 2008; World Health Organization 2004).

Twenty-five percent of participants said that they consistently lied to their families as a result of the selfish nature of their addiction. Jennifer (Week 11) explained that this dishonesty was often in an effort to hide her drinking. She feared that the exposure of her drinking habits would cause her family to treat her with judgment and resentment. However, she went on to say that her drinking was often discovered despite her best efforts to conceal it. She explained:

So through the years I sort of isolated myself from my family because you’re trying to hide and I used to get caught all the time and there used to be arguments, rows, physical fights. And I was nasty to them. Really, really nasty.

Other lies were in the form of failed promises made by a participant to her children, spouse, or caregiver. These ranged from promising to take her child out for the day to remaining sober for

an evening out. Even when the women were caught in their deceit, more than thirty percent said that their addiction did not allow them to feel guilty or affected by the other person's disappointment, anger, or concern. As Amy (Week 8) explained, "Well when I was drinking I didn't feel anything. Selfish. I can get on my own, I thought. I would have said to them I don't need you. That's how selfish the drink is." These feelings offer support to Tannenbaum's (1938) theory that the behavior of a deviant may not change even when faced with ostracizing or stigmatized treatment. In light of such narratives, the behavior of the women may not have changed because they could not feel the stigmatized treatment enacted against them. While several women voiced gratitude that their families continued to offer unconditional support to them despite their dishonesty while in addiction, this was not the experience of every woman interviewed. In fact, two participants stated that they had suffered complete estrangement from their families as a result of their behavior in addiction.

Self-Hatred

Almost fifty percent women of women described being overcome with feelings of intense self-hatred while in addiction. Jennifer (Week 11) spoke at length about her self-hatred, saying:

I hated myself. Absolutely hated myself. I had no self-esteem. I was completely and utterly numb. The only feeling that I had was the hatred for myself. I had no love for anybody at all. Absolutely no feelings at all apart from hatred.

For these women, it became impossible to let go of such negativity towards themselves. The tendency of participants to hold onto feelings of self-hatred for extended periods of time shows an inability to practice mindfulness (Shorey et al. 2014). This supports research that alcohol dependents suffer from low self-esteem and diminished levels of mindfulness (Shorey et al. 2014).

The inability to practice mindfulness while experiencing negative emotions manifested itself with increased drinking and physical acts of self-harm. Candice (Week 6) explained that when she felt poorly about herself, “I would have cut myself. I would have drank [...] I would have took it to heart. It was just any excuse and I would have a drink.” Jennifer (Week 11) also went into great detail about the physical manifestation of her self-hatred, saying that she had cut her wrists several times and had a strong desire to commit suicide prior to her arrival at Fáilte. Hannah (3 years sober) and Candice, too, openly admitted to attempting suicide in their interviews. While these physical acts may be readily identified as signs of self-hatred, one counselor, Christine, framed drinking as a form of self-hatred as well:

[W]hen you know you have a problem and you know it’s hurting you and your family yet you continue it’s a form of self-hatred. It’s self-harming. You know it’s hurting you and everyone around you. Yet you keep hurting yourself. Some people have medical issues due to their drinking yet they keep drinking. That is a form of self-hate.

Self-Criticism

When reflecting on their behavior in addiction, more than thirty percent of women described unrelenting feelings of self-criticism. For example, Amy (Week 8) said that prior to entering the program, her thoughts were permeated with a fear of failure. She described the feeling, saying, “It was always the paranoia, not being good enough, you know.” Jennifer (Week 11) echoed such self-criticism, describing, “I would have beat myself up and then I would have drank more to cover how I was feeling. You know, the hatred for me personally. I couldn’t do no right. It didn’t matter. I couldn’t do no right anyway. I never did anything right at all.” These comments support research that those with low self-esteem engage in high rates of self-criticism (Gilbert and Procter 2006).

Absence and Avoidance of Emotions

Approximately twenty percent of women described their emotions in addiction as non-existent. Amy (Week 8) described this, saying, “Well when I was drinking I didn’t feel anything.” Nicole (Week 4) also described her experience:

It’s to do with the alcohol but you’re just in your own world and you aren’t aware. I remember that you aren’t aware. I was never aware of what was going on. It was just like everything was happening away from me and nothing affected me. It’s hard to explain. You sort of sit in your house and it’s like you’re in a goldfish bowl and the whole world is revolving and everyone is going about their business and everything is going on but you’re just not a part of it.

When these women felt emotions starting to emerge, they described intense urges to medicate them with alcohol. This will be discussed in more depth in later themes.

What Those in Addiction Need

All of the counselors directly referenced these narratives when discussing the purpose and goals of compassion-focused therapy. They believed that therapy should address the self-hatred and self-criticism practiced by those who entered the program (Gilber and Procter 2006; Neff 2011). Staff members said the primary goal of the program is to teach and show participants that they are loved. Laura explained the process was “like building back from scratch, building them back. Giving them their worthiness that they need, their love that they need. That they are loved, but they can’t see it because they’re beating themselves up each day, you know.”

Staff members believed that showing unconditional love to participants would encourage the women to practice such compassion towards themselves (Germer and Neff 2013). The practice of self-compassion was seen as essential to maintain sobriety following completion of the program.

So if you've gone through a program and you've learned to love yourself or the idea that you should love yourself and respect yourself and you go into face the reality of the world when you leave here and you decide to pick up a drink, you haven't found the love for yourself. (Christine)

Hannah, a former resident and current counselor at Fáilte, offered an interesting perspective on the goals of staff members and the needs of participants. She explained that she could not have decreased her drinking without first learning to accept herself unconditionally. She said that the program is “not just about listening, talking. It's knowing that you're a better person.” While this self-acceptance required her to accept her flaws, it also increased her awareness of her own goodness. Hannah believed that finding this goodness allowed her to begin to treat herself in a more positive and compassionate way, which has enabled her to maintain her sobriety for three years. This narrative supports Neff's (2011) argument that therapy changes that way in which participants relate to themselves.

A Point of Comparison

Both Dawn (18 months sober) and Janet (8 months sober) had previously attended treatment centers that practiced confrontational therapy. Their experiences offered interesting points of comparison to the compassion-focused goals and methods practiced by counselors at Fáilte. Dawn spent a great deal of her interview describing the differences between the two programs. She said that the first treatment center, which I will call Conas, was much harsher than Fáilte. She said that the program at Conas “was very much trying to break you down.” Her interpretation of the objectives of such therapy mirrors the definition of confrontational therapy presented by Rose and Cherpitel (2011) as well as White and Miller (2007). She went on to describe a typical day at the center:

[I]n the group therapy, each day the counselor would come in and you didn't know who was going to get targeted. But if it was you, you knew you were in trouble. I can think of a time when there was actually a counselor [...] and he was an ex-priest and he just tore me to shreds. Like I was wailing uncontrollably. It was about my children and even some of the others sort of said this is a bit much, you need to stop. And he did it with the others as well but they were very much about breaking you down to build you back up. And I think it was trying to get you to wake up because when we're in addiction we don't always see the damage we're doing and I think that was very much their approach.

When asked how this method of therapy made her feel, Dawn responded:

Awful. You know when you go into any treatment program, you're already broken. You're already completely destroyed and the guilt you're carrying is like an elephant on your shoulder already. So I don't know if it works. I'm not necessarily sure whether it works, that approach.

She went on:

I think you do have to have an honest look at yourself, there's no doubt about that. You really do you have to have a good honest look at yourself. But I don't know if just taking you down the way they do if it is that... it is about starting to find yourself. Love as well because when you're in addiction you probably haven't loved yourself before the drinking got really bad. But once you're in it you hate yourself. You can't even bear to look at yourself in the mirror. You know, before you go near the treatment program and then they get in there and then you know... that Wednesday felt like an exercise in humiliation. Definitely. [...] So the approach here worked better for me.

Although Janet spent less time describing her experience with confrontational therapy, she found that such therapy made no effort to encourage her to feel better about herself before, during, or after the program. She said, "Basically the method is strip the client down and then put them back on the street. And this is what happened [...] There's no building up whatsoever.

Absolutely none. They broke me down and put me out." As a result of the program, Janet said that she was left vulnerable and subsequently returned to drinking upon her return home. Sadly, her drinking was more excessive than it had been prior to treatment. Janet's experience supports warnings of the harm of confrontational therapy, while Dawn's confirms the negative effects of shaming interactions between counselors and participants (Rose and Cerpitel 2011; White and Miller 2007; William, Strupp, and Schacht 1990).

Entry into Therapy

Inklings of Self-Worth

When asked to explain why they decided to enter treatment, more than thirty percent of participants said that they were doing the program for themselves and that they sought help because they deserved a life in which they were happy, content, and at peace. As Brianna said, “I deserve more [...] Because I’m a good person. I just deserve a life and to be happy. You know, nobody deserves to be like this.” Such narratives suggested that women at Fáilte arrived with initial feelings of self-worth and therefore a baseline of self-compassion (Neff 2011). Dawn (18 months sober) referenced such initial feelings of self-compassion when she said:

There must have been something in me. And I was talking to people about this and I think you have to have some sort of self-love to even come here. And I think it just came from being loved as a child [...] I think I still had a wee semblance of self-love somewhere in there. It was buried deep, but it was there and it was enough to get me through those doors.

All of the women who enter the program at Fáilte are required to voluntarily submit themselves to treatment. This policy is in place because staff members believe that a participant will not get better if she does not want the help for herself. Interestingly, none of the women said that they were pressured by others to enter into the program. Instead, they described instances in which they came to their own realization that they had no option but to enter Fáilte. Although Jellink (1991) argues that alcohol dependents may be “induced” through their interactions with non-alcohol dependents to enter therapy, this was not the case of those interviewed. Instead, participants described being blind to the outside expectations of their families and communities while in addiction. Cindy said that women in addiction “can’t hear and they can’t see.” Even the women that were aware of the concerns of others ignored their pleas to get help, saying that their addiction caused them to be “selfish” and focus solely on getting the next drink. In these

scenarios, it is apparent that the women knew that they were deviant, yet still continued their behavior. As Jessica (Week 12) explained, “I think [I wanted] to just go back to normal. Because I think when I was drinking... You know I knew, I knew that I wasn’t. I just wouldn’t admit it to anybody but I knew myself that it wasn’t right.” Participants described that it was not until they grew tired of their own behavior that they were ready to seek help. Therefore, women’s entry into the program may seem to be more of a self-induction than one enabled through an awakening to or confrontation with expectations of broader society as Jellink (1991) contends.

Goals and Motivations

Almost sixty percent of women stated that, after hitting rock bottom, they had a choice between treatment and death. Dawn (18 months sober) said, “I knew in my heart I had to do it. I was really at the point of all or nothing. I was either going to lose my life or everything I had.” In this choice, the women did not have any goal beyond that of survival. Hannah (3 years sober) described her mentality, saying, “When I first came in I just wanted anything. You know. I didn’t hope for anything. I had no hopes for anything. I just wanted to get well.” The choice to enter therapy therefore suggests that these women wanted to regain not only control of their lives, but save their lives entirely (Centers for Disease Control and Prevention 2014). Maxwell (1962:578) supports this perspective, saying that individuals must suffer from disillusionment with alcohol before they are ready to commit themselves to the A.A. recovery program. He says:

It appears, furthermore, that the alcoholic has to become completely disillusioned, not only with his own ability to solve his alcohol problem, but also with alcohol as his method of solving any problems. This includes the conviction that his drinking which for years was considered to be an asset has definitely become a liability and, if continued, will only lead to more suffering, degradation, and perhaps insanity, or even death. For the disillusionment with alcohol to be complete, however, it apparently must include the conviction that any compromise goal of safe, controlled drinking is utterly impossible for him.

Other women voiced desires for a new life with long-term goals of happiness, peace, contentment, and self-acceptance. For example, Amy (Week 8) said that she arrived at Fáilte hoping to gain a “a peaceful life and contentment.” After spending several weeks at the program, Hannah said that she began to adopt these goals as well, saying, “I just wanted to be happy and to feel peaceful within myself and like myself and to feel comfortable within my own self.”

Labeling

Reclaiming the Label

Participants varied in their ability to accept the label of “alcoholic” due to the negative stigma associated with it. Staff members generally concurred that this stigmatization was troublesome for many alcohol dependents.

I think it leaves a stigma, as you were saying, because people don't want to be known as an alcoholic. And people's interpretations of an alcoholic can be somebody lying in the gutter, somebody who steals, somebody who is untrustworthy. Whatever their imagination ties in. So it is not a nice label I suppose for people to be stuck with. Now, some people can cope with it and lots of people can't. Everybody is so different. (Cindy, Counselor)

With this negativity, many participants said that identifying as an “alcoholic” made them feel ashamed and embarrassed. These narratives support research that shame is a common theme in treatment for alcohol dependents (Gray 2010; Randles and Tracy 2013). Other women voiced desires to reduce the stigma associated with the label, believing that it would result in increased help-seeking amongst alcohol dependents. At the same time, three women described their own personal acceptance of the label, and stated that they were unaffected by the stigma attached to the word. These women acknowledged that the label of “alcoholic” was stigmatized, but did not believe that such stigma applied to them, did not internalize self-stigma, and therefore did not

feel that their self-concept was affected by the label itself (Mead 1943). Interestingly, none of the women interviewed came to entirely reject the label of “alcoholic.” Instead, participants frequently expressed how they came to accept the label by reclaiming in their own terms.

“I have an illness”

Six participants found it possible to accept the label of “alcoholic” by framing it through the lens of medicalization. Through this lens, alcohol was seen as something that alcohol dependents were “allergic” to, with A.A. and aftercare being presented as medicine that would treat this allergy. Understanding alcohol dependence as a disease enabled several participants to accept the label of “alcoholic” and not be ashamed of their dependence. Dawn (18 months sober) explained that she used to have feelings of guilt and shame about her alcohol dependence. However, when she gained an understanding of the nature of alcohol dependence as an illness, such personal blame and embarrassment were relieved. She said, “I think I had to accept the label and [...] I think a better understanding of the illness has helped me [do that]. I think that’s how I overcame the label. I’ve accepted the label for what it is, which is an illness.”

Jennifer (Week 11), Amy (Week 8), and Dawn also voiced concerns that their families failed to understand that alcohol dependence was not a choice, but an illness. To address this, staff members at Fáilte commonly meet with the family members of those in the program. In these meetings, families are presented with the medicalization concept of alcohol dependence. When their families came to medicalize alcohol dependence, all three women reported feeling grateful and said that they felt less stigmatized treatment from their family members.

I had my family meeting last Friday and my mom even talked about it as an illness, whereas before she would have said to me – Oh you’re only a drunk. You’re useless [...] for me that was positive. Like that was my mom sounding positive instead of being negative all the time towards me. (Jennifer, Week 11)

These narratives support research that the way in which alcohol dependence is framed affects notions of responsibility for the condition, as well as responsibility to offer assistance to those suffering (Kelly and Westerhoff 2010). However, in contrast to Kelly and Westerhoff's (2010) study, none of the women that were interviewed felt a need to completely change the terminology of alcohol dependence to that of a "substance use disorder." Instead, they were able to obtain the same decrease in self-stigma by modifying their personal definition of the stigmatized label and encouraging others to do the same.

"I'm doing something about it"

Roughly fifty percent of participants were more comfortable accepting the label of "alcoholic" and their own alcohol dependence if they were able to reclaim it according to their own terms. In these interviews, women stated that they were not ashamed of being an alcoholic as long as they were one that was in recovery and on a journey of sobriety. Dawn (18 months sober) carefully voiced this distinction, saying:

I'm not proud of being an alcoholic. Well, it's not that I'm not proud of it, but I'm fully proud of being a recovering alcoholic. I have no shame about being an alcoholic as long as I'm in recovery. If I'm an active alcoholic that's a different story.

In telling their experiences, the women compared themselves to others who did not take such an approach to "doing something" about their addiction. By comparing themselves to those who did not seek help, the women were able to position themselves as un-blameworthy. As Amy (Week 8) explained, "As I said, too, it's not our fault we're alcoholics but it's our faults if we don't do something about it." This framing allowed the women to resist commonly-held notions of their own personal responsibility for and voluntary participation in their alcohol dependence (Schomerus et al. 2011).

Murray, Malcarne, and Goggin (2003) argue that women who make such claims to have control over their alcohol dependence have an internal locus of control. In contrast, those who believe that something greater than themselves determines their fate are externally oriented. The fact that women claimed that they were “doing something” about their addiction suggests that they had an internal orientation, which is a predictor for the maintenance of sobriety (Murray, Malcarne, and Goggin 2003). However, Jarusiewicz’s (2008) research complicates this suggestion, as it found that individuals who maintain sobriety for longer periods of time have greater levels of spirituality, and may therefore be externally oriented, than those who repeatedly relapse. The relationship between spirituality and sobriety found in this study will be discussed in later themes.

By positioning themselves not as passive acceptors of their fate as alcohol dependents, but as active participants in its control, women were able to decrease their reported feelings of guilt about their identity as “alcoholics.” For example, both Jessica (Week 12) and Jennifer (Week 11) reported feeling less ashamed of being an alcohol dependent. When asked whether she was worried about what people would think of her when she came out of treatment the following week, Jessica said, “the way I look at it is, I’ve done something about it. So I’m not really worried about [what people think of me].” Jennifer echoed this when asked about her identification as an “alcoholic,” saying, “I would almost say that I feel content saying it. Because I have accepted it and I know that I am doing something about it.”

“Normal people are alcoholics”

Five participants and two counselors spoke of the nature of alcohol dependence to affect anyone. The condition was therefore seen as something that does not discriminate on the basis of

race, class, or gender. This understanding was gained through exposure to other women suffering from alcohol dependence either through A.A. or group meetings at Fáilte. Women reported that this realization allowed them to feel less ashamed, as it implied that they did not have to identify with the negative images of “alcoholics” in order to accept their own dependence. Furthermore, learning that other women had similar experiences enabled participants to feel less alone and ostracized from notions of normality. These descriptions suggest developments of the potential to see one’s “common humanity” and therefore the emergence of self-compassion (Neff 2011).

Pauline (Week 9) described how group meetings increased her self-acceptance, saying:

You just feel more comfortable. You start not to feel like a freak. You know, maybe I’m not a freak you sort of say. And you just listen to everybody and take it all in and you know you sort of go to yourself maybe I’m not a freak.

Janet (8 months sober) also echoed how sharing her experiences with others who could understand helped her feel less ashamed, saying:

And there may be a topic I would be too ashamed to bring up and some other girl would bring it up because she has more power. Once she has opened up, I open up. And there is great healing in being with the group of likeminded people and you realize no, hey I am not mad.

However, the revelation of shared experience did not necessarily mean that a woman would freely identify with the stigmatized label. In her interview, Nicole (Week 4) said that discovering the normalcy of addiction helped her to feel less ashamed about entering treatment. She explained, “One of the first things I did before I came in here was Google famous alcoholics and you wouldn’t believe the number of people that you would have never dreamed would have a problem with alcohol.” Yet, this realization did not translate in a way that allowed her to readily identify with the label of “alcoholic” and the negative connotations often associated with it.

When asked if she could say that she identified with the label of “alcoholic,” Nicole responded, “I’m not sure, I don’t know. I’m not really sure.”

“I never use a label”

All four counselors stated that they make an active effort to avoid labeling participants as “alcoholics.” Many justified such an effort by saying that they believed that a label cannot define a person, especially if that label is negative. Several staff members also stated that they would not like to be labeled and judged according to a label, and therefore refrained from doing the same thing to participants.

But the thing that I keep remembering is it goes deeper than that. That’s just a label. ‘Alcoholic’ or ‘drug addict’ or somebody is ‘bipolar’ do you know it’s just a label. And that there is more, there is a person underneath that label. So I personally don’t look at anybody as an alcoholic or drug addict or a anorexic or bulimic or whatever it may be. I never use a label. I believe there is a person underneath that label that needs help.
(Hannah)

Instead, counselors at the program work to treat and label participants as “good people” with an alcohol problem, thereby separating them from the negative stigma of “alcoholic.” Laura described her way of interacting with the women, saying, “I treat them with respect. Total, total respect. I treat them as human beings. I treat them as an equal to me.” This was received well by participants, who said that staff members “treat everybody fairly” and “treat everybody like themselves” (Amy, Week 8; Jessica, Week 12). As discussed in the literature review, the labeling and anti-stigmatizing treatment practiced by counselors is an important delineation from the way in which alcohol dependents may be labeled by society (Gray 2010). As Dawn (18 months sober) explained, “I don’t remember ever being spoken to like that before. And it’s not particularly in our nature to always be praising one another so I remember sort of being slightly shocked at some of the words being used in here like you are unique.”

When Jennifer (Week 11) was asked if she had ever been labeled or treated such a positive way, she answered:

No, no. Definitely not. My husband, well my ex-husband, he always put me down all the time. You know he'd call me useless and I wasn't a good mother. So no I haven't. Never, never. So it's good to be told you're good. It feels good to be told that you're good. Even if at first you don't believe it. You don't, you really don't believe it at first. Then it starts to sink in and then you believe yourself. And it feels damn bloody good to be told you're good. It really does.

Here, Jennifer's narrative seems to confirm the theory that a self-label is modeled after external labeling (William, Strupp, and Schacht 1990). When Jennifer's ex-husband called her "useless," she came to accept herself as person worthy of negative treatment and viewed herself negatively. However, when staff members at Fáilte began treating and labeling her as a good person, over time, she adopted this view of herself. This supports the notion that anti-stigmatizing treatment may be a significant factor in modifying a participant's self-label and resultant self-concept (Shaw 2002). However, it is also evident that some women struggled with relabeling themselves in a positive light, even with the anti-stigmatizing treatment practiced by counselors. For example, when Pauline (Week 9) was asked if she believed the counselors when they told her she was a good person, she responded, "Yeah I got to now, don't I. Oh, I do. I don't know [...]. Hmm it's really hard to shake them feelings off because you've thought you were just... well I thought I was bad. Just bad."

All of the counselors believed that participants must come to accept themselves as good people. However, two believed that staff members could only enable this acceptance to occur to a certain extent. Christine explained that she could treat the women respectfully and tell them that they were good, but that the women ultimately needed to change their own self-perception in order to find success in the program. She explained, saying:

I can't fix anyone. Fáilte is a place you can change yourself and no one else and the same applies to me. I can't fix anyone. I can only say things and give them the space and the opportunity to help themselves and that's about it.

Three participants confirmed that, while the program offered them support in their recovery, they could ultimately only change themselves. Janet (8 months sober) said, “Of course they were very kind and caring [...] But through what I learned and the change within myself, it was more me. They only facilitated the change within me.” Hannah (3 years sober) agreed, saying, “[U]nless I wanted to change myself nobody else can help me. It’s like you change yourself, nobody else can change you.” These narratives support Shaw’s (2002) argument that self-labeling, whether positive or negative, is more important than external labeling. Furthermore, they offer qualitative support to the theory that modifications in self-concept cannot take place until a new self-perception and self-label is accepted (Shaw 2002).

Self-Labeling

Staff members at Fáilte encourage women to view and label themselves as good people, separate and apart from their stigmatized behavior during addiction. This self-labeling allows participants to refrain from perceiving themselves to be the harm that their behavior caused (Shaw 2002). In doing so, participants avoid shifting the stigmatized treatment of alcohol dependence onto themselves (Tannenbaum 1938). In fact, Cindy said that this was the most important lesson for women to learn while at the center. She said that the women must learn:

That they are good. They are good. They are not their bad behavior, they are good. They are good people and they really are. I’ve never met a bad person yet. I’ve met plenty of bad behavior, mind you. But never a bad person and I can honestly sit in this chair and say that. I’ve never met a bad person.

Laura agreed, saying that the program emphasizes that, “It’s the addiction. It’s not the person. It’s not the human being. We have to separate the addiction from the person. And I feel that we have to separate the addiction.” Jennifer (Week 11) confirmed the efforts made by staff members to encourage this separation, saying, “[Y]ou’re told when you come in here you are a good

person. You're not a bad person. Your behavior was bad, but you're not bad. You're a good person. And they do instill that in you when you come in."

"I am good"

To begin to self-label themselves as good people, participants are encouraged to say the phrase "I am good. I was always good. God made me good" to themselves several times a day. All four counselors said that they tell the women to say this mantra regardless of whether they believe it at first. When asked why she accepted this phrase when it was introduced to her, Candice (Week 6) responded, "You don't. You just say it [...] Yeah, you just try and believe it." Candice went on to describe her attempts to practice this self-labeling, saying, "I don't know, I just look at myself and laugh. I'd be like this is mad. But I do it." Although several other women also voiced initial resistance to the mantra, they were encouraged to continue repeating that they are good people, and over time a majority of women came to accept that they are the good people suggested in the phrase. When Hannah (3 years sober) was asked how she came to believe that she was good, she responded, "Saying a thousand times a day I am good, I was always good, God made me good. I didn't believe it at the start but eventually it goes down into my subconscious and I start to believe it."

"It's my behavior, it's not me"

In explaining their acceptance of this self-label, almost sixty percent of women pointed out clear differences between their behavior during addiction, which evoked self-shame, and their behaviors without alcohol. When referring to her argumentative behavior in addiction, Jessica (Week 12) said:

And that would be sort of like the things that I would have done and stuff... you know it was totally out of character for me. And I think it's just accepting that now so I have accepted that. I know that I wouldn't be the type of person to annoy anybody. But when you're drinking, you're completely drinking. Like that wasn't me, that was drinking.

Amy (Week 8) made similar comparisons. She explained:

I know that I'm a good person. It's just with the alcohol, you know it does change you. I'm not an abusive person. I wouldn't fight or anything like that but if somebody annoyed me with a drink my tongue could be loose you know. I could say things I didn't mean. You know I'm not like that at all in my nature. But no, I am a good person.

By separating themselves from their harmful behaviors during addiction, the participants began to accept themselves as good people. Cameron (Week 6) said that she was learning "to accept that it wasn't me. It was my addiction that caused a lot of pain."

Resistance

Although accepting such an understanding may be beneficial in the development of self-compassion, more than forty percent of the women interviewed found it challenging to accept that they were a good person and apply such a label to themselves. This was largely attributed to the severity of harm that their behaviors caused while in addiction. Jennifer (Week 11) explained that she struggled to believe that she was a good person because she had thought she was a bad person for so long. She said:

And even though I knew deep down I wasn't a bad person, my behavior was bad which made me think I was a bad person [...] Because of the things I had done and said and the people that I hurt.

She went on:

You're so used to being accepting of yourself as the bad person. It's like... it's almost like you don't want to be a different person because you're so used to being that person. So it's the acceptance of knowing that you have to change or you are changing. You know, and your behavior is changing. It really is like oh my god it's like being reborn again, it really is.

Dawn (18 months sober) said that she, too, had never felt that she was a good person. She said this was due to the culture of Northern Ireland and found it difficult to begin to relate to herself in a more positive way. She said:

Northern Ireland has a very self-deprecating culture. You know other countries, even in America, I think other places it's okay to say something good about yourself whereas in Northern Ireland or Ireland in general I think that's probably why we have so much alcoholism. We're always putting ourselves down. And that's what you do. So it's difficult. That's engrained from birth. So it's difficult to really congratulate myself about things.

Pauline (Week 9), Candice (Week 6), and Sarah (Week 3) found it challenging to separate themselves from the behaviors of their addiction for different reasons. Their narratives described an inability to define themselves apart from their behavior because they did not know who they were without their addiction. In other words, they had been in their addiction for such a long time that they had internalized it as a part of their identity and did not know who they were in their new life of sobriety. This was evident when Pauline was asked to describe herself. She responded, "I haven't a clue who I am. You know, I am lost."

Peace and Self-Compassion

Those who were able to separate themselves from the harm they associated with their addiction found great peace. Brianna (Week 3) described her feelings after realizing that she is not her addiction. She said:

It's great. It's just a sense of peace within yourself. I can't describe it. You feel like a whole person again [...] You know and it's just a peace inside. You know, you're at peace with yourself. Your head isn't working overtime. You're at peace with yourself.

Such peace brought women a relief from guilt and shame, as Dawn (18 months sober) described that she is no longer "disgusted" with herself. With this separation, women began to forgive themselves for the harm that was caused by their alcohol dependence. Janet (8 months sober)

explained that gaining an understanding of herself as a good person and not defined by her past behavior allowed her to forgive herself. She said:

I hated myself. But I didn't realize it was the behavior I hated [...] And through our program here we learn from very, very early on that this appalling behavior is not us. It's not Janet, it's my alcoholism. Out of control. Functioning alcoholism. Drinking. It's my behavior, it's not me [...] And] I've forgiven myself. I don't beat myself up anymore. I learn to forgive myself for what I have done. It was not me. It was my behavior through addiction.

In light of the literature review, self-forgiveness can be seen as the opposite of self-criticism and depression. Therefore, increased feelings of self-forgiveness may suggest a development of self-compassion. This development may be enabled through a separation of oneself and one's behaviors resulting from alcohol dependence (Goss and Allan 2012; Neff 2011). Research by Robinson et al. (2011) asserts that self-forgiveness is a predictor of sobriety maintenance, and suggests that an adoption of such forgiveness may be found in and promoted by spirituality.

Spirituality

The program at Fáilte encourages women to increase their spirituality. While the center was created by a Catholic nun and participants are required to attend mass two times a day, several counselors were quick to state that the program does not believe that the benefits of spirituality may solely be found in Catholicism. Hannah said, "We're all different religions but nobody cares about different religions. We are all equal. And we respect other religions and other religions respect us. So we're all spiritual in some way." With an open-minded acceptance of other religions, the program encourages women to find their own connection with spirituality. As supported in the literature review, such spirituality is not limited to a relationship with God (Murray, Malcarne, Groggin 2003). Instead, Fáilte views spirituality as a connection with a higher power that knows each woman to be a good person, loves her, and wishes for her to come

to love herself in the same way. As such, a higher power “can be anybody. It can be their sponsor, it could be their dog, it could be anything” (Cindy, Counselor). Cindy went on to say that each woman’s higher power wants her to have “A quality of living without alcohol.” For many women, such a connection was completely absent while in addiction. As Amy (Week 9) explained, “When I am drinking, now prayer is out the window and that’s bad.” Nicole (Week 4) concurred, saying that through the program, “You become a bit more in touch with your spiritual side which drinking completely wipes out.” The narratives of the women interviewed provide evidence to the way in which connecting with spirituality is associated with their development of self-compassion, and may support abstinence following treatment (Polin and Zemore 2004; Robinson et al. 2011; Zemore and Kaskutas 2004). The benefits of finding a higher power that provides unconditional support, love, and purpose will be discussed in more depth.

Unconditional Support

Fifty percent of participants believed that their higher power provided them with unconditional support. Candice (Week 6) explained the effects of such unconditional support, saying, “It makes you feel a wee bit better. It’s like you have somebody as your guardian angel. Like you have somebody there looking after you. It’s good.” Hannah (3 years sober) identified God, Our Lady, and her grandmother as her higher powers. She felt that their help was a major factor in maintaining her sobriety. She said, “I believe that there is a higher power greater than me helping me today and that is what is keeping me in recovery.”

While in addiction, many women were overcome with intense feelings of worry that resulted in both negative feelings about the future and increased levels of drinking. As Sarah (Week 12) described:

Normally when I'm thinking about the future, say about something that might never happen or might happen or whatever the case may be, I would always come up with a negative outcome to the future. I never see that it's going to work out or it's going to have a good outcome.

As the women held onto negative feelings of worry for extended periods of time, it may be suggested that the women in this study lacked mindfulness while in addiction (Shorey et al. 2014). However, while in therapy, the women are encouraged to hand their worries over to a higher power, who would make sure everything would be alright. In their interviews, women spoke of a higher power who would help them through challenges, which in turn decreased their worrying and increased their hope for the future. Dawn (18 months sober) explained the freedom she found by placing her worries about the future with God, saying:

For me, the way it works is if I believe that He's going to look after me and things will be okay, then I don't have to worry as much. You know, before I obsessed and I think a lot of people do who are not even in addiction. You worry, worry, worry. Worry, worry, worry. You know, I'm worried about the kids when they're teenagers – are they going to be alcoholic? Whereas with God, I believe that He is looking after me and the boys and then I can sit back and not worry as much.

This narrative parallels Martin et al.'s (2011) understanding of the way in which religious coping mechanisms, such as asking for help, are used to maintain sobriety. By accepting a higher power, women described being able to release themselves from such feelings. This could suggest increases in self-compassion to be associated with a development of spirituality.

Purpose

Approximately forty percent of women said that connecting with a higher power allowed them to see that their life had purpose. These purposes usually involved using their experiences with addiction in a meaningful way to help others. The women said that they came to believe that

God created them for this purpose, which gave their life meaning and worth. Hannah (3 years sober) also believed that her higher power wanted her to start to love herself. She said:

You know and it does start to click with me and that God didn't put me here in this Earth for no reason. And plus He didn't take me away. You know I should have died because I put myself through hell but God kept me alive so obviously there's a purpose for me in this Earth and the most important thing to start to do is love myself before I do anything else.

Self-worth, or an understanding of one's life as significant, was largely absent for women during addiction. This is evidenced in narratives of self-harm and suicide attempts, as was previously discussed. As presented in the literature review, a development of self-compassion is closely associated with increased feelings of self-worth (Neff 2011). Therefore, the increase of self-worth and purpose described in women's narratives suggest that women were beginning to develop self-compassion. The notion that a development of a connection with a higher power may motivate such a change suggests that spirituality may be an important factor to increase a participant's self-worth and therefore her development of self-compassion. The implications of such a development are supported by research that shows that having a purpose in life is strongly associated with the maintenance of sobriety (Kelly and Greene 2014; Robinson et al. 2011).

Unconditional Love

Fifty percent of participants spoke of the unconditional love of their higher powers. With this love, it is understood that God knows that each woman is a good person and accepts her with and despite of her flaws. Dawn (18 months sober) said that her program allowed her to come to this understanding, saying:

I think God knows that there's nothing in me that would deliberately hurt another person and would never hurt anybody on purpose. And I would help somebody if I can. But I mean there are flaws too and I know He knows them. [... But] I think God knows fundamentally that I'm good [...] I didn't even know there was a God before I came in. I

just wasn't sure He was real. But I think the experience in here changed that for me. Definitely. I don't think, I know. It definitely did.

For many women, coming to accept the unconditional love of God was a difficult journey.

Candice's (Week 6) interview highlights this challenge. When asked what God thought of her, she said, "I don't know. I'm told He has to love us like no matter what." However, when asked whether she believes that God actually did love her no matter what, she responded, "Hmm.... Sort of."

By connecting with a higher power that loved them unconditionally, women were encouraged to love themselves. However, it is unclear whether the knowledge of the unconditional love of God actually helped women practice love to themselves. While many of the women did not speak of their journey to accept that God loved them, the two that did said that they did not believe that God could love them until they had already developed self-love and self-compassion. Brianna (Week 9) said that she came to believe that God loved her unconditionally only after started feeling at peace with herself. She said, "I believe it now because I have so much peace inside that I never had before." Dawn reflected on her journey to accept the unconditional love God offered her, saying:

[T]eaching us that self-love allowed me to believe that maybe God might love me. Before I came in here I thought if there is a God, He certainly doesn't want me. That's definitely what I thought. You know, if He does exist. I thought that's maybe why I couldn't reach Him or He couldn't reach me because why would He given the person I was [...] I think it was learning self-love in here helped me believe that there was a God and that He loved me. And that things were possible again.

Yet, the notion that a woman's higher power wants her to love herself provides complication to the theory that a woman must love herself before accepting that God loves her unconditionally. The narratives of several women suggested that they had not come to love themselves, yet still accepted the existence of their higher powers and their unconditional love. For example, Hannah

(3 years sober) said, “You know I believe they love me. I didn’t believe that before. I didn’t even love myself before but I believe that they want me to love myself and my higher power – which is God or Our Lady, my granny, anybody close that has died – is helping me every step of the way.”

While it proves to be difficult to determine the relationship between a woman’s newfound connection with spirituality and her development of self-compassion, such a relationship may be suggested when examining the narratives of the women as a whole. Most significantly, Janet (8 months sober) directly associated spirituality with traits of self-compassion. She said:

[T]o be able to wake up in the morning and to have such freedom, to have discovered myself at the age of fifty. To have such confidence back, to have a meaning in life, a purpose, and to be free. To be finally free and rid of so many hang-ups and negativity and inferiority complexes, etc. That freedom cannot be bought. And that is spirituality. That is what I have received, it’s that freedom.”

Shared Understanding

Several participants said that they were not comfortable being honest about themselves and their experiences with alcohol dependence prior to their arrival at Fáilte. They said that they feared that being honest would cause them to be hurt, judged, or unaccepted by those around them. Candice (Week 6) explained why she had never been honest while in addiction, saying, “I don’t know, getting hurt I think. Scared of people looking their nose down and not wanting anything to do with me.” However, seventy-five percent of participants said that they felt accepted by the other women in therapy with them because of their shared understanding of and experience with alcohol dependence. Cameron (Week 6) explained that she felt comfortable sharing her story with the girls, “Because they know where you’re coming from and they understand. They’ve been there. Even though we might all have different backgrounds and that,

but the common denominator is alcohol has brought us here.” While the particulars of their stories were different, the women felt that such a shared understanding allowed them to be honest in group therapy, and also to feel less alone. Sarah (Week 3) said that the commonalities between the women allowed her to avoid feeling judged or ashamed in front of the other women. She said:

Well I suppose because we’re all really on the same wavelength. Even though all of our stories are different, you know there’s that common denominator. So say if you’re sharing in a general way at a group meeting, you wouldn’t feel as if it sounds silly or stupid what you did or what you think. Because everybody kind of has thought, has done something similar or something sort of a similar experience of what you’re going through.

Janet (8 months sober) agreed:

And often for people this is the first time in their life in a group that they can be so honest. Because everybody else in that group has done the exact same as you. Different circumstances, different places, different people. We all have suffered from the shame, the guilt. We all understand one another very clearly. Other people don’t understand our conversations, how we behave. But we all know.

This comfort was also felt when in the presence of counselors, many of whom were recovering alcohol dependents themselves. Brianna (Week 3) said that she felt at ease with the staff members at the center “because they understand what it’s like. Because a lot of them are ex-alcoholics which I think is fantastic because nobody knows better than another alcoholic.” Cameron agreed, saying, “[I]t’s perfectly natural for one alcoholic to know exactly what the other alcoholic is going through.”

Denzin (1991) argues that such comfort is common in groups of alcohol dependents that share a commonality of experience and therefore an “alcoholic understanding.” He uses A.A. as an example and explains that, “Alcoholic understanding refers to the process whereby each in a pair of alcoholics interprets, knows, and comprehends the meaning intended by others in terms of previously experienced interactions with the active and recovery phases of alcoholism” (Denzin

1991:705). While others are outsiders to this experience, A.A. allows its members to participate in conversations about their stigmatized behavior and express feelings and emotions that may be felt as shameful in other settings (Goffman 1963). The same understanding and reduction in shame may be felt when groups of alcohol dependents come together to discuss their experiences, as is enabled by the group therapy setting of Fáilte.

The women found it especially powerful that other participants and staff members accepted them even when they displayed candid honesty about their life in addiction, which had previously invoked feelings of shame. By accepting a woman regardless of her harmful and stigmatized behavior, both the other women in the program and the counselors showed her compassion. This acceptance encouraged a woman to practice a similar compassion towards herself, and is therefore related to the development of self-compassion. Pauline (Week 9) spoke of the interactions between an “alcoholic understanding,” acceptance, and self-acceptance, saying:

I think because we all have different stories and I think hearing it from somebody that is as tormented as yourself telling you that you know they're proud of you, or you done well today. And you're not sitting feeling like a fraud. You're sitting being brutally honest about something if you know what I mean. And they are all looking at me and they're dead proud of me and they're happy. Yeah, I say maybe I'm not a fraud. Maybe I can sort it out myself and not feel guilty about liking myself.

In a similar manner, Janet found the acceptance of a staff member to be significant, saying that “She has seen the worse in me and she accepted me as myself.” With this unconditional acceptance, women felt decreased feelings of shame and increased self-acceptance, which may be tied to a development of self-compassion (Goss and Allan 2012; Neff 2011).

Mindfulness

“I have got all of my feelings back”

As they moved through the program, women’s experiences were permeated with the re-emergence of feelings and emotions that were absent during addiction. Cameron (Week 6) compared her new emotions to the lack of emotions she felt before she arrived. She said, “And see I’m starting to get my emotions again, which I don’t have. I have cried since I came in and I don’t cry. I don’t let it out.” Jennifer (Week 11) reflected on what she gained in the program, saying:

Like, I have got all of my feelings back and I’m really, really happy. I’m in a happy place at the minute because I have feelings. Oh my god, the love that I feel for my kids again is unbelievable. It’s like they’re newborns. Whereas before I didn’t have that. [...] I’m so grateful that I have learned to laugh, love, live, cry, everything in here. Every emotion has been brought back.

“Show them how to talk”

Unfortunately, not all of the emotions that emerge in the program are positive ones. When negative feelings of pain, shame, self-criticism, and cravings emerge, participants learn to deal with their emotions appropriately. They learn, as Christine stated, “ [that] you can’t make a big deal out of everything.” More than fifty percent of participants said that talking about their feelings allowed them to deal with their emotions for appropriate lengths of time and not allow them to be blown out of proportion. These narrative descriptions parallel the development of mindfulness, and therefore self-compassion, as presented in the literature review (Neff 2011). Hannah (3 years sober) described the relief she gained from verbalizing her internal thoughts, saying:

Well, it's breaking the power out of it. If I hold it within myself, I've still got the power to go and do something silly that I'd regret. But when I talk to somebody, it's taking the power out of it. That control out of it.

Jennifer (Week 11) agreed, explaining:

I talk to myself now. I try to rationalize it, trying to make it not a bigger problem. To try and be realistic about the problem or what I've done or I own up to it. But at least it came out. If it stays in, it'll just get bigger and bigger and bigger.

In particular, talking about cravings and negative emotions allowed women to release their internal thoughts without feeling the need to alleviate them with the use of alcohol. Dawn (18 months sober) said that it had been difficult for her to learn to talk because she had never disclosed her feelings to anybody before arriving at Fáilte. However, she went on to describe the dangers of not talking:

[T]he biggest risk I think for any alcoholic is that because you hold it in and then you isolate. And then the loneliness. To escape out of it you either go and talk about it or else you go and have a drink.

The Value of Attentiveness

Three of the counselors discussed that developing attentiveness also allows participants to handle emotions appropriately and without the use of alcohol. While attentiveness is not a specific component of self-compassion as defined in the literature review, it is clear that it may be very closely related to mindfulness. Hannah described, "Attentive [is] being in the now. Not looking ahead to the future... not looking ahead, not looking back. Being in the now." Being attentive is therefore to refrain from holding onto emotions from the past or about the future for an extended length of time, and instead focusing on the ones at present. This parallels Shorey et al.'s (2014) understanding of mindfulness as an ability to observe an experience with appropriate attention.

In the past, women would often drink when they were overwhelmed with negative or anxious feelings about the past and future. Christine explained that this occurs when “you bring the pain and the hurt and the burdens from yesterday and the fear and the anxiety of what’s going to happen to tomorrow.” Laura concurred, and said that, in particular, women in addiction drink after remembering emotionally painful memories of the past. She explained that, “they want to live in the past. But the past is no good because they don’t want to be in the past. They have to be in the present to move on.” Women were often only able to let go of these negative emotions when they drank to forget about them. Jennifer (Week 11) described her medication of her emotions, saying, “I would have drank to hide the feelings – to hide the pain, to hide the hurt.”

In their narratives, several women said that when they were not attentive, their heads would “go.” This phrase was associated with compulsive over-thinking that often resulted in drinking. Forty percent of participants said that practicing attentiveness by staying in the present moment allowed them to avoid thinking about past pains or worrying about the future, and subsequently to avoid drinking in an effort to subdue such emotions. Therefore, both the participants and counselors saw being attentive as essential to maintaining sobriety. Brianna (Week 3) explained, “As I say again, it’s just the way that I’m teaching myself now to live in the moment. Don’t think about everything else. You have to because your head will just take over.” When asked what happens after this moment, she responded, “I’ll put a drink in my mouth again.” Hannah (3 years sober) agreed when she said, “Even when I am still in recovery today, if I start to think what’s ahead of me or my past, my head will go. I have to keep bringing myself back to the now. And that’s where I find peace and happiness.” Christine echoed these thoughts when she explained the usefulness of attentiveness, saying, “A lot of people drink because

they're not happy. So if you can stay focused on your sobriety today and keep happy today, why should you pick up that drink.”

In several cases, the ability to practice attentiveness did much more than reduce the risk to drink. Three women associated their ability to practice attentiveness with peace of mind. As Janet (8 months sober) described:

I live for today and in today and if what I do today and I do it to the best of my ability and we're all not perfect but if I do what is good and what is right for today, I don't have to worry about yesterday and I don't have to worry about tomorrow. Because when tomorrow comes I've looked after yesterday. And that was fantastic freedom. When you wake up in the morning and you know I might not have done everything perfect and you might not have done everything right but you did your best. And nothing, no money in this world, could buy that peace of mind. It's so amazing and it's so hard to explain.

The notion of attentiveness, and the mindfulness it promotes, as essential to sobriety are further discussed in the section on self-efficacy and relapse.

The Development of Attentiveness

As discussed previously, developing spirituality helped some women improve their mindfulness and attentiveness. The program at Fáilte also encourages women to strengthen their mindfulness by practicing thirty minutes of meditation two times a day. Dawn (18 months sober) said that she learned how to be attentive directly from these meditation exercises. Brianna (Week 3) also spoke highly of the benefits she experienced from meditation, saying:

[I]t's bringing you back to yourself. You don't have to think about anything else. It's just time for you. Even when I come out of it, I would be in great form because it's just time to shut yourself down and have rest, think about nothing, and then get up and start again.

However, the women's narratives also highlighted the fact that it often took significant time and effort to be able to succeed at meditation. Candice (Week 6) and Sarah (Week 3) both voiced their frustration at the difficulty of perfecting meditation. Candice explained her experience with

mediation saying, “It’s hard sometimes because things can come into your head. Like meditation, I’m struggling with that really bad. So meditation I would overthink and overthink and then I have to keep trying to bring myself back.” Sarah had similar feelings about meditation, as she described, “I’m not great at meditation. I do try but it’s hard. I just can’t get the grasp on it yet.” Nonetheless, Sarah was still able to see the potential offered by mediation. She said:

[One time] I was able to say the ma-ra-na-tha and not have any other thoughts. And it was great because you just felt relaxed and at ease because there were no other thoughts in your head. So I do think if I could get a good grasp on meditation, it would be a good help to sort of settle your mind and slow you down.

Staff members make a conscious effort to encourage participants to remain mindful and practice attentiveness outside of meditation. For example, Christine said that she would often try to encourage participants in the program to be attentive even when in day-to-day conversations.

When she heard a woman talking about her plans for the future after she left the program, she would say:

[L]isten, can we bring it back to the now and talk about whatever we were talking about today. And it’s not that, and I say to them as well, it’s not that I’m being rude and saying that we can’t talk about it but I can only say this to you so many times and I am going to keep on saying it. I don’t mind being that annoying person who brings you back because in six weeks, ten weeks time when you are home you have to call yourself back on it. I’m not here, the staff’s not here. You need to be the person who calls yourself on it. I’ve gone too far ahead, I need to focus on the now.

Self-Confidence

Both participants and counselors frequently pointed to increases in self-esteem and self-concept as signs that the program had a positive impact on women. In fact, almost sixty percent of participants said that their self-confidence had increased significantly while participating in the program. However, when reviewing their narratives, it is apparent that their definitions of self-confidence fall in line with self-compassion.

While in the program, women learn that it is important to refrain from comparing themselves to others. In doing so, they are encouraged to focus on accepting their goodness and imperfections instead of being self-critical when comparing themselves to others they deem to be “perfect.” Counselors model this component of self-compassion by not comparing the girls to one another, and encouraging the girls to do the same (Neff 2011). For example, Hannah said:

I keep saying this in groups, we’re all equal. But never compare yourself to anyone else. Because comparing yourself to somebody else or to somebody else’s story would drive you mad. Comparing yourself will really lead you back to addiction because, if you compare yourself to anyone – I want to be like them – you’re not happy within yourself [...] You know and I never compare girls because they’re all going to get it at their own time. They’re all unique individuals.

Jennifer’s (Week 11) interview showed that she was able to accept her own imperfections. She said:

It was all to do with accepting myself that I’m not perfect, nobody is perfect. Because I would have beat myself up. Like I’m sitting here today – I’m not dressed, we have no hair dryer to do our hair. Before [...] I would have had to have the perfect figure. I had to have the perfect makeup, perfect hair for people to like me. Whereas now I realize that I don’t have to be perfect for people to like me. So then that gives you more confidence within yourself, so then you naturally start to feel better and feel the goodness in yourself because you gained the confidence.

As Jennifer correlates her ability to accept her imperfections with an increase in self-confidence, she serves to support the existence of a close relationship between understandings of self-confidence and self-compassion (Gilbert and Procter 2006).

Self-Efficacy and the Potential for Relapse

While the literature review failed to produce a conclusive determination of the benefits of self-efficacy in the maintenance of sobriety, participants and counselors spoke freely of the need to maintain cautious optimism about their future (Kadden and Litt 2011). With this caution, the

women in Fáilte frame their future with positivity while practicing attentiveness to avoid falling victim to complacency.

The Notion of a Program as Lifelong

Throughout therapy, counselors make an active effort to instill in participants the necessity of continuing their program long after leaving the treatment program itself. Therefore, neither participants nor counselors viewed therapy as a quick fix to alcohol dependence. In fact, counselors made no promises about whether any women would be able to maintain their sobriety after leaving the twelve-week program. Hannah described this, saying:

We don't know who will be successful or not. But all we can do is encourage every single girl to go to A.A. meetings when they get out, to go to N.A. meetings when they get out, come back for aftercare.

With this mindset, the journey of sobriety was framed as one that was lifelong and requires constant effort, time, and attention in order to maintain. Staff members explained that continuing the program meant continuing to practice the tools learned in therapy. These tools include self-discipline, honesty, and attentiveness. All four counselors that were interviewed stressed the helpfulness and necessity of attending aftercare and A.A. meetings to continue strengthen these tools after leaving treatment. As Laura explained:

So the alcoholic has to be fed [...] they must go to their aftercare because somebody was saying A.A. plus aftercare equals sobriety. So they have to do that, it's a must. It's a must for them to stay sober. To have their sobriety.

These lessons were readily accepted by most participants, whose self-efficacy was prefaced with cautious optimism.

Cautious Optimism

More than ninety percent of the women in both the beginning and the end of the program voiced confidence, hopefulness, and expectations about their new lives of sobriety following therapy. Nicole (Week 4) was particularly optimistic about completing the remainder of treatment and entering into a new phase of her life, saying, “I’m just looking forward to the life that I’m going to have.” She said that this hope kept her motivated to continue staying with the program even during difficult days. Jennifer (Week 11) also reflected this positivity when she spoke of the quality time she would get to spend with her children after leaving the center. She said, “I am so excited now at the thought of being sober.” Significantly, only one participant, Pauline (Week 9), stated that she was worried about leaving the program and maintaining her sobriety without the support of the staff.

However, even optimistic comments were presented with the understanding that too much confidence of success could lead to complacency that may lead to relapse. Janet (8 months sober) voiced this caution saying, “But I’m not cured, I never will be cured. And I know that and I’m very aware of becoming complacent. Because once I become complacent I’m back down that bottle again.” This statement contrasts the previous comments of unbarred optimism and confidence about maintaining sobriety. Unlike Nicole and Jennifer, Janet had already suffered multiple relapses on her journey of sobriety and had attended more than five treatment centers. Her understanding and awareness of the danger of complacency may therefore be granted by her previous experiences with relapse. Yet, this period of sobriety remained her longest and Janet maintained hope that this would be her final encounter with therapy.

With the danger of complacency in mind, in forty percent of interviews with both participants and counselors it was emphasized that alcohol dependents cannot make claims that

they will never drink again. Instead, the program encourages participants to focus on staying sober in the day by using the tools they learn in therapy. More specifically, counselors draw upon lessons of attentiveness and mindfulness of emotions when encouraging women to refrain from drinking. Christine gave a short script of a conversation she would have with a participant who wanted to drink, with Christine encouraging her to be mindful of her cravings by being attentive to her present emotions.

Christine: “You feel like drinking now. Ok.”

[Waits several minutes]

Christine: “Do you feel like drinking now?”

Participant: “Well I was thinking...”

Christine: “No, you’re living in the past. You’re thinking about how you felt like drinking there. Do you feel like drinking now?”

Janet explained that looking at sobriety in these simple terms helped to relieve the pressure of never being able to pick up a drink again. She said:

I can’t get complacent. So I can only joke about for today. And I’d love to say to you – Oh yeah, look, I’ll see you next year and I’ll be dead sober – I don’t know. I don’t know. And yet again if I look after today, yesterdays and tomorrows will look after themselves. So it’s only today. That’s what makes it easy, it makes it simple for me. Just today. That is so simple.

Dawn (18 months sober) agreed, saying:

The key is to stay sober today. If you want to have a drink tomorrow that’s okay, but stay sober today. Because as an alcoholic if somebody says you can’t drink ever again in your whole life, that is so scary. But if somebody says to you just don’t drink today, just today, that’s something you can get your head around. So I don’t even think about the fact that I can never drink. I have to think I’m just not going to drink today. But if I want to drink tomorrow, we’ll see what it’s like. And that’s the only way we can do it.

Women’s acceptance of the potential to relapse offers an interesting insight into the concept of self-efficacy. While research argues that increased measures of self-efficacy result in increased levels of success following therapy, the approach favored by Fáilte and its residents views over-confidence to be detrimental, as it can lead to a failure to maintain a program and practice its

tools following treatment (Ilgen, McKellar, and Tiet 2005; Moos and Moos 2006). The literature review also showed evidence that self-efficacy may increase the longer abstinence is maintained (Romo et al. 2009). However, in what may offer a point of contrast to this argument, the three participants who had maintained their sobriety for the longest periods of time did not voice strong feelings of self-efficacy. Instead, Hannah (3 years sober), Dawn (18 months sober), and Janet (8 months sober) were more likely to attribute their continued sobriety to a careful and conscious control of their confidence a refrain from making claims or promises about long-term sobriety.

I think you have to be careful not to be under any illusions that you've done it. And I think that can be dangerous. I think you have to have a healthy fear and an understanding of what it means to live as a recovering alcoholic [...] You know you have to be in the mindset that I can only stay sober if I do certain things every day. If not, generally people go out again. You have to be very humble. Very, very humble. And accepting of your weakness. (Dawn)

Framing Relapse with Self-Compassion

As discussed in the literature review, in traditional notions of success, relapse may be viewed as the failure of an individual to be strong enough to resist alcohol. Therefore, to many, the potential to relapse (or a relapse itself) may be seen as a weakness on the part of the dependent pursuing sobriety. This study confirmed this argument, as several participants described experiences of relapse that were followed by strong feelings of shame, guilt, and failure. Counselors were aware that such feelings may dissuade a woman from returning to the program to seek help. With this in mind, they made an effort to welcome a woman back to the program regardless of whether she was returning for her second or twentieth time. Amy (Week 8) described her interactions with a staff member after relapsing and returning to repeat the program for her second time. While she was worried about what the counselors would think of

her, she said that she did not experience any judgment upon her return. She described her interaction with a staff member, saying:

She came over to myself and John and she sat down. Hello Amy. She remembered me and I said Sister, Sister. [She said] Oh, you did a runner last year you left. And I said I know, sorry Sister. She said you know it's never too late. You know you might get it this time. You know she was lovely [...] And the same with the other staff too. They were all really supportive. There's no looking at you as if you're wasting their time.

Staff members at Fáilte also attempt to decrease the potential for shame and guilt by framing relapse as a part of the journey of sobriety. Christine even saw relapse as a positive experience that enlightened participants to the danger of complacency. She said:

I see it as a benefit to me and to them because they already know what it's like to do a program. They already know what it's like to do a program, to go out maybe have a couple of months of sobriety. Maybe go out and drink the week later. They have that extra knowledge, the fear of the unknown when you come out.

The framing of relapse as something that is positive helped participants to avoid seeing it as their own personal flaw if they failed in maintaining their sobriety. This effort helped increase participants' self-compassion and proactively prepared them to treat the challenge of relapse with self-compassion (Goss and Allen 2012). As counselors framed relapse in this light, participants subsequently came to accept this framing. However, in the light of this thesis, the harsh honesty and acceptance of the potential to relapse may in fact only be made possible with self-compassion.

Discussion

The self-concept of women who sought treatment at Fáilte was extremely negative, as participants described patterns of self-criticism and self-hate while in addiction. In fact, most women were aware that they were not acting "normal" and were therefore aware of the deviance

of their actions. This realization resulted in isolative behaviors and perpetuated the harmful drinking that caused their initial isolation. However, such an understanding and self-concept did not seem to motivate an entry into therapy. Instead, the women's narratives frequently stated that they chose to enter therapy because they believed that they deserved to be content and have a meaningful life without addiction. In other words, they loved themselves enough to get help. These desires suggest that the women who entered Fáilte already possessed initial feelings of self-worth, and therefore self-compassion.

Cindy said that she often explained this to the women in hopes that it would encourage them to begin to look at themselves more positively, saying:

The first thing I would always say to people is the first good thing you have actually done is coming here. You knew you were in trouble with your living and something wasn't going right and the first big step for you is walking through those doors.

Therefore, it does not seem that Fáilte enables a development of self-compassion in an individual who possesses none, but that the program increases initial feelings of self-compassion.

Counselors aimed to decrease the self-hatred and self-criticism practiced by women who entered the program. Through an examination of the interview data, it is apparent that the program at Fáilte enabled such reductions by increasing participants' abilities to practice self-compassion. The successful development of self-compassion is evident, as a majority of women described the way in which they came to accept themselves over their twelve weeks in the program. Janet (8 months sober) explained her self-concept after therapy, saying, "I do like myself. I do like myself. And that is a hell of a change coming from hating myself." Yet, even participants did not seem to understand how such a development of self-compassion occurred. Jennifer (Week 11) voiced her own confusion at the change she saw in herself, saying:

I don't understand how I have changed so much without realizing it [...] I don't understand how it happened. We know we've got our topics and we know that we have

the tools and we know what we're supposed to do. But as I say, for me it happened naturally. I would love to get inside my mind and to be able to read it. To know how it's actually happening if that makes sense. But it's the program. The program just worked. It has worked for me, definitely has worked for me.

Through an examination of the program and participants' subjective experiences with it, it is apparent that both relabeling and spirituality mediated substantial improvements in self-compassion.

All participants were aware of the stigmatization of alcohol dependence and agreed that the label of "alcoholic" carried such stigma. Interestingly, the program requires participants to accept that they have alcohol dependence in order to begin their journey of sobriety. However, it also encourages them to reconstruct the label of "alcoholic" in the process. While a majority of participants adopted this self-label, they did not subsequently accept or apply the stigma of the label to themselves. Instead, participants refrained from feeling self-stigma by regaining control of the label.

Women regained control of the label by framing an "alcoholic" as an individual who has an illness that does not discriminate. This framing allowed women to reclaim feelings of normalcy and reduce their feelings of blame or shame for having the condition. Although women expressed shame of their alcohol dependence at the beginning of therapy, they often said that hearing that other women had experienced the same thing reduced such shame. As a result, the women did not feel judged or condemned by others for identifying with the label of "alcoholic." By allowing alcohol dependence and its resultant behaviors to be normalized, the women were able to increase their acceptance of the condition. The existence of an "alcoholic understanding" shared by participants and counselors was therefore a significant factor in the acceptance of such a self-label. Women further separated themselves from negative conceptions of "alcoholics" by emphasizing that they were doing something about their addiction. Therefore, participants

accepted the label of “alcoholic” by framing it in a light that recognizes its harm, but does not confer anything about themselves as people and simultaneously places themselves as proactive actors in its control.

The women also accepted the label of “alcoholic” with the precondition that they were “good.” In this light, participants adopted two self-labels. The self-label of a “good person” was constructed intentionally by staff members and encouraged through therapeutic techniques. Counselors made efforts to tell women that they were good people and to treat them as such. The primary barriers to accepting this label and to subsequently develop self-compassion were a woman’s existing self-perceptions and beliefs about the treatment she deserves. Women had never felt that they were good people because others had never treated them as such. For example, several women described instances in which they were sexually assaulted at a young age by family members or trusted family friends. Others described experiences in which they felt rejected, isolated, or disrespected. As this treatment continued over the course of their childhood and into their adult lives, women began to accept that they would feel rejected and alone for the rest of their lives, and started to believe that they deserved to be treated that way. When these attitudes became engrained in their self-concept, women found it difficult to begin to relate to themselves in a more positive way. Sarah (Week 3) explained what was holding her back from accepting herself, saying, “Just years of not feeling that. It’s just years of thinking that I wasn’t good enough [... So] the biggest challenge is to feel properly good about myself. A proper good feeling that will last.” Pauline (Week 9) agreed, saying:

You’re used to feeling pain like that every day and I don’t know a support worker said to me the other day you’re just used to being unhappy and you’re scared to be happy which is probably right because I can’t remember the last time I was happy [...] I don’t know how to like myself. I think everything has been buried for so long. Like life hardens you, if you know what I mean.

Therefore, a major obstacle to self-compassion and the benefits it has to sobriety is the modification of a woman's self-concept.

In Fáilte a change was initially mediated by the non-shaming, non-judgmental, and anti-stigmatizing treatment of the staff members. Over time, this treatment was accepted by participants, who began to believe that they were worthy of such positive treatment and modified their self-concept accordingly. When asked if being told she was good by counselors helped her feel better about herself, Jennifer (Week 11) responded:

Yes because I haven't been told. I haven't been told that. So it does, it really helps. It gives you a boost. It really helps your confidence so now actually, when you have more confidence you feel better within yourself so it really just helped.

As such, the anti-stigmatizing treatment of counselors is deemed to be a significant factor in reducing self-shame and self-stigma. This self-label was also encouraged through repetitions of the mantra "I am good. I was always good. God made me good." While this phrase was often not accepted at first, the women slowly came to believe it as the concept sank into their subconscious. This was further encouraged as participants began to realize that their destructive and harmful behaviors during addiction did not continue when they had extended periods of sobriety.

The fact that both labels could exist simultaneously was often surprising to women, and was met with resistance. This was largely due to the significant amount of harm caused by each woman while she was in addiction, and for which she often felt guilt and shame. However, over time, participants came to accept that the labels were not mutually exclusive, and that they were both "good" people and "alcoholics." This acceptance allowed them to see their goodness while not holding resentment towards themselves for having alcohol dependence. As Dawn (18 months sober) explained:

I had not truly accepted my alcoholism before I came in here. I came to accept it for what it was and not hate myself for it. When I went back out again it was so different. I have no shame now. I don't run about telling everybody I'm a recovering alcoholic but if it came up I wouldn't be ashamed or embarrassed.

A majority of women also expressed the benefits that they found from increasing their spirituality. With spirituality, women were aware that a higher power loved them for both their goodness and their flaws, and was protecting them in the present and in the future. This understanding enabled women to feel less worried about their own future and gave them a feeling of self-worth. Several participants resisted the fact that God loved them, mostly due to the fact that they believed they were bad people. However, as participants began to slowly accept the self-label that they were "good," spirituality came more naturally to them and provided a source of support throughout their recovery.

It is difficult to determine the degree to which self-compassion initiated modifications in self-labeling and increases in spirituality, or whether self-compassion resulted from such increases. For example, the self-label of a "good person" could not be accepted until participants were able to see their own goodness and not possess consuming feelings of self-hatred. Therefore, participants were required to have some underlying understanding of themselves as good people, which could be facilitated by the inklings of self-compassion as previously discussed. In a similar way, participants found it difficult to accept the unconditional love of God until they came to believe they were good people and therefore worthy of love. In both situations, it seems as if initial feelings of self-compassion were necessary to initiate modifications of self-labeling and an increase in spirituality. However, once these processes began, they worked as a positive feedback mechanism in which each encouraged the further development of self-compassion. As participants were often not able to explain the complex

interactions between these variables, these interpretations are merely theoretical. Nevertheless, they seem to be related.

Participants and counselors viewed sobriety as a journey with the ever-present potential to relapse. For this reason, participants were reminded of the necessity to continue practicing the tools that they had learned in therapy. The most significant of these tools was the practice of mindfulness. Mindfulness was particularly essential to participants who were newly sober because sobriety brought back emotions that were absent or suppressed during addiction. While some emotions, such as joy and love, were welcomed by participants, other emotions were more difficult to cope with. Participants were encouraged to overcome feelings of self-hate, negativity, self-criticism, and cravings by practicing mindfulness and attentiveness.

Participants found that it was beneficial to talk about their emotions with other people in order to remain mindful. They believed that this was an essential practice to continue once leaving treatment, and could be facilitated by attending A.A. and aftercare. Additionally, participants said that framing situations with mindfulness allowed them to let go of hurts of the past and worries about the future that would have previously led to the consumption of alcohol as a coping mechanism. The specific way in which mindfulness increased was not found in the interview data. While some women found meditation to help in its development, others did not. Staff members therefore adopted the habit of constantly reminding participants to be mindful and hoped that it would eventually be accepted.

With these tools and a self-compassionate mindset developed in therapy, participants felt strong notions of self-efficacy upon their departure from the program. However, participants were aware that their program is lifelong and could therefore never vow to refrain from drinking for the rest of their lives. In fact, participants frequently said that being over-confident might

nurture the complacency that would lead to relapse. As such, the women believed that it was important to remain mindful of not drinking day by day. Therefore, the women were both optimistic and cautious when asked about their futures. This caution seemed to grow as the length of sobriety increased for each participant, and offers insight into the way in which sobriety is assisted by restrained self-efficacy.

Conclusions

Self-Compassion

Self-compassion was seen as essential to maintain sobriety following therapy. Christine explained that possessing self-compassion allows women to pick themselves up when they have negative feeling about themselves that urge them to drink. She described how women face two paths when they get out of therapy, saying that they have a choice of “the hard road of bringing yourself back up, loving yourself and protecting your sobriety or go find the drink that use to help you escape all of your thoughts and feelings.” She said that with self-compassion, “you can pick yourself up and remind yourself that you are good, you’re kind, you’re considerate, you’re loving” and get through difficult situations without turning to alcohol.

These Things Take Time

Through an examination of the interview data, it is apparent that the development of self-compassion takes significant time. Several women said that their negative self-perceptions were encouraged by Irish culture, which manifested itself in marital and familial relationships that did not positively influence a woman’s self-concept. Although it is essential to decrease self-hate and

the harmful drinking that it promotes, it proves to be difficult to change women's habitual and cultural ways of relating to themselves. As Dawn (18 months sober) explained:

And to be honest, for a long time I was thinking this is rubbish, this is not going to work. You've got to tell people that they need to bloody change or else. And it happened very slowly but I think subconsciously maybe just slowly it just being constantly drilled into you and then I started [...] to feel that I was worth something [...] And as I say it didn't happen just in the first week or two, in the first meeting or second. It was twelve weeks of that.

Counselors therefore encouraged participants to be patient in their journey with the program and in their search for sobriety. Even upon completing the program, participants may not have developed complete self-compassion or self-acceptance. This necessitates the importance of continuing the program after they leave in order to continue strengthening their self-compassion, which will work to mitigate harmful drinking levels. Hannah (3 years sober) highlighted this, saying:

It's one day at a time and yes I do love myself and respect myself a lot more but it's a lifelong journey. You know it's lifelong. I know I have a lot of things I still have yet to change about myself and my own patterns, but there's a time for everything. And it takes time and it's lifelong.

Recommendations and Challenges for the Future

The narratives presented in this study suggest that women arrived at Fáilte with and because they had a baseline of self-compassion. Although the program significantly increased the development of this capability, it was essential to possess an inkling of self-worth in order to decide to pursue therapy. As such, the question about what happens to those who do not have such traces of self-compassion remains. It is imaginable that those individuals never make it to treatment, as they do not believe that they deserve it, or that they are pressured by others to enter a program and leave early because they are not committed to it for themselves. However, any claims such as these are merely hypothetical, as those who were interviewed all stated that they

independently chose to pursue therapy. It is nevertheless crucial to begin to ask how dependents who have no baseline of self-compassion may be motivated to seek help or to desire sobriety. Additionally, whether the program is beneficial to those who do not have a starting point of self-compassion remains to be explored.

This study suggests that it is not necessary to change the terminology of “alcoholic” in order to reduce the self-shame felt from its stigmatization. This is because women did not resist the label of “alcoholic” itself, but the stigma that it carries and what that stigma implies about them if they were to accept and identify with the label. Alcohol dependents should instead be encouraged to not solely identify themselves according to this label. Of course, there will be those who resist this encouragement because they feel that they fulfill the existing negative descriptions of “alcoholics.” In this situation, it is useful to encourage the dependent to realize that she is *more* than those descriptions by identifying as a “good person.” By adopting a simultaneous, if not primary, self-label of herself as “good person,” an alcohol dependent is able to resist applying the negative connotations that are implied from the “alcoholic” label onto herself as a person. In doing so, she is able to define what the term “alcoholic” means in a way that she can accept without having to identify with negative and stereotypical representations of “alcoholics.” A helpful framing may utilize components of medicalization in which the definition of “alcoholism” promotes understandings of the normalcy of the condition and reduces the self-shame of those who are alcohol dependents. In this situation, the stigmatized label is reclaimed and defined according to standards that encourage society to look less judgmentally upon an alcohol dependent and an alcohol dependent to look more positively upon herself.

The non-stigmatizing treatment and acceptance given to women by counselors and other participants was a significant factor in increasing their self-concept, self-acceptance, and self-

compassion. Participants' experiences in therapy showcase the way in which modifying the treatment of alcohol dependents may alter their self-treatment. In doing so, this study supports the flexibility and fluidity of the construction of one's self-concept and the way in which the development of self-compassion may support positive modifications of one's self-concept. However, the relative ease with which a self-concept may be changed that is evidenced by this study provides concerns for the future of alcohol dependents upon their completion of the program. Upon leaving, many participants are faced with the challenge of returning to environments that may lack the affirming treatment offered by counselors, and women may instead feel the shaming and judgmental treatment that initiated and perpetuated their addiction. With this treatment, it is entirely possible that participants will again modify their self-concept back to what it originally was at the start of treatment. To mitigate these risks, it is important for participants to surround themselves with supportive networks upon their departure, which may be found in A.A. or aftercare. These networks will encourage women to maintain and strengthen their self-compassion throughout their journey of sobriety.

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Appendices

Appendix A: Interview Guides

Interview Guide for Participants:

Therapy

- Can you tell me the story of why you think that you are here?
- Why did you choose to come to this center in particular?
- What do you think of therapy today? Has this changed from when you first arrived?
- What do you think is the most useful part of therapy? On the flip side, is there anything you've found particularly difficult or challenging?
- What is the most important lesson you will take away from therapy? When did you learn this?

Staff interactions

- How do you interact with the counselors?
- How does this impact your treatment and recovery?
- How do you get along with your counselor? Do you see eye to eye? Do you have the same goals?
- How would you describe the staff's approach to treating addiction?
- Can you describe a time when you had a conflict with your counselor? Can you describe your favorite counselor?
- What does your counselor think of you? How do you know they feel this way? What do they do?

Prior to therapy

- What is your family like? How did your addiction affect your relationship with your family and friends?
- How did your addiction affect your finances, your employment, your community involvement or sense of belonging to your community?
- Follow up questions will ask the participant to compare these feelings to how they felt when first entering therapy and how they feel now
- How did you view and treat yourself prior to entering treatment? Has this changed?

Result of therapy

- What are you hoping to get out of treatment?
- Have you come to see yourself in a different way? How did you see or think of yourself before coming here and now?
- Have your relationships with those around you changed at all? How do you know? When did this start happening?
- Do the counselors treat you differently than other people you have interacted with (ie. family, friends)? How so?
- Before coming here, how was your relationship with your family? How is it now? How do you hope it will be?

- How do various aspects of treatment make you feel? Ie. How do the meetings make you feel? How does occupational therapy make you feel? How does the meditation make you feel? Etc.
- If applicable, did your family treat you differently following your relapse? Did your counselors? How did that make you feel?
- Has religion played a role in treatment for you? To what extent?

Comparisons

- If applicable, what do you think of your previous treatment experience in comparison to this one? Did you like it more or less and why?

Closing

- Is there anything you're worried about in the long or short-term future? (health, relationships, etc.)
- If you were to bring yourself back to the start of your recovery, would you go to the same center? Why or why not? (Or, if applicable, why did you choose to come back?)
- Is there anything that I am misunderstanding? Is there anything else you would like to share with me that I have missed?

Interview Guide for Counselors:

Before the interview, I will state that no confidential information about participants may be shared with me. The questions I ask are intended to be broad generalizations about the participants of the center as a whole and no specific information about participants may be said on record or off of the record. Additionally, I will ensure that the interviewee is aware that (s)he may skip any questions that (s)he does not want to answer.

Participant interactions

- Do you have a sense when you do an intake about whether someone will be successful?
- How do you feel when somebody relapses? How do they usually feel? What sorts of things do you try to say to somebody who relapses?
- Are there any rules for participants? Why are these in place?

View of participants

- Generally, what do you think of people who come to seek treatment at the center? How do you make them feel this way? What do you do to show them this?
- Do you look at somebody differently if they have been to treatment 20 times compared to once?
- How do families or society often view participant's behaviors and actions? Do you agree? Why or why not? How do you confirm or challenge these views?

Measures of success

- What do you think is the most important thing for participants to take away from treatment? How do you make sure that this happens?

Closing

- Is there anything that I am misunderstanding? Is there anything else you would like to share with me that I have missed?

Appendix B: Informed Consent Forms

Boston College [*School of Arts and Sciences*]
 Informed Consent to be in study [*Understanding Compassion-Based Addiction Therapy from a Participant's Perspective*]
 Researcher [*Kristin Gordon*]
 Type of consent [*Adult Consent Form - Participant*]

Introduction

- You are asked to be in a research study. The study will look at how people react to and interpret therapy.
- You were selected to be in the study because you have had compassion-based treatment.
- Please read this form. Ask any questions that you may have before you agree to be in the study.

Purpose of Study:

- The purpose of this research is to study how people respond to compassion-based addiction therapy.
- The total number of people in this study is expected to be twelve.

What will happen in the study:

- If you agree to be in the study, you will answer questions and your answers will be recorded. The interview will last for about one hour.

Risks and Discomforts of Being in the Study:

- During this study, you will be asked to remember your life before, during, and after treatment. These may be sensitive topics.
- You will be asked to give your age, education level, income level, the occupation of your parents, and your marital status but no other identifying information will be collected about you.

Benefits of Being in the Study:

- There are no direct benefits offered to people who participate in the study. However, there may be indirect or unintended benefits during and following the study.

Costs:

- There is no cost to you to be in this research study.

Confidentiality:

- The records from this study will be kept private. In any report that I publish, I will not include any information that will identify you. Research records will be kept in a locked file.

- All electronic material will be stored in a password-protected file. Audio recordings will only be available to the researcher and will be erased when the interview has been copied to an electronic written format.

Subject's Initials _____

- The researcher will have access to information. A few other people may also have access. These may include government agencies, the Institutional Review Board at Boston College and internal Boston College auditors.

Choosing to be in the study and choosing to quit the study:

- It is your choice to be in this study. If you choose not to be in this study, it will not affect your current or future relationship with the University.
- You are able to stop at any time, for any reason.
- There is no penalty for not taking part or for quitting.

Contacts and Questions:

- Kristin Gordon is the researcher for this study. For questions about this research, you may call her at (206) 304-2906.
- If you think you may have suffered research related harm, call Kristin Gordon at (206) 304-2906 who will give you further directions.
- If you have any questions about your rights in this research study, you may contact: Director, Office for Research Protections, Boston College at (617) 552-4778, or irb@bc.edu.

Copy of Consent Form:

- You will be given a copy of this form to keep for your records.

Statement of Consent:

- I have read (or have had read to me) this consent form. I have been encouraged to ask questions. I have received answers to my questions. I give my consent to be in this study. I have received (or will receive) a copy of this form.

Signatures/Dates

- Study Participant (Print Name): _____ Date _____
- Participant Signature: _____ Date _____

Subject's Initials _____

Boston College [*School of Arts and Sciences*]
Informed Consent to be in study [*Understanding Compassion-Based Addiction Therapy from a
Participant's Perspective*]
Researcher [*Kristin Gordon*]
Type of consent [*Adult Consent Form - Counselor*]

Introduction

- You are asked to be in a research study. The study will look at how people react to and interpret therapy.
- You were selected to be in the study because you have been a counselor involved in compassion-based treatment.
- Please read this form. Ask any questions that you may have before you agree to be in the study.

Purpose of Study:

- The purpose of this research is to study how people respond to compassion-based addiction therapy.
- The total number of people in this study is expected to be twelve.

What will happen in the study:

- If you agree to be in the study, you will answer questions and your answers will be recorded. The interview will last for about one hour.

Risks and Discomforts of Being in the Study:

- During this study, you will be asked to remember your life before, during, and after treatment. These may be sensitive topics.
- No identifying information will be collected about you.

Benefits of Being in the Study:

- There are no direct benefits offered to people who participate in the study. However, there may be indirect or unintended benefits during and following the study.

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- There is no cost to you to be in this research study.

Confidentiality:

- The records from this study will be kept private. In any report that I publish, I will not include any information that will identify you. Research records will be kept in a locked file.
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Statement of Consent:

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Signatures/Dates

- Study Participant (Print Name): _____ Date _____
- Participant Signature: _____ Date _____

Subject's Initials _____

Appendix C: Codebook

- Medicalization: Comments about medical definitions of alcohol dependency as an illness as opposed to a lifestyle choice.
- Honesty: Perspectives on the necessity and challenges of being honest in the program.
- Talking: Comments on the necessity and challenges of vocalizing one's experiences while in meetings.
- Support of other women in group: Remarks about the other girls going through the program with them and how their presence impacted the participant's experience.
- Counselor/Participant Interaction: Statements regarding the relationships between counselors and participants.
- Spirituality/God/Higher power: Comments made about spirituality, God, a higher power or related concepts.
- Acceptance of self and alcohol dependency: Statements regarding the separation of oneself and one's behaviors as well as acceptance of one's dependency.
- Relapse: Remarks made about relapse.
- Family relationship: Observations about a participant's relationships with her family.
- Self-love/compassion: Statements pertaining to components of self-love or self-compassion. This will specifically focus on loving oneself (even with imperfections), seeing one's goodness, and avoiding self-criticism.
- Self-concept: Interpretations of one's self-concept at any point before, during, or after the program.
- Self-confidence: Remarks about a participant's self-confidence at any point before, during, or after the program.
- Attentiveness/"Living in the Now"/Mindfulness: Comments about remaining attentive to the present moment at any point before, during, or after the program. This will include focusing on the present by giving it proper attention and remaining positive about the future.
- Success: Statements made about goals for the program as well as perceived indications of maintaining sobriety.
- Labeling/Delabeling: Comments related to labeling oneself or others as "alcoholics" as well as any statements about the removal or acceptance of these labels.
- Self-efficacy: Statements pertaining to a belief, or lack of belief, that a participant has of remaining sober following treatment.