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Shame, Guilt, and Depression in Men and Women in Recovery From Addiction

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Abstract—Men and women in recovery from addiction were compared on levels of depression and self-conscious affect including proneness to shame, guilt, externalization, detachment, and pride. The sample consisted of 130 subjects (88 men and 42 women; mean age 33.04), 90 of whom were active participants in a 12-step recovery program, and 40 of whom were in a residential treatment community. Subjects completed *The Beck Depression Inventory* and *The Test of Self-Conscious Affect*. Significant differences between the sexes were found for proneness to shame, detachment, and depression. Women were significantly higher on shame and depression; men were significantly higher on detachment. The subjects were compared to subjects who were not chemically dependent. It was found that these recovering drug-addicted subjects scored significantly higher in proneness to shame and externalization and significantly lower on proneness to guilt. Treatment implications of proneness to shame in the drug-addicted population, and particularly in women, are discussed. The use of confrontational drug treatment strategies may be contraindicated.

Keywords—addiction; depression; guilt; recovery; shame.

MORE MEN THAN WOMEN enter and complete treatment for addiction, despite an increasing awareness of the problems of drug-addicted women and an increase in the number of women seeking treatment. In 1988-1989 outpatient and residential drug treatment programs in San Francisco reported that between 30% and 40% of their admissions were women (John Newmeyer, Haight Ashbury Detoxification Program, and Tim Troyer, Walden House, personal communication). National

surveys have reported that 24% of alcohol treatment admissions are women, and 33% of drug-dependent clients in treatment are women (Engs, 1990). While there may be fewer drug-addicted women than men, other factors may account for the lower numbers of women in treatment. There may be a greater stigma placed on women who abuse drugs, and thus the shame of chemical dependency may be heavier for women. Women may turn to mental health agencies rather than to drug or alcohol treatment for their addiction-related problems. The risks to women who enter treatment may be greater; they may lose their husbands and/or children (Blume, 1990a, 1990b; Engs, 1990; Mason, 1991; Reed, 1987).

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Also, in some cases treatment programs may not be sensitive to the particular needs of drug-addicted women and thus may fail to attract women or to keep

them in treatment (Kasl, 1989; Kirkpatrick, 1977, 1986; Murphy & Rosenbaum, 1987; Reed, 1985; Weisner & Schmidt, 1992).

Historically women's drug use has predominantly involved legal drugs, such as alcohol and prescription medication (Davis, 1990), and the problems of drug-addicted women were hidden from public view (Nellis, 1980; Sandmaier, 1980). Drug-addicted men were more often visible (Reed, 1987); chemically dependent women were at home where their addiction was considered a private family affair. Treatment programs were largely male centered in both administration and focus (Reed, 1987), and research efforts were primarily directed toward men (Annis, 1980; Babcock & Condon, 1981; Forth-Finegan, 1991; Henderson & Anderson, 1982; Karn, 1990; Vanicelli, 1984a, 1990b).

Many drug programs have followed a model of treatment developed for recovering men, emphasizing behavior modification techniques for gaining control of anger and antisocial impulses and for confronting denial. This model addresses a tendency of drug-addicted men to blame others for their addiction and to minimize their own emotional problems. This strategy may be problematic for women who tend to suffer from an exaggerated sense of responsibility, low self-esteem, and depression (Reed, 1987) and who may enter treatment with emotional needs that are different from those of men. Women often enter treatment with greater feelings of shame and guilt, as the result of their addiction and perhaps predating their addiction (Mason, 1991).

Confrontational strategies may be counterproductive for women, reinforcing feelings of shame, helplessness, and depression (Davis, 1990; Kasl, 1989; Kirkpatrick, 1986; Morrison, O'Connor, Bremond, & Weiner, in press). According to some authorities, many women may have developed "learned helplessness" in response to abuse they have experienced and over which they feel no control (Walker, 1979). "Tactics that are used early in treatment, which were developed to help men face what they have long denied, may cause women with learned helplessness pattern to feel even more helpless and out of control" (Reed, 1987, p. 155). Treatment for women may need to specifically counter shame, guilt, helplessness, and depression (Gomberg, 1987) and to work to empower women (Bepko, 1989). Many investigators report an incidence of depression that is higher in drug-addicted women than in men (Hesselbrock, Meyer, & Keener, 1985; McLachlan, 1976). In a national panel it was noted that women's rates of depression were more than twice that of men (McGrath, Kieta, Strickland, & Russon, 1990).

Depression and pessimism have been linked to the tendency to attribute blame for negative events to one's self (Peterson & Seligman, 1984). It has been noted that the tendency to explain negative events by attrib-

uting them to something internal, global, permanent, and uncontrollable—that is, something bad about the self—has been associated with the specific affect of shame and noted as a problem common to women (H.B. Lewis, 1971; M. Lewis, 1992; Nathanson, 1987; Tangney, 1990). H.B. Lewis (1971, 1987) and others (Barrett, Zahn-Waxler, & Cole, 1993; Harder & S.J. Lewis, 1987; Harder, Cutler, & Rockart, 1992; Tangney, 1990) suggest that shame relates to a negative feeling about the self as inadequate and vulnerable and wanting to hide, whereas guilt refers to a negative feeling about one's actions that causes regret and inspires the desire to make retribution. This distinction between shame and guilt has been investigated empirically in recent years, with inconclusive results (Harder & S.J. Lewis, 1987; Hoblitzelle, 1987; Jones, Kugler, & Adams, in press; Kugler & Jones, 1992; Tangney, 1990). Kugler and Jones (1992) and Hoblitzelle (1987) found that they were not able to clearly demonstrate the distinction between shame and guilt. Tangney (1990), however, was able to demonstrate this distinction with the use of a recently developed empirical measure. According to Tangney's measure, guilt results from the attribution of a negative event to one's self in a specific situation-, time-, and behavioral-limited way. Shame, on the other hand, results from the attribution of a negative event to one's self in a global, pervasive, and persistent way.

Some authorities have suggested that early trauma is associated with global self-attributions for negative events (H.B. Lewis, 1971, 1987; M. Lewis, 1992). This attributional style closely relates to the definition of shame given above, although it also relates to guilt (M. Lewis, 1992). Depressed mothers often blame themselves for their problems, and their children also blame themselves for both their own and their mothers' problems (Zahn-Waxler & Kochanska, 1990). Lewis suggests that troubled families, including drug-addicted families, may produce more empathic behaviors in their children, as the children attempt to help disturbed parents. He hypothesizes that as these children fail in their efforts to help their parents, they then blame themselves globally for this failure, and tend to develop a more global attributional style, or proneness to shame.

M. Lewis also reports that "women are likely to make internal attribution for their failures and external attribution for their successes, whereas men are likely to do the reverse . . . women are socialized to blame themselves for their failures, but not to reward themselves for their successes" (M. Lewis, 1992, p. 103). Other researchers have also reported differences between men and women in attribution of failure and success (Beck, 1979; Dweck & Leggett, 1988; H.B. Lewis, 1971).

In recent empirical research related to self-conscious affects and attribution, Tangney (1990) has developed

measures with subscales of proneness to shame, proneness to guilt, detachment, externalization, and pride. Using The Self-Conscious Affect and Attribution Inventory (SCAAI) and The Test of Self-Conscious Affect (TOSCA), Tangney, Wagner, and Gramzow (1992) reported that proneness to shame is associated with psychopathology, whereas proneness to guilt (as defined above and operationalized by Tangney's measure(s)), is associated with a nonpathological, adaptive tendency to be empathic. Tangney (1990), incidentally, has reported finding women significantly higher in proneness to shame and guilt than men.

The present study was designed to examine the differences in proneness to shame and depression between men and women in recovery from drug addiction. It has been assumed from clinical experience, but not empirically tested, that drug-addicted women suffer more from shame than do men. Prior empirical studies have confirmed that women are more likely to suffer from depression. In the present study it is hypothesized that both shame and depression will be greater in recovering women than in recovering men. It is assumed that these problems may require special efforts in the treatment of drug-addicted women.

METHODS

The subjects were 130 recovering chemically dependent individuals; 90 were participants in the Narcotics Anonymous (NA) program, and 40 were in recovery at a residential program in San Francisco, California. There were 88 men and 42 women, ranging in age from 16 to 55, with a mean of 33.04 ($SD = 8.23$). Time abstinent from all drugs ranged from less than a month to 14 years. The mean abstinence time was 2.6 years, the median 1.3 years. The ethnic breakdown of the sample was as follows: European Americans ($n = 78$), African American ($n = 24$), Latin American ($n = 4$), Asian American ($n = 1$), Other ($n = 3$). Of those who reported a drug of choice, there were 10 amphetamine abusers, 46 cocaine abusers, 22 opiate abusers, 21 alcohol abusers, and 13 marijuana abusers. Of those who responded to questions regarding education, 21 had not completed high school, 76 were high school graduates, and 31 had completed college. Men and women were comparable on all demographic variables.

Materials

Materials included a biographical questionnaire, the Test of Self-Conscious Affect (TOSCA), and the Beck Depression Inventory (BDI).

The Biographical Information Questionnaire (O'Connor, Berry, Morrison, & Brown, 1992) is a self-report instrument to collect demographic information, family psychiatric and drug history, personal psychiatric and

drug history, treatment history, and personal abuse history, revised from Brown (1985a).

The Test of Self-Conscious Affect (TOSCA; Tangney et al., 1992) is a measure of cognitive, affective, and behavioral aspects of shame, guilt, externalization of blame, detachment/unconcern, and alpha pride and beta pride. Alpha pride refers to a general pride in oneself, which is a more global pride, and beta pride refers to a pride in a specific behavior or accomplishment. The TOSCA was modeled after the Self-Conscious Affect and Attribution Inventory (SCAAI) (Tangney, Burgraf, Hamme, & Domingo, 1988), revised for use with a broader population. Items on the SCAAI were developed by researchers for application to a college population; those on the TOSCA were generated from both college and noncollege populations. The TOSCA consists of 10 negative and 5 positive scenarios, with response choices that reflect the dimensions listed above. Respondents are asked to rate each of several possible responses to each scenario, on a scale of 1 to 5. Tangney reported that preliminary analyses of reliability and validity showed the TOSCA to be equivalent to and possibly superior to the SCAAI (Tangney et al., 1992). Tangney reported estimates of internal consistency (Cronbach's alpha) for the Shame and Guilt scales to be .76 and .66, respectively.

The Beck Depression Inventory (BDI; Beck, 1972) is a reliable and well-validated 21-item self-report inventory representing cognitive, affective, and vegetative symptoms of depression.

Procedure

Subjects were given a packet that included a written statement of informed consent and the materials described before. All materials were anonymous. In the NA sample, the subjects were solicited at an NA Convention in Sacramento, California. Research assistants, who were participants in the program, solicited subjects outside of, but near to, official functions. Everyone was asked to participate if they were interested, and those who volunteered completed the materials at that time. Subjects in the residential treatment program sample were solicited by a counselor, and those who wished to participate were given materials.

RESULTS

Men and women were compared on the TOSCA and the BDI, using unpaired t tests (Table 1). Significant differences between the sexes were found for shame, detachment, and depression. Results indicate that women scored significantly higher on shame and depression, and men scored significantly higher on detachment. All tests reported are two-tailed.

Other analyses not directly related to the a priori hypotheses of the study were conducted. Men and women were compared on history of abuse as children.

TABLE 1
Sex Differences on Major Dependent Variables

	Males			Females			<i>t</i>
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	
BDI	74	9.57	8.52	35	14.11	8.77	-2.58*
Shame	71	38.28	9.01	33	44.42	10.23	-3.10**
Guilt	68	53.40	8.39	33	66.21	9.96	-1.49
Detachment	73	32.48	5.35	33	28.70	6.82	3.09**
Externalization	68	37.96	8.89	33	37.90	8.31	.03
Alpha pride	73	19.47	3.18	36	18.86	2.80	.97
Beta pride	73	20.10	3.18	37	19.65	2.72	.73

* $p < .05$. ** $p < .01$.

Of 88 men, 19 (21.6%) reported experiencing sexual abuse as children. Of 41 women, 25 (60.98%) reported experiencing sex abuse. A chi-square test comparing these proportions was significant, $\chi^2(1) = 19.30, p < .001$. Subjects who were sexually abused were compared to those who were not, on shame, guilt, and depression, using *t* tests. Sex abuse related significantly to shame, with those reporting abuse ($n = 35, M = 44.77, SD = 9.98$) scoring significantly higher than those reporting no abuse ($n = 68, M = 38.12, SD = 8.84, t(101) = -3.46, p < .001$). Sex abuse also related significantly to depression, with those reporting abuse ($n = 39, M = 14.33, SD = 9.65$) scoring significantly higher than those reporting no abuse ($n = 69, M = 9.29, SD = 7.82, t(106) = -2.96, p < .01$). Those reporting abuse ($n = 35, M = 56.4, SD = 9.87$) scored higher on guilt than those reporting no abuse ($n = 65, M = 53.49, SD = 8.08$), however, this difference was not statistically significant $t(98) = -1.59, p = .12$. In order to determine if sex was a significant factor in shame and depression without the experience of sex abuse in childhood, two-way ANOVAs were calculated (Table 2). The main effect for sex was statistically significant for shame; this effect approached significance for depression.

In a final set of analyses, subjects were compared to a sample of non-drug-addicted subjects on the subscales of the TOSCA; comparisons for men and women were done separately. The means for the non-drug-addicted men ($n = 186$) and women ($n = 241$) were obtained from a previous study conducted by Tangney (Tangney, personal communication, 1992); these means were used as the population parameters in one-group *t* tests (Table 3). Results indicate that scores of both male and female drug-addicted subjects, compared to those of non-drug-addicted subjects, were significantly elevated on proneness to shame and externalization, and were significantly lower on proneness to guilt. In addition, the drug-addicted men scored significantly higher on detachment than the non-drug-addicted men. There were no significant differences between the scores of drug-addicted and those of non-drug-addicted subjects on either measure of pride.

DISCUSSION

The results of this study support persistent anecdotal reports among chemical dependency professionals that women coming into treatment tend to suffer from a greater sense of shame, self-blame, and depression

TABLE 2
Two-Factor ANOVAs: Sex x Sexual Abuse

	Depression				Shame				Detachment						
	Males		Females		Males		Females		Males		Females				
	<i>N</i>	<i>M</i>	<i>N</i>	<i>M</i>	<i>N</i>	<i>M</i>	<i>N</i>	<i>M</i>	<i>N</i>	<i>M</i>	<i>N</i>	<i>M</i>			
Sexual abuse	18	12.89	21	15.57	14	41.36	21	47.05	15	32.40	21	27.95			
No sexual abuse	56	8.50	13	12.69	57	37.53	11	41.18	58	32.50	11	29.36			
Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Sex	1	238.76	238.76	3.34	.07	1	383.94	383.94	4.62	.03	1	258.58	258.58	7.53	.007
Sex abuse	1	266.85	266.85	3.73	.06	1	413.29	413.29	4.97	.03	1	10.27	10.27	0.30	.59
Sex x sex abuse	1	11.52	11.52	0.16	.69	1	18.20	18.20	0.22	.64	1	7.73	7.73	0.23	.64
Error	104	7435.7	71.50			99	8228.00	83.11			101	3467.6	34.33		

TABLE 3
TOSCA: Abusing versus Nonabusing Groups

	df	Abusers (M)	Nonabusers (M)	t
Women				
Shame	32	44.42	39.45	2.79**
Guilt	32	56.21	61.05	-2.79**
Detachment	32	28.70	28.1	.50
Externalization	32	37.91	34.95	2.05*
Alpha pride	35	18.86	19.6	-1.58
Beta pride	36	19.65	19.8	-.34
Men				
Shame	70	38.28	35.10	2.98**
Guilt	67	53.40	57.00	-3.54***
Detachment	72	32.48	30.40	3.32**
Externalization	67	37.96	35.70	2.09*
Alpha pride	72	19.47	19.70	-.63
Beta pride	72	20.10	20.10	-.01

* $p < .05$. ** $p < .01$. *** $p < .001$.

than do men. Further empirical research is indicated by these results. These differences between men and women may contribute to the lower number of women entering and completing drug treatment programs.

The investigation yielded several intriguing results. The population studied here—both men and women—showed elevated levels of proneness to shame and externalization and lower levels of guilt when compared with a non-drug-addicted population. These results, if substantiated by further research, suggest a reevaluation of treatment strategies. The elevation of shame in this population suggests that shame-inducing confrontation may be detrimental to many chemically dependent clients—to women, in particular, and perhaps also to men. Confrontational strategies may include methods such as isolating clients, making them sit in uncomfortable situations for long periods of time with their heads down, and making eye contact with no one. Avoiding eye contact is in fact a behavioral symptom of shame (H.B. Lewis, 1971; M. Lewis, 1992). Other confrontational and potentially shame-inducing methods of treatment include putting clients on the “hot seat” and subjecting them to verbal attacks from other clients and staff members. One method commonly referred to as “being on a contract” may include the repeated and unnecessary performance of menial labor and other possibly shame-inducing punishments. Another common though perhaps less frequently used method involves ignoring the client. In this strategy a person is not to be spoken to or looked at by anyone in the community; they are to be treated as if they are not there and are invisible. All of these methods might contribute to intensifying feelings of shame. A confrontational approach, though motivated by the interest in helping drug-dependent clients to begin assuming personal responsibility, may have the effect of exaggerating a tendency to self-blame and shame. If, in the

treatment process, negative global accusations or labels are used, individuals may be reinforced in their negative view of the self. Women, already higher in proneness to shame, may comply with this treatment strategy, accept the blame, and so become more ashamed. They may react by leaving treatment. Moreover, since both the men and women demonstrated elevated levels of shame, confrontation may in some cases be detrimental regardless of sex.

A potentially shame-inducing confrontational model and attitude has been accepted by many treatment professionals as well as by recovering individuals working as peer counselors. Recovery programs using confrontational therapy methods and relying on moral authority have been considered to be more successful for the addicted population than traditional psychotherapy approaches. Poor treatment outcome with traditional psychotherapy has sometimes been explained as the result of therapists not being confrontational enough with clients who require a “tough love” approach. However, some have suggested that traditional psychotherapy methods may have failed to work well with chemically dependent clients because therapists who emphasized underlying psychological problems were denying or minimizing the significance of drug use per se (Bean, 1981; Brown, 1985b). Furthermore, it has been suggested that some traditional psychotherapies misunderstood the problems common to drug-addicted clients, particularly the proneness to shame and maladaptive guilt (O'Connor, 1993; O'Connor & Weiss, 1993). Confrontational strategies have been considered more appropriate because they have appeared to focus, at least initially, on addiction and on changing destructive behaviors. Additionally, it may be noted that in some more traditional psychotherapy theories and methods, a subtle form of confrontation may be included in the use of interpretation, which for some addicted clients may be shame-inducing. And the subtle power distinctions common in the traditional therapy relationship may also be felt by some clients as inherently humiliating (Goffman, 1967; Haley, 1962; H.B. Lewis, 1971).

Along with the wide acceptance of a potentially shame-inducing confrontational model of treatment, the high rate of attrition in drug treatment has also been accepted by many as inevitable in this population. However, if chemically dependent clients as a group tend to suffer from exaggerated proneness to shame, it is possible that confrontational methods may contribute to this frequent treatment failure, for both men and women.

The results of this study also demonstrate an elevation in proneness to externalization and indicate a lower level of guilt for this population, as compared with a non-drug-addicted group. The tendency of drug-addicted persons to externalize and overtly deny responsibility for their problems, including their own

drug use, may have led to these confrontation strategies which could, paradoxically, elevate levels of shame. Thus, there may be a dilemma for the treatment professional: How may the treatment professional refrain from any potentially shame-inducing tactics while continuing to provide treatment that confronts the denial of the drug-addicted person? One line of compromise sometimes heard in 12-step and other treatment programs is: "You aren't responsible for your addiction, you are responsible for your recovery." An approach directed to reducing shame, may also reduce externalization which defends against shame.

The lower level of guilt found in this population may also constitute a defense against shame. However, it also may be a reflection of the particular conceptualization used in the TOSCA and may exclude the types of guilt commonly associated with psychopathology. In fact, proneness to guilt as measured on the TOSCA has been associated with altruism and lower levels of pathology (Tangney, 1991, 1992), and thus it may fall into the category described by Zahn-Waxler and Kochanska (1990) as "adaptive guilt." The TOSCA may not detect maladaptive guilt, which is common in the drug-addicted population and an important factor in the etiology of addiction disease (Lieb & Young, 1994; O'Connor, 1993; O'Connor & Weiss, 1993). Specifically, the TOSCA does not include separation guilt to family members and loved ones, nor survivor guilt, nor the more global sense of omnipotent responsibility guilt, or fear of harming others in an ongoing way. We hypothesize that these types of guilt are often part of unconscious and inhibiting pathogenic beliefs in people's lives (Brown, 1988; Weiss, 1990, 1993; Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986). Many chemically dependent clients come from alcohol- and drug-dependent families. To refuse to take drugs or to drink may be considered an act of disloyalty (Brown, 1988). Many clients believe that if they abstain from drugs they will be harming family members by making them feel inferior and inadequate. For example, if a client believes that his recovery is going to make his alcohol-addicted father feel inadequate, he risks, if he is abstinent, feeling the guilt of being better off than his father. This may include an on-going feeling of being a harmful person, which in some instances may constitute a sense of guilt that is both global and pervasive. It is suggested that further research investigate maladaptive guilt—for example survivor guilt, separation guilt, and omnipotent responsibility guilt—in the drug-addicted population.

This study also indicates a need for research into specific shame-reducing treatment strategies for chemically dependent clients. Several current approaches to individual and group psychotherapy may be particularly helpful in reducing shame. One approach, developed by Joseph Weiss (see Weiss et al., 1986; Weiss, 1993) and sometimes referred to as Control Mastery

Theory, emphasizes the modification of clients' pathogenic beliefs derived from childhood traumas, particularly those beliefs that give rise to shame and guilt (O'Connor & Weiss, 1993; Lieb & Young, 1994). While this approach to treatment is case specific, it takes the view that all drug-addicted clients have an unconscious plan to stop using drugs and to recover, and that they are inhibited in their normal and healthy development by these pathogenic beliefs as well as by their drug use. In individual or group treatment, a consistent disconfirmation of these beliefs by the treatment professional and/or program may have success in reducing shame and maladaptive guilt. Furthermore, this theory assumes that the need for relationships and effectance (to be effective) are primary motives, and this positive perspective on clients' motivation may itself be shame-reducing. Other current treatment philosophies that may also be helpful in reducing shame include cognitive treatments of addiction that focus on discovering and disconfirming irrational beliefs and understanding the objective circumstances, both internal and external, that lead a person to psychological problems and, in some cases, addiction (Beck, Wright, Newman, & Liese, 1993; Marlatt & Gordon, 1985; Marlatt, Somers, & Tapert, 1993; Wright, Beck, Newman, & Liese, 1993).

In summary, the results of this study indicate the need for further research into the particular emotional problems of chemically dependent clients entering recovery, in order to improve treatment strategies and programs and thus facilitate the recovery process. It may be helpful to modify or discard potentially shame-inducing methods, while furthering the development of programs that counter proneness to shame and encourage healthy responsibility in recovery for the chemically dependent population as a whole, and especially for recovering women.

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