Shame and guilt: Divergent Implications for Substance Use Disorders and Clinical Practice in ATOD treatment settings

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Overview

• **Shame** and **guilt**: Theory and correlates

• Divergent implications of **shame** and **guilt** for the regulation of substance use

• Strategies for managing **shame** and **guilt** in clinical ATOD settings
Defining the constructs

**Shame and Guilt**

Both are negative emotions that occur in response to personal failures and transgressions (Tangney et al., 2007).

Both involve internal attributions for these failures (Tracy & Robbins, 2004).

Any type of failure or transgression can potentially give rise to shame and or guilt (Tangney, 1994).
Differentiating **shame** and **guilt** (important)

<table>
<thead>
<tr>
<th>Shame</th>
<th>Guilt</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Feel badly about self</td>
<td>• Feel badly about a specific behavior</td>
</tr>
<tr>
<td>• Extremely aversive</td>
<td>• Moderately aversive</td>
</tr>
<tr>
<td>• Sense of shrinking, exposure, feeling small</td>
<td>• Sense of tension, remorse</td>
</tr>
<tr>
<td>• Motivation to hide, avoid conceal, deny, lie, externalize blame</td>
<td>• Motivation to “fix” the situation</td>
</tr>
<tr>
<td>• Self is paralyzed</td>
<td>• Motivation to learn from the failure</td>
</tr>
<tr>
<td>• “I <em>did</em> that horrible thing”</td>
<td>• “I <strong>did</strong> that horrible <strong>thing</strong>”</td>
</tr>
</tbody>
</table>

Tangney and Dearing (2002)
Shame, guilt and substance use disorders

- Failure of self-regulation underlies an important component of DSM-IV-TR (2000) diagnostic criteria for abuse/dependence SUDs
  - Failure at exerting sufficient control over intake to avoid harms
  - Failure to meet obligations in important life domains due to substance use
  - Controlled experimentation → uncontrolled /compulsive use (Lubman et al., 2004)
    - Continued use despite significant negative consequences
- SUDs are often (but not always) chronic, relapsing-remitting conditions (see McLellan, 2002)
  - Provide the opportunity for repeated failure and experiences of shame and or guilt (due to abstinence/limit violation effects + other consequences)
Shame and guilt: Dispositions and experiences in discrete domains

• Shame and guilt-proneness
  – Proneness to shame and or guilt across a wide range of life domains
    • Implications for self-regulation generally (Tangney & Dearing, 2002)

• Domain-specific shame and guilt (see Tangney et al., 2007)
  – Substance misuse-related shame and guilt
    • Implications for motivation/behavioural change/other variables

• Levels of transgression (discrete vs. more global)
  – Shame and or guilt experienced about discrete consequences (e.g., an abstinence violation, a DUI, hospitalization, legal trouble etc)
  – Chronic shame experienced as a result of longstanding disordered substance use (ties in with self-labelling “addict”, “junky”, “alcoholic”)
    • Is regrettably reinforced by societal stigma associated with SUDs
    • Far greater stigma attached to SUDs vs. other chronic relapse-remit conditions (e.g., asthma, diabetes mellitus, hypertension)
Shame is a largely maladaptive negative emotion

- Consistently linked to a range of maladaptive functioning variables (Tangney et al., 2007)
  - Psychopathology (Tangney et al., 1992)
  - Reduced self-control (Tangney et al., 2004)
  - Poor anger-regulation (Tangney et al., 1992, 1996)
  - Antisocial behavior / criminal recidivism (Hosser et al., 2008)
  - Treatment complexity (Heffernan et al., 2007)
  - Reluctance or failure to disclose therapy-relevant information in clinical settings (Swan & Andrews, 2003)

- ↑ Proinflammatory cytokine activity  
  - Cortisol release  
  - Activation of sympathetic nervous system (Dickerson et al., 2004)
  - Negative implications of chronic shame/ stigmatization on physiological and health outcomes (e.g., Immune function in HIV populations) (Dickerson, 2004)
Guilt is a largely adaptive negative emotion

- Consistently linked to a variety of adaptive functioning and self-regulatory variables (Tangney et al., 2007)
  - Healthy interpersonal relationships and empathy (Tangney, 1995)
  - Enhanced self-control (Tangney et al., 2004)
  - Inversely related to antisocial behavior and criminal recidivism (Hosser et al., 2008)
  - Tends to be unrelated to psychopathology (Tangney et al., 1992)

Shame-proneness is positively related to problematic alcohol and other substance use

- Positively associated with AUDIT scores
- Loss of control of alcohol intake
- Indicators of alcohol dependence
- Positively associated with an array of negative alcohol use-related consequences
- Positively associated with using alcohol to down-regulate negative affect states (i.e., drinking to cope)

(Dearing et al., 2005; Meehan et al., 1996; O'Connor et al., 1994; Treeby, 2011, Treeby & Bruno, 2012)
Guilt-proneness promotes the successful regulation of alcohol and other substance use

- Appears to buffer individuals against the development of disordered substance use
- Inversely associated with AUDIT scores
- Helps individuals avoid negative alcohol use-related consequences
- Appears to lessen the extent of heavy episodic drinking
- Positively associated with the use of protective behavioural strategies during drinking episodes
- Inversely associated with using alcohol to manipulate mood states (both positive and negative)

(Dearing et al., 2005, 2012; Meehan et al., 1996; O’Connor et al., 1994; Treeby & Bruno, 2012)
Relationships between **shame** and **guilt** with alcohol use disorder symptomatology and negative alcohol use-related consequences

<table>
<thead>
<tr>
<th>Measure</th>
<th>Shame (residual)</th>
<th>Guilt (residual)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AUDIT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample 1</td>
<td>.11*</td>
<td>-.19**</td>
</tr>
<tr>
<td>Sample 2</td>
<td>.13*</td>
<td>-.15*</td>
</tr>
<tr>
<td><strong>Alcohol Problem Severity Index</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample 1</td>
<td>.11*</td>
<td>-.17**</td>
</tr>
<tr>
<td>Sample 2</td>
<td>.19**</td>
<td>-.17**</td>
</tr>
<tr>
<td><strong>Total YAACQ</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample 1</td>
<td>.10*</td>
<td>-.16**</td>
</tr>
<tr>
<td>Sample 2</td>
<td>.20**</td>
<td>-.18**</td>
</tr>
</tbody>
</table>

*Note. * $p < .05$. ** $p < .01$. Sample 1 $N = 425 - 428$. Sample 2 $N = 281$. 
Relationships between **shame** and **guilt** with drinking to down-regulate negative affect states

<table>
<thead>
<tr>
<th>Drinking Motive</th>
<th>Shame (residual)</th>
<th>Guilt (residual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping-Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample 1</td>
<td>.23**</td>
<td>-.10*</td>
</tr>
<tr>
<td>Sample 2</td>
<td>.30**</td>
<td>-.09</td>
</tr>
<tr>
<td>Coping-Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample 1</td>
<td>.21**</td>
<td>-.16**</td>
</tr>
<tr>
<td>Sample 2</td>
<td>.30**</td>
<td>-.13*</td>
</tr>
</tbody>
</table>

*Note.* *p* < .05. **p** < .01. Sample 1 *N* = 421 - 427. Sample 2 *N* = 278 - 281.

Uncertain whether these “using-to-cope” results extend to other substances
Shame – substance use – shame spiral hypothesis

Shame-proneness (Negative Affect) → Using to Cope

Shame-proneness (Negative Affect) → Using to Cope

Using to Cope → Negative consequences / Impaired control / Dependence

(Dearing et al., 2005; Potter-Efron, 2002; Stuewig & Tangney, 2007; Tangney & Dearing, 2002; Wiechelt, 2007)
Shame and guilt and the use of protective behavioral/harm reduction strategies while drinking

<table>
<thead>
<tr>
<th>Protective Strategy</th>
<th>Shame (residual)</th>
<th>Guilt (residual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stopping/limiting</td>
<td>-.05</td>
<td>.16**</td>
</tr>
<tr>
<td>Manner of drinking</td>
<td>-.14*</td>
<td>.23**</td>
</tr>
<tr>
<td>Serious harm reduction</td>
<td>.00</td>
<td>.20**</td>
</tr>
<tr>
<td>Total protective behavioral strategies</td>
<td>-.09</td>
<td>.24**</td>
</tr>
</tbody>
</table>

*Note. *p < .05. **p < .01. N = 278 - 281.

Uncertain whether these results extend to other substance use harm reduction behaviours (e.g., safer injecting practices)
Changes in hazardous drinking for high vs. low guilt-prone individuals over time in the absence of treatment.

Motivation/readiness to change correlates of alcohol use-related shame and guilt

Perceptions of Drinking Scale (PODS): Alcohol use related-shame, guilt, unconcern, externalization of blame
For clinicians: Strategies for minimising *shame* in clinical settings

- Unconditional positive regard / psychoeducation
- Praise process (e.g., coping skill/strategy use) rather than performance variables (e.g., abstinence) (See Dweck, 2007)
- Normalization of lapses/relapses as “part of the journey” to avoid problematic AVEs (psycho-education / fire drill)
- Cognitive-Behaviour Therapy techniques
  - Restructuring/reframing/self-compassion/responsibility pie
- Dialectical Behaviour Therapy techniques
  - Chain analysis (or lapse/relapse analysis)
  - Taking opposite action
- Motivational Interviewing
  - Non judgement, empathy, enhance self-efficacy
For clinicians: Strategies for (carefully) harnessing motivational components of guilt

- Motivational Interviewing
  - Building discrepancy between self/values/goals and substance use behaviour
  - Eliciting concerns re: substance use
- For the pre-cont/contemplative: Concern and problem awareness building via assessment/objective feedback (e.g., LFTs, CO readings, norms based feedback, self-report questionnaires, self-report discrete consequence measures, timeline followback techniques)
  - Helping the individual come to realise that their substance use is excessive/hazardous
- Help with proactive problem solving to resolve experiences of guilt
  - Making amends, new learning, and shifting behaviour
On the importance of not setting up our clients for failure

• Consider capacity for self-regulation, change, and new learning when developing interventions
  – ABI/neuropsychological impairment is common in AOD populations (e.g., Yücel et al., 2007)
  – Gain a cognitive assessment screen if possible (e.g., MOCA, RBANS)
• Does the individual have significant memory impairment?
  – Implications for capacity to learn/remember to apply new skills
• Does the individual have significant executive function (frontal) impairment?
  – Implications for initiation, behavioural shifting in response to consequences, inhibitory control, insight, planning, strategic decision making
• If self-regulation capacity/self-care neglect are significant issues due to SUD and ABI, do other avenues of intervention need to be considered?
  – Changes in housing? Contingency management? Guardianship and or administration order?
Summary

Shame
- Feel badly about self
- Extremely aversive
- Positively associated with substance use disorder Sx and using to cope
- Adds to treatment complexity
- Provide assistance to resolve shame with non-judgment, psychoed, CBT/DBT/ACT/MI strategies
- Shift shame to guilt?

Guilt
- Feel badly about a specific behavior
- Moderately aversive
- Buffers against the development of SUDs
- Motivation to “fix” the situation / make changes
- Can be elicited through MI and objective feedback
- Provide assistance to resolve experiences of guilt (new learning / change)
Thank you. Questions?