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)

Shame

- Feel badly about *self*
- Extremely aversive
- Sense of shrinking, exposure, feeling small
- Motivation to hide, avoid conceal, deny, lie, externalize blame
- Self is paralyzed

- **"*I* did that horrible thing"**

Guilt

- Feel badly about a specific *behavior*
- Moderately aversive
- Sense of tension, remorse
- Motivation to "fix" the situation
- Motivation to learn from the failure

- **"I *did* that horrible *thing*"**

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 experimenta□on → 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 ac□vity ↑ cor□sol release ↑ activation of sympathetic nervous system (Dickerson et al., 2004)
    - Negative implications of chronic shame/ stigmatization on physiological and health outcomes (e.g., Ź 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)

  Morrison (1984) notes “guilt feelings bring material into an interview”, shame “…keeps [material] out” (p.11).

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

Measure		Shame (residual)	Guilt (residual)
AUDIT	Sample 1	.11*	-.19**
	Sample 2	.13*	-.15*
Alcohol Problem Severity Index	Sample 1	.11*	-.17**
	Sample 2	.19**	-.17**
Total YAACQ	Sample 1	.10*	-.16**
	Sample 2	.20**	-.18**

Note. * $p < .05$. ** $p < .01$. Sample 1 $N = 425 - 428$. Sample 2 $N = 281$.

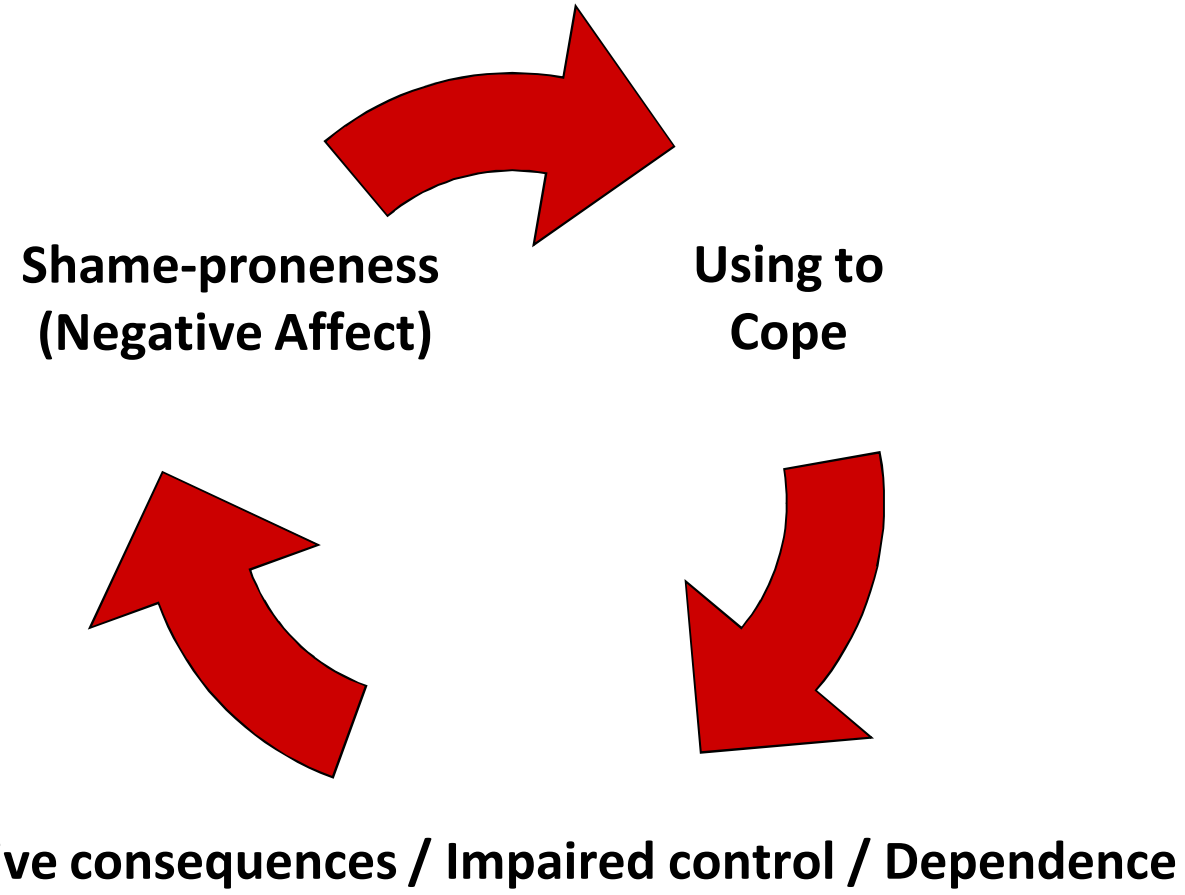
Relationships between shame and guilt with drinking to down-regulate negative affect states

Drinking Motive		Shame (residual)	Guilt (residual)
Coping-Anxiety	**Sample 1**	**.23****	**-.10***
	Sample 2	**.30****	**-.09**
Coping-Depression	**Sample 1**	**.21****	**-.16****
	Sample 2	**.30****	**-.13***

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



(Dearing et al., 2005; Potter-Efron, 2002; Stuewig & Tangney, 2007; Tangney & Dearing, 2002; Wiechelt, 2007)

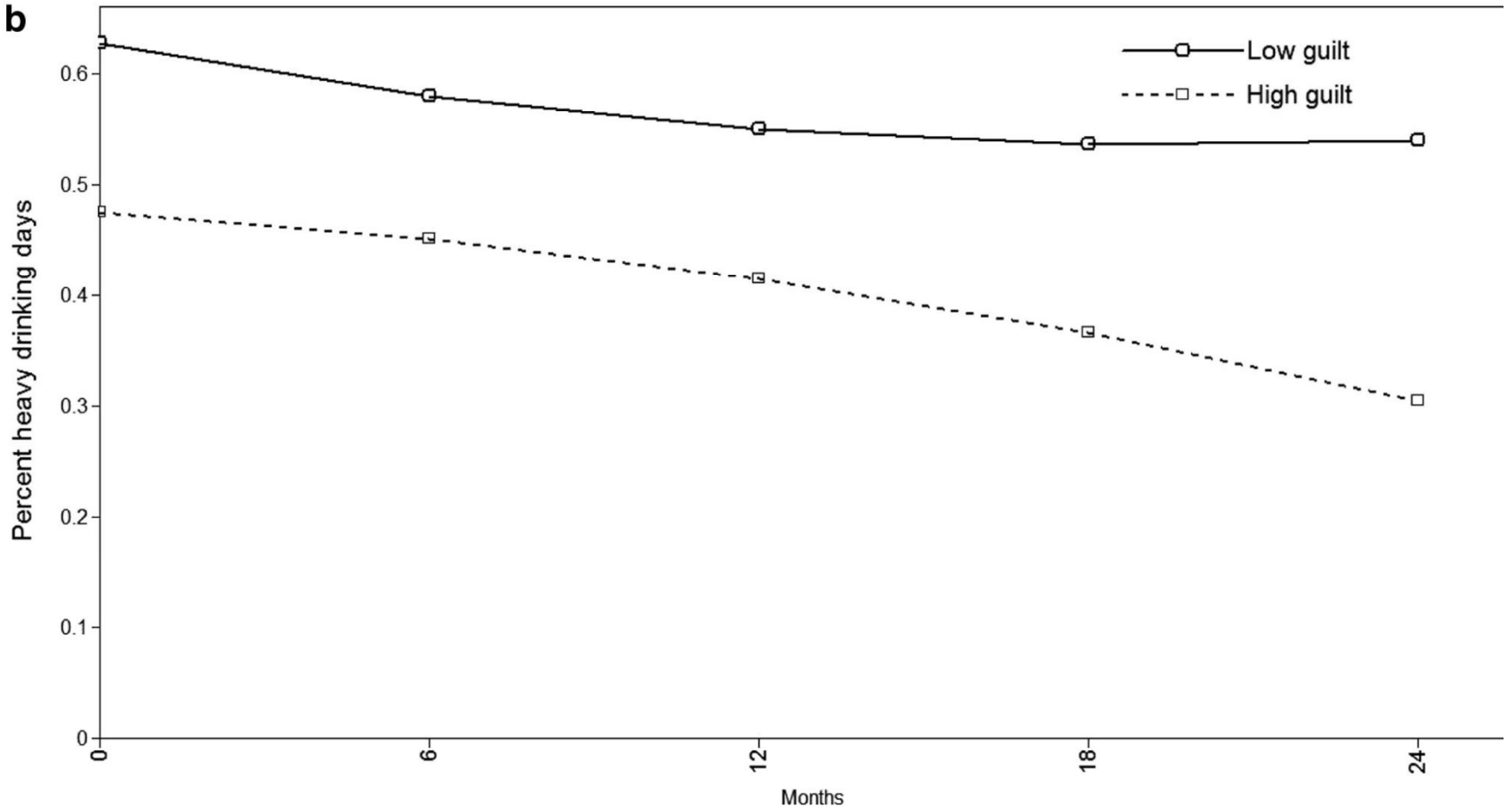
Shame and guilt and the use of protective behavioral/harm reduction strategies while drinking

Protective Strategy	Shame (residual)	Guilt (residual)
Stopping/limiting	**-.05**	**.16****
Manner of drinking	**-.14***	**.23****
Serious harm reduction	**.00**	**.20****
Total protective behavioral strategies	**-.09**	**.24****

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

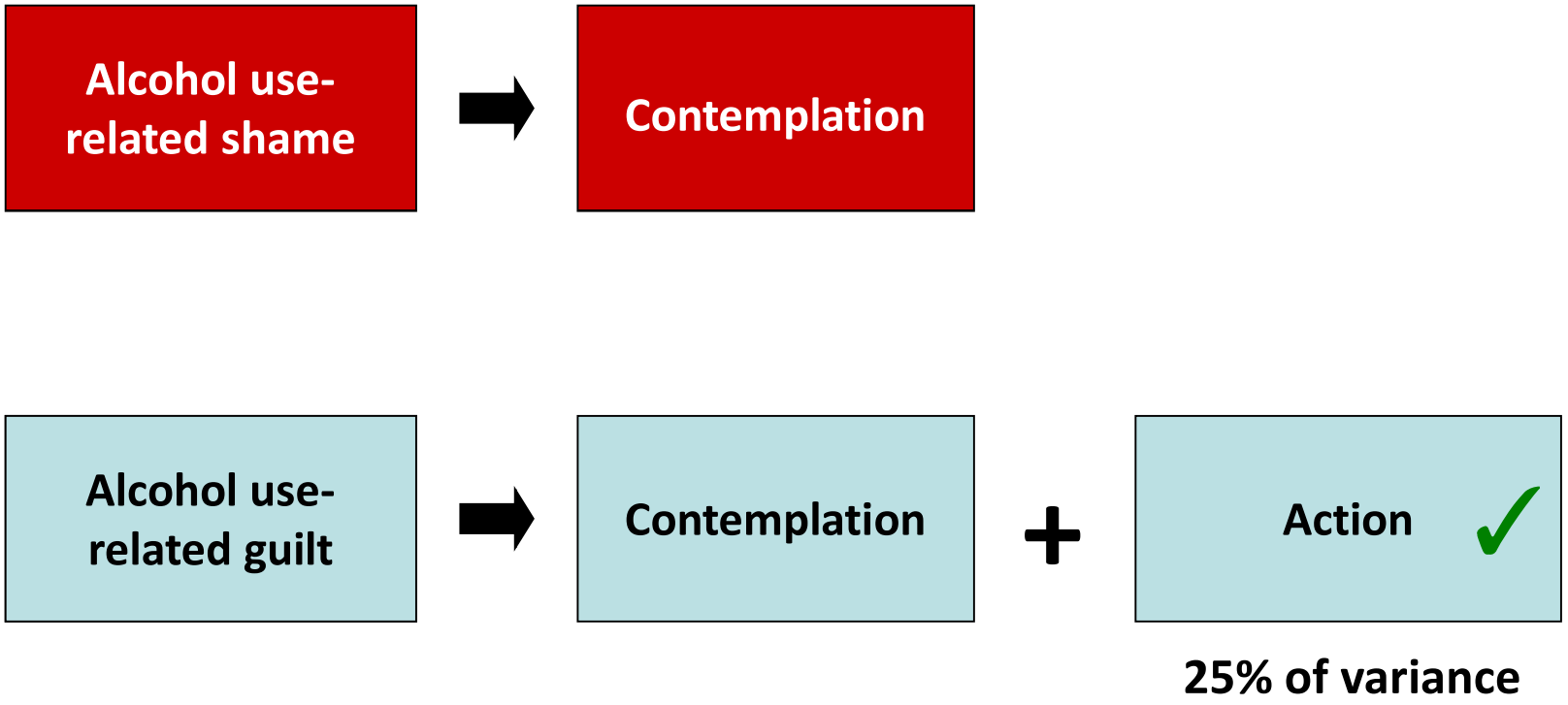
Uncertain whether these results extend to other substance use harm reduction behaviours (e.g., safer injecting practices)

Changes in hazardous drinking for high vs. low guilt-prone individuals over time in the *absence* of treatment



Dearing, R. L., Witkiewitz, K., Connors, G. J., & Walitzer, K. S. (2012, May 21). Prospective Changes in Alcohol Use Among Hazardous Drinkers in the Absence of Treatment. ***Psychology of Addictive Behaviors. Advance online publication. doi: 10.1037/a0028170***

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?

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