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# The Specter of Shame in Substance Misuse

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*This article provides an introduction to the concept of shame as it relates to substance misuse. Empirical research on shame and addiction and the theoretical and operational definitions that underpin them are discussed. Potential areas of further inquiry are highlighted. Implications for clinical practice are discussed.*

**Keywords** affect theory; shame; substance abuse;<sup>1</sup> theory; research

Shame is the affect of indignity, of defeat, of transgression, and of alienation, striking deep into the heart of the human being and felt as an inner torment, a sickness of the soul.

Silvan S. Tomkins

## Introduction

It has been suggested that shame is a contributor to the development and maintenance of substance use related problems and that shame should be addressed in substance abuse treatment programs (Potter-Efron, 2002). On the surface, it appears easy enough to recognize how shame influences the behavior of the addicted person and that treatment should help individuals with their shame. Common sense would suggest that people who misuse substances are likely to engage in behaviors that they feel ashamed of and therefore develop a sense of shame. However, shame and its contribution to the addictive cycle appear to be more complex. Additionally, the nature of shame makes it elusive and difficult for clinicians to assess and treat. Consequently, the specter of shame continues to manifest itself in the intrapsychic and interpersonal lives of people who have substance use problems and may impede their recovery process. The purpose of this article is to provide a brief introduction to the concept of shame and its relation to substance misuse and its treatment as well as to point to potential areas of inquiry on the relationship between shame and substance use problems.

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<sup>1</sup>The journal’s style utilizes the category *substance abuse* as a diagnostic category. Substances are used or misused; living organisms are and can be *abused*. Editor’s note.

## **Shame**

Theorists and researchers have endeavored to conceptually and operationally define the theoretical construct of shame (see Cook, 2001; Kaufman, 1996; Tangney and Dearing, 2002). The definitions postulated to date vary considerably. Generally, the concept of shame means that an individual perceives himself or herself as being flawed and feels bad about who they are. Shame is fundamentally about exposure of a flawed self. The exposure does not have to occur in the presence of others; it can be experienced within the individual alone.

Shame is usually discussed in juxtaposition to guilt. The concept of guilt is generally defined as feeling bad about doing something wrong. In the United States, the terms shame and guilt are often used interchangeably or inconsistently in both colloquial and professional use (Tangney and Dearing, 2002). People tend to use the word guilt to describe their feeling state regardless of whether they are feeling shame or guilt. Individuals appear to be able to distinguish between shame and guilt on an internal feeling level, but often do not verbally express the two emotions differentially (Tangney and Dearing, 2002).

It appears that people and Western culture have developed a tendency to suppress shame. Scheff (1997) notes that shame played a central role in the thought of early Greeks. The Greeks had several words that described distinct shades of shame. Today, every European language, except English, has words that distinguish shame as a *disgrace* and shame as *modesty*. Society seems to mirror the tendency of individuals to keep the experience of shame hidden in that shame is hidden in the social discourse as well (Scheff, 1997). This tendency to be ashamed of feeling shame results in shame having an elusive quality. Individuals have difficulty articulating their experience of shame and clinicians may misunderstand the shame experience or have difficulty assessing and treating it.

The research on the links between shame and addiction has largely been based on two different theoretical conceptual and operational definitions of shame. In one conception, shame is viewed as an innate affect that becomes internalized when it is triggered chronically or inappropriately (Cook, 1996); in the other shame is viewed as a self-conscious and moral emotion that individuals experience differentially depending on their self-evaluation and dispositional proneness to experiencing it (Tangney and Dearing, 2002).

### ***Internalized Shame and Affect Theory***

The concept of internalized shame (Kaufman, 1996) is rooted in affect theory as posited by Tomkins (1962, 1963). In affect theory, shame is seen as being a part of an innate affective system, meaning that people are “hard-wired” to experience it under certain conditions. Tomkins (1962, 1963) delineates nine affects that are part of the affective system (surprise-startle, fear-terror, interest-excitement, enjoyment-joy, distress-anguish, anger-rage, dismissal, disgust, and shame-humiliation). In affect theory, an affect is defined as the biological component of emotion; feeling is the conscious awareness of an affect using knowledge and understanding; and emotion is the combination of affect with experiential memories when the affect(s) were triggered (Cook, 2001). In Tomkins’s view, shame, guilt, shyness, and discouragement have an identical core affect; however, they are experienced differentially as emotions due to differences in coassembled perceptions, cognitions, and intentions. Shyness involves strangeness of the other; guilt is about immorality; discouragement is about defeat; and shame is about inferiority (Tomkins, 1991).

Shame can occur in the context of both intrapersonal and interpersonal experiences and is triggered when the positive affects of interest or enjoyment are impeded. When the shame affect is triggered, it becomes apparent in the face; eyes are cast downward, the head

is lowered, blushing occurs, and the gaze is averted (Cook, 1996). Research findings suggest that the facial expression of shame may be universal across cultures and is evident in infants and young children, thus supporting the notion that shame has biological components (Kaufman, 1996; Scheff, 1997). As individuals become aware of their physiologic experience of shame, i.e., blushing, they tend to feel shame about feeling shame. In the shame experience, one feels that their inner self is suddenly exposed and scrutinized (Kaufman, 1996). Shame is designed to be a highly painful experience to pull the individual away from a source of interest or enjoyment (Nathanson, 1992).

In this view, shame is thought to have a role that contributes to healthy functioning. Healthy shame helps individuals to monitor themselves, recognize limits, and adjust behavior. Thus, shame contributes to the development of conscience. Shame makes people aware of indignities and inappropriate treatment being foisted upon them (Kaufman, 1996). Healthy shame is transitory and temporarily distressing (Potter-Efron, 1993).

Problematic shame develops when individuals are exposed to frequent, long-lasting, or intense shaming experiences. Shame is internalized and becomes part of the identity rather than a self-regulatory affect. The shame affect is magnified in its association with scripts or scenes of shame triggering events (Cook, 2001). Affects, drives, and needs that are shamed become bound with the shame affect and trigger a freefall into a complex web of cognitive and emotional scripts that are infused with shame when they are experienced. These shame scenes become a “principal source of identity” (Kaufman, 1996, p. 84). The shame experience is emotionally and psychologically painful. Individuals who are shame based have a sense of inner wounding and feel vulnerable, disconnected, alone, and isolated. Nathanson (1992) developed a “compass of shame” that he uses to describe the scripted behaviors that people use to defend against the shame experience. Poles on the shame compass include withdrawal (silence, hide, depression), attack self (self-derogation), attack others (reduce the self-esteem of other via put-downs or attacks), and avoidance (abuse substances, be prideful as in narcissism).

Affect theory was instrumental in the development of a measure of shame. Cook (1987, 1996, 2001) developed the Internalized Shame Scale (ISS) to assess individuals on their level of internalized shame. At its inception, the ISS was based on the phenomenology of shame as it was described in the existing literature. As the measure progressed in its development, it became cast in the context of affect theory (Cook, 2001). The measure consists of 30-items on a Likert-type scale. Twenty-four of the items are negatively phrased and compose the shame scale. The remaining six items are derived from Rosenberg’s Self-Esteem Scale (Rosenberg, 1965). Internal consistency reliability is reported for both non-clinical and clinical groups ( $\alpha = .95$  and  $.96$ , respectively). A test–retest reliability of  $.84$  was obtained from retesting a subset of graduate students 7 weeks after the initial measurement. Evidence is provided for both criterion and construct validity. The clinical samples that were used to develop and test the ISS included individuals who had substance use problems and norms are available for individuals who are alcoholic. The ISS can be used for both clinical and research purposes. Detail on the psychometric properties of the ISS, norms, and how to use the measure are available (see Cook, 2001).

### *Shame as a Self-Conscious and Moral Emotion*

The conception of shame as a self-conscious and moral emotion is underpinned by the work of Helen Block Lewis. Lewis (1971) posits that shame and guilt are two separate and distinct emotions. In her view, shame is a more painful and problematic emotion than guilt. Shame is evoked when the focus of negative evaluation is on the self and guilt is

evoked when the focus of negative evaluation is on a specific behavior. Shame involves the evaluation of the self in the eyes of a perceived other; thus, the shame experience necessarily contains a sense of exposure. While in the shame experience, one feels helpless and small, that they could sink through the floor, or die from shame (Lewis, 1971). Guilt has more to do with an awareness that one has done or not done some behavior and feels responsible and remorseful about it. An individual experiencing guilt characteristically feels tension to make reparations. Reparation in guilt is possible by changing bad behavior where reparation for the individual in shame seems impossible because it is the self that is viewed as being bad. Extensive empirical data supports Lewis's conception of shame and guilt as distinct emotions (see Tangney and Dearing, 2002).

June Price Tangney built upon the work of Lewis (1971) and conducted extensive research on shame and guilt. Tangney and Dearing (2002) describe shame and guilt as self-conscious and moral emotions. Shame and guilt are seen as self-conscious emotions because they are evoked differentially depending on the individual's evaluation of the self and behavior. The evaluation of the self and behaviors against certain standards is required to evoke the experience of shame or guilt. Given that this evaluative process requires both an awareness of self and advanced cognitive abilities, it is thought that children cannot experience shame or guilt at birth. Shame and guilt are seen as moral emotions because they are thought to affect one's propensity towards moral behavior.

In this view, shame is seen as a primitive emotion that's adaptive function has been long lost (Tangney and Dearing, 2002). Most people are capable of experiencing both shame and guilt, but when faced with ambiguous negative situations some people are more prone to experience shame and others are more prone to experience guilt (Tangney, 1991). Research indicates that shame-prone individuals are likely to blame others and become angry and hostile in an effort to defend against the pain of shame (Tangney, 1990; Tangney and Dearing, 2002; Tangney, Wagner, Fletcher, and Gramzow, 1992). Shame-prone individuals are also more likely to experience psychopathology (Tangney, Wagner, and Gramzow, 1992). Although guilt that has become fused with shame is problematic, shame-free guilt has been found to be rather adaptive in that it motivates individuals to change their behavior. Guilt-prone individuals are more likely to be empathetic, able to accept responsibility, and manage anger (Tangney, 1990, 1991; Tangney, Wagner, Fletcher, et al., 1992).

Tangney and colleagues developed scenario based measures of shame and guilt for adult, adolescents, children, and socially deviant people (see Tangney, 1996; Tangney and Dearing, 2002 for detail). The original measure was the Self-Conscious Affect and Attribution Inventory (SCAAI) (Tangney, 1990). The Test of Self-Conscious Affect-Adult (TOSCA-A) was designed to improve on the SCAAI by obtaining scenarios from college students and other adult participants thus improving its ecological validity and making it pertinent to adults of any age (Tangney, Wagner, Hill-Barlow, Marschall, and Gramzow, 1996). The TOSCA-A consists of a series of ten negative and five positive scenarios followed by descriptions of both shame and guilt responses. Participants are asked to rate how likely they are to respond in each manner that is described on a Likert scale of one to five. This method is utilized to allow for the possibility that a respondent may experience both shame and guilt in response to a scenario. The internal consistency reliability for the TOSCA-A is reported to be .74 for adults and college students on the shame scale and .61 and .69 for the adults and college students on the guilt scale, respectively. Evidence for construct validity is provided (Tangney et al., 1996). The newest version of the adult TOSCA (TOSCA3) offers the option to use a shortened version and is available for review in Tangney and Dearing (2002).

In sum, these two conceptual views of shame and consequent operational definitions are quite different. Both measures have acceptable psychometric properties and have been used

extensively. The ISS has had much more use with clinical samples that include people who had substance dependency problems. Empirical research on shame in relation to addiction problems is limited. More research is needed to better understand the nature of shame and its relationship to substance use problems.

### *Shame and Addiction*

Shame is often described in the clinical literature on addiction as a factor that is both a contributor to the development and maintenance of addiction problems and an effect of addiction problems. This notion suggests that the relationship between shame and addiction may be cyclical in nature. An individual that is shame based discovers that using a substance sedates their pain to an extent. They continue to use the substance and develop an addiction to it. In the process of developing the addiction, the individual feels increasing shame and humiliation associated with their loss of control. They again attempt to sedate their shame, thus a cycle of addiction and increasing shame emerges. The idea of a shame–addiction cycle and the necessary and critical conditions for it to occur, to my knowledge, has not been examined empirically. There is evidence suggesting that individuals who have substance use problems have higher levels of shame than either individuals with other mental health problems or the general population (O'Connor, Berry, Inaba, Weiss, and Morrison, 1994) and that individuals with higher levels of shame are prone to more addiction problems (Cook, 1987). Also, higher levels of shame are associated with relapse for women who are members of Alcoholics Anonymous (AA) (Wiechelt and Sales, 2001). Finally, children in the fifth grade who were shame prone were more likely to use drugs at age 18 than less shame-prone peers (Tangney and Dearing, 2002). Taken together, these findings lend support to the notion of a shame–addiction cycle. However, with the exception of the Longitudinal Family Study described by Tangney and Dearing (2002), these studies were cross-sectional and used small convenience samples and therefore must be interpreted cautiously.

It appears that shame may be problematic for individuals with substance use problems even when they are in recovery. Wiechelt and Sales (2001) found that their sample of women who were members of (AA) had a problematic level of shame overall. Also, the individuals who had higher levels of shame were more likely to have difficulty in social adjustment than those with lower shame levels. The study conducted by O'Connor and colleagues (1994) described above used a sample of individuals in recovery in Narcotics Anonymous (NA) and a residential treatment program. The results from these studies suggest that individuals who have had substance use problems may need treatment aimed at reducing shame in order to improve their quality of life and increase the likelihood that they will be able to maintain their recovery.

### *Sources of Shame*

Though there are many potential sources of shame ranging from cultural oppression to parenting styles to biological predisposition, two sources of shame that stand out among individuals with substance use problems for inquiry are family of origin and trauma. Individuals with substance use problems often report that they have grown up in an addicted or otherwise dysfunctional family system (Bradshaw, 1988; Fossum and Mason, 1986). The interactional patterns of a shame-bound family system may result in increased levels of shame in the children raised there (Fossum and Mason, 1986), and shame-prone children are likely to misuse substances later in life (Tangney and Dearing, 2002). Cook (1991) suggests that there are links between attachment problems and internalized shame. Children who are raised in an environment where they are neglected, abused, or rejected are likely

to internalize shame. One possible defense against shame is substance use. Tangney and Dearing (2002) note that fathers' moral styles (shame proneness vs. guilt proneness) seems to influence the moral styles of sons and that parenting style seems to influence the development of shame proneness vs. guilt proneness as well. It seems likely that the functioning of the family of origin contributes to the development of shame. Given that not all children who grow up in addicted or dysfunctional families develop substance use problems, the link to later substance use is less clear and is likely mediated by other factors.

Research has shown that there is a link between trauma and substance use disorders (see Chilcoat and Menard, 2003, for review). Exactly how trauma and substance use problems are linked is unclear. Shame may be a factor that contributes to the link. Stone (1996) suggests that the effect that a traumatic event has on an individual is mediated through the affect system. Further, posttraumatic stress disorder (PTSD) is "*a disturbance in which the identification, regulation, and expression of affect is severely impaired*" [italics added] (Stone, 1996, p. 293). Individuals may engage in substance abuse in an effort to medicate their dyscontrol. Wong and Cook (1993) report that they found an association between shame and PTSD. There is some evidence suggesting a relationship between experiencing the traumatic event of childhood sexual abuse (CSA) and higher levels of shame (O'Connor et al., 1994; Playter, 1990). High rates of CSA have consistently been reported among women who have substance use problems (Miller, Downs, Gondoli, and Keil, 1987; Miller, Downs, and Testa, 1993; Wiechelt and Sales, 2001; Wilsnack, Vogeltanz, Klassen, and Harris, 1997). Higher rates of shame have been noted in women who have substance use problems (O'Connor et al., 1994) and in addicted women with more severe CSA, compared to addicted women with no CSA or moderately severe CSA experiences (Playter, 1990). These findings suggest that, at least for women, there may be a link between CSA, shame, and substance use problems. More research is needed to understand how traumatic events in general and CSA in particular link to shame and substance use.

### ***Implications***

Existing research does support the assertions made in the clinical literature suggesting that shame is an important etiological and treatment issue for people who abuse substances in general (Bradshaw, 1988; Fossum and Mason, 1986; Potter-Efron, 2002) and that shame may be especially important to the etiology and treatment of women's addictive disorders (Gomberg, 1988). Existing research also suggests that the line of inquiry into the links between shame and addiction may be productive. Additional research using longitudinal designs and larger samples is needed to both establish that there is a relationship between shame and substance use problems and to examine the nature of the relationship. Having a better understanding of shame and its involvement with substance use problems will improve and enhance treatment efforts.

Even though the exact nature of the relationship between shame and substance use warrants much more research, it appears that addressing shame in treatment with individuals who misuse substances will enhance the quality of their lives and improve their ability to change their substance use behaviors. Clinicians who work in substance use treatment settings can use the measures described above during the assessment process to gain a better understanding of the individual's experience of shame. The ISS could also be used to evaluate the effectiveness of a given intervention or program on reducing individuals' shame levels. Moreover, several authors describe therapeutic strategies that may be useful in alleviating shame in general (Balcom, Call, and Pearlman, 2000; Cook, 2001; Kaufman, 1996; Lee and Wheeler, 1996; Nathanson, 1996; Tangney and Dearing, 2002). Others discuss interventions

designed to reduce shame specifically in addicted individuals and their families (Bradshaw, 1988; Cook, 1991; Fossum and Mason, 1986; Potter-Efron, 2002).

Nevertheless, there is a dearth of research on the effectiveness of interventions designed to alleviate shame. Consequently, the practitioner is left with making a determination as to which therapeutic approaches best fit their client in the context of the treatment setting or program. Existing research can be used to guide the clinician's determination. For example, there is a great deal of evidence supporting the use of cognitive behavioral therapies to reduce depression or anxiety and they would likely be effective at reducing shame as well (see Milestone, 1996; Tangney and Dearing, 2002). Mounting evidence suggests that eye movement desensitization and reprocessing (EMDR) is effective at reducing symptoms associated with traumatic experiences and preliminary evidence that it is effective at reducing shame (Balcom et al., 2000). Tangney and Dearing (2002) suggest that educating individuals on the difference between shame and guilt promotes a spontaneous shift from making negative attributions about the self to negative judgments about specific behaviors. Taking this idea a step further, it may be helpful to use social skills training techniques (Bandura, 1977) to assist individuals in shifting their negative evaluations from the self to behaviors and in developing their ability to recognize and change problematic behaviors. This skill development could reduce shame and increase the individual's sense of self-efficacy, power, and pride.

Clinicians should also attend to manifestations of shame within the context of the therapeutic relationship (Retzinger, 1998). Both the individual in treatment and the clinician may experience shame, which could potentially lead to problems in the therapeutic process if it is left unnamed and unaddressed. Individuals who enter treatment may experience shame if they perceive themselves as having failed at their own efforts to resolve their problems (Jacobs, 1996) or have been mandated to seek treatment by someone in authority. Also, the research described above suggests that individuals who misuse substances experience problematic levels of shame or are shame-prone. The sources of their shame may include cultural oppression, childhood abuse or neglect, family dysfunction, adult experiences of violence and trauma, behavior associated with substance use, disposition, and learned ways of coping. The power differential in the therapeutic relationship also makes individuals in treatment vulnerable to experiencing shame (Simon and Geib, 1996). In any case, individuals are likely to experience feelings and engage in psychological and behavioral defenses associated with their shame within the context of the therapeutic relationship. Due to the nature of shame and the way western society represses it, individuals often are not aware that they are experiencing shame. It appears that rage and anger are common responses to feeling shame (Tangney, Wagner, Fletcher, et al., 1992; Tangney et al., 1996). Clinicians need to be aware of shame and how it manifests itself in individuals in order to help their clients manage and cope with it. If the clinician misses the individual's shame or responds to his defensiveness with confrontation, he may increase the individual's experience of shame and reach an impasse in treatment.

Clinicians also need to be aware of their own experience of shame, what triggers it, and how they tend to manage it (Kaufman, 1996). Clinicians who can tolerate their own shame and manage it are more likely to be able to help others learn to manage their shame. Clinicians who deny or repress their own shame will be likely to miss it in their clients and may experience problems in the therapeutic relationship. The clinician's own shame can be activated in the context of the therapeutic relationship by such things as a client's anger, blame, or demands being directed at them or a client's lack of progress in treatment (Kaufman, 1996). A clinician may experience shame if they inadvertently shame their client or feel inadequate and insecure about their ability to help. A clinician who experiences shame and does not know how to manage it is likely to engage in behaviors to defend against it,



such as being angry at or blaming their client. It is important that the clinician learn to identify, tolerate, and manage their own shame experience to enable them to recognize and manage shame when it arises in the context of the therapeutic relationship.

In general, treatment needs to occur in a safe environment and individuals who are experiencing shame or who are shame based should not be further shamed (Potter-Efron, 2002). Treatment techniques or programs that are designed to be shame inducing are contraindicated. Program administrators and clinical supervisors need to provide their staffs with training and supervision on: (a) how to identify shame in individuals that they are working with; (b) how to provide interventions to diminish shame; and (c) how to recognize their own experience of shame and how to manage it when it arises in the context of the therapeutic relationship. Teams of administrators, supervisors, and clinicians can work together to identify policies and procedures within programs that may be shaming to individuals in treatment and develop new ones to replace them. Individual therapists could benefit themselves and those they work with by obtaining training on shame and engaging in peer supervision groups. In sum, addiction treatment professionals need to attend to shame and its potential effects in themselves, in the treatment delivery system, and in their clients in order to minimize its negative effects and maximize healing in the individuals that they are working with.

### RÉSUMÉ

Cet article fournit une introduction au concept d'honte comme il relate à l'usage impropre de substance. La recherche empirique sur l'honte et la dépendance et les définitions théoriques et opérationnelles qui les étaient sont discutées. Les secteurs potentiels de plus ample enquête sont soulignés. Les implications pour la pratique clinique sont discutées.

### RESUMEN

Este artículo proporciona una introducción al concepto de la vergüenza como relaciona al maltrato de la sustancia. Investigación empírica en la vergüenza y la vicio y en las definiciones teóricas y operacionales que apuntalan ellos se discuten. Las áreas potenciales de la indagación adicional se destacan. Las implicaciones para la práctica clínica se discuten.

### THE AUTHOR



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## Glossary

*Affect*: in affect theory, the affect is seen as the innate biological portion of emotion; an analog amplifier of its stimulus conditions. The affect that is triggered is determined by the suddenness in the rising or falling of the density of neural firing. The auxiliary affects are thought to have developed later in human evolution than the other affects. The nine affects identified in affect theory and their associated facial expressions are listed and defined below (definitions were adapted from Cook, 2001; Kaufman, 1996; and Nathanson, 1992, 1996).

*Anger, Rage*: affect that is triggered by a high density and constant stimulus; i.e., being yelled at. Expressed by a red face, frown, and clenched jaw.

*Disgust*: auxiliary affect to the hunger drive with the original purpose of causing a person to spit out food that tastes bad. It later developed in to an auxiliary affect related to turning away from an interaction or relationship that was previously perceived as being good. Expressed by lower lip lowered and protruded and head forward and down.

*Dismell*: auxiliary affect to the hunger drive with the original purpose of causing an individual to turn away from food that smells bad. It later developed into an auxiliary affect that causes a person to turn away from repulsive interpersonal contact as well. Expressed by upper lip raised and head pulled back.

*Distress, Anguish*: affect that is triggered by constant and dense stimulus; i.e., cold. Expressed by crying, arched eyebrows, rhythmic sobbing, mouth down.

*Enjoyment, Joy*: affect that is triggered by the relief of a preexisting stimulus; i.e., a distressed child is comforted. Expressed by a smile or laughter.

*Fear, Terror*: affect that is triggered when a rapid rise in the gradient of stimulus occurs, i.e. sudden movement in the dark. Expressed by hair standing on end, eyes frozen in stare, pale, cold skin.

*Guilt*: feeling bad about doing something wrong.

*Interest, Excitement*: affect that is triggered by an optimal rise in the stimulus gradient; i.e., seeing something new. Expressed by a furrowed brow, face appears to be tracking, looking or listening.

*Self-Conscious Emotion*: emotions that involve the self evaluating the self.

*Shame*: a process and condition in which an individual perceives himself or herself as being flawed and feels bad about who they are. Shame is fundamentally about exposure of a flawed self.

*Shame, Humiliation*: Auxiliary affect to the affective system that is triggered when the affects of interest or enjoyment are impeded; i.e., waving at someone you perceived as a familiar friend and realizing she was a stranger. Expressed by downcast eyes, head lowered and averted, and blushing.

*Surprise, Startle*: Affect that is triggered by a sudden and abrupt stimulus; i.e., car backfiring. Expressed by raised eyebrow and eye blink.

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