Guilt, Shame, and Depression in Clients in Recovery from Addiction

William Meehan, M.A.*; Lynn E. O'Connor, Ph.D.*; Jack W. Berry, Ph.D.*; Joseph Weiss, M.D.**; Andrea Morrison, Ph.D.*** & Alfonso Acampora, M.A.****

Abstract—Men and women in recovery from addiction were compared on levels of depression, guilt, and shame. The measurement of guilt included subscales of Survivor Guilt, Separation Guilt, Omnipotent Responsibility Guilt, Trait Guilt, State Guilt, and Adaptive Guilt. The sample included 75 men and 33 women in treatment in a residential treatment community. It was found that women were significantly higher than men in depression. The recovering subjects were compared to nonaddicted subjects and established norms, and it was found that the recovering people were higher on depression, shame, and the subscales of maladaptive guilt. Both men and women in recovery were significantly lower than norms in adaptive guilt.

Keywords—addiction, depression, guilt, men, recovery, shame, women

It is generally accepted that chemically dependent clients frequently suffer from depression as well as addiction, and from difficulty regulating and coping with uncomfortable emotions. Many theorists have associated drug addiction with an inability to regulate anger or to alleviate depression. For example, it has been suggested that clients addicted to depressants are attempting to modulate feelings of anger and those addicted to stimulants are trying to cope with depression (Khantzian 1994, 1985, 1980; Bell & Khantzian 1991; Dodes 1990; Krystal 1982; Zimberg 1982; Mack 1981; Corman & Khantzian 1976).

In recent years psychoanalytic thinking has increasingly focused on the role of shame and guilt in the etiology of psychopathology (Weiss 1993, 1986, 1983; Morrison 1983; Sampson 1983; Kohut 1971; Lewis 1971; Modell 1971, 1965). Joseph Weiss, in a recently developed theory of psychopathology and psychotherapy, has suggested that emotional distress, including addiction, may be closely associated with primary problems of excessive guilt and shame, with anger often occurring secondarily in response to these affects (O'Connor & Weiss 1993; Weiss 1986). The present study derives from this theoretical framework.

*San Francisco Psychotherapy Research Group; The Wright Institute, Berkeley, California.

**San Francisco Psychotherapy Research Group, San Francisco Psychoanalytic Institute.

***The Wright Institute, Berkeley, California.

****Walden House, San Francisco.

Please address correspondence and reprint requests to Lynn E. O'Connor, Ph.D., San Francisco Psychotherapy Research Group, 2420 Sutter Street, San Francisco, California 94115.

Weiss's theory, as applied specifically to chemically dependent populations, suggests that people become vulnerable to drug addiction because they are prevented from pursuing ordinary developmental goals by grim pathogenic beliefs (O'Connor & Weiss 1993). Pathogenic beliefs are derived from disturbing childhood experiences, and warn people that if they pursue certain normal goals they may harm themselves or their parents, siblings, or other loved ones. Because they predict harming another person, pathogenic beliefs often cause feelings of altruism-based guilt or shame. In reaction to these beliefs, people may inhibit themselves from pursuing normal goals in order to avoid or minimize guilt, and this may lead to depression, other symptoms of psychological distress, and a vulnerability to addiction. Chemically dependent clients often come from troubled families with a history of addiction. From this background many addicted clients inherit both a genetic predisposition to addiction as well as a myriad of pathogenic beliefs inhibiting them from pursuing normal goals and causing them to suffer from maladaptive guilt and shame. And the lifestyle and behaviors associated with drug use lead to further increased feelings of guilt and shame.

O'Connor and Weiss's theoretical insight is supported in a number of empirical studies. In a recent study it was found that subjects in recovery from addiction were elevated in proneness to shame and depression, as well as on several other measures of self-conscious affect, when compared to subjects from nonaddicted samples (O'Connor et al. 1994.) These subjects were also found to be lower than

norms in a measure of adaptive guilt, which is a type of guilt associated with empathy and good social adjustment.

A large body of research has described the prevalence of depression in alcoholics (Dackis et al. 1986; Woodruff et al. 1973; Fox 1967) and in subjects dependent on illicit drugs (Handelsman et al. 1992; Jacobsen & Kosten 1989; Tarighati 1980; Woody, O'Brien & Rickles 1975; Robbins 1974). Depression has been associated with the tendency to attribute blame for negative events to the self (Peterson & Seligman 1984) and self-blame in turn has been linked to shame (Tangney, Burggraf & Wagner 1995; M. Lewis 1992; Tangney, Wagner & Gramzow 1992; Tangney 1990; Nathanson 1987b; H.B. Lewis 1971) as well as maladaptive guilt (O'Connor et al., In press; O'Connor 1995; O'Connor, Berry & Weiss 1995; Menaker 1995).

In a study of shame and addiction, Cook (1987) found that students reporting alcohol abuse had significantly higher scores on a 39-item internalized shame scale. Vinney, Westbrook and Preston (1985) found shame to be the chief component of the pattern of anxiety that differentiated addicted from nonaddicted subjects. Flanigan (1987) and Kurtz (1988) both singled out shame as a major problem for alcoholics, and other researchers have focused on the role of shame in relapse (Brown 1991) and as a contributing factor to failure to seek help (Potter-Efron 1988). In a study of opiate addiction, Blatt and colleagues (1984) noted that the pattern of depression in addicted subjects centered not on issues of abandonment or rejection but on self-criticism, guilt, and shame.

One line of research on the association between addiction and both shame and depression originated in questions about whether women seeking treatment for chemical dependency were more prone to shame and guilt, and thus might be less responsive to confrontational therapies than their male counterparts (Morrison et al., In press; McLachlan 1976; O'Connor et al. 1994; Mason 1991; Blume 1990a, 1990b; Reed 1987; Johnson 1986; Hesselbrock, Meyer & Keener 1985).

Findings on the relationship between chemical dependency and guilt have been less clear cut—in part because researchers have not always clearly differentiated between guilt and shame, and also because of variation in the definition of guilt (Jones & Burdette, In press; O'Connor et al., In press; O'Connor 1995; O'Connor, Berry & Weiss 1995; Harder, Cutler & Rockart 1992; Tangney 1990). Studies by Millard (1991) and Washton (1988) have addressed the need to manage or reduce the guilt of clients seeking recovery from active addiction. Shafiq (1987), in a study comparing hospitalized heroin-addicted subjects to nonaddicted subjects, found the addicted subjects particularly high in feelings of guilt and sin. Tuite and Luiten (1986), in a meta-analysis of addiction studies using the 16PF Questionnaire, also found guilt to be a major component of the addicted profile; and Sheppard and Mitchell (1986), in a study of young people's views of alcohol, found a distinct gender difference in attitudes with females associating guilt with drinking twice as often as male respondents. Ward (1983) found an opposite gender difference in her study of opiate addicts, which showed addicted subjects higher in two forms of irrational guilt than a comparison group of college students, but also found addicted female subjects reporting significantly less guilt than addicted males.

The distinction between shame and guilt has been a subject of discussion in the past several decades. Early theorists (Benedict 1946; Freud 1896) saw shame as a response to public exposure of some fault or deficiency in the person experiencing the emotion, and they saw guilt as an internal matter between the self and the conscience. Freud viewed guilt as the result of unconscious hostility; a person wished to harm another and therefore felt guilty. More recent formulations have abandoned this public-private distinction in favor of definitions that distinguish shame from guilt in terms of the way in which negative events are attributed to the self, or in terms of the shamed person's urge to turn away from further interaction as opposed to the guilty urge to repair a damaged relationship (Morrison 1994, 1989, 1983; Nathanson 1992, 1987a, 1987b; H.B. Lewis 1987, 1971). In this formulation, shame is defined as the emotion that arises when negative events are attributed to the self in a global and persistent fashion; guilt is viewed as resulting from negative attributions associated with a behavior occurring in a specific situation.

In recent empirical research, measures have been developed that distinguish between proneness to shame and to guilt (with other subscales for detachment, externalization, and pride) (Tangney, Wagner & Gramzow 1992; Tangney 1990). Tangney defined shame as a negative condemnation of the whole self, and guilt as a negative condemnation of a single act or behavior. According to this definition, proneness to shame was found to be associated with a range of psychopathology and proneness to guilt was found to be associated with a nonpathological tendency to empathy and good social adjustment. One group of researchers distinguish between guilt resulting from transgression of moral codes from that stemming from acts that threaten a relationship (Jones, Kugler & Adams 1995; Jones & Kugler 1993; Kugler & Jones 1992). For the purposes of their research they distinguish three kinds of guilt: a pervasive trait guilt; a more immediate state guilt; and formal moral standards (Jones & Kugler 1993; Kugler & Jones 1992). Of the three, moral standards is the formulation that most approximates the notion of guilt operationalized by Tangney and her colleagues.

Recent interpersonal conceptualizations of guilt differ from the Freudian concept of guilt as derived from feelings of hostility, and instead view guilt as based in altruism and concerns about harming others. In this perspective, guilt functions to maintain attachments;

however, it becomes maladaptive when it is exaggerated or associated with pathogenic beliefs (Jones & Burdette 1994; Jones, Kugler & Adams 1995; Tangney, Burggraf & Wagner 1995; Baumeister, Stillwell & Heatherton 1994; Weiss, 1993, 1986; Tangney, Wagner & Gramzow 1992; Zahn-Waxler & Kochanska 1990; Lewis 1987, 1971). Interpersonal guilt may be defined as a painful affect arising from the belief that one has harmed another. There are several identified types of maladaptive interpersonal guilt, including guilt associated with survivor syndromes and guilt associated with separation from family of origin and other adaptive activities (Weiss 1993, 1983; Bush 1989; Friedman 1985; Sampson 1983; Niederland 1981, 1968; Modell 1971, 1965; Freud 1896). These types of guilt have recently been the subject of empirical study using the Interpersonal Guilt Questionnaire (O'Connor et al., In press; O'Connor 1995, 1994; O'Connor, Berry & Weiss 1995). This measure was constructed to assess guilt that relates to the fear of harming others. Using 45 items generated by senior clinicians, the Interpersonal Guilt Questionnaire-45 (IQG-45) has been piloted on one sample of 36 therapists (O'Connor 1994) and another sample of 62 normal adult members of a community organization (Katrichak 1995).

The IGQ-45 includes subscales designed to assess four different kinds of interpersonal guilt. The first, survivor guilt, stems from the irrational belief that there is a limited amount of good to be had, and that any good that a person experiences comes at the expense of others. A person suffering from survivor guilt may believe that his or her success will make others feel bad simply by comparison. The second, separation/disloyalty guilt, is based on the belief that separating from, or differing from, one's family or friends is disloyal and harmful to them. The third, omnipotent responsibility guilt, is related to the belief that one is responsible for the happiness and well-being of others. Finally, self-hate guilt is an extreme negative sense of the self, a general sense of badness maintained in compliance with the image of the self presented by neglectful or abusive parents. The first three subscales are directly related to the fear of harming others; self-hate guilt is theoretically related to interpersonal guilt in that the negative view of self is seen as a form of compliance that serves to maintain the attachment to parents or other loved ones.

The present study was based on previous empirical investigation of gender differences in proneness to shame, guilt, and depression among patients in recovery from addiction (O'Connor et al. 1994). The present study was conducted to investigate the association between shame, guilt, and depression in a group of drug-addicted clients in recovery in a residential treatment program, using several measures of both maladaptive as well as adaptive guilt. In this study, addicted subjects were assessed for survivor guilt, separation guilt, omnipotent responsibility guilt, self-hate guilt, trait guilt, state guilt and moral standards, along with depression, shame, and adaptive guilt as measured in the earlier study. It was hypothesized that the treatment facility residents of both sexes would score higher than nonaddicted women and men on the measures of depression, shame, and on state and trait guilt, as well as on the four types of interpersonal guilt. It was further hypothesized that women would score higher than men on adaptive guilt, shame, and depression measures.

METHODS

Subjects

The subjects were 122 clients recovering from chemical dependency in Walden House, a residential drug treatment program in San Francisco. Of those responding, 75 were male and 33 were female; ages ranged from 19 to 64 years, with a mean age of 33 (SD=8.81). Time abstinent from drugs ranged from a minimum of .13 months to a maximum of 30 months. Mean abstinence time was 4.91 months and the median was 3.5 months. The ethnicity of the sample was as follows: African-American (N=55), European-American (N=28), Latin American (N=10), Native American (N=8), and other (N=6). Of those reporting a drug of choice, the largest group was of those citing cocaine either by itself (N=33) or in conjunction with alcohol (N=12). Polydrug abuse was the next largest category (N=23), followed by heroin (N=17), amphetamines (N=12), alcohol (N=6), and PCP (N=1). Analysis of the demographic questionnaire also revealed that 82% (N=74) of those responding to questions about family drug use in childhood grew up in families with one or more drug-abusing members; 43% (N=46) reported a history of suicide attempts, and 21% (N=23) reported having suicidal ideation at the time of the study; 42% (N=45) reported having seen a psychotherapist at some time prior to entering the treatment facility and 62% (N=66) reported having undergone prior treatments for chemical dependency.

Assessment Materials

Assessment materials included a demographic questionnaire, the Beck Depression Inventory (BDI), the Test of Self Conscious Affect (TOSCA), the Guilt Inventory (GI), and the Interpersonal Guilt Questionnaire (IGQ-45).

The demographic questionnaire (revised from O'Connor et al. 1992) is a self-report instrument designed to collect demographic information, drug use histories of the subjects and their families, and personal and family psychiatric history.

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

The Test of Self Conscious Affect (Tangney, Wagner & Gramzow 1992; Tangney 1990), revised from the Self-

TABLE 1
Differences Between Male Subjects and Norms on Shame and Guilt Scale Variables

	Walden House Men		Nonaddict Men	
Variable	DF	M	M	t
TOSCA Shame	58	40.71	35.10	4.99*
TOSCA Guilt	56	53.53	57.00	-3.56*
TOSCA Detachment	57	30.81	30.40	0.54
TOSCA Externalization	57	41.10	35.70	4.88*
TOSCA Alpha pride	60	19.92	19.70	0.54
TOSCA Beta pride	58	20.39	20.10	0.69
KJGI State Guilt	64	33.02	24.67	10.44*
KJGI Trait Guilt	61	70.87	54.08	13.31*
KJGI Moral Standards	60	45.57	49.08	-4.24*
IGQ Survivor Guilt	48	79.37	71.92	4.83*
IGQ Separation Guilt	54	14.49	10.37	7.45*
IGQ Self-Hate Guilt	52	15.47	11.73	4.97*
IGQ Omnipotence Guilt	54	29.33	25.54	5.28*

*p<.001

Conscious Affect and Attribution Inventory, is a paper-and-pencil measure constructed in the form of 15 short scenarios (5 positive and 10 negative) drawn from written accounts of shame, guilt, and pride experiences collected from a nonclinical sample consisting of several hundred college students and other adults not in college. Each of the negative scenarios is followed, in random order, by responses indicating shame (globally negative feelings about the self), guilt (behavior-specific negative feelings about the self), detachment/unconcern, and externalization. The response sets following the positive scenarios contain expressions of shame, guilt, externalization, alpha pride (pride in self), and beta pride (pride in behavior). The measure is not constructed to force a choice among the various response sets but rather asks subjects to consider each of the responses separately and to rate the likelihood of their responding in a similar manner. Rating is done on a five-point Likert scale. The measure is scored by summing the ratings for each class of responses across the scenarios. This creates indices for shame-proneness, guilt-proneness, externalization, detachment/unconcern, alpha pride, and beta pride. For the shame and guilt scales (the two most relevant to the hypotheses under investigation in this study), Tangney, Wagner and Gramzow (1992) reported estimates of internal consistency (Cronbach's alpha) of .76 and .66, respectively.

The Guilt Inventory (Kugler & Jones 1992) is a 45-item self-report measure consisting of researcher-generated statements thought to be indicative of three conceptually different kinds of guilt: guilt relating to current feelings (State Guilt), guilt that is more pervasive and continues beyond a set of immediate feelings (Trait Guilt), and a third subscale relating to a code of moral principles (Moral Standards). The inventory includes 20 items designed to assess Trait Guilt (e.g., "Frequently I just hate myself for something I have done."), 10 items to assess State Guilt (e.g., "Recently, I have done something that I deeply regret.") and 15 items to assess Moral Standards (e.g., "I believe in a strict interpretation of right and wrong."). Subjects are asked to respond to each item by rating it on a five-point Likert scale with verbal anchors ranging from "strongly agree" to "strongly disagree." The measure is scored by summing responses in each of the separate subscales. For the Trait Guilt subscale, Kugler and Jones reported coefficient alpha=.89, mean interitem correlation=.29; for State Guilt, coefficient alpha=.84, mean interitem correlation=.34; and for Moral Standards, coefficient alpha=.88, mean interitem correlation=.33.

The Interpersonal Guilt Questionnaire-45 (O'Connor et al., In press; O'Connor 1994) is a 45-item self-report questionnaire composed of statements generated by senior clinicians to assess four categories of guilt related to a concern about harming others. The measure includes four subscales. The subscale for Survivor Guilt (the irrational belief that any good that a person experiences comes at the expense of others and that one's success will make others feel bad simply by comparison) includes such items as "I conceal or minimize my success"; "I am depressed around unhappy people"; and "It makes me very uncomfortable to receive better treatment than the people I am with." The subscale for Separation/Disloyalty Guilt (a feeling that separating or differing from one's family or friends is disloyal and harmful to them) includes items like "I feel

TABLE 2
Differences Between Female Subjects and Norms on Shame and Guilt Scale Variables

	Walden House Women		Nonaddict Women	
Variable	DF	M	M	t
TOSCA Shame	27	43.46	39.45	2.22*
TOSCA Guilt	26	51.70	61.05	-4.41***
TOSCA Detachment	26	33.30	28.10	3.56**
TOSCA Externalization	25	44.65	34.95	5.76***
TOSCA Alpha pride	28	20.21	19.60	0.81
TOSCA Beta pride	27	20.11	19.80	0.35
KJGI State Guilt	27	34.00	24.31	8.44***
KJGI Trait Guilt	25	72.62	54.12	8.35***
KJGI Moral Standards	27	45.25	50.79	-4.29***
IGQ Survivor Guilt	24	79.08	72.03	2.77*
IGQ Separation Guilt	22	15.96	10.86	6.26***
IGQ Self-Hate Guilt	23	17.54	12.58	4.73***
IGQ Omnipotence Guilt	26	28.00	27.94	0.05

*p<.05
**p<.01

that bad things may happen to my family if I do not stay in close contact with them"; "It makes me uncomfortable to have critical thoughts about my parents"; "I prefer to do things the way my parents did them." The Omnipotent Responsibility Guilt subscale (an exaggerated feeling of responsibility for the happiness and well-being of others) has items such as "It is very hard for me to cancel plans if I know the other person is looking forward to seeing me"; "I can't stand the idea of hurting someone else"; and "I often find myself doing what someone else wants me to do rather than doing what I would most enjoy." The subscale for Self-Hate Guilt (a compliance with the image of the self presented by neglectful or abusive parents) includes such items as "I always assume I am at fault when something goes wrong"; "I do not deserve other people's respect or admiration"; and "If I fail at something I want to harm myself."

Internal consistencies for each subscale were calculated using Cronbach's alpha resulting in a coefficient of .79 for the Survivor Guilt subscale (26 items, 171 observations); .67 for Separation Guilt (5 items, 175 observations); .74 for Omnipotent Responsibility Guilt (8 items, 179 observations); and .85 for Self-Hate Guilt (6 items, 173 observations) (O'Connor et al., In press). Validity was established by correlations with other measures of guilt and related constructs.

Procedure

Subjects were given a packet containing a letter of introduction and all of the materials described above. All materials were anonymous. The packets were distributed at two meetings arranged by the treatment facility staff. Of 122 people solicited for participation, 13 declined to participate. The remaining 109 people received packets, which they returned in varying stages of completion. A small number of participants at one facility failed to finish before the end of the meeting and this is reflected in the fact that the last instrument in the packets, the IGQ-45, had the lowest completion rate of all of the measures.

RESULTS

The first set of hypotheses was that treatment facility residents of both sexes would score higher than nonaddicted women and men on the measures of depression (BDI), shame (TOSCA), state and trait guilt (GI), and interpersonal guilt (IGQ-45). To test these hypotheses, one-sample t-tests were conducted to compare means of the treatment facility sample to previously published data for each relevant measurement scale. Subjects' scores on the guilt and shame scales of the TOSCA and on the GI were compared to previously collected data obtained from nonaddicted samples; comparisons for men and women were done separately (see Tables 1 and 2). Means for the TOSCA comparisons—males (N=186) and females (N=241)—were obtained from a previous study conducted by Tangney (cited in O'Connor et al. 1992). Means for the GI comparisons—males (N=79) and females (N=130)—were taken from a previous study by Kugler and Jones (1992). Means for the IGQ-45 comparisons were obtained from data previously

TABLE 3
Sex Differences on Major Dependent Variables

	Males			Females			
Variable	N	M	SD	N	M	SD	t
BDI	72	12.85	9.77	32	19.47	9.45	-3.22*
TOSCA Shame	59	40.71	8.64	28	43.46	9.59	-1.34
TOSCA Guilt	57	53.53	7.37	27	51.70	11.01	0.90
TOSCA Detachment	58	30.81	5.77	27	33.30	7.60	-1.67
TOSCA Externalization	58	41.1	8.43	26	44.65	8.59	-1.77
TOSCA Alpha pride	61	19.92	3.18	29	20.21	4.03	-0.37
TOSCA Beta pride	59	20.39	3.21	28	20.11	4.64	0.33
KJGI State Guilt	65	33.01	6.44	28	34.00	6.07	-0.69
KJGI Trait Guilt	62	70.87	9.93	26	72.63	11.29	-0.72
KJGI Moral Standards	61	45.57	6.45	28	45.25	6.83	0.22
IGQ Survivor Guilt	49	79.37	10.80	25	79.08	12.73	0.10
IGQ Separation Guilt	55	14.49	4.11	23	15.96	3.90	-1.46
IGQ Self-Hate Guilt	53	15.47	5.48	24	17.54	5.14	-1.56
IGQ Omnipotence Guilt	55	29.33	5.32	27	28.00	6.29	1.00

*p<.01

collected by Katrichak from a nonclinical adult sample (O'Connor et al., In press; Katrichak 1995; O'Connor 1995, 1994). Results show that both the men and women clients at the treatment facility scored significantly higher than the norms on Tangney's measures of proneness to shame and externalization, on Kugler and Jones's measures of state and trait guilt, and on the Survivor Guilt, Separation Guilt, and Self-Hate Guilt subscales of the IGQ-45. Men in the treatment facility also scored significantly higher than nonaddicted males on the IGQ-45 Omnipotent Responsibility Guilt subscale. Treatment facility clients of both sexes had significantly lower scores on Tangney's measure of proneness to guilt and on Kugler and Jones's measure of moral standards. These findings support this study's initial hypotheses on the relationship between this recovering population and norms on these specific measures of shame and guilt. In addition, it was found that women clients scored significantly higher than norms on the TOSCA detachment subscale. On the pride scales there were no significant differences between male or female treatment clients and their respective norms.

The second set of hypotheses was that women would score higher than men on the adaptive guilt (TOSCA), shame, and depression measures. Independent samples t-tests were used to compare male and female clients on depression, shame, and all guilt measures (see Table 3). The only statistically significant finding was for depression, $t(102)=-3.22$, $p<.01$, with women having significantly higher BDI scores. On the BDI, a range of 0–9 is considered normal. The mean for treatment facility men (mean=12.85) falls in the range considered moderate. The women in treatment (mean=19.47) scored in the moderate to severe range. Gender differences in shame and guilt were not significant.

A series of one-way ANOVAs was used to analyze subjects' scores in terms of the effect of ethnicity for the three ethnic groups with the largest representation in the sample: African-American, European-American, and Latin American. Significant differences were found in the scores on the GI measure of moral standards, on the TOSCA measures of shame and externalization, and on the IGQ-45 Self-Hate Guilt subscale (see Table 4). On the moral standards measure, Fisher's PLSD indicated that African-Americans scored significantly higher than both of the other two groups, which did not differ significantly from each other. On the measure of proneness to shame, the PLSD showed Latin Americans significantly higher than African-Americans. On the measure of externalization, Latin Americans were significantly higher than either African-Americans or European-Americans, who did not differ significantly from each other. For Self-Hate Guilt the PLSD showed African-Americans significantly lower than both European-Americans and Latin Americans, who did not differ significantly from each other.

Men and women were compared on history of suicidality. Of 74 men, 26 (35%) had attempted suicide and 11 of 73 men responding (15%) reported current suicidal ideation. Of 33 women, 13 (61%) had a history of suicidality and 11 (33%) reported current suicidal ideation. A chi-square test comparing the gender differences in suicide attempts was statistically significant, $\chi^2(1)=6.04$, $p<.05$. A chi-square test comparing the gender differences in current suicide ideation was also statistically signifi-

TABLE 4
Ethnicity: One-Way ANOVA — BDI, TOSCA, KJGI and IGQ-45

	African-American		Euro-American		Latin American		
Variable	M	SD	M	SD	M	SD	F
BDI	14.58	10.13	16.00	10.59	15.40	13.32	.16
TOSCA Shame	39.71	7.83	43.17	7.32	48.75	11.74	4.71*
TOSCA Guilt	52.32	7.58	52.08	10.78	54.50	7.35	.25
TOSCA Detachment	32.48	6.74	30.68	6.81	32.67	6.08	.62
TOSCA Externalization	42.35	7.74	41.80	7.14	49.75	9.02	3.54*
TOSCA Alpha Pride	20.16	3.42	19.44	3.81	19.44	3.64	.39
TOSCA Beta Pride	20.64	4.10	19.54	3.58	19.25	2.92	.89
KJGI State Guilt	33.11	6.56	34.04	6.13	33.00	7.84	.17
KJGI Trait Guilt	69.76	11.12	72.36	7.48	75.25	14.26	1.14
KJGI Moral Standards	47.54	5.81	43.35	6.82	41.00	8.12	5.64**
IGQ Survivor Guilt	77.95	10.09	80.11	11.31	87.83	15.98	2.09
IGQ Separation Guilt	15.41	3.98	13.89	4.22	18.00	3.80	2.49
IGQ Self-Hate Guilt	14.60	4.79	17.83	4.67	21.17	7.60	5.76**
IGQ Omnipotence Guilt	28.74	6.09	28.11	5.98	30.00	5.02	1.37

*p<.05
**p<.01

cant, $\chi^2(1)=4.61$, $p<.05$. A chi-square test assessing the effect of ethnicity on these two variables failed to yield significant results.

DISCUSSION

The results of this study support the theoretical assertion that drug-addicted clients suffer from problems related to shame and excessive interpersonal guilt, particularly guilt derived from altruism and the fear of harming others (O'Connor 1993; O'Connor & Weiss 1993). In prior research, O'Connor and colleagues reported addicts to be lower in adaptive guilt. They suggested that this reflected a particular definition of guilt and they hypothesized that if guilt were redefined to include survivor guilt and other types of potentially irrational and excessive guilt related to the fear of harming others, drug-addicted clients would be found to be higher in guilt than a normal population (O'Connor et al. 1994). The present study supports that hypothesis and found drug-addicted clients to be elevated in subscales of the IGQ-45, Survivor Guilt, Separation Guilt, Omnipotent Responsibility Guilt and Self-Hate Guilt, as well on two of the subscales of the GI, Trait Guilt and State Guilt. The elevation of drug-addicted clients' scores on these two measures supports the hypothesis that excessive interpersonal guilt may be a major factor in the etiology of chemical dependency. Furthermore, this study has confirmed the prior discovery that drug-addicted clients are lower than norms in the type of adaptive guilt as measured by the Guilt subscale of the TOSCA, which has been found to be associated with empathy and good social adjustment (Tangney, Wagner & Gramzow 1992).

These results support the clinical impressions of treatment specialists who find that while drug-addicted clients may be lower in adaptive guilt and appear to externalize blame and behave irresponsibly, at the same time they frequently suffer from excessive, maladaptive, and irrational guilt. This leads to the standard dilemma in chemical dependency treatment, in which efforts to encourage the acceptance of healthy responsibility may inadvertently also support already excessive and irrational feelings of self-blame, guilt, and shame. While appearing to avoid normal responsibility, drug-addicted clients are often worrying excessively about others.

Results of the present study support the well-established clinical and research evidence that drug-addicted subjects have higher levels of shame and depression than nonaddicts. The high proneness to shame in this population may be one factor in the difficulty in developing successful treatment models. People who are highly prone to shame may often be unable even to seek help.

The results of this study also support anecdotal and research evidence that women entering drug abuse treatment tend to suffer from higher levels of depression than their male counterparts. On the variable of shame, however, these results do not confirm the findings of earlier research that suggested that chemically dependent women were higher in proneness to shame. In previous research (O'Connor et al. 1994; Tangney 1990), women have been found to be elevated in shame relative to men. The current

findings suggest that in a population that includes psychologically disturbed men, there may be less difference between the sexes in regard to shame.

A clinically important, though incidental, finding in this study was that significantly more women than men reported current suicidal ideation and a history of suicide attempts, and that both men and women in treatment report a high incidence of suicidal ideation. The threat of suicide is an ever-present undercurrent in treatment programs in which many clients suffer from depression, and it is likely that many recovering people, both men and women, may need ongoing psychotherapy as well as more traditional chemical dependency treatment.

The results of the ethnicity analysis are not conclusive, but they do suggest that culture/ethnicity may be a variable affecting the way people experience and/or report certain kinds of shame and guilt. At the very least they make clear the need for cultural sensitivity in applying and interpreting these measures and they suggest the need for more comparative cross-cultural research.

Taken together, the results of this study suggest the need for more research to investigate the pathogenic potential of maladaptive guilt, and its correlates shame and depression, in chemically dependent people. Furthermore these results may have wide-ranging clinical implications, suggesting the need to question many currently accepted facets of both residential and outpatient drug abuse treatment. In many contemporary programs it is common to use various types of confrontational approaches to break down chemically dependent clients' proneness to externalization and avoidance of responsibility, as well as denial of drug use and psychological problems. This approach is currently accepted as standard and appropriate within many traditional therapeutic communities, within many hospital-based programs, and within chemical dependency outpatient programs that also rely heavily on confrontational groups. And many individual therapists, reacting in part to the history of failure on the part of more traditional psychoanalytically informed treatment providers in working with these clients, began to use the chemical dependency confrontational style in their one-on-one work, hoping to get better results. They adopted the point of view that addicted clients require a "tough-love," hard-line, and highly directive approach in order to achieve abstinence and be otherwise helped in the treatment process. In fact it may be said that much of the field of chemical dependency treatment has absorbed this basic approach at least to some extent. And the belief that drug-addicted people need harsh confrontations in order to recover has permeated the self-help components of treatment, including Alcoholics Anonymous and other organizations. Recovering clients often describe the "tough" approaches of their sponsors and fellow 12-Step members.

The results of this study call into question this widespread treatment assumption. Drug-addicted clients are described in this study as a fragile and vulnerable population. They appear to be highly prone to guilt and shame, excessively burdened by irrational feelings of responsibility and fears of harming others, as well as often being deeply depressed. Many of these clients may need treatments specifically designed to alleviate the effects of a heightened tendency to shame and maladaptive guilt instead of confrontational therapeutic strategies. According to O'Connor and Weiss (1993), drug-addicted clients suffer from maladaptive guilt and shame as the direct result of pathogenic beliefs derived from disturbing experiences with their parents, siblings, and other care-givers in childhood. These beliefs specifically warn a person that if they attempt to pursue normal developmental goals they may bring harm to a loved one. Drug-addicted clients often enter treatment with the belief that abstaining from drugs may harm someone they love, family members, or friends (Leib & Young 1994; O'Connor & Weiss 1993). The results of this study support the view that drug-addicted clients are suffering from pathogenic beliefs that lead to an excessive and inhibiting fear of harming others. It is suggested that treatment that addresses and attempts to modify the pathogenic beliefs that give rise to this irrational guilt and sense of responsibility may be far more helpful than is treatment focused on confrontation of externalization, denial, and the appearance of irresponsibility. The tendency to externalize blame and avoid some types of responsibility that treatment specialists observe and believe calls for confrontation, may in fact be a defense against feelings of shame and guilt. Treatment that relieves these unpleasant self-conscious emotional states may prove to be a more effective method of helping addicted clients achieve abstinence and a more successful, responsible, and productive lifestyle.

REFERENCES

Baumeister, R.F.; Stillwell, A.M. & Heatherton, T.F. 1994. Guilt, an interpersonal approach. *Psychological Bulletin* 115 (2): 243–67.

Beck, A.T. 1972. Measuring depression: The Depression Inventory. In: T.A. Williams, M.M. Katz & J.A. Shields (Eds.) *Recent Advances in the Psychobiology of the Depressive Illnesses*. Washington, D.C.: U.S. GPO.

Bell, C. & Khantzian, E.J. 1991. Contemporary psychodynamic perspectives and the disease concept of addiction: Complementary or competing models? *Psychiatric Annals* 21 (5): 273–81.

Benedict, R. 1946. *The Chrysanthemum and the Sword: Patterns of Japanese Culture*. Boston: Houghton Mifflin.

Blatt, S.J.; Rounsaville, B.; Eyre, S.L. & Wilbur, C. 1984. The psychodynamics of opiate addiction. *Journal of Nervous and Mental Disease* 172:343–52.

Blume, S.B. 1990a. Alcohol and drug problems in women: Old attitudes, new knowledge. In: H.B. Milkman & L.I. Sederer (Eds.) *Treatment Choices for Alcoholism and Substance Abuse*. Lexington, Massachusetts: Lexington Books.

Blume, S.B. 1990b. Chemical dependency in women: Important issues. *American Journal of Drug and Alcohol Abuse* 16:297–307.
Brown, H.M. 1991. Shame and relapse issues with a chemically dependent client. *Alcoholism Treatment Quarterly* 8:77–82.
Bush, M. 1989. The role of unconscious guilt in psychopathology and psychotherapy. *Bulletin of the Menninger Clinic* 53 (2): 97–107.
Cook, D.R. 1987. Measuring shame: The internalized shame scale. *Alcoholism Treatment Quarterly* 4:197–215.
Corman, A.G. & Khantzian, E.J. 1976. Psychiatric care of a methadone patient. *Psychiatric Annals* 6 (4): 158–64.
Dackis, C.A.; Gold, M.S.; Pottash, A.L.C. & Sweeney, D.R. 1986. Evaluating depression in alcoholics. *Psychiatry Research* 17:105–9.
Dodes, L.M. 1990. Addiction, helplessness and narcissistic rage. *Psychoanalytic Quarterly* 59 (3): 398–419.
Flanigan, B.J. 1987. Shame. *Alcoholism Treatment Quarterly* 4:190–94.
Fox, R. 1967. Alcoholism and reliance upon drugs as depressive equivalents. *American Journal of Psychotherapy* 21:585–96.
Freud, S. 1896 [1953]. Further remarks on the defense of neuro–psychosis. In: J. Strachey (Ed. and Trans.) *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. Vol. 3. London: Hogarth Press.
Friedman, M. 1985. Toward a reconceptualization of guilt. *Contemporary Psychoanalysis* 21 (4): 501–47.
Handelsman, L.; Aronson, M.J.; Ness, R. & Cochrane, K.J. 1992. The dysphoria of heroin addiction. *American Journal of Drug and Alcohol Abuse* 18:275–87.
Harder, D.W.; Cutler, L. & Rockart, L. 1992. Assessment of shame and guilt and their relationships to psychopathology. *Journal of Personality Assessment* 59 (3): 584–604.
Hesselbrock, M.N.; Meyer, R.E. & Keener, J.J. 1985. Psychopathology in hospitalized alcoholics. *Archives of General Psychiatry* 42 (11): 1050–55.
Jacobsen, L.K. & Kosten, T.R. 1989. Naloxone challenge as a biological predictor of treatment outcome in opiate addicts. *American Journal of Drug and Alcohol Abuse* 15:355–66.
Johnson, E.M. 1986. Women's health: Issues in mental health, alcoholism and substance abuse. Substance abuse and women's health. *Public Health Reports* Suppl. July–August.
Jones, W.H. & Burdette, M.P. 1994. Betrayal in close relationships. In: A.L. Weber & J. Harvey (Eds.) *Perspectives on Close Relationships*. New York: Allyn & Bacon.
Jones, W.H. & Kugler, K. 1993. Interpersonal correlates of the Guilt Inventory. *Journal of Personality Assessment* 61 (2): 246–58.
Jones, W.H.; Kugler, K. & Adams, P. 1995. You always hurt the one you love: Guilt and transgression against relationship partners. In: K. Fischer & J.P. Tangney (Eds.) *Shame, Guilt, Embarrassment and Pride: Empirical Studies of Self–Conscious Emotions*. New York: Guilford.
Katrichak, M. 1995. The relationship between childhood trauma, guilt, shame and the experience of urban violence: Study of Oakland residents. Unpublished paper, The Wright Institute, Berkeley, California.
Khantzian, E.J. 1994. Some treatment implications of the ego and self disturbances in alcoholism. In: J.D. Levin & R.H. Weiss (Eds.) *The Dynamics and Treatment of Alcoholism: Essential Papers*. Northvale, New Jersey: Jason Aronson.
Khantzian, E.J. 1985. The self–medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. *American Journal of Psychiatry* 142 (11): 1259–264.
Khantzian, E.J. 1980. The alcoholic patient: An overview and perspective. *American Journal of Psychotherapy* 34 (1): 4–19.
Kohut, H. 1971. *The Analysis of the Self*. New York: International Universities Press.
Krystal, H. 1982. Character disorders: Characterological specificity and the alcoholic. In: E.M. Pattison & E. Kaufman (Eds.) *Encyclopedic Handbook of Alcoholism*. New York: Gardner.
Kugler, K. & Jones, W.H. 1992. On conceptualizing and assessing guilt. *Journal of Personality & Social Psychology* 62 (2): 318–27.
Kurtz, E. 1988. Shame in the '80's. *Alcoholism Treatment Quarterly* 3:1–7.
Lewis, M. 1992. *Shame: The Exposed Self*. New York: The Free Press.
Lewis, H.B. 1987. Shame—the "sleeper" in psychopathology. In: H.B. Lewis (Ed.) *The Role of Shame in Symptom Formation*. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
Lewis, H.B. 1971. *Shame and Guilt in Neurosis*. New York: International Universities Press.
Lieb, R.J. & Young, N.P. 1994. A case-specific approach to the treatment of alcoholism: The application of control mastery theory to Alcoholics Anonymous and professional practice. *Journal of Substance Abuse Treatment* 11:35–44.
Mack, J.E. 1981. Alcoholism, AA and the governance of self. In: M.H. Bean, E.J. Khantzian, J.E. Mack, G. Vaillant & N.E. Zinberg (Eds.) *Dynamic Approaches to the Understanding and Treatment of Alcoholism*. New York: The Free Press.
Mason, M. 1991. Women and shame: Kin and culture. In: C. Bepko (Ed.) *Feminism and Addiction*. New York: Haworth.
McLachlan, J. 1976. A short adjective check list for the evaluation of anxiety and depression. *Journal of Clinical Psychology* 32 (1): 195–97.
Menaker, A.R. 1995. The relationship between attributional style and interpersonal guilt. Ph.D. diss., California School of Professional Psychology, Alameda, California.
Millard, T.L. 1991. Combating drug abuse in the workplace: Effective intervention strategies and techniques. *Employee Assistance Quarterly* 7 (1): 45–56.
Modell, A.H. 1971. The origin of certain forms of pre-oedipal guilt and the implications for a psychoanalytic theory of affects. *International Journal of Psychoanalysis* 52:337–46.
Modell, A.H. 1965. On having the right to a life: An aspect of the superego's development. *International Journal of Psychoanalysis* 46:323–31.
Morrison, A.P. 1994. The breadth and boundaries of a self-psychological immersion in shame: A one-and-a-half-person perspective. *Psychoanalytic Dialogues* 4 (1): 19–35.
Morrison, A.P. 1989. *Shame: The Underside of Narcissism*. Hillsdale, New Jersey: Analytic Press.
Morrison, A.P. 1983. Shame, ideal self and narcissism. *Contemporary Psychoanalysis* 19 (2): 295–318.
Morrison, A.; O'Connor, L.; Bremond, D. & Weiner, W. In press. Women in psychology: Changing drug treatment. In: *Raising the Glass Ceiling: The Changing Role of Women in Psychology*. Papers from the 1991 Meetings, National Council of Schools of Professional Psychology, American Psychological Association. Washington, D.C.: American Psychological Association.
Nathanson, D.L. 1992. *Shame and Pride: Affect, Sex and the Birth of the Self*. New York: Norton.
Nathanson, D.L. 1987a. The shame/pride axis. In: H.B. Lewis (Ed.) *The Role of Shame in Symptom Formation*. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
Nathanson, D.L. 1987b. A timetable for shame. In: D.L. Nathanson (Ed.) *The Many Faces of Shame*. New York: Guilford.
Niederland, W.G. 1981. The survivor syndrome: Further observations and dimensions. *Journal of the American Psychoanalytic Association* 29 (2): 413–25.
Niederland, W.G. 1968. Clinical observations on the "survivor syndrome." *International Journal of Psychoanalysis* 49:313–15.
O'Connor, L.E. 1995. Survivor guilt and depression: Empirical studies. Paper presented at a meeting of Division 39 of the American Psychological Association, Los Angeles.
O'Connor, L.E. 1994. Shame and guilt. *San Francisco Psychotherapy Research Group Process Notes* 1 (1): 12–15.
O'Connor, L.E. 1993. Control Mastery theory and treatment of the addict. *California Psychologist* 25 (6): 24–29.
O'Connor, L.E.; Berry, J.W.; Weiss, J.; Inaba, D. & Morrison, A. 1994. Shame, guilt and depression in men and women in recovery from addiction. *Journal of Substance Abuse Treatment* 2 (6): 503–10.
O'Connor, L.E.; Berry, J.W.; Morrison, A. & Brown, S. 1992. Retrospective report of psychiatric symptoms before, during, and after drug use in a recovering population. *Journal of Psychoactive Drugs* 25 (4): 65–68.
O'Connor, L.E.; Berry, J.W. & Weiss, J. 1995. Interpersonal guilt and psychopathology. Unpublished paper.
O'Connor, L.E.; Berry, J.W.; Weiss, J.; Bush, M. & Sampson, H. In press. Interpersonal guilt: The development of a new measure. *Journal of Clinical Psychology*.
O'Connor, L.E. & Weiss, J. 1993. Individual psychotherapy for addicted clients: An application of Control Mastery theory. *Journal of Psychoactive Drugs* 25 (4): 283–91.

Peterson, C. & Seligman, M.E. 1984. Causal explanations as a risk factor for depression: Theory and evidence. *Psychological Review* 91 (3): 347–74.

Potter–Efron, R.T. 1988. Shame and guilt: Definitions, processes and treatment issues with AODA clients. *Alcoholism Treatment Quarterly* 4:7–23.

Reed, B.G. 1987. Developing women-sensitive drug dependence treatment services: Why so difficult? *Journal of Psychoactive Drugs* 19 (2): 151–64.

Robbins, T.R. 1974. Depression and drug addiction. *Psychiatric Quarterly* 48:374–86.

Sampson, H. 1983. Pathogenic beliefs and unconscious guilt in the therapeutic process: Clinical observations and research evidence. Bulletin #6. The Psychotherapy Research Group, Department of Psychiatry, Mount Zion Hospital and Medical Center, San Francisco.

Shafiq, M. 1987. Self-perceptions of heroin addicts and nonaddicts. *Pakistan Journal of Psychological Research* 2 (3–4): 38–49.

Sheppard, M.A. & Mitchell, M. 1986. Young people's view of alcohol and its use. *Journal of Alcohol & Drug Education* 31 (2): 1–7.

Tangney, J.P. 1990. Assessing individual differences in proneness to shame and guilt: Development of the self-conscious affect and attribution inventory. *Journal of Personality and Social Psychology* 59 (1): 102–11.

Tangney, J.P.; Burggraf, S.A. & Wagner, P.E. 1995. Shame-proneness, guilt-proneness and psychological problems. In: J.P. Tangney & K.W. Fischer (Eds.) *Self Conscious Emotions: The Psychology of Shame, Guilt, Embarrassment and Pride*. New York: Guilford.

Tangney, J.P.; Wagner, P.E. & Gramzow, R. 1992. Proneness to shame, proneness to guilt, and psychopathology. *Journal of Abnormal Psychology* 101 (3): 469–78.

Tarighati, S.H. 1980. An exploratory study on depression in Iranian addicts. *International Journal of Social Psychiatry* 26:196–99.

Tuite, D.R., & Luiten, J.W. 1986. 16PF research into addiction: Meta-analysis and extension. *International Journal of the Addictions* 21 (3): 287–323.

Vinney, L.L.; Westbrook, M.T. & Preston, C. 1985. Sources of anxiety in drug addiction. *Journal of Clinical Psychology* 41:124–29.

Ward, R.M. 1983. An investigation of irrational belief and its implications on trait guilt: A study of male and female opiate addicts. *Dissertation Abstracts International* 44:332B.

Washton, A.M. 1988. Preventing relapse to cocaine. APT Foundation North American Conference: Cocaine abuse and its treatment (1987, Washington, D.C.). *Journal of Clinical Psychiatry* 49 (Suppl.): 34–38.

Weiss, J. 1993. *How Psychotherapy Works: Process and Technique*. New York: Guilford.

Weiss, J. 1986. Unconscious guilt. In: J. Weiss & H. Sampson (Eds.) *The Psychoanalytic Process: Theory, Clinical Observation and Empirical Research*. New York: Guilford.

Weiss, J. 1983. Notes on unconscious guilt, pathogenic beliefs and the treatment process. Bulletin #6. The Psychotherapy Research Group, Department of Psychiatry, Mount Zion Hospital and Medical Center, San Francisco.

Woodruff, R.A.; Guze, S.B.; Clayton, P. & Carr, D. 1973. Alcoholism and depression. *Archives of General Psychiatry* 28:97–100.

Woody, G.E.; O'Brien, C.P. & Rickles, K. 1975. Depression and anxiety in heroin addicts: A placebo-controlled study of doxepin in combination with methadone. *American Journal of Psychiatry* 132 (4): 447–50.

Zahn-Waxler, C. & Kochanska, G. 1990. The origins of guilt. In: R. Thomson (Ed.) *36th Annual Nebraska Symposium on Motivation: Socio-emotional Development*. Lincoln: University of Nebraska Press.

Zimberg, S. 1982. Psychotherapy in the treatment of addiction. In: E.M. Pattison & E. Kaufman (Eds.) *Encyclopedic Handbook of Alcoholism*. New York: Gardner.