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Exploration of shame and disclosure in chronic drug dependence

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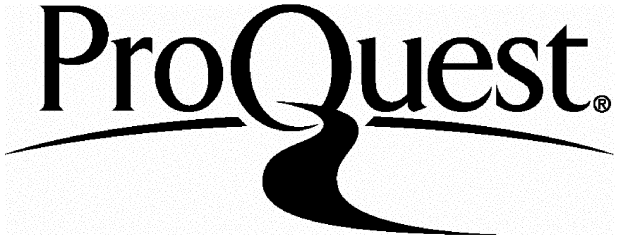

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ABSTRACT

This thesis explores levels of shame in 31 chronic poly-drug users, in an out-patient methadone prescription program, compared to 31 non-drug users closely matched on gender, ethnicity, and socio-economic and employment status. In addition to this, this thesis looks at the relationship between shame and disclosure. All participants completed the Experience of Shame Scale (ESS; Andrews et al., 2002) as well as standard measures of depression, aggression and dissociation. Chronic drug users scored significantly higher on levels of characterological and behavioural shame, but not on bodily shame. However, when controlling for levels of depression, only the group difference on characterological shame remained. Within the chronic drug user group, the level of shame about drug use was significantly higher than characterological, behavioural and bodily shame. Thirty-two percent of the chronic drug users were identified as non-disclosers. Non-disclosure was associated with increased levels of depression and shame on all three standard shame sub-scales on the ESS, but not with shame about drug use. This study replicates previous findings, based on shame measures more susceptible to mood-state effects, that drug dependence is associated with increased shame. It extends the existing literature in terms of suggesting possible sources of shame particular to drug dependence and their relationship to non-disclosure. Implications for treatment and future research are discussed.

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CHAPTER 1

Introduction

Over recent years attention has been drawn to the possible influence of shame in the aetiology, maintenance and treatment of various psychopathologies. Several studies have found associations between feelings of shame and depression, eating disorders, post-traumatic stress disorder and substance abuse. However, the meaning of these associations has been called into question by some writers. For example, it has been suggested that some of the measures used to assess shame in these studies failed to tap into the concept of shame, and instead measured general negativity (Andrews, 1998a) or low self-esteem (Tangney, 1996), which of course is likely to be associated with mental health problems.

This thesis aims to explore the link between different types of shame and chronic drug use using the recently developed Experience of Shame Scale (Andrews, Qian & Valentine, 2002), which is based upon Andrews's tripartite conceptualisation of shame (e.g. Andrews, 1998a). A further aim is to look at the influence of shame on disclosure in treatment.

The first part of this chapter looks at the concept of shame, what it is, the functional and dysfunctional roles of shame and how shame-proneness develops. The concept of shame has been defined in many ways and has been controversial, not least, because of the overlap with other related emotions (such as guilt, embarrassment, humiliation and low self-esteem) and the myriad of theoretical perspectives used in the area. A review of research linking shame with various psychopathologies, including substance abuse, will then follow. A critique of measures of shame used in previous studies of substance abuse is presented before the rationale and the research questions addressed in the empirical study of this thesis.

1.1. Cognitive, affective and behavioural components of shame

Shame is generally recognised as a particularly intense and often incapacitating, negative emotion involving feelings of inferiority, powerlessness and self-consciousness, along with the desire to conceal deficiencies (Tangney, Miller, Flicker, & Barlow, 1996a). According to Michael Lewis (1995), shame is the product of a complex set of cognitive activities, which involve the evaluation of an individual or his or her actions in regard to the individual's standards, rules, and goals. He also argues that shame involves the global evaluation of the self as no good, whereas Andrews (1998a) suggests that an individual might be ashamed of parts of themselves only, such as their character, behaviour or body. According to Lewis' (1995) cognitive conceptualisation of shame, shame is not produced by any specific situation; rather it is produced by an individual's interpretation of a situation. Shame is classed as a self-conscious emotion and is often linked to an individuals concern about how they look in the eye of others. However, although shame is often public it is not necessarily related to the public or private nature of the situation (Tangney, 1996), and we can probably all think of private incidents when we have said to ourselves: "I am ashamed for having done that".

Gilbert (1998a) argues that theories of shame have tended to focus on this aspect too, but without clearly separating the domains. Shame has therefore been considered either in terms of the social world (beliefs about how others see the self), the internal world (how one sees oneself) or both (how one sees oneself as a consequence of how one thinks others see the self). Gilbert (1998a) suggests the terms *external shame* (how one is seen by others or how one lives in the eyes of others) and *internal shame* (how the self judges the self) to refer to this distinction. Some shame measures predominantly measure one or the other. For example, the Test of Self-Conscious Affect (TOSCA: Tangney, Wagner & Gramzow, 1989) and the Internalised Shame Scale (ISS, Cook, 1987) measure internal shame, whereas the Other As Shamer scale

(Goss, Gilbert & Allan, 1994) measures external shame. Although internal and external shame are often highly correlated, Gilbert suggests that this distinction is important, as it is related to the issue of the difference between "being shamed" and "feeling shamed". The controversy being whether a person, who is being shamed for something, can feel ashamed unless they themselves have a negative self-evaluation about the action or characteristic for which they are being shamed.

According to Gilbert (1998a), behaviours associated with shame can be divided into four categories. The first group are behaviours aroused during a shame "attack" - the hot response, such as the immediate "hide" reaction. The hide reaction, the wish to disappear or even die (Lewis, 1995), is probably one of the least controversial aspects of shame in that all theories consider this type of behaviour as fundamental to shame. It is also one of the elements that differentiate shame from the rather overlapping feeling of guilt, as it is argued that hiding to cope with one's fault is not part of the guilt experience (e.g. Tantam, 1998). The immediate experience of shame also includes non-verbal appeasement communications, such as hunched posture and eye gaze avoidance. Gilbert suggests that these behaviours, which are used by animals to signal surrender, may have a similar evolutionary protective function for humans (Gilbert, 1992, 1997), helping them to survive threatening situations. In addition to the hide reactions and appeasement behaviours, the painful state of shame is likely to lead to disruption of ongoing behaviour, confusion of thought and inability to speak (Lewis, 1971).

The second class of behaviours associated with shame are behaviours triggered to cope with, or conceal, shame as it occurs. This sort of behaviour might be called upon when an individual fears that the display of shame might signal to others that the shamed individual recognises they are in the wrong (Gilbert, 1998a). Anger and even aggression have been identified as substitutes for shame by many writers, based on clinical material (e.g. Nathanson, 1994) and several empirical studies have found

high correlations between shame and anger (Tangney, Wagner, Fletcher & Gramzow 1992a; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996b; review by Gilbert, 1998a).

Thirdly, there are behaviours instigated to avoid being shamed, sometimes referred to as safety behaviours. One way to avoid shame is by never putting oneself in situations where shame could arise and might involve avoiding help-seeking, social and competitive situations. Others might try to avoid being shamed, not by avoiding the actual situations that are likely to elicit shame, but by compensating for potential sources of inferiority. Traits such as perfectionism are thought to be linked to this type of shame coping (Nathanson, 1994). The aim of other behaviours might be to prevent the occurrence of shameful events from being discovered. Secrecy is one such behaviour, which might be employed in an attempt to avoid the occurrence of, for example, child sexual abuse from being known. Such secrecy might occur both at an individual and familial level, and some writers suggest that secrecy also occurs at a societal level stopping discussion of shameful issues, such as racism, from taking place (e.g. Lindisfarne, 1998).

The fourth and final group of behaviours associated with shame, suggested by Gilbert (1998a), are behaviours used to repair shame. However, not all writers agree with this idea as they suggest that guilt motivates a desire to repair, to confess, to apologise and make amends, whereas shame motivates a desire to hide - to sink into the floor and disappear (e.g. Zahn-Waxler & Robinson, 1995). Determining which coping styles are used is important as the choice of coping with shame significantly influences the manifestations and form of any psychopathology (Gilbert, 1998a).

1.2. Functional and dysfunctional roles of shame

From the above description of shame, one could easily come to the conclusion that it would be desirable to try to eradicate this painful feeling. However, the proneness to feel shame is considered an innate capacity (Gilbert & McQuire, 1998) and different intensities of this negative feeling appear to have important functional roles in human emotion. For example, shame has been considered to be valuable and not damaging, as long as it is temporary in duration and moderate in intensity, as it may help point people towards ways to feel better about themselves (Potter-Efron & Potter-Efron, 1999). The anticipation of shame may also act as a sensible voice of moderation and morality, stopping people from trying to fulfil their inappropriate or excessive drives, wants and needs. Seeing shame as an involuntary (primitive) defence, Gilbert, one of the main writers in the field, considers shame to have an evolutionary protective role (e.g. Gilbert, 1992). He thus suggests that even brief intense feelings of shame can be functional, such as when intense feelings of shame result in submissive and appeasing behaviour, which might help people to survive in abusive situations (e.g. Gilbert & McGuire, 1998). Brief periods of both moderate and high intensity of shame thus appear to be functional. This is in line with Tantam's (1998) idea that shame can be a transient emotion and that *state shame*, as he refers to it, is not indicative of any emotional disorders. In fact, Tantam argues quite the opposite, that the inability to experience state shame is often taken to be an indication of a person being particularly immoral or unfeeling, or maybe even psychopathic.

On the other hand, a sentiment to feel shame, *trait shame*, is what is thought to be associated with emotional disorders (Tantam, 1998). Excessive shame, in terms of intensity and frequency, sometimes also referred to as shame-proneness (Tangney, Wagner & Gramzow, 1992b) or toxic shame (Bradshaw, 1988), is thus what is thought to be dysfunctional. Indeed, shame proneness is associated with self-perceptions of being personally inferior and flawed (Tangney, Burggraf & Wagner,

1995), repetitive patterns of behaviour leading to maladaptive coping styles, such as desire to hide and escape (Tangney et al., 1995), increased isolation and suicidality (Potter-Efron & Potter-Efron, 1999), increased anger proneness in interpersonal situations (Tangney et al., 1992a) and destructive ways of dealing with anger (Tangney et al., 1996b).

As mentioned, proneness to feel shame is an innate capacity (Gilbert & McGuire, 1998). But how does it develop? Being one of the self-conscious emotions, shame is based on the appraisal of others' judgements of oneself, and it has therefore been argued that shame only develops after a child has started to acquire theory of mind at around the age of two (Tantam, 1998). This being the developmental step that leads to the child's first self-awareness, Tantam, informed by his understanding of psychoanalytic teaching, suggests that emotions regularly experienced at this time of life may be particularly likely to influence the development of beliefs about the self. These may, in turn, influence the readiness with which particular emotions are evoked in the future.

In line with this idea, other writers have suggested that excessive shame-proneness arises from internal, negative representations of the self, derived from previous experiences of "being shamed" (Lewis, 1987; Nathanson, 1994; Gilbert & Gerlsma, 1999). In terms of events that might be potentially shaming, child sexual abuse has received by far the most attention. For instance, shame has been found to be the mediating factor between child sexual abuse and later depression (Andrews, 1995; Andrews & Hunter, 1997). However, child sexual abuse is not the only predisposing factor for later shame-proneness. Being the child of a parent with alcoholism may also be shaming, independently of any risk of abuse (Hibbard, 1993), and recollections in adulthood of childhood experiences of shaming parents or siblings have been associated with current levels of shame (Gilbert & Gerlsma, 1999). Moreover, it has been suggested that shaming experiences in adulthood may lead to

chronic concealment with mental health consequences (Tantam, 1998). One such source of shame-inducing experiences could be failure in role expectations, such as experiencing reproduction difficulties or having mental health problems in the family. From this it can be seen that a propensity to feel shame might have developed due to a variety of causes. As mentioned, *trait shame* has been thought of as a factor in emotional disorders (Tantam, 1998) and studies, which have identified this link, will be reviewed shortly. However, before doing so it is important to note that the concept of shame should be treated with caution due to reasons which will be outlined in the section below.

1.3. Theories and perspectives used in the study of shame

In the preface to an edited volume on shame, Paul Gilbert and Bernice Andrews wrote (Gilbert & Andrews, 1998, preface, p. i):

> *"Shame has been recognised since antiquity. A strong theme of shame exists in the early stories of Adam and Eve. However, it has only been in the last 20 years or so that shame has been subject to systematic research and theory development..."*

However, they also noted that despite the accumulation of research, caution has to be exercised when looking at the various studies of shame not least because there is still little consensus about shame, what it is and how it works.

One of the reasons for the lack of consensus about what shame is, is probably due to the fact that the wide variety of theories on shame are rooted in such different schools of thought. Initially, most of the writing was driven by experiences in the clinical setting of psychoanalytic psychotherapists. According to several writers,

Freud himself (1909/1955, 1917/1957, 192/1961) had rather neglected shame in favour of guilt (e.g. Tangney et al., 1992b). Indeed, it was not until Helen Lewis in 1971, with her landmark book 'Shame and guilt in neurosis', that particularly attention was called upon the importance of feelings of shame. In recent years there has been an enormous flood of books and articles, and theories have been based on a variety of psychoanalytic theories, such as Jungian (Jacoby, 1994) and Kohutian self-psychology (Morrison, 1987; Wurmser, 1987) (as cited in Gilbert, 1998a). Driven by less clinically oriented theorists an alternative characterisation of shame was set forth based on Tomkins' affect theory (1987), of which Nathanson was a particular proponent (e.g. Nathanson, 1994). Recently, theories of shame have been based on affect-cognitive (e.g. Lewis, 1995), cognitive behavioural (e.g. Beck, Emery & Greenberg, 1985) and evolutionary (e.g. Gilbert, 1992) theories. In addition to the different schools of thought underlying the different 'psychological' shame theories, shame has also been studied from sociological (Cohen, Vandello & Rantilla, 1998) and anthropological (e.g. Lindisfarne, 1998) perspectives. Within these theories, shame has been considered as an emotion, a cognition, a behaviour, an evolving mechanism and as an interpersonal dynamic interrelationship. All of this highlights that there are a lot of facets of the 'emotion' of shame to consider and study.

Another major definitional issue to consider, with which a whole section of the field of shame has been preoccupied, is the long-standing debate about the differences between, and the extent to which it is possible to differentiate, shame and the related emotions of guilt, embarrassment, humiliation and low self-esteem. Please see table 1 below, taken from Tantam (1998), for an outline of some of these differences.

According to this table, the self-conscious emotions of guilt, depression, embarrassment and humiliation are compared to three elements of the shame situations: (i) The perception that others find fault with self, (ii) perception of self as at fault and (iii) hiding to cope with fault. From this table, it can be seen that Tantam

considers that guilt and shame are alike, apart from guilt not being associated with hiding. Depression, like shame, does involve hiding and perceptions of self as being at fault, but not perceptions that others find fault with the person. Embarrassment, on the other hand, is seen as the impulse to hide and conceal, without the justified self-blame associated with shame. Finally, in humiliation people perceive others to find fault with them, which they themselves do not perceive, and these faults are associated with hiding.

Table 1: The family of self-conscious emotions and their relation to the three responses to shame

Self-conscious emotion	Perceptions that others find fault with self	Perceptions of self as at fault	Hiding to cope with fault
Shame	+	+	+
Guilt	+	+	
Depression		+	+
Embarrassment			+
Humiliation	+		+

A plus sign indicates the emotion is present (Tantam, 1998).

However, for a further review on this, see the book edited by Tangney and Fisher (1995), 'Self-Conscious Emotions: The Psychology of Shame, Guilt, Embarrassment, and Pride', which focus on this debate).

All of this indicates that shame is a rather complex, elusive concept and suggests that the study of shame is not straightforward. Firstly, shame consists of affective, cognitive and behavioural aspects together with inter- and intra- personal

components. Added to this, there are numerous different theoretical and methodological perspectives from which it can be explored and there is the problem of distinguishing shame from other related emotions. Bearing this in mind, I shall now review some of the studies of shame in relation to psychopathology.

1.4. Shame and psychopathology

As mentioned, the earliest writings on the role of shame in psychopathology sprang from clinical observations by psychoanalytic psychotherapists. However, interest in shame was slow to get going and as late as 1987, Helen Lewis, a psychoanalyst and one of the pioneers in the field, wrote of shame as the "hidden emotion" and the "sleeper of psychopathology", as at the time there was a lack of both research and clinical interest in the topic of shame (Lewis, 1987). Since then there has been an increasing clinical and academic interest in shame and its role in the aetiology, maintenance and treatment of various psychopathologies both inside and outside of psychoanalytic schools of thought. Moreover, with the introduction of the first shame questionnaires the earlier clinical assertions of the importance of shame appear to be confirmed, as several studies in the 1990's identified associations between shame and various psychopathologies.

For example, in student samples shame-proneness has been associated with symptoms of depression (e.g. Allen, Gilbert & Goss, 1994; Tangney et al., 1992b), anxiety (Tangney et al., 1992b) and social anxiety (Gilbert, 1998b). Shame about the body has also been identified as a mediating factor between early experiences of sexual and physical abuse and depressive symptoms in a community sample (Andrews, 1995; 1997) and shame has been associated with chronic or recurrent depression in a clinical sample (Andrews & Hunter, 1997). Shame proneness has also been related to dispositions to feel certain types of emotions, e.g. anger, anxiety

and/or disgust (Gilbert, 1998a; Tangney et al., 1995), increased anger proneness in interpersonal situations (Tangney et al., 1992a) and destructive ways of coping with anger (Tangney et al., 1996b). Shame and anger have also been found to be predictive of post-traumatic stress disorder symptoms at one month post-crime, and shame, not anger, was the only independent predictor of symptomatology at six moths post-crime (Andrews, Brewin, Rose & Kirk, 2000). An association between shame proneness and various eating disorders was found in a student sample (Sanfter, Barlow, Marschall & Tangney, 1995). Shame about the body was identified as predictive of disordered eating and bulimia in a community sample (Andrews, 1997) and was associated with eating disorders in a clinical sample together with shame about eating and shame about one's character (Swan & Andrews, in press). According to a review by Gilbert and Gerlsma (1999), shame has also been associated with social anxiety (Gilbert, 1998b), suicide and personality disorders, especially narcissism (e.g. Mollon, 1984; Nathanson, 1994). However, it was unclear whether the shame referred to here was proneness to feel shame. These studies appear to confirm that shame is a factor in numerous psychopathologies as suggested by much clinical literature. Though the limitations of some of these earlier studies into shame, which will be reviewed shortly, calls this somewhat into questions. Before going into the specifics of shame in relation to psychopathology of chemical substance dependence, I shall briefly introduce the field of drug dependence.

1.5. Drug dependence

The term dependence was formally introduced as an alternative to 'addiction' by the World Health Organisation (WHO) in 1964, in an attempt to differentiate between physical and psychological components of dependence. However, these two components tend to be inextricably linked in such a way that it is difficult to

maintain the distinction between them (Gossop, 1994). The term addiction is thus still widely used and according to a recent editorial on theories of addiction, addiction may now be construed in terms of biological, social or psychological processes, or some combination of these (West, 2001). Addiction and dependence thus now appear to be used interchangeably. Addiction is currently defined as a behaviour over which an individual has impaired control with harmful consequences (e.g. West, 2001). That is, individuals whilst recognising that the behaviour is harming them, or those whom they care about, find themselves unable to stop engaging in the behaviour when they try to do so (Heather, 1998). Due to the negative connotation of the words 'addicts' and 'junkies', which seem closely associated with the term addiction, I have chosen to use the term dependence, rather than addiction, in this thesis. Unless otherwise specified, I will generally be referring to dependence on substances, such as drugs or alcohol, though it should be noted that dependence on behaviours not involving substances, such as gambling, also exist.

The severity of the medical, psychological and social harm that can be caused by substance dependence, together with the fact that it violates the individual's freedom of choice, means that it is appropriate to consider dependence a psychiatric disorder in its own right (West, 2001). In addition to this, the reported prevalence of mental health problems in substance abuse is high, especially for mood and anxiety disorders (e.g. Gossop, 1994). For example, prevalence rates of mood disorders in cocaine abusers of approximately 40-50% have been reported in a series of studies with relatively small samples (see review by Kush & Sowers, 1996). However, it should be borne in mind that the prevalence of depression is difficult to estimate, as diagnosis of depression is complicated due to the symptom overlap between the syndrome of depression and that of substance abuse/dependence. More specifically, symptoms, such as impairment in cognitive functioning, sleep disturbance, fatigue/loss of energy, appetite disturbance, changes in sexual functioning and psychomotor agitation, are often associated with substance abuse and withdrawal,

independent of depression (Buckley et al., 2001). Many theorists have also associated drug dependence with an inability to regulate anger (e.g. Meehan, O'Connor, Berry, Weiss, Morrison, & Acampara, 1996). This led to debates about whether drug dependence produces secondary anxiety and dysthymic syndromes in otherwise psychologically healthy individuals, or whether drug misuse is an attempt by people to self-medicate pre-existing psychopathology. This issue has evident implications for studies into shame in drug dependence as it makes it difficult to ascertain whether any associations identified are the result of drug dependence or some other underlying psychopathology. The occurrence of psychiatric comorbidity clearly also means that psychological and psychiatric interventions are often part of the treatments offered to people struggling with dependence.

As mentioned, drug dependence is associated not just with physical dependence on the drug, but also with medical problems, primary and secondary psychological problems and social problems. Treatment is therefore tailored to the individual's needs and is often multidisciplinary. However, as people with dependence problems have been found to be at different stages of readiness for change: Pre-contemplative, contemplative, action, maintenance or relapse (Prochaska & DiClemente, 1983), the individual client's needs have to be considered in light of this, and treatment plans tailored accordingly. For instance, drug users in the *pre-contemplative stage* will rarely be in contact with services, because they do not consider themselves to have a problem. Drug users at the *contemplative stage,* are not yet sure if they want to give up drugs, and might therefore be offered medical assistance and access to clean needles in conjunction with motivational interviewing sessions (Miller & Rollnick, 1991) to help them come to a decision. At this stage drug users, who are dependent on opiates, will also be offered a methadone maintenance programme in order to stabilise their drug use while they contemplate the future of their drug use. Whereas

drug users in the *active stage* of change will be offered detoxification programmes, some of which might be carried out in the community or in in-patient facilities. Thus, it is at this stage that drug users dependent on opiates are likely be offered a methadone detoxification programme. Medical, key-work and relapse prevention interventions are generally essential components of any detoxification programme. However, a whole range of other treatments are also available to drug users at the active stage, such as Narcotics Anonymous, group therapy and various types of individual psychotherapy, including Cognitive Behavioural Therapy and Motivational Interviewing. People in the *maintenance stage*, who are clean of substances, might be offered a range of psychological interventions, including Relapse Prevention (Wanigaratne, Wallace, Pullin, Keaney, & Farmer, 1990), to consolidate gains attained during the active stage. Finally the stage of *relapse* has to be considered because relapse is very common in people with dependence problems. Interventions here are aimed at assisting the client in getting back into the cycle of change.

There is thus much heterogeneity and varying sub-populations within drug dependent people. This is to be expected given that (i) dependence consists of several components, (ii) drug dependence is often to several different substances (poly-drug use), (iii) psychiatric comorbidity is high and (iv) drug users may be at different stages of change. Any findings on the relationship between shame and dependence therefore have to be considered within this broader context.

The present study involved chronic drug users who were attending a methadone maintenance treatment (MMT) program. Methadone is used primarily in the

treatment of heroine dependence and involves substituting heroine with this orally administered, longer acting opiate, which means that the drug users in this study were addicted to opiate. However, like many chronic drug using populations, the participants in the present study were generally poly-drug users, co-dependent on other substances, such as alcohol. Methadone maintenance has been extensively used in the treatment of opiate dependence for many years, especially since the advent of HIV and AIDS (Gossop, 1994), though evidence is inconsistent as to whether retention in MMT reduces the likelihood of becoming infected with the virus. The prevalence of HIV and AIDS also lead to a shift from abstinence-orientated programs to harm-reduction. Thus facilitating a move from an outright 'do not use drugs' approach, to treatments that focus on achievable goals, which vary along a continuum of harm-reduction behaviours. For example, one such continuum could be from use bleach to clean shared needles, do not share needles, always use sterile equipment, do not inject drugs, to do not use heroine at all. In conjunction with allied psychosocial approaches, MMT is the first line in treatment aimed at harm reduction if not eventual abstinence.

As part of the MMT programme, all the participants in the current study received a daily dose of methadone in order to stabilise their drug use with the view to decreasing the need for additional drugs bought on the street. Thus, it is likely that some of the drug users who took part in the study were at the beginning of the contemplative stage of change, not yet sure if they wanted to give up drugs. Whereas others might have been at the end of the pre-contemplative stage of change, with the hope that after an initial period of stabilisation they might move on to a methadone detoxification programme with the aim of total abstinence. An essential part of the

MMT treatment package is thus to assist the drug users in their move through the stages of change, and all the participants in the current study therefore attended compulsory weekly key-working sessions.

1.6. Shame and substance abuse

Several writers have suggested connections between shame and substance misuse, including Blatt and colleagues (Blatt, Rousaville, Eyre, & Wilber, 1984a; Blatt, Macdonald, Sugarman, & Wilber, 1984b), Weiss (O'Connor & Weiss, 1993), Potter-Efron (1987), Nielsen (1987), Bradshaw (1988) and Brown (1991). According to Potter-Efron and Efron's review (1993), most of these authors have focused on explaining the relationship between shame and substance misuse in the context of general theories. That is, they have applied existing theories of shame to the field of substance dependence. There are three main groups of theories that have been applied to this field, namely self-psychology, affect theory and family/systems theories.

Both self-psychology and affect theories have their origins in psychoanalytic writings. According to writings on self-psychology, addiction is classified under the category of narcissistic behavioural disorders (Nathanson, 1994). People with such personalities attempt to shore up their crumbling self-esteem through perverse, delinquent or addictive behaviours, and shame is seen as one of the components which lead to this low self-esteem as it represents the self's condemnation of the self. Within affect theories, shame is seen as regulating an individual's needs and drives, and substance misuse functions primarily to help the individual flee from any strong negative affect, including, but not limited to, shame. Within this school of thought an addiction is seen to begin with a "sedative script", a pattern of rules and roles

organised around the principle of reducing negative affect, and the addiction becomes established when the individual starts to dread the absence of the sedative effect (e.g. Tomkins, 1987). Family therapists place shame within the larger context of systems and see the use of addictive substance as an attempt to modify the effect of shame-generating systems (Nielsen 1987; Potter-Efron, 1987; Evans, 1987). However, until recently these theory-driven ideas were based mainly on anecdotal clinical accounts, and had only received confirmation from a few case studies and one or two qualitative studies.

For example, Vinney and colleagues found shame to be the chief component of the pattern of anxiety that differentiated opiate dependent from non-opiate dependent subjects in their qualitative study (Vinney, Westbrook, & Preston, 1985). The theme of shame was also identified in the narratives of 26 male survivors of child sexual abuse of whom a majority were substance abusers (Lisak, 1994). In fact, this qualitative study of narratives appears to be one of the few studies linking past events with present experiences of shame within drug dependence literature. Based on case studies, shame has been identified as an issue in the relapse of alcoholics (Brown, 1991) and as a contributing factor in failure to seek help (Potter-Efron, 1987).

Blatt and colleagues (1984a) were among the first researchers to use quantitative methods in the area of dependence. Using the Depressive Experiences Questionnaire (Blatt, D'Afflitti & Quinlan; Blatt & Shich, 1982; as cited in Blatt et al., 1984a) they noted that the pattern of depression in substance dependent subjects centred, not on issues of abandonment or rejection, but on self-criticism, guilt and shame. Cook, one of the main pioneers in the area of shame and substance misuse, constructed one of the first shame self-report measures, the 39-item Internalised Shame Scale (Cook, 1987). Each item of this scale has to be rated according to the frequency of its occurrence (from 0-never to 4-almost always).

To illustrate, the first three items of the ISS are as follows:

1. I feel like I am never quite good enough
2. I feel somewhat left out
3. I think that people look down on me

Using this scale, Cook found that students who reported alcohol abuse had significantly higher scores on the ISS (Cook, 1987). Using the ISS, Hawkins (1997) found that adult offspring of alcoholics in both a clinical and student population scored significantly higher on internalised shame, depression and traits of a shame-based 'Adult Children of Alcoholism Syndrome' (Black, 1981; as cited in Hawkins, 1997).

However, the relationship between drug dependence and shame as measured by the ISS has to date only been reported in a number of unpublished theses rather than in published articles. From one such abstract it appears that a strong relationship between shame, PTSD and methadone dose level was found using the ISS (Paddy, 1999). Paddy also found a strong correlation between child sexual abuse, age of first drug use, shame and PTSD levels. Though, it should be noted that in another unpublished thesis of 53 women recovering from alcoholism (AA-members) no relationship between child sexual abuse and internalised shame was found (Wieschelt, 2000). In another study, a correlation between parental rejection and increased levels of shame, and between high levels of shame and high levels of chemical dependence was found (Patton, 1993). Unfortunately, Patton did not state the measures used to assess levels of shame and chemical dependence in the abstract of this unpublished thesis, and the thesis itself was not obtained.

More recently a number of studies in substance dependence have utilised the widely-used shame measure, the Test of Self Conscious Affect (TOSCA; Tangney et al.,

1989). This self-report measure is constructed in the form of 15 short scenarios to which respondents have to rate a number of responses as to the likelihood of each of them (from 1- not very likely to 5-very likely). Each of the responses is designed to assess proneness of shame, guilt, detachment and externalisation. Below is an example of one of the scenarios followed by the four responses to be rated:

1. You make plans to meet a friend for lunch. At 5 o'clock you realise you stood him up
    a) You would think: 'I'm inconsiderate'
    b) You would think: 'Well, they'll understand'
    c) You would try to make it up to him as soon as possible
    d) You would think: 'My boss distracted me just before lunch'

Using the TOSCA in two studies with just over 100 participants in each, O'Connor and colleagues found that recovering drug users scored higher on shame as compared to the norms available for the TOSCA (O'Connor, Berry, Inaba, Weiss & Morrison 1994; Meehan et al., 1996). Women were found to have higher levels of shame and depression than men in the first of these studies (O'Connor et al., 1994). However, in the second study by O'Connor and colleagues no gender difference was found (Meehan et al., 1996). Consistent with the findings of O'Connor et al.'s study (1994), the findings outlined in the abstract of an unpublished thesis using the TOSCA suggest that women scored higher on shame than men (Lynch, 1994). From this abstract it also appears that the 54 participants had elevated levels of shame when they entered long-term residential treatment for substance misuse as compared to the norms for the TOSCA.

In summary, clinical observations and qualitative studies suggest that shame is an important factor to consider when dealing with chemical substance misuse. Studies using self-report measures appear to give credence to this idea, as increased levels of

shame, as measured by the ISS and the TOSCA, have been found in both alcohol and drug dependent populations.

1.7. Limitations of studies into shame and psychopathology, including substance dependence

There are two main limitations of the studies assessing the link between shame and psychopathology, including the studies on chemical substance misuse.

Shame has been identified as a predictor of post-traumatic stress symptoms (Andrews et al., 2000) and depressive symptoms (Andrews et al., 2002), and as a mediating factor between child sexual abuse and depression (Andrews, 1995) and eating disorders in adulthood (Andrews, 1997). Apart from that, cross-sectional designs were used in most of the studies mentioned above. Although these cross-sectional associations might indicate the value of considering shame-related issues in the treatment of these psychopathologies, the question still remains as to what the associations actually mean. This type of design simply does not afford answers to questions about the role of shame in the aetiology of the various disorders, as it is not possible to differentiate whether shame is an antecedent, concomitant or consequence in the particular psychopathology studied. This neglect in the research is possibly due to the fact that research previously was driven predominantly by clinical interest, where much discussion centred on the relation of shame to psychopathology, and consideration of its role in the onset of particular disorder was relatively neglected (Andrews et al., 2002). This shortcoming is even more prominent in the studies of the link between shame proneness and substance abuse, as all the studies reviewed above were based on cross-sectional designs. Indeed, the qualitative study of the narratives of survivors of child sexual abuse, of whom a majority were drug dependent, is one of the only studies within the field of substance abuse, which has

looked at the link between past events and current feelings of shame.

The second main limitation of the studies into psychopathology concerns the issue of how to measure shame. The central question being whether measures used in these studies actually measure shame or some other concept (i.e. construct validity). Most of the studies outlined above, including those on substance misuse, have focused on the association between the extent to which the individual feels shame and their level of psychopathology.

The TOSCA, the ISS and most questionnaire measures used to assess shame have been developed to assess the construct indirectly, using items that are thought to reflect different components of the shame experience. Using this indirect method it is hoped that the questionnaires are able to identify high-shame individuals. However, it has become apparent that depending on the theory upon which shame is based and the different measures used, high-shame individuals are conceptualised differently. According to Andrews (1998a), the TOSCA conceptualise high shame individuals as:

> *"Individuals who are especially sensitive to feeling shame in potentially shame-eliciting situations, that is, people we might call shame-prone* (p. 40)."

Whereas the ISS conceptualise them as:

> *"Individuals who frequently or continuously feel generalised or global shame* (p. 40)."

Both of these conceptualisations of high shame individuals have been criticised by Andrews (1998a). She argues that there are two limitations in questionnaires like the TOSCA, which identify high-shame individuals by assessing how people will respond to a set of hypothetical scenarios. The main limitation of the TOSCA, in

particular, is that in most of the scenarios respondents are asked to consider and focus on evaluating personal behaviour. In the light of evidence that a propensity to feel shame about personal characteristics, physical as well as psychological characteristics, is to some extent independent of a propensity to feel shame in response to personal behaviour (Andrews & Hunter, 1997), it appears that the TOSCA fails to assess this important characteristic of high shame individuals. A second limitation is that the approach of using hypothetical scenarios may lack ecological validity, as subjects' responses to the TOSCA items may not reflect what they actually do or feel in real-life situations (Brewin & Andrews, 1992).

The second group of shame questionnaires, of which the Internalised Shame Scale (Cook, 1987) is the most widely used, measures global shame. In this group of questionnaires, high shame individuals are conceptualised as frequently or continuously feeling generalised or global shame. In these scales respondents are asked to indicate the frequency with which they find themselves experiencing feelings described in self-referent statements reflecting shame. Unlike the TOSCA, the ISS is not subject to the problem of focusing exclusively on behaviour. However, none of the generalised shame scales assess the length of time over which feelings have been experienced, and global negative self-referent questionnaires tend to be highly mood-dependent (Andrews & Brown, 1993). It has therefore been suggested that these measures may simply be reflecting negative mood states, rather than any enduring characteristic that is present in the absence of negative affective states (Andrews, 1998a). Indeed, for the ISS in particular, high correlations in the region of .71-.72 have been found with different measures of depression (Allen et al., 1994), suggesting that the two concepts are not that distinguishable. Tangney (1996) has also criticised the ISS on grounds that this measure has more to do with low self-esteem than shame.

These criticisms question whether these two groups of measures, especially the

TOSCA and the ISS, upon which much of the research in the field is based, actually manage to identify high-shame individuals. The main problem is that measures of psychopathology and shame are actually measuring the same, or at least overlapping, concepts. Given the limitations of the TOSCA and the ISS, links between shame and substance abuse in previous studies should be interpreted with caution. It is suggested that associations identified can reflect measurement error. Considering this and the fact that comorbidity is common in substance using populations, measures like the TOSCA and the ISS may, in particular, reflect higher levels of negativity (e.g. depression) and low self-esteem when used with this population. I shall now present an alternative conceptualisation and measure of shame, which addresses some of these shortcomings.

1.8. Andrews' conceptualisation and measure of shame

Studies by Bernice Andrews and colleagues of associations between shame and various psychopathologies have been based on a third conceptualisation of high-shame individuals, which is as follows:

> *"Individuals who are chronically ashamed of their behaviour or particular personal characteristics* (Andrews, 1998a; p. 40)."

In contrast to Tangney and colleagues (Tangney et al., 1989) and (Cook 1987), Andrews' conceptualisation does not rest on the assumption that high-shame individuals have generalised, global shame, but focuses on specific areas in which respondents might feel shame (Andrews et al., 2002). In earlier studies, Andrews and colleagues used interviews as their preferred method of collecting data, but recently, based on the interview method (Andrews & Hunter, 1997), Andrews and colleagues constructed the Experience of Shame Scale (ESS; Andrews, Qian, &

Valentine, 2002).

In contrast to other questionnaire measures, in which scores are based on responses to hypothetical transgressions (TOSCA; Tangney et al., 1989) or global self-descriptions (ISS; Cook, 1987), in the ESS respondents are asked direct questions about whether they have felt ashamed. Thus, the ESS does not rely on the researchers' characterisation of indirect aspects that make up shame, but instead relies on the respondents to define what shame means to them. Moreover, in the ESS, respondents are asked whether they have felt ashamed about particular aspects of themselves (body, character and behaviours). This is based on Janoff-Bulman's influential distinction that negative judgements can be directed at one's behaviour and one's character (Janoff-Bulman, 1979). This ensures that several sources of shame are considered, behaviours as well as personal characteristics, and thus addresses the shortcomings of the TOSCA in particular. Thus, the ESS does not rest on the assumption that high-shame individuals will have generalised shame, but rather that there might be particular aspects of themselves about which they feel shame. Thus, for example, an individual may report feeling intensely ashamed about their behaviour, but not about their body or other non-physical characteristics. Because of this, it was thought that the measure would be less vulnerable to mood-state effects than the other two measures (Andrews, 1998a). It was also thought, that asking the respondents to consider experiences of feeling ashamed "over the last year", should help to decrease this potential vulnerability further. Indeed, Andrews and colleagues found support for this lower sensitivity to negative affectivity in one of their recent studies (Andrews et al., 2002). When comparing the predictability of the ESS with the TOSCA in terms of depressive symptoms, it was found that only the ESS predicted additional significant variance in depression symptoms at time 2 (11 weeks after the initial test at time 1), when symptoms at time 1 were controlled. This finding led them to suggest that the relationship between the ESS and depression was not solely a function of any general negative affectivity apparent in

both scales. The ESS has also proven effective in prospective studies in predicting post-traumatic stress symptoms (Andrews et al., 2000). In this study shame, not anger with self or others, or history of physical or sexual abuse in childhood, was the only independent predictor of PTSD symptoms at six months post-crime, when one-month post-crime symptoms were controlled.

As mentioned previously the incidence of mental health problems, in particular depression, is high in people with drug dependence problems. It was therefore deemed especially important, when looking at shame in this population that the measure used to assess the level of shame should have the lowest mood-state sensitivity possible. Thus due to the decreased sensitivity to negative affectivity outlined in the studies above, and the potential richer source of information to be gained from the tripartite operationalisation of shame in the ESS, this shame scale was considered the best available measure to use in the present study.

1.9. Disclosure

Dealing with problems in help-seeking behaviours is common in a population of substance dependent people and is fundamental to working with this population, so much so that the model of motivation for change (Prochaska & DiClemente, 1983) has been developed to try to deal with this (as outlined above). This model has been used to explain the reluctance to seek help and the low treatment-retention rates, including high rates of dropout and re-engagement in this client group. However, it might be that shame and not just level of motivation can explain some of the problems encountered at the different stages of treatment. For example, dropouts are often linked to relapse into substance misuse, and relapse has been associated with feelings of shame (e.g. Brown, 1991). However, it might also be difficult for clients to remain in treatment as they may find the experience of talking about themselves

shameful. Furthermore, it might be that interventions offered by staff as a result of the disclosure are experienced as shameful. Indeed, feelings of shame have been linked to a reluctance to disclose (see review by Macdonald, 1998).

Theoretically, given the tendency to hide and conceal, which is a fundamental aspect of shame (e.g. Tangney, 1992), it seems likely that shame influences an individual's ability to talk about themselves (Macdonald, 1998). Since talking and disclosing important personal information are essential elements in most psychological treatments, it seems likely that excessive feelings of shame would interfere with clients' ability to use this type of treatment. Shame thus has important clinical implications. However, only a few studies have explored the relationship between shame and disclosure. In one such study, of participants who had either been, or were currently in treatment for eating disorders, it was found that non-disclosure in treatment was associated with higher feelings of characterological and behavioural shame, and shame around eating (Swan & Andrews, in press). Qualitative analysis of interviews with people coming for a psychotherapy assessment revealed that participants appeared to be habitual non-disclosers of emotional and personal experiences (Macdonald & Morley, 2001). Moreover, they found that non-disclosure was related to the anticipation of negative interpersonal responses to disclosure (in particular labelling and judging responses), in addition to more self-critical factors, including shame.

Issues of shame thus might have important implications for theories of change and treatment retention in drug dependence, and issues of shame in disclosure, in particular, could have important clinical implications. As yet, no study has looked into the role of shame in disclosure in the field of substance dependence, and one of the aims of the present study was therefore to explore this issue.

1.10. Dissociation

One way to hide from shameful feelings may be through dissociative experiences (Evans, 1987). The essential feature of Dissociative Disorders has been defined as: A disruption of the usual integrated functions of consciousness, memory, identity and perception of the environment in the Diagnostic and Statistical Manual of mental disorders (fourth edition) (APA, 1994). Indeed, research suggests that parents, who have unresolved issues around abuse in their own childhood, are more likely to have dissociative experiences when they provide care for their own children, for example, they might disengage from reality through flashbacks (see review by Carlson, Cicchetti, Barnett & Braunwald, 1989). It has been suggested that chemical substances may be used as a tool for dissociation to hide from feelings of shame (Evans, 1987). Indeed, recent studies have started to look at the dissociative function of drug use. For example, use of Ketamine was associated with an increase in dissociative experiences both on the day of drug use and three days post-drug use (Curran & Morgan, 2000). If this dissociative effect is one of the prime motivations for drug use, for example in order to get away from painful feelings, it could be hypothesised that there is a relationship between levels of shame and levels of dissociation. One of the aims of the present study is therefore to explore the relationship between shame and dissociation.

1.11. Overview of literature and rationale for present study

Due to the overlap between shame and related emotions, such as guilt and depression, there is still little consensus as to the conceptualisation of shame. Consequently different shame scales measure different aspects of shame, some of which have been argued to be particularly sensitive to negative affectivity. Due to this, and the prolific use of cross-sectional designs, it is unclear what many of the identified associations between shame and the various psychopathologies mean.

Considering the limitations of the measures used in the studies on shame in drug dependence to date (e.g. O'Connor et al., 1996; Meehan et al., 1996), a central aim of this thesis is to explore whether the association identified in these studies remains, when shame is assessed by a more robust measure, such as the ESS, and when compared to a matched sample. Using the ESS, this study will also be able to identify whether shame about the individual's character, body, behaviour in general or shame about drug use is of particular importance in substance dependence. Identifying these aspects of shame should increase our understanding of this client group. The current study will look at chronic poly-drug users dependent on opiates and possibly other chemical substances, and unlike previous studies, it will look at drug users who are in the first stages of treatment and in the contemplative stage of change.

In order to be able to determine whether any possible shame association identified in the present study is associated with chronic drug use, and not a result of psychopathology, chronic drug users with mental health problems will be excluded from the study and depression controlled for statistically. Likewise, as anger has been associated with feelings of shame in several studies (e.g. Tangney et al., 1995; Gilbert, 1998a), anger will be measured and controlled for statistically. In addition, the present study will explore the relationships between shame and disclosure, and

shame and dissociation.

Due to the explorative nature of the present study with this drug dependent population, the aims of the study are phrased as research questions.

1.12. Research questions

1. Do chronic drug users in methadone maintenance treatment differ from people who are not substance dependent on characterological, behavioural and/or bodily shame?

2. Is chronic drug users' shame about drug use associated with a propensity for shame in general, or with a specific shame subtype?

3. Is there a relationship between shame, dissociation and depression in chronic drug users and/or non-drug using controls?

4. Is there a relationship between shame and disclosure for chronic drug users attending a methadone maintenance treatment programme?

As Meehan et al. (1996) and O'Connor et al. (1994) reported higher levels of shame in recently abstinent drug users, as assessed by the TOSCA, it was hypothesised in relation to research question 1, that chronic drug users in MMT would have higher levels of shame compared to a group of non-drug using controls, as assessed by the ESS.

CHAPTER 2

Method

2.1. Ethics

The study was approved by the local NHS Ethical Committee (See Appendix 1) and permission was gained from the local Jobcentre to recruit participants on their premises.

2.2. Design

An independent group design was used to compare chronic drug-users with matched controls on levels of shame and dissociation. Two within-group factors addressed whether high levels of shame were associated with non-disclosure in treatment, and with increased levels of dissociative experiences.

2.3. Participants

Sixty-two people took part in the study. Of these, 31 were chronic drug users (CDUs) and 31 were controls without a history of drug or alcohol abuse (non-drug users; NDUs). The two groups of participants were matched in pairs as far as possible on gender, ethnicity and age.

The chronic drug using participants were recruited from a local Drug Dependence Unit (DDU), which they attended as outpatients. They were all on a maintenance methadone prescription. Initially potential CDU participants were identified from the Daily Methadone Dispensing client list by the researcher and in discussion with the clients' key-workers, using the following two exclusion criteria: i) Any severe mental health problem in the past two years (diagnosed mental health problem, any treatment or in-patient stay for mental health problem) and ii) attending key-working session for less than one month in the current treatment episode. Over the course of the data collection period 42 potential participants were identified from the 70 clients on the Daily Dispensing Programme as fulfilling the inclusion criteria. Twenty-eight took part in the study, eight failed to attend any of the testing sessions offered to them and six declined to take part.

In order to increase the pool of potential CDU participants, potential participants were also identified from a list of clients who had their methadone dispensed by their local chemist and attended the DDU for weekly/fortnightly key-working sessions only. Out of eleven such potential participants identified, three took part in the study.

All the CDU participants were paid £5.00 for their participation, in the form of a voucher to a local shop or a telephone card.

It was thought that members of the public attending a local Jobcentre would be the best matched control group to the CDUs, as it was hoped that they would be similar in terms of socio-economic status, educational background and level of intelligence.

Thirty-two job seekers, attending a Jobcentre located in a deprived inner-city area, who did not report a history of mental health difficulties or alcohol or drug dependence in the past two years, took part in the study. One of the job-seekers was later excluded due to a depression score in the severe range (BDI-II; Beck, Steer & Brown, 1996). An estimated 60 people were approached in the Job Centre, seven of which were excluded after having completed the exclusion criteria questions. They were recruited personally by the researcher in the waiting area of the Job Centre and were paid £5.00 for their participation in the form a voucher to a local shop.

2.4. Recruitment Procedure

Chronic Drug Users:

Participant information sheets (See Appendix 2) were given to each of the potential participants attending the Daily Methadone Dispensing programme. They were then recruited by the researcher in person when they next attended the centre, using the following procedure. When a potential participant attended the DDU for the dispensing of their daily dose of methadone, staff at the dispensing counter would identify them to the researcher. Once they had settled in at the dispensing counter, and before they had been given their methadone dose, the regular staff would introduce the researcher. The researcher would then refer to the information sheet, while presenting an identical information sheet, and ask if they would like to take part in the study. Of the interested participants, some agreed to take part there and then, some preferred to set up appointments to coincide with future dispensing attendance, while permission was sought from others to approach them at the

dispensing counter again at a future date.

The recruitment procedure for chronic drug users, who had their methadone dispense by their local chemist and who only attended the DDU for weekly/fortnightly key-working sessions, was somewhat different. Key-workers with such clients on their caseload, who fulfilled the inclusion criteria, were asked to give these clients an information sheet. The clients were then asked to contact the researcher if they were interested in taking part in the study.

Non-Drug Using Controls:

Potential NDU control group participants were recruited personally by the researcher on the premises of the Jobcentre, either while they were queuing to see staff or when they were browsing on the Jobs Points computers. They were approached by the researcher, who wore a visitor's badge and identified herself as a non-employee of the Jobcentre, asking them if they wanted to take part in a research study. If they were interested a quick outline of the aim of the study and the exclusion criteria was given, and they were handed the Jobcentre information sheet (See Appendix 3). Potential participants who were interested in taking part in the study were taken to a private part of the waiting area. Here they were presented with the list of exclusion criteria questions and asked to point to their responses. When an interested participant fulfilled any of the exclusion criteria, as assessed by the alcohol and drug dependence and mental health screens (as outlined on page 47), they were informed that due to the aims of the study they did not represent the group of people this part of study was trying to assess. They were then offered an information sheet with contact addresses for local mental health and drug/alcohol services (See Appendix

4). If they were eligible to take part in the study, they were either taken to a private office in the Jobcentre or an appointment was made to meet later that day.

2.5. Procedure

All participants provided written informed consent on the day they completed the questionnaire pack. They were assured that their participation would be confidential and that it would not influence the management of their case in any way.

When a potential participant was available to take part in the study, they were taken to a private room, the CDUs to a secure consultation room immediately adjoining the dispensing room and the NDU controls to an office in the Jobcentre. Once in the private office, they were asked to re-read the information sheet (or it was read to them if they had literacy problems), and they were invited to ask questions about the study. Then the limits of confidentiality were explained and written consent was sought.

Before completing their respective questionnaire pack, the NDU participants were asked to complete the mental health, and alcohol and drug use screening questions in writing, and both the NDUs and CDUs were asked a number of questions about demographic details as a 'warm-up' exercise. The researcher paced the completion of the individual questionnaires and was available in case a participant experienced any difficulties in filling-in the questionnaires. At the end of each data-collection, the participant's score and profile on the BDI-II (Beck Depression Inventory - II,

Beck et al., 1996) was checked and discussed with the participant. Finally the meeting was concluded with a discussion of any concerns the data-collection process might have raised in the participant, and consent was gained to inform the key-worker if any such issues, or the BDI responses, were cause for concern. NDU participants in a similar position were encouraged to contact their GP or local Accident & Emergency and were offered an information sheet with contact details of relevant local services (See Appendix 4).

2.6. Measures

The CDU-questionnaire pack included the question sheets and questionnaires outlined below, which were presented in the order: 1-7. The NDU-questionnaire pack consisted of similar questionnaires, which were presented, in the following order: 8 and then 1-7, excluding 4.

1. Demographic details. All participants were asked to complete a set of demographic questions (gender, age, ethnicity and occupational details) (See Appendix 5a). In addition, information as to the methadone dose level was recorded from the case notes of the CDU participants.

2. Anger and aggression. All participants filled in the 29-item Buss-Perry Aggression Questionnaire (AQ-questionnaire; Buss & Perry, 1992), which assesses two types of aggression, physical and verbal, and anger and hostility (See Appendix 5b). Here participants were asked to rate how close each of the 29 statements related to them

on a 5-point scale, from 1 (extremely uncharacteristic of me) to 5 (extremely characteristic of me). Several studies have found good internal validity and stability over time for the original AQ scale (Buss & Perry, 1992; Harris, 1997) and translations there of (e.g. Meesters, Muris, Bosma & Shouten, 1996). Evidence of construct validity has been found in that AQ scores correlate with other measures of aggression (Harris, 1997) and the AQ hostility scale has been found to predict feelings of suspicion, resentment and sensitivity to mistreatment (Felsten, 1999). Peer ratings of aggression have also been found to correlate highly with the AQ (Buss & Perry, 1992; O'Connor, Archer & Wu, 2001), thus providing evidence of congruent validity.

3. Shame. All participants completed the Experience of Shame Scale (ESS; Andrews, Qian & Valentine, 2002) based on the interview measure used by Andrews and colleagues (e.g. Andrews & Hunter, 1997) (See Appendix 5c). The 25-item questionnaire assesses recent feelings of shame ("over the past year") covering four areas of characterological shame, three areas of behavioural shame and one area of bodily shame. Each of these eight areas was assessed in terms of experiential, cognitive and behavioural components of shame. In addition, bodily shame had a fourth item assessing avoidance of mirrors. The ESS questionnaire has been shown to have good validity, internal reliability (Cronbach's alpha = .92, Andrews et al., 2001) and test-retest reliability of the total scale (e.g. r = .83; Andrews et al., 2002) and the three sub-scales. Moreover, factor analyses have confirmed the existence of the three separate sub-scales (Andrews et al., 2002). For the purpose of the current study, the ESS was extended to include an additional two sets of three-item scales to assess shame in relation to drug taking (shame about having a drug problem and

shame about activities associated with drug use). This sub-scale was developed in line with the existing ESS sub-scales so that each of the two drug shame areas to be tapped included an experiential item (e.g. "Have you felt ashamed of having a drug problem?"), a cognitive item (e.g. "Have you worried about what other people think of any of the things you have done in relation to taking drugs?"), and a behavioural item (e.g. "Other than for legal reasons have you tried to hide or conceal anything you have done in relation to taking drugs?").

4. Disclosure in treatment. The level of disclosure in treatment was assessed by asking CDU participants to rate two statements regarding the extent of their disclosure and the importance disclosure has on the efficacy of their treatment (See Appendix 5d). Visual analogue scales were used, which asked participants to make a mark on a line to indicate how strongly they agreed or disagreed with the statements at the end of each line. One item was provided for practice. These marks were later converted into scores of 10.

For participants who had not felt able to disclose important personal issues, two open-ended questions were used to explore (i) what the nature of these issues were and (ii) the reasons they had not been able to disclosure these. If participants had disclosed close to everything to staff (according to the first visual analogue question) and/or did not comment on the non-disclosure questions, they were prompted to give a response in order to ascertain their reasons for not completing the two open-ended questions. For people who had disclosed close to everything the following prompt was used: "As you have ticked close to having told staff everything about yourself it may not be relevant for you to fill in this section". Other participants were prompted

with this comment: "Those last questions are probably not so easy to fill in".

5. Dissociation. The 28-item Dissociation Experiences Scale (Bernstein & Putnam, 1986) was used in this study to assess the participants' general tendency to dissociate (See Appendix 5e). Participants rated the frequency of the occurrence of each of the 28 dissociative experiences in their daily lives from 0% (never) to 100% (always) in increments of 10%. The scale was designed to measure dissociation in normal and clinical populations and has been used extensively in alcohol and drug using populations. In a recent meta-analysis of over 100 studies using the DES, excellent convergent validity (N=22), impressive predictive validity in particular for Dissociative Disorders and trauma experiences (N=79), high internal reliability and high re-test reliability were found (van Iljendoorn & Schuegel, 1996). However, discriminant validity was less well established (N=34) as the DES has been found to correlate with general distress, anger, somatisation and depression.

6. Pre-morbid intelligence. In order to be able to assess whether the two participant groups were matched on intelligence a measure of pre-morbid intelligence was sought. The National Adult Reading Test (NART; Nelson & O'Connell, 1978), a widely used measure of pre-morbid intelligence was considered. However, the Spot-the-Word IQ test, version A, (Baddeley, Emslie & Nimmo-Smith, 1993), a sub-test of the Speed and Capacity of Language-Processing Test, which has shown to be a robust estimate of verbal intelligence based on lexical decision (Baddeley et al., 1993; O'Carroll, 1995; Yusep & Vanderploeg, 2000), was chosen instead (See Appendix 5f). The main reason being that this test addresses a number of criticisms levelled at the NART, which were considered particularly relevant to the study of

shame and the type of participants under investigation. Firstly, the Spot-the-Word requires the participant to identify the real word from a pair of words (60 pairs in total), one of which is made up. Thus the test does not rely on the task of reading words out loud as in the NART, a task that would often not have been performed since school, which many of the CDUs left early. The Spot-the-Word also does not penalise the self-educated, who might have learned the meaning of words through reading, but not the correct pronunciation. Finally, as it is a silent test, failure should cause minimal embarrassment and might thus be less shame provoking than the NART. In terms of psychometric qualities, scores on the Spot-the-Word test correlates highly with the NART (e.g. .83 for Form A and .86 for Form B, Baddeley et al., 1993) suggesting adequate reliability and validity. Findings by Yusep and Vanderploeg (2000) also suggest adequate convergent validity with other pre-morbid estimation measures (NART and WAIS-vocabulary and information sub-tests) and discriminant validity with non-hold measures (e.g. CERAD word list) for the Spot-the-Word test.

7. Depressive symptoms. The Beck Depression Inventory - II (BDI-II; Beck, Steer & Brown, 1996) was used to provide an estimate of the current level of depression in both participant groups (See Appendix 5g). All 21 items were answered by circling the one of four or six statements that best described the way the participant had felt during the two weeks prior to, and including, the day of testing. The BDI-I and -II are widely used self-report measures for assessing level of depression in a variety of clinical and research populations. However, identifying depression in chemical dependent populations is complicated due to the symptom overlap between the syndrome of depression and that of substance abuse/dependence (e.g. Buckley et al.,

2001). This might explain why, compared to the 'gold standard' SCID-NP (Structured Clinical Interview for DSM-III-R - non-patient edition), the BDI and the CESD (Centre for Epidemiological Studies Depression Scale; Radloff, 1977) were found to be equally poor in their ability to detect depression in 264 inner-city opiate-users as reported in the abstract of an unpublished dissertation (Goodwill, 1997). They had the same weaknesses: Identifying as 'cases' many subjects for whom the SCID-NP found 'no diagnosis' and failing to identify 90% of participants diagnosed with major depression and 100% dysthymic. Also, a meta-analysis of 1200 studies on the reliability of the BDI concluded that reliability estimates were generally lower for substance abuser than normal subjects, and suggested that this might be due to restriction of range problems (Yin & Fan, 2000). Though, it should be noted that this meta-analysis was based on a very small number of studies using the BDI with this population. However, findings from studies comparing the BDI to other self-report measures available to assess depression suggest that the BDI is somewhat superior in chemically dependent populations. For example, the BDI-I was found to offer a better combination of sensitivity and specificity than the Hamilton Rating Scale for depression (Schwab, Bialow & Clemmons, 1967) and the SCL-90 (Derogatis, Rickels & Rock, 1979) in a study of 149 hospitalised cocaine abusers (Weiss, Griffin & Mirrin, 1989). The results from a study of 84 cocaine abusers, suggest that the BDI had better discriminative validity, in particular in distinguishing genuine Unipolar Depressive Disorders from Organic (cocaine) Induced Mood symptomatology and Dysthymia from Organic Mood Disorder, whereas the SCL-90 was able to distinguish between the latter two disorders only (Kush & Sowers, 1996). Also, on the basis of evidence of good internal consistency and a confirmatory factor-analysis of the use of the BDI-II with 416 chemically dependent patients in a

recent study, it was suggested that the BDI-II could be used with this client group provided population-specific normative data was utilised when making clinical decisions (Buckley et al., 2001).

8. Screening questions for alcohol and drug dependence, and severe mental health problems in the control group participants. A revised version of the four-item CAGE alcohol dependence screening measure (Ewing & Rouse, 1970; as cited in Ewing, 1984; See Appendix 5h) was used to determine whether any of the potential control participants had had a recent drug dependence problem. CAGE is an acronym consisting of one letter from each of the four items in the screen: C – Cut-down, A – Annoyed with alcohol use, G – Guilty about alcohol use and E – Eye-opener (alcohol intake in the morning). The revision entailed changing the beginning of each of the four standard questions from "Have you ever..." to "In the past two years have you...". Early validation studies of the CAGE found it to be a sensitive detector of alcohol dependence at a two- or three- item criterion, in the study of 366 patients in a psychiatric service (Mayfield, McLeod & Hall, 1974). The CAGE was found to function most effectively at a cut-off point of two or more affirmative replies, with a sensitivity of 84%, a specificity of 95% and a positive predictive value of 45% when used in a GP setting (King, 1986). The CAGE is widely used in primary care and medical settings to identify people with alcoholism and has been shown to be equal or superior to other measures of alcohol dependence in primary care (e.g. Cherpitel, 1998). However, when used with members of the public, two recent studies suggested that the TWEAK (Tolerance, Worried, Eye-opener, Amnesia, K(c)ut), a 5-item questionnaire, had higher sensitivity than the CAGE: 83% compared to 75% (Cherpitel, 1998) and 98.6% compared to 84.5% (Chan, Pristach, Velte & Russell,

1993). The first question of the TWEAK is about tolerance, and research suggests that the following phrasing gives the best sensitivity with members of the general public: "How many drinks does it take before you fall asleep or passes out?" (Chan et al., 1993). Considering this, and the nature of the recruitment setting for the control group in the current study, where privacy and speed of administration were essential, it was thought that the usability of the CAGE as a screening tool outweighed its somewhat lower sensitivity levels. Indeed, this is in line with one of the advantages associated with the CAGE that it allows doctors to avoid focussing on the specifics of drinking (Ewing, 1998). In the current study, a cut-off of two or more affirmative responses was used.

A drug version of the CAGE, based on an adaptation by Midanik, Zahnd & Klein (1998), was used in the current study to screen for drug dependence using a cut-off of two or more affirmative responses (See Appendix 5h).

An affirmative response, to one of two questions about use of medication or services for mental health problems over the past two years, was used to screen out potential control participants with recent, serious mental health problems (See Appendix 5h). In addition, it should be noted that the information sheet, which informed the potential participants that they would be asked about their drug and alcohol use in order to determine whether they could participate in the study, is likely to have led some people to exclude themselves prior to the screening questions.

CHAPTER 3

Results

3.1. Statistical analyses performed

Please see Appendix 6 for a detailed account of the processes used in the preparation of the data for statistical analysis.

As the distributions of scores for most variables were normal, parametric tests were generally used, e.g. Independent- and Related-Samples T-tests, Pearson's correlation (2-tailed) and the general factorial model of Univariate Analysis of Variance with covariates. However, for non-normally distributed data, non-parametric tests (Mann-Whitney U, Spearman's Rho (2-tailed) and Pearson's Chi Square) were used.

3.2. Descriptive data for the two groups of participants (Tables 2 & 3)

Comparisons of participants' demographic details. There were 20 males (65%) and 11 females (35%) in the chronic drug user (CDU) group and 19 males (61%) and 12 females (39%) in the non-drug user (NDU) control group. In the drug user group, 28 participants (90%) described themselves as White and 3 (10%) as Black or Asian. Compared to the control group, where 26 (84%) described themselves as White, 3 (10%) as Black or Asian and 2 (6%) as other or mixed. The CDU group and the NDU control group did not differ significantly in terms of gender (X^2 (1, N = 62) =

.07 (p=0.79)) or ethnicity (X^2 (2, N = 62) = 2.07 (p = 0.35)).

Table 2: Group means (Standard Deviations) for participants' age, age scaled IQ scores, weeks since last at work and age when left education.

	Chronic Drug Users		Non-Drug Users			
	Mean	SD	Mean	SD		
Age	35.90	6.80	32.03	8.19	t(60) = 2.04	p = .046
Age-scaled IQ score	8.77	3.09	11.07	2.83	t(53) = -2.86	p = .006
Weeks since at work	54.68	61.52	12.68	35.88	U(25,30) = -4.14	P < .001
Age when left educat.	15.82	1.89	17.27	2.78	U(28,30) = -2.42	p = .016

As seen in Table 2, CDUs were almost four years older than the NDU controls and scored significantly lower in terms of age-scaled scores on the IQ test. These age-scaled IQ scores translate into just below the 50th %-tile on average for the CDUs and around the 70th %-tile for the control group. The drug users had also been out of work longer than the control group (mean rank: 37.78 and 19.85, respectively) and had left school at a younger age (mean rank: 24.05 and 34.58, respectively). As seen in Table 3, the CDUs had passed exams of a lower academic standard than the control group (X^2 (2, N = 60) = 11.60, p = .003).

Table 3. The number of participants for each group passing different levels of exams

	Chronic Drug Users	Non-Drug Users
	Count	Count
No exams	13	5
GCE, O-level & vocational training	14	13
A-levels & degrees	2	13

Participants' demographic details and ESS sub-scale scores. Further analysis was conducted to determine whether any of the five identified demographic group differences (age, IQ, age when left school, level of exams taken and time passed since last in work) might be related to the ESS scores. Neither IQ, nor time since last at work, was significantly correlated with any of the shame sub-scales (characterological, behavioural, bodily or shame about drug use) or total shame scale scores excluding shame about drug use. Furthermore, no significant differences were found between the three different levels of academic exams the participants had completed and all the shame sub-scales and total shame scale scores (characterological shame ($F(2, 28) = .94$, $p = .40$), behavioural shame ($F(2, 28) = 1.74$, $p = .19$), bodily shame ($F(2, 28) = .40$, $p = .67$) and total shame (excluding shame about drugs) ($F = .91$, $p = .41$)). Participants' age at the time they left education was significantly correlated with behavioural shame ($Rho = .27$, $p = .04$). It should be noted that, although this correlation was significant, it was quantitatively small and thus accounted for little shared variance.

3.3. Comparison of the chronic- and non-drug using groups on shame, controlling for depression and aggression.

Group differences on shame. The various shame sub-scales consisted of a different number of items and therefore mean sub-scale scores are given in Table 4 (dividing the total sub-scale scores by the number of items in each scale). This score reflects the mean range on the 4-point scale for each item (from 1-not at all, to 4-very much).

Table 4: Group means (SDs) for total shame and shame sub-scale scores.

	Chronic Drug Users		Non-Drug Users			
	Mean	SD	Mean	SD		
Total shame (excl. drug shame)	2.28	0.78	1.72	0.54	$t(55.58) = 3.26$	$p = .002$
-Characterological shame	2.34	0.85	1.56	0.45	$t(45.47) = 4.48$	$p < .001$
-Behavioural shame	2.13	0.76	1.88	0.64	$t(60) = 1.42$	$p = .160$
-Bodily shame	2.43	0.97	1.81	0.89	$t(60) = 2.74$	$p = .008$
Drug shame	3.16	0.88				

CDUs scored significantly higher than NDU controls on total shame and on the two sub-scales of characterological and bodily shame. However, there was no significant difference in terms of behavioural shame. Interestingly, behavioural shame was the source of lowest shame for chronic drug users, whereas it was the source of highest shame for the non-drug using controls.

Group differences on depression and aggression. The depression, total aggression, physical aggression and hostility scores were significantly higher for chronic drug users compared to non-drug using controls (see Table 5). There was no significant difference in terms of anger and verbal aggression.

Table 5: Group means (SDs) for depression, aggression and dissociation

	Chronic Drug Users		Non-Drug Users			
	Mean	SD	Mean	SD		
Depression	24.87	11.96	9.55	8.00	t(50.40) = 5.86	P < .001
Total aggression	67.15	18.55	55.77	16.05	t(60) = 2.58	P = .012
-Physical aggression	18.35	7.36	12.65	6.35	t(60) = 3.27	P = .002
-Hostility	23.16	7.33	19.64	6.45	t(60) = 2.00	P = .050
-Anger	11.74	5.75	9.45	4.97	t(60) = 1.68	P = .098
-Verbal aggression	13.90	3.34	14.03	2.53	t(60) = -.17	P = .752
Dissociation	23.89	17.64	10.38	6.05	t(60) = 4.72	P < .001

Group differences on ESS scores when controlling for depression and aggression. As the literature reviewed in the introduction suggests that depression is related to shame, further analyses were conducted to determine whether any of the group differences identified in ESS scores were due to depression. Depression was therefore entered as a covariate in the analysis. The comparisons between the CDUs and NDU controls, with depression entered as a covariate, indicated that the CDUs had significantly higher mean scores than the NDU controls in terms of characterological shame only ($F(2,58) = 4.09$, $p = .048$) and that depression was a significant covariate ($F(2,58) = 10.11$, $p = .002$). Group differences on bodily shame

and total shame (excluding shame about drug use) were no longer significant after controlling for depression ($F(2,58) = .33$, $p = .57$ for bodily shame and $F(2,58) = .254$, $p = .62$ for total shame). As anger and aggression have been linked to shame, and higher level of aggression has been found in CDUs in this sample, it was considered important to look at whether aggression contributed to the differences in shame between the two groups. Total aggression score was therefore entered as a covariate together with depression in the following analysis. This did not affect the pattern of the results as the group difference in characterological shame just reached significance ($F(3, 57) = 3.92$, $p = .053$) and aggression was not a significant covariate.

3.4. The relationship between shame about drug use and characterological, behavioural and bodily shame.

CDUs' mean drug shame scores (see Table 4) were significantly higher than all other shame sub-scale scores, all at $p < .001$ (characterological ($t(30) = 5.68$), behavioural ($t(30) = 7.23$) and bodily shame ($t(30) = 4.93$)). Drug shame was positively correlated with all shame sub-scale scores, all at $p \leq .001$ (characterological ($r = .55$), behavioural ($r = .53$) and body shame ($r = . 61$)). That is, a CDU who had a high drug shame score was likely to have high scores on the other three sub-types of shame, though drug shame only explained between 28% and 37% of the variance of the scores on the other shame sub-scales.

A number of correlations were calculated, post-hoc, in order to explore whether there

were any relationships between shame about drug use and a number of demographic variables. However, as a stricter α-level has to be applied to post-hoc statistics, none of the correlations reached significance. Although there was a trend for drug shame to correlate negatively with age ($r = -.36$, $p = .045$), suggesting that the older CDU is, the lower their level of shame about drug use would be. No significant correlations emerged with any of the aggression sub-scales, depression, age when CDUs left education or time passed since they were last at work, even at $p < .05$.

3.5. Exploration of the relationship between dissociation, shame and depression.

As seen in table 5, chronic drug users had significantly higher mean dissociation scores than non-drug using controls, at $p < .001$. It has been suggested that feelings of shame might be associated with an increase in dissociative experiences, it was therefore decided that dissociation should be entered as a covariate to see if the group differences in shame noted above would remain. Following this, only the group difference in characterological shame remained ($F(2,59) = 9.90$, $p = .003$). The group differences in bodily and total shame (excluding shame about drug use) were no longer significant, however, dissociation was also not a significant covariant in either of these. When controlling for both dissociation and depression the group difference in characterological shame was marginally significant ($F(3,57) = 3.89$, $p = .053$) and depression was a significant covariate ($F(3,57) = 7.31$, $p = .009$).

A series of statistical tests were carried out to explore the relationship between

dissociation and the shame, depression and aggression variables. As these tests were carried out post-hoc, the significance level was reduced to $p < .01$. In the CDU group dissociation was correlated with depression ($r = .60$, $p < .001$) but not with any of the shame subscales. Likewise, in the NDU control group dissociation was not correlated with any of the shame subscales, but the correlation with aggression almost reached significance ($r = .44$, $p = .012$).

3.6. The relationship between disclosure in methadone maintenance treatment and shame levels for chronic drug users

Extent of disclosure and the effect of this on the efficacy of treatment. Responses on the two visual analogue scales used to assess level of disclosure (disclosure question 1) and the ability of staff to help depending on level of disclosure (disclosure question 2) were positively correlated ($r = .47$, $p = .009$). That is, the more information CDUs had told staff involved in their care, the more they thought staff were unable to help unless they knew everything about the participant. Neither the level of disclosure, nor the level of perceived ability of staff to help were correlated with any of the shame sub- or total- scale scores.

Comparison of CDUs who had disclosed a lot, or a little, on shame. Neither the level of disclosure, nor the level of ability of staff to help was correlated with any of the shame sub- and total- scale scores. Using the median of 8.5 as a cut-off on the level of disclosure (disclosure question 1), half the CDUs were categorised as having disclosed a lot and the other half as having disclosed little personal information. No

significant differences were found in the level of any shame sub-scales or total scale scores between participants who had disclosed a lot and those who had disclosed a little. Using the median of 2 as cut-off on the extent to which CDUs felt staff can help without knowing about their clients (disclosure question 2), half the CDUs were categorised as ascribing low efficacy to staff if they do not know everything about their clients, and the other half was categorised as ascribing high efficacy to staff if they did know about their clients. No difference in level of shame was found between those who thought the ability of staff to help did, or did not, depend on how much the participants had disclosed.

Comparison of CDUs, who had failed to disclose and those not concerned about non-disclosure, on shame when controlling for depression. Two open-ended questions were used to explore what important personal issues the CDUs had not been able to talk to their key workers about, and the reasons for such non-disclosure. These questions were therefore only relevant to CDUs who had important personal issues, which they had not felt able to disclose. Chronic drug users to whom these questions were irrelevant were therefore deemed to have either disclosed all their important personal issues, or not to have any important personal issues to disclose. Using the responses to, and about, these two open-ended questions, the CDUs were split into these two groups: Those who had failed to disclose important personal information (non-disclosers) and those not concerned about non-disclosure. Twenty-one (68%) of the CDUs did not appear to see non-disclosure as an issue, as they did not answer any of the two qualitative questions about non-disclosure, and gave reasons for the non-relevance of the questions, either verbally or in writing, such as:

- *"I have told them everything, so irrelevant"* (P16).
- *"Have not been any* (issues to disclose)*"* (P23).

Ten (32%) of the CDUs identified themselves as non-disclosers, having failed to disclose important personal issues, by answering one or both of the questions about failure to disclose: (1) If you have not been able to tell staff involved in your care about important personal issues, what were these issues? And (2) why did you not feel able to tell staff about these issues? Here are a couple of replies to question 1:

- *"Because I am frightened of it getting out"* (P3).
- *"I also don't really like people to get to know the 'real' me"* (P24).

All the responses from this group of CDUs are listed below in section 3.7.

As seen in Table 6, the CDUs categorised as non-disclosers, according to their qualitative responses, had disclosed significantly less than the CDUs to whom non-disclosure was not an issue, according to responses on the visual analogue scale for disclosure question 1. However, it should be noted that the range of scores possibly indicates that there was some confusion about filling in the visual analogue scale, in that non-disclosers scored between 0 - 10 on disclosure question 1 (a score of ten indicating that one of these CDUs had disclosed everything).

Table 6 shows that non-disclosers had significantly higher scores on characterological, behavioural, bodily and total shame (including shame about drug use) than CDUs who were not concerned about disclosure.

Table 6: Means (SDs) for level of disclosure, shame sub-scales, depression and total aggression for each of the two groups of disclosurers.

	Non-Disclosers (N = 10)		No issues re. non-disclosure (N = 21)			
	Mean	SD	Mean	SD		
Level of disclosure	6.63	2.53	8.40	2.74	U(10,21)= -54.5	p = .031
Total shame (incl. drug shame)	2.99	0.58	2.19	0.68	t(29) = 3.22	p = .003
-Characterological shame	2.91	0.70	2.06	0.80	t(29) = 2.86	p = .008
-Behavioural shame	2.65	0.64	1.89	0.69	t(29) = 2.95	p = .006
-Bodily shame	3.12	0.89	2.10	0.83	t(29) = 3.14	p = .004
-Drug shame	3.58	0.61	2.97	0.91	t(29) = 1.92	p = .065
Depression	31.00	10.08	21.80	11.85	t(29) = 2.10	p = .045
Total aggression	65.90	18.45	67.75	19.02	t(29) = -.26	p = .800

Furthermore, the CDUs who had failed to disclose important personal information had significantly higher depression scores than the non-concerned CDUs, but there was no group difference in terms of total aggression. As mentioned previously, depression has been associated with elevated levels of shame, and depression was therefore entered as a covariate. The analysis showed that the significant difference in characterological ($F(2,27) = 4.52$, $p = .043$), behavioural ($F(2,27) = 4.32$, $p = .047$), and total shame ($F(2,27) = 5.40$, $p = .028$) remained. The difference in bodily shame was marginally significant ($F(2,27) = 4.16$, $p = .051$) and depression was a significant covariate ($F(2,27) = 14.65$, $p = .001$). There was no significant difference in terms of shame about drug use with or without depression covaried.

Comparison of CDUs, who had failed to disclose and those not concerned about non-disclosure, on shame when controlling for shame avoidance/concealment tendencies.

One item, in each of the eight standard areas of questioning in the ESS and in the two shame about drug use components, measures the respondent's tendency to hide or conceal particular 'characteristics' about which they feel shame. A significant part of the ESS is thus concerned with avoidance. To control for the possibility that a shame avoidance/concealment tendency accounted for the differences in shame scores noted above, the analyses were repeated, excluding these items, following the procedure used by Swan & Andrews (in press). The exclusion of the shame avoidance items did not change the results as the CDUs who had failed to disclose still had significantly higher shame scores than the CDUs not concerned about disclosure on characterological ($t(29) = 2.67$, $p = .012$), behavioural ($t(29) = 3.24$, $= .003$) and bodily shame ($t(29) = 2.84$, $p = .008$).

3.7. The nature of issues not disclosed and reasons for non-disclosure

The responses made to the open-ended questions about non-disclosure by the ten CDUs (32%) who had not felt able to disclose important personal issues were explored to identify themes in their responses. Some participants gave more than one response thus their comments were counted more than once. To index this, an identification number of each participant (P) has been written after each comment.

Nature of important personal issues not disclosed. Two themes emerged from the responses given by the ten CDUs who had not been able to disclose important personal information. The first theme identified was about current issues, which included three sub-groups: The CDUs' relationships with their children and partners, their mental health state and other current issues. The second theme was about previous or historical issues, such as the CDUs' upbringing and events that happened in childhood. One participant replied "Don't want to answer" in response to this question and then wrote "cause I feel ashamed" as a response to the question about why they had not been able to disclose. It might be that this was also the reason they felt unable to disclose in the research setting.

Current issues. Nine of the ten non-disclosers reported that they had not been able to talk about current issues. Five of these CDUs had not felt able to bring up issues around role expectations and their relationships with their partners or their children:

- *"My own worries about my family, my children and family traumas"* (P12).
- *"Not everything about my relationship with my partner and my* (child)" (P22).
- *"I have not been totally honest about the stress I put up with, with my partner"* (P27).
- *"They should have more person-centred counselling especially for women/men with children either in or out of care or living with relatives*" (P10).
- *"I think I am gay.."* (P3).

In addition, three non-disclosers had not been able to talk about their current mental state:

- *".. also about myself and my strong feelings of dislike for myself"* (P24).
- *"Depression"* (P15).
- (A brief description of suicide attempt) (P29).

Two non-disclosers reported a number of other current issues they had not be able to talk to their key-workers about, such as current drug use and legal and health matters:

- *"Taking more drugs than my key-worker would be happy with"* (P27).
- *"Legal and health reasons* (from the context it was deemed that the participant meant issues rather than reasons)" (P13).

Past issues. Only two non-disclosers (20%) reported having not been able to talk about issues from their past, such as their upbringing and events that happened in childhood:

- *"..there are still a lot of personal issues I need to talk with* (key-worker) *about, like my parents and their drug use. My upbringing..."* (P24).
- *"Childhood. Things that happened in my childhood"* (P12)

Reasons for non-disclosure. Two main themes emerged from the responses about why the participants had not been able to disclose, a shame-related and an 'other effects' of disclosure theme. The shame-related theme included three aspects of shame: Feeling ashamed about one self, fears that others might judge you unfavourably and difficulties in talking about sensitive topics. All, but one, response *"Not* (had) *the time yet"* (P15) were classified under these two main themes.

Shame-related reasons for non-disclosure. A shame-related theme was identified in the responses of seven of the non-disclosers (70%). Included under this theme were responses from two CDUs suggesting they had not disclosed because they felt ashamed about themselves:

- *"Cause I feel ashamed"* (P19).
- *"I also don't really like people to get to know the 'real' me"* (P24).

Responses from three participants suggested that they feared that others might judge them negatively were they to disclose:

- *"Disappointment (by staff), although I don't feel there is anything they could do or say to change that"* (P27).
- *"..due to peer and family pressure I have not been able to talk about this. Because I am frightened of it getting out"* (P3).
- *"I feel I need to get to know* (my key-worker) *more, so that I feel I can trust* (him/her)*"* (P24).

The following comments from three non-disclosers indicated that they were concerned that it would be difficult to talk about their identified important personal issues, which possibly suggests that they worried it might be a shaming experience for them to disclose them:

- *"Very emotional issues"* (P12).
- *"I tried but didn't quite get there"* (P29).
- *"I approached most issues but didn't cover everything in detail as I*

Non-shame-related reasons for non-disclosure. A second theme, concerning non-shame-related effects of disclosure, was identified from the responses of three non-disclosers:

- *"Because it might have affected my script"* (P13).
- *"I don't honestly feel anyone but me could change or do anything about my relationship"* (P27).
- *"Staff here don't really care or at least don't seem to. I have mentioned things above and nothing has ever been done before"* (P10).

CHAPTER 4

Discussion

This study aimed to investigate whether previous findings, suggesting that shame levels were elevated in drug dependent populations, would be replicated when using the Experience of Shame Scale (Andrews et al., 2002), a more robust measure of shame. To do this a group of chronic drug users (CDUs) attending a methadone maintenance treatment program were compared to a group of non-drug- or non-alcohol- using people (NDU) attending a local Jobcentre, who were matched with CDUs. The potential confounding effects of depression and aggression on shame were also explored, in addition to links between shame and disclosure, and shame and dissociation.

A summary of the main findings of this study will be outlined in this chapter. The findings will then be discussed in relation to existing literature and the limitations of the present study. Finally, future directions for research and clinical implications are considered.

4.1. Summary of findings

Demographic differences. The two groups of participants were matched on gender and ethnicity. However, the CDUs were on average 4 years older and this difference just reached significance. The CDUs had lower age-scaled IQ scores, had left school

at a younger age, had taken exams at a lower level, and had been out of work for longer than the NDUs. However, none of the essential demographic differences, such as IQ and age, correlated with scores on shame sub-scales. Moreover, the level of exams completed by the participants did not influence levels of shame.

Group differences on shame, depression, aggression and dissociation. Compared to the non-drug using controls, the chronic drug users appeared to experience higher levels of characterological, bodily and total shame, and higher levels of depression, aggression and dissociative experiences. However, when controlling for depression, and depression and aggression together, CDUs appeared to experience higher levels of characterological shame only. In fact, the difference in depression between the two groups accounted for the differences in bodily and total shame. Likewise, only the group difference in characterological shame remained when controlling for dissociative experiences. However, dissociation did not account for the group differences in behavioural and bodily shame.

The relationship between shame about drug use and characterological, behavioural and bodily shame. Amongst CDUs, drug use appears to be associated with higher levels of shame about the individual's general character, behaviour or body. That is, the higher the level of shame a CDU experiences about their drug use, the higher the levels of shame they are likely to experience about any one of these three additional types of shame, and vice versa. It should be noted, however, that shame about drug use only explains between 28% and 37% of the variance of any of the other sources of shame.

An exploration of the relationship between shame about drug use and demographic data showed a trend for shame about drug use to be related to the age of chronic drug users. The older the CDU was, the lower their shame about drug use tended to be.

The relationship between disclosure, shame and shame avoidance/concealment tendencies. Two approaches were used to assess levels of disclosure. The first approach used a visual analogue scale to assess the extent of disclosure or non-disclosure. The second approach used qualitative responses to classify the CDUs into one of two categories: (i) having failed to disclose important personal information (non-disclosers) or (ii) having disclosed all or having had nothing to disclose.

Using the first approach, findings on the visual analogue scales suggested that the more CDUs had disclosed, the more they believed disclosing was needed for staff to be able to help them, and vice versa. However, there was no relationship between either the level of disclosure or the level of perceived ability of staff to help, and levels of shame experienced. There were also no differences in levels of shame found between those who had disclosed a lot and those who had disclosed a little, or between those who felt disclosure was necessary for treatment to be effective and those who did not hold this belief.

According to the second classification approach, based on qualitative responses, ten (32%) of the CDUs were identified as non-disclosers, as they had not disclosed important personal issues. Findings based on this suggested that there were group differences in levels of shame. When compared to those who had either disclosed

all, or had nothing to disclose, non-disclosers experienced higher levels of shame in all the shame subscales, apart from shame about drug use, and all of these remained after controlling for depression. After removing eleven items of the ESS, pertaining to shame avoidance/concealment, non-disclosers still experienced higher characterological, behavioural and bodily shame scores than those who had either disclosed all or had nothing to disclose.

Nature of issues not disclosed and reasons for non-disclosure. As mentioned, according to the classification on qualitative response, ten (32%) of the CDUs were identified as non-disclosers. The themes outlined below, about the nature of the issues not disclosed and the reasons for non-disclosure, were identified from the responses of these ten non-disclosers to two open-ended questions about non-disclosure.

The nature of the issues, which these participants had not been able to disclose, fell into two categories: Current and past issues. Ninety percent of the non-disclosers had not felt able to disclose about current issues, such as their relationships with their partners and their children, their mental health state, and other current issues. Only 20% had not felt able to disclose about historical issues, such as their upbringing, parental drug use and events that had happened in childhood. Two main themes were identified amongst the reasons given for not feeling able to disclose these issues: Shame-related and non-shame-related reasons. Sixty percent of the non-disclosers identified shame-related reasons for their non-disclosure. These included worries about feeling ashamed about themselves and fears that others might judge them negatively if they were to disclose. They also expressed concerns that their

personal issues were of such a nature that it would be difficult to talk about them. Non-shame-related reasons for non-disclosure were brought up by three of the non-disclosers. These included worries that disclosure would affect their methadone prescription, or that staff could not, or would not be able to help with the important personal issues, were they to disclose.

4.2. Comparability of groups and reasons for differences in demographic details

In trying to identify a suitable control group for the drug dependent population in the present study, it was hoped that members of the public who were unemployed would be the best match of the groups available, as they were considered to be broadly similar in socio-economic status and basic demographics such as age, IQ and education. The best access we could find to this population was to approach people who were attending the local Jobcentre.

During recruitment, controls were matched in pairs to chronic drug users on gender, ethnicity and age as far as possible. In fact, the two groups of participants were matched on gender and ethnicity, lived in similar inner-London boroughs and most participants in both groups were out of work. The differences observed in IQ, age of the participants when they left school, time passed since they were last in work and levels of exams completed, could possibly all be explained in terms of IQ differences. Children who have low to average IQs might experience difficulties in staying at school, passing exams and staying in jobs. All of these factors may also

increase the vulnerability to drug use and dependence. However, none of the essential demographic differences, such as IQ and age, correlated with scores on shame sub-scales. Considering this, and the geographical and socio-economic similarity between the two groups of participants, it appears that they were well matched.

4.3. Comparability of groups on depression and reasons for differences

Despite excluding CDUs and NDU controls who had experienced identifiable mental health problems in the past two years, CDUs in this study still experienced higher levels of depression. The actual mean level of depression, as measured by the BDI-II, was in the 'moderate' depression range for CDUs as compared to the 'minimal' depression range for NDUs, when using norms for the general public (Beck et al., 1996). However, due to the overlap between symptoms of drug dependence and depression, it has long been suggested that the BDI cut-off points identified for the general population should not be used. Unfortunately, population-specific norms do not as yet exist for drug dependent populations. As an alternative, it has been suggested that the use of a cut-off of one standard deviation from the mean might be used to identify drug dependent people who may have depression (Buckley et al., 2001). However, these writers also noted that this method should only be used to identify potentially depressed clients and that a diagnosis should be based on further assessments. Using this method, four of the 31 CDUs were identified as possibly having depression, despite not having been formally diagnosed prior to taking part in the study. This, however, is in line with studies suggesting that mood disorders are

prevalent and difficult to diagnose in this clinical population due to the overlap in symptomatology between mood disorders and chemical dependence (e.g. Buckley et al., 2001).

4.4. Characterological, behavioural and bodily shame in drug dependence

The findings of increased levels of shame in CDUs in out-patient methadone maintenance treatment replicate findings by O'Connor and colleagues in a group of recently abstinent drug users (including poly-drug users) who had come into a residential treatment program (O'Connor et al., 1994; Meehan et al., 1996). In the present study, outpatient CDUs were compared to a group of non-drug using controls from a similar socio-economic background, who were matched on gender and ethnicity. Whereas O'Connor and colleagues' findings, using the TOSCA (Tangney et al., 1989), were compared to norms, which had been collected by a different group of researchers and no information was given as to the participants on which these norms were collected. In addition, a more robust measure of shame was used in the current study (ESS), which has been deemed to be less mood-state sensitive than the TOSCA (Andrews et al., 2002). Unlike the present study, which excluded people with identified mental health problems, 42% of the sample in Meehan et al.'s study (1996) reported having seen a psychotherapist at some time prior to the study.

The use of the ESS also made it possible to identify the sources of shame in drug dependence. At first glance, it appeared that chronic drug use was associated with shame about character and body, but not with behaviour. However, it was

considered important to control for depressive and aggressive tendencies. In doing so, the findings suggest that shame about the body is linked with depression, rather than drug dependence. In fact, bodily shame has been linked to depression in several studies by Andrews and colleagues (e.g. Andrews & Hunter, 1997). The difference in characterological shame appears to be robust in that it remained after controlling for differences between the groups in depression and aggression.

In summary, the robust finding of increased characterological shame adds support to the idea that drug dependent populations experience increased levels of shame. Characterological shame in the ESS assesses three areas about which the respondent might feel ashamed: Personal habits, manners with other people and the sort of person the respondent is. It is thus likely that increased scores on characterological shame may be due to drug users' thoughts about their drug habits and themselves as drug dependent. However, it may also be due to shame about other personal characteristics, which might be independent of drug use.

4.5. Shame about drug use

None of the previous studies looked specifically at whether drug use was a source of shame in drug dependence. According to this study, CDUs felt most ashamed about their drug use. Two sources of drug shame that were assessed were feelings of shame about having a drug problem and feeling ashamed about actions the drug user carries out in relation to their drug use. This finding might be explained in terms of drug users feeling there is a stigma attached to having a drug problem. Indeed, the

literature on stigma supports the idea of stigma as a cause of shame (see review by Lewis, 1998). This is also akin to the literature on labelling theory, which has identified that being labelled as having a mental health problem can be a source of shame (Scheff, 1998). The fact that drug use is illegal and that society punishes such behaviour by legal action, is possibly intended to have a shaming effect on drug users. However, for someone who is already battling with feelings of shame this is unlikely to have a deterrent effect but rather add to the source of this crippling emotion. Indeed, findings from this study suggest that an increase in feelings of shame about drug use is associated with increases in all the three other types of shame.

In addition to the labelling theory, high levels of drug shame might also be explained in terms of social rank theory (Gilbert, 1992). According to this, perceived low social attractiveness is linked to feelings of shame. Indeed, it was found that people who see themselves as relatively low down the rank tend to blame themselves for criticism (Gilbert & Miles, 2000). In addition, self-blame was associated with social anxiety, depression, shame, anger proneness and hostile attitudes. This is in line with previous findings that shame is associated with perceptions of unfavourable social comparisons (e.g. Gilbert 1998b; Allan et al., 1994). The fact that CDUs leave school early, complete exams at lower academic levels and have been out of work longer suggest that they might have a history of experiencing being at a lower social rank than others. Seeing themselves as drug dependent might also act as confirmation of this existing belief of lowered social standing and inadequacy. This might also go some way to explain the reluctance, observed across a variety of dependence types, on the part of the dependent person in accepting that they have a

problem, and the long time it often takes to move from the pre-contemplative stage in the cycle of change (Prochaska & DiClemente, 1983).

In this study, CDUs who experienced high levels of shame about drug use did not experience higher levels of depression or aggression. In addition, no relationship was found between age of drug users and the experiences of characterological, behavioural and bodily shame. There was, however, a trend for older drug users to experience lower levels of shame about drug use. It might be that older drug users feel less shame about the label, as they may define themselves in other terms apart from drug dependent, and/or may have additional roles, such as being a parent. Alternatively, it might be that they have come to be more accepting of the label as they have been drug users for longer, or have been in treatment longer.

4.6. Disclosure in methadone maintenance treatment

The lack of relationship found between levels of disclosure and experiences of feelings of shame, according to the numeric data collected using visual analogue scales, could possibly be explained in terms of measurement problems. During data collection a number of participants appeared to have difficulties using the visual analogue scales to record their answers. Furthermore, the wording of the statements on the visual analogue scales did not allow CDUs who felt they had nothing to disclose to record this. It is likely that scores from such CDUs might have skewed the data. In fact, non-disclosers did experience higher levels of shame when they were defined according to their qualitative responses. The classification according to

qualitative responses was cross-validated by use of the mean scores on the extent of disclosure as assessed by the visual analogue scores. However, the spread of scores also highlighted that there was some inconsistencies in completing the visual analogue scales. These factors suggest that the findings based on the qualitative categorisation approach may have more validity.

In the current study, non-disclosure in drug dependence was associated with higher levels in all three sub-scales of the ESS, whereas in an eating disordered population there were only differences in terms of characterological and behavioural shame (Swan & Andrews, in press). In their study, non-disclosure was associated with increased shame around eating, whereas shame about drug use was not. This suggests that disclosure of different types of information may be differentially shaming according to the clinical population assessed.

In this study, increased depression did not account for the increased levels of shame in non-disclosers, which suggests that non-disclosure is related to shame and not dysphoric mood in drug dependence. Support was therefore found for the theoretical assertion by Macdonald (1998) that shame influences the individual's capacity to talk about personal issues.

Having removed those items from the ESS which concerned shame avoidance/concealment, the remaining items assess the extent to which the individual feels ashamed about a particular aspect of themselves in addition to worry about what other people think of that aspect in the respondent. The fact that non-disclosure was associated with increased characterological, behavioural and bodily shame after

shame avoidance items had been removed suggests that CDUs who do not disclose, feel ashamed about their character, behaviour and body themselves, in addition to worrying what other people might think of these aspects. This replicates Swan and Andrews' (in press) findings from the study on eating disorders. The current study thus lends support to the idea that non-disclosure is related to the anticipation of negative interpersonal responses to disclosure (in particular labelling and judging responses) and self-critical factors, including shame (Macdonald & Morley, 2001). Reasons for non-disclosure identified from the qualitative responses in the current study also lend support to this idea, as feeling ashamed about one self, and worry that disclosure would lead to feelings of shame in the discloser or to negative judgements by others, were identified by 60% of the non-disclosers. The non-shame-related reasons for non-disclosure included worries that methadone prescriptions might be changed or that staff could not, or would not, help with the important personal issues, were they to be disclosed. Some writers might see this as evidence that some clients experience institutional procedures as shaming (Nielsen, 1987).

From the responses about the nature of the issues which CDUs had not felt able to disclose to key-workers, it seems that CDUs are particularly reluctant, or find it difficult, to talk about their relationships with partners and children. Social rank theory (Gilbert, 1992) and failure to fulfil normal role expectations may explain this reluctance. By not disclosing it might be that CDUs try to avoid social comparison with staff, who are likely to have partners or children themselves, in areas so fundamental to human functioning that problems (lower rank) in these areas are particularly painful. So much so that hiding the problem is preferable. However, the power of the fear of social services involvement may also explain this tendency. The

shaming effect of the stigma (Lewis, 1998) that has been associated with mental health problems (Scheff, 1998) might account for the reluctance of some of the CDUs to bring up current mental health problems. Likewise, physical and child sexual abuse has been associated with shame in numerous studies with later mental health problems (see reviews by Andrews, 1998b; Tantam, 1998) and with stigmatisation (Lewis, 1998). This might be why such events are often kept secret and could possibly account for why some of the CDUs in this sample had difficulties in bringing up "things that happened in my childhood". One CDU reported not being able to talk about his/her upbringing and parental drug use. This is in line with research which has associated recollection of shaming parents and siblings with current mental health problems (Gilbert & Gerlsma, 1999), and parental alcohol dependence with increased internalised shame and alcohol use in their children (Hawkins, 1997). Feelings of shame may make it difficult to disclose such issues and account for some of the long-term toxic effects of such experiences.

4.7. Methodological issues and limitations of the study

The design. Unfortunately, as the design used in this study was cross-sectional, one of the main limitations of the study is that it does not allow for commenting on the direction of causality. Thus this study is not able to clarify the role of shame in chemical substance dependence and determine whether shame is an antecedent, concomitant and/or consequence of dependence.

Most clients attending the Daily Methadone Maintenance program drop in and out of

treatment. Due to time constraints and in order to maximise the sample pool, it was decided that the minimum time in current treatment for CDUs was to be at least one month, that is, having attended key-work sessions for at least one month, to qualify to take part in the study. However, this has obvious implications for the findings on disclosure, as time constraints rather than feelings of shame might have dictated the level and type of disclosure that had taken place.

The research samples. The sample of CDUs who took part in this study were on an out-patient methadone maintenance treatment program, consisting of the dispensing of a daily methadone maintenance dose in conjunction with regular key-working sessions held depending on need or fortnightly as a minimum. CDUs, who had recently joined the daily dispensing program, were observed in order to determine whether their drug use was stable enough for them to attend a local pharmacy. However, a large majority of the CDUs attended the Drug Dependence Unit daily as their drug use (poly-drug use) and lifestyles were deemed too chaotic to warrant collection of their methadone at a local pharmacy. Due to the chaotic nature and severity of the drug dependence in the population attending this local centre, a harm minimisation philosophy was followed when appropriate, rather than a strict methadone only ideal, which means that some of the CDUs in the sample were using drugs on top of the methadone. The population available to this study therefore included a particularly chaotic group. This meant recruitment and data collection was difficult as CDUs often failed to turn up, or felt unable to take part in the data collection on the day in question. Potential participants were often prompted several times and two participants had to return to complete the questionnaire batch, as they felt unable to complete it in one sitting. It is likely, however, that the CDUs who did

manage to take part in the study were a less chaotic sample of this population.

CDUs who had experienced recent mental health problems were excluded from taking part in the study in order to be able to ascertain whether shame was related to drug dependence per se and not psychopathology. The exclusion of CDUs with recent mental health problems suggests that the actual levels of shame found in this population may be lower than in other similar drug dependent populations. As psychiatric comorbidity is very prevalent in drug dependence (e.g. Gossop, 1994) it might be argued that the findings from this study only apply to a very particular sub-sample of the drug using population, namely CDUs without mental health problems. However, it should be noted that the level of depression in this study suggests that the sample of participants was not free of dysphoric mood problems. The fact that the severity of the drug use and socio-economic deprivation of the inner London population is deemed to be amongst the highest in the UK, suggests that the generalisability of the finding that shame is an issue in drug dependence, is possibly limited to groups of more severely poly-drug dependent drug users who are still actively using.

The NDU controls were recruited in person from the waiting area of the Jobcentre. It is therefore possible that the people who agreed to take part experienced lower levels of shame than those who declined to take part, as they may have declined due to shame avoidance tendencies. However, Macdonald (1998) reports that despite the avoidance/concealment component of shame, people are willing to talk about shame in research settings.

Validity of measures. The choice of each of the standard measures used in this study was based on a thorough review of the literature on the use of each of the measures with drug dependent and non-clinical populations (see Method Chapter). This section will therefore only discuss the use of the ESS, as this was the first time it was used with a drug dependent population, and problems identified in the use of the other scales. However, it should be noted that as all measures used were self-report measures, they relied on the individual participant's memory of events and conscious awareness of feelings.

Cronbach's alpha inter-item correlations on the relatively newly established ESS showed adequate internal validity in both the standard ESS and the shame about drug use section constructed for the present study, in line with levels found in previous studies by Andrews and colleagues (e.g. Andrews et al., 2002). However, by not specifying whether drug users were to think of their drug use, or not, when completing the standard ESS, it was not possible to say whether the increase in characterological shame was due mainly to issues around drug use, or some other personal characteristics which were independent of drug use.

Visual analogue scales were chosen in an effort to get richer and more precise data about disclosure, than could be provided by, for example, a 4-point scale. As discussed above, the data collected on the level of disclosure and CDUs' perception of the ability of staff to help them, by the use of visual analogue scales, were deemed to be invalid. This was due to the fact that the wording of the statements on the visual analogue scales did not allow CDUs who felt they had nothing to disclose to record this. More generally, it might be that compared to other styles of

questionnaires, which are more frequently used in surveys in the public media, the visual analogue scales were too unfamiliar to the chronic drug users, even though, a practice item was included. It might also be that the mental state of the CDUs and their lower level of education meant that the visual analogue scales were inappropriate to use with this group of participants.

Statistical power. Power analyses, based on the effect size from a study by O'Connor and colleagues (Meehan et al., 1996), suggested that a minimum of 38 chronic drug users were needed in order to be able to ascertain whether shame was associated with drug dependence. Due to difficulties in recruitment/data collection, a preliminary analysis was completed after the collection of data from 31 chronic drug users and 31 non-drug using controls, and when significant results were found on shame with a sample of that size, data-collection was terminated.

Thus, there was adequate statistical power to determine that drug dependence was associated with characterological and bodily shame and that, when controlling for depression, only characterological shame remained. However, as the probability associated with group differences in behavioural shame was $p = 0.16$, it might be that there was not enough statistical power to determine that drug dependence is not associated with increased behavioural shame. The lack of difference on levels of shame about drug use, between CDUs who failed to disclose and those who had either disclosed all or had nothing to disclose, might also be due to lack of statistical power, as $p = 0.14$. It can therefore not be said with certainty that non-disclosure is not linked to the experience of shame about drug use.

The small sample size may also account for the fact that is was not possible to determine whether or not there is a relationship between age of drug user and experience of drug shame, at the stricter α-level applied to post-hoc statistics.

4.8. Directions for future research

It may be sufficient to ascertain that shame is a factor to consider in drug dependence when offering treatment and developing services for CDUs (Tantam, 1998). However, if we want to be able to understand the effect of shame in the development, maintenance and cessation of drug dependence, studies using longitudinal designs have to be completed. In the mean time, however, assessing the effect of shaming parents and siblings, as done in a study by Gilbert and Gerlsma (1999), may go some way to address the issues of causality, albeit indirectly.

Another area of future research concerns the issue of high prevalence of comorbid psychiatric disorders in drug dependence. Due to the potential confounding effect of psychopathologies, other than substance dependence, on shame, it is important to control for the presence of these in any future studies trying to establish the role of shame in substance dependence. However, diagnosing psychiatric disorders in people with drug dependence is complicated by the symptom overlap between the two categories of disorders. In terms of depression, for example, no scale has as yet been developed specifically for drug dependent populations to address the problem of overlap between some of the biological symptoms of depression and drug dependence. Until such a scale has been developed, future studies with this clinical

population might address these issues by looking at the relationship between shame and the cognitive symptoms of depression, by excluding the relevant biological items from established measures of depression.

From the present study it appears that CDUs experience high levels of shame while being on a methadone maintenance program. Some writers suggest that drugs are used as a method of self-medication (e.g. Khantzian, 1985). According to this, the consumption of methadone or any drug might be used to blunt feelings of shame. Future studies might look at the effect of an additional methadone dose on state and trait shame, to explore this further. On a methodological note, this would also help to answer the question as to whether measures of shame are valid when used to assess shame in samples of chronic drug users who are currently under the influence of drugs. Assessing whether different stages of treatment, or the five stages of change (Prochaska & DiClemente, 1983), are associated with different levels of shame might also help to inform the debate about self-medication. Using the ESS (including the shame about drugs use sub-scale) would make it possible to address this question in detail. For example, it might be that current drug users are higher on shame about drug use than drug users who have stopped using. In addition, this group of CDUs might experience high levels of shame about 'original' aspects of their person, as assessed by the standard ESS subscales.

It would also be of interest for a study based on a larger sample of CDUs to explore whether the experience of shame about drug use is linked to the age of drug users, length of time in treatment, or length of drug history, in that this might inform us about the effect of shame, labelling and stigma attached to drug dependence. If

older, more 'experienced' drug users did experience lower levels of drug shame, this might help us to develop interventions to help younger drug addicts reduce their levels of drug shame. This might lower the barriers caused by the perceived stigma attached to drug use and primary or secondary mental health problems. In turn this might increase CDUs' capacity to use treatment services and help them integrate back into peer-groups away from drug subcultures.

Some CDUs who took part in this study mentioned that their views of themselves, their drug use and the help offered to them had changed since their first treatment episode. In previous interview studies by Andrews and colleagues, both experiences of current shame and shame they had felt at any other time in their lives were assessed (Andrews, 1995; Andrews & Hunter, 1997). Future studies could identify CDUs whose levels of shame had changed by asking participant to fill in an ESS for different time periods or treatment episodes. Further exploration, for example, by the use of interviews could then be conducted to ascertain what caused the change and the effect this had had on the CDU's capacity to use the treatments offered to them. Alternatively, a study of 'success stories' (CDUs who had been abstinent for a number of years) could explore these drug users' experience of shame throughout the cycle of change and drug use history, the role this played in their recovery and how treatments were perceived to affect levels of shame, and vice versa. Information as to how such changes came about could have important clinical implications.

4.9. Clinical implications

Chronic drug users are generally seen by a variety of staff when they come for treatment, and the fact that some CDUs experience high levels of shame, therefore, has implications not just for offering therapy but also for key-working sessions and service provision in general. Such clinical implications will be outlined below. However, before doing so, the effects of shame on psychological functioning and how such effects might be addressed in psychological therapy, will be addressed.

According to Gilbert (1992) bio-social model of shame, it is suggested that shame is an involuntary (primitive) defence, which is caused by submissive behaviour and a realisation of subordinate status. The idea that shame has a defensive function has also been suggested by writers from the cognitive school of thought (e.g. Lewis, 1995; Kessler & Bieschke, 1999). Gilbert's bio-social model indicates that shame is an involuntary defensive response to threatening situations. The cognitive-behavioural model, on the other hand, suggests that some level of control and separation of emotion and cognitive processes occur. In this model emotions are only elicited after some "meaning" has been given to a situation (e.g. Lewis, 1995). Based on his work on stigmatisation, Lewis (1998) proposed that the formation of a shame schema might result from the creation of internal, stable and global attributions for negative events (this happened because I am a bad person) subsequent to an abusive situation. One of the reasons people may choose to ascribe this shame-inducing, self-referencing meaning to events is that this gives them a sense of control and protects their view of the world as just and orderly, thus reducing the perceived odds of something bad happening (Kessler & Bieschke, 1999). In the same vein, Sanderson (1990) suggests that threat of injury or annihilation, often accompanying the potentially shame-inducing experience of abuse, may lead to disempowerment and a subsequent feeling of shame about being

ineffectual (why did I not run away is often heard in clinical cases) thus reducing the victim's sense of self-efficacy. If the victim instead was to limit this feeling to just feeling ashamed about their behaviour, this would generally lead to the less toxic feeling of guilt, rather than shame.

From these ideas it follows that shame not only serves as a defence in shaming or abusive situations, but may also lead to defensive withdrawal behaviour at a later stage, thus ensuring that no one gets so close to the shame-prone person as to get to know "what they are really like". Indeed, findings from the current study suggest that feelings of shame are associated with failure to disclose, and vice versa. It is within this framework that the original defences employed by people, who are being shamed, can be viewed as adaptive survival strategies that later form the core of the person's psychopathology (Carmen & Rieker, 1989). This schema also provides clinicians with a way of understanding the obstacles to treatment and recovery, to which I shall now turn. In doing so, the effects of the tendency to attribute negative events to internal, stable and global aspects of oneself and the effects of the avoidant defensive coping style, which are both associated with shame-proneness, will be described in more detail.

Looking at treatment from a chronological perspective, the first issue to consider is help-seeking. As shame motivates avoidance, hiding and concealment (Tangney, 1996), and help-seeking requires insight and openness (first in terms of acknowledging that there is a problem and then in terms of telling others that their help is required), the deleterious effect of shame, even before therapy commences, is evident (Potter-Efron, 1987).

According to Gilbert (1998b), what makes shame a particularly complex therapeutic problem is that the cognitions and emotions aroused can spin off in many different directions and be associated with other emotions. Thus therapists have to be

particularly vigilant to spot shame as an underlying theme, not just due to hiding, but also due to concealment under other emotions, such as sadness, anxiety, disgust and anger (Tantam, 1998). Shame-anger spirals, in particular, have been discussed in the literature (e.g. Gilbert, 1998b) and some research suggest that shame may be presented differently in men and women, with a propensity for men to be angry. For example, domestic violence has been associated with shame in men (Dutton & Golant, 1995; as cited in Tantam, 1998).

The therapeutic relationship has often been cited as the central medium in healing shame because it is through social interaction that shame is most likely to be activated. Due to the inherent mistrust and preoccupation of clients with shame problems, as to how they are seen in the mind of others and their need for social approval (Andrews, 1997), the therapist has to be particularly skilled in building a therapeutic alliance and proceeding at the client's pace. Thus, spotting shame as an underlying theme is important in that it alerts the therapist to be particularly aware of their own non-verbal communication and speech pattern, and the client's tendency to hold back and test out the relationship (Gilbert, 1998b). Clinicians should also be aware of their own issues of shame, in particular in relation to drug use, so as not to inadvertently communicate this to clients (Nielsen, 1987). Indeed, amongst experts in the field of substance dependence, taking part in a recent Delphi survey of good practice (Jeffery, Ley, Bennun & McLaren, 2000), there was almost 100% agreement that training for all workers in this field should encourage a more positive attitude towards this client group. This possibly suggests that it might be particularly difficult to be non-judgmental when working with this type of clients. Being aware of shame is also important in terms of understanding the therapeutic process, particularly keeping an eye on counter-transference thoughts of being inadequate, not being good enough, and so forth. Otherwise the therapist may decide to increase the therapeutic input, in an attempt to compensate, whereas the client may feel a need to slow down to be able to follow (Retzinger, 1998). Also, shame-prone clients can

easily induce shame in others, and so, without good supervision such clients may be labelled manipulative or resistant (Nathanson, 1994). The importance of avoiding being pulled into shaming interactions is another area to be aware of, such as avoiding siding with the client against an abusive partner (Gilbert, 1998b).

In order not to set up therapy as a shame-eliciting experience, the process must be collaborative in order to minimise feelings of helplessness, subordination and submission. Thus, the consent and motivation to proceed with any task, in the session or in homework setting, must be sought and monitored. This must be done within a setting of clear boundaries so that the client feels some sense of stability, control and safety.

The label resistant may also be applied incorrectly to shame-prone individuals as they may appear not to volunteer information, or be emotionally distant. However, considering the fact that, for some clients, one of the aetiological factors of shame might have been the experience that disclosure in the past resulted in disbelief or ridicule from 'caring' others (Gilbert, 1992a), clients' lack of candour in therapy is understandable. Thus, discussion of the fears of disclosing is essential with such clients (Macdonald, 1998). Understanding that many shame effects happen involuntarily and are difficult to control, means the therapist can not only help the client to understand their experiences (e.g. paralysis, dissociation or mind-blanking) but also assist them in controlling or even getting out of such 'black holes' (Gilbert 1998b). Helping clients to gain an understanding of the functions of such experiences may be particularly important for some clients, as they might otherwise view these experiences as evidence that they are 'going mad', or that they are deficient in some way. In turn such understanding can help the therapist consider the whole spectrum of difficulties with disclosure.

Both the negative self-schema and the avoidant coping style associated with shame are associated with withdrawal behaviour. Such behaviour is likely to lead to social exclusion and feelings of loneliness, and ultimately might lead to problems in maintaining long-term relationships, which is one of the main risk factors in developing mental health problems. Thus, helping clients to understand that concealment (an attempt to avoid negative judgements by others) and a propensity to evaluate oneself negatively both come from feelings of shame, may help some clients to gain an alternative understanding of their patterns of relationship, which might include abusive relationships or lack of relationships. An awareness of how such propensities influence one's behaviour or lack of behaviour and one's attraction to certain people and situations could be a starting point. Using a CBT framework, clients may also be helped to understand why they have never changed, for instance, by looking at how the avoidant coping style led them to avoid opportunities which might otherwise have disproved their dysfunctional thinking. Helping clients to understand that their feeling of being stuck may be driven by shame may enable clients to engage further in treatment. The therapeutic task will then be to allow negative information to be tolerated in order to integrate this into a new self-schema.

The current study suggests that CDUs have a propensity to feel ashamed about their drug use, character and body, and that depression is likely to be a feature if clients present with bodily shame. Considering this, it might be advisable to explore these areas, in particular, with CDUs presenting with shame problems. However, the main implication here is probably that a full assessment of the individual's sources of shame should be carried out and interventions tailored accordingly in the context of other mental health and drug dependence problems.

Looking at the final stage of therapy, that of ending treatment, particular attention again has to be paid to the process with the now hopefully less-shame prone client. Generalising this new-found knowledge of relationships to outside the clinical room

is essential to prevent relapse. At the end of treatment the issue of betrayal, which for some clients might have been one of the aetiological proponents of shame, has to be borne in mind. Lewis (1998), in particular, suggests that clients should be helped to talk about their attributional processes around endings, in order to decrease the likelihood of clients ascribing the ending of treatment to some internal, global, and stable feature.

The above suggests that when offering therapy to clients with shame-based problems, a shame-based treatment is required, at least as a first step, before any drug dependence specific treatment is carried out. In addition, as research shows shame is associated with difficulties in disclosing, it might be that issues of shame have to be addressed when clients first come to the drug dependence services and are assessed by generic drug workers. Indeed, it might be that a full assessment cannot be completed before such issues are addressed. For instance, it may be that the reliability of the drug histories taken at intake, and updates of levels of current drug use in ongoing key-work sessions, is lowered unless issues of shame and service policy are openly and repeatedly discussed. The validity of assessments might also be improved, if key-workers are trained to address issues of shame and difficulties in talking about family and mental health issues in particular, as this study identified these to be the most regular issues not brought up.

As key-workers often are gatekeepers to psychological services, it would also be important to train this staff group to identify if shame is a particular issue for clients. Consultations could then be offered to the key-worker or a referral made, and facilitated sensitively, to psychology.

One of the main implications of the findings from this study is that it is paramount that services to drug dependent clients are based on a philosophy of non-shaming. This seems self-evident and it is hoped that all mental health services operate under this philosophy. However, in practice it is complex, in particular as one is dealing with a problem that is illegal at a societal level. For instance, a service policy that CDUs who are using street drugs in addition to their methadone will be discharged, may be experienced as punitive or as shaming by the individual client who is struggling with their drug use. Even when a harm-minimisation policy is adhered to instead, CDUs may be reluctant to disclose their additional drug use, which means the underlying problem causing the increased need is not addressed. The findings of this study thus emphasise the importance of transparency of service policies. In addition, this highlights how important it is that staff at all levels, including reception and secretarial staff, and the physical environment assists in providing a non-shaming environment for drug users. Training of staff and consultation into service development and provision are thus some of the main implications for clinical psychologists working in this field.

4.10. Conclusion

In summary, this thesis explored levels of shame in 31 chronic poly-drug users, in an out-patient methadone maintenance prescription program, compared to 31 non-drug users closely matched on gender and ethnicity. All participants completed the Experience of Shame Scale (Andrews et al., 2002) and standard self-report measures on depression, aggression and dissociation. Chronic drug users scored significantly higher on levels of characterological and behavioural shame, but not on bodily shame. However, when controlling for depression, only the group difference on characterological shame remained. Within the chronic drug-using group, the level of shame about drug use was higher than characterological, behavioural and bodily shame. 32% of CDUs were identified as non-disclosers. Non-disclosure was associated with increased levels of shame on all three standard shame sub-scales of the ESS, but not with shame about drug use. Shame-related issues and reasons for non-disclosure were identified from responses from the non-disclosers. This study replicates existing findings, based on shame measures more susceptible to negative affectivity, that chronic drug use is associated with increased shame. It extends existing literature in terms of suggesting possible sources of shame particular to drug dependence and their relationship to non-disclosure. However, it should be noted that all the findings were based on self-report measures and thus rely on the participant's memory of events and conscious awareness of feelings. Also, as the design was cross-sectional, it was not possible to infer any direction of causality and, thus, it was not possible to ascertain the role shame plays in drug dependence. Ideas for future research and implications for treatment were discussed.

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Appendix 1

Ethical permission letter from Camden & Islington NHS Mental Health Trust

Camden and Islington Community Health Service
LOCAL RESEARCH ETHICS COMMITTEE

Research & Development Unit, 3rd Floor, West Wing, St. Pancreas Conference Centre
St Pancreas Hospital, London NWI OPE
tel: 020 7530 3376 fax: 020 7530 3235
e-mail: ayse.all@clchs-tr.nthames.nhs.uk
Chair: ***Stephanie Ellis*** **Administrator:** ***Ayse All***

05 October 2001

Dr Paul Davis
ADDRESS

Dear Mr Davis

LREC Ref: 01/65 **(please quote in all further correspondence)**

Title: Exploration of Shame, Dissociation and Disclosure in Opiate Users

Thank you for addressing the comments the Committee had made. I am pleased to inform you that after careful consideration the Local Research Ethics Committee has no ethical objections to your project proceeding. This opinion has also been communicated to the Research and Development Unit of Camden & Islington Mental Health NHS Trust.

PLEASE NOTE THAT THIS OPINION ALONE DOES NOT ENTITLE YOU TO BEGIN RESEARCH.

Camden and Islington Community Health Service LREC considers the ethics of proposed research projects and provides advice to NHS bodies under the auspices of which the research is intended to take place. It is that NHS body which has the responsibility to decide whether or not the project should go ahead, taking into account the ethical advice of the LREC[1]. Where these procedures take place on NHS premises or using NHS patients, the researcher must obtain the agreement of local NHS management, who will need to be assured that the researcher holds an appropriate NHS contract, and that indemnity issues have been adequately addressed.

[1] Governance Arrangements for NHS Research Ethics Committees, July 2001

N.B. Camden and Islington Community Health Service LREC is an independent body providing advice to the North Central London Community Research Consortium. A favourable opinion from the LREC and approval from the Trust to commence research on Trust premises or patients are **NOT** one and the same. Trust approval is notified through the Research & Development Unit.

The following conditions apply to this project:

- You must write and inform the Committee of the start date of your project. The Committee (via the Local Research Ethics Committee Administrator or the Chair at the above address) must also receive notification:

  a) when the study commences;
  b) when the study is complete;
  c) if it fails to start or is abandoned;
  d) if the investigator/s change and
  e) if any amendments to the study are made.

- The Committee must receive immediate notification of any adverse or unforeseen circumstances arising out of the project.

- It is the responsibility of the investigators to ensure that all associated staff, including nursing staff, are informed of research projects and are told that they have the approval of the Ethics Committee and management approval from the body hosting the research.

- The Committee will require a copy of the report on completion of the project and may request details of the progress of the research project periodically (i.e. annually for longer projects).

- If data is? to be stored on a computer in such a way as to make it possible to identify individuals, then the project must be registered under the Data Protection Act 1998. Please consult your department data protection officer for advice.

- Failure to adhere to these conditions set out above will result in the invalidation of this Letter of no objection.

Please forward any additional information/amendments regarding your study to the Local Reseach Ethics Committee Administrator or the Chair at the above address.

Yours sincerely
Stephanie Ellis
Chair, LREC

Appendix 2

Chronic drug user participant information sheet and consent form

PARTICIPANT INFORMATION SHEET & CONSENT FORM

Study title: ***Feelings of shame in people who use or have used opiates.***

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and to decide whether or not you wish to take part. Please ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
To be able to improve the way services are offered to people who have problems with drugs it is important to find out if there are specific feelings that staff should be aware of when trying to help. This study looks at whether feelings of shame are important for people who have problems with drugs.

Why have I been chosen?
We have asked you to take part in the study as we want to hear from people who are on a maintenance methadone script. We hope to hear from 40 people who attend the XX Centre and from 40 people from the general public who have not got a drug misuse problem.

Do I have to take part?
You do not have to take part in this study if you do not want to. Your decision whether to take part or not will not affect the standard of your care or the management of your case in any way. If you do decide to take part you will be asked to sign a consent form but you are still free to withdraw at any time and without giving a reason. We will give you a copy of the consent form and this information sheet for you to keep.

What will happen to me if I take part?
If you decide that you would like to take part in this study I will ask you to fill in some questionnaires about your mood and feelings, and answer some questions about your experiences of the help offered to you. This should take about 45-50 minutes. After completion of all the questionnaires I will give you a £5.00 voucher for Woolworths or a BT telephone card as a thank you for your time. All information collected about you during the course of the research will be kept **strictly confidential.** The information will be coded by number and your name will not appear on any forms. However, if during our meeting you should say something that might make me concerned for your safety or the safety of others, I may have to inform staff at the XX Centre. If that should become necessary I will, however, inform you before doing so.

What will happen to the results of the research study?
The results of the research will be written up as part of a thesis which it is hoped will be published. You will not be identified in any report or publication. A summary of the findings will be available to all those who take part in the study.

Who is organising and funding the research?
This research is organised and funded by the University College London and Camden & Islington Mental Health NHS Trust.

Contact for further Information
If you would like any more information about the research or have any questions please do not hesitate to contact me (**Karen Andersen**) or Paul Davis on 7530 3057, or ask for me or Paul when you are next at the XX Centre.

Thank you very much for taking the time to read this and for taking part in this study!

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Camden and Islington Health Services NHS Trust Ethics Committee.
Date: _____ (version CDU).

(headed paper)

CDU Participant Number:

CONSENT FORM

Confidential

Title of Project: ***Feelings of shame in people who use or have used opiates.***

Name of Researcher: Karen Andersen

	Please tick
1. I confirm that I have read and understand the information sheet dated ..... (version CDU) for the above study	☐YES ☐ NO
2. I have had an opportunity to ask questions and discuss this study	☐YES ☐ NO
3. I understand that I am free to withdraw from this study:- • at any time, • without giving any reason, • without it affecting my medical care	☐YES ☐ NO
4. I understand that sections of any of my case notes from the CDU Centre may be looked at by the researcher where it is relevant to my taking part in this study. I give permission for this individual to have access to my records.	☐YES ☐ NO
5. I agree to take part in the above study.	☐YES ☐ NO

Name of Participant	**Date**	**Signature**
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

(1 for participant; 1 for researcher; 1 to be kept with case notes)

Appendix 3

Jobcentre participant information sheet and consent form

PARTICIPANT INFORMATION SHEET & CONSENT FORM

Study title: ***Feelings of shame in people who use opiates.***
You are being invited to take part in a research study. Before you decide it is important to understand why the research is being done and what it will involve. Please take time to read the following information carefully and to decide whether you wish to take part. Please do not hesitate to ask me if there is anything that is not clear.

What is the purpose of the study?
To be able to improve the way services are offered to people who have problems with drugs it is important to find out if there are specific feelings that staff should be aware of when trying to help. Recently feelings of shame have been found to be important in various mental health problems. This study aims to look at whether such feelings are also important for people who have problem with drugs.

Why have I been chosen?
We have asked you to take part in this study, as we would like to compare the results we have gained from people with drug problems to the responses from a group of people from the general public who do not have drug- or alcohol- misuse problems. We hope to hear from 40 people from the Jobcentre and from 40 people who attend a local Drug Dependency Unit.

Do I have to take part and who organises the research?
You do not have to take part in this study if you do not want to. The Jobcentre has given permission for the research to take place on their premises, but the research is completely independent from the Jobcentre. The research is funded and organised by University College London and Islington Mental Health NHS Trust and they employ the researcher who is a trainee psychologist. Your decision whether to take part or not will not affect your Benefit Rights or the management of your case with the Jobcentre or Benefits Agency in any way. If you do decide to take part you will be asked to sign a consent form but you are still free to withdraw at any time and without giving a reason. You will be given a copy of the consent form and this information sheet for you to keep.

What will happen to me if I take part?
I will ask you to fill in some questionnaires about your mood and feelings, which should take about 30-40 minutes. After completion of all the questionnaires, I will give you a £5.00 gift voucher to Woolworth's as a thank you for taking part. However, as I am looking to hear from people who do not have a drug- or alcohol- misuse problem and who are not currently in contact with any mental health services, you will first have to answer a few questions about your drug- and alcohol- use, recent contact with mental health services and give a few personal details (age, gender & ethnic background). This is in order to find out if there are any reasons why you cannot take part in the study. All information collected about you will be kept **strictly confidential** and Jobcentre staff will not have *any* access. The information will be coded by number and your name will not appear on any forms. However, if during our meeting you should say something that might make me concerned for your safety or the safety of others, I may have to inform your GP. However, if that should become necessary I will inform you before doing so.

What will happen to the results of the research study?
The results of the research will be written up, as part of a thesis, which it is hoped, will be published. You will not be identified in any report or publication. If you would like a summary of the findings please leave your address with me.

Contact for further Information
Please do not hesitate to contact me, **Karen Andersen**, or Paul Davies on 7530 3057 at the CDU Centre (Drug Dependency Unit) in Camden, if you would like any more information about the research or have any questions.

Thank you very much for taking the time to read this and for taking part in this study!

Date: _____ (version Jobcentre).

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Camden and Islington Mental Health NHS Trust Ethics Committee.

(headed paper)

Jobcentre Participant Number:

CONSENT FORM

Confidential

Title of Project: ***Feelings of shame in people who use or have used opiates.***

Name of Researcher: Karen Andersen

	Please tick
1. I confirm that I have read and understand the information sheet dated ..... (version Jobcentre) for the above study	☐YES ☐ NO
2. I have had an opportunity to ask questions and discuss this study	☐YES ☐ NO
3. I understand that I am free to withdraw from this study:- • at any time, • without giving any reason, • without it affecting my medical care	☐YES ☐ NO
4. I agree to take part in the above study.	☐YES ☐ NO

Name of Participant	**Date**	**Signature**
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

(1 for participant; 1 for researcher)

Appendix 4

Local mental health and drug/alcohol services information sheet

Information about NHS services in Hackney:

Services for people who are experiencing mental health problems:

If you feel in the need of immediate help you can go to one of the following services:

***Emergency Clinic @ Homerton Hospital*, East Wing**
Homerton Row, Hackney, E9
Telephone: 020 8510 8176
This emergency service takes self referrals and is open 9am-5pm

Your local Accident & Emergency Department

Your General Practitioner (GP)

Otherwise, please contact one of the following services:

Your General Practitioner (GP).
They will then refer you to the service that is most suitable for you.

South East Locality Mental Health Team
26 Shore Road, South Hackney, E9
Telephone: 020 8533 6116
This service takes self-referrals. Please ring for an appointment

South West Locality Mental Health Team
100 Shepherdess Walk, Hoxton, N1
Telephone: 020 7445 7900
This service takes self-referrals. Please ring for an appointment

Services for people who are experiencing problems with alcohol use:

City & Hackney Alcohol Counselling Service
134 Kingsland Road, Shoreditch, E2
Telephone: 020 7613 1313
This service takes self-referrals. Please ring for an appointment

Cross-Road Centre - drop-in service
2 Westgate Street, London Fields, E8
Telephone: 020 8525 1313
No appointment needed, just go to their drop-in centre: Monday to Thursday, 1-4pm.

Services for people who are experiencing problems with drug use:

Hackney Community Drug Service
98 Upper Clapton Road, Upper Clapton, E5
Telephone: 020 8442 9678
No appointment needed, just go to their drop-in centre: Monday to Friday, 1-4pm.

Drug Dependency Unit @ Homerton Hospital, East Wing
Homerton Row, Hackney, E9
Telephone: 020 8510 8629

Appendix 5a

Demographic questions sheet

DEMOGRAPHIC QUESTIONS:

1. **Age** _____ years

2. **Gender**: ☐ Female ☐ Male

3. **Ethnicity** (Ask participant to point to category on standard list)

☐ White-British
☐ White-Irish
☐ White-Other.....(please specify)

☐ Mixed-White and Black Caribbean
☐ Mixed-White and Black African
☐ Mixed-White and Asian
☐ Mixed-Other.....(please specify)

☐ Asian or Asian British-Indian
☐ Asian or Asian British-Pakistani
☐ Asian or Asian British-Bangladeshi
☐ Asian or Asian British-Other.....(please specify)

☐ Black or Black British-Caribbean
☐ Black or Black British-African
☐ Black or Black British-Other.....(please specify)

☐ Chinese
☐ Arab
☐ Other ethnic group.....(please specify)

4. **Education** _____ age when left school.
Qualifications: O-level, A-level, Higher education:_____

5. **Later qualifications or training**_____

6. **Occupation**_____

Appendix 5b

Aggression Questionnaire

Please read each of the statements below carefully and rate each item as it relates to you on the scale of 1 (extremely uncharacteristic of me) to 5 (extremely characteristic of me).

Please circle the number that most closely related to you.

	extremely uncharacteristic of me				extremely characteristic of me
1. Some of my friends think I'm a hothead.....	1	2	3	4	5
2. When people annoy me I may tell them what I think of them.....	1	2	3	4	5
3. I know that "friends" talk about me behind my back.....	1	2	3	4	5
4. There are people who pushes me so far that we come to blows.....	1	2	3	4	5
5. When people are especially nice, I wonder what they want.....	1	2	3	4	5
6. Given enough provocation, I may hit another person.....	1	2	3	4	5
7. When frustrated, I let my irritation show.....	1	2	3	4	5
8. My friends say that I'm somewhat argumentative.....	1	2	3	4	5
9. I sometimes feel that people are laughing at me behind my back.....	1	2	3	4	5
10. I am sometimes eaten up with jealousy.....	1	2	3	4	5
11. I have threatened people I know.....	1	2	3	4	5
12. I can think of no good reason for ever hitting a person.....	1	2	3	4	5
13. At times I feel I get a raw deal out of life.....	1	2	3	4	5
14. I sometimes feel like a powder keg waiting to explode.....	1	2	3	4	5
15. I am an even-tempered person.....	1	2	3	4	5
15. I tell my friends openly when I disagree with them.....	1	2	3	4	5
17. Once in a while I can't control the urge to strike another person.....	1	2	3	4	5
18. I am suspicious of overly friendly strangers.....	1	2	3	4	5
19. Sometimes I fly of the handle for no good reason.....	1	2	3	4	5
20. I have become so mad that I have broken things.....	1	2	3	4	5
21. If somebody hits me, I hit back.....	1	2	3	4	5
22. Other people always seem to get the breaks.....	1	2	3	4	5
23. I have trouble controlling my temper.....	1	2	3	4	5
24. I often find myself disagreeing with people.....	1	2	3	4	5

	extremely uncharacteristic of me				extremely characteristic of me
25. I get into fights a little more than the average person.....	1	2	3	4	5
26. I wonder why sometimes I feel so bitter about things.....	1	2	3	4	5
27. I flare up quickly but get over it quickly.....	1	2	3	4	5
28. I can't help getting into arguments when people disagree with me...	1	2	3	4	5
29. If I have to resort to violence to protect my rights, I will.....	1	2	3	4	5

Appendix 5c

Experience of Shame Scale (incl. shame about drug use scale)

These questions are about your feelings about yourself and the way you look at **any time in the past year**. There are no 'right' or 'wrong' answers.

Please tick the response which applies to you.

	not at all	**a little**	**moderately**	**very much**
1. Have you felt ashamed of any of your personal habits?	( )	( )	( )	( )
2. Have you worried about what other people think of any of your personal habits?	( )	( )	( )	( )
3. Have you tried to cover up or conceal any of your personal habits?	( )	( )	( )	( )
4. Have you felt ashamed of your manner with others?	( )	( )	( )	( )
5. Have you worried about what other people think of your manner with others?	( )	( )	( )	( )
6. Have you avoided people because of your manner?	( )	( )	( )	( )
7. Have you felt ashamed of the sort of person you are?	( )	( )	( )	( )
8. Have you worried about what other people think of the sort of person you are?	( )	( )	( )	( )
9. Have you tried to conceal from others the sort of person you are?	( )	( )	( )	( )
10. Have you felt ashamed of your ability to do things?	( )	( )	( )	( )
11. Have you worried about what other people think of your ability to do things?	( )	( )	( )	( )
12. Have you avoided people because of your inability to do things?	( )	( )	( )	( )
13. Do you feel ashamed when you do something wrong?	( )	( )	( )	( )
14. Have you worried about what other people think of you when you do something wrong?	( )	( )	( )	( )
15. Have you tried to cover up or conceal things you felt ashamed of having done?	( )	( )	( )	( )

	Not at all	a little	moderately	very much
16. Have you felt ashamed when you said something stupid?	( )	( )	( )	( )
17. Have you worried about what other people think of you when you said something stupid?	( )	( )	( )	( )
18. Have you avoided contact with anyone who knew you said something stupid?	( )	( )	( )	( )
19. Have you felt ashamed when you failed in a competitive situation?	( )	( )	( )	( )
20. Have you worried about what other people think of you when you failed in a competitive situation?	( )	( )	( )	( )
21. Have you avoided people who have seen you fail?	( )	( )	( )	( )
22. Have you felt ashamed of your body or any part of it?	( )	( )	( )	( )
23 . Have you worried about what other people think of your appearance?	( )	( )	( )	( )
24. Have you avoided looking at yourself in the mirror?	( )	( )	( )	( )
25. Have you wanted to hide or conceal your body or any part of it?	( )	( )	( )	( )
26. Have you felt ashamed of having a drug problem?	( )	( )	( )	( )
27. Have you worried about what people think of you having a drug problem	( )	( )	( )	( )
28. Other than for legal reasons, have you tried to cover up or conceal that you have a drug problem	( )	( )	( )	( )
29. Have you felt ashamed of any of the things you have done in relation to taking drugs?	( )	( )	( )	( )
30. Have you worried about what other people think of any of the things you have done in relation to taking drugs?	( )	( )	( )	( )
31. Other than for legal reasons, have you tried to hide or conceal any of the things you have done in relation to taking drugs?	( )	( )	( )	( )

Appendix 5d

Disclosure questions sheet

Please indicate **how far you agree** with each of the statements below by putting a mark on each of the lines:

Practice item:

I LIKE the colour red	_____	I DONT LIKE the colour red

Test items:

1. I have told staff involved in my care EVERYTHING about myself	_____	I have told staff involved in my care NOTHING about myself
2. Staff CAN help me even without knowing everything about me	_____	Staff CANNOT help me unless they know everything about me

Please feel free not to answer the following questions:

If you have not been able to tell staff involved in your care about important personal issues, what were these issues?

_____
_____
_____
_____
_____
_____

Why did you not feel able to tell staff about these issues?

_____
_____
_____
_____
_____
_____

Appendix 5e

Dissociative Experiences Scale

DISSOCIATIVE EXPERIENCES SCALE

DIRECTIONS: This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. To answer the questions, please determine to what degree the experience described in the question applies to you and circle a number, as shown in the example below, to show what percentage of the time this happens to you.

Example: 0% (never) 10% 20% 30% 40% (50%) 60% 70% 80% 90% 100% (always)

1	Some people have the experience of driving or riding in a car or bus or train and suddenly realizing that they don't remember what has happened during all or part of the trip. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
2	Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said/ 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
3	Some people have the experience of finding themselves in a place and having no idea how they got there. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
4	Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
5	Some people have the experience of finding new things among their belongings that they do not remember buying. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
6	Some people sometimes find that they are approached by people who they do not know who call them by another name or insist that they have met them before. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
7	Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as it they were looking at another person. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
8	Some people are told that they sometimes do not recognize friends or family members. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
9	Some people find that they have no memory for some important event in their lives (for example, a wedding or graduation). 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
10	Some people have the experience of being accused of lying when they do not think they have lied. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
11	Some people have the experience of looking in a mirror and not recognizing themselves. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
12	Some people have the experience of feeling that other people, objects, and the world around them are not real. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
13	Some people sometimes have the experience of feeling that their body does not seem to belong to them. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

14	Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
15	Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
16	Some people have the experience of being in a familiar place but finding it strange and unfamiliar.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
17	Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
18	Some people find that they become so involved in a fantasy or daydream that it feels as thought it were really happening to them.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
19	Some people sometimes find that they sometimes are able to ignore pain.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
20	Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
21	Some people sometimes find that when they are alone they talk out loud to themselves.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
22	Some people find that in one situation they may act so differently compared with another situation that they feel almost as it they were two different people.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
23	Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.)										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
24	Some people find evidence that they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it).										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
25	Some people find evidence that they have done things that they do not remember doing.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
26	Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
27	Some people sometimes find that they hear voices inside their head that tell them to do things or comment on thing that they are doing.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
28	Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear to be far away or unclear.										
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Appendix 5f

Spot-the-Word Test

The Spot-the-Word Test Version A

This is a test of your knowledge of words. You will be asked to decide which of two items, such as 'bread' and 'glot', is a real word and which is an invented item; 'bread', of course, it the real word.

Each of the pairs of items below contains one real word and one nonsense word, invented so as to look like a word but having no meaning. Please tick the item in each pair that you think is the real word. Some will be common words, most will be uncommon and some very rarely used. If you are unsure, guess, you will probably be right more often than you think.

Before you begin the main test try the following Practice

kitchen	-	harrick
puma	-	laptess
plorinum	-	levity
cuticle	-	andrinand
flonty	-	xylophone
craxent	-	sofa

Are they any questions?

broxic - oasis
pinnace - strummage
mannerism - whitten
daffodil - gombie
bellissary - cyan
vellicle - sampler
necromancy - ghoumic
narwhal - epilair
venady - monad
plargen - savage
clegger - minim
knibbet - mandrake
canticle - grammule
threnody - epigrot
brastome - banshee
shako - strubbage
paraclete - elezone
froopid - clod
rouse - choffid
goblet - prelly
flexipore - viscera
agipect - almond
tarantula - hostent
trelding - rafters
legify - archaic
obsidian - plassious
restance - zombie
pimple - brizzler
frellid - static
hilfren - domain

livid - trasket

thrash - listid

holomator - dross

orifice - serple

phalanx - distruvial

chloroleptic - lapidary

biothon - palfrey

arhchipelago - zampium

groudy - toga

moxid - tangible

moralist - florrical

quince - bostry

lignovate - epicene

gibbon - wonnage

hipple - osprey

element - pargler

viridian - psynoptic

glorvant - onyx

plankton - whippen

akimbo - periasty

centaur - tritonial

vinady - bargain

prinodal - mango

reticule - fluxent

frembulous - ontology

loxeme - legerdemain

hoyden - clinotide

aboriginal - hostasis

clavanome - bestiary

zando - albatross

Appendix 5g

Beck Depression Inventory-II

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best described the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement form any group, including Item 16 (changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness 0 I do not feel sad. 1 I feel sad much of the time. 2 I am sad all the time. 3 I am so sad or unhappy that I can't stand it.	**6. Punishment Feelings** 0 I don't feel I am being punished. 1 I feel I may be punished. 2 I expect to be punished. 3 I feel I am being punished.
2. Pessimism 0 I am not discouraged about my future 1 I feel more discouraged about my future than I used to be. 2 I do not expect thing to work out for me. 3 I feel my future is hopeless and will only get worse.	**7. Self-Dislike** 0 I feel the same about myself as ever. 1 I have lost confidence in myself. 2 I am disappointed in myself. 3 I dislike myself.
3. Past Failure 0 I do not feel like a failure 1 I have failed more than I should have. 2 As I look back, I see a lot of failures. 3 I feel I am a total failure as a person.	**8. Self-Criticalness** 0 I don't criticize or blame myself more than usual. 1 I am more critical of myself than I used to be. 2 I criticize myself for all of my faults 3 I blame myself for everything bad that happens.
4. Loss of Pleasure 0 I get as much pleasure as I ever did from things I enjoy. 1 I feel don't enjoy things as much as I used to do. 2 I get very little pleasure from the things I used to enjoy. 3 I can't get any pleasure from the things I used to enjoy.	**9. Suicidal Thoughts or Wishes** 0 I don't have any thoughts of killing myself. 1 I have thoughts of killing myself, but I would not carry them out. 2 I would like to kill myself. 3 I would kill myself if I had the chance.
5. Guilty Feelings 0 I don't feel particularly guilty. 1 I feel guilty over many things I have done or should have done. 2 I feel quite guilty most of the time. 3 I feel guilty all of the time.	**10. Crying** 0 I don't cry anymore than I used to. 1 I cry more than I used to. 2 I cry over every little thing. 3 I feel like crying, but I can't.

Continue on Back

____ Subtotal Page 1

11. Agitation 0 I am no more restless or would up than usual. 1 I feel more restless or would up than usual. 2 I am so restless or agitated that it's hard to stay still. 3 I am so restless or agitated that I have to keep moving or doing something.	**17. Irritability** 0 I am no more irritable than usual. 1 I am more irritable than usual. 2 I am much more irritable than usual. 3 I am irritable all the time.
12. Loss of Interest 0 I have not lost interest in other people or activities. 1 I am less interested in other people or things than before. 2 I have lost most of my interest in other people or things. 3 It's hard to get interested in anything.	**18. Changes in appetite** 0 I have not experienced any change in my appetite. 1a My appetite is somewhat less than usual. 1b My appetite is somewhat greater than usual. 2a My appetite is much less than before. 2b My appetite is much greater than usual. 3a I have no appetite at all. 3b I crave food all the time.
13. Indecisiveness 0 I make decisions about as well as ever. 1 I find it more difficult to make decisions than usual. 2 I have greater difficult in making decisions than I used to. 3 I have trouble making any decisions.	**19. Concentration Difficulty** 0 I can concentrate as well as ever. 1 I can't concentrate as well as usual. 2 It's hard to keep my mind on anything for very long. 3 I find I can't concentrate on anything.
14. Worthlessness 0 I do not feel I am worthless. 1 I don't consider myself as worthwhile and useful as I used to. 2 I feel more worthless as compared to other people. 3 I feel utterly worthless.	**20. Tiredness or Fatigue** 0 I am no more tired or fatigued than usual. 1 I get more tired or fatigued more early than usual. 2 I am too tired or fatigued to do a lot of the things I used to do. 3 I am too tired or fatigued to do most of the things I used to do.
15. Loss of Energy 0 I have as much energy as ever. 1 I have less energy than I used to have. 2 I don't have enough energy to do very much. 3 I don't have enough energy to do anything.	**21. Loss of Interest in Sex** 0 I have not noticed any recent changes in my interest in sex. 1 I am less interested in sex than I used to be. 2 I am much less interested in sex now. 3 I have lost interest in sex completely.
14. Changes in Sleeping Pattern 0 I have not experienced any change in my sleeping pattern 1a I sleep somewhat more than usual. 1b I sleep somewhat less than usual. 2a I sleep a lot more than usual. 2b I sleep a lot less than usual. 3a I sleep most of the day 3b I wake up 1-2 hours early and can't get back to sleep.	

____ Subtotal Page 2
____ Subtotal Page 1
____ Total Score

Appendix 5h

Mental Health, CAGE and Drug-CAGE screening questions sheet

You may remember from the information sheet that I am looking to speak to people who are **not** currently experiencing any mental health difficulties or have a problem with their alcohol- or drug- use. I therefore need to ask the following questions to find out if you can take part in the study.

Please circle your reply to each of the following questions.

1a. Have you seen anyone in the past 2 years about a mental health problem (e.g. a psychologist or psychiatrist)? ..... Yes No

1b. Have you taken any medication for a mental health problem in the past 2 years? ..... Yes No

2a. In the past 2 years have you felt you ought to cut down on your drinking? ..... Yes No

2b. In the past 2 years have people annoyed you by criticising your drinking? ..... Yes No

2c. In the past 2 years have you felt bad or guilty about your drinking? ..... Yes No

2d. In the past 2 years have you had a drink first thing in the morning to steady your nerves or to get rid of a hangover? ..... Yes No

3a. In the past 2 years have you felt you ought to cut down on your drug use? ..... Yes No

3b. In the past 2 years have people annoyed you by criticising your drug use? ..... Yes No

3c. In the past 2 years have you felt bad or guilty about your drug use? ..... Yes No

3d. Sometimes people feel bad when a drug wears off:

-Has that happened to you in the past 2 years? ..... Yes No

-In the past 2 years, have you had to take another drug when that happened? ..... Yes No

Appendix 6

Preparation of the data for statistical testing

Preparation of the data for statistical testing

Processes used to address issues of outliers, missing data and non-normal distributions. Before any statistical tests were performed the data set was 'cleaned' by checking all variables for outliers and missing data following the procedures outlined below. In order to determine whether parametric or non-parametric statistical tests could be carried out, the degree of fit with the normal distribution was assessed by looking at the histograms, level of skewness, kurtosis and Kolmogorow-Smirnov (K-S) test for each variable.

Outliers. Using a cut-off of more than three standard deviations from the mean all variables were checked for statistical outliers. Using this method one outlier was identified in the characterological shame sub-scale ($Z = 3.18$) and one in the verbal aggression sub-scale ($Z = 3.54$), both of which were for participants from the control group. Following standard procedures, both outliers were replaced by the highest score on that particular variable plus one (30 + 1 and 18 + 1, respectively). One outlier was identified in the total depression scores in the control group ($Z = 3.78$). The associated total depression raw score of 52 was in the higher end of the severe depression range of the depression (28-63). As one of the exclusion criteria was to not include people with mental health difficulties all data for this case was removed from the data set. One outlier was identified in the total dissociation scores in the control group ($Z = 4.60$), which was replaced by the highest score plus one (57+ 1).

Missing values. Missing items from demographic variables were left blank and thus decreased the number of participants in some of the statistical tests. For example, two participants in each of the groups could not read and the questionnaires were read out aloud for them, and they were therefore not asked to complete the Spot-the-Word IQ tests. One Spot-the-word score was not included for one of the participants in the drug users group as English was their second language. Thus the number of participants for this variable was reduced to 57.

One item from the behavioural shame sub-scale and one from the bodily shame sub-scale were missing from the shame questionnaires filled in by drug user participants. From one aggression questionnaire in the drug users group, one verbal aggression and one hostility item were missing, and one verbal aggression item was missing from an aggression questionnaire in the control group. As the distribution of scores for all of these sub-scales were not significantly different from the normal distribution for the group of participants where the values was missing, each missing value was substituted with the mean value of the respective sub-scale. One of the drug users failed to complete the whole questionnaire pack and as a result no depression scores was available for this participant.

Tests of shape of distribution of scores. As mentioned above, the shape of the distribution was assessed by looking at histograms, level of skewness, kurtosis and K-S tests for each variable. Any variables with an associated K-S probability $< .01$ were deemed to be significantly different from the normal distribution. This would generally mean that non-parametric tests would be carried out on such variables, unless various transformations (including reflecting and squaring the values)

improved the fit with the normal distribution.

The distributions of scores for age and IQ of participants, depression, dissociation, all aggression sub-scales and total aggression scale for both groups of participants were not significantly different from the normal distribution, thus parametric tests were carried out. Scores on the age of participants when they left school and the time lapsed since they last worked were significantly different from the normal distribution (all K-S Lillifors ps < .01) and thus non-parametric tests were used on this data.

In terms of total shame scores (excluding shame about drug taking), the distribution of scores was not significantly different from the normal distribution for the experimental group (K-S Lilliefors (31) = .16, p = .04) but was significantly different from the normal distribution for the control group (K-S Lilliefors (31) = .19, p < .01). However, as the distribution based on a transformation of these scores, by way of squaring, was no longer significantly different from the normal distribution for both the drug users group (K-S Lilliefors (31) = .13, p = .16) and the control group (K-S Lillifors (31) = .17, p = .02), all the statistical tests were performed on the transformed scores using parametric tests. Neither the characterological shame sub-scale for both the experimental and the control group (K-S Lilliefors (31) = .14, p = .12 and (31) = .16, p = .03, respectively), nor the behavioural shame sub-scale for both groups of participants (K-S Lillifors (31) = .120, p > .20 and (31) = .145, p = .094, respectively) had distributions that were significantly different from the normal distribution, and so parametric tests were used when looking at these shame sub-scales.

For the drug users group the distribution of scores on the bodily shame sub-scale was not significantly different from normal (K-S Lillifors (31) = .15, p = .06), but the distribution for the control group was (K-S Lillifors (31) = .25, p < .001) with a skewness of 1.02 and kurtosis of .82. Transforming the bodily shame scores using Log10 gave the best shape of distribution and increased the K-S Lillifors (31) to = .09, p > .20 for the drug users and K-S Lillifors (31) = .19, p = .0065 for the control group. The p-value for the control group was thus just below the acceptable level of p < .01, indicating that the distribution of transformed scores had been improved considerably but was still significantly different from the normal distribution, thus suggesting that non-parametric tests should be used. However, by computing non-parametric analyses on the original data-set as well as their parametric equivalents on the transformed data-set for all the tests carried out on this variable, as seen below, the result were discovered to be very similar:

Correlations between bodily shame and age of participants:
Spearman's Rho (62) = -.14, p = .26
Pearson's r (62) = -.15, p = .24

Correlations between bodily shame and age-scaled IQ of participants:
Spearman's Rho (62) = -.14, p = .32
Pearson's r (62) = -.12, p = .39

Difference in bodily shame between the three levels of exams gained:
Kruskal-Wallis (2) = .75, p = .68
One-way ANOVA: F (2, 57) = .40, p = .67

Mean differences in bodily shame scores between the drug users and the controls:
Mann-Whitney U(31,31) = -2.63, p = .009
Independent samples t-test(62) = 2.74, p = .008.

Correlations between bodily shame and Depression:
Spearman's Rho (61) = .61, p < .001
Pearson's r (61) = .62, p < .001

To reduce repetition, only the parametric analyses were reported in the result section. These observed similarities between the non-parametric and parametric results

suggest that it was acceptable to use parametric statistics with this variable for those particular tests. Bearing this in mind, and the fact that the level of the p-value only fell marginally below the .01-level, it was decided that it would be acceptable to use the parametric analysis Univariate analysis of variance with covariates as no non-parametric equivalent exists, with this proviso that it was not possible to compare the results with a non-parametric equivalent. The distribution of the shame about drug use sub-scale scores was almost significantly different from the normal distribution (K-S Lilliefors (31) = .17, p = .02), and as a transformation of these scores, reflection and squaring did not result in any improvement, parametric tests will be carried out on the original scores.