Unraveling Shame: Exploring the Pathways That Connect Shame and Substance Use Disorders. An Attachment-Based and Polyvagal Approach.

by

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Abstract

Shame is a powerful emotion that has long been theorized to play a role in the development and maintenance of substance use disorders. Despite the significant prevalence of substance-related deaths in Canada, limited research has investigated the influence of shame on substance addiction among substance-using populations (Government of Canada, 2024). In this capstone, I explore the existing research and literature and attempt to unearth the various ways that shame intersects with and influences the experience of substance use. Combining attachment-based and polyvagal principles, I provide a psychoeducational approach for discussing the subject of shame with individuals in substance use treatment within a group format. It is further proposed that the workshop material may serve as a resource for clinician groups to deepen their understanding of and comfort with their own shame-related responses.

*Keywords: s*hame, substance use treatment, polyvagal theory

Dedication

This capstone is dedicated in loving memory to my furry companion, Evie, whose unwavering presence during my writing process helped me understand the power of co-regulation and its transformative ability to alleviate feelings of shame. I finally finished it Evie!

This paper is also dedicated to anyone who has ever been made to feel that they weren't good enough. I see you. You are a remarkable being.

Acknowledgments

I would like to acknowledge and thank my capstone advisor, Maria Stella, for the patience and space she held for me to work through the capstone process and whose own passion for the topic of shame served as inspiration for me to move forward with exploring this important topic.

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Chapter 1: Introduction

Overview of the Topic

No matter how you define it, one cannot refute that addiction is a complex process that impacts, and in some cases devours, many precious lives. The Canadian Centre on Substance Use and Addiction (2023) estimates that in 2020, 73,994 deaths in Canada were attributed to substance use. Moreover, in the first quarter of 2024, the Government of Canada reported an average of 21 lives lost to opioid and/or stimulant-related deaths each day (Government of Canada, 2024). These numbers are substantial and have been moving in an upwards trajectory year over year (Government of Canada, 2024). What is more, such deaths are largely preventable with appropriate treatment. And while extensive technological and medical advancements have been achieved over the past few decades, we are still far from effectively treating and understanding the full nature of addiction.

While death is the gravest consequence of addiction, a myriad of suffering is often encountered beforehand. At problematic levels, substance use often leads to substantial loss in various domains of one's life, including relationships, health, career, and finances, among others. The farther down the path of substance use, one may even begin to lose their sense of identity and connection to the world. Genuine experiences are traded in for the effects of psychoactive substances, however fleeting those effects may be. Substance addiction has significant individual, familial, and societal ramifications, and effective interventions and guidance on how to support individuals with SUDs are needed more than ever.

In October 2023, the Government of Canada published The Canadian Drugs + Substances Strategy, which outlines the extent of substance use related harms and the overdose crisis in Canada between January 2016 and March 2023. The publication also outlines the

government's strategy for tackling the issue and specifies the importance of taking a holistic approach to the crisis, which includes pharmacological interventions, peer support, vocational training, and access to trauma informed evidence-based services such as counselling (Government of Canada, 2023). Such an approach aligns with the biopsychosocial model of addiction that views SUDs as the product of a complex interplay of biological, psychological, and social factors (Alderson, 2019). Evidence-based practices for SUDs include Cognitive Behavior Therapy (CBT), Motivational Interviewing (MI), and Contingency Management (Alderson, 2019). While these approaches have immense merit, none of them directly address one's emotional experience. Determining how to work with the deeper, underlying material that lives within the body largely rests on the counsellor to figure out.

For decades, the emotion of shame has been discussed and theorized to play a role in the development and maintenance of SUDs and substance use related problems (Batchelder er at., 2022; Wiechelt, 2007). On the surface this makes sense, given the vast stigma that exists around the topic of substance addiction – much of which stems from political and social narratives that pathologize such behavior. However, as this capstone will address, societal stigma is just the tip of the iceberg when it comes to SUDs. One only needs to insert a few cracks in the ice to see that there's a complex assembly of shame that lay in the depths beneath. By shining a light on these deeper layers and the brave researchers who have ventured there, we can hopefully gain more clarity on how to incorporate shame in clinical work for substance use recovery.

Purpose Statement

The primary inspiration for this paper was drawn from the numerous clients that courageously walked into the counselling room during my internship with a willingness to explore their struggles with substance use. While the content of each of their stories was

different, a common thread interwove clients' experiences on a collective level. Felt in the room as a dark, albeit invisible, heaviness, this shared thread was the emotion of shame. And although the emotion took on different shapes and sizes, its presence could not be packaged up and set aside for later. It was clear that this shame needed to be incorporated into the course of treatment.

Another common and persistent theme throughout my internship and my work with clients was the prevalence of trauma. Narratives of terrifying instances of abuse, parental abandonment, and punishment for emotions that were "too much" enveloped the counselling room on more occasions than I would like to admit. The lingering shame from these events was observable in my clients' speech, posture, and selection of words. It was clear that this resulting shame was keeping many of my clients stuck in various ways. I became fascinated with how this shame takes hold and the possibilities that exist for unraveling the experience.

In light of this, the primary research question guiding this capstone is: What are the distinct layers of shame that arise in substance use counselling, and where do they originate from? With this information, my secondary question is: How do clinicians begin to facilitate conversations about shame in substance use counselling?

Contribution to the Field

As discussed by renowned researcher Brené Brown in relation to shame –everybody has it and no one wants to talk about it (Brown, 2021). This capstone project will contribute to the counselling field by opening up the conversation around shame. Even more, this capstone will shine a light on shame; an emotion that's so often cast as a side character to the emotions of fear, anger, and sadness. Readers will gain an understanding of the various layers of shame that are intricately connected to the experience of substance use and addiction, going all the way back to early development. This exploration will also demonstrate that shame carries more than

emotional properties. Rather, the shame experience also touches upon physiological, social, and cognitive dimensions that comprise a more holistic view of SUDs within the biopsychosocial framework.

Lastly, I will highlight the windows of opportunity for counsellors to talk about shame with their clients. I will offer a group approach for aiding both clients and counsellors in making contact with their experience of shame. This will also set the foundation for deeper work should individuals wish to carry on their shame journey further. While the focus of this capstone falls within the context of substance use, much of the information and supporting research can be utilized in more general counselling work with clients. Shame does not discriminate and plays a significant role in various mental health conditions and challenges that bring clients to counselling.

Reflectivity and Positionality Statement

I would first like to acknowledge that I'm a Caucasian female who was born and raised in Canada in a middle-class family. The intersection of several of these cultural locations granted me access to attend postsecondary education and then later pursue my Masters of Counselling while in search of a career that aligned with my authentic self. I do not take it lightly that I hold privilege as a white, hetero, cis, able-bodied human being, and further that I am able to study and work in a field that lights me up inside. In addition to the different cultural groups that I belong to, I possess both personal and professional connections to the topic of substance use.

I also believe it is important that I highlight my personal connection with substance use. A very close family member has struggled with substance use for almost 20 years. The experience of witnessing the destruction it has caused to both them and others in their life is heartbreaking. Out of deep compassion for my loved one, I have been active in wanting to learn

as much about substance addiction as I can. I have always intuitively known that it cannot be deduced to a single factor or reason, and this has motivated me to seek out answers from various experts and knowledge holders in the field. Thus, my hope from this capstone is that the synthesization of the topics of shame and substance use will further the conversation around its etiology and implications for treatment, with an overarching goal to further reduce the level of stigma associated with substance use.

Definition of Terms

Attachment theory

A psychological theory of human development that highlights the importance of the emotional bond that transpires between infant and caregiver to ensure the newborn's survival and ensuing development (Bartholomew & Horowitz, 1991).

Autonomic nervous system

The autonomic nervous system is comprised of two branches—the sympathetic and parasympathetic nervous system—and is responsible for the survival responses of fight, flight, freeze, fawn, and shutdown (Dana, 2021).

Chronic shame

Shame that is recurring, long lasting, and persistent, and targets the core of an individual as worthless or defective (Brown, 2021; Dolezal, 2022).

Complex-PTSD

A variation of posttraumatic stress disorder that exerts significant effects on the developing brain and body as a result of repeated exposure to events that overwhelm the nervous system and may include experiences such as sexual abuse, parental neglect, and harsh or severe punishment (Briere & Scott, 2014).

Guilt

An emotion that transpires when one believes they've bestowed harm on another or done something wrong (Brown, 2021).

Implicit memories

Memories are activated outside of conscious awareness and typically present in the form of physical sensations or emotional reactions within the body (Fisher, 2021).

Internalized shame

Shame that has been turned towards the self and often stems from messages received during childhood from parents or other significant individuals (Walker, 2013).

Internalized shame scale (ISS)

A shame assessment tool that includes 30 statements that ask individuals to rate the frequency with which they find themselves feeling or experiencing the described statement. 24 items on the scale assess trait shame and six items assess self-esteem (Cook, 1994 as cited in Saraiya et al., 2018).

Polyvagal theory

A theory developed by Dr. Steven Porges that explains the neural mechanisms that are responsible for the ability of social mammals to achieve safety and social connection with others and their environment (Dana, 2021).

Self-Conscious Affect and Attribution Inventory (SCAAI)

A scenario-based measure of shame that includes 10 negative and three positive scenarios that are rated on a 5-point scale and designed to assess state shame. The scenarios are researcher-derived and include scenarios that college students are likely to encounter in their daily life (Tangney et al., 1992).

Shame

"The intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love, belonging, and connection" (Brown, 2021, p. 137)

Substance use disorder (SUD)

A diagnosis, as laid out in the DSM-5, that refers to the continued and compulsive consumption of substances despite negative consequences. Other characteristics of SUDs include impaired control, marked craving, increased tolerance, and preoccupation with one's substance(s) of choice (American Psychiatric Association, 2013).

Test of Self-Conscious Affect (TOSCA)

A revised version of the SCAAI that is made up of 15 scenario-based questions: 10 negative and 5 positive. The scenarios are derived from written accounts of college and non-college adults (Tangney et al., 1992).

Trauma

Trauma is an inner wounding or injury that occurs as a result of events or difficult circumstances that overwhelm the nervous system, leaving lasting impacts on the mind, body, and spirit. More specifically, "trauma is not what happens *to* you but what happens *inside* you as a result of what happens to you" (Maté & Maté, 2022, p. 20).

Window of tolerance

A concept developed by Dr. Dan Siegel that described the optimal zone of arousal wherein an individual is able to access both thought and emotion and experience a feeling of relative safety (National Institute for the Clinical Application of Behavioral Medicine, n.d.).

Outline of the Capstone Project Chapters

In the literature review that follows, I will begin by painting a more detailed picture of the emotion of shame, including the various functions it serves as a primary human affect. I will then explore how early socialization experiences shape the way individuals internalize and embody shame throughout their lives. I will begin this journey by discussing how shame is learned within one's primary attachment relationships and then explore how it persists within relationship to oneself. I will conclude this initial exploration of shame by presenting the distinct qualities that differentiate shame from guilt.

Chapter two will then examine the topic of substance use, beginning with a summary of the different theories of substance addiction that have garnered a specific place in history. I will then take a deep dive into attachment theory and polyvagal theory, as an alternative to understanding the development of SUDs. An in depth discussion on trauma will follow, given its intricate connection to both shame and SUDs.

Chapter two will end with a summary of the empirical research that's been conducted on the topics of shame and SUDs. The section begins with an outline of common shame measures utilized in psychological research, followed by research studies that comprise individuals at various points in their substance use journeys. I will also address the concept of relapse and societal stigma in the context of substance use and recovery, since they can add further complexity to the experience of shame.

Chapter three begins with a discussion on the research presented in chapter two, including study limitations and important cultural considerations. I will then outline a two day workshop on the topic of shame for clients in treatment for substance use. The workshop will be structured for delivery in a group setting.

Chapter 2: Literature Review

While a plethora of emotions color the experience of substance addiction, one of the most profound and insidious is the emotion of shame. Defined by renowned researcher Brené Brown as "the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love, belonging, and connection" (Brown, 2021, p. 137), shame can exert significant influence on various domains of one's life. In healthy doses, shame can provide valuable information for sustaining safety and maintaining relationships with others. In this way, shame is a normal and purposeful human emotion just like fear, anger, and sadness. However, shame can also reveal a dark and destructive side, entangling those struggling with SUDs.

The Emotion of Shame

Characteristics of Shame

Like all emotions, shame expresses itself in myriad ways. Physical presentations of shame include downcast eyes, blushing of the cheeks, rounded shoulders, shortening of the spine, and averted gaze (Herman, 2011; Nathanson, 1996; Wiechelt, 2007). Studies have shown that bodily expressions of shame are present across different cultures and have been observed in infants who've yet to develop the cognitive skills to express their emotions verbally, suggesting that biological factors play a fundamental role in the experience of shame (Kaufman, 1996; Scheff, 1997, as cited in Wiechelt, 2007). Unlike prosocial cues that foster connection and proximity to others, physical expressions of shame often initiate attempts to hide and/or make oneself small (Herman, 2011; Nathanson, 1996). Imagine a young boy sinking into his chair or a teenager curled up in a ball on the floor — two somatic manifestations of shame. An alternate, albeit less common expression of shame is displayed through a bravado stance; puffy, pronounced chest, signaling a grandiose sense of pride (Yau, J, 2019). While 'tough' and

'powerful' on the outside, the vulnerability of rejection and/or disconnection remains close beneath the surface.

On a cognitive level, shame is frequently expressed via self-degrading statements such as, "I'm such a failure," "I mess everything up," or "I don't deserve to find a loving partner." As illustrated, these narratives target the *core* of an individual and make hefty proclamations of one's shortcomings (National Institute for the Clinical Application of Behavioral Medicine [NICABM], n.d.). Such scripts are often developed early in life as a way of making sense of threatening or harmful situations (Fisher, 2021). They may also stem from echoes of words spoken by significant individuals in a child's life such as primary caregivers, teachers, coaches, or siblings (Walker, 2013).

In the wake of destructive self-talk, a behavioral tendency to avoid and/or withdraw is commonly observed (Nathanson, 1992 as cited in Wiechelt, 2007). Such behavior may include distancing oneself from a group or declining an invitation to an event where personal deficiencies could be exposed. At extreme levels, an individual may isolate themselves completely, retreating inside and closing themselves off from the world. In isolation, self-criticism may pick up further steam and lead to wagering attacks on the self. Conversely, attacks may be aimed at others in order for the aggressor to create an illusion of superiority and self-importance (Nathanson, 1992 as cited in Wiechelt, 2007). Psychiatrist, Donald Nathanson, captures these behavioral responses in his model the "Compass of Shame" which identifies withdrawal, avoidance, attack self, and attack others as the four ways that individuals cope with the emotion of shame, rather than dealing with the origin of the emotion head on (Elison et al., 2006).

Purpose of Shame

Evolutionary Purpose

Shame plays several roles as a universal part of the human experience. Research suggests that one of the primary functions of shame is to regulate behavior in the social world, which is achieved by alerting individuals to signals of rejection or disapproval (Irons, 2019). From an evolutionary perspective, such socialization was necessary for the advancement and survival of humans beings. To support the successful acquisition of food, shelter, and safety, our early ancestors had to learn how to cooperate and function in groups. To achieve such cooperation, adherence to social norms and a commitment to the welfare of the group was required. By inducing an aversive bodily experience, shame could be utilized to accomplish such a task by steering individuals between socially acceptable and unacceptable behaviors (Gilbert & Andrews, 1998). For example, suppose a group member is caught lying to another. A strong display of disappointment by the deceived could evoke a profound sense of shame in the other party, serving as a strong deterrent against future dishonesty. Put simply, shame allows people to form meaningful connections by fostering awareness of how their actions may affect or impose harm on others. Shame thus involves consideration and appraisal of how one is perceived in the eyes of another (Wiechelt, 2007).

Safety and Development

From a developmental standpoint, shame plays a key role in socializing children and orienting them towards safety (Schore, 1998). This is achieved via the recruitment of inhibitory mechanisms in the nervous system which have the ability to rapidly suppress positive affective states (Schore, 1998). Consider this process as analogous to a set of traffic lights. In order to

avoid a dangerous collision at an intersection, a red light communicates a powerful "STOP!" Once safe, the vehicle can return to movement and proceed towards its destination of interest.

Within the context of parenting, picture a two-year old child with a piece of Lego dangerously close to their mouth. With no time to waste, the mother shrieks, "Put that down!" from across the room. The mother's stern demand creates an immediate physiological response in the child's body, dampening their interest in the Lego. This quick response powerfully protects the child from harm and supports the nervous systems' number one priority – to ensure survival. In this sense, shame functions as a means for teaching children how to distinguish between right and wrong / safe and unsafe and is a powerful mechanism that parents can use to support healthy functioning in their children (Wiechelt, 2007).

Some of these teachings are universal, such as where physical safety is concerned. Across international waters, I suspect that most parents would agree that it's dangerous for a child to walk out into a busy street. Other teachings are determined by the particular social and familial systems to which a child belongs. The acceptability of expressing certain emotions, for example, tends to differ greatly based on caregivers' emotional maturity and the degree of emotional attunement that they received growing up. Different cultures and ethnicities also carry stories about when and how particular emotions should be expressed, such as "big girls don't cry," and "toughen up and be a man!" As a result, shame may be used as a mechanism to control such emotions to meet the needs of the grownups in the household. The nuances of a child's experience of shame during development will be explored in greater detail in a later section.

Survival Responses

Beyond its socialization functions, shame also plays an important role in our survival response system, particularly when a threat is interpersonal in nature. When a person finds

themselves in a position of lesser power—whether physically, socially, or otherwise—escaping or defending oneself may not be feasible options. Rather, such responses could evoke further harm in an already dangerous situation. Fortunately, evolution and the wonders of human biology have granted us additional defense responses which include collapse/shutdown and the fawn response (otherwise known as please and appease); both of which recruit the parasympathetic nervous system to initiate their demobilization features (Fisher, n.d.).

The shutdown response can be likened to an organism feigning death. In a technical sense one's heart is still beating, however it may have drastically slowed down, making it appear as if there's no life left in the organism (Fisher, n.d.). Collapse/shutdown is the oldest survival response in the evolution of the nervous system, arising approximately 500 million years ago and is connected to the branch of the parasympathetic nervous system called the 'dorsal vagal' (Dana, 2021).

The power of the collapse/shutdown response lies in its ability to decrease one's exposure in the external world—both literally and/or figuratively. This may manifest physically as curling up into a ball or playing dead in hopes that a threat loses interest and/or moves onto a different target (National Institute for the Clinical Application of Behavioral Medicine, n.d.). Shutdown can also comprise dissociative features, wherein the conscious mind is to some degree 'checked-out,' and can be a particularly useful strategy in the event of a sexual assault wherein a victim has a poor chance of successfully fighting and/or running away from the aggressor (Fisher, 2021). The body's employment of a shutdown response could insulate against some of the terror that such a situation would impose by inducing a sense of numbness and/or disconnection that allows the victim to momentarily escape their horrific reality.

Shame is also suggested to play a role in the fawn response (sometimes referred to as please and appease). The strategy of the fawn response is to attune to the needs of a dominant figure in a valiant attempt to minimize imposing harm. As such, the fawn response is often referred to as a "damage limitation strategy" and requires the person in the subordinate position to remain vigilant to another's needs, while simultaneously hiding aspects of themselves that could further activate or set off the more powerful figure (Fisher, n.d.). These processes require the recruitment of both the sympathetic nervous system—for the purpose of maintaining a high level of alertness, and the parasympathetic nervous system—for shutting down forbidden parts of the self in the eyes of the other (Fisher, n.d.). The fawn response is employed by an individual in a position of lesser power and is commonly observed in the enactment of submissive and obedient behaviors (Herman, 2011).

Development of Shame

Experts suggest that shame develops between 12-15 months of age (National Institute for the Clinical Application of Behavioral Medicine, n.d.; Schore, 1998). The first 12 months of an infant's life largely revolve around the attunement of positive affective states within the caregiver-infant dyad (Schore, 1998); think excitement, joy, interest, and pleasure. In year two, toddlers typically display an expanded sense of curiosity and now have the motor skills necessary to explore such interests (Schore, 1998). While a positive emblem along the continuum of development, greater physical freedom carries an increased risk of harm for vulnerable offspring who're still largely dependent on their caregivers for survival (Schore, 1998). Now, in addition to supplying nurturance, caregivers are tasked with socializing their offspring to surrounding environments and helping them discern between socially acceptable and

unacceptable behaviors (Schore, 1998). Relying solely on experiences of congruous attunement is no longer an option within the attachment relationship.

American psychologist and researcher, Dr. Allan Schore, posits that shame functions by rapidly reducing positive affective states so as to steer children away from problematic behaviors, such as unrestricted tantrums or toileting wherever they please (Schore, 1998). In other words, shame turns down the dial on pleasurable emotional states to teach children right from wrong / safe from unsafe. Such socialization processes help support a child's physical safety, as well as their interpersonal safety, which becomes increasingly important in later years when peer relationships take on greater significance in a child's life.

Repair

While shame plays an essential role in a child's development, how a parent uses shame and addresses the child afterward is of great significance (Schore, 1998). Instead of keeping the child in an inhibited state, Dr. Schore's research highlights the importance of relational repair subsequent to an incident of misattunement (1998). Following on the heels of the Lego example from earlier, this might look like the mother wrapping her two-year old in her arms and saying: "It's okay hunny, mommy was just worried about your safety and doesn't want you to choke on that small piece of plastic. You're okay now." Such a response aids the child in being able to regulate their negative affect and lays the groundwork for future regulatory abilities (Schore, 1998). As Dr. Allan Schore puts it, after such a response "shame is metabolized and regulated" (1998, p. 67) and secure relating is restored.

When a responsible figure fails to engage in reparative action with their child, a return to emotional equilibrium is thwarted and poses risk to the child's future abilities to recover from strong affective states (Schore, 1998). This is particularly true when there are numerous ruptures

without repair. Such conditions also make it challenging for a child to experience emotional safety in relationships and can lead to an internal working model that perceives others as unsafe (Schore, 1998). A child can then carry such a belief with them through to adulthood wherein future relationships continue to activate distressing experiences of fear, stress, and/or shame (Fisher, 2021). This may significantly complicate recovery from SUDs, given that a large proportion of treatment for substance use centers around group support and connection with others. Although one's ability to regulate their emotions is amenable at any age, it becomes more challenging after one's psychological foundation has been set.

Spectrum of Shame

While cognition and rational thought have largely reigned supreme in Western society, our emotions are capable of extraordinary means and provide valuable information that allow us to make sense of the world around us. Similar to all emotions, shame can be experienced within a range of intensities and for various durations of time. On one end of the spectrum shame can be a helpful force acting as a kind of moral compass, guiding a person towards their ideal self (Irons, 2019). Shame can also indicate when we've crossed another's boundaries, reminding us of the limits that exist within our relationships in order to support a sense of safety for all. Further, as already discussed shame is a powerful tool for protecting children as they move through the different stages of development—so long as these experiences are brief and create only temporary distress (Potter-Efron, 1993 as cited in Wiechelt, 2007).

On the opposing end of the spectrum, shame may take on a chronic and/or toxic quality, impeding on a person's self-esteem and/or self-worth (Brown, 2021). Chronic/maladaptive shame is often the result of shaming experiences that are frequent, long-lasting, and/or intense in nature (Irons, 2019). Under these conditions, the shame response can become an entrenched

pattern that is triggered in the face of even the slightest dose of criticism or perceived rejection. As a result, physiological manifestations of shame often become coupled with cognitive narratives that maintain a negative self-image and perpetuate a vicious cycle between the body and mind (Fisher, n.d.). While social narratives commonly declare punishment an effective strategy for creating change, research has shown that such tactics can have extremely adverse effects by motivating people to retreat and/or hide (Randles & Tracy, 2012). Rather than allow someone to tap into the valuable aspects of the shame they're feeling, this approach is likely to activate one's stress-response system, sending the thinking part of the brain offline and in turn inhibiting learning from the experience.

Internalized Shame

As a result of growing up in a shame-inducing household, a child may develop a deep-seated believe that "I am bad," or "I am defective." Heard on repeat, accusations that overtly or implicitly suggest defectiveness can transform from words spoken by an external voice (critical parent, an abusive sibling, etc.) to an oppressive inner voice that taunts similar sentiments towards the self. This process is often referred to as "internalized shame." Clinical psychologist Helen Block Lewis highlighted the internal split that makes this possible wherein an individual's observer self (the agent) both witnesses and degrades the focal self (the object) (Tangney and Dearing, 2002). Thus, one can be in solitude and directing shameful messaging towards themselves. Further, in addition to impeding on an individual's self-respect, such statements can trigger a self-fulfilling prophecy whereby one acts in a way that coincides with their beliefs about themselves (Randles & Tracy, 2013). For example, "why work so hard on my recovery if I'm such a horrible person inside? I don't deserve to get better and live a happy life."

In addition to punishing and critical parenting styles, a similar conclusion about the self may be drawn when a child is neglected or fails to get their needs met. Without widespread maturation of cortical areas of the brain, a child or infant is unable to consider the full context around why a parent may be behaving in a terrifying or poor manner towards them. The simplest conclusion is that there's something inherently wrong with the child. As Janina Fisher points out, it's much more dangerous to presume that a parent is the source of pain or terror, given the extent of the dependence that the young have on their caregivers (Fisher, 2021). Over time, this patterning of self-blame may culminate into a negative self-concept that the child carries with them throughout the course of their lives (Fisher, n.d.).

Discerning Guilt and Shame

With the basic foundation of shame now cast, discernment between the emotions of shame and guilt are warranted. This distinction is important, given that guilt and shame frequently produce varying outcomes on research measures (Batchelder et al., 2022; Tangney and Dearing, 2002). Moreover, while often used interchangeably in conversation, people commonly report distinct somatic experiences between the two emotions (Tangney and Dearing, 2002).

As discussed previously, shame is typically directed towards the self or one's identity. Shame hits deep and is often all-consuming, analogous to a tidal wave that washes one out to sea. Guilt on the other hand is concerned with one's behavior, and does not wage attack on the inherent worth of the individual who initiated it (Brown, 2021). In other words, in the case of guilt an individual's identity is considered separate from their actions. As aptly stated by clinical psychologist, Helen Block Lewis, "in guilt, the self is not the central object of negative evaluation, but rather the *thing* done or undone is the focus. In guilt, the self is negatively

evaluated in connection with something but is not itself the focus of the experience" (Tangney and Dearing, 2002, pg. 18). Lewis also emphasized a difference in the operation of the self in the experience of shame versus guilt (Tangney and Dearing, 2002). Metacognitive abilities allow the self to play the role of both agent and object of observation in the case of shame, enabling an individual to scrutinize and evaluate themselves as they predict others might (Tangney and Dearing, 2002). Guilt on the other hand tends to arise from a unified sense of self (Tangney and Dearing, 2002).

Consider Annie who sent her friend several rude text messages last night while under the influence. When Annie wakes up in the morning, a shame response might sound like "I'm such a terrible friend! I don't deserve to have any friends." By comparison, the emotion of guilt may drive an internal dialogue that says, "What I texted to my friend yesterday wasn't nice. I should really send her an apology." As the later response illustrates, guilt often leads to a desire to repair harms inflicted on another party. This reparation is mediated/instigated by the feeling of remorse. Further, healthy guilt can motivate a person to take action to improve their performance in the future. In other words, the originating event can serve as a learning experience for personal growth. Shame on the other hand often leads to opposing and potentially harmful effects.

Substance Use Disorders

Early Theories of SUDs

Disagreement concerning the etiology of substance use disorders (SUDs) has plagued societal discourse for decades. Initially, dialogue on the topics of choice and morals occupied the conversation around substance use. Along with such viewpoints came significant judgment towards substance users and an emphasis on discipline and willpower that must be lacking in these individuals. If only those struggling with substance use could 'smarten up' or rid

themselves of sinful tendencies, they'd be liberated from the hands of addiction. Such theories rest on the foundation that human behavior can be reduced to such dualistic categories – good or bad / use or don't use. Such theories are simple at best and incredibly shameful at worst.

Fortunately, the discussion around the development and cause of SUDs did not end there. During the 1980's, the more widely accepted perspective of 'addiction as disease' became the prevalent framework through which to view SUDs (Alexander, 1987). Within the disease model of addiction, SUDs are characterized by chronic changes in brain structure and function caused by repeated substance use and the neurophysiological effects of the chemical compounds in one's substance(s) of choice. Such changes in the brain are believed to perpetuate the compulsive behaviors that keep individuals stuck in the cycle of addiction. From this perspective, one's brain is seen as having a 'defect' in need of repair. While this explanation is conceivably less shaming than the choice or moral model of addiction, the needle has shifted only a short distance from an individual who's viewed as being 'bad' or 'lazy' to a person who's 'sick' (Winhall, 2021).

The 'addiction as disease' conceptualization aligns well with the current Western medical model. Alterations in the physical body, coupled with the long-term nature of addiction, reflect other conditions classified as chronic diseases including diabetes, asthma, and lupus, among others. As such, treatment often takes a similar approach: view the condition as arising from a specific organ or system in the body and prescribe medications and/or behavioral adaptations to manage said symptoms. Within this model, SUDs are often seen as lifelong conditions that require reliance on the medical system for support. There is no doubt that certain brain circuits are both central to and impacted by the addictive process. These neurological circuits include the oxytocin affiliation system, the dopamine reward system, and the glucocorticoid stress response system (Strathearn et al., 2019). Although these biological systems are essential in the

development and maintenance of SUDs, substance addiction extends beyond biological mechanisms and cannot be fully explained by them alone.

Scientific research has demonstrated that the human brain remains malleable throughout the life course (a concept known as 'neural plasticity'), and that one's life experiences are instrumental in the sculpting and pruning of the very circuits involved in the addictive process. These experiences comprise not only external events, but also the many relational interactions that one encounters throughout their life, particularly during their formative years. These interactions shape the architecture of the self, including the mental and emotional processes that define how one perceives the world.

Biopsychosocial Model of SUDs

A framework that captures the complexity of SUDs is the biopsychosocial model of addiction. This model considers the biological components of addiction, such as genetics, brain chemistry, and neurodevelopmental factors, in addition to the cognitive, emotional, and social factors that are deeply intertwined in the addiction process (Alderson, 2019). Social factors that may increase an individual's vulnerability to addiction include low socioeconomic status, minimal supports, an abusive living environment, and cultural norms. Psychological factors that may heighten an individual's susceptibility to addiction include a propensity towards self-criticism, poor emotion regulation, and the presence of concurrent disorders such as Attention Deficit Hyperactivity Disorder (ADHD), Depression, and PTSD, among others (Maté, 2010; Connolly et al., 2019; Maddux & Winstead, 2019;). A disposition towards shame would fall under the umbrella of psychological factors, however it's important to note that no one dimension is completely distinct or inseparable from the other.

As outlined previously, shame is initially experienced and learned within one's primary attachment relationships (the social dimension), while also being heavily influenced by the development of one's nervous system (the biological dimension). As such, a theory of SUDs is required that speaks to the biological, psychological, and social components of substance addiction. I will discuss two such theories next – attachment theory and polyvagal theory – and explore how they contribute to our understanding of SUDs and their relationship with shame.

Attachment Theory

An extensive body of research has demonstrated that a child's earliest attachment relationships have a significant impact on their psychological development (Maté, 2010; van der Kolk, 2015; Marriott & Kelley, 2024) Originating in the 1950s out of the work of John Bowlby, attachment theory highlights the importance of the emotional bond that transpires between infant and caregiver to ensure the newborn's survival and ensuing development (Bartholomew & Horowitz, 1991). Various neurochemicals and brain regions are stimulated within the caregiver-infant dyad to support such processes (Schore, 1998).When this bond is strong and enriched with positive relational experiences, the child develops a safe and dependable base from which positive models of the self and others can be established (Marriott & Kelley, 2024). This is known as the development of a 'secure attachment.' It is also within this early bond that a child learns how to regulate their emotions (Schore, 1998). When this attachment relationship is compromised, or when emotional attunement is lacking, however, research shows that children become increasingly vulnerable to later psychological distress (Farr et al., 2021). This is particularly true when repeated encounters of caregiver criticism, rejection, and/or devaluation become the crucial experiences through which a child formulates their sense of self. In comparison, caregivers who mirror and validate positive and negative emotional experiences

with their children foster regulatory flexibility that supports emotional resiliency throughout life (Schore, 1998; Maté, 2010).

Unlike mammals who exit the womb with fully-developed brains, the human brain is largely dependent upon others for maturation. This is particularly true of brain regions needed to regulate one's emotions, which have not yet been established at birth (Maté, 2010). Infants gradually acquire the capacity to manage states of stress and arousal by drawing on their caretaker's right brain as a template for self-regulation (Maté, 2010; Manley & De Jong, 2014). A symphony of subtle interactions, largely conducted via nonverbal communication, take place to modulate positive and negative affective states until a child's nervous system is able to regulate on its own (although the importance of co-regulating with other nervous systems never cease to exist across one's lifespan) (Schore, 1998). Accordingly, the nature of the caregiver-infant bond plays a crucial role in shaping a child's psychological resilience for navigating life's ups and downs and forming meaningful and stable interpersonal connections.

Polyvagal Theory

Intricately connected to the attachment system are the neurons and neural pathways that make up the autonomic nervous system. This system was the subject of interest for Dr. Steven W. Porges who developed polyvagal theory in the 1990's, which highlighted the profound role that biology plays in seeking safety and connection, and modulating affective states (Dana, 2021). Dr. Porges identified the importance of three neural pathways that support these important tasks within the autonomic nervous system: the sympathetic, dorsal vagal, and ventral vagal pathways (Dana, 2021). These pathways are organized in a hierarchical structure with the system of shutdown (dorsal vagal) on the bottom, the system of action (sympathetic) in the middle, and the system of connection (ventral vagal) at the top (Dana, 2021).

As life events take place, one moves along the hierarchy in a sequential fashion. When a sense of safety is experienced, the ventral vagal pathway is active and an individual could be regarded as being engaged in life, grounded, and able to make connections with others and their environment with relative ease. In the event that a threat or stressor arises during the day that feels overwhelming, an individual moves down the hierarchy one step and the sympathetic pathway is activated. The sympathetic pathway is home to the "fight or flight" response and prepares the body for action. Finally, if the threat persists and action in the sympathetic stage is unsuccessful, an individual may venture even further down the ladder and employ the dorsal vagal pathway, characterized by a sense of numbness, disconnection, and collapse or shutdown. Let's take a closer look at the autonomic nervous system and a concept by Dr. Dan Siegel that is useful for pulling this all together – the window of tolerance.

Autonomic Nervous System

The autonomic nervous system (ANS) is divided into two branches – the sympathetic nervous system and the parasympathetic nervous system. The sympathetic nervous system is comparable to the accelerator of a car, a mechanism that speeds up and injects energy into the system. Meanwhile, the parasympathetic branch is akin to the brakes of a car, slowing the system down, and when necessary, bringing the system to a complete stop. The ANS controls levels of arousal by altering various functions in the body including heart rate, breathing tempo, muscle tension, and pupil dilation (Evans, 2023).

The coordination of these branches allow for flexible responses to threats. When functioning optimally, they're also what allow us to relax and decompress at the end of a long day. An individual is said to be within their "window of tolerance" when they're in touch with the present and able to integrate both cognitive and emotional experience (National Institute for

the Clinical Application of Behavioral Medicine, n.d.). This concept was developed by Dr. Dan Siegel, a pioneer in the field of interpersonal neurobiology, and captures the essence of Porges' findings on polyvagal theory.

Window of Tolerance

The window of tolerance is referred to as the zone of optimal arousal wherein flexibility and synchronicity in the nervous system creates a feeling of relative safety. It is within this zone that intimate connection with others and values-driven behavior can be realized. The size of one's window of tolerance depends on a variety of factors including genetics, family of origin, intergenerational trauma, adverse childhood experiences, and the quality of one's attachment relationships (Marriott & Kelley, 2024; National Institute for the Clinical Application of Behavioral Medicine, n.d). While these factors can influence the sensitivity of one's nervous system to indicators of stress and/or threat, an individual's bandwidth for managing said stress can expand through intentional actions that strengthen the nervous system. In other words, one's capacity to tolerate distress is not set in stone.

When one is frequently thrown out of their window of tolerance, the nervous system adapts and can become more sensitive to indicators of stress and/or threat. Extreme stressors infuse a significant amount of activation into one's system, which without resolution can remain lodged in the body, impacting future responses to similar stimuli. This is particularly true within the context of trauma, which can narrow one's window of tolerance and require stronger regulatory strategies to achieve a sense of safety – enter substances.

Pseudo Window of Tolerance

Living outside of one's window of tolerance for any length of time can be extremely uncomfortable and taxing on the nervous system. While nurturing relationships, psychotherapy,

and coping strategies are viable ways to manage a dysregulated state, these are not accessible to all and often require significant effort and consistency in order to reap regulatory benefits. Substances on the other hand provide almost immediately relief and have been demonstrated to produce a *pseudo* window of tolerance. In this *pseudo* window, safety is artificially obtained via the triggering of neurochemical responses from one's substance(s) of choice (Fisher, 2021).

As explored extensively at the beginning of Chapter 2, the emotional experience of shame often carries a momentous amount of pain and discomfort. In the absence of strong self-regulatory abilities or the presence of a safe and empathic other, such shame can feel unbearable to sit with alone. Substances can be utilized to temporarily soothe or numb out from such distress, making life somewhat manageable, at least in the short-term. Dr. Gabor Maté captures this sentiment poignantly when he asserts: "The question is not why the addiction, but why the pain" (Maté, 2017, para. 4). With a few swigs of a bottle or the swallow of a pill, a swift escape from a painful reality can be realized.

Trauma and SUDs

Ample research has demonstrated a link between trauma and SUDs. Whether stemming from a singular event or repeated experiences over time, substances offer an effective means for coping with trauma symptoms, including the emotion of shame (Fisher, 2021). Particularly when trauma symptoms are frequent and/or intense, substance use can bestow a way for trauma survivors to carry on with the tasks of daily living (Fisher, 2021). Without this coping strategy one may be paralyzed by fear or spaced out in bed all day, making it extraordinarily difficult to attend school, work, take care of children, or maintain any kind of relationship. Due to the powerful impact that substances impart on one's neurochemistry, disturbing thoughts, feelings, memories, and sensations can be placed on pause to make such activities at least somewhat

possible (Fisher, 2021). However, the transitory effects of substances on the body necessitate repeated use in order to stave off the return of trauma symptoms. In turn, this pattern introduces a new set challenges including the need for greater quantities of one's substance(s) of choice (i.e. tolerance), the possibility of physical dependence, and other substance-related problems that come along with progressively dangerous and frequent use, such as financial difficulties, physical injury or illness, and trouble maintaining employment (Alderson, 2019; Fisher, 2021).

International trauma expert, Dr. Janina Fisher, illustrates the intricate relationship between trauma symptoms and substance use in the "The Abstinence/Relapse Cycle" included in Appendix A and outlined in her workbook, Transforming the Living Legacy of Trauma (2021, Figure 5.1, pg. 49). Dr. Fisher's diagram highlights the inextricable relationship between abstinence and self-destructive patterns of coping, such as substance use. As depicted, without the chemical support from substance, PTSD symptoms tend to increase. With the resurgence of distressing symptoms marked by emotional overwhelm, reactivity, flooding, and increased nervous system activation, the urge to engage in self-destructive behavior understandably intensifies. Without effective regulation strategies, the likelihood of returning to unsafe behavior increases. Now, in addition to the shame carried from a trauma experienced, an individual may develop an additional layer of shame around the self-destructive behaviors used to manage their distress (Fisher, 2021).

Contrary to fear and anxiety which tend to rev the nervous system up, shame produces a down regulating effect that manifests via symptoms of lethargy, brain fog, depressed mood, and dissociation, among others. Renowned psychiatrist and researcher, Dr. Judith Herman, suggests that this down-regulation is a prominent feature of "traumas of human design," particularly within a dynamic of dominance and subordination (Herman, J. L., 2011). Such traumas include

experiences of sexual abuse, emotional abuse, and/or interpersonal violence. Besides needing to remain vigilant in these situations, one must also wrestle with the frightening reality of holding less power. This power imbalance may be reflected through differences in body size and strength, as well as financial, social, and intellectual measures. In this way, shame functions as a "damage limitation strategy," motivating submissive and obedient behaviors to satisfy a perpetrator's desires, in hopes that such satisfaction will minimize the extent of harm imposed upon the victim (Fisher, 2021; Herman, 2011).

PTSD vs. Complex-PTSD

While Posttraumatic stress disorder (PTSD) is more commonly cited in research literature in connection to SUDs, another form of trauma that has the ability to exert significant effects on the developing brain and body is complex-posttraumatic stress disorder (C-PTSD). PTSD is typically associated with a singular traumatic event, whereas C-PTSD develops through exposure to events that overwhelm the nervous system repeatedly over time and may include experiences such as sexual abuse, parental neglect, and harsh or severe punishment (Briere & Scott, 2014). According to research, C-PTSD is linked to greater psychopathological challenges in adulthood, including difficulty regulating negative emotional states (Holl et al., 2017). In particular, shame appears to carry more weight following experiences of childhood abuse as compared to other negative emotional states such as fear and/or anger (Holl et al., 2017).

Implicit Memories

Advancements in the field of psychology and neurobiology have highlighted the significance of implicit memories in the lasting legacy of trauma (Fisher, 2021). Implicit memories are activated outside of conscious awareness and typically present in the form of physical sensations or emotional reactions within the body that go beyond logic or language

(Fisher, 2021). Stored within deep emotional centers in the brain, implicit memories can activate remnants of a traumatic past months, years, or even decades following the experience (Fisher, 2021).

In the context of shame mild criticism from a boss could initiate a cascade of distressing physiological reactions as the body "remembers" an authoritarian parent who used severe physical punishment when anything lower than as 'A' was received on their school report card. As a result, the employee may suffer an intense and sustained experience of shame that leads to a complete collapse at the end of the workday, coupled with condemnations such as "Gosh, I'm so stupid," and "I better not make one more mistake or I'm going to get fired." In this example, an emotional memory is being recalled that activates Sarah's threat system, recruiting the most appropriate or familiar survival response for the moment. In Sarah's case, it was not safe to fight back or leave home when punishment loomed, therefore as soon as the interaction was finished she would escape to her room and collapse on her bed, making herself as small as humanly possible. This was still Sarah's familiar response pattern to criticism several decades later. The past was continuing to live on in Sarah's nervous system.

Research on Shame and Substance Use

While shame has long been hypothesized to be a central emotion in the experience of substance addiction, research demonstrating the specificity of its role remains in infancy. Despite this, one cannot refute the existence of a powerful network that underpins the relationship between shame and SUDs. It becomes particularly complex when one examines the directionality and precise role that shame plays in the addictive process. Several studies have attempted to address this important topic and will be discussed in the proceeding section. Before

diving into the studies themselves, I will provide a brief overview of the different assessments commonly used to measure shame in research.

Internalized Shame Scale

The Internalized Shame Scale (ISS) developed by David R. Cook in 1988 includes 30 statements that ask individuals to rate the frequency with which they find themselves feeling or experiencing the described statement (Cook R., 1988/2008). Sample statements include 1. I feel like I am never quite good enough, 29. I cannot stand to have anyone look directly at me, and 35. I would like to shrink away when I make a mistake and are rated from 0-Never to 4-Almost Always (Cook R., 1988/2008). Assessment of the ISS has demonstrated internal reliability and construct validity for both clinical and nonclinical populations and was originally developed for research in the field of drug dependence (Cook R. 1988; Rybak and Brown, 1996). The ISS seeks to measure "trait shame," which is an overall propensity to shame that an individual experiences across various situations that could evoke the emotion (Rybak and Brown, 1996). In other words, trait shame is akin to a general quality that an individual possesses over the course of their life.

Self-Conscious Affect and Attribution Inventory

The Self-Conscious Affect and Attribution Inventory (SCAAI) is a scenario-based measure of shame that includes 10 negative scenarios and three positive scenarios that college students are anticipated to encounter in their daily lives (Tangney et al., 1992). Participants are instructed to choose the response that best aligns with how they would react in the situation, as laid out on a 5-point scale (Tangney et al., 1992). The different selections are designed to assess affective, cognitive, and behavioral elements of shame, guilt, externalization of blame, detachment/unconcern, and pride (Tangney et al., 1992). Unlike the ISS, which looks at the

enduring nature of shame across time, the SCAAI targets "state shame," which is the experience of shame in a particular situation that typically dissipates when the situation is over (Rybak and Brown, 1996). The SCAAI has demonstrated satisfactory reliability and was the first assessment tool to differentiate shame and guilt in a clear way (Tangney et al., 1992).

Test of Self-Conscious Affect

The Test of Self-Conscious Affect (TOSCA) is a revised version of the SCAAI that is made up of 15 scenario-based questions; 10 negative scenarios and 5 positive scenarios (Tangney et al., 1992). Unlike the SCAAI, which features questions developed by its original researchers, the TOSCA draws its scenarios from written accounts of college and non-college adults describing personal experiences of shame, guilt, externalization, and detachment (Tangney et al., 1992). Analyses suggest that the TOSCA and SCAAI exhibit similar reliability and validity, however the TOSCA is considered to have greater ecological validity than the SCAAI, as its scenarios are based on firsthand accounts from a broad pool of adults, rather than being created solely by the researchers themselves (Tangney et al., 1992).

Drinking to Cope Model

A model that has been used to explain the connection between trauma and SUDs is the drinking to cope model. This model suggests that substances provide much desired relief from distressing emotions that persist following aversive experiences such as trauma (Holl et al., 2017). In other words, substance use serves as an external coping strategy for regulating one's emotions; particularly, negative emotional states. Although such an approach is maladaptive in the long-run, short-term benefits of substance use include protection from internal experiences that feel so overwhelming they threaten to consume the individual. Without a strong

psychological foundation to govern and withstand such emotional experiences, substances become akin to a life raft thrown out to a drowning swimmer at sea.

Julia Holl and colleagues (2017) demonstrated evidence for this model in a longitudinal study that measured the presence and intensity of shame and sadness in 151 research participants over a period of 14 days and the emotion regulation strategies utilized to manage said emotions. Participants were split up into three different groups: participants with a diagnosed SUD, per DSM-IV criteria, and a history of childhood abuse and neglect (traumaSUD group), healthy controls with a history of childhood abuse and neglect, but without any present or lifetime psychopathology (traumaHC group), and healthy controls without psychopathology or past trauma (nontraumaHC) (Holl et al., 2017).

Significantly higher mean values of intensity of shame and sadness were observed in the traumaSUD group compared to the other two groups, with the nontraumaHC group reporting the lowest mean intensity for both emotions (Holl et al., 2017). Further, the study found a positive linear relationship between subjective intensity of shame and sadness and substance use among all three groups (Holl et al., 2017). Perhaps most illuminating was the variance in substance use between participants in the traumaSUD group and the traumaHC group. Holl et al. (2017) discovered an almost fourfold increase in substance use in the traumaHC group as intensity of shame increased from low to high, indicating a much steeper increase compared to the rise in substance use among participants in the traumaSUD group as they moved along the continuum from low to high shame intensity.

Shame-Addiction Cycle

A couple research studies have sought to examine the shame-addiction cycle that has long been theorized to play a role in the perpetuation of substance use disorders. The cycle

suggests that individuals initially use substances to escape negative affective states such as shame; an idea that's supported by the mechanisms of negative reinforcement and tension-reduction models of addiction (Batchelder et al., 2022). However, the story doesn't end there. Substance misuse also carries a hefty social stigma, which is suspected to inflict further shame on individuals struggling with SUDs (Alderson, 2019; Batchelder et al., 2022). What is more, problematic substance use (particularly as it grows over time) increases the odds of experiencing negative consequences that violate social norms such as drunk driving or missing several days of work (Luoma and Guinther, 2018). These added layers of shame related to one's substance use are believed to perpetuate the shame-addiction cycle, driving individuals to turn to substances to soothe their distress once more (Batchelder et al., 2022).

In a 2018 study, researchers Luoma and Guinther started by examining how daily reported shame affected same-day alcohol consumption. Study participants included 70 community participants who's alcohol consumption ranged from light-heavy To gather the data for their study, the participants were asked to keep a diary for 21 days in which they were required to record three measures: 1) daily ashamed mood, 2) number of alcoholic drinks consumed alone/with others, and 3) daily negative affect (Luoma and Guinther, 2018). Prior to the start of the study, all participants completed the 30-item Internalized Shame Scale and the Alcohol Use Disorders Identification Test (Luoma and Guinther, 2018).

Results demonstrated that participants who were more prone to experiencing shame drank alone more often and drank larger amounts of alcohol during those solo drinking episodes than their study counterparts (Luoma and Guinther, 2018). Interestingly, higher daily reported shame impacted between-group participants (average high shame individuals vs. average low shame individuals) in a distinct manner (Luoma and Guinther, 2018). Shame-prone subjects were

less likely to drink alone on days that they experienced above average levels of shame (Luoma and Guinther, 2018). However, if drinking was initiated, the quantity of alcohol consumed tended to be greater than normal. In contrast, subjects with lower average levels of shame were more likely to drink alone on days that they experienced particularly high shame, albeit the quantity of drinks consumed tended to be lower (Luoma and Guinther, 2018).

Next, Luoma and Guinther (2018) measured the extent to which participants' previous night's drinking predicted feelings of shame the next day. No meaningful correlation was identified between solidary drinking and next-day shame (Luoma and Guinther, 2018). However, for participants who drank in a social setting, subjects who regularly consumed more alcohol than their peers experienced greater shame the day after drinking a larger than normal amount of alcohol (Luoma and Guinther, 2018).

Another study that attempted to explore the merits of the shame-addiction cycle was a study by Batchelder and colleagues (2022) who recruited 110 sexual minority men utilizing stimulants including powder cocaine, crack-cocaine, or methamphetamine. The study took place over 15 months and included six points of data collection (Batchelder et al., 2022). All 110 study participants were also living with HIV.

Results of the study found that higher initial levels of shame resulted in slower decreases in stimulant use over time, supporting the researcher's first hypothesis that higher shame would perpetuate substance use (Batchelder et al., 2022). However, the researchers did not discover a significant relationship between initial levels of stimulant use and the proceeding trajectory of shame (Batchelder et al., 2022). Thus, only the first half of the shame-addiction cycle was supported by this study.

Posttraumatic Stress, Shame, and SUDs

In a 2018 study, Saraiya et al. examined how posttraumatic stress symptoms (PTSS) relate to substance use in Asian Americans (AAs) and the moderating role of shame between the two variables. Substance use measures utilized in the study included binge drinking, tobacco use, and hazardous drug use (Saraiya et al., 2018). The researchers were particularly interested in the Asian American population given that they are more likely to experience persistent SUDs with increasingly severe consequences in comparison to other racial and minority groups (Saraiya et al., 2018). The study consisted of 199 participants who were 1.5 or 2nd generation AAs. Participants completed an online survey, which included the Drug Abuse Screening Test (DAST-10), 4-item National Institute on Drug Abuse (NIDA), Quick Screen, Adverse Childhood Experiences Scale (ACE), PTSD Checklist for *DSM-5* (PCL-5), and the Internalized Shame Scale (ISS).

Results indicated that PTSS was positively associated with tobacco and illicit drug use, however severity of PTSS symptoms did not appear to influence number of binge drinking days (Saraiya et al., 2018). When shame was added to the equation, moderating effects between PTSS and substance use were different among high and low levels of shame. At lower levels of shame, an increase of 5% in binge drinking days could be observed for every one-unit increase in PTSS symptoms. For the same one-unit increase in PTSS symptoms, high shame individuals did not experience a statistically significant increase in binge drinking days. The relationship was similar with tobacco use, wherein low shame individuals experienced a greater increase in tobacco use as PTSS went up compared to their high shame counterparts. There was no significant relationship between shame and PTSS on forecasting hazardous drug use levels. The culmination

of these findings suggest that Asian Americans with lower levels of shame appear to be more sensitive to traumatic stress and more likely to utilize substances to cope.

Current Substance Use

Even when individuals seek treatment and have started preparing to make changes to their substance use, shame often persists over ongoing use and why one hasn't been able to stop sooner. Compassion and grace get buried by the more forceful voices of failure and contempt. Substance use goals are often viewed in black-and-white terms, with using on one end and complete abstinence on the other. Sobriety is frequently perceived similarly as either success or failure. Take the example of Alcoholics Anonymous (AA) wherein an individual must return to Day 1 of sobriety whenever they experience a slip or relapse. While the individual is welcomed back to the group without hesitation, their success is wiped from the board and implicit messaging relays that they must try harder next time. Experiences of relapse thus create an additional layer of shame for many individuals with SUDs that get interwoven with more ancient and rigid deposits.

Relapse

Despite genuine efforts to change a behavior(s), the brain's preference for familiarity and comfort can easily pull an individual back into old habits. In the context of SUDs, this is commonly referred to as a "slip" or "relapse"; a "slip" being a temporary return to substance use (often at a reduced level/quantity), and a "relapse" defined as a return to the frequency and level of consumption utilized in active addiction (DiClemente & Crisafulli, 2022). Once abstinence has been achieved, research shows that an estimated 40% to 60% of people receiving treatment for substance use will experience a relapse (NIDA, 2020). Given such high percentages, relapse prevention planning (RPP) is often a critical piece of the work performed with clients.

Although a well-documented part of the recovery process, a relapse often carries a hefty dose of self-criticism and shame along with it. This not only adds fuel to the fire, but can also heighten one's distress to the point that the most feasible solution seems to be avoiding that shame by using even more substances. Frustrations that commonly enter the counselling room following a relapse include, "I failed again," "I'll never be able to stay clean," or "I'm so weak, I might as well just give up now;" statements blatantly dripping with shame. And in addition to an individual's own emotional experience following a relapse, there are often many others anxious to chime in with their feelings and perspective on the situation. Understandably, many of them come with good intentions and wish they had a simple answer that could 'solve' their loved ones' struggles; however, without mindful awareness, one could unintentionally hinder their recovery and reinforce the cycle of addiction.

In a study of 105 members from Alcoholics Anonymous (AA) in Vancouver, British Columbia, Randles and Tracy (2012) examined participants' nonverbal displays of shame while they described the last time they drank to an interviewer. The interviews were recorded on video at what the researchers referred to as Wave 1. Following, research assistants closely analyzed the first 10 seconds of each video and documented physical presentations of shame, including narrowing of the chest and slumped shoulders (Randles & Tracy, 2012). Randles & and Tracy, 2012 found that participants' nonverbal displays of shame were associated with higher probability of relapse over a 4-month period (Wave 2). Interestingly, self-reported state shame at Wave 1 was not associated with greater likelihood of relapse at Wave 2, demonstrating that somatic expressions of shame may be a more powerful indicator of the emotion than conscious identification. While Western society has long privileged logic over emotion, Randles and Tracy's research (2012) illuminates the wealth of information that is stored within the body and

may provide counsellors with a more accessible pathway for recognizing and making contact with their clients' emotional experience.

While Randles and Tracy (2012) were successful in demonstrating a link between shame and substance use, it's important to note that such findings should be interpreted with caution. First, only 44% of the original 105 study participants returned at Wave 2 to measure incidence and severity of relapse, characterizing a relatively small sample size (Randles & Tracy, 2012). As the researchers document, such high attrition was largely due to difficulty reaching participants at Wave 2 given unstable and transient housing situations. In addition to the small sample size, participants were all recruited from a 12-step treatment model that holds a distinct perspective on the etiology of substance use and the best approach to treatment, including the necessity of complete abstinence. To substantiate the findings of Randles and Tracy (2012), research should be conducted that includes participants from a more diverse set of treatment locations and approaches to substance use including harm reduction service settings, community-based counselling programs, and bed-based treatment sites.

Societal Stigma

One cannot talk about shame and SUDs without acknowledging the extensive amount of stigma that persists around substance addiction in society today. This stigma is explicit within cultural discourse and is often named by clients and/or counsellor within the therapeutic space. Such stigma adds another heavy layer of shame on top of an already deep-seated sense of worthlessness, thus creating an additional barrier that persons with SUDs must contend with. While a thorough exploration of the role of social stigma in the maintenance of SUDs is beyond the scope of this paper, it's important to note that this layer is often only the icing on the cake.

What is not so visible are the layers of shame that lay beneath such judgments; layers that likely took root long before the first taste of a substance was consumed.

Summary

It is evident from the research that shame presents itself in distinct ways and is a product of various factors that may take place across the life course. While some layers are directly related to the consumption of and stigma associated with utilizing substances themselves, numerous additional layers are formed early in life through interpersonal experiences that leave a lasting imprint on the individual. As a result, I would argue that addressing shame in substance use treatment requires an approach that acknowledges both present sources and/or triggers of shame, in addition to historical shame points that likely originated during crucial developmental periods in the clients' life.

Chapter 3: Discussion and Application

It is evident from the research that numerous pathways exist to connect shame and substance use, emphasizing the need to bring awareness to and work with shame in the therapeutic setting and beyond. However, as outlined throughout this capstone, shame does not tend to be communicated in a direct manner by clients and is arguably one of the most painful emotions to make conscious. Given this, guidance around how to have these conversations with clients is crucial. In Chapter 3, I will begin by highlighting themes and limitations from the research I examined. I will then propose a psychoeducational approach for exploring the topic of shame with clients in substance use treatment.

Discussion

The research observed for this capstone undoubtedly demonstrated a relationship between shame and substance use, however many of the research findings only partially substantiated researchers' original hypotheses. Among all five studies examined, researchers across the board anticipated that higher shame would result in more pronounced effects on participants' substance use. While that was certainly true in some cases, the relationship ended up being substantially more complex. Average levels of shame across time (trait shame), the presence or absence of trauma, cultural factors, and different kinds of substances all appeared to impact findings and made it difficult to make comparisons across studies.

Contrary to the hypotheses across the studies examined, in certain cases, shame seemed to carry a protective element in relation to substance use. Saraiya et al. (2018) suggested that the protective mechanism may lie in shame's downregulatory effect on the nervous system, withdrawing life force from the individual needed to take action and carry through all the steps required to secure one's substance of choice. Thus, individuals with lower shame may

demonstrate reduced self-restraint and thus reach for substances to cope when emotions are strong or posttraumatic stress surfaces.

Limitations

There are several limitations in the research for this capstone that warrant address. First, while the role of shame in relation to substance use has been discussed from a theoretical perspective for decades, limited empirical evidence exists to support how the two variables play out in the real world/study participants. From the research databases that I had access to, I could only locate a handful of studies that explicitly explored the interrelationship between shame and substance use. Moreover, when trauma was added to the equation, I came across only two studies that examined the three variables –shame, trauma, and substance use—together.

Another limitation to the research examined is the variety of measures that were used to assess shame in study participants. Shame measures included the Internalized Shame Scale, Differential Emotions Scale-IV, Self-Conscious Affect and Attribution Inventory, Test of Self-Conscious Affect, and an EMA design that was created to measure intensity of shame and other emotions throughout participants' daily life. While most of these are supported for use by reliability and validity measures, they measure diverse qualities of shame (e.g. trait shame vs. state shame) and therefore cannot be easily compared. Moreover, as discussed throughout this paper shame can be a difficult emotion to detect and may take on various forms. Only the study by Randles and Tracy (2012) looked beyond self-report measures of shame and utilized physical expressions that were being demonstrated in the body as an alternative to more conventional measures of shame.

Another limitation that makes it difficult to compare the results of the different studies is the variability in participants' motivations and levels of substance use. For example, participants

in Randles and Tracy's (2012) study were actively recruited from the recovery context of AA. These subjects would likely place themselves further along the stages of change (either contemplative, preparation, action, or maintenance) versus the community participants in Luoma and Guinther's (2018) study who identified as drinkers but were not necessarily concerned with doing anything about it. Given that the aim of this capstone is to support clinicians working with clients with SUDs (or clients who would like to make a change to their substance use), studies with participants across various treatment settings would be beneficial for enhancing clinical relevance.

Cultural Considerations

Highlighted at different points throughout this capstone is the role that the social environment plays on a child's first introduction to and experience of shame. A social element that hasn't yet garnered the same exploration is the impact of culture on shame. In the preamble to their study, Saraiya et al. (2018), emphasize the presence of shaming parenting techniques that are common within Asian culture to safeguard the integrity of the family. This sentiment is captured in the colloquial phrase "losing face," and refers to abstaining from behaviors that would bring shame upon one's family, such as problematic substance use (Leong & Lau, 2001 as cited in Saraiya et al., 2018). Within this context, the spotlight is turned to the 'family as object' of potential ridicule or humiliation in the eyes of others versus the individual on their own, and reflects a fundamental difference between the cultural values of individualist and collectivist cultures. These findings demonstrate the need for future research to include greater cultural diversity and further, to examine how differences in meaning and cultural discourse may influence the expression of the various properties of shame.

Application

Helping clients connect with shame in therapy can be a particularly challenging process. Moreover, a counsellor may be unfamiliar with their own relationship with shame and how the emotion influences their way of being in the world. Naturally then, it can be tempting to keep the emotion from entering the therapeutic conversation. While potentially more comfortable for client and therapist, such avoidance can negatively impact therapeutic outcomes and impede on client progress.

The research and information outlined in this capstone will be used to run a two-day workshop for clients at various stages of their substance use recovery journey. The workshop will be conducted in the format of group therapy, wherein members will be encouraged to interact with one another and opportunities for processing will be available. The group format will support the aim of shining light on the emotion of shame and offers an environment in which the universality of the experience can be readily observed.

Structure of the Group

Facilitators are encouraged to obtain interest/confirmation from 12 clients before scheduling the date of the sessions. While the ideal target size for the group would be eight clients, a higher number of interest provides a buffer for the percentage of attendees who will likely drop out or be unable to make it due to unforeseen circumstances. Clients will be required to attend and complete the first group session in order to proceed on to session two. The material will be delivered over the course of two group sessions that are 90 minutes each in duration, for a total of three hours over two days. Sessions will take place over a two-week period, with 1 week in between each session. The content will be split this way to ensure that clients aren't overloaded with information in one sitting and so that members have space to process the

material between each session. This is of particular importance for upholding a trauma-informed approach to the topic of shame and will be discussed further in the section on ethical considerations. See Appendix B for the workshop material, which I've presented as a set of handouts that can be provided to group members for taking notes and following along.

Type of Group

The group will be largely psychoeducational in nature, with the addition of experiential exercises and opportunities to share and process as a group. As stated previously, the purpose of this group is to provide a deep dive into the topic of shame and a psychoeducational group is the most appropriate format for disseminating a substantial quantity of information to members. Experiential components have been added to give group members a chance to apply and personalize the session material to their own lives. The exercises are also anticipated to enhance members' learning experience, as both the right and left brain will be activated in the activities. While the group will follow a predetermined structure on both days, openings have been included in the schedule to give group members a chance to share what's coming up for them en vivo and be supported in processing what is shared by the facilitators.

Ethical Considerations

As discussed thoroughly throughout the scope of this capstone, shame frequently carries a vast amount of pain and may be particularly triggering for some members to make contact with. In keeping in line with polyvagal theory, facilitators will want to do their best to keep members' social engagement systems online, as it is difficult to venture into vulnerable territory without some degree of safety and security (Dana, 2021). The content and activities that make up the group have been organized with the Somatic Experiencing (SE) concepts of "titration" and "pendulation" in mind. Titration refers to *gradually* bringing attention to difficult experiences,

which is done to avoid the likelihood of flooding and/or re-traumatizing the client (Payne et al., 2015). Relatedly, pendulation is the process of moving out of discomfort once you've made contact with a difficult experience in order to foster restoration and balance in the nervous system following activation (Payne et al., 2015). Further, interpersonal neurobiology has taught us that learning takes place when one is within their window of tolerance (Marriott & Kelley, 2024). Once we go out of that optimal zone, the capacities of the thinking brain decrease and may even shut down completely, inhibiting members' ability to integrate the session material (Marriott & Kelley, 2024).

Another aspect for aiding safety in the group is to have two facilitators present for both sessions. This is important in the event that a member becomes activated and needs to step out. With two facilitators, one can check-in on the affected member if needed without disrupting the flow of the whole group. Further, in consideration for the well-being of the facilitators, shame—particularly when combined with the subject of substance use—can be a heavy topic to carry with a group for a significant length of time. The depths that a particular group reaches will likely differ based on the composition of members, however some activation is expected and in fact desired over the course of the sessions. Facilitators are suggested to adopt a dialectical mindset that holds the importance of trauma-informed care on one side and the qualities of courage and boldness in talking about shame on the other side. The goal is not to shield group members from topics that may be triggering or uncomfortable. Being triggered, particularly when one has a history of trauma, is a normal part of human experience and cannot be avoided. What facilitators can do however is ensure that clients are supported in regaining contact with the present moment, and additional grounding breaks could be woven in to support such responses to the material. It's key to remember that the facilitators' own nervous systems are a

tool that can be utilized for co-regulation throughout the sessions. An empathic response, articulated with a calm and rhythmic prosody can be enough to soothe excess arousal in another's nervous system (Flores & Porges, 2017). In the case of an extreme downregulated system, such as when shame is highly active, some form of movement or contact with the senses would be recommended to bring the member's sympathetic system back online (National Institute for the Clinical Application of Behavioral Medicine, n.d.).

As the research indicates, trauma is often an intermingling factor with experiences of shame and substance use and could also become triggered over the course of the group. Again, having a second facilitator is instrumental so that one facilitator can focus on the delivery of the material and the other is left with more capacity to scan the room periodically and attune to indicators of distress and/or dysregulation that may be surfacing in the group. The presence of two facilitators also opens up opportunities for picking up on expressions of shame that may not be so visible at quick glance or may not have words spoken to them in the group. For example, is a member able to engage in eye contact with a facilitator but has trouble doing so with their peers in the group?

Conclusions

As illustrated in the preceding pages, shame is a multifaceted emotion. Further, shame executes various roles across different points in one's substance use journey. This knowledge highlights the need for clinicians to have a thorough understanding of the emotion of shame when working with substance using populations. Undertaking this task requires a high level of self-awareness for the counsellor, in addition to the qualities of willingness and courage that are needed to venture into the dark with clients. By gradually increasing the light on shame, we can utilize its wisdom for growth and transformation.

References

Alderson, K. (2019). *Addictions counseling today: Substances and addictive behaviors*. Sage. (9781483308265).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.).* American Psychiatric Publishing.

Andrews, D. K. L., & Gilbert-Harker, D. (1998). The forms and functions of the nonverbal signal of shame. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 78–98). Oxford University Press. https://doi.org/10.1093/oso/9780195114799.003.0004

Briere, J. N. & Scott, C. (2014) *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed.). Sage.

Brown, B. (2021). *Atlas of the heart: Mapping meaningful connection and the language of human experience.* Random House.

Batchelder, A. W., Glynn, T. R., Moskowitz, J. T., Neilands, T. B., Dilworth, S., Rodriguez, S. L., & Carrico, A. W. (2022). The shame spiral of addiction: Negative self-conscious emotion and substance use. *PloS One, 17*(3), e0265480. https://doi.org/10.1371/journal.pone.0265480

Alexander, B. K. (1987). The Disease and Adaptive Models of Addiction: A Framework Evaluation. *Journal of Drug Issues, 17*(1), 47-66. https://doi.org/10.1177/002204268701700104

Connolly, R. D., Speed, D., & Hesson, J. (2019). Probabilities of ADD/ADHD and related substance use among canadian adults. *Journal of Attention Disorders, 23*(12), 1454-1463. https://doi.org/10.1177/1087054716647474

Dana, D. (2021). *Anchored: How to Befriend Your Nervous System Using Polyvagal Theory*. Sounds True.

DiClemente, C. C., & Crisafulli, M. A. (2022). Relapse on the Road to Recovery: Learning the Lessons of Failure on the Way to Successful Behavior Change. *Journal of Health Service Psychology, 48*(2), 59-68. https://doi.org/10.1007/s42843-022-00058-5

Dolezal, L. (2022). The Horizons of Chronic Shame. *Human Studies, 45*(4), 739-759. https://doi.org/10.1007/s10746-022-09645-3

Elison, J., Pulos, S., & Lennon, R. (2006). SHAME-FOCUSED COPING: AN EMPIRICAL STUDY OF THE COMPASS OF SHAME. *Social Behavior and Personality, 34*(2), 161-168. https://doi.org/10.2224/sbp.2006.34.2.161

Evans, O. G. (2023, April 20). *Fight, flight freeze, or fawn: How we respond to threats*. Simply Psychology. Fight, Flight, Freeze, or Fawn: How We Respond to Threats (simplypsychology.org)

Farr, J., Ononaiye, M., & Irons, C. (2021). Early shaming experiences and psychological distress: The role of experiential avoidance and self-compassion. *Psychology and Psychotherapy: Theory, Research and Practice.*, *94*(4), 952–972. https://doi.org/10.1111/papt.12353

Fisher, J. (n.d.). *Complex trauma certification training: Level 1 & 2 (CCTP/CCTP-II)* [Online training course]. PESI. https://janinafisher.com/workshops/

Fisher, J. (2017). Changing roles for client and therapist. *Healing the fragmented selves of trauma survivors* (1st ed., pp. 42-64). Routledge. https://doi.org/10.4324/9781315886169-4

Fisher, J. (2021). *Transforming the living legacy of trauma: A workbook for survivors and therapists*. PESI Publishing & Media.

Flores, P. J. & Porges, S. W. (2017). Group Psychotherapy as a Neural Exercise: Bridging Polyvagal Theory and Attachment Theory. *International Journal of Group Psychotherapy, 67*(2), 202-222. https://doi.org/10.1080/00207284.2016.1263544

Herman, J. L. (2011). Posttraumatic stress disorder as a shame disorder. In R. L. Dearing, & J. P. Tangney (Eds.), *Shame in the therapy hour.* (pp. 261-275). American Psychological Association. https://doi.org/10.1037/12326-011

Holl, J., Wolff, S., Schumacher, M., Höcker, A., Arens, E. A., Spindler, G., Stopsack, M., Südhof, J., Hiller, P., Klein, M., Schäfer, I., & Barnow, S. (2017). Substance use to regulate intense posttraumatic shame in individuals with childhood abuse and neglect. *Development and Psychopathology, 29*(3), 737-749. https://doi.org/10.1017/S0954579416000432

Irons, C. (2019). *The compassionate mind approach to difficult emotions: Using compassion focused therapy*. Robinson.

Khoury, L., Tang, Y. L., Bradley, B., Cubells, J. F., Tang, Y. L., Cubells, J. F., & Ressler, K. J. (2010). Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population. *Depression and Anxiety.*, *27*(12), 1077–1086. https://doi.org/10.1002/da.20751

Maddux, J. E., & Winstead, B. A. (2019). *Psychopathology: Foundations for a contemporary understanding*. (5th ed). Routledge.

Manley, A., DeJong, C. (2014). A therapeutic approach to working with trauma and dysregulation: The example of eating disorders and substance use disorders. *Insights into Clinical Counselling*, December, 27-29, 31, 33.

Marriott, S., & Kelley, A. (2024). *Secure relating: Holding your own in an insecure world*. Harper.

Maté, G. (2017, April 5). *Beyond drugs: The universal experience of addiction*. https://drgabormate.com/beyond-drugs-the-universal-experience-of-addiction/

Maté, G. (2010). *In the realm of hungry ghosts: Close encounters with addiction*. North Atlantic Books.

National Institute for the Clinical Application of Behavioral Medicine. (n.d.). *What is shame (and strategies to overcome shame)*. NICABM. https://www.nicabm.com/topic/shame/

National Institute for the Clinical Application of Behavioral Medicine. (n.d.). *How to help your clients understand their window of tolerance [Infographic]*. https://www.nicabm.com/trauma-how-to-help-your-clients-understand-their-window-of-tolerance/

National Institute for the Clinical Application of Behavioral Medicine. (n.d.). *How the nervous system responds to trauma*. NICABM. https://www.nicabm.com/how-the-nervous-system-responds-to-trauma/

NIDA. 2020, July 6. Treatment and Recovery. Retrieved from https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery on 2025, March 29

Payne, P., Levine, P. A., & Crane-Godreau, M. A. (2015). Somatic experiencing: using interoception and proprioception as core elements of trauma therapy. *Frontiers in psychology*, *6*, 93. https://doi.org/10.3389/fpsyg.2015.00093

Randles, D., & Tracy, J. L. (2013). Nonverbal displays of shame predict relapse and declining health in recovering alcoholics. *Clinical Psychological Science, 1*(2), 149-155. https://doi.org/10.1177/2167702612470645

Rybak, C. J., & Brown, B. (1996). Assessment of Internalized Shame: Validity and Reliability of the Internalized Shame Scale. *Alcoholism Treatment Quarterly*, *14*(1), 71–83. https://doi.org/10.1300/J020V14N01_07

Strathearn, L., Mertens, C. E., Mayes, L., Rutherford, H., Rajhans, P., Xu, G., Potenza, M. N., & Kim, S. (2019). Pathways relating the neurobiology of attachment to drug addiction. *Frontiers in Psychiatry*, *10*, 737. https://doi.org/10.3389/fpsyt.2019.00737

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt* (2nd ed.). Guilford Press.

Tangney, J. P., Mashek, D., & Stuewig, J. (2005). Shame, Guilt, and Embarrassment: Will the Real Emotion Please Stand Up? *Psychological Inquiry*, *16*(1), 44–48.

Tracy, J. L., & Matsumoto, D. (2008). spontaneous expression of pride and shame: Evidence for biologically innate nonverbal displays. *Proceedings of the National Academy of Sciences - PNAS, 105*(33), 11655-11660. https://doi.org/10.1073/pnas.0802686105

van der Kolk, B. A. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Books.

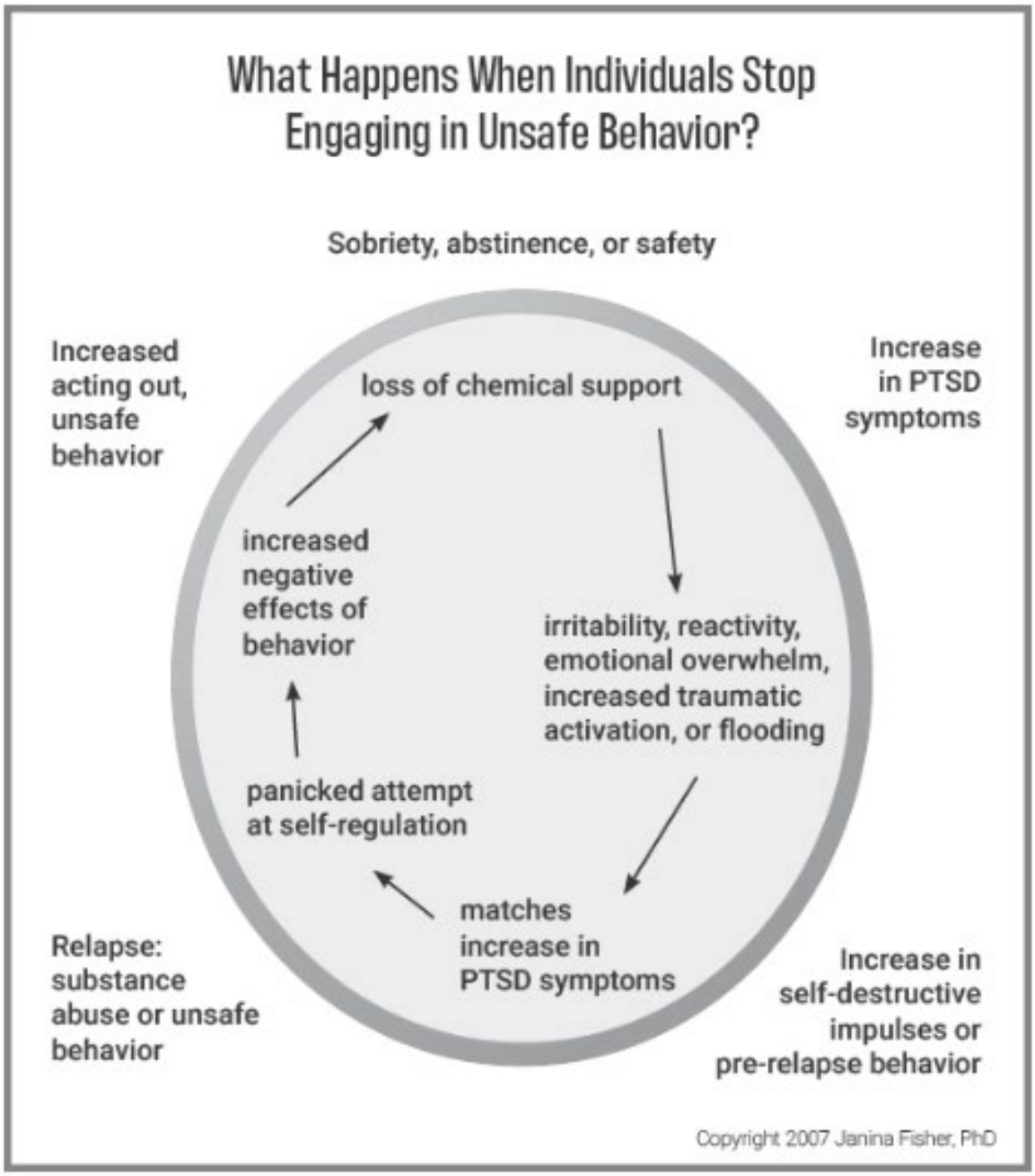
Walker, P. (2013). *Complex PTSD: From surviving to thriving: A guide and map for recovering from childhood trauma*. Azure Coyote.

Wiechelt, S. A. (2007). The specter of shame in substance misuse. *Substance use & Misuse, 42*(2-3), 399-409. https://doi.org/10.1080/10826080601142196

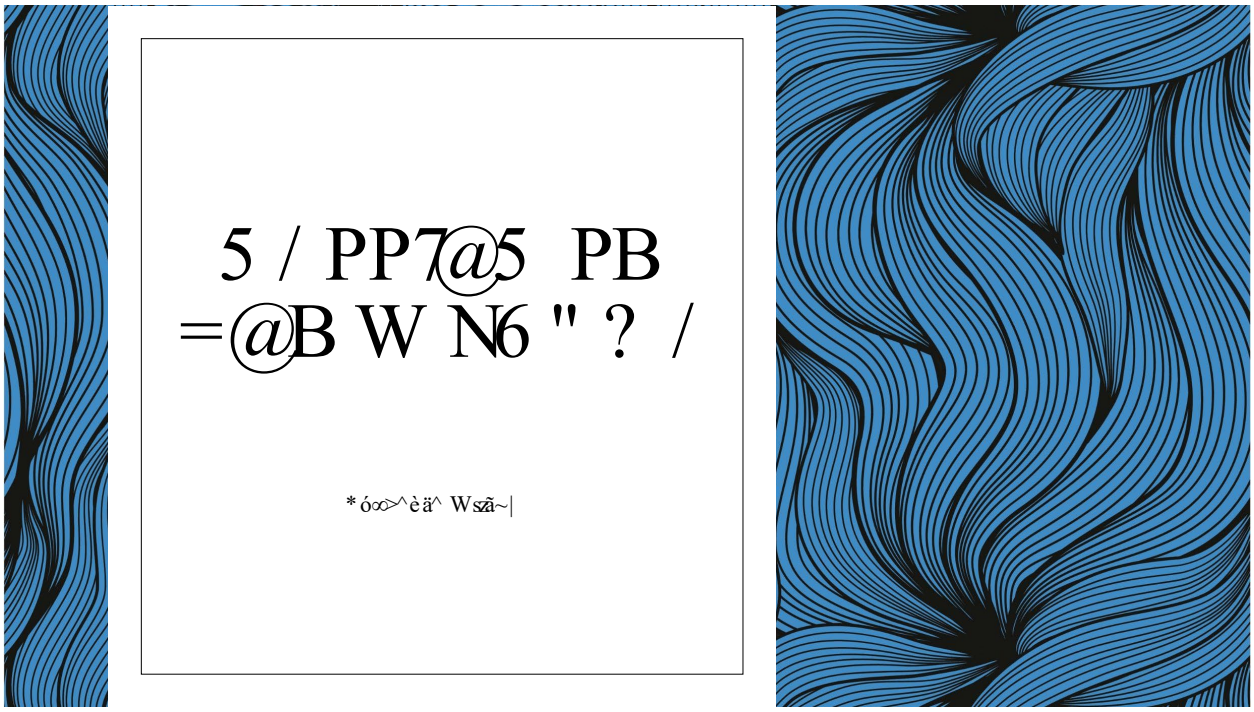
Winhall, J. (2021). *Treating trauma and addiction with the felt sense polyvagal model: A bottom-up approach*. Routledge.

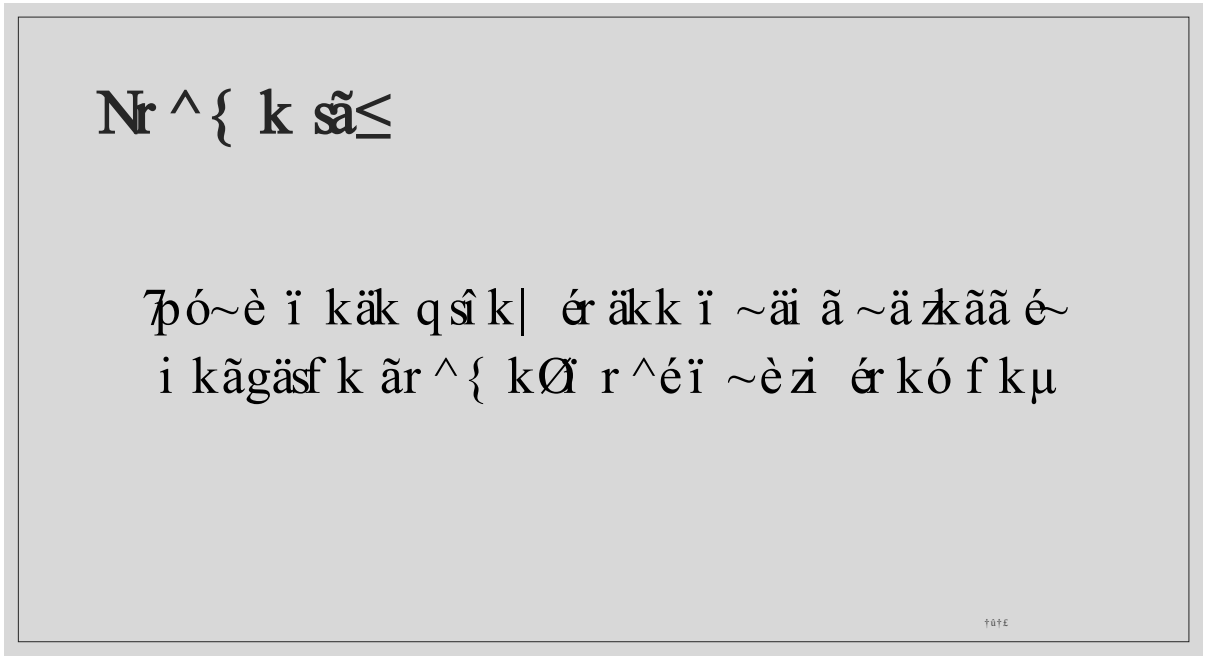
Yau, J. B. (2019). *The body awareness workbook for trauma: Release trauma from your body, find emotional balance, and connect with your inner wisdom*. Reveal Press.

Appendix A: The Abstinence/Relapse Cycle



Appendix B: Unraveling Shame Workshop Slides





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- Emotions are sources of information
- Emotions are neither good nor bad; all emotions serve a purpose
- Curiosity over judgment

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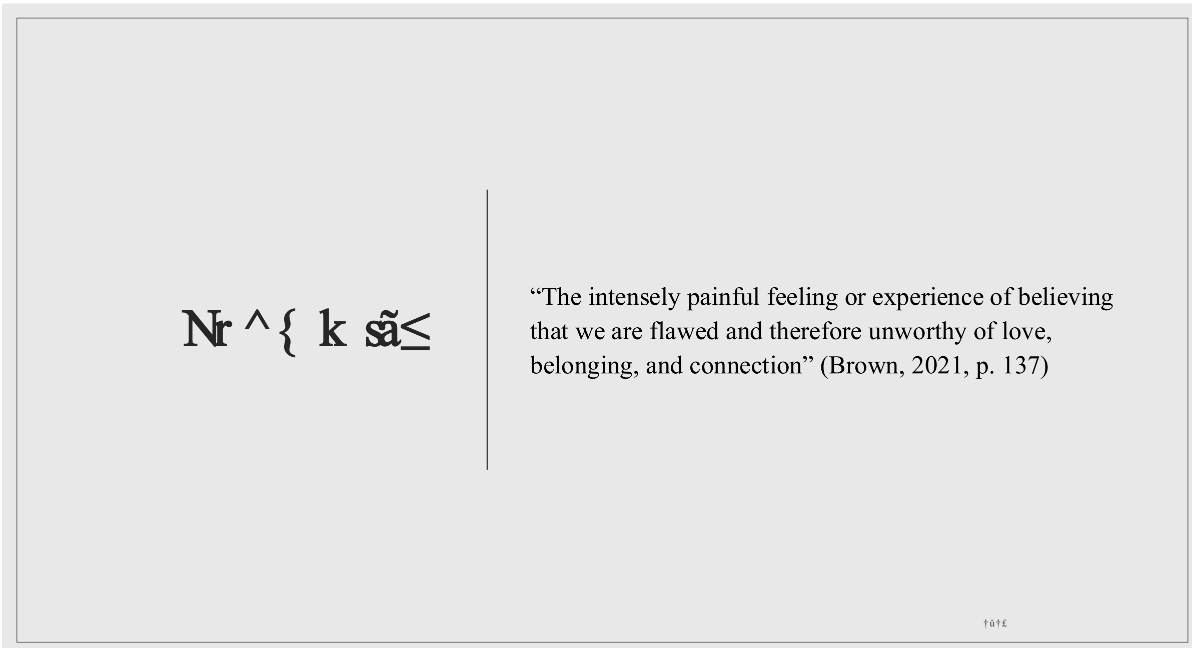
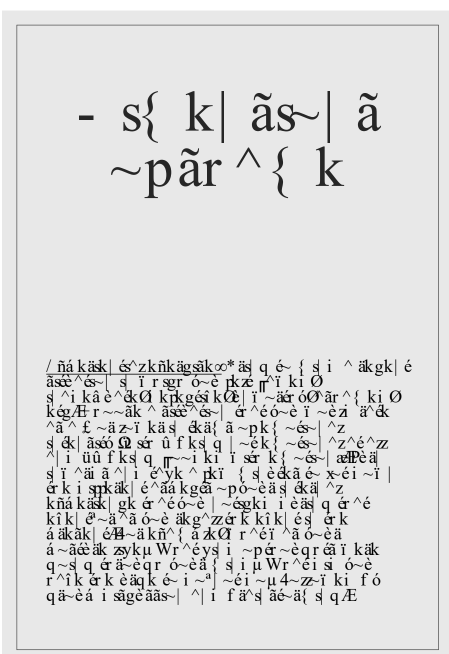
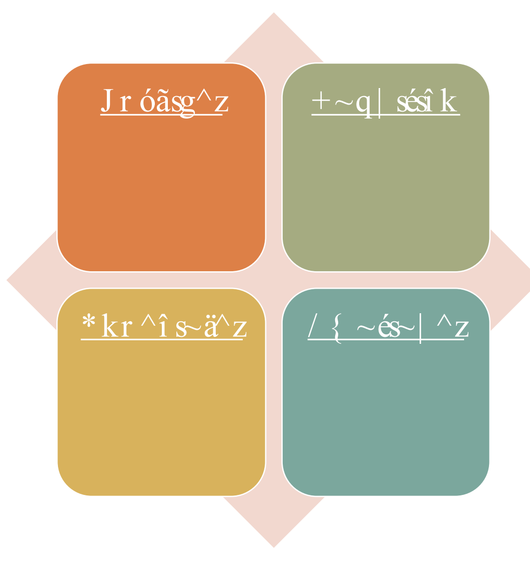

"The intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love, belonging, and connection" (Brown, 2021, p. 137)





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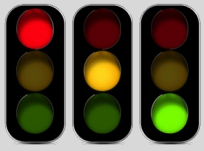

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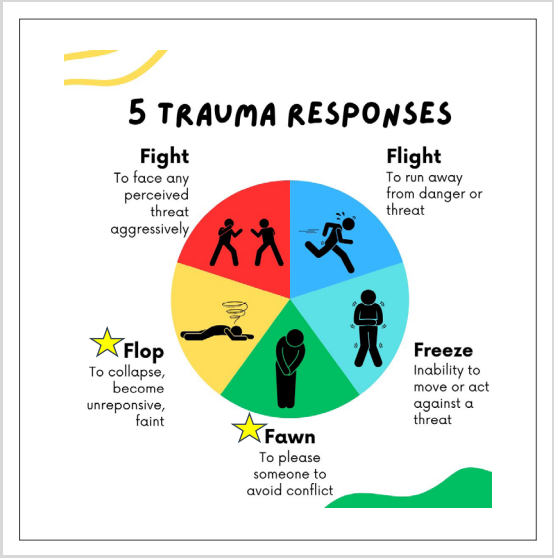

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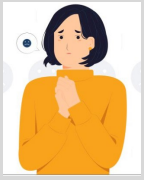

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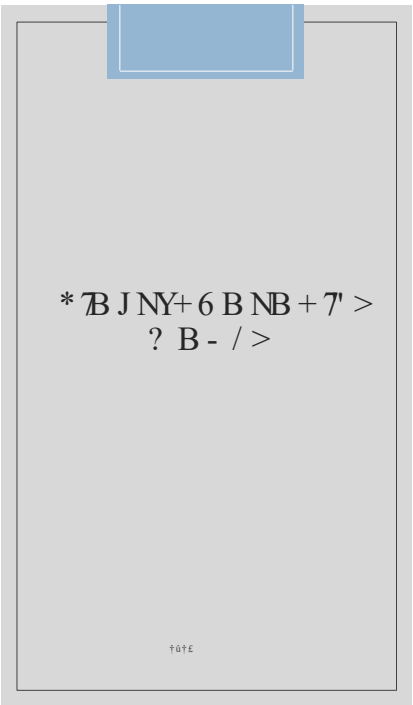

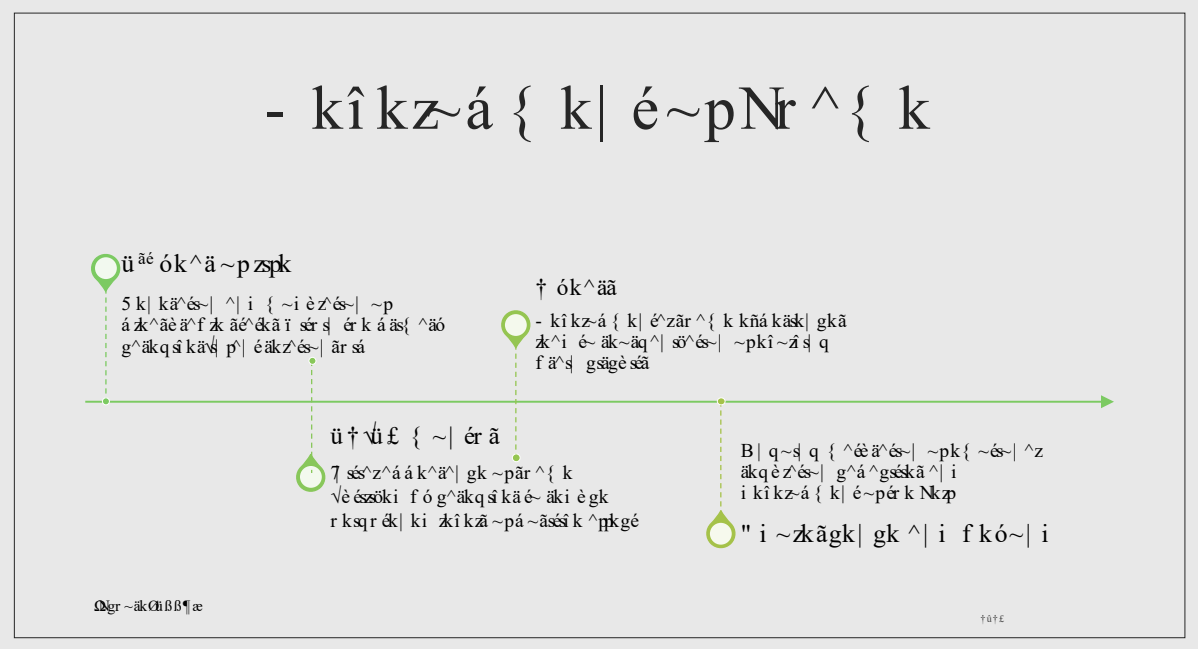

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A psychological theory of human development that highlights the importance of the emotional bond that transpires between infant and caregiver to ensure the newborn's survival and ensuing development (Bartholomew & Horowitz, 1991).

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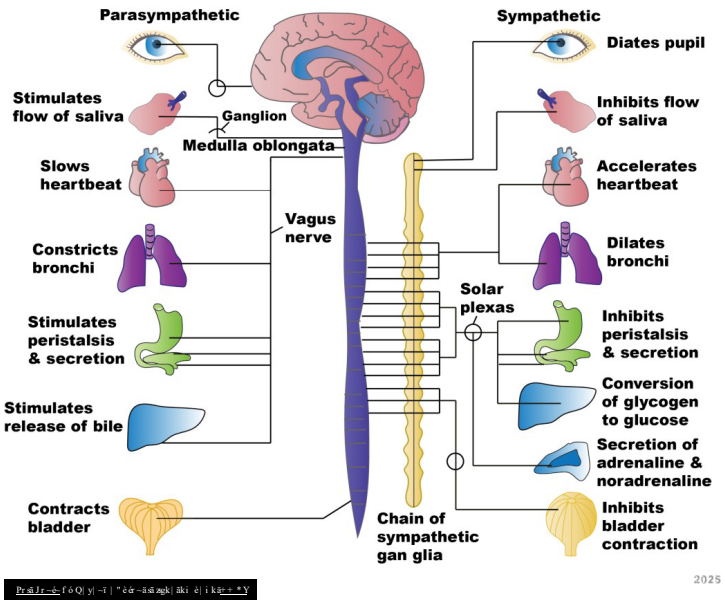

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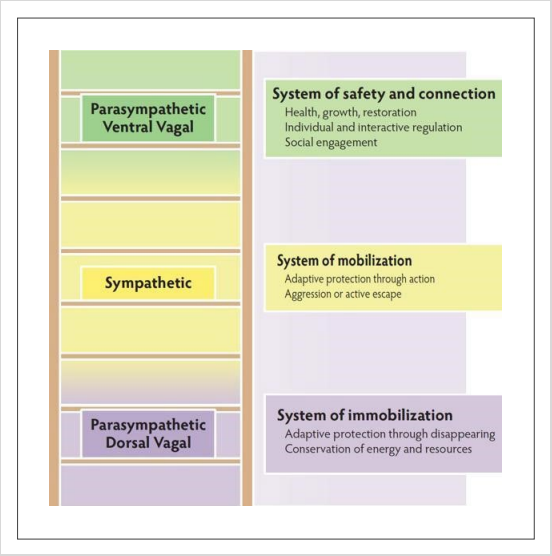

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A theory developed by Dr. Steven Porges that explains the neural mechanisms that are responsible for the ability of social mammals to achieve safety and social connection with others and their environment (Dana, 2021).

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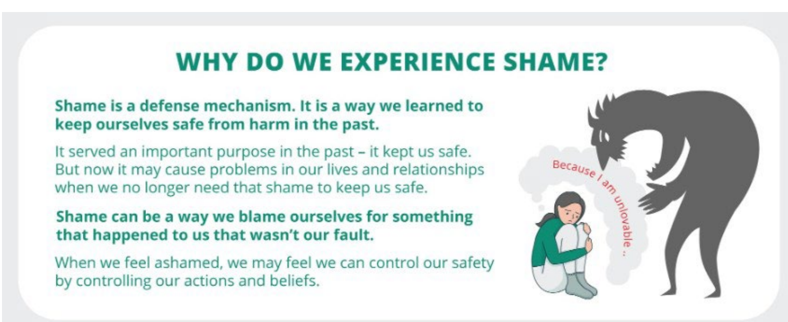
WHY DO WE EXPERIENCE SHAME?
Shame is a defense mechanism. It is a way we learned to keep ourselves safe from harm in the past.
It served an important purpose in the past – it kept us safe. But now it may cause problems in our lives and relationships when we no longer need that shame to keep us safe.
Shame can be a way we blame ourselves for something that happened to us that wasn't our fault.
When we feel ashamed, we may feel we can control our safety by controlling our actions and beliefs.
Because I am unlovable...

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Memories are activated outside of conscious awareness and typically present in the form of physical sensations or emotional reactions within the body (Fisher, 2021).

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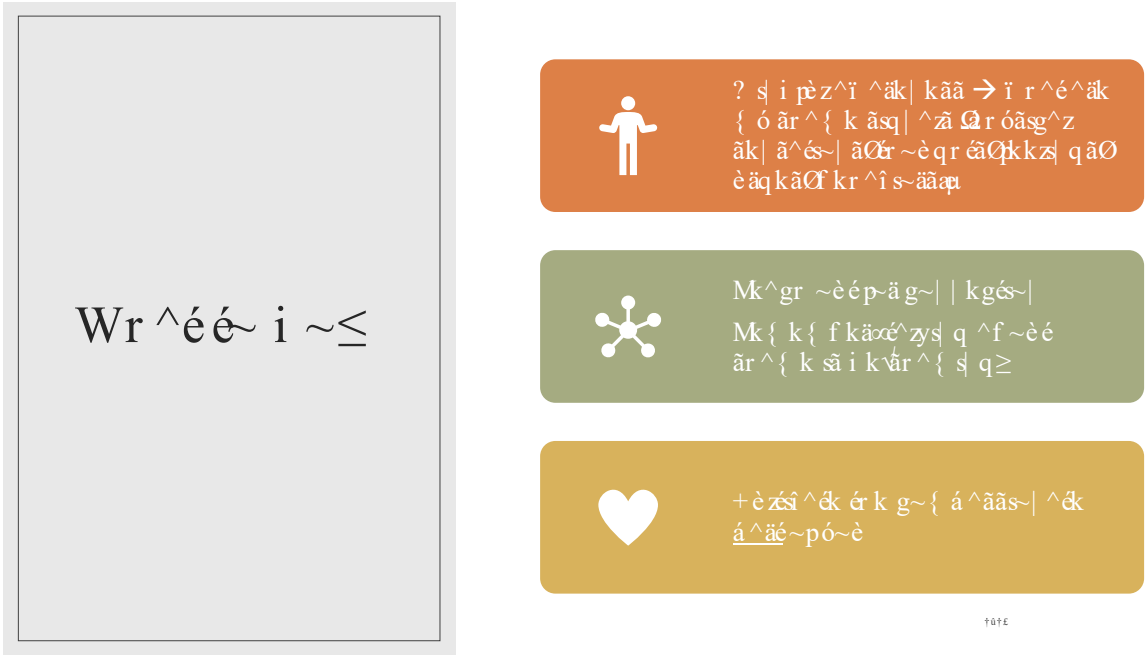
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