# Ashley Braun-Gabelman, Disclosures

- No Disclosures

*The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.*

# Accreditation Statement

- American Academy of Addiction Psychiatry (AAAP) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

# Designation Statement

- American Academy of Addiction Psychiatry (AAAP) designates this enduring material for a maximum of 1 (one) *AMA PRA Category 1 Credit*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.
  - Date of Release: August 26, 2016
  - Date of Expiration: ~~August 26, 2017~~

PCSS TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Opioid Therapies

# Target Audience

- The overarching goal of PCSS-O is to offer evidence-based trainings on the safe and effective prescribing of opioid medications in the treatment of pain and/or opioid addiction.

- Our focus is to reach providers and/or providers-in-training from diverse healthcare professions including physicians, nurses, dentists, physician assistants, pharmacists, and program administrators.

# System Requirements

- In order to complete this online module you will need Adobe Reader. To install for free click the link below:
  - http://get.adobe.com/reader/

# Educational Objectives

- At the conclusion of this activity participants should be able to:
  - Define shame and differentiate between shame and guilt
  - Identify the relationship between shame and OUD
  - Discuss shame as it relates to particular subsets of people with OUD including:
    - People who inject heroin
    - Opioid-addicted pregnant women and mothers
  - Recognize indicators of shame in patients

# Outline

- Definition of shame
- Case examples
- Recognizing and understanding shame in patients with OUD
- Treatment implications

# Case Vignette #1

- 24 year-old, Caucasian male
- Severe heroin use disorder, IV administration
- OD reversed with Naloxone
- Now stable on Suboxone and active in NA
- Participates in group therapy, but usually sits with shoulders hunched forward and downward gaze
- Describes family members not understanding addiction
- Describes stigma in NA regarding Suboxone

# Case Vignette #2

- 48 year-old female, high SES
- Married mother of 3 teenagers
- Works as nurse anesthetist
- Severe opioid use disorder
- Diverted fentanyl from work
- Participates actively in group therapy, usually trying to help other patients

# Case Vignette Questions

- What are the indicators of shame in this patient?
- What issues may be contributing to his/her feelings of shame?
- What are appropriate treatment targets and goals?

# What is shame?

- I feel intensely inadequate and full of self doubt
- I have an overpowering dread that my faults will be revealed in front of others
- At times I feel so exposed I wish the earth would open up and swallow me

# What is shame?

"A powerful, but unquestioned, conviction that in some important way one is flawed and incompetent as a human being… The self-condemnation and self-loathing that shame precipitates are part and parcel of a pervasive, persistent, and destructive set of emotions that grips the sufferers with a crippling sense of terror and pessimism, preventing them from living harmoniously and confidently."

(Goldberg, 1991)

# What is shame?

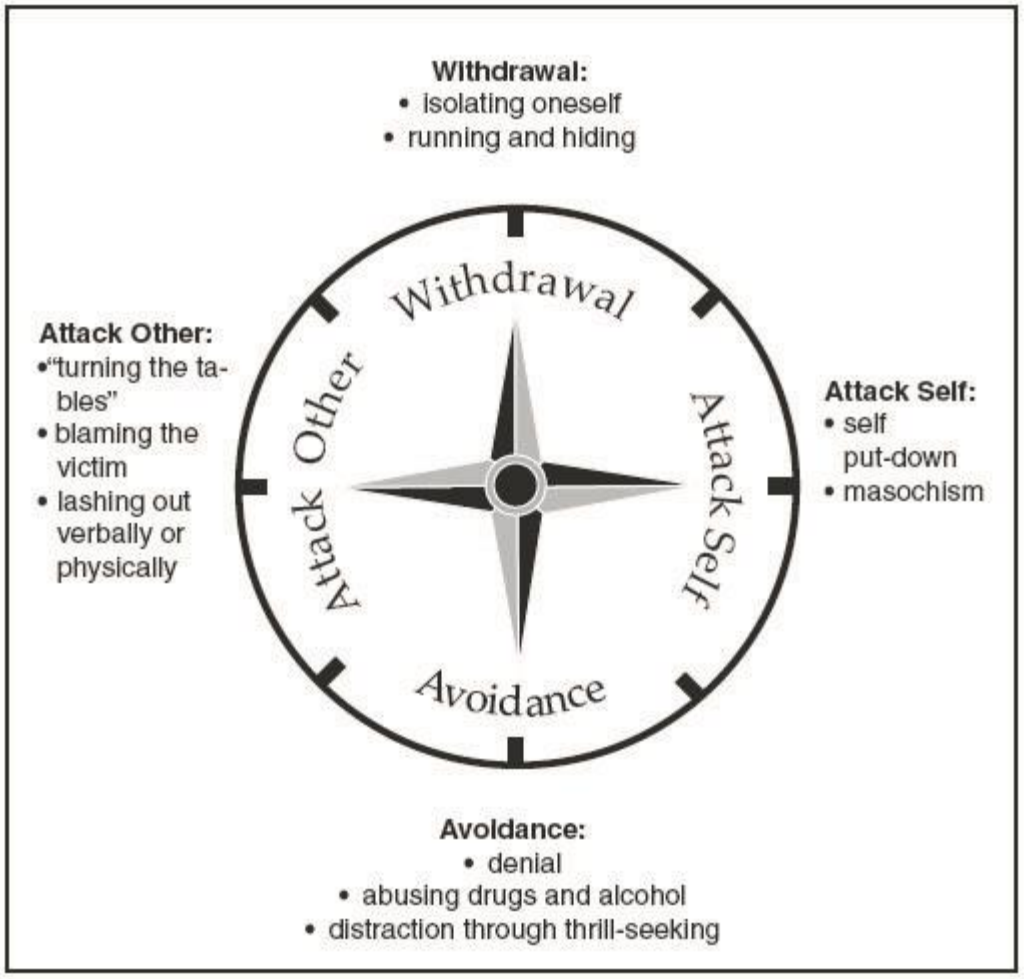
- Exposure of a flawed self
  - Internal or external
- Competence: an expression of the ability, fitness, and capacity to live effectively and well
  - Shame involves feeling incompetent
- Primitive emotion that's adaptive function has been lost (Darwin, 1872)

# Shame vs. Guilt

- Shame = Focus on self
- Guilt = Focus on specific behavior (Tangney & Dearing, 2002)
- I made a mistake vs. I am a mistake
- Shame and guilt often fused
- Shame-free guilt found to be adaptive
  - In prison sample, guilt found to be correlated with lower rates recidivism; shame correlated with higher rates (Hosser et al., 2008)

# Compass of Shame

(Nathanson, 1992)

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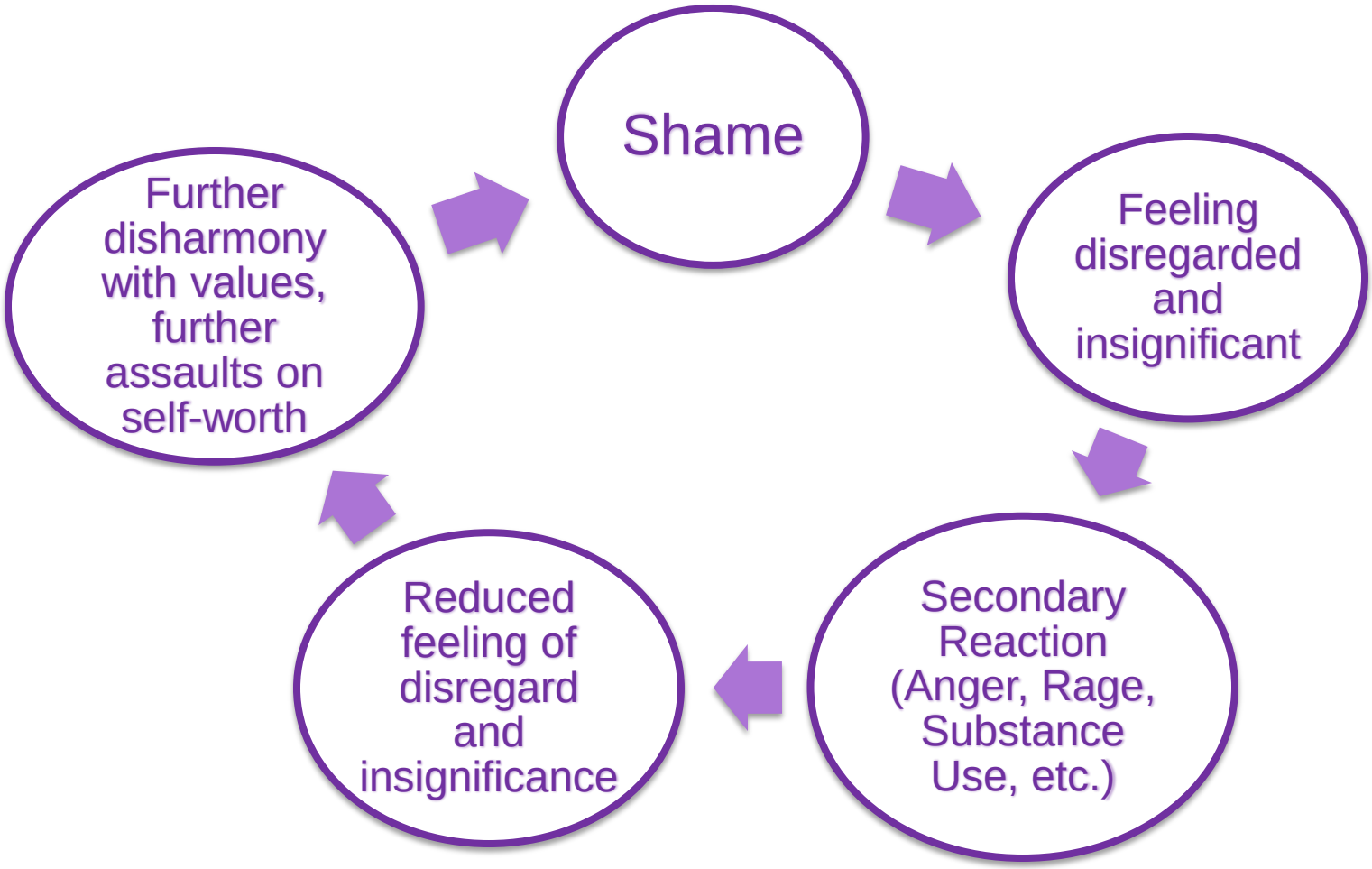
# Secondary Reactions

- Anger
- Rage
- Resentment
- Jealousy
- Shamelessness
- Arrogance
- Self-glorification
- Aggressiveness
- Substance Use
- Self-harm

(Bursten, 1973; Horowitz, 1981; Rycroft, 1968)

# Cycle of Shame

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# Why aren't we better at working with shame?

- "Pathological shame is both a crucial cause of human suffering, and at the same time, a silencing vehicle that keeps the misery a secret, unavailable to those who may be in a position to help."
  (Goldberg, 1991)
- Hard to recognize
- Often masked by other emotions and/or behaviors
- Shame comes with hiding

# Transference and Countertransference Issues

- Transference
  - Entering treatment may be shaming
  - Power differential in the therapeutic relationship

- Countertransference
  - What are our own experiences with and reactions to shame?
    - Patient may exhibit anger, blame, demands
    - Clinician may feel insecure, inadequate

# Assessment Tools

- Internalized Shame Scale (ISS; Cook, 2001)
  - Used with SUD populations
- Rosenberg's Self-Esteem Scale (Rosenberg, 1965)
- Test of Self-Conscious Affect (Tangney, 1990)

# Nonverbal Signs of Shame

- Often better predictor than self-report
- Nonverbal indicators of shame, not self-report predicted time to first suicide attempt or self-injury (Brown, 2009)
- Nonverbal displays of shame predicted tendency to relapse, severity of relapse, overall health (Randles & Tracy, 2013)

# Recognizing Shame

# Nonverbal Indicators

- Gaze directed downward or averted
- Head lowered
- Some people blush
- Shoulders slumped
- Chest narrowed
- Face touching

(See Keltner & Harker, 1998 for review)

# Shame and Substance Use

- SUD vs. general population or other MH problems (O'Connor et al., 1994)
  - SUD: Higher shame
  - SUD: Lower levels of adaptive guilt
- Higher levels of shame associated with relapse (Wiechelt & Sales, 2001)
- Higher shame-prone children more likely to use drugs at age 18 (Tangney & Dearing, 2002; Stuewig et al., 2015)
- Shame about past drinking predicts future drinking (Randles & Tracy, 2013)

# Shame and Opioid Use

- Can be precursor and consequence; often cyclical
- Opioid use “protects” from the pain of shame
- People who use opioids and other drugs, highly avoidant of shame

# Shame and Heroin

- Heroin users looked down on by people who use other opioids and other drugs
- Shame may be masked while actively using, often becomes more apparent when sober
- Important treatment target in recovery
- In Republic of Georgia, shame around heroin has led to increased problems with buprenorphine (Cleaver, 2007)
  - Seen as a Western drug that is more “clean” and “safe”

# Injection Drug Use

- Injection users looked down on by other heroin users
  - "I try my hardest for people not to know that I'm banging up (injecting). I tell them that I smoke it." (Rhodes et al, 2007)

- Between injection users (Rhodes et al, 2007)
  - Public vs. private environment
  - Cleanliness of the environment

# Medication Assisted Treatment

- Many patients using MAT report shame and stigma in NA meetings
- Some NA members view those on Suboxone as not truly sober
- Challenge as to whether or not to disclose use of MAT in NA groups

# Pregnancy and Motherhood

- Research shows that mothers who abuse substances are judged more harshly by the public and even by healthcare providers (Castillo & Waldorf, 2008)

- Shame can be a barrier to seeking and sustaining treatment
  - "I was really ashamed to have to go and say I'm a heroin addict, and I couldn't really reconcile that with my self image… because I've never really thought of myself in those terms."
    (Varty & Alwyn, 2011)

# MAT in Pregnancy

- Common themes among pregnant women receiving MAT (Varty & Alwyn, 2011)
  - Denial
  - Guilt
  - Shame
  - Embarrassment
  - Parenting concerns
  - Perceived lack of support from health professionals

# Family

- Increased shame for the addict when:
  - Drug use is discordant with family values
  - Trust has been broken
  - Values have been violated
  - Family members do not understand addiction
  - Stigma about addiction in the family system
- Some family members of addicts may experience shame
- Family education
  - Important treatment component

# Treatment Questions

- Safety
- What is the right time in recovery to address shame?
- Individual vs. Group

# Treatment Considerations

- First teach healthy coping skills
- Psychoeducation:
  - Shame vs. guilt, self vs. behavior
- Substance use treatment often group-based
  - Group members' shame can interfere with group functioning
  - Issues of shame often common among group members

# Group Vignette

- Suboxone after-care group
- N = 10
- Common themes:
  - Suboxone in NA
  - Hiding evidence of past drug use (e.g., scars from injecting, lost teeth)
  - Being misunderstood/rejected by non-addicted people
- Talking about these issues in group takes them from hidden to exposed

# Treatment Options

- 12-Step Programs
- Seeking Safety
- Matrix
- ACT

# 12-Step Programs

- Shame can interfere with a sense of belonging
  - Joining a group

- 12 steps: Shame can interfere or be improved
  - Step 4: Moral Inventory
  - Step 5: Admitting the nature of wrongs
  - Steps 8 & 9: Making amends

# Seeking Safety

- Treatment for SUD + PTSD

- Focus on:
  - Compassion
  - Harsh vs. compassionate self-talk
  - Ways to increase compassion for self

# Matrix

- Intensive outpatient treatment for people with stimulant use disorder (SAMHSA, 2006)
  - Can be applied to OUD
- Guilt and Shame module
- Differentiating between guilt and shame
- Asks patients to forgive themselves for past mistakes
  - Focuses more on guilt
  - Opens the discussion

# Matrix Guilt and Shame Module

RP 5

## Guilt and Shame

Guilt is feeling bad about what you've done: "I am sorry I spent so much time using drugs and/or gambling and not paying attention to my family."

What are some things you have **done** in the past that you feel guilty **about?**

_____

_____

Feeling guilty can be a healthy reaction. It often means you have done something that doesn't agree with your values and morals. It is not unusual for people to do things they feel guilty about. You can't change the past. It is important to make peace with yourself. Sometimes that means making amends for things you've said and done.

Remember the following:

It's all right to make mistakes.

It's all right to say, "I don't know," "I don't care," or "I don't understand."

You don't have to explain yourself to anyone if you're acting responsibly.

Do you still feel guilty **about** the things you listed? What can you do to improve the situation?

_____

_____

Shame is feeling bad about who you are: "I am hopeless and worthless."

Do you **feel ashamed of being dependent on substances and/or gambling?** Yes___ No____

RP 5

## Guilt and Shame

Do you feel you are weak **because** you couldn't or can't **stop using or gambling?**
Yes ___ No ___

Do you feel you are stupid **because** of what you have **done?**
Yes ___ No ___

Do you feel that you are a bad **person because** you are involved with **substance use or excessive gambling?**
Yes ___ No ___

Recovery is always a hard process. No one knows why some people can stop using substances or gambling excessively once they enter treatment and decide to be abstinent and other people struggle to maintain abstinence. Research shows that family histories, genes, and individual physical differences in people play a role. Being dependent on drugs or alcohol does not mean you are bad, stupid, or weak.

What we do know is that you cannot recover by

Trying to use willpower  Trying to be good

Trying to be strong

Two things to make recovery work are

Being smart  Working hard

Everyone who is successful at recovery will tell you, "It was the hardest thing I ever did." No one can do it *for* you, and it will not happen *to* you.


(SAMHSA, 2006)

# Acceptance and Commitment Therapy

- Luoma, Kohlenberg, Hayes, & Fletcher, 2012
- ACT vs TAU
- N=133
- 6 hours of group ACT intervention over 1 week

# ACT vs. TAU Results

- Outcomes one week post-treatment:
  - Shame: TAU lower than ACT
  - Quality of Life: TAU higher than ACT
  - Social Support: No difference

- Outcomes 3 months post-treatment:
  - Shame: ACT lower than TAU
  - Relapse rates: ACT lower than TAU
  - Quality of Life: ACT higher than TAU
  - Social Support: ACT higher than TAU
  - Treatment Engagement: ACT superior

# ACT vs. TAU Conclusions

- ACT is not a quick-fix, but given time, a more effective treatment for shame
- An open, self-compassionate, values based approach

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# Case Vignette Questions

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- What are appropriate treatment targets and goals?

# Summary

- Shame = a conviction of a deeply flawed, inadequate self
- Shame vs. guilt
  - Self vs. behavior
  - Maladaptive vs. adaptive
- Nonverbal indicators of shame often more informative than self-report

# Summary

- Shame is common among individuals with OUD and associated with use and relapse
- Within individuals with OUD, particular subgroups associated with shame include injection heroin users and pregnant women and mothers
- Shame should be a focus of OUD treatment

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# PCSS-O Colleague Support Program and Listserv

- PCSS-O Colleague Support Program is designed to offer general information to health professionals seeking guidance in their clinical practice in prescribing opioid medications.
- PCSS-O Mentors comprise a national network of trained providers with expertise in **addiction medicine/psychiatry and pain management.**
- Our mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.
- The mentoring program is available at no cost to providers.

**For more information on requesting or becoming a mentor visit:**

**www.pcss-o.org/colleague-support**

- **Listserv:** A resource that provides an "Expert of the Month" who will answer questions about educational content that has been presented through PCSS-O project. To join email: pcss-o@aaap.org.

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For more information visit: www.pcss-o.org
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