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Comparison of Guilt and Shame Between Men and Women with Drug Addiction

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Abstract

The purpose of this study was to explore the comparison of Guilt and Shame between Men and Women with Drug Addiction. The main objective was to determine whether both genders feel guilt or shame or not. Cross- Sectional research design was used to assess moral emotions. State Shame and Guilt questionnaire was used for this purpose. A sample of (N=70) patients (35 men and 35 women) was taken from Pak Clinic, Promise Clinic, Umeed Clinic and Shaaf Clinic from Lahore. Statistical analysis was carried out through Spss (16.5) thus obtaining frequencies and percentages of the data. For further analysis t-test was run to see the differences. The finding of the results showed that both genders had feelings of guilt as well as shame, whether they were from nuclear or joint family, whether they were taking medicines first time or for a long time. Furthermore, the findings of this work have important implications for Researchers who should also study various aspects of drug addict's behavior. It is also important for the treatment and prognosis of drug addicts. In addition, it is important for our Government who must take some serious steps for reducing the rate of drug use. Above all, the research is important for our society that people should not negatively labialize to drug addicts as an evil soul because drug addicts are also human being.

Keywords: Guilt, Shame, Moral Emotions, Drug Addiction, Men and Women, Negative persistent emotions, Biopsychosocial, Childhood experiences, Psychopathology, Attribution Theory, Drug use among Females

Introduction

It is generally accepted that chemically dependent clients normally agonize from many psychological and physical problems as well as addiction. As a result, they face difficulty regulating also handling with painful emotions. In recent years, psychoanalytic theory has increasingly fixated on the role of shame and guilt in the etiology of addiction also addiction may lead towards the negative persistent emotions. Weiss [1] has developed theory of psychopathology and psychotherapy, unfolding that excessive shame and guilt are closely connected with addiction. To explore this study, Purposive sampling strategy was used to explore the feelings of drug addicts. The State Shame and Guilt Scale were applied to see the difference of male and female's feelings. A cross sectional study design was used to investigate guilt and shame feelings as it involves different groups of people who differ in the variable of interest but share other characteristics, such as socioeconomic status, educational background, and ethnicity. However, the present study derives from this theoretical framework. In this comprehensive research study, description of guilt and shame, relationship between shame guilt and addiction and the biopsychosocial theories of substance abusing become even more complex.

Weiss's theory as applied specifically to chemically dependent population suggest that people become vulnerable to drug addiction when they are prevented from chasing ordinary development goals by forbidding pathogenic beliefs. Pathogenic beliefs are derived from disturbing childhood experiences and warn people that if they peruse some certain goals, they may harm themselves or their parents, siblings or their loved ones. Because they undertake themselves as harming person, the belief often causes humanity-based guilt or shame. In reaction to these beliefs, people inhibit themselves from pursuing normal goals in order to avoid or minimize guilt and susceptibility to addiction. Chemically dependent clients often come from troubled families with a history of addiction. From this background many addicted clients inherit both a genetic predisposition and pathogenic beliefs cause them to suffer from maladaptive guilt and shame.

Furthermore, the lifestyle and behaviors linked with drug use lead to additional disturbed feelings of guilt and shame. substance referred to in this study include alcohol and the illicit substances, marijuana and cocaine. According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders DSM-V (2013), substance abuse is defined as a cluster of cognitive, behavioral and physiological symptoms signifying that the individual lasts consuming the substance despite significant substance related problems. An important characteristic of substance use disorder is underlying change

in brain circuits that may be persist beyond detoxification particularly in individuals with sever disorders. The behavioral effect of these changes may be exhibited in the repeated relapses and intense rug craving when the individuals are exposed to drug related stimuli. These persistent drug effects may benefit from long term approaches to treatment. (DSM-V, 2013).

Hrome examined that 30 to 90% of students drink regularly and up to 70% had tried at least one illegal drug. Bachman, O Malley, Schulenberg, Johnston, Bryant & Merline, 2002 reported that in 2008 almost 70% of 21 to 25-year-olds Illegal drug use was highest among 18 to 20-year-olds at 23%, followed by 21 to 25-year olds at 19%. The same report showed that binge drinking was the highest among 21 to 25-year-olds (44%) and second highest among 18 to 20-year olds (37%). Substance dependence/abuse was also the highest in the 18 to 25-year-old range at 22% (Arnett, 2000). Hence, substance use is predominant and warrants further inspection into the factors that lead to increased use.

Shame and Guilt

Shame is also a threat emotion and motivates escape behavior, concealment and submissive behavior [2]. Often shame results in actual withdrawal from the problematic situation. A person experiencing a shame reaction may undergo a sudden affect-shift, such as a surge of anger or anxiety. They may be crippled by a blank mind, lose confidence and the ability to think and act freely. It is thought that shame has distinctive, submissive facial expressions, and may also engender a range of involuntary behaviors, experiences, including blushing, a hunched posture, avoidance of eye-contact and changes in speech. Because of its intense self-focus, shame impairs one's ability to generate effective solutions to interpersonal problems, also diminishes confidence in one's ability to implement solutions.

The distinction between shame and guilt has been a subject in the past several decades. Early theorist [3]. saw that shame as a response to public exposure of some fault and deficiency in the person experiencing the emotion and they saw guilt as an internal matter between the self and the conscience. However, for, these feelings are used conjointly. Shame has been described as a failure of being or global self-condemnation, while guilt has been referred to as a 'failure of doing'. The former may result in feelings of inadequacy, deficiency and being exposed. It appears that shame is directed primarily at the self, whereas guilt addresses the particular act, and may be concerned in conformity to societal norms.

Shame relates to negative feelings about the self and has been described as an intense negative emotion which can result in feelings of inferiority and powerlessness. Shame can arise from a difference between the ideal self and the actual real self-leading to feelings of inadequacy and disgust. Shame-proneness is often internalized and has been associated with the development of psychopathology, whereas proneness to guilt, generally more overt, correlates with non-pathological, adaptive empathy. However, far from being a purely negative emotional state, feeling shameful warns the individual that their actions are socially unacceptable and may result in them being rejected by others. In order to avoid rejection, the individual seeks to find alternative ways of behaving. Consequently, shame is characterized by hiding the self.

Theories of Drug Addiction

Biological and Genetics Theories

Brain dopamine systems have been the focus of considerable attention in behavioral neurobiology. In particular, the ventral tegmental dopamine system appears to have an important role in motivated behavior in some types of psychopathology. This dopamine system has its cell bodies located in the ventral tegmental area and sends its axonal projections to several brain regions. It receives neural inputs from many diverse brain sites and modulates neural activity in cortical and limbic areas which motive human to adopt repeated behaviors. Addiction is one of the major highly adaptive behaviors.

Social Learning Theories

One branch of conditioning theory, social-learning theory Bandura has opened itself to the subjective elements of reinforcement. Bandura described the essential insight that reinforces gain meaning only from a given human context enables to understand [1] why different people react differently to the same drugs, [2] how people can modify these reactions through their own efforts, and [3] how people's relationships with their environments determine drug reactions rather than vice versa [4]. according to the theory of social learning, believes that the observations of other people engaging in addictive behavior can lead to the development of addiction. When a person observes the behavior and reactions of other people using addictive substances (or activities), he may wish to repeat what he saw. The theory concluded that this learning occurs by observing how other people act and the consequences of these actions. If another individual receives a reward for a certain action, this will encourage an observer to adopt the behavior. It is Bandura's and Harlow's contention that observing an action can have as much impact as directly experiencing it.

The ability of people to model behavior is highly advantageous. For instance, if they can observe the negative impact of abusing drugs, it can save a lot of pain. It means that the individual can learn about drugs without having to take them. It is argued that individuals become addicted to alcohol or drugs because of modeling. If a person observes that other people are getting enjoyment from these activities, it can make them appealing. Certainly, behavior modeling does play a part in why people fall into substance abuse [5].

Attribution Theory

Shame and guilt are inherently related to perceptions of ourselves. They can be discriminated according to Abramson, Seligman & Teasdale's dimensions of causal attributions, which

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consider locus of control (internal versus external), globality (global versus specific) and stability (stable versus unstable). In both shame and guilt, internal attributions are made. Whereas guilt is associated with specific and unstable attributions, shame involves global and stable attributions. For example, a person who gets 'too' drunk at someone else's birthday celebration and behaves inappropriately to the point that it spoils the atmosphere might feel guilt. They may experience a sense of tension and remorse over what they have done, focusing on that specific indiscretion. They know that they are responsible for their behavior (internal attribution), but acknowledge that the causes of this misdemeanor are rather specific; they know that they are not generally an irresponsible or rude person (specific attribution), and that the antecedents to their behavior were unique to that particular event (unstable attribution).

Conversely, shame involves a focus on the entire self and is likely to be relatively persistent. Often internal, stable and global attributions are made when one experiences shame. Another person in similar circumstances may experience an acute sense of shame, feeling disgraced, small and wanting to hide. With a clear self-focus, they also know they are responsible (internal attribution) but may believe that the causes of this misdeed are a reflection of their personality - irritating, loud, aggressive (global attribution), and that this type of behavior occurs within various settings (stable attribution).

Drug use among Females

In many developed countries, drug abuse is no longer an exclusively or predominantly a male activity. In general, male and female drug use patterns seem to be more even in industrialized countries. Substance use disorder is a collection of physiological, cognitive, and behavioral symptoms that appear when an individual continues to use a substance even though it is producing significant problems in the individual's life American Psychiatric Association [6]. Substance dependence is exhibited when a person uses a substance to produce a mood change but then begins to need the drug more often and in larger amounts to achieve the same effect. Until the 1970's, substance abuse was seen almost exclusively as a male problem [7].

In the 1950's, it was estimated that there were five or six male substance abusers to every female substance abuser. Estimates in the 1990's indicate that this ratio is now approximately three males to every one female. The Center for Substance Abuse Treatment (1996) reports that 4.5 million women are alcohol abusers, 3.1 million women use illegal drugs on a regular basis and 3.5 million women misuse prescription drugs. The growing recognition that substance abuse is a seriously debilitating disorder for women has caused tremendous concern within the past 30 years. This concern has resulted in a dramatic increase in research surrounding the female substance user. Results from etiology it indicates women may begin to abuse substances as a form of self-medication for such disorders as depression, post-traumatic stress disorder (PTSD), and or an eating disorder.

One of the major factors which favor the increase of drug use among women is the transition of women from the traditional roles of mother and homemaker to that of an economic provider for the family. Although this can be considered a positive gain it can also impose greater levels of stress and drug use is a possible response in the absence of other coping mechanisms (United Nation Offices on Drugs and Crimes Country Office Pakistan). There is growing evidence that the effects of drug abuse and addiction do not always impact men and women in the same manner and the biological mechanisms involved in drug abuse and dependence are not identical in males and females. As happens generally with drug abuse, its occurrence among women has an impact that goes beyond the individual. Women may be more vulnerable than men to particular consequences of drug abuse, including addiction.

This greater vulnerability may stem from gender-specific differences in motivations for drug use, differing sensitivities to drug effects and a host of other biological and environmental factors. On the other hand, females who use drugs are more likely to be stigmatized by society than male drug users because their activities are considered to be doubly deviant. Because of this stigma, females are more likely to conceal their drug using behavior. The drug use scenario among women is not different for Pakistan as well. However, the available research data reveal that not much information is available on drug abuse by women in Pakistan United Nation Offices on Drugs and Crimes Country Office Pakistan [8].

Data from the Drug Abuse Warning Network DAWN (1998) support various gender patterns perceived elsewhere in the public health literature. Although few significant differences have been witnessed in the drug involvement of men's and women's emergency room episodes for the past 10 years. But in 1997, data suggested that the type of drug variation in drug related deaths by gender. Women more frequently die from antidepressants. Men also have higher death rates from taking illegal drugs rather than prescribed drugs. This finding is consistent with the previous evidence that women are prescribed psychotropic drugs more often than men. Data show that cocaine, heroin, and alcohol in combination with other drugs were stated most often linked in deaths for both males and females. However, males had higher rates of above mentioned for each of these drugs than did females.

Hequembourg and Dearing examined the interrelationships among shame-proneness, guilt-proneness, internalized heterosexism, and problematic substance use among 389 gay, lesbian, and bisexual men and women. Problematic alcohol and drug use were positively related to shame-proneness and negatively related to guilt-proneness. Bisexuals reported riskier substance use behaviors, lower levels of guilt-proneness, and higher levels of internalized heterosexism than gay men and lesbians. Furthermore, study findings indicated that shame and internalized heterosexism are related. Additional investigations

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of these associations would supplement current understanding of sexual minority stress and would advance the development of substance-related intervention and prevention efforts targeting sexual minorities.

Tracy [9] reported public shaming has long been thought to promote positive behavioral change. However, studies suggest that shame may be a detrimental response to problematic behavior because it motivates hiding, escape, and general avoidance of the problem. Researchers tested whether shame about one's past addictive drinking (measured via nonverbal displays and self-report) predicts future drinking behaviors and changes in health among newly recovering alcoholics (i.e., sober < 6.5 months; N = 105; Wave 2, n = 46), recruited from Alcoholics Anonymous meetings. Results showed that nonverbal behavioral displays of shame expressed while discussing past drinking strongly predicted.

(a) the tendency to relapse over the next 3 to 11 months

(b) the severity of that relapse

(c) declines in health.

All results held controlling for a range of potential confounders (e.g., alcohol dependence, health, personality). These findings suggest that shame about one's problematic past may increase, rather than decrease, future occurrences of problem behaviors [10-15].

McGiffin and Lyon found that people with drug or alcohol problems frequently experience feelings of shame and guilt, which have been associated with poorer recovery. Self-forgiveness has the potential to reduce negative experiences. The current study tested theorized mediators (acceptance, conciliatory behavior, empathy) of the relationships between shame and guilt with self-forgiveness. A cross-sectional sample of 133 individuals (74.4% male) receiving residential treatment for substance abuse completed self-report measures of shame, guilt, self-forgiveness, and the mediators were assessed. Results were consistent with research; guilt had a positive association with self-forgiveness, whereas shame was negatively associated with self-forgiveness. Acceptance mediated the guilt and self-forgiveness relationship and had an indirect effect on the shame and self-forgiveness relationship. These findings emphasize the importance of targeting acceptance when trying to reduce the effects of shame and guilt on self-forgiveness [16].

Meehan and Berry conducted a research and investigated men and women recovery from addiction were compared on level of depression, guilt and shame. The measurement of guilt included subscales of survivor guilt, separation guilt, omnipotent responsibility guilt, trait guilt, state guilt, and adaptive guilt. The sample included 75 men and 33 women in residential treatment community. It was found that women were significantly higher than men in depression and men were higher in shame. The recovering subjects to compared with non-addicted subjects and established norms and it was found that recovering people were higher of depression, shame and the subscales of guilt. Both men and women were significantly lower than norms in adaptive guilt [17-20].

Summary

This review has considered the moral standards and moral emotion for moral behavior. In this sense, the structure of this review reflects the current state of the field. Little research has examined the relation between moral standards and moral emotional factors, much less their interactive influence in moderating the link between moral standards and people's moral behavior. Future directions for research including evaluating the relative importance of cognitive and emotional factors in various domains of morality, as well as the degree to which particular emotional factors are differentially more important in influencing behavior among particular subpopulations (e.g., corporate managers, criminal offenders) and at different points in development [21-23].

Rationale

The present research focuses on comparison of guilt and shame between male and female addicts. This study aims at finding out difference in guilt and shame between male and female. It is important to see the difference as it can be helpful in understanding prognosis, treatment of drug addiction in both genders. It is also an attempt to investigate differences between genders with the respect to the addictive behaviors. Moreover, many people don't understand why or how other people become addicted to drugs. They may mistakenly think that those who use drugs lack moral principles or willpower and that they could not stop their drug use even after getting treatments. To know the other related factors of addiction. It is also an attempt to investigate the comparison of male and female behavior towards addiction [24-26].

Objectives

To compare the guilt and shame feelings between male and females.

To assess the related factors which effect on drug addiction.

Hypothesis

a) There is significant difference in shame and guilt feelings between male and female drug addicts

b) There is a difference in shame and guilt between addicts living in joint or nuclear family

c) There is a difference in shame and guilt between drug addicts getting treatment first time or patients getting treatment many times

Materials and Methods

Sample

The Purposive sampling strategy was used to explore the feelings of drug addicts. A purposive sample is a non-probability

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sample that is selected based on characteristics of a population and the objective of the study which is intended to explore in this research [27]. The State Shame and Guilt Scale were applied to see the difference of male and female's feelings. The sample comprised of 35 males and 35 females from various rehabilitation centers. 12 females were taken from Promise Rehabilitation Centre, 4 from Shaaf Clinic, and 4 from Pak Clinic. Remaining data was taken from the Umeed Clinic outdoor. Furthermore, the male data was also gathered from Pak Clinic and Shaaf Clinic. Those research participants were selected who fulfilled the following attachment criteria:

a. Hospitalized patients already diagnosed for addiction disorder by psychiatrist.

b. No history of any dual diagnosis.

c. Participants who are willing and accessible in all process of research trial.

d. The sample for the patients with disorder was collected from different addiction units of Lahore city of Pakistan.

Measures

The present study was conducted to measure the guilt and shame among drug addicts. Guilt involves feelings of tension, remorse, and regret, but does not affect one's core identity. Shame is associated with the desire to undo aspects of the self, whereas guilt is reported to involve the desire to undo aspects of behavior. Firstly, a questionnaire was used to investigate the demographic information of drug addicts. Secondly, State Shame and Guilt Scale were administered to explore the feelings of guilt and shame. A cross sectional study design was used to investigate guilt and shame feelings. Statistical analysis of the data was carried through the SPSS 16 program, thus obtaining frequencies and percentages. The individual responses from participants were Tran scripted using t-test allowing to record frequencies of specific responses [28-32].

Analyses

Analysis was carried out to know the mean difference of male and female addicts. Analysis was carried out through SPSS 16. Frequencies and percentages of data were obtained. Individual responses from participants were transcribed using t-test. Frequencies of specific responses were record [33].

Ethical consideration

Participants were assured that identifying information will not be available to anyone who is not directly involved in the study. Participant had right to withdraw from participation and terminate at any time they wish. Verbal consent was taken from the participant after having explained them the aim and nature of research [34-36].

Results

The present study was an attempt to know about the comparison of shame and guilt between men and women with drug addiction. As stated in the previous chapter, the researcher selected a sample of 70 respondents from various hospitals and addiction centers. On this representative sample, a cross sectional study was carried out to find out the result with close ended questions. The results for each test were presented in this chapter. The results were presented in table form. The results displayed include t-test to see the difference in prescribed sample. Note: M=Mean, S=Standard Deviation, LL=Lower limit, UL=Upper limit

Table 1 show that there are significant differences in shame and guilt among both genders [37-40].

Table 1: Frequency Table of Demographic Characteristics of Sample.

Variables	F (%)	M (SD)
(1) Age of Respondents		29.54 (7.489)
(2) Gender of Respondents		
Males	35(50.0)	
Females	35(50.0)	
(3) Education		
First Matric	38(54.3)	
Matric-Masters	32(45.7)	
(4) Socioeconomic Status		
Upper-class	14(20.0)	
Middle-class	16(22.9)	
Lower-class	40(57.1)	
(5) Marital Status		
Single	40(57.1)	
Married	27(38.6)	
Divorced	3(4.3)	
(6) Family System		
Joint	48(68.6)	
Nuclear	22(31.4)	
(7) Treatment of addiction		
First time	34(48.6)	
Many times,	36(51.4)	

Note: SD = Standard Deviation, M = Mean, F= frequency, % = percentage.

Table 2 indicates that males have significantly higher feelings of guilt and shame than females. Table 2 show that there are no significant differences in shame and guilt among family systems of drug addicts in both genders. Table indicates that people from nuclear as well as joint family both are equally addicted and feel shame and guilt. Table 3 show that there are no significant differences in shame and guilt among patients whose getting treatment first time or many times. Table 4 indicates that people who are taking first time medicines and many times both are equally involved in drug addiction and feel shame and guilt [41].

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Table 2: Gender differences to see the comparison of guilt and shame feelings in male and female

Variables	Males		Females		T	P	95% CI	
	M	SD	M	SD			LL	UL
Number of participants	49.28	8.165	47.97	5.35	0.796	0.005	1.979	4.608

Note: M=Mean, S=Standard Deviation, LL=Lower limit, UL=Upper limit.

Table 3: To See the Comparison of Guilt and Shame in Family System of Both Genders.

Variables	Joint		Nuclear		T	P	95% CI	
	M	SD	M	SD			LL	UL
Number of participants	48.47	6.81	49	7.201	0.261	0.929	4.04	3.09

Note: M=Mean, S=Standard Deviation, LL=Lower limit, UL=Upper limit

Table 4: To See the Comparison of Guilt and Shame in Patients Getting First Time Treatment and Many Times in Both Genders.

Variables	First Time		Many Times,		T	P	95% CI	
	M	SD	M	SD			LL	UL
Number of participants	49.11	6.776	48.2	7.052	0.575	0.358	4.25	2.35

Note: M=Mean, S=Standard Deviation, LL=Lower limit, UL=Upper limit

Summary of findings

1. It was found that the male patients with drug addiction felt more guilt and shame feelings.

2. It was also observed that the patients with drug addiction from any family system both feel shame and guilt equally.

3. It was also examined that patients with drug addiction whether getting treatment first time or many times both feel guilt and shame equally.

Discussion

The purpose of this research was to investigate the feelings and thoughts of shame and guilt about addiction between male and female drug addicts. In this chapter, the main findings with regard to the hypothesis are summarized and general conclusions based on the findings of the studies presented in this thesis are described. Furthermore, the strengths and limitations of this thesis are considered and suggestions for further are presented [42].

The main hypothesis was that there is significant difference in shame and guilt feelings between male and female drug addicts. The finding of the result confirming the first and main hypothesis as well as indicates that males are significantly higher on shame. Beehan and Merry conducted a research and investigated men and women recovery from addiction were compared on level of depression, guilt and shame. It was found that women were significantly higher than men in depression and the men were significantly higher in shame than females.

The secondary hypothesis that there is a difference in shame and guilt among drug addicts living in joint or nuclear families. Although the hypothesis could not be accepted due to some cultural or methodological factors, but it is assumed that poor relationship with family and conflictual bonding play an important role in adopting addiction. Hence, it can be clearly demonstrated that individual from joint or nuclear family is equally involved in drug addiction. Schiniedar examined the relationship of addiction with family patterns. Research has identified a strong connection between disrupted family relationships and alcohol and another drug addiction. The results show that the majority of participants had experienced painful and traumatic childhoods in their families of origin, which contributed to their subsequent addictive behavior and which they felt had affected their current familial relationships. All participants and their families had suffered from various forms of family disruption, such as loss of custody of their children, loss of employment, marital breakdown, physical and psychological abuse, depression and ill health.

The third hypothesis that there are significant differences in drug addicts whose getting treatment first time, or many times could not be accepted due to cultural and methodological factors. Yet it can be concluded that patients whether taking medicines first time or for long time both are equally feel shame and guilt. Zupalko work has shown length of time in drug abuse treatment is associated with better outcomes, but the role of therapeutic engagement and process needs further examination. In the study, the total number of counseling sessions attended by 557 clients in their first 90 days of community-based outpatient treatment was examined in relation to indicators of treatment delivery and progress. Significant client improvements were found on behavioral criteria and psychosocial functioning during the first 3 months of treatment, and session attendance was positively related to favorable behavioral changes as well as to positive perceptions by clients and counselors of their therapeutic interactions.

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Conclusion

In current study, it was found that the male patients with drug addiction felt more guilt and shame feelings. Moreover, it was also observed that the patients with drug addiction from any family system both feel shame and guilt equally and it was also examined that patients with drug addiction whether getting treatment first time or many times both feel guilt and shame equally.

Limitations

Here is some limitation of this study

It was long and complicated procedure in terms of getting the permission for collecting the data regarding female drug patients. Complete information regarding the demographics of the patients could not be found.

Many participants did not cooperate to fill the questionnaire seriously. The tool used for data collection should have more probing question that could identify the problems of inmates more deeply [42].

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