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EFFECTS OF A SELF-FORGIVENESS INTERVENTION ON RECOVERY FROM SUBSTANCE USE DISORDERS

Michael G. Saltzman, Ph.D.
Western Michigan University, 2023

Previous research has highlighted the relationship between shame, guilt, and problematic substance use (Gueta, 2013; Luoma et al., 2019; McGaffin et al., 2013; Rahim & Patton, 2015). Self-forgiveness has been associated with positive outcomes for individuals in recovery with substance use disorders (SUDs), though only one prior study has explored the effects of a self-forgiveness intervention for individuals in treatment (Scherer et al., 2011). This study examines the effects of a self-forgiveness intervention on state shame and guilt, state self-forgiveness, and drug avoidance self-efficacy, and it is the first intervention study to focus on self-forgiveness for individuals with SUDs receiving inpatient treatment. State shame and guilt was measured by the State Shame and Guilt Scale (SSGS; Marschall et al., 1994). State self-forgiveness was measured by the State Self-Forgiveness Scale (SSFS; Wohl et al., 2008), and drug avoidance self-efficacy was measured by the Drug Avoidance Self Efficacy Scale (DASES; Martin et al., 1995).

Data was gathered at three points in time (T1, T2, & T3) and analyzed with the use of mixed ANOVAs and correlations. Findings indicated that all participants experienced significant decreases in state shame and guilt and increases in drug avoidance self-efficacy and state self-forgiveness over time, but their experiences did not differ based on their participation in a self-forgiveness intervention. State self-forgiveness scores at T2 were positively and significantly
correlated with drug avoidance self-efficacy, while state shame scores at T2 were negatively and significantly correlated with drug avoidance self-efficacy. State guilt was significantly and positively correlated with state shame at T2, but no relationship was found between state guilt and drug avoidance self-efficacy or state-self-forgiveness at T2.
EFFECTS OF A SELF-FORGIVENESS INTERVENTION ON RECOVERY FROM SUBSTANCE USE DISORDERS

by

Michael G. Saltzman

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I have received a great deal of support throughout my time in graduate school, and I could not have completed this process without it. To my dissertation committee, your guidance as I conducted this study has allowed me to feel confident in and proud of the work that I have done. Dr. Lee, I appreciate your consistent encouragement and insight regarding my chosen topic. Dr. Vandiver, I am grateful for your willingness to challenge me and ask difficult questions. I have learned so much from you during my time in the doctoral program, and I have grown as a result. Dr. Sauer, thank you for your support, reassurance, and belief in both me and this project. You were there for me during the most difficult times of this process, and I am so appreciative of your guidance. I would also like to thank my research assistant, Jordan, who helped make this project possible, and Dr. Jung for his support regarding data analyses.

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Michael G. Saltzman
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CHAPTER I
INTRODUCTION

Over the past two decades, rates of substance use in the United States have increased dramatically. In 2002, approximately 8.3% of individuals (19.5 million people) age 12 or older had used an illicit substance in the previous month (SAMHSA, 2003). Illicit substances include cannabis, cocaine, opioids, hallucinogens, inhalants, methamphetamines, tranquilizers, and sedatives (SAMHSA, 2022). Nearly 20 years later, 14.3% of people (40.0 million people) aged 12 or older reported the use of an illicit substance in the past month (SAMHSA, 2022). These data notably do not include alcohol use, and in 2021, 60.0 million people (21.5%) aged 12 and older in the U.S. reported binge drinking in the last 30 days (SAMHSA, 2022). Binge drinking is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as the consumption of “five or more alcoholic drinks for males or four or more alcoholic drinks for females on the same occasion.” The rate of binge drinking has decreased slightly, as 54 million (22.9%) people in 2002 reported binge drinking in the past month (SAMHSA, 2003; SAMHSA, 2022). Though the rates of alcohol use have not risen in the past 20 years, the Centers for Disease Control and Prevention (CDC) notes that excessive alcohol use remains the leading preventable cause of death in the United States (CDC, 2022).

The misuse of substances has the potential to lead to a substance use disorder (SUD), physical and mental health concerns, and/or death. Substance use disorders are broadly defined by the American Psychological Association (APA) as a pattern of substance use that leads to clinically significant impairment or distress and can be diagnosed in both medical and nonmedical users of a substance (APA, 2013; Kolodny et al., 2015). The rates of substance use disorders, or substance dependence and abuse as it was defined in the 2002 National Survey on
Drug Use and Health (NSDUH), have increased in the past 20 years as well. In 2002, it was estimated that 22.0 million Americans aged 12 or older (9.4%) met criteria for substance abuse and dependence as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV). Nearly 20 years later, the number of people aged 12 and older with a substance use disorder had increased to 46.3 million people (16.5% of the population) (SAMHSA, 2022). The consequences associated with substance misuse can be devastating. In 1999, 16,849 people died of a drug overdose, while in 2021, there were 106,699 overdose deaths (NIH, 2023). Additionally, it is estimated that around 140,000 people die in the United States each year due to excessive alcohol consumption (Esser et al., 2022). These concerns have only increased during the Covid-19 pandemic, as the social isolation and stress Americans experienced often led to substance use as a coping mechanism (Czeisler et al., 2020; SAMHSA, 2022).

In addition to the dangers associated with substance use for those with SUDs, substance dependence has been shown to negatively affect both those closest to individuals struggling with substance use as well as society (Daley, 2013; Gilson & Kreis, 2009). The burden of a family member’s substance use often leads to emotional issues and relationship concerns for members of the family (Daley, 2013). There is also a financial cost associated with use for the individual, their families, and society. It was estimated that the economic cost of opioid use disorders (OUDs) alone related to health care, treatment, and the criminal justice system in the United States in 2013 was $78.5 billion (Florence et al., 2021). The upward trend has continued over the past few years, with costs of OUDs increasing to $179.4 billion in 2018 (Davenport et al., 2019). These calculations include health care, treatment, mortality, child and family assistance, education, lost productivity, and criminal justice costs (Davenport et al., 2019). The economic
impact is even larger when including alcohol, tobacco, and other illicit substances into the calculation, as the United States Department of Health and Human Services estimated that the yearly economic impact of substance misuse was $249 billion for alcohol misuse and $193 billion for illicit drug use in 2007 (USDHHS, 2016). These social and economic costs demonstrate a clear need for additional and improved access to effective treatment for those with SUDs. Despite this reality, individuals with SUDs often have difficulty obtaining supportive care.

Barriers to treatment faced by individuals with SUDs include the stigma, discrimination, and shame that are often associated with the diagnosis (Baldwin et al., 2010; Luoma et al., 2007). Goffman (1963) defined stigma as an “attribute that is deeply discrediting” to the evaluation of the individual as a whole (p. 3). The stigma related to a SUD diagnosis is often accompanied by feelings of shame (Scherer et al., 2011; Stuart, 2019). These feelings may be exacerbated by the prevalence of stigmatizing beliefs regarding substance use. The general public has been shown to hold highly stigmatized beliefs regarding individuals with SUDs that can have a particularly damaging effect on an individual’s attempt at recovery (Kennedy-Hendricks et al., 2017). These perceptions can negatively influence a person’s ability to acquire a job, housing, or build relationships (Bielenberg et al., 2021, van Boekel et al., 2015). Negative beliefs and assumptions regarding the trustworthiness and aggression of those with SUDs have also been endorsed by healthcare providers including general practitioners, mental health professionals, and addiction specialists (van Boekel et al., 2015). These same providers have failed to demonstrate an appropriate level of competence when it comes to providing care to those with SUDs (Bielenberg et al, 2021; van Boekel et al., 2015). Additionally, these pervasive stereotypes negatively influence the research that is done regarding substance use disorders (Earnshaw, Smith, &
Copenhaver, 2013). While these harmful beliefs do apply broadly to those with SUDs, it is important to acknowledge that the degree of interpersonal discrimination one may experience is likely exacerbated by a number of factors including race, gender, sexual orientation, and type of substance used (Young et al., 2005).

The stigma and resulting shame associated with SUDs may also be magnified for some due to medications used in the treatment of SUDs (MSUDs; Stuart, 2019). These medications are used most regularly in the treatment of opioid use disorders (OUDs) and alcohol use disorders (AUDs). Specific medications for OUDs (MOUDs) include methadone (Dolophine), buprenorphine and naloxone (Suboxone), and buprenorphine (Subutex), while a common medication used in the treatment of AUDs is disulfiram (Antabuse) (Fisher & Roget, 2009). Naltrexone is used in the treatment of both OUDs and AUDs (Fisher & Roget, 2009). Despite their efficacy for many in recovery, some of these medications remain highly stigmatized (Bart, 2012; Earnshaw et al., 2012). As was noted by one participant in the Earnshaw and colleagues (2012) study, some people view those who use methadone as “‘not clean’ and simply receiving free drugs” (p. 119). Liu and colleagues (2013) noted that individuals using MOUDs may feel more “looked down upon” or ostracized within the treatment community when compared to those not using MOUDs (p. 4).

Though the expectation is often that treatment will provide a safe space for individuals to recover from SUDs, this is not always the case. In fact, “patients with SUDs often experience discrimination in the healthcare setting and receive lesser quality care” than those without substance related concerns (Luoma et al., 2014, p. 207). SUDs are often framed as a moral or criminal issue as opposed to a health concern (Ahern et al., 2007; Stuart, 2019). When those with SUDs are able to access treatment, those in recovery may not feel as though they are safe,
understood, or respected for who they are as individuals (Lee & Zerai, 2010). These factors may help to explain the high attrition rates that are seen in the recovery community (Luoma et al. 2014). The average dropout rate for in-person psychosocial SUD treatment studies over the last fifty years was approximately 30%, with some variation seen across primary substances used, racial identity, and socio-economic status. (Lappan et al., 2019). As a result, it is necessary to consider the stigmatizing experiences and resulting shame for those with SUDs when conceptualizing future directions for treatment.

Substances can be used as a way to cope with aversive issues one may be experiencing (Mauro et al., 2015; Rhodes & Jason, 1990; Smith et al., 2022). Thus, it may be helpful to consider ways to address the guilt and shame experienced by those who use substances (Lee & Zerai, 2010). One approach that has been shown to be efficacious in reducing the shame experienced by individuals with alcohol use disorders (AUDs) is a self-forgiveness intervention (Scherer et al., 2011). Self-forgiveness is defined as the process in which one works to develop compassion for themselves while taking responsibility for their objective wrong (Enright, 1996). The goal of self-forgiveness is to avoid judging one’s self-worth based on individual behaviors while being willing to alter certain actions in the future (Enright, 1996).

Though the concept of self-forgiveness was introduced over two decades ago, only five identified studies have examined the concepts of self-forgiveness, shame, and guilt for individuals with SUDs. Two of the five studies focused on the self-forgiveness process for students who had committed a transgression or experienced shame and guilt due to their alcohol use (Ianni et al., 2010; Peterson et al., 2017). Ianni and colleagues found shame to be a significant predictor of alcohol use, and students who displayed a self-forgiving coping style were significantly less likely to misuse alcohol than those with low self-forgiveness scores.
These participants were not identified as having alcohol use disorders (AUDs), though, and they were not in treatment for an SUD.

Peterson and colleagues (2017) randomized participants into a self-forgiveness condition and a neutral condition that required students to reflect on a past alcohol related transgression. Results indicated that there was no difference in self-forgiving feelings and actions, self-forgiving beliefs, remorse and self-condemnation, or intention for future drinking between those in the self-forgiveness reflection group and those in the neutral reflection group. They did find, though, that the self-forgiveness reflection was helpful in reducing self-condemnation when individuals took responsibility for their actions and believe that their interpersonal conflict was related to their alcohol use. The conclusions drawn by Peterson and colleagues suggest that there are potentially beneficial outcomes associated with self-forgiveness for those who find their alcohol use to be problematic, though there are also several limitations. Similar to the Ianni et al. (2010) study, participants were comprised of college students whose drinking behaviors are often very different from the general public and those in treatment for AUDs. Data were only collected at one point in time, so it is not clear if the benefits identified in the study are lasting in any way. Additionally, they did not find any difference in intention for future drinking between participants in the two groups.

McGaffin et al. (2013) and Scherer et al. (2011) both designed studies to better understand the experiences of individuals in treatment for SUDs. Participants in the McGaffin and colleagues’ study were comprised predominantly of middle-aged, Australian men in religiously affiliated treatment centers for the use of a variety of substances. Their results suggest that while shame-proneness may impede the self-forgiveness process and negatively affect recovery, guilt-proneness may help to promote self-forgiveness and positively influence
recovery. Because of the cross-sectional design of this study, though, causality cannot be determined (McGaffin et al., 2013). There was also no intervention used, and data were only collected at one point in time.

Scherer et al. (2011) utilized a self-forgiveness intervention in their study focusing on shame, guilt, self-forgiveness, and drinking refusal self-efficacy. Participants were randomly assigned to either the treatment as usual (TAU) group or the self-forgiveness group, and those in the experimental group completed a self-forgiveness intervention. Results suggest that individuals in the intervention condition experienced more significant gains on self-forgiveness and drinking refusal self-efficacy compared to those in TAU, and they also experienced a more significant decrease in shame and guilt. Additionally, their findings for the experimental group were found to persist over time. While this study addresses numerous gaps in the literature, there is still work to be done to better understand the role of self-forgiveness for those with SUDs.

Scherer and colleagues focused specifically on alcohol use, and their sample was predominantly comprised of White men receiving outpatient treatment. Additionally, all participants were mandated to complete either community service or attend psychoeducational groups in addition to their enrollment in treatment. It is unclear if these results could be replicated when compared with TAU at an inpatient facility or a more diverse sample of individuals with a range of SUDs, and the current study aims to address these limitations.

While four of the five studies utilized homogenous samples comprised predominantly of either college students or middle-aged White men with alcohol use disorders, one study used a more diverse sample (Ianni et al., 2010; McGaffin et al., 2015; Peterson et al., 2017; Scherer et al., 2011). Gueta et al. (2013) used a qualitative methodology to examine the experiences of Israeli mothers in recovery with SUDs over the course of two years. The majority of these
women \((n = 23)\) were polysubstance users who identified heroin as their primary substance of abuse. They were all also mothers, and the long-term nature of their treatment is somewhat unique. The findings of this study suggest that “self-forgiveness is a way to break the vicious cycle in which many addicts find themselves when they attribute blame to their immoral character, thus throwing themselves deeper into addiction” (Gueta, 2013, p. 462). Those who were able to engage in this process were able to take responsibility for their actions while recognizing that their past actions do not define them. They were also reportedly better able to manage the shame and stigma that is often associated with substance use and relapse. Life story interviews were conducted to collect data. These results highlight the need for a more detailed understanding of the role that shame and guilt play in the recovery process, and the present study seeks to address this need. Additionally, the qualitative nature both adds powerful anecdotal evidence and reduces the ability to draw conclusive results.

The identified studies indicate a need for additional research focused on the role of self-forgiveness in the treatment of substance use disorders, as do increasing mortality rates related to substance use. While research in this area is promising, more work needs to be done to better understand the experiences of those in recovery. This study works to both build on and address the limitations of previous research by utilizing a diverse sample of individuals with SUDs to better understand the effects of a self-forgiveness intervention on state shame, guilt, self-forgiveness, and drug avoidance self-efficacy.
CHAPTER II

LITERATURE REVIEW

In this chapter, I will begin by briefly reviewing the history of substance use and substance use disorders in the United States. This context is important, as it contributes to the experiences both in treatment and in active addiction for those with SUDs. Next, I will review models of addiction that are present in the literature before exploring research regarding recovery from substance use disorders. The changes in models of addiction over time reflect the ways that perceptions regarding substance have shifted, and both these perceptions and research regarding recovery continues to influence the treatment provided. I will then examine literature focused on self-efficacy, shame, guilt, and self-forgiveness before discussing the proposed study. Finally, I will identify the contributions to the literature that this research hopes to provide.

Substance Use

Psychoactive substances have been used for a variety of reasons throughout human history (Tracy & Acker, 2004). Substances such as stimulants have been more valued for their day-to-day utility, while others, such as hallucinogens, have traditionally been important aspects of religious ceremonies (Denning & Little, 2012). The majority of societies have one or more substances that are generally regarded as acceptable in certain amounts or contexts, while others are often widely vilified and criminalized (Wells, 2007). Examples include the coca plant, alcohol, and marijuana. Though the coca plant has been used for both religious and medical purposes in the Andes and Amazonia throughout history, international pressure that began in the mid 20th century led to eradication campaigns due to the role the plant plays in the production of cocaine (Wells, 2007). Conversely, the worldwide legal marijuana market has been destigmatized and growing in value over the past decade, and the United States is leading the
way despite drastic differences between state and federal law (Simkins & Allen, 2020). Other substances such as alcohol, nicotine, and caffeine are currently legal, regulated, and widely accepted throughout the world, despite past policies of prohibition (Crocq, 2007). Though the types of substances being consumed, the reasons for their use, and the way that use is perceived in society have all changed over time, the use of psychoactive substances has been a constant (Crocq, 2007).

**Temperance and Prohibition**

Concern regarding the harm caused by the use of psychoactive substances, and particularly alcohol, in the United States began to spread in the early 19th century. While perceptions have changed, this history continues to influence the stigma and shame those with SUDs experience. The temperance movement began at this time in response to the belief that alcohol was evil and was led by physicians, including Benjamin Rush, and religious groups (Murdach, 2009; Peele, 2010; Tracy & Acker, 2004). Proponents of the temperance movement initially argued for responsible consumption and restrictions on hard liquor (Hart & Ksir, 2015). Ultimately, however, they shifted their approach and decided that the only way to ensure that the public would avoid alcohol’s damaging effects was to advocate for complete abstinence from alcoholic beverages (Peele, 2010). The temperance movement led to the establishment of the American Society for the Promotion of Temperance (ASPT) in 1826, which eventually worked to increase public support for a campaign of total abstinence (Tracy & Acker, 2004).

Changing social views regarding alcohol led to temporary legislative prohibition in some states in the 1850s, and eventually prohibition on a national scale from 1920 to 1933 (Peele, 2010; Tracy & Acker, 2004). Though outlawed, alcohol did not cease to be consumed during those times. The prohibition of alcohol allowed for the development of unregulated markets that
required participants to break the law (Hall, 2010; Inaba & Cohen, 2007). These legal restrictions and perceptions of alcohol use supported by the ASPT have contributed to the stigma associated with SUDs. During the temperance movement, alcohol use was associated with criminality, a lack of morals, and antisocial behavior (Hart & Ksir, 2015). While federal prohibition of alcohol lasted just over a decade, the temperance ideology continues to influence the American public’s perceptions of those with alcohol use disorders (AUDs; Peele, 2010). These negative perceptions pertain not only to the use of alcohol, but also to a variety of other psychoactive substances.

**Cultural Differences**

While substances have been portrayed as inherently dangerous and problematic at times throughout history, laws restricting substance use have not always been rooted solely in concern for public health (Rosino & Hughey, 2018). As larger numbers of immigrants began to move to the United States and African Americans began to move out of the South, predominantly White communities were exposed to different cultures and customs associated with psychoactive substances (Tracy & Acker, 2004). In addition to the stated desire of those involved in the temperance and treatment movements of wanting to remove the harmful effects of substance use from society, many in those movements “cited drug use by Chinese, Irish, or African Americans as evidence of Anglo Saxon racial superiority” (Tracy & Acker, 2004, p. 7). Laws regarding substance use were “often based more on racial scapegoating prejudices than on a concern for the harmful impact of drugs on people” (Fields, 2017, p. 11). As a result of these policies and their continued influence, individuals often have very different treatment experiences based on their identity factors (Mennis & Stahler, 2015).
Throughout history, drug policies that directly target and discriminate against members of racial and ethnic minority communities have been enacted by White politicians. In the 1870s, attempts were made to shudder opium dens as a way to control interactions between Chinese and White communities. More recently, criminal sentencing laws have differed drastically for crack and powdered cocaine, leading to a disproportionately negative impact on Black and Brown communities (Bjerk, 2017; Fields, 2017). The Anti-Drug Abuse act of 1986 established mandatory minimum sentences for substance related crimes, and it took possession of 100 times the amount of cocaine as it did crack to trigger those mandatory minimum sentences (Bjerk, 2017). This is despite the fact that the active ingredient in both substances is the same. As crack was used in predominantly low-income, Black neighborhoods in the early 1980s, the negative effects of these sentencing laws were disproportionately borne by members of those communities. In fact, as of the year 2000 “over 80 percent of those convicted for crack” were African American (Bjerk, 2017). Those same thresholds for mandatory minimums remained in place until the Fair Sentencing Act of 2010 was implemented, and the ratio was only reduced from 100:1 to 18:1 (Wells, 2022).

As Alexander (2012) notes, “the War on Drugs has given birth to a system of mass incarceration that governs not just a small fraction of a racial or ethnic minority, but entire communities of color” (p. 188). While politicians over the last 50 years have attempted to claim that they are focused on reducing the negative effects of drug use, the results of the Drug War suggest that those negative effects have not only increased but been disproportionately distributed to marginalized communities in this country. White people use and sell substances at a very similar rate to Black and Brown people, but they are not arrested, charged, or convicted of those crimes nearly as frequently. Though White individuals made up nearly 65% of the
population in the 2014 NSDUH, only 29.1% of drug criminals in state and federal institutions at that time were White (Koch et al., 2016). This was despite the fact that approximately 65% of the individuals who self-identified as having used an illicit substance in the past month in the NSDUH were White (Koch et al., 2016). Differential rates of incarceration for substance-related offenses based on race have done significant damage to families and communities of color over the past half century (Alexander, 2012; Rosino & Hughey, 2018). In 2006, one in every 14 Black men was incarcerated, while only one in every 106 White men were behind bars. In addition to the time lost and the effects of family separation, formerly incarcerated individuals often have difficulty obtaining housing and/or employment upon release (Alexander, 2012). In most states, those incarcerated for a felony are not allowed to vote, and those returning home face both structural barriers and the shame associated with their conviction (Alexander, 2012). When developing treatment options for individuals with SUDs, it is necessary to consider the differing experiences of racial minorities with SUDs.

The War on Drugs

In the early 1970s, President Nixon stated that the largest threat to citizens of the United States was substance use (Fisher, 2006). He declared a War on Drugs that has led to large increases in the correctional population in the United States and continues to operate to this day (Cooper, 2015). Nixon’s declaration received legislative backing nine years later when President Ronald Reagan signed the 1981 Military Cooperation with Law Enforcement Act, which allowed military equipment and tactics to be used in the War on Drugs (Rosino & Hughey, 2018). Similar to past policies regarding substance use, the War on Drugs has disproportionately affected minority and immigrant populations and been used to portray individuals in these communities
as criminals (Sirin, 2011). This criminalization of substance use has also contributed to the negative and stigmatizing perception many have of those with SUDs.

Despite continued support, the War on Drugs has been unsuccessful at combating drug use in the United States based on metrics including money spent and rates of addiction (Scherlen, 2012; Sirin, 2011). While the amount of money spent on the Drug War has increased drastically in the past 30 years, so have the rates of substance use and addiction in this country (SAMHSA, 2002; 2022). In 1980, the budget for the War on Drugs was less than one billion dollars, while the financial request for 2013 from the federal government was for $25.6 billion (Hart & Ksir, 2015). Similarly, the percentage of individuals aged 12 and older with a substance use disorder in the past year increased from 9.4% in 2002 to 16.5% in 2021 (SAMHSA, 2002; 2022). Not only have rates of addiction failed to decrease during the War on Drugs, but the mortality rates attributed to accidental drug overdoses have been steadily increasing since 1978 (Jalal et al., 2018). In 1980, around one person in every 100,000 died due to an unintentional drug overdose (Jalal et al., 2018). These numbers have steadily risen over the past 50 years to a rate of nearly 17 unintentional drug overdose deaths per 100,000 people in the United States (Jalal et al., 2018). In addition to the lack of effectiveness regarding a reduction in overdose deaths or the availability and use of illicit substances, the War on Drugs has coincided with increased availability and use of pharmaceutical medications (Agarwal & Landon, 2019; Piper et al., 2018; Rudd et al., 2016).

**Pharmaceutical Movement**

One subset of substances that has traditionally been less stigmatized and considered to be safer than illicit drugs are prescribed medications (Fleary et al., 2013). Throughout the 19th century, opioids were isolated from the opium plant, cocaine was derived from the coca plant,
and heroin was introduced as a cough remedy (Inaba & Cohen, 2007; Tracy & Acker, 2004). Heroin and cocaine were marketed as miracle cures and sold by pharmaceutical companies such as Bayer as medicines and even treatments for addiction (Inaba & Cohen, 2007; Tracy & Acker, 2004). These substances were prescribed by doctors, dispensed by pharmacists, and could often be consumed free of the stigma associated with other substances. When substances began to be synthesized in a lab in the mid 20th century rather than extracted from natural sources, new classes of drugs, including barbiturates, benzodiazepines, and opioids such as fentanyl and carfentanil, were developed. These drugs often cost less to make and are more potent than natural or semi-synthetic substances (Inaba & Cohen, 2007). As a result, accessibility increased, and the use of pharmaceuticals became more widespread (Inaba & Cohen, 2007). Since this development occurred, a variety of synthetic opioids have been developed, marketed, and sold for their analgesic (pain reducing/pain killing) effect (Hart & Ksir, 2015).

The pharmaceutical movement which led to the development of substances such as morphine has continued to expand over the past few decades. Between 1999 and 2010, opioid prescriptions in particular increased by more than 300% (Betses & Brennan, 2013). This increase followed a campaign by the American Pain Society entitled “Pain is the Fifth Vital Sign,” in which doctors were taught to assess and treat pain with the use of opioids (Kolodny, 2015). The American Pain Society, along with many other organizations, received funding from Purdue Pharma following the introduction of OxyContin in 1995 (Kolodny, 2015). Due to the profits gained from the sale of these substances, practices such as inappropriate prescribing have grown (Betses & Brennan, 2013). Organizations such as “pill mills” existed in which licensed physicians provide legal prescriptions to mainly younger patients for large quantities of opioids while serving individuals from across the country who pay in cash (Betses & Brennan, 2013).
These practices have contributed to the rise in opioid addiction rates and opioid overdose deaths over the past 20 years (Kolodny, 2015).

In addition to opioids, pharmaceutical companies have developed medications which are designed to assist with a wide range of both physiological and psychological concerns. Some of those medications, including opioids, stimulants, and sedatives, have grown in prevalence while the drug war continues (Argawal & Landon, 2019; Piper et al., 2018; Rudd et al., 2016). It is important to note that “the top priority for industry is to make profits for the shareholders,” and the pharmaceutical industry now sees sales exceeding $290 billion a year (Hart & Ksir, 2015; Herxheimer & Sanz, 2008, p. 110). While the medications they produce can be beneficial, the commercialization and the fiscal interests of companies developing and selling the substances may lead to a paucity of research available to the public regarding the implications of use (Haffajee & Mello, 2017). Specifically, negative findings from randomized controlled trials may be perceived as potentially damaging to a company’s bottom-line, and results have allegedly been withheld by corporations in the past for that reason. In lawsuits brought against pharmaceutical companies such as Purdue Pharma, the maker of the opioid pain medication OxyContin, allegations have been made that “opioid manufacturers deliberately withheld information about their products’ dangers” (Haffajee & Mello, 2017, p. 2301). For example, dependence and the potential for overdose were not often advertised, at times intentionally, as side effects of a medication by the companies selling them (Van Zee, 2009). In 2020, Purdue Pharma, pled guilty to criminal charges “related to its marketing” of OxyContin (Hoffman & Benner, 2020). The settlement reached with the company and its owners, the Sackler family, involved a $6 billion settlement and the dissolution or sale of the company (Boffetti, 2022). While this resolution ensures that those responsible are held accountable in some way, the
damage done to those who became dependent on opioids, their families, and their communities cannot be reversed.

Over the past 15 years, the main cause of unintentional drug poisonings has been opioids (Kennedy-Hendricks et al., 2017; Rudd et al., 2016). Due to the addiction potential and withdrawal effects of the substance, individuals often struggle when attempting to stop the use of their opioid medications. These people can turn to the use of cheaper, unregulated opioids such as heroin when they are no longer able to obtain their prescription, which may be more deadly and contain other substances such as fentanyl (Alpert et al., 2017; Fischer & Rehm, 2017). Fentanyl is a synthetic opioid that is 25-50 times more powerful than heroin, and in 2014 it cost approximately 90% less money to buy a dose of fentanyl than an equivalent dose of heroin (Miller, 2020). As a result, it is often used by drug dealers to increase potency and profits while decreasing their cost. Deaths in the last 25 years involving opioids have risen dramatically, with 12,940 opioid related deaths in 2003 and 80,411 in 2021 (CDC, 2022; Rudd et al., 2016). The drastic upward trend is expected to continue unless action is taken to reduce the consumption of opioids (Jalal et al., 2018). One important step involves understanding past perceptions and models of addiction and the ways those beliefs influence current treatment options for individuals with SUDs.

**Models of Addiction**

Over the past two centuries, numerous models of addiction have been used to describe the development of SUDs. These models have helped to shape both the public’s perception of those with SUDs and the treatment options available. Three of the most common models cited in the literature are the moral model, the disease model, and the biopsychosocial model (Heather,
In the following section, I will define and review these models in detail.

The moral model of addiction posits that addiction is caused by a character defect, moral failing, or lack of will, and both the cause and resolution of a SUD is the responsibility of the individual (Kauffman & Poulin, 1996). Proponents of this ideology tend to believe that those who abstain from use or consume substances in moderation are morally good, while problematic use is indicative of issues with one’s morality (Westermeyer, 2013). These purported failings in morality have been used to judge those with SUDs over the years (Pickard et al., 2015). The model has been connected to the diversity of organized religion after 1600 AD as well as the temperance movement of the 19th century (Schmidt, 2018; Westermeyer, 2013). Numerous religions have identified substance use as a “moral dilemma,” and many religions promote either abstinence (e.g., Hinduism, Buddhism, Islam) or use only in specific contexts and ceremonies (e.g., alcohol in Roman Catholicism) (Westermeyer, 2013). Despite its historical roots, the moral model of addiction still informs the beliefs of the general public and the treatment options available for those with SUDs (Schmidt, 2018; Westermeyer, 2013). While some providers may view this model as a way to empower those in recovery to make their own decisions, the stigma that may result from attributing past struggles to a moral failure may be devastating (Schmidt, 2018).

The American Medical Association declared alcoholism a disease in 1957, and the disease, or medical, model of addiction continues to be used by many (Blume et al., 2013; Borsos, 2009; Fields, 2017). The disease model reflects the belief that addiction is a result of a genetic predisposition to the development of a SUD (Thombs, 2009). Additionally, alcohol and other SUDs were initially identified as diseases because they were thought to have a known
cause, symptoms of the disorder worsen over time, and those with SUDs experienced similar outcomes (Fields, 2017). This model helped to challenge the tenets of the moral model and reduce stigma by defining addiction as a disease that leads to a loss of control (Blume et al., 2013). Specific neurobiological pathways have been identified as relevant for those with SUDs, and research indicates that the disease model has led to improvements in public policy, perception, and treatment (Volkow et al., 2016). Critics have argued, though, that a medical model of addiction removes accountability for those with the disease and that a broader perspective is necessary to fully capture the development of SUDs (Satel & Lilienfeld, 2014).

The disease model has helped move the public away from a moral explanation that blames those for their SUDs and provides treatment options as opposed to incarceration, though some concern exists that the model may still contribute to stigma for those seeking recovery (Hartje, 2009; Heather, 2017). In a 2013 meta-analysis, Kvaale and colleagues noted that while biogenetic explanations of psychological problems significantly reduce the blame received by those in recovery, they have been shown to increase perceptions of dangerousness and decrease the belief that one will succeed in their recovery. Additionally, concern is often expressed that the “loss of control” that is often described as an aspect of the disease model may allow those with SUDs to attribute inappropriate actions to their disease rather than take responsibility for their actions (Hartje, 2009).

One prevalent model that works to address the varying factors which have been shown to contribute to the development of SUDs is the biopsychosocial model. While acknowledging the potential role of genetics and psychological health, the biopsychosocial model includes one’s psychosocial environment and interpersonal relationships as factors that influence the development of a SUD (Bethea, 2009; Hart & Ksir, 2015; Wells, 2011). This model
acknowledges that while some individuals may be predisposed to SUDs, there are other factors that play a role in one’s substance use. “The National Institute of Drug Abuse has estimated that genetics account for 30% of the cause of addictions, and other environmental factors account for the other 70%” (Borsos, 2009, p. 12). The way that these factors interact and influence SUDs is a key component of the biopsychosocial model of addiction (Skewes & Gonzalez, 2013). With the use of the biopsychosocial model, the substance abuse treatment field is moving towards a more integrative model of substance use and treatment which considers a comprehensive list of factors that may contribute to the development of a SUD. It may also be important for this evolution and integration to occur when it comes to determining the goals of treatment and recovery for those with SUDs.

**Recovery from Substance Use Disorders**

Recovery is used to describe positive changes in substance use and a return to health for individuals with SUDs (Worley, 2017). Despite first appearing in the literature in the 1800s, it was not until the emergence of Alcoholics Anonymous (AA) in the 1930s that the term recovery started to become more synonymous with the treatment of substance use disorders. The term recovery represents a shift away from a moral explanation for substance use to a medical one (White, 2005). In AA, “recovery” is used to depict “the ongoing cognitive, emotional, behavioral and spiritual reconstruction of the sobered” individual (White, 2005, p. 8). Recovery is typically thought of as a long-term process. As a result, those working to address their dependence on substances are often “considered to be in a state of ongoing ‘recovery’ rather than to have ‘recovered’ from SUDs” (Worley, 2017, p. 83). The question remains, though, if abstinence is the central aspect of recovery or one of many strategies that can be used (White, 2007).
Defining Success in Recovery

Those seeking treatment for SUDs often find that success is defined in one of three ways: (a) abstinence, (b) harm reduction, and (c) medications for substance use disorders (MSUD). Abstinence refers to the decision to refrain from all substances at all times (Inaba & Cohen, 2004). Harm reduction encompasses any approach that may reduce the damage an individual is doing to themselves or society (e.g., using clean needles, testing substances before using them; Denning & Little, 2012; Drucker et al., 2016). MSUDs most regularly refer to methadone and suboxone, which are both medications designed to help control use, manage cravings, and treat physical withdrawal symptoms related to opioid use. They also include medications such as Vivitrol, or naltrexone, for individuals with alcohol use disorders. Naltrexone, an opioid antagonist, has also been shown to be effective for individuals in treatment with an OUD (Bart, 2012). Naltrexone works by blocking the body’s mu-opioid receptors, which both reduces cravings for opioids and prevents opioid intoxication (Singh & Saadabadi, 2022). There is a great deal of power in defining recovery, as the definition can influence perceptions both of treatment providers and those with the disorder (White, 2007).

Abstinence. The most widely accepted treatment approach promotes abstinence (Best et al., 2013). Many in the recovery community have argued that complete abstinence from all drugs and alcohol is a crucial component of the process (White, 2007). While it has been noted that the process of recovery can look very different depending on the individual, organizations such as the Substance Abuse and Mental Health Services Administration (SAMHSA) have determined that “abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions” (SAMHSA, 2012, p. 5). These beliefs are often reflected in recovery literature and by those tasked with providing care. In a 2007 study carried out by the Betty Ford
Institute Consensus Panel, recovery was defined as “a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship” (Schwarzlose & McLellan, 2007, p. 222). Sobriety was emphasized as the superordinate goal in recovery, which meant that success in treatment was impossible without abstaining from all substances.

The prominence of the abstinence-based approach is at least partially rooted in the influence of the 12-step model on the treatment community (Laudet, 2007). The community endorses a belief that all people with substance use disorders are incapable of responsible reduction of use. This view has been bolstered by the medical model of addiction, which posits that “consumers are diseased, sick, and in need of treatment rather than wholesale punishment” (Williams & Arrigo, 2007, p. 57).

While the abstinence-only approach may be necessary and beneficial for some, failing to identify other options may be harming others. Brown and Lawrence (2009) note, “even with successful detoxification and the sincerest of intentions during abstinence, relapse can be an insurmountable challenge for many addicted individuals (p. 187). Too often, relapse is viewed as a failure both by treatment providers and the individuals in treatment adhering to the abstinence-only approach (Brown, 1998). The pervasive belief that relapse negates progress for those in recovery may be dangerous. For example, one participant noted that when she relapsed, “the whole world fell apart on me, everything was black and the only thing I wanted was to die” (Gueta, 2013, p. 456). Despite having five years clean and sober, this individual felt as though all was lost after one relapse.

The term “relapse” has been shown to evoke negative connotations regarding those who return to use, and the avoidance of the term may help to reduce the bias associated with something that, for many, is part of the recovery process (Ashford et al., 2018). White (2007)
points out that the absolutist view of abstinence could be problematic, and recent research has shown that a reduction in both use and the physical, interpersonal, and economic harm caused by use is possible for a large number of individuals with substance use disorders. In addition to the damage a complete abstinence mindset can do to those in recovery, it may also have an impact on those who initially present for treatment. While some individuals may be wary of entering treatment if they know that abstinence is a prerequisite, a more inclusive, harm-reduction focused approach could encourage individuals to become involved in recovery (Lee & Zerai, 2010).

**Harm Reduction.** The American Society of Addiction Medicine (ASAM) defines recovery as “a process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction” (ASAM, 2013, p. 2). Notably, the organization also acknowledges that medication assisted treatments and harm reduction approaches can be appropriate for some individuals (ASAM, 2013). The concept of harm reduction works to reduce harm to those with SUDs, their families, and the public without requiring a reduction in the amount of substances that are consumed (Denning & Little, 2012; Drucker et al., 2016). The harm reduction approach focuses specifically on the resolution of substance-related problems and supports the belief that for some people, that resolution can occur through moderated use (Marlatt & Witkiewitz, 2002). Harm can be reduced through the use of approaches such as safe injection facilities, medications for opioid use disorders (MOUD), and clean needle and syringe exchanges (Drucker et al., 2016). Those advocating for a harm reduction approach argue that the focus of recovery should be on resolving the problems created by use and that the method used should not define success in treatment (White, 2007).
Approaches focused on the reduction of harm are becoming more accepted, as the Betty Ford Institute Consensus Panel took the position in 2010 that individuals who use prescribed medications such as methadone under the care of a physician can still qualify as being in recovery (White, 2012). This is important, as research has indicated that a harm reduction approach can be particularly effective at addressing the marginalization many experience due to their substance use or other aspects of their identity (Blume & Lovato, 2010; Lee & Petersen, 2009; Lee & Zerai, 2010). It can be a way to help empower those seeking treatment, center the values and experiences of individuals in recovery, and ensure that progress made is celebrated (Blume & Lovato, 2010; Lee & Zerai, 2010).

A harm reduction approach can also allow for a more collaborative therapeutic relationship. Strausser (2012) noted the power of this client-focused approach, as it allows individuals to set their own goals rather than working towards a successful outcome as defined by the therapist. In the treatment of many other disorders, clinicians are taught to take direction from their clients in identifying goals and avoid leading them towards a specific solution. In the area of substance treatment, however, “positive outcomes in substance user treatment are often dualistically conceived, where long term sobriety is considered to be success, and where ‘failure’…is the norm” (Lee & Zerai, p. 2412). For this reason, defining success based on the individual needs of a client becomes much more difficult. This approach to treatment may be due to providers’ beliefs regarding substances that are rooted in the temperance movement and disease model, which stresses complete abstinence as vital. White (2007) points out that “if abstinence is a defining element of recovery, then a moderated resolution of AOD (alcohol or drug) problems would, by definition, not constitute recovery” (p. 232).
Approaching treatment from a harm reduction perspective allows for clients to think of themselves in less binary terms (e.g., clean or dirty, using or not using; Denning & Little, 2012). Lee and Zerai (2010) conceptualized success in treatment in a number of different ways. Notably, the authors recognized positive changes in drug use (e.g., reduction, abstinence, or safe use) and social functioning (i.e., one’s ability to set and complete goals) as potential indicators of success. The positive impact that these changes can have on an individual’s view of self-efficacy and their interactions with society may be necessary to recognize when determining appropriate approaches to treatment.

**Medications for Substance Use Disorders.** The treatment of substance use disorders often involves the use of medications for substance use disorders (MSUDs) or medications for opioid use disorders (MOUDs). The two most common forms of medication in this category are methadone (dolophine) and suboxone (buprenorphine and naloxone; Schukit, 2016). Both contain opioids designed to reduce withdrawal symptoms and encourage treatment retention. There are differences, though, both in the mechanism of action of these medications and their effects for those in treatment. For example, Proctor and colleagues (2014) found methadone to be more effective at keeping individuals in treatment than suboxone. While longer stays in treatment can be perceived as a positive, the fact that methadone is a full opioid agonist may help to explain why individuals are less likely to leave treatment when receiving it. The chemical differences mean that the withdrawal process is more severe for those using methadone when compared to those tapering off of suboxone (Proctor et al., 2014).

Unlike methadone, the inclusion of naloxone, an opioid antagonist, in suboxone impedes individuals from using other opioids in concert with their medication. Individuals on both methadone and suboxone have reported short-term improvements in their health-related quality
of life after starting the medications (Nosyk et al., 2015; Wang et al., 2012). After initial improvements in the first few months of treatment, though, the increase in participants’ quality of life scores began to diminish. As a result, it is important to consider the long-term effects of MOUDs. When used correctly, though, MOUDs can be a cost-effective treatment method that helps to reduce relapse, death, criminal behavior, and infections while increasing social functioning and retention in treatment (Bart, 2012; Shidlansik et al., 2017; Volkow & Blanco, 2020).

The pharmacological approach of MSUDs is not an available treatment option for those in recovery from the majority of other substance use disorders, and those who seek MOUDs for their OUD often experience stigma (O’Conner & Rosen, 2008). While a medical detoxification process may be necessary for individuals with alcohol and benzodiazepine use disorders and medical treatments have been examined for those experiencing cocaine withdrawal, medications used to treat opioid use disorders are often used for longer periods of time (Morgen, 2017). Due to the unique nature of the medication-assisted approach in the treatment of OUDs, individuals both in the treatment and recovery communities tend to have strong opinions regarding the topic (Liu et al., 2013). While many people believe that MOUDs are appropriate for use in both abstinence and harm reduction programs, there are still those who are opposed to this sentiment.

The lack of agreement in the field regarding the appropriateness of MSUDs is another way that individuals with substance use disorders may experience rejection and marginalization. There are still those who view individuals who use methadone as “‘not clean’ and simply receiving free drugs” (Earnshaw et al., 2013, p. 119). As a result, people using MOUDs may be ostracized or refused treatment by some providers and recovery communities (Blaney & Craig, 1999; Shidlansik et al., 2017). In a qualitative study of 10 White individuals and two Black
individuals (eight men and four women) receiving methadone, all participants reported experiencing prejudice and discrimination from family, friends, coworkers, or health care providers regarding their methadone use (Earnshaw et al., 2013). Similar results were found in a qualitative study published in 2004, in which Vigilant found that 98% of his 44 participants identified stigma as an essential component of their methadone treatment. Individuals with opioid use disorders face a number of barriers when seeking treatment for their diagnosis, and the lack of consensus regarding appropriate treatment can act as an additional impediment and way to shame those with OUDs (Ahern et al., 2006; van Boekel et al., 2015).

**Self-Efficacy**

Regardless of the way that one decides to define success for themselves in recovery, it is important for individuals to believe in their ability to change. Bandura (1977) defined self-efficacy as the level of confidence individuals have in their ability to achieve a desired outcome. Self-efficacy beliefs have been positively correlated with a wide variety of outcomes, including academic achievement, health-related outcomes, reductions in substance use, and athletic performance (Hayaki et al., 2011; Holden, 1992; Kadden & Litt, 2011; Kane et al., 1996; Lent et al., 1986). Individuals tend to be more willing to persevere through difficult situations if they believe they have the ability to achieve their goals (Bandura, 1999).

Due to the level of stigma experienced by individuals with substance use disorders, it is necessary to consider whether or not those seeking treatment believe success is possible. Ilgen and colleagues (2005) examined abstinence self-efficacy beliefs and abstinence one year after SUD treatment. The authors utilized a sample of 2,967 men completing inpatient treatment through the Veterans Affairs Health Care System and self-report measures to determine the influence of abstinence self-efficacy beliefs on abstinence (Ilgen et al., 2005). No information
was provided regarding the race or ethnicity of participants. Results indicated that high levels of abstinence self-efficacy beliefs were the single strongest predictor of abstinence one year after treatment (Ilgen et al., 2005).

Chavarria and colleagues (2012) also examined the effects of self-efficacy in the context of substance use over the course of a two-year period. Participants for the study included 150 individuals from residential treatment facilities in the Chicago area (Chavarria et al., 2012). The sample was 77% African American, and 62% of participants were women (Chavarria et al., 2012). Individuals were randomly assigned to either the usual aftercare condition or an Oxford House condition. Oxford houses are self-run and financed by individuals in recovery, and residents are required to remain abstinent from the use of substances (Harvey et al., 2016). The usual aftercare conditions included recovery homes, self-help groups, and outpatient treatment centers (Chavarria et al., 2012). Once assigned to a condition, participants completed measures regarding self-control, drug and alcohol abuse abstinence self-efficacy, and addiction severity (Chavarria et al., 2012). Higher ratings of self-efficacy beliefs and the Oxford House Condition were both associated with a significantly decreased likelihood of relapse (Chavarria et al., 2012).

Gwaltney et al. (2009) conducted a meta-analysis of 54 studies with 11,121 participants on smoking (tobacco) abstinence self-efficacy beliefs and smoking cessation. Results indicated that individuals who started treatment with a higher sense of abstinence self-efficacy were significantly more likely to succeed in their attempt to stop smoking than those with low abstinence self-efficacy beliefs. The relationship between abstinence self-efficacy and relapse varied based on whether the self-efficacy measure was given before or after the quit attempt (Gwaltney et al., 2009). Notably, the effect size was substantially weaker in analyses of abstinent smokers when compared to participants whose smoking was uncontrolled. When the
abstinence self-efficacy measure was given after the start of the quit attempt, the relationship between self-efficacy and smoking cessation was stronger than when the measure was given prior to the start of the quit attempt.

The authors posit that the predictive strength of the post-quit abstinence self-efficacy measure may be due to the better understanding individuals have of the recovery process and associated challenges once they have quit (Gwaltney et al., 2009). Knowing what barriers lie ahead may have allowed participants to more accurately assess their abstinence self-efficacy. While a significant relationship between abstinence self-efficacy and outcome was found, it only accounted for 2% of the variance in the outcome (Gwaltney et al., 2009). It is important to consider the role of potential moderating factors, including race, gender, and type of substance used when considering the relationship between drug-avoidance self-efficacy and relapse. Due to its predictive ability of success in recovery, a measure of drug avoidance self-efficacy will be used to operationalize success in recovery for this study.

**Shame and Guilt**

Potential barriers to the development of abstinence self-efficacy in recovery include feelings of guilt and shame, which are common among individuals in the recovery community (Crapanzano et al., 2018; Gueta, 2013; Luoma et al., 2018; Tangney & Dearing, 2002). The concepts of guilt and shame are often differentiated by the focus of one’s negative judgment (Lewis, 1971; Tangney & Dearing, 2002). Guilt has been described as a negative evaluation of one’s own behavior following a personal transgression (deHooge et al., 2011; Wolf et al., 2010). Shame, on the other hand, “involves a global negative feeling about the self in response to some misdeed or shortcoming” (Dearing et al., 2005, p. 1393). While guilt is typically focused on an individual action or behavior, shame involves a negative evaluation of one’s self (Tangney &
A specific focus on the individual and accompanying self-criticism are the defining aspects of shame (Brown et al., 2008; Leach & Cidam, 2015). Shame involves a shift in the way that an individual may view or perceive themselves. While those experiencing guilt may endure momentary questions regarding their worth as an individual, those feelings typically do not persist.

The other main perspective regarding shame and guilt is concerned with whether a transgression was public or private (Cohen et al., 2011). The public-private distinction of shame and guilt was first made by Benedict (1946). This perspective posits that guilt results from a personal sense of doing wrong, while shame is associated with personal wrongs being made public (Tangney & Dearing, 2002; Wolf et al., 2010). While guilt leads one to judge their own behavior through a personal moral compass, shame occurs when others judge that person in a negative way. Though it is important to understand the history and development of shame and guilt, the public-private distinction is no longer the predominant way of differentiating between these two concepts.

**Trait and State**

While there is general consensus among researchers regarding the broad definitions of shame and guilt, there are numerous alternative ways to conceptualize these constructs. Shame and guilt are commonly measured in two distinct ways: trait (dispositional) and state (situational; Tangney & Dearing, 2002). The concepts of dispositional shame and guilt refer to the likelihood that one will experience shame or guilt in response to specific situations (Martinčeková & Enright, 2018; Tangney & Dearing, 2002; Tangney et al., 2011). Others have referred to the dispositional shame and guilt as shame or guilt proneness (del Rosario & White, 2006; Ent & Baumeister, 2015; Woien et al., 2003). Another interpretation of the concept of trait shame is
internalized shame (del Rosario & White, 2006; Luoma et al., 2014). Internalized shame is believed to involve persistent feelings of incompetence due to excessive experiences of shame throughout development (del Rosario & White, 2006). High trait shame has been positively correlated with substance use problems (Dearing et al., 2005).

While important to understand how one’s propensity to experience shame and guilt may lead them to respond in a specific situation, there is also a need to examine “in the moment” feelings of shame and guilt (Tangney & Dearing, 2002). State shame and guilt describe one’s feelings at a specific point in time regarding a particular transgression (Davis et al., 2015). High levels of state shame have also been associated with problematic substance use (Ianni et al., 2010). Shame can be damaging in the context of social interactions, while guilt has the ability to be adaptive and reparative (Fedewa et al., 2005). Interventions that focus specifically on the reduction of shame coupled with the acknowledgment of one’s actions have been shown to be effective in the treatment of SUDs (Luoma et al., 2012; Scherer et al., 2011). It is unclear, though, whether these treatment approaches are effective with diverse populations or individuals who have been diagnosed with a range of substance use disorders.

For the purpose of this research, measures of state shame and guilt will be used. This was the approach used by Scherer et al. (2011), and it allows for consistency across all measures due to the use of the state self-forgiveness scale and the drug avoidance self-efficacy questionnaire. While measures of shame and guilt proneness can be beneficial when attempting to understand responses in future situations, this study was more focused on determining the ways in which a self-forgiveness intervention could influence in the moment feelings of shame, guilt, self-forgiveness, and drug avoidance self-efficacy.
Outcomes of Guilt

Guilt is typically considered to be adaptive and related to prosocial behaviors, while shame is more often maladaptive and associated with a tendency to withdraw from others (Tangney & Dearing, 2002). In the development of the Self-Conscious Affect and Attribution Inventory (SCAAI), a shame and guilt-proneness scale, Tangney (1990) noted that “motivation and behavior arising from the guilt experience tend to be oriented toward reparative action, such as confessing, apologizing, undoing, repairing” (p. 103). Others have supported this idea when stating that “guilt appears to serve multiple relationship enhancing functions” (Baumeister et al., 1994, p. 263). Guilt may help individuals strengthen relationships, question their own actions, and maintain respect and empathy for others (Baumeister et al., 1994). Guilt can also help to maintain emotional balance in relationships, as it ensures that the transgressor experiences a negative emotional state similar to that of the victim (Baumeister et al., 1994).

Guilt has the potential to encourage people to maintain the status quo and adhere to a certain set of common values. Ent and Baumeister (2015) examined samples of undergraduate students and found that those who were prone to experience feelings of guilt following an interpersonal transgression were significantly more likely to view the avoidance of harm as more important than obeying an authority figure (Ent & Baumeister, 2015). Over half of the participants identified as female (n = 56), but no other demographic information was provided. Participants who had higher guilt scores on the measure of Guilt and Shame Proneness (GASP; Cohen et al., 2011) were found to disobey the experimenter at a rate greater than chance by assigning a more pleasant task to a confederate compared to those with low guilt scores (Ent & Baumeister, 2015). This suggests that guilt-prone individuals in treatment for an SUD may be
more likely to avoid substance related transgressions in the future, even if it means resisting peer pressure or changing past behavior.

Tangney and colleagues (2014) attempted to increase the generalizability of these findings by using a more diverse sample comprised of 45% African American, 35% White, and 9% Latino individuals (67% male, 33% female) in a county jail. Results indicated that “inmates prone to feelings of guilt about specific behaviors are less likely to subsequently re-offend than their less guilt-prone peers” (Tangney et al., 2014, p. 803). Feelings of guilt may encourage the individual to examine their actions, take responsibility for them, and engage in the reparative behavior necessary to ensure nothing similar occurs in the future (Ent & Baumeister, 2015). For those in recovery with SUDs, this represents a significant shift from the avoidant coping mechanism of substance use. Rather than leading to feelings of shame and as though one needs to hide or disappear, guilt can be motivational and help to encourage change. Guilt-prone individuals have been found to be more likely to seek out constructive solutions to their problems and less likely to exhibit aggressive responses when compared to people who are more prone to feelings of shame (Tangney et al., 1996).

**Outcomes of Shame**

Shame, on the other hand, has been found to be positively correlated with anger and the propensity to act in a negative way as a result of that anger (Tangney et al., 1996). In a study of 600 Swedish single parents who had recently gone through a family breakup, results indicated that shame, as opposed to guilt, was positively and substantially correlated with feelings of depression which were mediated by rumination (Orth et al., 2006). An individual experiencing shame may identify another individual, structure, or event as being responsible for the predicament in which they find themselves. They may also be less likely to trust the treatment
provider or engage in treatment (Lee & Zerai, 2010). These factors may limit a person’s ability to succeed in a structured environment, such as an inpatient treatment facility. This externalization of blame may partially explain why shame has been linked to higher rates of recidivism among those in prison compared to guilt (Hosser et al., 2007).

Multiple researchers have reported a significant relationship between problematic substance use and shame, with findings consistently indicating that there is a positive relationship between shame and substance use in the short term (Dearing et al., 2005; Luoma et al., 2019; Rahim & Patton, 2015; Stuewig et al., 2015). Substance use is a way to escape in the short term and suppress feelings of shame (Luoma et al., 2012). Individuals who experience shame have also been found to be less likely to forgive themselves and more likely to punish themselves following a transgression (Griffin et al., 2016). Furthermore, those same individuals may be more likely to excuse themselves of blame, thereby removing some of the motivation to correct the behavior that led to the emotional state in the first place.

Rather than address potentially problematic behavior, individuals who experience high levels of shame may be more likely to rely on past coping mechanisms which have provided temporary relief from long-term pain. In fact, factors such as discrimination, stigma, and shame may help to explain the high attrition rates in the recovery community (Luoma et al. 2014). Understanding effective ways to address shame in particular for individuals with OUDs is an important step towards supporting those with substance use disorders.

Self-Forgiveness

As an approach that has already demonstrated some efficacy in treatment for individuals with alcohol use disorders, the concept of self-forgiveness may hold potential for the treatment of SUDs (Peterson et al., 2017; Scherer et al., 2011; Webb & Toussaint, 2018). Enright (1996)
defined self-forgiveness as “a willingness to abandon self-resentment in the face of one’s own acknowledged objective wrong, while fostering compassion, generosity, and love toward oneself” (p. 116). The self-forgiveness treatment’s focus on addressing shame is particularly relevant for those with SUDs due to the stigma they experience (Hall & Fincham, 2005; Webb & Toussaint, 2018). This stigma can contribute to guilt, shame, and marginalization that negatively affect help-seeking and treatment outcomes (Lee & Zerai, 2010; Luoma et al., 2014).

Self-forgiveness has been positively correlated with the resolution of emotional distress (Davis et al., 2015; Lin et al., 2004; Massengale et al., 2017). The pattern of marginalization and resulting shame and guilt experienced by many of those with substance use disorders has the potential to make the process of self-forgiveness quite relevant. The connection between self-forgiveness and the resolution of emotional distress indicates that individuals who are able to forgive themselves may be able to rid themselves of self-stigma regarding mental health and experience greater psychological and physiological health (Carpenter et al., 2019; Davis et al., 2015).

**Taking Responsibility**

While many accept the definition put forth by Enright (1996), other researchers have expressed a concern that self-forgiveness may allow those with SUDs to ignore the harm they have done (Squires et al., 2012; Wenzel et al., 2012). Enright’s focus on the acknowledgment of an objective wrong is an important conceptual distinction. True self-forgiveness does not allow for an individual to move towards self-love without recognizing the physical, interpersonal, financial, and societal damage they may have done. For example, people who steal medications from their grandparents while in active addiction must first take responsibility for those actions before self-forgiveness and self-love can occur. Hall and Fincham (2005) stated that “to forgive
oneself is not to say that one’s behavior was acceptable or should be overlooked” (p. 623). It is important to make the distinction between excusing one’s own behavior and actually forgiving the self. While self-forgiveness requires the acknowledgment of a wrong done, excusing behavior simply allows one to convince themselves the problematic behavior was not their fault, not harmful, or entirely justified.

Though the personal responsibility portion of self-forgiveness was clearly important to Enright (1996), there are those who argue that the harms of self-forgiveness outweigh the potential benefits. Squires and colleagues (2012) posit that specifically “in the case of enduring or chronic problem behaviors, forgiving the self can remove the motivation to stop the injurious behavior” (p. 339). The authors note in their conclusion that it is necessary for individuals to face facts and take responsibility for their actions to effectively address their gambling addiction (Squires et al., 2012). Without this recognition and acceptance of responsibility, there is nothing to forgive (Wenzel et al., 2012). As a result of the importance of acknowledging the wrong that one has done, the term “pseudo self-forgiveness” has been developed to use when discussing the concept of forgiving the self without taking responsibility (Hall & Fincham, 2005).

**Pseudo Self-Forgiveness**

Pseudo self-forgiveness occurs when “offenders fail to accept responsibility and minimize or excuse the behavior and its consequences” (Wenzel et al., 2012, p. 617). It has been noted that some individuals are able to convey genuine feelings of self-forgiveness without actually accepting responsibility for their actions (Wohl & McGlaughlin, 2014). There are those who argue that self-forgiveness may allow one to avoid accepting responsibility and the negative feelings that accompany the acknowledgment that a wrong has been done (Squires et al., 2011). The difference, though, is that true self-forgiveness requires a potentially uncomfortable process
of self-examination, while pseudo self-forgiveness is often accomplished through self-deception (Hall & Fincham, 2005). Experiencing the guilt and regret that accompanies many individuals with substance use disorders is a necessary condition for effective self-forgiveness (Fisher & Exline, 2006; Gueta, 2013; Hall & Fincham, 2005). Pseudo self-forgiveness will likely keep an individual in the same patterns of behavior that led them to treatment, as it is another way to avoid the consequences of one’s behavior (Hall & Fincham, 2005). For the purpose of this dissertation, I will use the definition of self-forgiveness employed by Enright (1996) which stresses the importance of taking personal responsibility.

**Trait Self-Forgiveness**

Researchers also diverge when it comes to whether self-forgiveness is measured as a trait or as a state. A recent review of the literature regarding self-forgiveness and well-being indicated that a majority of the studies conducted ($n = 54$ of 64), used measures assessing trait self-forgiveness (Massengale et al., 2017). When conceived as a personality trait, self-forgiveness refers to the likelihood that one would be able to accept responsibility for their actions and forgive themselves were they to commit a range of transgressions (Hall & Fincham, 2005, Massengale et al., 2017). Individuals who are less likely to rely on self-punitive responses to perceived transgressions may be less likely to anticipate judgment and experience self-stigma related to the need for help (Carpenter et al., 2019). Measures of trait self-forgiveness have indicated a stronger relationship with psychological well-being than have state measures of self-forgiveness, though both approaches suggest a positive correlation with mental health (Davis et al., 2015). While trait self-forgiveness has been found to be positively correlated with physical health, no measures of state self-forgiveness have been used to examine the relationship between self-forgiveness and physical health.
State Self-Forgiveness

State self-forgiveness refers to an individual’s ability to forgive themselves for a specific incident or transgression (Massengale et al., 2017; Wohl et al., 2008). A partial explanation for the disparity in the frequency with which state self-forgiveness is examined compared to trait self-forgiveness is the fact that a viable measure of state self-forgiveness was not developed until 2008 (Wohl et al., 2008). Studies of state self-forgiveness indicate a positive relationship between forgiving the self and improved mental health (Massengale et al., 2017; Wohl et al., 2008). Forgiving one’s self for an identified transgression has also been associated with increased feelings of self-efficacy regarding one’s ability to avoid alcohol use (Scherer et al. 2011). Similarly, Peterson et al. (2017) found that higher levels of state self-forgiveness were correlated with a reduction in disordered eating and a desire to reduce problematic drinking.

Research on Self-Forgiveness and SUDs

Though researchers have reported that the process of self-forgiveness is positively and significantly correlated with the resolution of emotional distress, little research has focused on the potential efficacy of self-forgiveness in addressing the shame experienced by individuals with SUDs in treatment (Davis et al., 2015; Lin et al., 2004; Massengale et al., 2017). Additionally, there has been little consistency in the measures used to study these constructs. Five studies were identified that examined the role of self-forgiveness and its effect on shame and guilt for individuals in recovery with SUDs (Gueta, 2013; Ianni et al., 2010; McGaffin et al., 2013; Peterson et al., 2017; Scherer et al., 2011). Ianni et al. (2010) were interested in the relationship between state shame and guilt and dispositional self-forgiveness, while McGaffin and colleagues were focused solely on trait shame, guilt, and self-forgiveness. Peterson et al. (2017) and Scherer et al. (2011) used state measures of shame, guilt, self-condemnation, and
self-forgiveness to better understand the relationship between problematic alcohol use and self-forgiveness.

One of the studies noted above was qualitative in nature and examined the experiences of Israeli mothers in recovery with SUDs (Gueta, 2013). Gueta examined the self-forgiveness experiences of 25 Israeli women in various stages of the recovery process. The ages of the participants ranged from 22 to 46. Groups were divided based on time in treatment: early stage of recovery (first 1-3 months), advanced (6-12 months), and long-term recovery (2-7 years). This study was done by conducting life story interviews and asking specific questions regarding the self-forgiveness process (Gueta, 2013). Responses indicated that shame and stigma, particularly regarding relapse, can be particularly damaging for women in recovery (Gueta, 2013). Gueta highlighted the importance of the self-forgiveness process for substance-dependent Israeli mothers by noting that it “is accompanied by diminishment of guilt and enables construction of a new shame-free identity” (p. 450). Women in this study who engaged in the self-forgiveness process reported the ability both to acknowledge past transgressions and separate their personal identity from those actions. While the results of this qualitative study suggest that self-forgiveness can be an important component of the recovery process for women with substance use disorders, causality cannot be determined. Additionally, the author did not explicitly differentiate between state and trait concepts of self-forgiveness, shame, and guilt, and nearly all of the women identified one substance (opioids) as the reason they were in treatment. All of the women who participated in this study had children, and they were interviewed 35 times over the course of two years. Gueta also highlighted the influence of Israeli culture on the women’s self-perception due to cultural expectations which “see mothers as the child’s primary caregiver” (Gueta, 2013, p. 462). For these reasons, the results have limited generalizability.
Two of the five studies were focused on the self-forgiveness process for students who had committed a transgression or experienced shame and guilt due to their alcohol use (Ianni et al., 2010; Peterson et al., 2017). Ianni and colleagues examined the association between self-forgiveness and alcohol use through the use of a sample comprised of 567 college students ($M_{age} = 21.98$) from a medium-sized public university in Southwestern Ontario. No additional information regarding gender, racial, or ethnic identity was provided. Participants were given an online questionnaire for course credit comprised of the shame subscale from the State Shame and Guilt Scale (SSGS; Marschall, 1994; Saftner, & Tangney, 1994), the Alcohol Use Disorders Identification Test (AUDIT; Fleming et al., 1991), and the self-forgiveness subscale from the Heartland Forgiveness Scale (HFS; Thompson et al., 2005). Alcohol use was found to be significantly negatively correlated with self-forgiveness ($r = -0.10$) and significantly positively correlated with shame ($r = 0.15$; Ianni et al., 2010). Regression results identified shame as a significant independent predictor of alcohol abuse, while self-forgiveness was not found to be a significant predictor. The study indicated that students who experienced high levels of shame and displayed a self-forgiveness coping style were significantly less likely to misuse alcohol than those who experienced high levels of shame and low self-forgiveness scores (Ianni et al., 2010). These findings indicate that self-forgiveness may help to act as a protective factor when it comes to alcohol misuse for those who experience shame.

Peterson and colleagues (2017) examined the relationship between state self-forgiveness, feelings of remorse and self-condemnation, and intention to drink responsibly in the future. Participants in this study were recruited from a large, public university in the Southwest and were comprised of 462, predominantly female ($n = 327$) individuals ranging in age from 18 years old to 64 years old. The mean age of participants was 21 years old ($SD = 4.72$). Self-reported
race/ethnicity included White (46.9%), Latino(a) (22.9%), Black/African-American (13.2%), Asian (5.8%), Native American (0.9%), and Other (3.2%). Individuals in the self-forgiveness condition completed a reflection that required them to engage in a process of self-forgiveness regarding a past alcohol-related transgression, while the control condition completed a neutral reflection that encouraged them to reflect on an offense (Peterson et al., 2017). Reflections for those in the self-forgiveness condition were based on a set of eight questions provided by the researchers, including “what do you believe about forgiving yourself” and “what will it take for you to forgive yourself” (Peterson et al., 2017, p. 162). Reflections prompts for those in the neutral condition included eight different questions such as “how do you think the other person felt while you were committing the transgression?” (p. 162). After completing the reflection, participants completed measures of remorse and self-condemnation, state self-forgiveness, cause of the transgression, and future responsible drinking intentions (Peterson et al., 2017). Self-forgiveness was measured by the State Self-Forgiveness Scales (SSFS; Wohl et al., 2008).

The relationship between the self-forgiveness condition and drinking intentions was moderated by the degree to which the individual blamed alcohol use for their transgression (Peterson et al., 2017). Among individuals who believed their mistake was due to their alcohol consumption, the self-forgiveness prompt was associated with greater self-forgiving beliefs compared to those who did not attribute their transgression to drinking (Peterson et al., 2017). For participants who did not attribute their transgression to their drinking, the authors found that the self-forgiveness condition significantly increased feelings of remorse and self-condemnation when compared to the neutral condition. Findings also showed that the ability to forgive one’s self for an alcohol-related transgression was associated with decreased feelings of self-condemnation, though the authors did not identify significant results regarding either the main
effect or interaction effect on one’s intention to drink responsibly in the future (Peterson et al., 2017). Peterson and colleagues hypothesized that the null findings regarding their self-forgiveness condition may have been due to its intrapersonal nature, as the focus of the intervention was on eliciting a change in beliefs about the self. As many of the transgressions reported were interpersonal in nature, it is believed that developing a prime that elucidates the connection between self-forgiveness and relationships could be beneficial.

McGaffin and associates (2013) examined the relationship between trait shame and guilt on dispositional self-forgiveness for 133 Australians who were actively receiving treatment for a SUD. The sample was predominately male (n = 99), and the mean age of participants was 37.52 years (SD = 11.24). No information regarding racial or ethnic identity was reported. Participants had been in treatment for an average of four months and reported use of a number of different substances. Over half of participants identified alcohol as their primary substance (n = 69), while only nine of the 133 participants identified an opioid (heroin) as the reason they were seeking treatment (McGaffin et al., 2013). Remaining primary substances identified by participants included cannabis (n = 21), amphetamines (n = 20), cocaine (n = 2), and other (n = 2). The authors were also interested in the way that acceptance, conciliatory behavior, and empathy mediated the relationships between shame and guilt with self-forgiveness (McGaffin et al., 2013). Participants completed measures regarding dispositional shame and guilt, dispositional self-forgiveness, acceptance, empathy, and conciliatory behaviors (McGaffin et al., 2013). These scales included the Test of Self-Conscious Affect-3 (TOSCA-3; Tangney et al., 2000) to measure trait shame and guilt and the Heartland Forgiveness Scale to measure trait self-forgiveness (HFS; Thompson et al., 2005).
The researchers found that guilt proneness positively predicted acceptance of one’s actions and self, while shame proneness negatively predicted acceptance. The relationships between both shame proneness and self-forgiveness and guilt proneness and self-forgiveness were found to be mediated by acceptance. Their findings suggest that if a person can accept, rather than avoid the emotions related to their transgression, they may be more able to self-forgive. Additionally, guilt-prone individuals may be more likely to engage in a reparative response that does not include substance use to a perceived transgression as opposed to shame-prone individuals (McGaffin et al., 2013). Guilt-prone individuals were also more likely to forgive themselves, while shame prone individuals were shown to be less likely to forgive themselves (McGaffin et al., 2013). This provides support for the theory that the outcomes of guilt are more adaptive or prosocial, while shame tends to be more detrimental for the person experiencing that emotion.

Scherer and colleagues (2011) used state measures of self-forgiveness as well as state shame and guilt to examine the effectiveness of an intervention designed to promote self-forgiveness for predominantly White, male, Western Michigan residents in recovery with Alcohol Use Disorders (AUD). All participants were also court mandated to either attend psychoeducational groups or complete community service in addition to their enrollment in treatment. Initially, 176 individuals receiving outpatient treatment were deemed to be eligible for the study, but only 79 participants completed the first round of questionnaires. As a result, participants whose data were able to be analyzed included 79 individuals, 67 of whom were male with a mean age of 36.1 years ($SD = 12.6$). Thirty-eight individuals were randomly assigned to treatment as usual (TAU), and 41 individuals were assigned to the intervention condition. A large majority of the sample self-identified as European American ($n = 75$). This intervention
was split up over three consecutive weeks into three 90-minute sessions. Measures of shame, guilt, self-forgiveness, and drinking-refusal self-efficacy were completed during the first week of treatment, during the fourth week of treatment, and at a three week-follow up. Scales used included the Personal Feelings Questionnaire (PFQ-2; Harder & Lewis, 1987) to measure state shame and guilt, the Self-Forgiving Feeling and Action scale (SFFA; Wohl et al., 2008), and the Drinking Refusal Self-Efficacy Questionnaire-Revised (DRSEQ-R; Oei et al., 2005). The intervention was conducted between the first and fourth weeks of treatment. Results indicated that the 4-hour self-forgiveness intervention was effective at significantly increasing feelings of self-forgiveness over time when compared to TAU. The researchers also reported that the intervention significantly decreased shame and guilt scores over time. Increases in self-forgiveness over time were shown to be significantly associated with reductions in shame and guilt and increases in drinking-refusal self-efficacy (Scherer et al., 2011).

The results identified in these five studies help to support the conclusion that additional research is needed to better understand the role of self-forgiveness in the recovery process for individuals with SUDs. Each of the studies identified shame as harmful for those in recovery, with Peterson et al. (2017) focusing specifically on self-condemnation. Additionally, self-forgiveness was highlighted by each study as an approach that can help individuals process feelings of shame and avoid future problematic substance use. In the present study, I will work to build on this research by adding to what is already known about shame, guilt, and self-forgiveness in the context of recovery from SUDs while addressing gaps that currently exist in the published literature.
Gaps in the Literature

Although five groups of researchers have examined associations among guilt, shame, and self-forgiveness in the context of substance use, key limitations exist in each of these studies. There was a lack of consistency in the way that shame, guilt, and self-forgiveness were measured, and the researchers’ definition of a positive outcome differed by study. Notably, authors used a mixture of both state and trait measures of self-forgiveness, shame, and guilt, and little was done to explicate the difference. In the present study, I used measures of state shame, guilt, and self-forgiveness to better understand the in-the-moment feelings of those receiving inpatient care. Success will be defined by changes in those variables, as well as a focus on drug avoidance self-efficacy.

There was also variation in the populations studied. Three of the studies focused on the experiences of individuals in treatment with substance use disorders (Gueta, 2013; McGaffin et al., 2013; Scherer et al., 2011), while the other two studies used samples comprised of college students (Ianni et al., 2010; Peterson et al., 2017). While college student participants in the self-forgiveness condition in the Peterson et al. (2017) study did complete reflections based on self-forgiveness prompts, only Scherer et al. (2011) examined the effects of a self-forgiveness intervention for individuals in recovery. The focus of Scherer and colleagues, however, was on the experience of individuals with AUDs receiving outpatient care. This is an important factor, as previous studies have shown that people receiving inpatient care are significantly more likely to complete treatment than those receiving outpatient care (Stahler, Mennis, & DuCette, 2016). Additionally, inpatient care is often identified as the appropriate option for those with more severe SUDs (Allen & Olsen, 2016). As this study is interested in the self-forgiveness process for those actively seeking treatment for a SUD, I will be conducting research at in a residential
treatment facility. This approach will address gaps present in the literature by allowing conclusions to be drawn regarding the efficacy of a self-forgiveness intervention for individuals who are also completing a comprehensive inpatient treatment program.

Additionally, the authors did not appear to consider how the self-forgiveness process, feelings of shame and guilt, or substance use may vary by race/ethnicity (Ianni et al., 2010; McGaffin et al., 2013; Scherer et al., 2011). While Peterson and colleagues (2017) used a more representative and diverse sample, results were not delineated by race, ethnicity, or gender. Similarly, Gueta’s (2013) examination of the experiences of Israeli women in recovery did not differentiate between participants who were born in Israel and those who were born in the former Soviet Union. Other than the Gueta study, samples used by previous researchers were comprised predominantly of White men (McGaffin et al. 2013; Scherer et al., 2011) or college students (Ianni et al., 2010; Peterson et al., 2017). Other authors provided minimal information regarding the demographics of their samples (Ianni et al., 2010; McGaffin et al., 2013). The lack of diversity in samples is especially important due to the role that stigmatization and discrimination may play in the development of shame and guilt. Additional experiences of discrimination due to one’s gender and race may compound the negative effects of stigmatizing attitudes regarding substance use. More information is needed to determine how additional experiences of stigma and discrimination influence the development of internalized shame and the self-forgiveness process for a diverse sample with SUDs. In this study, I worked to recruit a racially and gender diverse sample to address this gap.

Finally, most of the studies reviewed focused on alcohol use as the problematic substance, with no research being done specifically regarding the effects of self-forgiveness for individuals with SUDs. While individuals in treatment for any substance use disorder will be
eligible to participate in the present study, attempts will be made to recruit a sample seeking
treatment for a wide range of SUDs. Additionally, only Gueta (2013) and Scherer and colleagues (2011) explored the way that experiences of shame, guilt, and self-forgiveness may influence the recovery process or one’s propensity to use substances over a period of time. The other three studies cited in this section used in-the-moment predictive measures to determine how shame, guilt, and self-forgiveness may influence substance use (Ianni et al., 2010; McGaffin et al., 2013; Peterson et al., 2017). In the current study, I collected data at three points in time for this dissertation in an attempt to determine the effects of a self-forgiveness intervention over time. This study will help to determine whether the promising results regarding the effects of self-forgiveness on shame for those in recovery can be extended to a diverse group of individuals in treatment with SUDs.

Purpose of Study

The purpose of this study was to examine the effects of a 4.5-hour group self-forgiveness intervention on state shame, guilt, self-forgiveness, and drug avoidance self-efficacy scores for individuals in residential treatment with substance use disorders. While these constructs have been examined to some degree, little attention has been given to the experiences of individuals other than White men with AUDs. The intervention will be broken up into three 1.5-hour meetings that occur over the course of one week. I sought to contribute to the literature through the inclusion of a racially diverse sample of both Black and White participants with a variety of SUDs. This approach will allow for results to be generalized to a broader population of individuals. The goal of the study is to determine if the self-forgiveness intervention developed by Scherer and colleagues (2011) is effective in reducing shame and guilt scores while increasing self-forgiveness and drug avoidance self-efficacy scores for adults with SUDs.
Research Questions

1. Does the addition of a self-forgiveness intervention increase state self-forgiveness beyond treatment as usual (TAU) for those with SUDs between T1 (the beginning of the intervention) and T2 (immediately following the intervention)?

2. Does the use of a self-forgiveness intervention reduce state shame beyond TAU between T1 and T2?

3. Does the use of a self-forgiveness intervention reduce state guilt beyond TAU between T1 and T2?

4. Does the use of a self-forgiveness intervention increase drug avoidance self-efficacy beyond TAU between T1 and T2?

5. In the intervention condition, are gains maintained from T2 to T3 (three weeks after the completion of the intervention) on guilt?

6. In the intervention condition, are gains maintained from T2 to T3 on shame?

7. In the intervention condition, are gains maintained from T2 to T3 on drinking refusal self-efficacy?

8. In the intervention condition, are gains maintained from T2 to T3 on self-forgiveness scores?

Hypotheses

1. It is hypothesized that there will be an interaction effect between time and treatment on self-forgiveness, such that there will be a greater increase in state self-forgiveness scores from T1 to T2 in the intervention group compared to the TAU.

2. It is hypothesized that there will be an interaction effect between time and treatment conditions on shame scores. It is expected that those who complete the self-forgiveness
intervention will report a smaller reduction in state shame scores from T1 to T2 compared to those in the TAU condition.

3. It is hypothesized that there will be an interaction effect between time and treatment conditions on guilt scores. It is expected that participants in the intervention condition will report a smaller reduction in state guilt scores from T1 to T2 compared to those in the TAU group.

4. It is hypothesized that there will be an interaction effect between time and treatment conditions on drug avoidance self-efficacy scores. It is expected that those who complete the self-forgiveness intervention will exhibit a greater increase in drug-avoidance self-efficacy scores from T1 to T2 compared to those in the TAU condition.

5. Within the treatment condition, it is expected that no differences will be observed on guilt scores between T2 and T3.

6. Within the treatment condition, it is expected that no differences will be observed on shame scores between T2 and T3.

7. Within the treatment condition, it is expected that no differences will be observed on drug avoidance self-efficacy scores between T2 and T3.

8. Within the treatment condition, it is expected that no differences will be observed on self-forgiveness scores between T2 and T3.
CHAPTER III
METHOD

Participants

Participants initially consisted of 49 individuals who were in the early stages of inpatient treatment (first four weeks) for a substance use disorder. An a priori power analysis was conducted with the use of G*Power 3.1, and results suggested that a sample size of at least 36 participants was needed to detect a significant effect. All participants were attending the same private treatment facility in the Midwestern United States. As is common in other substance treatment/intervention studies, retention was an issue in the current study. In past substance treatment studies, the average dropout rate has been around 30% (Lappan et al., 2019). This rate of attrition is high, and the Covid-19 pandemic added an additional variable that likely influenced dropout rates. In the present study, nineteen individuals who signed consent forms dropped out prior to its completion. This means that the dropout rate in this study was closer to 39%. Eleven individuals were randomized to either the control group (seven participants) or the intervention group (four participants) and completed at least one point of data, though they did not complete the study. Eight more individuals signed consent forms but dropped out prior to the time of data collection. As a result, the final sample size was 30 individuals. Eighteen of the participants who completed measures at time one (T1) and time two (T2) were in the intervention condition, while 12 of the participants who completed T1 and T2 measures were in the treatment as usual condition (TAU).

In the final sample of 30 participants, as is shown in Table 1, 27 individuals identified as White, one person identified as Black, one person identified as Latino, and one person identified as an American Indian. Participants ranged in age from 20 to 57 years old ($M = 37.17$, $SD =$ 50
Two thirds (66.7%; n = 20) of the participants identified as male, nearly one third (30.0%, n = 9) identified as female, and one participant identified as a transgender man. The majority of those in the study identified as heterosexual (83.3%, n = 25). One participant identified as gay/lesbian, two individuals identified as bisexual, one person identified as pansexual, one participant indicated that they preferred not to say. Of the 30 participants, just over one third of individuals (36.7%; n = 11) were in treatment for the first time. The remaining 19 people were returning to treatment for a substance use disorder. All participants denied being mandated to attend treatment. The number of times a participant had attended treatment (counting this episode) ranged from once to six times ($M = 2.67, SD = 1.77$).

Nearly two thirds of those in the sample endorsed having full-time employment (60.0%, n = 18), while three people indicated that they had a part-time job. The remaining nine participants indicated that they were unemployed. Total 2020 household income (THI) in the sample ranged from under $29,999 (n = 7) to $200,000 or more (n = 2). The most common THI endorsed by participants was between $30,000 and $49,999 (n = 11). There was a similarly broad range of educational levels achieved by participants, with the majority of individuals listing a high school diploma/GED (n = 7) or some college (n = 11) as their highest level of education. An additional four individuals obtained a bachelor’s degree, while four other participants indicated that they held a graduate degree. The most common substance for which individuals were seeking treatment was alcohol (n = 18), while another six people identified opioids as their primary substance of abuse. One participant was seeking treatment for hallucinogens, and another was in treatment for their stimulant use. The final four participants listed multiple substances as their “main substance used”. Two of these people listed both alcohol and opioids as their primary substances of abuse, with one of those individuals also
endorsing the use of benzodiazepines. The final two participants each endorsed the use of three or more substances, and detail can be found in Table 1.

**Table 1**

*Percentages and Frequencies, Sample Demographics and Study Variables*

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<td>20</td>
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</tr>
<tr>
<td>Woman</td>
<td>9</td>
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</tr>
<tr>
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</tr>
<tr>
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<td></td>
</tr>
<tr>
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</tr>
<tr>
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</tr>
<tr>
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<td>3.3%</td>
</tr>
<tr>
<td>American Indian</td>
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<td>3.3%</td>
</tr>
<tr>
<td><strong>Employment Status (n=30)</strong></td>
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<tr>
<td>Self-forgiveness intervention</td>
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</tr>
<tr>
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<td></td>
</tr>
<tr>
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<td>11</td>
<td>36.7%</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
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</tr>
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Research Design

The present study utilized a between and within-subjects experimental design with one intervention condition and one treatment as usual (TAU) group. Both the experimental and the TAU groups took pre-post surveys to assess the variables of state shame, state guilt, state self-forgiveness, and drug avoidance self-efficacy.

Conditions

Treatment as Usual. Participants in the treatment as usual group received treatment as usual at the substance treatment facility where they were enrolled. Treatment as usual consisted of a wide range of treatment approaches. Individuals received individual therapy, participated in groups, and engaged in physical activity while receiving medical care. Those at this treatment facility also had the opportunity to engage in 12-step and peer support meetings. Members of the control group were not offered the opportunity to complete the self-forgiveness intervention following the end of the study. This was due to their limited length of stay in treatment and the availability of both participants and the research assistant for this study. Participants were typically enrolled in treatment for approximately 30 days, and the inpatient nature of the facility meant that they transitioned out of the environment when they were done. Many participants did not live in the immediate area surrounding the treatment facility, and they did not continue to attend treatment actively at that facility after discharge. Additionally, there was only one trained research assistant for this study, and he lived and worked full-time 45 minutes away from the

<table>
<thead>
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<th>3.3%</th>
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<tbody>
<tr>
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<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>5 or more</td>
<td>4</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

Table 1 — continued
facility in which the study was conducted. As each group run was a 4.5 hour commitment for this person (excluding travel) over the course of one week and they were run consecutively for the study, it was not feasible to offer the intervention after the study ended.

**Self-Forgiveness Intervention.** Participants in the self-forgiveness intervention condition participated in three 90-minute group sessions designed to promote self-forgiveness. These group sessions occurred in addition to normal TAU. Self-forgiveness groups were scheduled in coordination with the Clinical Director at the treatment facility. The intervention was a group self-forgiveness intervention developed by Scherer et al. (2011), and intervention manuals for both providers and participants were reviewed to ensure that they were appropriate to use for this study. Intervention manuals were obtained following communication with Dr. Michael Scherer. The intervention manual for providers can be found in Appendix E, while the intervention manual for participants is in Appendix F. Scherer et al. (2011) examined the effectiveness of a self-forgiveness intervention at increasing drinking refusal self-efficacy and promoting self-forgiveness while reducing guilt and shame for alcohol-related offenses. The approach utilized motivational interviewing to reduce resistance in participants who were unwilling to change (Scherer et al., 2011).

The goal of the self-forgiveness intervention was to engender feelings of self-forgiveness and drug avoidance self-efficacy within participants while reducing feelings of shame or guilt they may have been feeling regarding their substance use. Psychoeducation was provided to help participants understand the process of self-forgiveness, common barriers to that process, and ways to reduce self-condemnation. In addition to discussion in both pairs and group format, individuals in the self-forgiveness condition had an opportunity to engage in multiple activities focused on addressing feelings of shame and guilt. Some of these activities included an
identification of values, recalling the hurt, and an empty chair exercise focused on forgiving the self. Participants were also taught how to maintain a sense of self-forgiveness following the completion of the intervention.

Participants in the intervention completed measures of state self-forgiveness, shame and guilt, and drug avoidance self-efficacy at the beginning of the intervention (T1), immediately following the completion of the intervention (T2), and four weeks after the intervention concluded (T3). These measures were completed by participants in the control group at T1 and T2, and they were presented to everyone in the same order. Participants in the control group did not receive the self-forgiveness intervention for the purposes of this study.

**Measures**

Participants were asked to complete a demographic questionnaire and four measures prior to the beginning of the intervention. Following the third group, participants once again completed a packet containing four measures. Individuals who were in the control group completed the measures on the same day as individuals in the treatment group. One month after the completion of the final 1.5 hour meeting, participants in the intervention group were provided with a link to the measures for one final time. Measures were provided in paper and pencil format at T1 and T2, and participants accessed electronic versions of the measures through the use of a QR code for T3. Participants who were willing to complete measures at T3 after they had finished their inpatient treatment stay were asked to fill out a self-addressed envelope. This envelope was mailed to them at the appropriate time, and it contained a Qualtrics link that allowed them to submit measures remotely. All participants endorsed verbal and written English literacy.
**Demographic Questionnaire**

A demographic questionnaire, seen in Appendix A, was completed by all participants to gather information including race, socioeconomic status (SES), gender identity, sexual orientation, age, number of days in treatment, number of times in treatment, substances used, whether or not they are using medications for substance use disorders (MSUD; yes or no), and whether or not they are mandated to be in treatment (yes or no). This information was collected to better understand the variables potentially associated with the treatment process.

**State Self-Forgiveness Scale**

Participants’ state self-forgiveness was measured by The State Self-Forgiveness Scale (SSFS; Wohl et al., 2008). This scale is a 17-item instrument that measures self-forgiveness for a specific transgression and can be found in Appendix B. The SSFS consists of two subscales entitled Self-Forgiving Feelings and Actions (SFFA) and Self-Forgiving Beliefs (SFB). The SFFA subscale is comprised of eight questions that assess the way one feels and acts towards themselves regarding a specific transgression. An example of a question from the SFFA subscale is, “as I consider what I did that was wrong, I show myself compassion.” The SFB subscale uses nine questions to gather information about specific beliefs individuals have about themselves when considering what they did that was wrong. An example question from the SFB subscale states, “as I consider what I did that was wrong, I believe I am acceptable.” Participants are asked to respond to questions using a 4-point Likert scale ranging from 1 (not at all) to 4 (completely). Four of the eight items on the SFFA subscale are reverse scored, as are five of the nine items on the SFB subscale. The responses are then summed to obtain a total score for each subscale. Higher scores on both subscales indicate higher levels of state-self-forgiveness.

Reliability estimates of scores on the full-scale SFFS ranged from .79 to .94 (Cornish &
Wade, 2015; Scherer et al., 2011; Wohl et al., 2008). Wohl et al. (2008) conducted an unrestricted factor analysis with principal-factor extraction to explore data collected from 113 undergraduate students. After their hypothesized three-factor model was challenged by the results of a scree plot, the authors decided on a two-factor solution. The SFFA subscale was found to have a Cronbach’s alpha of .86, and the SFB subscale was found to have a Cronbach’s alpha of .99. In a subsequent study, Griffin et al. (2015) found evidence supporting the reliability of the SFFA subscale scores with an alpha of .74 and the SFB subscale with an alpha of .89. Concurrent validity was demonstrated by showing that participants who scored higher on the SFFS also reported being further along in the process of self-forgiveness when asked directly about their progress. Evidence of discriminant validity was gathered by showing a lack of significant association between either of the SFFS subscales and state self-esteem ($r = .08; r = .04$) or feelings of guilt ($r = -0.05; r = .16$; Wohl et al., 2008).

**State Shame and Guilt Scale**

The State Shame and Guilt Scale (SSGS; Marschall et al., 1994), presented in Appendix C, is a 15-item instrument that was used to measure state feelings of shame, guilt, and pride. The SSGS consists of three subscales entitled Shame, Guilt, and Pride. Each subscale consists of five items. An example of a shame item is “I feel like I am a bad person,” while an example of a guilt question is “I feel remorse, regret.” Participants are asked to respond to questions using a 5-point Likert scale ranging from 1 (Not feeling this way at all) to 5 (Feeling this way very strongly). All items are scored in a positive direction, and responses are summed to create mean scores for each subscale. Higher scores on each of the subscales indicate higher levels of shame, guilt, and pride.

Reliability estimates of scores on the SSGS estimates for each of the subscales range
from .82 to .89 (Crocker et al., 2014; Randles & Tracy, 2013; Tangney & Dearing, 2002).
Marschall and colleagues (1994) initially created the SSGS to operate as a manipulation check for another study regarding shame and empathy (Tangney & Dearing, 2002). It was initially used as a way to check the mood of participants following the induction of shame (Tangney & Dearing, 2002). Participants were introductory psychology class students at a large east coast university. Sixty-nine percent of the sample identified as female, 70% identified as White, 9% identified as Black, 11% Asian, 4% Hispanic, and 8% other. The scale is unpublished, and no factor analysis is reported. Additionally, the majority of the studies which use the SSGS focus solely on the Shame and Guilt subscales. Some information regarding the factor structure, internal consistency, and convergent validity of the SSGS is available in a study in which a short version of the SSGS was developed (SSGS-8; Cavalera et al., 2017). The authors used a sample of 203 Italian college students to suggest that the factor structure found in the SSGS-8 is quite similar to that found in the original SSGS (Cavalera et al., 2017). Confirmatory factor analysis of the SSGS-8 supported a two-factor model of shame and guilt. Internal consistency is supported by a number of studies, with values ranging from 0.69 to .91 for the subscales (Black et al., 2013; Gruenwald et al., 2004; Held et al., 2015; Tilghman-Osborne et al., 2008). No psychometric data are available for the SSGS in studies using samples of individuals in the United States with substance use disorders.

**Drug Avoidance Self-Efficacy Scale**

The Drug Avoidance Self Efficacy Scale (DASES; Martin et al., 1995), located in Appendix D, is a 16-item measure that assesses participants’ beliefs regarding their ability to avoid the use of a range of substances. The authors initially embedded the items for the DASES within a more expansive 55-item self-efficacy questionnaire regarding concerns including social
and vocational issues. Items were developed through the use of descriptions given by clients in a residential treatment program regarding a recent incident of substance use. After being given the scale, authors reviewed results to identify themes and reinforcing consequences that were prevalent in the answers. The authors identified nine situations of risk, including: negative emotional states, boredom, social anxiety, celebration, unpleasant physical states, interpersonal conflict, interpersonal influence, negative thoughts, and the immediate availability of drugs. Two authors reviewed around 90 responses to create questions for the measure. The items created for the DASES were intended to reflect the themes reported by participants, and respondents were asked to consider their response in situations in which they might be at risk of using substances. For example, clients were presented with the following scenario: “Imagine that a good friend has accused you of being insensitive. Now you are feeling hurt and tempted to use drugs/alcohol. Could you resist?” Participants are asked to rate their belief that they would be able to avoid substance use using a 7-point Likert scale ranging from 1 (certainly no) to 7 (certainly yes).

When developing the DASES, Martin and colleagues (1995) initially administered the measure to 50 clients at a substance treatment facility. The validation sample was comprised of 259 multiple-drug users between the ages of 16 and 30 who had presented voluntarily for treatment at a facility in Canada. The internal consistency score for the scale was .91. Interitem correlations ranged from .25 to .67. A principal components analysis with varimax rotation was used, and Eigenvalues indicated that a one-factor solution was appropriate. Multiple factor analyses were run to examine the possibility of a multifactorial model, though none was identified. Additionally, the Spearman-Brown split half-reliability was .90, and the Guttman score was .90. Cronbach’s alpha for each half of the scale were .83 and .86. This information
supports the use of the DASES as a unidimensional scale to measure drug avoidance self-efficacy. It is important to note, however, that demographic information regarding the sample was not included in this study.

Saritas and Erci (2019) translated the DASES to Turkish and administered the measure to 320 Turkish undergraduate students to measure the statistical validity of the scale. Adaptations were made to the wording of the scale in an attempt to maintain necessary cultural context and equivalence across languages. The mean age of participants was 21.42 (SD = 2.0), and 55.3% of the sample identified as female. Despite the differences in the sample from the present study, results suggest that the SSGS measurements are consistent. Cronbach’s alpha for the measure was found to be .70. The test-retest reliability was reported to be .70 after four weeks. Norozi et al. (2016) adapted the DASES for use with a sample of Iranian individuals with substance use disorders and explored the psychometric properties of the measure. Reliability of the scores was found to be .79. Two factors were identified as negative affective status and social pressure. A validation sample of 160 individuals was used for a confirmatory factor analysis, and the two-factor structure was supported. Cronbach’s alpha for the revised scale was .80, and alpha coefficients for the negative affective status subscale were .86 and .81 for the social pressure subscale.

**Procedures**

Participants were recruited from one inpatient treatment facility in the midwestern United States through coordination with the clinical director. Individuals were eligible to participate in the study if they were at least 18 years of age and enrolled in a substance abuse treatment program. Participants must have also completed any necessary, medical detoxification process before providing consent (see Appendix G) to participate. This writer contacted seven separate
treatment facilities and organizations in the spring and summer of 2021 regarding the potential implementation of the self-forgiveness intervention and data collection, and I tried to identify facilities in which a diverse sample of individuals could be recruited for participation in this study. Out of the four responses that were received, two providers stated that they could not accommodate research due to facility regulations, and one indicated that the number of individuals with whom they worked who met criteria for the present study was minimal. Some of these regulations were related to the Covid-19 pandemic, and all of the providers to whom I spoke cited Covid-19 as a significant barrier to data being collected.

One treatment facility, though, agreed to allow recruitment and data collection. The study was granted approval by Western Michigan University’s Human Subjects Institutional review board (see Appendix H), and research continued. In coordination with the clinical director at this treatment facility and this study’s research assistant, times were identified during which study recruitment could occur. Recruitment consisted of a brief presentation discussing the purpose and requirements of the study during a weekly group for all individuals in treatment. Interested participants signed consent forms and were randomized to either the control group or the intervention group. Participants who completed the study were entered into a raffle to win one of four $50 Amazon gift cards. A random number generator was used to create 2 sets of 40 unique numbers ranging from 100-300. Participants were randomly assigned a number once they filled out a consent form, and this number determined their group. This researcher trained one licensed, master’s level clinician to administer the intervention for this study. Training consisted of multiple video conference meetings, during which the training manuals were reviewed in detail. The purpose of the study and a brief review of relevant literature was also discussed. Jordan Horan, M.A. completed in person recruitment, administration of the self-
forgiveness intervention, and data collection. Jordan is a White man in his early 30s, and he is a licensed, master’s level mental health provider. Additional information regarding the treatment providers for the TAU group was not obtained.

Throughout the course of two months in late 2021, five rounds of the self-forgiveness intervention and data collection were completed. It was expected that numerous participants would drop out at various points during this study, as was the case in the study that developed the self-forgiveness intervention being used (Scherer et al., 2011). Issues with retention when conducting research with individuals with SUDs are prevalent, and this pattern was seen in the present study (Lappan et al., 2019; Norhtrup et al., 2017). It is important to note, though, that more individuals dropped out of the treatment as usual condition than did those in the intervention condition. This is consistent with the findings of Scherer et al. (2011), as they also saw high levels of attrition in their TAU condition. Number of participants varied in each group, but a total of 18 individuals completed the intervention condition, while 12 individuals completed both sets of measures (T1 and T2) in the control condition. Additionally, eight individuals from the intervention condition completed follow up measures after leaving treatment (T3). The fifth round of the intervention finished with one member in both the control and intervention conditions, and it was determined that it was no longer feasible to collect data at this facility. This determination was made in concert with the clinical director for the treatment organization as well as the research assistant for this study. Attempts were made to contact additional treatment facilities regarding the continuation of the study, though no response was received. The dissertation committee for this study was consulted, and it was agreed that data collection would end with 30 participants having completed T1 and T2 data collection.
CHAPTER IV

RESULTS

The purpose of this study was to examine the effects of a self-forgiveness intervention on shame, guilt, self-forgiveness, and drug-avoidance self-efficacy for individuals in residential treatment for a substance use disorder (SUD). After reviewing relevant literature, I developed research questions and hypotheses regarding expected differences between participants in the intervention group and those who received treatment as usual (TAU). In this chapter, I will review the results of the study. I will begin by describing the data screening process and management of missing data. I will then review assumptions and descriptive statistics before summarizing the statistical analyses used for this study.

Data Screening

Following data collection, I organized participant responses into a Microsoft Excel spreadsheet. There were a total of 30 participants who completed measures at T1 and T2, with 18 individuals in the intervention group and 12 people in the TAU group. These responses were then imported into an SPSS dataset file which was subsequently used to run the analyses used in this study. I initially focused on the accuracy of the data entry, and a visual check was conducted. No inconsistencies were identified in the data, and this was confirmed after the review of box plots for scores across all variables revealed no outliers. Next, I checked the data for missing scores, and 17 individual missing points of data were identified. Six of 18 individuals in the intervention group left at least one question blank at Time 1 or Time 2. An additional four participants in the TAU group had at least one data point missing. There were no consistent patterns present in the question content that went unanswered by participants nor were there any improbable scores found in the responses. It should be noted, though, that all missing
values were found in either the Drug Avoidance Self-Efficacy Scale (DASES; Martin et al., 1995) or the State Self-Forgiveness Scale (SSFS; Wohl et al., 2008). At 16 and 17 questions respectively, these were the two longest measures participants were asked to complete. Additionally, questions 16 and 17 on the SSFS were found alone on the back of a page in the packet of measures given to participants. As three individuals left these questions blank and the questions were not notably different from others in the measure, it is assumed this was done accidentally. Fatigue when completing the measures was also considered as a possible explanation. The SSFS was the second measure in the packet completed by participants, though, and those who left the final two questions blank on the SSFS all completed the remaining measures. Only one participant left an answer blank on the demographic questionnaire, and this was regarding their use of medications for substance use disorders.

Due to the lack of a consistent pattern in missing data, cases were deleted if they had at least one missing data point in a particular measure. It was determined that strategies such as imputing the group mean for missing scores could potentially influence the results of the study due to the relatively small sample size and the potential for underestimation of error variance. Zhang (2016) notes that “mean, median and mode imputations are simple, but they underestimate variance and ignore the relationship with other variables” (p. 6). Two cases were removed from T1 SSFS, five cases were deleted from T2 SSFS, two cases were removed from T1 DASES, and two more cases were removed from T2 DASES. An additional eight participants from the intervention group completed measures at T3. Given the fact that less than half of the participants in the experimental group completed data collection at T3, it was determined that significant conclusions could not be drawn through data analysis. After consulting with the
faculty advisor for this dissertation, I decided to focus solely on the first four research questions in this study.

Skewness and kurtosis of the data was reviewed to test the assumption of normality (see Table 2). While there is some disagreement regarding acceptable ranges for these scores, recent literature suggests that scores between ±2 are indicative of a normal distribution (Demir, 2022). All skewness statistics were in the range of ±1, and all kurtosis statistics were between ±2. These results suggest that the assumption of normality was met. Skewness and kurtosis were also reviewed by treatment group. Scores all fell with the ±2 range, and normality can be assumed as a result.

**Table 2**

*Skewness and Kurtosis*

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<th>Variable</th>
<th>Skewness Statistic</th>
<th>Std. Error</th>
<th>Kurtosis Statistic</th>
<th>Std. Error</th>
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<td></td>
</tr>
<tr>
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<td>.441</td>
<td>.317</td>
<td>.858</td>
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<tr>
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<td>.833</td>
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<td>Time 2</td>
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<td>.441</td>
<td>-1.358</td>
<td>.858</td>
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</table>

To examine the assumption of homogeneity of variance (HOV), Levene’s tests were used to determine if samples had equal variances. None of these tests reached a level where \( p < .05 \), so they were deemed not to be significant. As a result, it was assumed that the population
variances across groups were equal. Assumptions related to sphericity could not be tested and could be assumed, as there are less than three levels of each factor used (Diana, 2015).

**Preliminary Analyses**

Following the screening of data and checking of assumptions, I compared mean differences in dependent variable scores by gender. While additional demographic information was collected from participants, sample size limited the analyses that could be run based on those factors. Additionally, gender was identified as particularly important for this study due to the intersecting experiences of discrimination women and people of color with substance use disorders face (Gueta, 2013; Koch et al., 2016; Rosino & Hughey, 2018). Research has also suggested that women and men exhibit different levels of shame and guilt-proneness, and these or other potential differences could influence substance use and the self-forgiveness process (Carpenter et al., 2019). A series of one-way analysis of variance tests (ANOVAs) was conducted to examine group differences by gender across four dependent variables (state shame, state guilt, state self-forgiveness, and drug avoidance self-efficacy) at two time points in time (T1 and T2). Participants self-identified with one of three listed gender identities in the demographic questionnaire: male \((n = 20)\), female \((n = 9)\), and transgender male \((n = 1)\). A significant difference was found in T1 state self-forgiveness scale scores \(F(2, 25) = 12.11, p < .001\) when comparing men and women in the study. The transgender individual was not included in this analysis due to the lack of representation in the current sample. Male participants began the study with much higher levels of state self-forgiveness \((M = 44.37, SD = 8.02)\) than did women \((M = 30.63, SD = 6.68)\). This finding suggests that there may be gender differences when it comes to one’s ability to self-forgive. These differences could be due to discrimination, stigma regarding gender roles, a person’s propensity for feeling shame or guilt, or other factors. While the
significant difference in state self-forgiveness scores at T1 by gender may have warranted separate analyses, it was determined that this separate analysis would not have been meaningful due to the small sample size. No other significant differences in scores were found between gender on any other measure. Analyses regarding differences based on race, primary substance of abuse, or other demographic variables could not be conducted due to the small sample size.

Estimates of internal consistency were also examined for each factor at both T1 and T2. Results should be interpreted with caution, though, given the small sample size. Past research has suggested that reliability scores in sample sizes of 20-30, as in the present study, are not reliable (Kennedy, 2022). Other research, though, has indicated that there may be benefits in reviewing reliability scores in sample sizes of 30 (Yurdogul, 2008). Because there were 30 total participants in the present study who completed measures at T1 and T2, analyses were conducted to analyze the internal consistency of the measures. The alpha coefficients were as follows for T1: .92 for SSFS, .92 for T1 Shame, .85 for Guilt, and .95 for DASES. For T2, the alpha coefficients were .95 for the SSFS, .91 for Shame, .80 for Guilt, and .91 for DASES. These estimates suggest that all measures have high levels of internal consistency within this sample, and the results are consistent with previous research. Reliability estimates of scores on the full-scale SFFS ranged from .79 to .94 in past studies (Cornish & Wade, 2015; Scherer et al., 2011; Wohl et al., 2008). On the SSGS, reliability estimates of scores for each of the subscales have ranged from .82 to .89 (Crocker et al., 2014; Randles & Tracy, 2013; Tangney & Dearing, 2002). Studies using the DASES scale in the past have found reliability estimates ranging from .70 to .80 (Norozi et al., 2016; Saritas & Erci; 2019).

After examining the internal consistency of the measures, relationships among the variables were explored using Pearson product-moment correlations (see Table 3). Similar to the
measures of internal consistency, these results must be interpreted with caution due to the small sample size. Recent research indicates that samples sizes of 20-30 may not be sufficiently large enough to yield stable correlation results (Kennedy, 2022). Other scholars, though, have suggested that a sample size of 30 is the minimum acceptable number of participants required to conduct correlational research (Fraenkel et al., 2012; Kaya, 2021). For this reason, correlational data were gathered. At time 2, State Self-Forgiveness scores were found to be negatively correlated with T2 Shame, \( r (26) = -0.75, p < .001 \). This suggests that as a participant’s scores on measures of self-forgiveness increased, their shame scores decreased. Conversely, T2 SSFS scores were found to be significantly, positively correlated with both T2 drug avoidance self-efficacy scores \( r (26) = 0.58, p = .003 \) and T2 Guilt, \( r (26) = 0.49, p = .011 \). This means that increases in self-forgiveness scores were associated with both higher levels of drug avoidance self-efficacy and higher levels of state guilt. This finding is in line with research suggesting that guilt can be adaptive for those engaging in a process of self-forgiveness, while shame can be very detrimental. A significant positive correlation was found between shame and guilt at T2, \( r (30) = 0.72, p < .001 \), suggesting that these variables tend to move in the same direction. This was not surprising, as past research suggests that these feelings are often experienced simultaneously (Fedewa et al., 2005; Holmstrom et al., 2021). While increased feelings of shame were found to be associated with increased feelings of guilt, their relationships with self-forgiveness and drug avoidance self-efficacy were very different. A significant moderate negative correlation was found between shame and drug avoidance self-efficacy, \( r (28) = -0.41, p = .033 \), indicating that as shame scores increased, drug avoidance self-efficacy scores tended to decrease. Interestingly, no significant correlation was found between guilt scores and drug avoidance self-efficacy scores at T2, \( r (28) = -0.11, p = .57 \).
<table>
<thead>
<tr>
<th>Measure</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. T1 SSFS</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. T1 Shame</td>
<td>- .66**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. T1 Guilt</td>
<td>- .49**</td>
<td>.73**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. T1 DASES</td>
<td>.70**</td>
<td>-.71**</td>
<td>-.51**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. T2 SSFS</td>
<td>.46*</td>
<td>-.53**</td>
<td>-.20</td>
<td>-.47*</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. T2 Shame</td>
<td>-.44*</td>
<td>.58**</td>
<td>.37*</td>
<td>-.38*</td>
<td>-.75**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. T2 Guilt</td>
<td>-.30</td>
<td>.41*</td>
<td>.49**</td>
<td>-.21</td>
<td>-.49</td>
<td>.72**</td>
<td></td>
</tr>
<tr>
<td>8. T2 DASES</td>
<td>.36</td>
<td>-.47*</td>
<td>-.06</td>
<td>.79**</td>
<td>.58**</td>
<td>-.41*</td>
<td>-.11</td>
</tr>
</tbody>
</table>

*Note.* SSFS = State Self Forgiveness Scale; DASES = Drug Avoidance Self-Efficacy Scale; Guilt = State Shame and Guilt Scale (Guilt Subscale); Shame = State Shame and Guilt Scale (Shame Subscale)  
** Correlation is significant at the .01 level (2-tailed)  
* Correlation is significant at the .05 level (2-tailed)

**Descriptive Statistics**

The mean scores and standard deviations for sample demographics and study variables are presented in Table 4. At T1, the mean score for the state self-forgiveness scale was 39.61, and at T2 it was 50.71. These scores are both noticeably higher than the mean scores at T1 (M = 25.73, SD = 12.75) and T2 reported by Scherer et al. (2011) in a study examining the effects of the same self-forgiveness intervention for individuals in treatment for an alcohol use disorder. The mean state shame scores at T1 and T2 in this study were 13.37 and 9.30, respectively. The mean state guilt score at T1 was 18.40, and at T2 it was 15.37. In a 2014 study by Crocker et al. examining body-related state shame and guilt in women, state shame and guilt scores were found to be relatively similar to those in the present study despite the difference in sample demographics: state shame (M = 15.8, SD = 4.74); state guilt (M = 13.2, SD = 5.10). Mean scores on the drug-avoidance self-efficacy scale (DASES) in the present study were 71.25 at T1 and 77.43 at T2. In a study of the experiences of 425 individuals seeking treatment for substance...
use in Iran, Norozi et al. (2016) found mean scores on the DASES to be lower than those in the present sample (M = 56.90, SD = 13.22).

Table 4

Means and Standard Deviations for Sample Demographics and Study Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>30</td>
<td>37.17</td>
<td>10.76</td>
<td>20</td>
<td>57</td>
</tr>
<tr>
<td>State self-forgiveness scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 1</td>
<td>28</td>
<td>39.61</td>
<td>10.35</td>
<td>20</td>
<td>63</td>
</tr>
<tr>
<td>Time 2</td>
<td>26</td>
<td>50.71</td>
<td>9.91</td>
<td>33</td>
<td>66</td>
</tr>
<tr>
<td>Shame scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 1</td>
<td>30</td>
<td>13.37</td>
<td>5.82</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Time 2</td>
<td>30</td>
<td>9.30</td>
<td>4.77</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Guilt scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 1</td>
<td>30</td>
<td>18.40</td>
<td>5.10</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Time 2</td>
<td>30</td>
<td>15.37</td>
<td>4.64</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>Drug avoidance self-efficacy scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 1</td>
<td>28</td>
<td>71.25</td>
<td>24.17</td>
<td>16</td>
<td>112</td>
</tr>
<tr>
<td>Time 2</td>
<td>28</td>
<td>77.43</td>
<td>18.84</td>
<td>45</td>
<td>104</td>
</tr>
</tbody>
</table>

Main Analyses

Hypothesis Testing

Mixed design ANOVAs were used to evaluate the first four of my research questions. This approach was determined to be appropriate given the presence of both within-subjects and between-subjects factors (Field, 2013). Results of this statistical method allow the researcher to identify both main effects and an interaction effect. In this study, a significant interaction effect is indicative of a difference in outcomes over time for the intervention group compared to TAU. In other words, an interaction effect suggests that as time changed from T1 to T2, there was also a change in intervention on the outcome variables. A main effect for time suggests that there was a significant difference in a dependent variable (i.e., shame, guilt, self-forgiveness, drug avoidance self-efficacy) from T1 (prior to the start of the intervention) to T2 (just following the
completion of the self-forgiveness intervention), and this change occurred regardless of the type of intervention used. A main effect for the intervention suggests that there were differences on outcome variables based on treatment, regardless of time.

**Research Question 1.** Does the addition of a self-forgiveness intervention increase state self-forgiveness beyond treatment as usual (TAU) for those with SUDs between T1 (the beginning of the intervention) and T2 (immediately following the intervention)? It was hypothesized that there would be an interaction effect between time and treatment on self-forgiveness, such that there would be greater increase in state self-forgiveness scores from T1 to T2 in the intervention group compared to the TAU.

A mixed analysis of variance (ANOVA) was used to test this hypothesis (see Table 5). The analysis showed a significant main effect for time, $F(1,23) = 19.33, p = .001, \eta^2 = 0.21$, on the state self-forgiveness score. For both participants in the intervention group and TAU, state self-forgiveness scores were found to increase during their time in treatment. No significant effects were found for the intervention group $F(1,23) = 1.99, p = .173, \eta^2 = 0.02$ or the interaction between time and therapy group $F(1,23) = 0.62, p = .441, \eta^2 = 0.02$. These results suggest that there was not a significant difference between self-forgiveness scores for those in the intervention group when compared to those in TAU. A bar chart displaying mean scores for the state self-forgiveness scale at T1 and T2 can be seen below Table 5 in Figure 1. Means and standard deviations for state self-forgiveness scores by therapy group and time can be found in Table 6.
Table 5

*Mixed ANOVA Summary Table for the State Self-Forgiveness Score (n = 25)*

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>F</th>
<th>Sig.</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between subjects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy Group</td>
<td>90.75</td>
<td>1</td>
<td>0.62</td>
<td>.441</td>
<td>.016</td>
</tr>
<tr>
<td>Error</td>
<td>3396.25</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within subjects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>997.37</td>
<td>1</td>
<td>19.33</td>
<td>.000</td>
<td>.209</td>
</tr>
<tr>
<td>Time x Therapy Group</td>
<td>102.08</td>
<td>1</td>
<td>1.99</td>
<td>.173</td>
<td>.018</td>
</tr>
<tr>
<td>Error</td>
<td>1186.92</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 1

*Clustered Bar Means for State Self-Forgiveness by Therapy Group and Time*
Table 6

*Means and Standard Deviation for the State Self Forgiveness Score by Therapy Group and Time*

<table>
<thead>
<tr>
<th>Therapy Group</th>
<th>N</th>
<th>Time 1 (SD)</th>
<th>Time 2 (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment as usual</td>
<td>10</td>
<td>40.90 (8.20)</td>
<td>47.10 (8.86)</td>
</tr>
<tr>
<td>Self-forgiveness intervention</td>
<td>15</td>
<td>40.73 (11.16)</td>
<td>52.77 (10.45)</td>
</tr>
</tbody>
</table>

**Research Question 2.** Does the use of a self-forgiveness intervention reduce state shame beyond TAU between T1 and T2? It was hypothesized that there would be an interaction effect between time and treatment conditions on shame scores. It was expected that those who completed the self-forgiveness intervention would exhibit a greater reduction in state shame scores from T1 to T2 compared to those in the TAU condition.

A mixed design analysis of variance (ANOVA) was used to test this hypothesis (see Table 7). The analysis showed a significant main effect for time, $F(1,28) = 20.04$, $p = .001$, $Ƞ^2 = 0.15$, on the shame score. For both participants in the intervention group and TAU, state shame scores were found to decrease during their time in treatment. No significant effects were found for the intervention group $F(1,28) = 0.06$, $p = .82$, $Ƞ^2 = .001$ or the interaction between time and intervention $F(1,28) = 0.29$, $p = .29$, $Ƞ^2 = .002$. These results suggest that there was not a significant difference between state shame scores for those in the intervention group when compared to those in TAU. A bar chart displaying mean scores for state shame can be seen in Figure 2. Means and standard deviations for state shame scores by therapy group and time can be found in Table 8.
Table 7

Mixed ANOVA Summary Table for State Shame (n = 30)

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>F</th>
<th>Sig.</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between subjects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy Group</td>
<td>2.50</td>
<td>1</td>
<td>0.06</td>
<td>.817</td>
<td>.001</td>
</tr>
<tr>
<td>Error</td>
<td>1283.83</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within subjects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>250.00</td>
<td>1</td>
<td>20.04</td>
<td>.000</td>
<td>.153</td>
</tr>
<tr>
<td>Time x Therapy Group</td>
<td>3.60</td>
<td>1</td>
<td>0.29</td>
<td>.289</td>
<td>.002</td>
</tr>
<tr>
<td>Error</td>
<td>349.33</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 2

Clustered Bar Means for State Shame by Therapy Group and Time
Table 8

*Means and Standard Deviation for the State Shame by Therapy Group and Time*

<table>
<thead>
<tr>
<th>Therapy Group</th>
<th>N</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment as usual</td>
<td>12</td>
<td>13.92 (5.99)</td>
<td>9.25 (3.79)</td>
</tr>
<tr>
<td>Self-forgiveness intervention</td>
<td>18</td>
<td>13.00 (5.84)</td>
<td>9.33 (5.42)</td>
</tr>
</tbody>
</table>

**Research Question 3.** Does the use of a self-forgiveness intervention reduce state guilt beyond TAU between T1 and T2? It was hypothesized that there would be an interaction effect between time and treatment conditions on state guilt scores. It was hypothesized that those who completed the self-forgiveness intervention would exhibit a greater increase in state guilt scores from T1 to T2 compared to those in the TAU condition.

A mixed design analysis of variance (ANOVA) was used to test this hypothesis (see Table 9). The analysis showed a significant main effect for time, F(1,28) = 10.57, p = .003, $\eta^2 = 0.098$, on the guilt score. For both participants in the intervention group and TAU, state guilt scores were found to decrease during their time in treatment. No significant effects were found for the intervention group F(1,28) = 0.16, p = .69, $\eta^2 = 0.004$ or the interaction between time and intervention F(1,28) = 0.01, p = .91, $\eta^2 < 0.001$. These results suggest that there was not a significant difference between state guilt scores for those in the intervention group when compared to those in TAU. A bar chart displaying mean scores for state guilt can be seen in Figure 3. Means and standard deviations for state guilt scores by therapy group and time can be found in Table 10.
Table 9

Mixed ANOVA Summary Table for State Guilt (n = 30)

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>F</th>
<th>Sig.</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between subjects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy Group</td>
<td>5.88</td>
<td>1</td>
<td>0.16</td>
<td>.690</td>
<td>.004</td>
</tr>
<tr>
<td>Error</td>
<td>1015.81</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within subjects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>134.44</td>
<td>1</td>
<td>10.57</td>
<td>.003</td>
<td>.098</td>
</tr>
<tr>
<td>Time x Therapy Group</td>
<td>0.18</td>
<td>1</td>
<td>0.01</td>
<td>.907</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Error</td>
<td>356.31</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3

Clustered Bar Means for State Guilt by Therapy Group and Time
Table 10

Means and Standard Deviation for State Guilt by Therapy Group and Time

<table>
<thead>
<tr>
<th>Therapy Group</th>
<th>N</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment as usual</td>
<td>12</td>
<td>18.08 (6.14)</td>
<td>14.92 (4.40)</td>
</tr>
<tr>
<td>Self-forgiveness intervention</td>
<td>18</td>
<td>18.61 (4.46)</td>
<td>15.67 (4.89)</td>
</tr>
</tbody>
</table>

**Research Question 4.** Does the use of a self-forgiveness intervention increase drug avoidance self-efficacy beyond TAU between T1 and T2? It was hypothesized that there would be an interaction effect between time and treatment conditions on drug avoidance self-efficacy scores. It is expected that those who complete the self-forgiveness intervention will exhibit a greater increase in drug-avoidance self-efficacy scores from T1 to T2 compared to those in the TAU condition.

A mixed design analysis of variance (ANOVA) was used to test this hypothesis (see Table 11). The analysis showed both a significant main effect for time, $F(1,24) = 6.77$, $p = .016$, $\eta^2 = .031$, on the drug avoidance self-efficacy score. For both participants in the intervention group and TAU, drug avoidance self-efficacy scores were found to increase during their time in treatment. No significant effects were found for the intervention group $F(1,24) = 0.22$, $p = .633$, $\eta^2 < .001$ or the interaction between time and intervention $F(1,24) = 2.18$, $p = .153$, $\eta^2 = .01$. These results suggest that there was not a significant difference between the change in drug avoidance self-efficacy scores for those in the intervention group when compared to those in TAU. A bar chart displaying mean scores for drug avoidance self-efficacy can be seen in Figure 4. Means and standard deviations for drug avoidance self-efficacy scores by therapy group and
time can be found in Table 12.

**Table 11**

*Mixed ANOVA Summary Table for the Drug Avoidance Self-Efficacy Scale (n = 26)*

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>F</th>
<th>Sig.</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between subjects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy Group</td>
<td>18.65</td>
<td>1</td>
<td>0.22</td>
<td>.833</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Error</td>
<td>20281.12</td>
<td>24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within subjects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>727.27</td>
<td>1</td>
<td>6.77</td>
<td>.016</td>
<td>.031</td>
</tr>
<tr>
<td>Time x Therapy Group</td>
<td>234.35</td>
<td>1</td>
<td>2.18</td>
<td>.153</td>
<td>.010</td>
</tr>
<tr>
<td>Error</td>
<td>2579.96</td>
<td>24</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 4**

*Clustered Bar Means for Drug Avoidance Self-Efficacy by Therapy Group and Time*
Table 12

*Means and Standard Deviation for the Drug Avoidance Self-Efficacy Scale by Therapy Group and Time*

<table>
<thead>
<tr>
<th>Therapy Group</th>
<th>N</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
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<td>Treatment as usual</td>
<td>11</td>
<td>72.91 (23.01)</td>
<td>76.18 (20.70)</td>
</tr>
<tr>
<td>Self-forgiveness intervention</td>
<td>15</td>
<td>67.40 (25.97)</td>
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</table>

**Summary of Findings**

The statistical analyses conducted yielded several statistically significant results. State shame and state guilt scores significantly decreased across time for all participants. Additionally, state self-forgiveness and drug avoidance self-efficacy scores were found to have significantly increased from T1 to T2 in the study for both the intervention group and treatment as usual (TAU). There was no significant difference found between the self-forgiveness intervention group and the treatment as usual group for any of the dependent variables. These finding suggest that while there may be importance in identifying interventions for those in treatment for substance use disorders which reduce shame and guilt while increasing self-forgiveness and drug-avoidance self-efficacy, the addition of a self-forgiveness intervention to TAU in this study did not significantly improve outcomes more than an inpatient treatment program using a comprehensive, biopsychosocial model.
CHAPTER V
DISCUSSION

This chapter will review the findings of this study and their implications. I will begin by discussing the results that were presented in Chapter 4 and exploring their connection to the current literature regarding self-forgiveness and substance use. I will then identify potential applications of the findings before reviewing limitations of the study and suggestions for future research.

Research Findings

The purpose of the present study was to examine the effects of a self-forgiveness intervention on state shame, guilt, self-forgiveness, and drug avoidance self-efficacy for individuals in residential treatment with substance use disorders (SUDs). Mortality rates related to substance use and associated societal costs in the United States continue to rise, and the need for more effective treatment methods is clear (Caulkins et al., 2014). Previous research suggests that increased feelings of shame are positively correlated with problematic substance use (Dearing et al., 2005; Luoma et al., 2019; Rahim & Patton, 2015; Stuewig et al., 2015). While past findings indicate that there may be some prosocial outcomes related to guilt, shame tends to be much more counterproductive (Gueta, 2013; McGaffin et al., 2013; Tangney et al., 1996). Substances can be used as a coping mechanism and method of avoidance, particularly when one is feeling ashamed (Luoma et al., 2012). This is especially relevant for those with SUDs, as this pattern can become cyclical and very difficult to exit. Limited research regarding this topic suggests that self-forgiveness may be helpful for those in outpatient treatment with alcohol use disorders (AUDs) due to its influence on the harmful effects of shame (Scherer et al., 2011).

It is unclear, however, if these results are generalizable to a diverse group of individuals
in residential treatment with substance use disorders (SUDs). Qualitative findings by Gueta (2013) regarding the experiences of Israeli women with substance use disorders (primary drug of choice was heroin) suggest that self-forgiveness process may be different based on a person’s identity factors (e.g., race, ethnicity, gender, sexual orientation) and substance used, but no quantitative studies have examined this. McGaffin and colleagues (2013) also focused on the self-forgiveness experiences of individuals with SUDs, though their sample was predominantly comprised of Australian men. Additionally, they were focused on the relationship between trait shame and guilt and dispositional self-forgiveness, and data was only gathered at one point in time.

Only one prior study has explored the effects of a self-forgiveness intervention on state shame, guilt, and self-forgiveness for people with SUDs (Scherer et al., 2011). This was the first intervention study focused on self-forgiveness, and they were specifically interested in the experiences of those receiving outpatient care for AUDs. As residential and outpatient treatment models have been shown to lead to differing outcomes, it was important to determine if their findings could be extended to people in inpatient facilities (Stahler et al., 2016). Scherer and associates (2011) found that the self-forgiveness intervention they used led to significant increases in self-forgiveness scores over time when compared to TAU in a sample of individuals with AUDs. Those increases in self-forgiveness were shown to be significantly associated with increased drinking refusal self-efficacy and decreased state shame and guilt (Scherer et al., 2011). The intervention used in the Scherer et al. study was employed in this dissertation to determine if their results could be replicated and extended to a more diverse group of individuals with both alcohol and other substance use disorders receiving inpatient care. My goal in the current study was to add to the body of literature regarding self-forgiveness and substance use by
comparing the effects of a specific self-forgiveness intervention on state shame and guilt, state self-forgiveness, and drug avoidance self-efficacy for those in residential treatment with SUDs to participants receiving treatment as usual (TAU). This is the first identified time a self-forgiveness intervention has been studied in an inpatient substance treatment facility. I also wanted to better understand potential differences in experiences based on a person’s identity factors (i.e., race, gender) and primary substance used.

**Self-Forgiveness Outcomes**

My first hypothesis posited that there would be an interaction effect between time and treatment on self-forgiveness. It was expected that individuals in the self-forgiveness intervention group would report a greater increase in state-self forgiveness scores from T1 to T2 than those randomly assigned to treatment as usual (TAU). Results indicated that there was not a significant difference between the change in scores for participants in the intervention group and those in TAU, though there was a main effect for time on state self-forgiveness. This means that state self-forgiveness scores did significantly increase over time for those in both groups. The increase in state self-forgiveness scores seen in this dissertation was expected due to past research and highlights the need for additional studies focused on self-forgiveness for those in recovery with SUDs (Gueta, 2013; Ianni et al., 2010; McGaffin et al., 2013; Peterson et al., 2017; Scherer et al., 2011). There was a greater increase in scores from T1 to T2 for those in the intervention group at T2, but the difference did not rise to the level of statistical significance. It is possible that these results were influenced by the small sample size in the TAU group, though findings suggest that further research regarding self-forgiveness and substance use is warranted.

The self-forgiveness intervention used by Scherer and colleagues (2011) was not found to be any less effective at increasing self-forgiveness than TAU in the current sample. Additionally,
state self-forgiveness scores at T2 were positively and significantly correlated with drug avoidance self-efficacy scores in this study. It is important to note, though, that there are differences when comparing results found by Scherer and associates to those in this study. Scherer and colleagues found a significant interaction between condition and time, such that participants in the self-forgiveness group reported greater increases in state self-forgiveness than did those in the wait list control group. Interestingly, the self-forgiveness scores went down slightly from T1 to T2 for those in TAU in that study, while they increased for those in the intervention condition.

One explanation for this reduction in self-forgiveness scores for those in TAU is that the “powerlessness inherent in twelve-step groups” and some treatment models, especially in the past, could conflict with the idea of forgiving one’s self (Herndon, 2001, p. 7). The first step in many treatment programs involves admitting powerlessness and acknowledging an inability to manage one’s life (Herndon, 2001). Attention is often given to acknowledging flaws and seeking help from others, and this could help explain the reduction in TAU self-forgiveness scores across time. While Enright (1996) highlighted the importance of taking responsibility for one’s actions, individuals may have had trouble doing this without an understanding of how to cope with their feelings or make desired changes. It is possible that the self-forgiveness intervention used by Scherer and associates helped to provide a unique coping mechanism for participants that did not exist in TAU.

The differences in findings between Scherer and colleague’s study and this dissertation could also be attributed to differences in the treatment provided and participant demographics, as the participants in that study were receiving treatment at an outpatient facility. If the inpatient treatment in the present study more directly or effectively encouraged participants to engage in
self-compassion and self-forgiveness than did the outpatient TAU in the study conducted by Scherer and associates, that could explain the difference in outcomes. Members of the TAU group in the current study may have also felt more supported and less ashamed, as they were living in a facility in which support was provided and exposure to societal stigma was limited. This could have mitigated those initial feelings of powerlessness and supported self-forgiveness in a way that participants in the Scherer and colleagues’ study did not experience. Additionally, participants in the study conducted by Scherer and associates received the intervention over the course of three weeks, while those in the present study completed the three self-forgiveness groups in one week. Those in the present study had less time to both internalize the information being taught and settle into early recovery, and this could account for the lack of significant differences seen between the intervention and self-forgiveness groups.

**Self-Forgiveness and Shame**

My second hypothesis was that individuals in the self-forgiveness intervention condition would report a greater reduction in state shame scores from T1 to T2 than those who were in the TAU group. This hypothesis was not supported by the results, as no significant interaction effect was found between time and treatment condition. There was, however, a main effect for time on state shame. Significant reductions in shame were reported by all participants from T1 to T2, but there was not a significant difference between the two conditions.

These findings differ from those in the Scherer et al. (2011) study, as participants in the self-forgiveness condition in their study reported significantly greater reductions in shame than those in TAU. The self-forgiveness intervention does not appear to be any less effective at reducing shame than TAU in the present study. It is possible, though, that changes in perceptions and legislation regarding substance use and treatment over the past 10 years led to differences in
the TAU conditions between the two studies that are not solely explained by the outpatient inpatient distinction. Notably, “the Patient Protection and Affordable Care Act (ACA) of 2010 required covered plans to offer SUD benefits as an essential Health Benefit,” and funding allocated by Congress for addiction treatment increased from only $1 billion in 2016 and 2017 to $6 billion in 2018 and 2019 (Richter et al. 2019, p. 116). People in the United States have had increased access to treatment as a result, and it is likely that TAU at both inpatient and outpatient facilities has evolved as well. Additionally, the prevalence of the opioid epidemic has led to changing levels of awareness for both the general public and treatment providers, and these factors could explain the differences in findings between this dissertation and the study by Scherer and colleagues (Skolnick, 2018). If the inpatient TAU in the present study more effectively addressed feelings of shame than did the outpatient TAU condition in the Scherer et al. study, that could explain the difference in findings.

It is also possible that the inclusion of participants with a range of SUDs, rather than focusing solely on alcohol use, could help to explain the differences in findings between this dissertation and the study conducted by Scherer and colleagues (2011). A number of individuals in the current study identified opioids as the reason they had sought treatment, and opioids are often more highly stigmatized than other substances (Stuart, 2019; Kennedy-Hedricks et al., 2017). Past research has suggested that race, substance of abuse, and the type of treatment provided are all important factors to consider when exploring shame and treatment outcomes, though the sample size obtained for this study did not allow for further analysis across these dimensions (Stahler et al., 2016). Future studies should be mindful of these variables and focus more directly on understanding the ways in which one’s experience in treatment may vary due these factors. Additionally, Scherer and colleagues used the Personal Feelings Questionnaire
(PFQ-2; Harder & Lewis, 1987) to measure state shame and guilt, while this dissertation utilized the State Shame and Guilt Scale (SSGS; Marschall, 1994; Saftner, & Tangney, 1994). Consistency in the measurements used to study these constructs in the future would be helpful.

Findings from the present study help to support conclusions previous research has drawn regarding the importance of addressing feelings of shame for those with substance use disorders. Feelings of shame decreased in the present study for all individuals, and this seems to be an important component of recovery. State shame scores at T2 were also negatively correlated with drug avoidance self-efficacy and state self-forgiveness scores at T2, which was expected based on previous research. Ianni et al. (2010) found shame to be a significant predictor of problematic alcohol use, while participants in Gueta’s (2013) study reported that shame can be particularly problematic for those seeking treatment for a substance use disorder. Similarly, McGaffin et al. (2013) found that shame-proneness may limit self-acceptance and increase feelings of distress by keeping those in recovery focused on their discomfort. While results from this dissertation suggest that shame is important to address for individuals in recovery, the self-forgiveness intervention used in the current study was not more effective than TAU at decreasing shame. More research is needed to understand the relationship between state shame and success in recovery for those with SUDs, though it seems clear that an individual’s self-image plays a role in their treatment experience.

**Self-Forgiveness and Guilt**

My third hypothesis was that there would be a significant interaction effect between time and treatment conditions on state guilt scores. Participants in the self-forgiveness condition were expected to exhibit a greater reduction in state guilt scores from T1 to T2 than those completing TAU. This hypothesis was not supported by the results. Similar to this study’s findings
regarding shame and self-forgiveness, a significant change in state guilt was found for participants from T1 to T2. While individuals in both groups reported a reduction in feelings of guilt across time, there was not a significant difference between the conditions. These results differ from those in the Scherer et al. (2011) study, as they found a significant interaction between condition and time. Participants assigned to the self-forgiveness condition in the Scherer and colleagues’ study reported decreases in guilt from T1 to T2, while guilt scores for those in TAU increased slightly across time. As was discussed for the first two hypotheses, potential differences in TAU between the two studies may help to explain these conflicting outcomes. While the self-forgiveness intervention was standardized and TAU for both studies occurred at treatment facilities in the Midwest, the experiences of participants assigned to TAU in the two experiments were likely very different.

Participants in the Scherer and colleagues’ study were enrolled in outpatient treatment, and those in the current study were living at a residential facility. If the focus in the outpatient TAU was on accepting that one is powerless and flawed without discussing the importance of acknowledging past transgressions and the difference between one’s actions and self-image, one could expect that feelings of guilt would initially increase. It seems that those in the intervention group may have learned how to cope with those feelings in a different way than those in TAU, which could explain the difference in state guilt scores. Additionally, participants in the Scherer and associates’ study were potentially continuing to interact with those they may have harmed in active addiction, as they were receiving outpatient care. Without the framework of the self-forgiveness intervention and the relative protection and isolation of residential treatment, TAU participants in that study may have experienced increased feelings of guilt in a way that those in residential care do not.
Based on the findings of this study, though, it is unclear how the reduction in guilt scores may have influenced a person’s ability to self-forgive or feel capable of avoiding future substance use. Previous research has suggested that guilt-prone individuals are more likely to forgive themselves, while there is a negative relationship between shame proneness and self-forgiveness (McGaffin et al., 2013). Other studies focused on self-forgiveness and substance use have not explored feelings of guilt and their effects on the recovery process (Gueta, 2013; Ianni et al., 2010; Peterson et al., 2017). There was a significant, positive relationship between state guilt and shame at T2 in the present study, but there was not a significant correlation between state guilt and any other construct at T2 in this study. State guilt at T1 was significantly, negatively correlated with drug avoidance self-efficacy and state self-forgiveness at T1, but this relationship was no longer present at T2. It seems that participants in both conditions in the present study learned how to cope with feelings of guilt, but conclusions could not be drawn in this dissertation regarding reductions in state guilt and any potential influence on the self-forgiveness or recovery processes. It is important to note that guilt-proneness and state guilt are slightly different constructs, and different measures and statistical analyses were used in the studies discussed. Additional research focused on better understanding the relationship between state guilt and success in recovery is warranted.

**Self-Forgiveness and Drug Avoidance Self-Efficacy**

My fourth hypothesis focused on drug avoidance self-efficacy. I expected that there would be an interaction effect between time and treatment conditions on drug avoidance self-efficacy scores, such that participants who completed the self-forgiveness intervention would exhibit a greater increase in self-efficacy regarding their ability to avoid substance use from T1 to T2 than those in TAU. This hypothesis was not supported by the results, though a main effect
for time was found. There were increases in drug avoidance self-efficacy for both groups (and a larger increase in the self-forgiveness intervention group), though there was not a significant difference between conditions when comparing change over time. These findings differ from the results detailed by Scherer and colleagues (2011), as they identified a significant interaction between condition and time for drinking refusal self-efficacy scores. While these scores increased for both groups in the study conducted by Scherer and associates, participants in the intervention group reported higher drinking refusal self-efficacy at T2 than did those in the TAU condition.

The differences between this dissertation and the Scherer and colleagues (2011) study could be explained by a number of factors. Though the goal of drug avoidance self-efficacy and drinking refusal self-efficacy measures are to quantify one’s belief in their ability to maintain their sobriety moving forward, experiences in treatment are likely dependent to some degree on an individual’s primary substance of abuse (Stahler et al., 2016). Information received in the inpatient, TAU condition in the current study may also have been more effective at providing participants with effective coping mechanisms and psychoeducation regarding their ability to make changes in their life when compared to the outpatient care provided in study conducted by Scherer and associates. Additionally, participants in both conditions in the current study may have been more ready to cease their substance use than those in the Scherer and colleagues’ study. As inpatient care has been associated with higher levels of severity, all participants may have been more likely to feel as though they had reached their “bottom.” This bottom and the accompanying loss of resources has been identified as a motivating factor for those seeking and receiving care, and there may have been a different desire to maintain sobriety and belief in their ability to do so as a result (Gruszczynska et al., 2016). It is notable, though, that the standardized
self-forgiveness intervention used in both studies was found to be correlated with a reduction in both drinking refusal and drug avoidance self-efficacy.

Long-Term Effects

I made four additional hypotheses in an attempt to examine whether or not any changes made on the dependent variables (shame, guilt, self-forgiveness, and drug avoidance self-efficacy) would be maintained following the completion of the intervention. That is, I expected that improvements would be maintained from T2 to T3 on each of these constructs, as this would have supported the findings of Scherer et al. (2011). In the Scherer and colleagues’ study, participants in the intervention condition maintained their intervention induced changes from T2 to T3 (no significant changes were reported) for guilt, self-forgiveness, and drinking refusal self-efficacy. Additionally, the same participants exhibited a continued reduction in shame scores even after the completion of treatment. In the present study, the limited number of responses received at T3 did not allow for statistical analysis of the data. Including these data in the final analysis would have reduced the usable sample size, and any comparison of mean differences could have allowed for inaccurate or misleading conclusions to be drawn. As a result, it is unknown if improvements seen for those in the intervention condition were maintained after treatment.

Limitations

There are several limitations to consider when reviewing the results of this study. As has been mentioned, the sample size in this study was small and retention of participants was an issue. This was expected, as previous research has highlighted the fact that “SUD samples typically suffer from high attrition” (Luoma et al., 2014, p. 206). Rates of attrition in the current study were similar to those seen in substance treatment studies conducted over the past 50 years.
Lappan et al., 2019). The rate of attrition in this study was also similar to research carried out by Scherer and colleagues (2011), though they began with a larger number of participants. As a result of the small sample, there is a chance that significant results that may have existed were not identified. While I did not find a significant interaction effect between time and condition, it is possible that a larger sample size would have led to a different conclusion.

The limited number of participants also meant that I was unable to meaningfully examine differences based on primary substance of abuse. Alcohol and opioids were most commonly listed as the primary substances of abuse in the current sample, while a number of other participants identified multiple substances as the reason they were seeking treatment. Recovery from certain substances, such as opioids, can necessitate the use of specific medications such as methadone and suboxone. While effective, these medications can also be highly stigmatized (Bart, 2012; Olsen & Sharfstein, 2014). Not only can the treatment for SUDs be different, but the experiences of those seeking care may differ due to the substances used. Some substances, such as alcohol, are legal and widely available, while others are illegal and highly stigmatized. As a result, levels of shame and a person’s ability to self-forgive may vary drastically. For this reason, future research should be conducted on a larger and more diverse sample of individuals who are in treatment for a wide range of SUDs.

Similarly, there was not enough data to determine whether differences existed for participants based on the number of times that they have been to treatment. Nearly two-thirds of the sample endorsed having some prior treatment experience. It is possible that some people felt increased shame and guilt due to their repeated attempts at recovery, while others may have felt more prepared and familiar with the treatment process given past experiences. Ensuring that a large enough sample is gathered to determine whether number of treatment attempts effects
outcomes will be necessary in future studies.

It is also important to be mindful of sample demographics when considering the generalizability of the findings. Both the research assistant for this study and the majority of the participants identified as male and White, and data was collected at an inpatient treatment facility in the Midwest. Additionally, the majority of adults with SUDs do not seek or receive treatment in the United States, so the current sample is not representative of all individuals with substance use disorders in the U.S (Paquette et al., 2022). These factors may limit generalizability to other treatment settings such as intensive outpatient treatment programs, 12 step meetings, jails, or prisons. Findings may also be different based on the geographic area in which research was conducted and the fact that this study was carried out during the Covid-19 pandemic. Attempts were made to obtain a larger and more diverse sample size, but the pandemic and retention issues were significant barriers to these efforts.

When initially searching for a treatment facility in which I could collect data, I reached out to seven different providers over the course of multiple months. The hope was that I would be able to collect data in multiple locations and build a large and diverse sample of participants. Four sites indicated that it was not possible for me to collect data due either to the Covid-19 pandemic or other organizational regulations, and I did not receive a response from two more locations despite multiple attempts to contact them over the course of a number of months. One organization was willing to allow me to conduct research in their facility, and it was determined that the was the only option for me to collect data. Additional attempts were made following data collection at this facility to find one more location in which the intervention could be implemented, but these attempts were unsuccessful. After consulting with the dissertation committee, it was determined that my small sample size would have to be a limitation of my
study. Studies in the future would benefit from collection of data at a variety of treatment locations with more diverse participants and group facilitators.

The small sample size was also problematic when attempting to collect and analyze data at T3. This required responses from participants after they had completed inpatient treatment, and less than half of the individuals in the intervention group completed this process. It was expected that there would be some issues with T3 data collection, but the small starting sample size meant that there was not enough data to determine what changes occurred, if any, from T2 to T3. Implications regarding the long-term benefits of the self-forgiveness intervention could not be determined, and this would be important information given the relapse rates for those with substance use disorders. Building in a T3 data collection time point for both the intervention group and those in TAU could be a helpful extension of both this study and Scherer et al. (2011).

**Implications**

The results of this study have implications for future research regarding both self-forgiveness and the treatment of substance use disorders. The primary findings from the current study were that the use of a self-forgiveness intervention led to similar significant reductions in shame and guilt and increases in self-forgiveness and drug avoidance self-efficacy when compared to TAU. It appears that the inclusion of the standardized self-forgiveness intervention for those in residential treatment supports the self-forgiveness and recovery processes for those with SUDs. This is a notable extension of previous research, as this is the first identified time that a self-forgiveness intervention has been tested with a group of participants who are seeking inpatient treatment for both alcohol and other substance use disorders.

While there was not a significant difference between TAU and the intervention group in this study, findings from both TAU and the self-forgiveness group seemed to emphasize the
importance of reducing feelings of shame for those in recovery from all substance use disorders. Drug avoidance self-efficacy scores were negatively correlated with state shame scores for all participants at T2, while there was no significant relationship between state guilt and drug avoidance self-efficacy at T2. These findings suggest that as feelings of shame decreased in the current study, participants felt more capable of avoiding substance use in stressful and/or celebratory environments in the future. Despite significant correlations between state shame and guilt scores in this sample, it appears that the effects of these constructs on participants were different. These findings help to support past research regarding the harmful effects of shame and its relationship with substance use (Dearing et al., 2005; Luoma et al., 2019; Rahim & Patton, 2015; Stuewig et al., 2015). Perceptions of substance use and those with SUDs are changing to focus less on the attribution of substance use to personal weakness and more on “clients’ responsibility and empowerment”, though the stigma individuals experience both while in treatment and in active addiction can still be quite harmful (van Boekel et al., 2015, p. 546). For clinicians who may still conceptualize substance use through the use of a moral model or feel that shame is a helpful motivator, the results of this and other studies highlight the importance of a more empathic, nonjudgmental approach (Lee & Zerai, 2010). Whether this involves the use of harm reduction or just an intentional focus on understanding, rather than judging, strategies that minimize and/or reduce shame seem to be quite important for those in recovery (Blume & Lovato, 2010).

Additionally, findings from the present study align with previous research suggesting that self-forgiveness may be a helpful approach when addressing feelings of shame for those in recovery with SUDs (Gueta, 2013; Ianni et al., 2010; McGaffin et al., 2013; Peterson et al., 2017; Scherer et al., 2011). While there was not a significant difference between groups in the
change of state self-forgiveness scores from T1 to T2, scores for all participants did rise significantly from T1 to T2. Additionally, state self-forgiveness scores at T2 were significantly and positively correlated with T2 drug avoidance self-efficacy scores. These results suggest that self-forgiveness may be both an important component of the recovery process and a construct that needs additional research.

In addition to implications regarding the recovery process for individuals in treatment with SUDs, this study also helps to highlight potential areas of growth for clinicians and training programs. The low treatment utilization by individuals with SUDs has been well documented, and the barriers to treatment include both practical ones (i.e. cost, availability) and those related to the experience they expect to have in treatment (Paquette et al., 2022). Expectations that individuals will be shamed, have success in treatment defined for them, and feel disempowered are just some examples of barriers that exist (Blume & Lovato, 2010, Lee & Zerai, 2010, Paquette et al., 2022). A willingness to broaden treatment objectives and treat those who use substances in a less stigmatizing and shaming way could lead to drastic changes in the experiences of those seeking care. This is particularly important in the field of counseling psychology as overdose rates continue to increase and the need for competent providers grows.

The treatment of substance use disorders is an issue of both social justice and diversity, two features often identified as most central to the future identity of counseling psychology (Taylor et al., 2018). Despite this need, those in training do not feel as though they are receiving adequate training to provide care to those with SUDs (Madson et al., 2008). Martin et al. (2016) notes that “counseling psychologists can bring their developmental, vocational, and strength-based lenses to better understand the role that alcohol and other substance use plays in life transitions to inform the development of empirically based prevention and intervention” (p.
This is not possible, though, if individuals in the field do not understand how to effectively support individuals with SUDs. Even for those who do not intend to focus on the treatment of SUDs, counseling psychologists can expect to meet with individuals with substance related concerns when providing general outpatient therapy (Martin et al., 2016). These reasons, combined with the results of this study, highlight the need for more comprehensive training methods regarding the treatment of SUDs for counseling psychologists.

The results of this study also emphasize the continuing need for self-forgiveness and substance treatment research which examines the different experiences of individuals based on their identity factors, primary substance used, and/or the type of treatment received. For example, in the current study, male identified participants were found to have entered the study with much higher levels of state self-forgiveness than did female identified individuals. While it is not possible to draw a definitive conclusion about this difference, previous literature suggests that women experience different cultural and social expectations which may influence their ability to self-forgive (Gueta, 2013). Women seeking treatment often “encounter images help by society (and often by themselves as well) of the alcoholic or drug-dependent woman as a ‘fallen woman’ incapable of living up to the image of a responsible person/mother” (Hecksher & Hesse, 2009). Mothers who are struggling with substance use are regularly portrayed as “monstrous moms,” and in some cultures they may be rejected by both society and institutions purporting to provide care (Frazer et al., 2019; Gueta, 2013). Additionally, the patriarchal nature of society and many treatment programs can be particularly damaging for those who do not identify as cisgender men (Herndon, 2001). Further research should focus on better understanding the experiences of women and gender minorities in treatment with SUDs.

It is also likely that there are differences in treatment outcomes based on racial identity,
sexual orientation, and primary substance of abuse (Stahler et al., 2016). Previous research has indicated that people of color in the United States, and Black people in particular, often have difficulty accessing treatment for substance use disorders (Lo & Cheng, 2011). Even when treatment can be accessed, White people are more likely to complete a round of treatment than African American or Hispanic individuals (Mennis & Stahler, 2016). Rarely is treatment adapted and tailored specifically to the “unique needs and cultural perspectives of clients of color” (Blume & Lovato, 2010, p. 189.). Similar conclusions have been drawn regarding the experiences of sexual minorities in treatment, as past research has highlighted experiences of discrimination and access to care issues for individuals who identify as a member of the LGBTQIA+ community (McCabe et al., 2013). In addition to these factors, individuals often have vastly different experiences based on their primary substance of abuse (Stahler et al., 2016). Individuals with opioid use disorders may experience particular difficulty due not only to stigma associated with their use of illicit substances, but also with treatments such as buprenorphine or methadone (Bart, 2012; Olsen & Sharfstein, 2014). In the present study, the homogenous demographics of the sample did not allow for additional analysis to determine whether differences were present based on these factors. A larger sample size and more diverse participants are needed to determine whether the effectiveness of the self-forgiveness intervention can be more broadly generalized.

**Conclusion**

This study found that individuals in treatment with substance use disorders reported significant decreases in shame and guilt and increases in self-forgiveness and drug avoidance self-efficacy over time, but their experiences did not differ based on their participation in a self-forgiveness intervention. The self-forgiveness intervention appeared to be as effective as TAU at
influencing the feelings of those in treatment, though it is unclear if the gains seen were maintained over time. Results suggest that the ability to self-forgive contributes to a decrease in shame and guilt and an increase in drug avoidance self-efficacy for those in residential treatment with an SUD. These findings indicate that the shaming and stigmatization of individuals with substance use disorders is counterproductive to their well-being and recovery, and self-forgiveness interventions may be important to include in all forms of treatment. Ultimately, more research is needed to fully understand the role of self-forgiveness in the recovery process.
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Appendix A

Participant Demographic Questionnaire
Participant Demographic Questionnaire

Instructions: Please answer each question below by filling in the blank or the bubble next to the answer you would like to choose.

1. What is your age?
   - 18 – 24
   - 25 – 34
   - 35 – 44
   - 45 – 54
   - 55 – 64
   - 65 +

2. Please indicate your racial/ethnic background
   - White
   - Black or African-American
   - Latino/a or Hispanic
   - American Indian or Alaskan Native
   - Asian American
   - Native Hawaiian or Other Pacific Islander
   - From multiple races/ethnicities: Please specify __________
   - Some other race or ethnicity: Please specify_____________

3. What is your current employment status?
   - Employed, working full time (40 hours a week)
   - Employed, working part-time
   - Unemployed

4. What was your total household income for all of 2019?
   - Under $29,999
   - $30,000 - $49,999
   - $50,000 - $74,999
   - $75,000 - $99,999
   - $100,000 - $149,999
   - $150,000 - $199,999
   - $200,000 or More

5. What level of education have you completed?
   - Some high school
   - High school/GED
   - Some college
   - Associate’s degree
   - Bachelor’s degree
   - Some graduate school
6. What is your gender identity?
   - Male
   - Female
   - Transgender Male
   - Transgender Female
   - Other. Please specify
   - Prefer not to say

7. What is your sexual orientation?
   - Straight (heterosexual)
   - Gay/Lesbian
   - Other. Please specify
   - Prefer not to say

8. How many days has it been since you entered treatment for a substance use disorder?
   Please write answer below.

   ____________________________________________

9. How many times previously have you been to treatment for a substance use disorder?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5 +

10. Main substance used:
    - Alcohol
    - Opioids (ex: Heroin, hydrocodone, oxycodone, morphine, hydromorphone)
    - Benzodiazepines (ex: Xanax, Ativan, Valium, Klonopin)
    - Cannabinoids (Marijuana)
    - Barbiturates (ex: Bulbatil, pentobarbital)
    - Hallucinogen (ex: LSD, psilocybin mushrooms)
    - Stimulants (ex: cocaine)
    - Inhalants (ex: solvents, aerosols)

11. Are you using medications for substance use disorders (MOUDs) as a part of your treatment?

12. Are you mandated to be in treatment? If so, by who?
    Please specify ________________________________
Appendix B

State Self-Forgiveness Scale (SSFS) – (Wohl et al., 2008)
**State Self-Forgiveness Scale (SSFS) – (Wohl et al., 2008)**

**Instructions:** Please think about a significant incident in which you feel you committed a wrong that harmed someone else. This event should be something for which you have taken responsibility. Take a moment to consider the circumstances of the situation and remember details of your actions. Please do not write about details of the event. Rather, think about the feelings you have in the moment regarding this incident while completing the questionnaire.

1 = Not at all   2 = At all   3 = Mostly   4 = Completely

<table>
<thead>
<tr>
<th><strong>Self-Forgiving Feelings and Actions (SFFA)</strong></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>1. As I consider what I did that was wrong, I feel compassionate toward myself.</td>
<td></td>
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<tr>
<td>2. As I consider what I did that was wrong, I feel rejecting of myself. (R)</td>
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<tr>
<td>3. As I consider what I did that was wrong, I feel accepting of myself.</td>
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<tr>
<td>4. As I consider what I did that was wrong, I feel dislike toward myself. (R)</td>
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<tr>
<td>5. As I consider what I did that was wrong, I show myself acceptance.</td>
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<tr>
<td>6. As I consider what I did that was wrong, I show myself compassion.</td>
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<td>7. As I consider what I did that was wrong, I punish myself. (R)</td>
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<td>8. As I consider what I did that was wrong, I put myself down. (R)</td>
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</table>

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<thead>
<tr>
<th><strong>Self-Forgiving Beliefs (SFB)</strong></th>
<th>1</th>
<th>2</th>
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<th>4</th>
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</thead>
<tbody>
<tr>
<td>9. As I consider what I did that was wrong, I believe I am acceptable.</td>
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<tr>
<td>10. As I consider what I did that was wrong, I believe I am okay.</td>
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<tr>
<td>11. As I consider what I did that was wrong, I believe I am awful. (R)</td>
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<tr>
<td>12. As I consider what I did that was wrong, I believe I am terrible. (R)</td>
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<td>13. As I consider what I did that was wrong, I believe I am decent.</td>
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<tr>
<td>14. As I consider what I did that was wrong, I believe I am rotten. (R)</td>
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<tr>
<td>15. As I consider what I did that was wrong, I believe I am worthy of love.</td>
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<tr>
<td>16. As I consider what I did that was wrong, I believe I am a bad person. (R)</td>
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</table>
As I consider what I did that was wrong, I believe I am horrible. (R)

SFFA Score: __________
SFB Score: __________
Appendix C

State Shame and Guilt Scale (SSGS) – (Marschall et al., 1994)
State Shame and Guilt Scale (SSGS) – (Marschall et al., 1994)

Instructions: The SSGS is a self-rating scale of in-the-moment (state) feelings of shame, and guilt experiences. Ten items (five for each of the two subscales) are rated on a 5-point scale Likert scale. The following are some statements which may or may not describe how you are feeling right now. Please rate each statement using the 5-point scale below. Remember to rate each statement based on how you are feeling right at this moment.

<table>
<thead>
<tr>
<th>Not feeling this way at all</th>
<th>Feeling this way somewhat</th>
<th>Feeling this way very strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I want to sink into the floor and disappear.</td>
<td>1------2------3------4------5</td>
<td></td>
</tr>
<tr>
<td>2. I feel remorse, regret.</td>
<td>1------2------3------4------5</td>
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<tr>
<td>3. I feel small.</td>
<td>1------2------3------4------5</td>
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<tr>
<td>4. I feel tension about something I have done.</td>
<td>1------2------3------4------5</td>
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<tr>
<td>5. I feel like I am a bad person.</td>
<td>1------2------3------4------5</td>
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<tr>
<td>6. I cannot stop thinking about something bad I have done.</td>
<td>1------2------3------4------5</td>
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<tr>
<td>7. I feel humiliated, disgraced.</td>
<td>1------2------3------4------5</td>
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<tr>
<td>8. I feel like apologizing, confessing.</td>
<td>1------2------3------4------5</td>
<td></td>
</tr>
<tr>
<td>9. I feel worthless, powerless.</td>
<td>1------2------3------4------5</td>
<td></td>
</tr>
<tr>
<td>10. I feel bad about something I have done.</td>
<td>1------2------3------4------5</td>
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</tbody>
</table>

Scoring Each scale consists of 5 items:
Shame - Items 1, 3, 5, 7, 9
Guilt - Items 2, 4, 6, 8, 10
All items are scored in a positive direction.

Total Shame (25 max): __________
Total Guilt (25 max): __________
Appendix D

Drug Avoidance Self-Efficacy Scale (DASES) – (Martín et al., 1995)
Drug Avoidance Self-Efficacy Scale (DASES) – (Martin et al., 1995)

Instructions: Please select a response for each question, indicating what you would be likely to do in each situation. Use the rating scale below.

1 = Certainly no
2 = Very likely no
3 = probably no
4 = Really can’t say
5 = Probably yes
6 = Very likely yes
7 = Certainly yes

<table>
<thead>
<tr>
<th>Question</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>Imagine that you are going to a party where you will meet new people.</td>
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<td>You feel that drug/alcohol use will relax you and make you more</td>
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<td>confident. Could you avoid drug/alcohol use?</td>
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<td>Imagine that you have just blown a good job, you are home alone and</td>
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<td>depressed. Would you give in to the urge to take drugs/alcohol which</td>
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<td>are in the house?</td>
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<td>Imaging that you are home with a loved one, and feeling angry after a</td>
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<td>fight. You want to make up, but at the same time you want to get</td>
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<td>stoned/loaded. Could you resist the urge to take drugs/alcohol?</td>
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<td>Imagine that you are feeling good and have not responsibilities for</td>
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<td>a couple of days. The only thing you see against getting a bit</td>
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<td>stoned/loaded is that you have promised yourself you would go straight</td>
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<td>for 2 months and you still have 3 weeks to go. Would you take</td>
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<tr>
<td>drugs/alcohol?</td>
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<td>Imagine it is late, you cannot sleep and drugs/alcohol are available</td>
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<td>in the house. You have decided not to use drugs. Could you resist the</td>
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<tr>
<td>urge to use drugs to help you get to sleep?</td>
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<td>Imagine that a new job is starting tomorrow, you are going out with</td>
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<td>friends and expecting a good time. Could you resist the urge to</td>
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<tr>
<td>celebrate with drugs/alcohol?</td>
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<tr>
<td>Imagine that you are home with your loved one, and very angry after a</td>
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<td>fight. You are tempted to get back at your partner by getting stoned/</td>
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<td>loaded. Would you give in to the temptation?</td>
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<td>Imagine that a very important relationship has just ended, and you are</td>
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<td>very depressed. Would you give in to the urge to take drugs/alcohol?</td>
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<td></td>
<td>Imagine that you have run into 2 friends who are celebrating $100 lottery win with drugs/alcohol. Could you resist their urging to join them in drug/alcohol use?</td>
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<tr>
<td>9.</td>
<td>Imagine that you are at a party and feeling uptight. Most people seem to be having a good time. You are tempted to use drugs/alcohol to loosen up. Would you?</td>
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<tr>
<td>10.</td>
<td>Imagine that you promised yourself to stay straight for 2 months but you have just blown your 5 week record with one hit or drink. Would this situation lead you to take a second one?</td>
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<tr>
<td>11.</td>
<td>Imagine that you had managed to stay straight for a near record time, but last night you blew it. Because of last night you are feeling weak. Would you take drugs/alcohol tonight?</td>
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<tr>
<td>12.</td>
<td>Imagine that you are home alone and depressed. Could you resist the urge to go out and find some drugs/alcohol?</td>
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<tr>
<td>13.</td>
<td>Imagine that a good friend has accused you of being insensitive. Now you are feeling hurt and tempted to use drugs/alcohol. Could you resist?</td>
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<tr>
<td>14.</td>
<td>Imagine that a good friend is feeling miserable. He wants you to join him in heavy discussion and drug/alcohol use to pick his spirits up. Could you resist the urge to take drugs/alcohol?</td>
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<tr>
<td>15.</td>
<td>Imagine that you are home alone; it is a dull weekend with nothing in particular to look forward to. You are bored. Would you give in to the urge to get stoned/loaded?</td>
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<td>16.</td>
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Appendix E

Self-Forgiveness Intervention: Leader Manual – (Scherer et al., 2011)
Self-Forgiveness Intervention: Leader Manual – (Scherer et al., 2011)

Materials Required

The following materials will be required throughout the course of the intervention:

- One *Forgiveness and the Bottle* Participant intervention manual per participant
- Consent forms and questionnaires for all participants
- One role of paper tape
- One (non-permanent) black marker
- Pens for all participants.

**Arrival, Consent, and Questionnaires (30-35 minutes)**

Participants will arrive and sign in (get contact information- phone number, mailing address, email address) for workshop. Introduce yourself if necessary. Briefly explain purpose of consent form and read over it with them. After they sign, give them questionnaire packet to fill out.

Collect completed questionnaires.

**Wait List control group:** Group leader will perform consent form prior to administering questionnaires. In wait list control group, participants are to complete questionnaires and continue alcohol treatment as usual. Group leader is to explain that the self-forgiveness intervention will take place in four weeks to establish a baseline in the questionnaires. Participants must complete questionnaires at all three time intervals for the duration of the study. After the four weeks have passed the intervention will be identical to the one administered to the immediate treatment condition (described in detail below).

**Immediate Treatment:** When participants are all done filling out questionnaires, collect them and then pass out name tags and participant manual. Introduce yourself to the entire group again (if necessary) and explain procedures for intervention workshop.

*First, I’d like to thank each of you for participating in this workshop. The goal of our work together will be to foster self-forgiveness within each of you and reduce any feelings of guilt and shame you may be experiencing from your previous history of alcohol or drug use, misuse, or abuse. Together, we will find out about and understand what holds us back from forgiving ourselves and to learn some ways that we can start to forgive ourselves. Everyone has things they feel guilt or shame about, so I think you’ll get a lot out of this workshop.*

*We’ll be spending about 4 hours over three group sessions learning about self- forgiveness, discussing related topics, and doing some experiential activities. When we’re finished, I’ll be asking you to complete another questionnaire like the one you completed earlier. Your contribution in answering our questions about this workshop will help us refine it and improve upon it, so we really appreciate you taking the time to participate in the workshop and fill out all our questionnaires.*
Answer any questions that they might have regarding consent, filling out questionnaires, etc.

**Confidentiality Discussion (2-3 minutes)**

Instruct the group that all personal information shared during this workshop should be treated as confidential. For example, if someone discusses a transgression they committed against someone else (e.g., arguing, insulting, etc.) other group members should not discuss that specific situation with people outside of the group. Emphasize that participants should only share information within the group setting that is both pertinent to the discussion and that they are comfortable sharing.

**Introductions and Icebreaker: Activity 1 (15-20 minutes)**

Introduce yourself by telling us your:
Leader should go first to model a brief and appropriate introduction

1) Name  
2) **BRIEF** description of why you feel it is important to forgive yourself. 3) One interesting thing about yourself

*Okay, great. Thank you. Now, when you were filling out our questionnaires, we asked you a lot of questions about shame and guilt and forgiveness. Let’s take a little time to flesh out exactly what those things mean. First, what do you think shame or self-condemnation is?*

**Group Discussion: Defining shame or self-condemnation**

- Ask participants what their definition of self-condemnation is?  
- Why is self-condemnation bad or unhealthy? How?

  - Explain that self-condemnation (or shame) is negative feelings we have towards ourselves when we feel that we have done something morally objectionable → we feel that we are not living up to our own standards. That is, because we did these morally objectionable things, we are bad people. This is unhealthy because it may lead to poor self-esteem, self-efficacy, and depression and anxiety all of which increase our chances for relapse.

**Group Discussion: Defining guilt or remorse**

- What is the difference between guilt and self-condemnation?  
- Is guilt a bad or unhealthy thing?

  - Explain that remorse (or guilt), though often enmeshed with self-condemnation, can actually have positive benefits. Primarily, remorse requires us to take responsibility for our actions and can then lead us to make amends to others we have wronged.
Importantly, the underlying message for remorse is “I have done a bad thing,” unlike self-condemnation, where the underlying message is “I am a bad person.”

Group Discussion: Defining forgiveness

- What is forgiveness?
- Does forgiving mean forgetting?
- How can forgiving ourselves help us when it comes to alcohol or drug use?

Explain that forgiveness, generally defined, is replacing negative feelings toward yourself (e.g., anger, shame, hatred, bitterness) with more positive and constructive feelings (e.g., acceptance, responsibility, efficacy). It does not mean forgetting, which is essential for accepting responsibility for our actions. By promoting self-forgiveness, we promote feelings of self-acceptance and self-efficacy which may reduce our likelihood of relapse. Importantly, what prevents us from forgiving ourselves, is self-condemnation.

The Problem of Self-Condemnation- Self-forgiveness assessment: Activity 2
(approx. 20-30 minutes)

- Explain self-condemnation- negative feelings we have towards ourselves when we feel that we have done something morally objectionable → we feel that we are not living up to our own standards.
- Split group into pairs. In pairs, they discuss how their offense was against their morals in some way, and the specific feelings they have when they think about their own offense (i.e., anger, sadness, shame, fear, etc.)
- Self-forgiveness assessment: Supply a piece of tape. Ask participants to line up on one side of the room and walk out in front of them.

Imagine this is a representation of how much self-forgiveness you feel right now. Imagine that there are 10 spaces here. If someone felt very condemning towards themselves, they would not feel very forgiving, so they might say they are right here (step 2-3 steps in front of the group) in a scale of 10 for forgiving themselves for their offense. If they were very forgiving of themselves, they might walk further (step 8-9 steps in front of the group). Right now, decide where you are on this scale. Where you’re standing right now is the ZERO LINE, now step out to where you are at forgiving yourself. Mark that spot with the tape.

- After participants have marked the floor ask them to have a seat and refer participants Worksheet # 1 in their packets. Ask them to think about the questions for a moment.

Now I’d like to go around the room and have each of you talk briefly about why you chose that spot on the self-forgiveness ruler and what two spots ahead of your spot would look like. For example, if you chose a five (step to where a five would be on the floor) explain why you didn’t choose a seven (step to seven). Specifically, how would a seven look different from a five? How would you know you’ve reached a seven?
• Go around the room and have each participant talk about these points. This is very important, so all participants must answer the questions thoroughly.

Okay, great. Thank you. The goal of this workshop is not to achieve complete and total forgiveness, but rather reduce the amount of self-condemnation you feel. Our goal, here together, is to get each of you to move forward two steps on the self-forgiveness ruler. That may not mean complete self-forgiveness, but it will mean less self-condemnation.

Effects of Self-Condensation discussion
(10-15 minutes)

• Large group discussion: Dealing with self-condemnation

How can we deal with these feelings of self-condemnation? What have you tried? (example: accept it and move on, forbearing, excusing ourselves, justifying our behavior, thinking I’ve suffered enough so justice has been done)

• List ways of dealing with self-condemnation that group identifies. After they are exhausted, ask for tally of how many people have tried each tactic.
• How did this work for you? What category do you think this belongs in? Attempt to categorize their list- avoidance, punishing self, justifying excusing, ruminate, forgiving self, etc.

Out of these ways of dealing with self-condemnation, what would be the best way? As you can see, there are many ways to deal with self-condemnation. Some effective, some not. Self-forgiveness is just one way of dealing with self-condemnation.

Identifying Our Values: Activity 3
(approx 15-20 minute)

• Break into pairs and refer participants to Worksheet #2 in their packets

Imagine you had to create a newspaper personal ad, or an internet personal ad and all you could post was 5 values that define you. How would you choose to create a picture of yourself? In the space in your manual write a personal ad that you feel adequately represents your top 5 values. Be sure to use “I” statements when composing the ad, and then answer the two questions below. After you have both completed the ad and questions, discuss what you wrote with your partner.

• Discuss in pairs
• Discuss as large group. Go around the room and have everybody list the values they wrote down. Discuss what themes the participants noticed in the personal ads. What kind of values did people in the group seem to share?
Okay, great. We’ve just spent some time talking about what our most salient values are. These values are how we identify ourselves and are what we want others to see when they look at us. Because these are our most important values, when they are violated we might feel ashamed and experience self-condemnation. How has drinking or using drugs violated these values? Take a few moments to discuss this with your partner.

- Give participants 5-10 minutes to discuss with partner, then discuss as a group.

Recalling the Hurt: Activity 4  
(approx. 25-30 minutes)

Often our offenses (or wrongs) affect more than just ourselves. Our decisions can affect many people. What compounds feelings of self-condemnation and other negative feelings is that our offenses contradict our values, so we find ourselves morally objectionable. To begin to resolve these complicated feelings effectively, we first need to spend some time recalling the hurt and how it influenced others as well as ourselves.

- Break into pairs and refer participants to Worksheet #3 in their packets

First, draw yourself in the center of the circle in your worksheet. You can use stick figures if you like, but be sure and label their names. Up until now, we have only been briefly discussing our offenses. Now, I would like you to speak about the offense you’ve been thinking about in great detail with your partner. As you do this, think about who else was affected by your offense, and how closely they were involved. As you think of each person affected by your offense, draw them into the circle. The more affected they were by it the closer to the center you should draw them. Remember, go into as much detail as possible when describing the specific offense to your partner.

- Process in larger group
  - What are their personal values that were involved with the offense?
  - How important are those values to their self-concepts? How important are they to how they see themselves?
  - What do they think would be necessary for them to forgive themselves?
  - Cognitive interventions- discuss what may be unrealistic standards or expectations (people should not be “should-ing all over themselves”).
  - Discuss automatic thoughts, thinking errors, and reality testing
Forgiving the Self- Empty Chair Exercise: Activity 5  
(approx. 30 -40 minutes)

Have participants break up into pairs again. Have participants turn their chairs to face one another. While both partners will do the exercise, one will stand and observe while the other uses both chairs for the activity.

When people feel self-condemnation or shame, it may feel like their skin is branded with their offense. They may feel like they are bad people for what they’ve done, and all the world can see it. For this next activity, you’re going to have a chance to begin to remove that brand from your skin. For this activity, you are going to take both sides of your argument. First, I want you to sit in your chair here (sit down and demonstrate) and talk to this chair, here, as if another you were sitting in it. There actually won’t be anybody sitting there, so you’ll be imagining that the empty chair is filled. When you sit in your chair, talk to your other self – who is sitting in the other chair - as if they deserve to feel the shame you do for what they’ve done. Make the best argument you can for why you should NOT forgive yourself. When you feel that you have said enough, and explained why you should not forgive yourself for your offenses, I want you to switch chairs (now switch seats). Now, while you are in this chair, you take the opposite viewpoint. You are now going to respond to that other self, the one who told you why you should not forgive yourself and make the best argument you can as to why you SHOULD forgive yourself.

If you’re the observing partner, you should just stand, observe, and pitch in an idea if your partner gets stuck talking about why he or she SHOULD forgive themselves.

When you feel you’ve said enough, switch with your partner so they can also take both sides of their argument and you can observe.

- Process in large group. While the group is discussing what it was like to do this exercise, pass around the non-permanent black marker and instruct participants to write a 3-4 word description of the offense on their hands.
- The discussion should focus on what was it like being on both sides? How was it to come up with reasons to forgive and not forgive yourself?

Okay, great. Thank you. Now you’ve spent some time logically thinking about why you need to forgive yourself. Why you deserve to forgive yourself. To forgive yourself, you need to wash your hands of the offense. Each of you has written the offense on your hands as a metaphor. One at a time, I would like each of you to go and wash your hands of the offense.

Ask participants to go wash the description of the offense off of their hands.

You may have noticed that even though you’ve washed your hands of the offense, it’s still there. It’s not as clear, but it is certainly still there. This is also the case with forgiving yourself for your offense. You won’t get rid of it all at once, and it may take several washings, but if you keep working on forgiving yourself, eventually, you won’t see the offense anymore.
Commitment to Self-Forgiveness: Activity 6  
(approx. 10-20 minutes)

- Large group discussion.
  o Draw a graph with many highs and lows, illustrating that self-forgiveness is not a one-shot deal, but it is a process. As a process, there will be times that you feel more or less forgiving of yourself for your offenses.
  o Discuss how we accept ourselves as human beings who can fail, and do imperfect things? (write down ideas as people come up with them)
  o Are some of these ideas better for some times than other times? When would you want to use each strategy?
  o Pick three strategies that you can use to hold onto your self-forgiveness when you feel less forgiving of yourself, and in the space in your manual, write these down in Worksheet 4.

Hold On to Self-Forgiveness: Activity 7  
(approx. 5 minutes)

Finally, we need to hold on to our self-forgiveness. We need to accept that we are flawed and imperfect as everyone is. While we need to accept responsibility for our actions, we also accept that we will commit other offenses in the future. That does not make us less worthwhile or bad people. That just makes us people. Now, please look at the letter of forgiveness at the back of your packet. Because saying something is much more significant that merely thinking it, I ask that you please read it out loud with me.

I am a person who has – as all people have – committed offenses unto myself and others. Despite this, however, I am worthy of the same love and respect that I give to others. I am a human being and therefore I may stumble and fall, and fail at things. Sometimes I will not live up to my own standards. Yet, though flawed, I am worthwhile. I can accept myself as a flawed person.

On this day, I forgive myself for one occurrence when I stumbled and failed to live up to my own standards. I accept that because I am flawed, this will happen again, and yet I know that I am a worthwhile person and deserve forgiveness.

There will be times when I feel less forgiving of myself. When those times arise, I have strategies to deal with them and use them to hold onto my forgiveness and the positive feelings towards myself, because I am a worthwhile person and deserve forgiveness.

Now, please sign the letter and hold on to it to remind yourself in the future of the things we talked about here today.
Letting Go of the Bad: Activity 8
(approx 15-20 minutes)

Congratulations!!

If you’re ready now, we have one more activity to do. Now it’s time to refer back to the ruler we looked at when we started in Worksheet 1. We’ve talked about committing to self-forgiveness and holding onto it when we feel less forgiving. Think about where you are going to commit to going in your process of self-forgiveness, and mark that spot on your ruler and tell us, based on what we’ve talked about in this group, how you’re going to do that.

- Large group discussion. Have each member of the group briefly talk about strategies he or she will use to forgive himself or herself and hold onto that forgiveness.
- Ask each member of the group what they learned and what they liked best about the group experience. As the leader, you should rephrase and reflect back each person’s statements.
Participant Worksheets

Worksheet 1
Self-Forgiveness Ruler

<table>
<thead>
<tr>
<th>No forgiveness</th>
<th>Complete Forgiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1   2   3   4</td>
<td>5   6   7   8   9   10</td>
</tr>
</tbody>
</table>

Why did you pick the spot on the ruler that you did?

What would two places below your spot look like? How are you thinking, feeling and behavior better than two spots below?

What would two places above your spot look like? How would your thoughts, feelings and actions be different than where you are now?
Worksheet 2
Personal Ad

Imagine you had to create a newspaper or internet personal ad and all you could post was 5 values that define you. How would you choose to create a picture of yourself? Be sure to use “I” statements.

Which of the values you listed would you describe as being the most important to you? Why?

How have you demonstrated these values in your personal life?
Worksheet 3
Recalling the Hurt

Because we don’t live in social bubbles, when we commit an offense we often hurt others besides ourselves. First, draw yourself in the center of this circle. Then, as you think about your wrong-doing, draw others in the circle. The close to you (and to the center) you draw the person, the more they were affected by the offense.

What personal values of yours were involved in the offense you described above?
Worksheet 4
Committing to Forgiveness

List some reasons why you deserve to forgive yourself for the offense so you can look back on them in the future.

Because how we feel about ourselves (and how likely we are to feel forgiving toward ourselves) may go up and down, it is important to deal with unforgiving emotions when they come up and accept ourselves as imperfect people who will make mistakes. List some ways you accept that you are an imperfect person who will make mistakes and that that is okay. This is how you will hold onto your self-forgiveness.
Letter of Self-Forgiveness

I am a person who has – as all people have – committed offenses unto myself and others. Despite this, however, I am worthy of the same love and respect that I give to others. I am a human being and therefore I may stumble and fall, and fail at things. Sometimes I will not live up to my own standards. Yet, though flawed, I am worthwhile. I can accept myself as a flawed person.

On this day, I forgive myself for one occurrence when I stumbled and failed to live up to my own standards. I accept that because I am flawed, this will happen again, and yet I know that I am a worthwhile person and deserve forgiveness.

There will be times when I feel less forgiving of myself. When those times arise, I have strategies to deal with them and use them to hold onto my forgiveness and the positive feelings towards myself, because I am a worthwhile person and deserve forgiveness.
Appendix F

Self-Forgiveness Intervention: Participant Manual – (Scherer et al., 2011)
Self-Forgiveness Intervention: Participant Manual – (Scherer et al., 2011)

Arrival, Consent, and Questionnaires
(30-35 minutes)

- Go over and sign consent forms and complete questionnaires.
- Collect completed questionnaires.
- Answer any questions you might have about the study, questionnaires, consent, or anything else.

Confidentiality Discussion
(2-3 minutes)

All personal information shared during this workshop should be treated as confidential. For example, if someone discusses a transgression they committed against someone else (e.g., arguing, insulting, etc.) you should not discuss that specific situation with people outside of the group. You should only share information within the group setting that is both pertinent to the discussion and that they are comfortable sharing.

Introductions and Icebreaker: Activity 1
(15-20 minutes)

Introduce yourself by telling us your:
Leader should go first to model a brief and appropriate introduction

1) Name
2) BRIEF description of why you feel it is important to forgive yourself. 3) One interesting thing about yourself

Group Discussion: Defining shame or self-condemnation
- Self-condemnation (or shame) is negative feelings we have towards ourselves when we feel that we have done something morally objectionable.

Group Discussion: Defining guilt or remorse
- Remorse (or guilt), though often enmeshed with self-condemnation, can actually have positive benefits. The underlying message for remorse is “I have done a bad thing,” unlike self-condemnation, where the underlying message is “I am a bad person.”

Group Discussion: Defining forgiveness
- Forgiveness is the replacement of negative emotions with positive ones. It does not mean forgetting, but rather accepting responsibility for your actions and allowing yourself to move on.

The Problem of Self-Condemnation- Self-forgiveness assessment: Activity 2 (approx. 20-30 minutes)
• Self-condemnation- negative feelings we have towards ourselves when we feel that we have done something morally objectionable we feel that we are not living up to our own standards.
• In pairs, discuss how your offense was against your morals in some way, and the specific feelings you have when they think about your own transgression (i.e., anger, sadness, shame, fear, etc.)
• Self-forgiveness assessment

Effects of Self-Condemnation discussion
(10-15 minutes)

• Large group discussion: Dealing with self-condemnation
• Listing ways of dealing with self-condemnation that group identifies.

Identifying Our Values: Activity 3
(approx 15-20 minute)

• Break into pairs and refer to Worksheet #2 at the end of your packet
• Discuss in pairs
• Discuss as large group
• Discuss how drinking or drugs have led you to violate some of your values. Discuss with partner, then discuss as a group.

Recalling the Hurt: Activity 4
(approx. 25-30 minutes)

• Break into pairs and discuss Worksheet #3 at the end of your packet
• Process in larger group
  o What are your personal values that were involved with the offense?
  o How important are those values to your self-concepts? How important are they to how you see yourself?
  o What do they think would be necessary for you to forgive yourself?
  o What may be unrealistic standards or expectations?

Forgiving the Self- Empty Chair Exercise: Activity 5
(approx. 30 -40 minutes)

Break up into pairs again. Take turns conducting empty chair exercise. You will both do the exercise, while partner does the exercise, the other will observe and support when necessary.

• Process in large group.
• Washing your hands of the offense.

Commitment to Self-Forgiveness: Activity 6
(approx. 10-20 minutes)
• Large group discussion.
  o How can we accept ourselves as human beings who can fail, and do imperfect things?
  o Are some of these ideas better for some times than other times? When would you want to use each strategy?
  o Pick three strategies that you can use to hold onto your self-forgiveness when you feel less forgiving of yourself, and in the space in your manual, write these down in Worksheet 4.

  **Hold On to Self-Forgiveness: Activity 7**
  *(approx. 5 minutes)*

  **Letting Go of the Bad: Activity 8**
  *(approx. 15-20 minutes)*

Large group discussion

  • Briefly describe strategies you will use to forgive yourself and hold onto forgiveness.
  • What have you learned and like (or dislike) about the group experience.
Participant Worksheets

Worksheet 1
Self-Forgiveness Ruler

No forgiveness          Complete Forgiveness

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Why did you pick the spot on the ruler that you did?

What would two places below your spot look like? How are you thinking, feeling and behavior better than two spots below?

What would two places above your spot look like? How would your thoughts, feelings and actions be different than where you are now?
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How have you demonstrated these values in your personal life?
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Because we don’t live in social bubbles, when we commit an offense we often hurt others besides ourselves. First, draw yourself in the center of this circle. Then, as you think about your wrong-doing, draw others in the circle. The closer to you (and to the center) you draw the person, the more they were affected by the offense.

What personal values of yours were involved in the offense you described above?
Worksheet 4
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Because how we feel about ourselves (and how likely we are to feel forgiving toward ourselves) may go up and down, it is important to deal with unforgiving emotions when they come up and accept ourselves as imperfect people who will make mistakes. List some ways you accept that you are an imperfect person who will make mistakes and that that is okay. This is how you will hold onto your self-forgiveness.
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On this day, I forgive myself for one occurrence when I stumbled and failed to live up to my own standards. I accept that because I am flawed, this will happen again, and yet I know that I am a worthwhile person and deserve forgiveness.

There will be times when I feel less forgiving of myself. When those times arise, I have strategies to deal with them and use them to hold onto my forgiveness and the positive feelings towards myself, because I am a worthwhile person and deserve forgiveness.
Appendix G

Participant Consent Form
You are invited to participate in this research project titled “Self-Forgiveness and Recovery for Individuals with Substance Use Disorders.”

STUDY SUMMARY: This consent form is part of an informed consent process for a research study, and it will provide information that will help you decide whether you want to take part in this study. Participation in this study is completely voluntary and you may choose to stop participating at any time. The purpose of the research is to examine the effects of a three session, 4.5 hour self-forgiveness intervention on feelings about the self and treatment outcomes for adults with substance use disorders and will serve as Michael Saltzman’s dissertation research for the requirements of the doctor of philosophy in Counseling Psychology. To take part in the research, you will be asked to participate in the group workshop or treatment as usual (TAU) and respond to survey items related to feelings about the self and thoughts regarding substance use.

If you are assigned to the self-forgiveness condition, your time in the study will take approximately 5 hours. If you are assigned to participate in the self-forgiveness group, the workshop will take place across three 90-minute sessions, and surveys will take approximately 15 minutes to complete. You will complete surveys three times: once prior to beginning the group, once after the final group session, and the final time three weeks after group has ended. If you are participating in TAU, you will be asked to complete surveys in your normal treatment groups at the same points in time as those in the self-forgiveness condition. The completion of these surveys should take approximately 15 minutes to complete (45 minutes total). Surveys will be administered online for the final administration.

Possible risks and costs to you for taking part in the study may be feelings of discomfort participating in group and answering questions related to your experiences with guilt and shame. Additionally, the time that it takes to participate in group and complete surveys may be a possible cost to you. If you are assigned to the self-forgiveness condition, you will be required to replace approximately five hours of your regular group programming (TAU) with the self-forgiveness group. Potential benefits from taking part in this study may be new learnings about the self from participation in the group workshop as well as helping to provide important information to inform treatment options for individuals in treatment for substance use disorders. Individuals in the TAU condition may not receive some of these potential benefits, though they still have the opportunity to contribute to the literature regarding self-forgiveness and substance use disorders. Your alternative to taking part in the research study is not to take part in it.
The following information in this consent form will provide more detail about the research study. Please ask any questions if you need more clarification and to assist you in deciding if you wish to participate in the research study. You are not giving up any of your legal rights by agreeing to take part in this research or by signing this consent form. After all of your questions have been answered and the consent document reviewed, if you decide to participate in this study, you will be asked to sign this consent form.

**What are we trying to find out in this study?**
We are trying to find out if participating in a group workshop about self-forgiveness influences feelings about the self and whether the group is helpful in the treatment of substance use disorders.

**Who can participate in this study?**
Adults participating in the residential treatment program for substance use disorders (SUDs) at Skywood Recovery Center are eligible for participation in this study. Minors, individuals who are still completing the detoxification process and are not yet participating in the regular group sessions provided at Skywood, individuals under guardianship, and people who are in their last week of treatment will not be eligible to participate in this study.

**Where will this study take place?**
The Self-Forgiveness Group will take place at Skywood Recovery Center in Augusta, MI. Data will be collected just before the start of the first group meeting, just after the third group meeting, and three weeks after the end of the workshop. The first two rounds of data collection will occur at Skywood through the use of paper surveys. These surveys will be provided by the research assistant and group facilitator for this project, Jordan Horan, M.A. Once completed, the surveys will be collected and placed in a lockbox that will be stored at Skywood in a locked room. The final round of data collection will take place electronically three weeks after treatment has concluded. You will be asked to fill out a postcard containing a link to an online survey that will be mailed to you following completion of the group intervention.
What is the time commitment for participating in this study?
For those of you who are assigned to the self-forgiveness condition, the time commitment for participating in this study is approximately five hours. The self-forgiveness workshop consists of three 90-minute group meetings (3.5 hours), and the completion of surveys at three points in time should take around 15 minutes each time (45 minutes total). Only the third round of data collection requires a time commitment in addition to the time already committed to group participation in treatment at Skywood. If you are participating in TAU, you will be asked to complete surveys in your normal treatment groups at the same points in time as those in the self-forgiveness condition. The completion of these surveys should take approximately 15 minutes to complete (45 minutes total). No further time commitment will be required for those of you in the TAU condition. Surveys will be administered online for the final administration. The completion of the online survey at this time should take approximately 15 minutes. Information will be gathered from you over the course of four and a half weeks.

What will you be asked to do if you choose to participate in this study?
If you choose to participate in this study, you will be asked to either complete treatment as usual or a self-forgiveness intervention workshop while at Skywood Recovery Center. Not all individuals will have the opportunity to complete the self-forgiveness group intervention. You will be randomly assigned to one of the two treatment conditions: TAU or Self-Forgiveness. If you are assigned to the self-forgiveness group, you will be asked to participate in a number of activities. These activities are designed to help you address feelings of shame and guilt while developing a better understanding of those emotions. If you are assigned to the self-forgiveness group, the intervention begins with introductions and a conversation regarding confidentiality. A group discussion then occurs in which shame, guilt, and forgiveness are defined and explored. Next, the focus shifts to the problem of self-condemnation, and participants work in pairs to discuss the ways that past offenses conflict with your morals or values. An activity is used to help you illustrate where you are in the process of self-forgiveness and how you would like your relationship with self-forgiveness to change, and time is then spent identifying values that are important to you. You are then encouraged to consider your past actions, discuss them with a partner, and identify who you have harmed (including yourself and others). Attention is then focused on forgiving the self, and exercises are used to help you think about self-forgiveness. Whether you are assigned to the TAU group or the Self-Forgiveness group, you will also be asked to fill out surveys at three points in time.
What information is being measured during the study?
The purpose of this study is to examine the effects of a three session, four-and-a-half hour self-forgiveness group intervention on success in treatment among a sample of U.S. adults with substance use disorders (SUDs). Measures will be used to gather information about your feelings of shame, guilt, self-forgiveness, and drug avoidance self-efficacy. A demographic questionnaire will be used to gather information including race, socioeconomic status (SES), gender identity, sexual orientation, age, number of days in treatment, substances used, and whether or not you are mandated to be in treatment (yes or no).

What are the risks of participating in this study and how will these risks be minimized?
You may experience some discomfort when engaging if assigned to the self-forgiveness intervention, as it requires the examination of a past transgression as well as feelings of shame and guilt. It is also important for you to be aware that the self-forgiveness condition is conducted in a group format, so confidentiality cannot be guaranteed. The importance of confidentiality and a commitment to maintaining it will be discussed at the start of the group, and all information gathered from you during the study will be kept in a locked and confidential location at Skywood. The risk associated with participation in this intervention is no greater than other group formats in which their treatment occurs. In addition to rules about confidentiality at Skywood, the intervention used in this study begins with a confidentiality discussion. During this discussion, expectations of confidentiality are identified, and participants are reminded to share information within the group setting that is both relevant to the group discussion and that they are comfortable sharing. Participants will be able to stop the survey at any time to minimize the potential risk and discomfort associated with disclosing sensitive information. Participants will be protected because the data will be de-identified and protected. Data collected at T1, T2, and T3 will be linked by a unique participant ID code. As such, no personal information related to other aspects of participants’ treatment at Skywood will be connected to data collected for this study.

What are the benefits of participating in this study?
Participants may be expected to indirectly benefit from this study due to general feelings of reward for being able to help with this research regarding treatment options for individuals with SUDs. Important benefits of this research include potential reduction of shame and guilt for participants, as well as an increase in self-forgiveness and drug-avoidance self-efficacy.

Are there any costs associated with participating in this study?
No costs will be incurred by you if you choose to participate in the study.

Is there any compensation for participating in this study?
You will be entered in a raffle to win one of four $50 Amazon gift certificates for completing the study.
Who will have access to the information collected during this study?
During data collection, the physical copies of the measures will be kept in a locked file cabinet at Skywood. Only the student co-investigator, Michael Saltzman, the principal investigator, Dr. Eric Sauer, and the research Assistant, Jordan Horan, will have access to the information collected during the study. Data will then be collected from the participating treatment facility and saved to the student co-investigator’s password protected computer for analysis. Data will be stored at WMU for a minimum of three years after the close of the study. Data will be saved in the principal investigator's (Dr. Eric Sauer) locked office in the Department of Counselor Education and Counseling Psychology, accessible by the co-student investigator and principal investigator.

What will happen to my information collected for this research project after the study is over?
After information that could identify you has been removed, de-identified information collected for this research may be used by or distributed to investigators for other research without obtaining additional informed consent from you.

What if you want to stop participating in this study?
Should you have any questions prior to or during the study, you can contact the principal investigator, Dr. Eric Sauer, at (616) 822-1185 or eric.sauer@wmich.edu, or the student investigator, Michael Saltzman, at (812) 449-3244 or michael.g.saltzman@wmich.edu.

You may also contact the Chair, Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.

This consent document has been approved for use for one year by the Western Michigan University Institutional Review Board (WMU IRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

I have read this informed consent document. The risks and benefits have been explained to me. I agree to take part in this study.

Please Print Your Name

Participant’s signature  Date
Appendix H

Human Subjects Institutional Review Board Approval
Date: August 30, 2021

To: Eric Sauer, Principal Investigator
Michael Saltzman, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: IRB Project Number 21-04-28

This letter will confirm that your research project titled “Opioid Use Disorders and Self-Forgiveness” has been approved under the full category of review by the Western Michigan University Institutional Review Board (IRB). The conditions and duration of this approval are specified in the policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may only be conducted exactly in the form it was approved. You must seek specific board approval for any changes to this project (e.g., you must request a post approval change to enroll subjects beyond the number stated in your application under “Number of subjects you want to complete the study”). Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the IRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: August 29, 2022

The Western Michigan University Institutional Review Board approved a renewal until August 29th, 2023.