HEALING SHAME WITH
THE TWELVE STEP PROGRAM

by

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HEALING SHAME WITH
THE TWELVE STEP PROGRAM

by

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ABSTRACT

This research explored how participation in the spiritually-based Twelve Step program, which unconditionally supports human worth, helps to heal toxic shame.

Initially the researcher assessed impressions gained through group experiences without the knowledge of the group. Subsequently, a questionnaire containing nineteen key questions was mailed to twenty-six subjects with a cover letter which proposed a relationship between shame and addiction. The questionnaire was designed to inventory two key issues. The first issue was Twelve Step participation and the second was identification of shame-based responses and/or behaviors of which the respondent might have been unaware. The inventory was constructed to assist the respondent in making the appropriate connections between his or her shame-based behaviors and how Twelve Step participation affected those behaviors. The results were then examined question by question to determine the percentage of responses for each question.

The average time reported as spent in recovery was 10.85 years ranging from two to forty-one years. All of the respondents regularly participated in some kind of Twelve Step work. Over 75 percent of the subjects could relate to feelings of shame as part of their disease, and over 75 percent reported that Twelve Step participation had helped heal their shame. Many respondents indicated in the narrative portion of their answers that although they continued to experience shame and manifest shame-based behaviors, their Twelve Step involvement helped to modify both the shamed responses and the resultant behaviors.
DEDICATION

To Carolyn, Rusty, Jim and Chris ... who teach me every day that life is precious even though it is often painful.
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CHAPTER 1

THE PROBLEM

Introduction to the Study

The study was undertaken to investigate the rationale that feelings of toxic shame, which reflect an attitude of individual unworthiness, were perpetuated by spiritual deprivation. Further, the Twelve Step program, which focuses on spiritual growth and unconditionally supports human worth, effectively counteracts the psychological condition known as shame.

Background

The researcher had a personal and professional awareness of the issues of shame and addiction and the overwhelming price that is paid by those who continue their addictive behaviors. The Twelve Step program, which originated as Alcoholics Anonymous, is an international fellowship of thousands of men and women who joined together to solve their common problems and to support fellow sufferers of alcoholism and other addictions (Pittman, 1988). The Twelve Steps are a group of spiritual principles, which, when practiced as a way of life, appear to effectively reduce or remove the obsession to rely on mood-altering substances and/or experiences. That such an apparently simplistic program is as effective as it is in counteracting a potentially life-threatening disease or situation is a difficult concept for most to grasp. The idea that
men and women choose to meet with one another at appointed times and openly discuss their life situations and personal shortcomings seems abhorrent to many and "unprofessional" to not a few; yet the Twelve Step tradition of "rigorous honesty" is recognized and supported by the psychotherapeutic community as a valid method of emotional healing.

The Twelve Step program is an effective coping mechanism in the struggle to maintain sobriety in that the dynamics of the program support the healing of shame. Additionally, it is used as an effective antidote to the debilitating psychological condition of toxic shame. This is evidenced by the growing number of recovering individuals who regular participate in this program and by the increasing number of addiction treatment centers which utilize the Twelve Step program as a platform for recovery (Alcoholics Anonymous, 1988).

**Synopsis of the Problem**

This research explored how toxic shame reflects an attitude of individual unworthiness perpetuated by spiritual deprivation, and how the regular practice of the spiritually based Twelve Step program and participation in Twelve Step support groups helped to heal the psychological scars of shame that perpetuate the addictive cycle.
**Purpose of the Study**

The purpose of this study was to show that working a Twelve Step program supported the recovery process for the shame-based addict by fostering spiritual growth which effectively interrupted the cycle of shame and addiction.

**Theoretical Basis**

The theoretical basis for this study was found in the work of Nathanson, Bradshaw and Mellody who state that addiction is one of the most common responses to shame. The healing of shame therefore would lead to increased sobriety.

**Significance of the Study**

The study was significant in that it examined a spiritual approach to the following psychological issues: The sources of shame, how shame recreates itself in the patterns of addiction, and how shame and addiction can be healed in a program based on spiritual principles found in the Twelve Step program.

**Operational Definition of Terms**

**Addictive Relationships:** Those relationships that are based on unresolved shame issues.

**Alcoholic:** Any person whose life has been adversely affected by his or her reliance on alcohol.

**Addiction:** Any reliance by an individual on a mind-altering substance, experience or person.
Al-Anon: A Twelve-Step program that concerns itself with the recovery and well-being of persons who are dealing with the problems incurred while in a relationship or relationships with alcoholics.

Biological Predisposition: Genetic abnormalities which can affect brain functioning and alter brain chemistry.

Carried Shame: Shame that the child absorbs from a primary caregiver as a result of that caregiver's being unwilling or unable to deal with his or her own shame issues.

Chemical Dependency: Reliance on any mood-altering drug (including alcohol).

Debilitating Guilt: See toxic guilt.

Denial: The refusal to acknowledge the existence of an external source of anxiety.

Dependent Love: See addictive relationships.

Displacement: The transference of repressed desires and impulses away from a dangerous object and onto a safer substitute.

Dissociation: An episode characterized by fugue amnesia or depersonalization.

Feelings Work: A psychotherapeutic process that helps the client to identify and explore his or her feelings.

Grandiosity: A delusion of inflated worth, power, knowledge, identity, or special relationship.

Healthy Shame: A sense of individual limitations.

Hypochondriasis: An obsessive focus on either real or imagined physical illness.

Imagery: The suggestion of images in a meditative process which promotes reconnection with the feeling self.

Inner Child: That part of the self whose emotional responses are uninhibited by social conditioning.

Intellectualization (Isolation): When one represses the emotional component of a reaction and resorts to logical treatment of the problem at hand.

Intimacy: Emotional honesty with the self and/or others.
Narcissistic: Having a grandiose sense of self-importance that often manifests itself in lack of empathy.

Passive-Aggressive Behavior: An attempt to control the lives of others by indirect means.

Obsessive-Compulsive Disorders: A pervasive pattern of perfectionism and inflexibility, beginning in adulthood and present in a variety of contexts.

Reaction-Formation: The adoption of behavior that is the exact opposite of impulses that one dare not express or acknowledge.

Recovery Or Sobriety: The freeing of oneself from the power of addiction in order to live a satisfying, healthy life.

Relapse: A return to the emotional responses, thinking, and/or behaviors that characterize addiction.

Rational Emotive Therapy (RET): A form of therapeutic intervention that is based on the premise that emotional problems are rooted in erroneous thought processes.

Repression: The avoidance of anxiety by not allowing painful or dangerous thoughts to become conscious.

Shame: A feeling of inadequacy or worthlessness.

Shame-based: Severely restricted in expression because of unresolved shame issues.

Shame-binds: Feeling "stuck" between the need for normal expression and the shame that accompanies it.

Shame-Cycle: A self perpetuating series of events that begin and end with a shamed response.

Spiritual Awakening: A renewed sense of the self as a worthwhile individual which manifests itself in connectedness with others.

Spiritual Principles: Basic tenets for daily living based on individual self-worth.

Spirituality: A sense of individual uniqueness and worth.

Sponsor: A Twelve-Step member who acts as a support person and mentor for another Twelve-Step member.
Toxic Guilt: A feeling of being overwhelmed by guilt feelings to the point of paralysis. Also debilitating guilt.

Toxic Shame: An overwhelming feeling of unworthiness.

Twelve-Step Program: A program which bases the recovery and continuing mental, spiritual and emotional health of its participants on the following steps as described in the A.A. Big Book.

Validation: Support by another or others of ideas and/or feelings.

Workaholism: Using work or the work place as an avoidant experience.

Working a Program: Regular participation in Twelve Step activities such as attending Twelve Step meetings and social functions, working on specific steps, obtaining a sponsor and/or consistent communication with other Twelve Step members.

Assumptions and Limitations

The results of this study were based on the assumption that the individual responses to the questionnaire were honest responses. There was no way of verifying the truthfulness of the respondent's answers. The researcher assumes that reliance on mood-altering experiences or substances is undesirable, although there are many in society who consider addictive behaviors to be life-enhancing.

The first limitation of this study lies in determining that the quality of life has actually improved by the recovering person's participation in the Twelve Step program. In the recovery process, the individual may make significant personal choices based on increased self-awareness that are considered the opposite of improvement by others who are affected by those choices. How much improvement is due to working a Twelve Step program and how much of it stems from individual initiative is impossible to measure.
The study was limited due to the lack of an accurate measure of the reduction of debilitating shame and how much individual healing of shame occurs as a result of participation in a Twelve Step program. The study was restricted to those persons who are now working a Twelve Step program. It does not take into account those individuals who have found this program to be of questionable value in the reduction of addictive behavior. Although many program participants have maintained sobriety, there is a recognized high relapse rate. The study findings were limited to the opinions expressed by a relatively small group of recovering individuals. The descriptive and phenomenological research lacks predictive power and only describes what is, not what will be. The researcher is biased as a long-standing member of the Twelve Step program who has been employed in a treatment center which utilizes that program as a part of the rehabilitation process.

**Organization of the Remainder of the Study**

The remainder of the study is organized into four chapters. Chapter Two reviews selected literature concerning shame, its manifestations, healing shame and the Twelve Step program.

Chapter Three reviews the purpose of the study, describes the methodology and outlines the design of the study. The source of the data and kinds of data to be collected is presented. The format for presenting the data and method of analyzing the collected data is discussed.
Chapter Four presents the data and the results of the analysis. The findings of the study are presented in terms of the results of the questionnaires returned by participants of the study.

Chapter Five summarizes the study problem, the findings and the conclusions. General recommendations and recommendations for future study are presented.
CHAPTER 2

LITERATURE REVIEW

Introduction and Organizational Structure

The purpose of this study was to show that working a Twelve Step program supported the recovery process for the shame-based addict by fostering spiritual growth which effectively interrupted the cycle of shame and addiction.

This chapter reviews selected literature concerning some common sources of shame, how the addictive response attempts to defend against shame, and suggests some interventions that support shame healing, including the Twelve Step program.

Some of the theorists cited in this chapter disagree concerning the roots or sources of shame, but all agree that addiction is one of the most common defenses against shame. Although Twelve Step participation is not the only existing strategy for the healing of shame, it is recognized by many addiction specialists as a powerful recuperative tool.

Shame

The theory of "toxic" or "carried" shame as a feeling of worthlessness is supported by many researchers in the addictions field as the root, or core, of addictive behavior. In contrast, the theory of "healthy" shame, as a realistic sense of human
limitations, is less emphasized. Mellody (1989), Kellogg & Harrison (1990), and Bradshaw (1988, 1992) argue that healthy shame is an integral part of our spirituality.

Mellody (1989) says that most carried shame originates in the childhood environment. Mellody discusses "need shame binds," which are created when the child is shamed for his legitimate needs. These needs include the need for touch, the need for nurturing, the need for identification, the need for affirmation, the need for power and the need for relationships. When the adult who has been shamed for a need as a child is in touch with that need, he begins the self-shaming cycle. This leads to addictive behavior during which the adult attempts to numb himself in order to avoid both the shamed response and the painful awareness of the unmet need.

In Broken Toys, Broken Dreams, Kellogg & Harrison (1990) state that shame becomes the controlling factor in the life of the shame-based person. Kellogg states that shame originates in broken relationships with survival figures, usually parents. When the parent is emotionally unavailable or using or abusing the child, the child learns that he cannot depend upon the parent. According to Kellogg & Harrison (1990), this denied dependency is the key aspect of shame. The child feels worthless and the worthless feelings become the belief system. The shame-based person learns to wear many masks---each one hiding a part of himself. Shame then empowers addiction in that good feelings come from externals and feed the need to prove one's worth. They say that shame is continuously reinforced through reenacting past abusive relationships.
John Bradshaw (1992) echoes this by stating that unless and until we deal with the shame that evolves from primary damaged relationships, we continue to reenact that shame through addictive behaviors.

Preponderant theory tends to support family of origin issues as the primary source of toxic shame. Some theorists, however, disagree. Nathanson (1992) argues that humans are born with an innate biological response to shame. This response, which begins in the preverbal stages of life, manifests itself physically in blushing, downcast eyes and a crawling sensation beneath the skin. Nathanson (1992) illustrates the four major defenses against shame found in Figure 1.

According to Nathanson (1992), when shame is triggered by an external event, the individual chooses the defensive strategy that best fits the given circumstances. In any such sequence of events, it is a natural response to attempt to fly to one of the four points of the compass. Each response is experienced differently and represents the way in which the individual has learned to handle shame. The purpose of any strategy is to alter the shamed feeling. Although all individuals use the techniques and strategies of all four systems, most tend to favor that strategy which has been learned in the early childhood environment. For instance, if the child has learned from his primary caregivers to withdraw in order to cope with shame, he may, as an adult, manifest that withdrawal in its extreme state, which is psychosis. The strategy of avoidance, which
FIGURE 1

COMPASS OF SHAME

Withdrawal

Attack Other

Avoidance

Attack Self

occurs at the opposite point of the compass, is most commonly expressed in addictive behavior.

Nathanson (1992) points out that those who suffer most from chronic shame are narcissistic because of their obsessive involvement in ideas and activities that produce more shame. He cites some of the more common environmental shaming messages which include transfer of blame, contempt, humiliation, and ridicule.

The Potter-Efrons (1989) designed a handbook for shame recovery which identifies the most common sources of shame and contains exercises that are designed to raise the individual’s awareness of his or her own shaming process. It also suggests steps for confronting shaming messages from others. The Potter-Efrons (1989) supports Nathanson’s theory that some individuals appear more biologically predisposed to shame than others, stating that biochemical depression may be the result of this predisposition. As does Nathanson (1992), they cite the physical responses to shame as proof of this theory. They also discuss the predictable actions of the shamed person such as hiding or withdrawing from others, uncomfortable thoughts and spiritual despair. The Potter-Efrons (1989) identify five sources of shame:

Genetic and Biochemical

Cultural

Family of Origin

Current Shaming Relationships

Our Own Self-Shaming Thoughts and Behaviors (p. 124).
Manifestations of Shame

Middleton-Moz (1990) theorizes that the function of debilitating guilt, which leads to depression, is an unconscious defense against shame. The following five statements illustrate this unconscious-process.

1. Because of the isolating nature of shame, it is far easier to express feelings of guilt.

2. There is more personal power in the experience of guilt. We feel guilt for what we have done or not done, and, therefore, have control over our future choices. When we experience shame, we feel helplessness and powerlessness.

3. When we experience guilt, we may fear punishment, but when we are punished or have made amends, the guilt is resolved. When we experience shame, we fear abandonment.

4. Feelings of shame and guilt frequently occur together. . . . Shame and guilt are frequently fused, and therefore, are confused. This applies primarily to debilitating guilt rather than to appropriate guilt.

5. We often feel ashamed of our shame. Although we may fear punishment, there is usually relief in - confessing guilt. The fear of abandonment often prevents us from expressing our shameful experiences or even the conscious awareness of shameful feelings. (pp. 55-56)

Woititz (1985) and Schaeffer (1987) discuss the role of shame in intimate relationships. According to Woititz (1985), we choose our significant others according to our self-shaming messages. Woititz (1987) defines intimacy as a love relationship with another person where you offer, and are offered, validation, understanding, and a sense of being valued intellectually, emotionally, and physically. Schaeffer (1987) states that old negative feelings are recreated in psychological games played out by dependent
lovers. Schaeffer defines this as addictive love, an experience which is characterized by repetitious feelings of emptiness, excitement, depression, guilt, rejection, anxiety, self-righteous anger, and low self-esteem. All of these manifestations tend to both mirror and increase the shamed response.

Woititz (1987) addresses how shame-based codependents carry dysfunctional functioning into the work place. In management positions, this dynamic is most often characterized by an overcritical attitude, unrealistic expectations, empty promises, workaholism, incompetence, and rescuing. The codependent response of the employee is characterized by constant attempts to prove individual worth, needing to be liked, making excuses for unfair behavior in management, self-demeaning messages, and inappropriate trust. All of these responses and behaviors are shame based and create an addictive work environment.

Whitfield (1987) illustrates how the cycle of shame and addiction recreates itself within any given context as illustrated by Figure 2. Whitfield (1987) says that some of the shame-based ego defenses of codependency include dodging, hiding, negotiating, caretaking, pretending, denying, and adapting. These defenses often manifest themselves in intellectualization, repression, disassociation, displacement, reaction-formation, projection, acting out, passive-aggressive behavior, hypochondriasis, grandiosity, and denial. Whitfield (1987) points out that although these defenses are functional in
FIGURE 2

CYCLE OF SHAME AND ADDICTION

dysfunctional families, they tend to work poorly in adult relationships in that using them stifles the inner child and promotes the false or codependent self.

**Healing Shame**

"Stephanie E." (1986), a pseudonym, states:

> You cannot find an addict without shame - or a shameful person without an addiction. Shame and addiction are attached at the heart, sharing the same blood that keeps them alive. Where one leads the other must follow. (p. 10).

She goes on to say that "Shame is most often expressed as what it is not: white rage, indifference, the need to control, depression, confusion, numbness, panic and the need to run" (p. 10). Ms. E. (1986) refers to Twelve Step recovery as "a journey rather than a destination . . . that leads to serenity, and ultimately, to love. No one can make that journey when shackled by shame" (p. 11). She continues by describing the healing process as it is experienced in a Twelve Step meeting:

> We begin to heal when we see that people will not cringe and turn away when they see the real us. Instead, as we let people in, we begin to learn how lovable we really are. (Ms. E, 1986, p. 13)

Stephanie E. also suggests working a First Step in shame, which includes looking at the ways that we have allowed shame to control us and accepting our unmanageability in this area.

Bradshaw (1988) discusses the differences in the therapeutic approach to shame and guilt. He states that participation in a Twelve Step program is the most effective treatment for all forms of addictions that have their roots in toxic shame. He
differentiates by saying that this same approach may not be as effective when dealing with toxic guilt. Bradshaw (1988) also recommends a strong rapport with the therapist, the confrontation of denial, feelings work, the examination of false beliefs, group therapy, imagery, and spirituality as therapeutic interventions for shame recovery. Bradshaw (1988) suggests twelve steps for transforming toxic shame into healthy shame. He defines healthy shame as a realistic acceptance of one’s own limitations. Toxic shame is defined as the feeling of worthlessness. Bradshaw (1988) agrees with Kellogg & Harrison (1990) and Mellody (1989) that healthy shame is an integral part of spirituality in that it supports love and respect for the self.

Bradshaw (1988) briefly recounts his own recovery through participation in Twelve Step groups:

Through the group’s support and mirroring love, I recovered my own sense of worth. I risked coming out of hiding and showing my shame-based self. As I saw myself reflected in the non-shaming eyes of others, I felt good about myself. I reconnected with myself. I was no longer alone and beside myself. (p. 133)

Sheehan (1989) recommends the use of Rational Emotive Therapy (RET) in order to evaluate shaming events, thoughts, and feelings. According to Sheehan (1989), feelings of shame are usually triggered by unrealistic demands, a tendency to awfulize and self-devaluation. The first step in the RET process is to identify these triggers. The second step involves critiquing the thoughts and questioning the logic that is being used. The third step focuses on developing a more rational alternative with respect to individual needs and values. Sheehan (1989) says that since shame is invented and learned, it can
be uninvented and unlearned, a statement which contradicts the theory of biological predisposition. He suggests the use of RET in conjunction with working a Twelve Step program for the successful healing of shame-based behavior.

Peck (1978) briefly discusses shame based denial systems by stating:

Truth or reality is avoided when it is painful. We can revise our maps only when we have the discipline to overcome that pain. To have such discipline, we must be totally dedicated to the truth . . . (and) always hold truth . . . to be more important . . . than our comfort. . . . mental health is an ongoing process of dedication to reality at all costs. (p. 50)

Powell (1969), in Why Am I Afraid To Tell You Who I Am?, supports the healing of shame by committing to and regularly practicing honest self-disclosure. In it he echoes our deepest and most secret fear by saying, "But if I tell you who I am, you may not like who I am, and it is all that I have" (p. 20).

**Twelve Step Program**

The Twelve Step program is presented in publications of Alcoholics Anonymous such as Twelve Steps and Twelve Traditions (1981) and Alcoholics Anonymous (1988). Alcoholics Anonymous took a unique and highly successful approach to alcoholism by emphasizing alcoholism as an illness, thus removing the social stigma associated with the condition (Alcoholics Anonymous, 1988). In 1951, Alcoholics Anonymous was given the Lasker Group Award by the American Public Health Association, stating that:

Historians may one day recognize Alcoholics Anonymous to have been a great venture in social pioneering which forged a new instrument for social action; a new therapy based on the kinship of common suffering; one having a vast potential for the myriad other ills of mankind. (p. 573).
The twelve steps of the program are listed below:

1. We admitted that we were powerless over alcohol (or relationships, food, drugs, etc.), that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people whenever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics (and other addicts) and to practice these principles in all our affairs. (pp. 59-60)

Working a Twelve Step program requires that one look honestly at the self and be willing to share that self openly with others. This philosophy combined with the
continuing unconditional support of the group promotes the healing of shame and increased self-acceptance and the psychological healing that occurs as a result of that participation.

**Conceptual Framework of the Study**

The conceptual framework of the study combines empirical and intuitive data collected through observation and participation in Twelve Step program groups with detailed questioning of participants in these groups. This framework permitted the researcher to predict outcomes for others who attempt to heal shame through participation in the Twelve Step program.
CHAPTER 3

METHODOLOGY

Purpose of the Study

The purpose of this study was to show that working a Twelve Step program supported the recovery process for the shame-based addict by fostering spiritual growth which effectively interrupted the cycle of shame and addiction.

Research Methodology

The methodology used for the study combined practices of ethnography and grounded theory research. The researcher became intimately familiar with the relationship of shame to addictive disorders. Based on this relationship, the researcher theorized that working a Twelve Step program was effective in healing the shame core of addiction in that it modified or eliminated resultant addictive behaviors.

Design of the Study

The study design initially used participant observation and the researcher’s experiences and impressions of the sample population. The second phase of the research provided selected participants with a questionnaire which requested responses to specific questions concerning shame. The responses to the questionnaire were analyzed to
provide the researcher with meaningful information to confirm the relationship between modification or elimination of shame and successful resolution of addictive problems when subjects work the Twelve Step program.

**Data Source**

The initial source of the data was attendees of Twelve Step recovery program meetings. The population contained both sexes ranging in age from twenty to sixty-five. Occupations of the population included blue collar workers, housewives, students, and professionals. Although some of the population were substance abusers, other addictions, such as eating disorders, sex addiction and codependency were represented.

The sample selected from the population were known to the researcher from involvement in the Twelve Step program. The sample was chosen to respond to a detailed questionnaire to elicit specific data unavailable through observation alone. The sample was drawn only from participants who had experienced two or more years of sobriety and continued to manifest personal growth as a result of their commitment to recovery through working the Twelve Step program. The participants were selected based on their willingness to respond to the questionnaire. The sample is neither random, nor does it purport to be representative of the population of those in a twelve step recovery program.
**Instrumentation**

The instrumentation used to collect specific data from the selected sample is a questionnaire, presented as Appendix A, devised by the researcher. The initial list of thirty-one questions was condensed by the researcher through a pilot test to eliminate questions that were misunderstood, or did not contribute significantly to the data collection. The researcher retained nineteen specific questions that focus on the Twelve Step recovery process and how it modified or eliminated shame felt by the respondent. The questions addressed attitude change, change in the quality of life as perceived by the respondent, changes in self-esteem and interpersonal relating, and outward change in lifestyle.

In some cases, the response requested was an either/or, for example, yes/no, or okay/not okay. Other questions gave more choices, such as yes/no/sometimes and worth/worthlessness/don’t know, or both. In these cases, respondents chose only one response. The third type of question asked for feelings or identification. Respondents identified feelings and causes of shame using either examples provided or based on their own experiences.

**Data Collection Procedures**

Initially, data was collected by the researcher as a complete participant in the recovery groups. The members of Twelve Step groups were unaware that the researcher compiled and assessed impressions during the experiences of the group.
Next, the researcher gave the questionnaire to twenty-six subjects. A questionnaire was mailed to each respondent. A cover letter, shown as Appendix B, explained how understanding of the relationship between toxic shame and addiction has grown. The letter further requested information from the respondent as to how and why working a Twelve Step program helps overcome and heal shame. Information was provided about how to contact the researcher if questions were misunderstood or to alleviate discomfort about answering the questions. Assurances of total confidentiality were included in the letter. A self-addressed stamped envelope was included with the questionnaire.

Twenty of the responses were received through the mail. The six respondents who did not return the questionnaire were contacted by telephone or in person to obtain answers to the questions.

**Presentation of the Data**

The data are presented in Chapter Four by question. The total number of respondents and percent response for each question is shown. The number and percentage of respondents who answered single choice questions is also shown. Percentages only were calculated where the respondents were able to choose more than one answer. Specific comments and explanations are included as a part of the data for each question, where applicable.
Data Analysis

The number and percentages of responses were calculated for each question. Most respondents responded to all questions; however, in three cases, one or two respondents chose not to answer a question.

The number and percent was calculated for each response in those cases where the respondent was given a choice. For questions where the respondent could give more than one answer, such as feelings, no number of respondents was calculated.

The respondents' answers were examined question by question by the researcher to determine similarities and differences. The researcher reviewed the responses for evident trends and insight into the Twelve Step process provided by the respondents.

Consideration was given only to general information provided by the respondents. There was no analysis based on individual characteristics of the respondents, such as sex, age, occupation, or ethnic heritage.
CHAPTER 4

PRESENTATION AND ANALYSIS OF THE DATA

Findings and Results

This chapter presents the data collected by the researcher through observation of and participation in Twelve Step meetings and the responses of twenty-six participants who answered nineteen questions contained in a questionnaire developed by the researcher. Although most participants answered the nineteen questions, a few omitted some questions without explanation.

Responses to each question are presented in a summary table. Explanations and comments from the respondents are included for those questions where a narrative answer was requested.

Question #1

Do you consider yourself someone who is recovering from some form(s) of addiction?

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Addiction was described as any substance, experience or process which had taken over one's life and over which one was powerless. Besides substance abuse, this would include eating disorders, codependency, love, sex and/or relationship addiction and debtor/spender behavior, to name a few.

**Question #2**

How long have you been active in your recovery process?

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</tbody>
</table>

Only participants who considered themselves in recovery from some form of addiction and who had been in recovery for at least two years and were currently active in the Twelve Step program were asked to respond to the questionnaire. Respondents reported years in recovery ranging two to forty-one years, averaging 10.85 years.

**Question #3**

Is participation in a Twelve Step program a part of your recovery process?

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>26</th>
<th>Percent Response</th>
<th>100.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes:</td>
<td>26</td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>No:</td>
<td>0</td>
<td></td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Question #4

Did you participate in a treatment program (hospital, public, or private) as a part of your recovery process?

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>Percent Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes:</td>
<td>22</td>
</tr>
<tr>
<td>No:</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>Percent Response</th>
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</thead>
<tbody>
<tr>
<td>26</td>
<td>100.0%</td>
</tr>
<tr>
<td>84.6%</td>
<td></td>
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<tr>
<td>15.4%</td>
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</table>

Question #5

If you did participate in a treatment program, did this program include Twelve Step work as part of the recovery process?

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>Percent Response</th>
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<tbody>
<tr>
<td>Yes:</td>
<td>20</td>
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<tr>
<td>No:</td>
<td>4</td>
</tr>
<tr>
<td>N/A:</td>
<td>2</td>
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</table>

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>Percent Response</th>
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</thead>
<tbody>
<tr>
<td>26</td>
<td>100.0%</td>
</tr>
<tr>
<td>76.9%</td>
<td></td>
</tr>
<tr>
<td>15.4%</td>
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<tr>
<td>7.7%</td>
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</tbody>
</table>

Although most of the respondents were in a treatment program, not all of these programs included Twelve Step work. This would indicate that some individuals sought out Twelve Step participation independently.
Question #6

When working a First Step, (accepting your powerlessness over your addiction(s)), what feelings came up for you?

| Total Responding | 26 | Percent Response | 100.0% |

First Step feelings:

- Anger: 62.0%
- Pain: 46.2%
- Loneliness: 30.7%
- Fear: 61.5%
- Shame: 76.9%
- Guilt: 23.1%
- Joy: 7.7%
- Relief: 7.7%
- Sadness: 7.7%
- Defeat: 7.7%

Many respondents selected more than one emotional response to describe their feelings; therefore, no number of respondents for each emotion was included. Of the universal feelings listed on the table in response to Question #6, shame exceeded all others, followed by anger and fear which were equally represented.
Question #7

Were you initially resistant to applying the Third Step (turning your life and welfare over to the care of God) as it pertained to your addiction? If so, please explain how your concept of God at that time influenced your response to that step. If you continue to experience conflict concerning this step, please briefly state why.

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>26</th>
<th>Percent Response</th>
<th>100.0%</th>
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</thead>
<tbody>
<tr>
<td>Yes:</td>
<td>14</td>
<td></td>
<td>53.8%</td>
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<tr>
<td>No:</td>
<td>12</td>
<td></td>
<td>46.2%</td>
</tr>
</tbody>
</table>

Responses indicated that slightly more than half were initially resistant to surrendering control of their addictions to a recognized higher power. Comments indicated that the concept of God often played a large part in this resistance. For example:

I could not think of God as my friend.

I had difficulty believing in something or someone that I couldn’t see.

I feared that God would reject me. I still struggle with this step at times because of my need to control.

I didn’t trust God and blamed him for everything bad in my life. I’m now able to turn my life and will over to Him.

Although nearly all respondents indicated that their difficulty in grasping the concept of a loving God had altered through Twelve Step work, one respondent remained adamant, stating: "I still struggle. There is no God."
Did you complete Fourth and Fifth Steps (personal inventory and sharing that inventory) as a part of your recovery? If you can, please identify the feelings that came up as a result.

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>26</th>
<th>Percent Response</th>
<th>100.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shame</td>
<td>38.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relief</td>
<td>46.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peace</td>
<td>23.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td>15.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Acceptance</td>
<td>15.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear</td>
<td>15.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guilt</td>
<td>15.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td>7.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Pity</td>
<td>7.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forgiveness</td>
<td>7.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joy</td>
<td>23.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Feelings</td>
<td>15.4%</td>
<td></td>
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</table>

Respondents again were able to choose more than one feeling in response to the question; thus, numbers for each response were not included. Fourth and fifth steps concern personal inventories and the sharing of those inventories. One hundred percent of the respondents indicated that they had worked these steps with varied emotional responses. Respondents selected more than one emotional response. Almost forty percent indicated that they experienced shame while working these steps. The shame was quickly followed by feelings of relief for nearly half, peace for nearly a quarter, and joy for a quarter of the respondents. Comments from respondents include:
I participated in Twelve Step work for three years before doing a fourth step because I was afraid to face my shame. When I had finished, I experienced peace and self-acceptance. Since that time, I have worked fourth and fifth steps many times over. I always end up releasing something that has been burdening me.

I felt overwhelming shame and guilt about my behaviors while using. Working fourth and fifth steps helped me to let go of these feelings.

**Question #9**

Can you relate to feelings of toxic shame (toxic shame is a feeling of worthlessness) as a part of your disease? In what ways did shame influence your attitude and behaviors? Has your Twelve Step work helped to heal some of your shame? If it has, please explain how this has occurred.

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>Percent Response</th>
</tr>
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<tr>
<td>26</td>
<td>100.0%</td>
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</table>

A. Relating to feelings of toxic shame.

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<td>Yes:</td>
<td>20</td>
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<td>No:</td>
<td>6</td>
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</table>

B. Has Twelve Step work helped heal shame.

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<tbody>
<tr>
<td>Yes:</td>
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<td>No:</td>
<td>6</td>
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</table>

Over three quarters of the respondents indicated that they related to feelings of toxic shame, while slightly under a quarter stated that they did not. Equal percentages
indicated that Twelve Step work helped heal some of that shame. Many comments were included in response to this question. For example:

The principle of rigorous honesty helped me to change from feeling worthless to feeling good about myself.

Toxic shame affected most of my choices. The unconditional support of the group helped heal my shame.

Twelve Step work helped heal me of my shame by encouraging me to make amends to those I had hurt with my behaviors. When I did this, I felt my self-respect returning.

People in (the) Twelve Step (program) accept me unconditionally. I trust them, listen to them, learn, and heal from their acceptance and love. (Now) I feel like I’m good enough, no matter what.

Shame was the source of my dishonesty. Twelve Step work raises my awareness of God working in my life.

My shame almost drove me to suicide while I was using.

I relate to feelings of shame as part of my disease. I covered my shame with addiction.

**Question #10**

When you do experience feelings of shame, do you also experience the temptation to "numb out" (relapse) with your drug of choice? If you have relapsed during your recovery, did the addictive behaviors increase your sense of shame?

| Total Responding     | 26 | Percent Response | 100.0% |
A. Respond to feelings of shame by "numbing out".

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<tbody>
<tr>
<td>Yes:</td>
<td>16</td>
<td>61.5%</td>
</tr>
<tr>
<td>No:</td>
<td>10</td>
<td>38.5%</td>
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</table>

B. Relapse caused an increase of shame.

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</thead>
<tbody>
<tr>
<td>Yes:</td>
<td>14</td>
<td>53.8%</td>
</tr>
<tr>
<td>No:</td>
<td>12</td>
<td>46.2%</td>
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</tbody>
</table>

Nearly two thirds stated that they were tempted to relapse into addictive behaviors when experiencing toxic shame. Of these, over half said that the relapse increased the sense of shame.

**Question #11**

Were you ever ridiculed, blamed unfairly, humiliated, abandoned or treated with contempt by one or both parents? If you can recall such incidents, how do they affect your feelings about yourself now?

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<tr>
<th>Total Responding</th>
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<tbody>
<tr>
<td>Yes:</td>
<td>12</td>
</tr>
<tr>
<td>No:</td>
<td>14</td>
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</tbody>
</table>

46.2% 53.8%

In response to Question #11, nearly half of the respondents indicated that they had been shamed in some way by one or both parents.
Question #12

Can you identify some of the sources of shaming messages that you have received about yourself?

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>22</th>
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<tbody>
<tr>
<td>Percent Response</td>
<td>84.6%</td>
</tr>
</tbody>
</table>

Identified sources of shame:

- Family          | 72.7% |
- Church          | 9.1%  |
- School          | 45.5% |
- Relationships   | 63.6% |
- Work            | 54.5% |
- Self            | 9.1%  |

Respondents were able to identify more than one source of shame; therefore, number of responses is not included. The answers indicated that nearly 75 percent considered family as the major source of shaming messages, while relationships came in second at 63.6 percent. Comments included:

I feel the majority of shaming messages come from my father--and still do. I feel like I'll never measure up to his expectations.

I still beat myself up with old shaming messages from my parents.

I never felt safe, secure or totally loved. I felt like a loner, and I couldn't count on anyone.

The ridicule and contempt (from family) makes me feel worthless and a failure.
I was rigidly controlled, which causes me feelings of inadequacy now.

**Question #13**

Do you continue to find yourself expressing shame related behaviors and attitudes such as the need to control, panic, rage, depression, numbness or indifference?

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<thead>
<tr>
<th>Total Responding</th>
<th>26</th>
<th>Percent Response</th>
<th>100.0%</th>
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</thead>
<tbody>
<tr>
<td>Yes:</td>
<td>16</td>
<td></td>
<td>61.5%</td>
</tr>
<tr>
<td>No:</td>
<td>10</td>
<td></td>
<td>38.5%</td>
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</table>

**Question #14**

Do you attack others as a defense against shame? Does your Twelve Step participation help reduce the need for this kind of aggression? If it does, please explain how or why?

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<tr>
<th>Total Responding</th>
<th>24</th>
<th>Percent Response</th>
<th>92.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes:</td>
<td>14</td>
<td></td>
<td>58.3%</td>
</tr>
<tr>
<td>No:</td>
<td>10</td>
<td></td>
<td>41.7%</td>
</tr>
</tbody>
</table>

In response to Question #14, which focused on shame related behaviors, almost two thirds confessed to continuing these behaviors in some manner. Over half of the respondents said that they continue to attack others as a defense against shame. Two
respondents chose not to respond to the question. Many indicated that they had modified these shame-based responses by making statements such as:

Twelve Step work has helped me become aware that I have choices and that I can’t control what other people think, say and do.

Yes, I do (attack as a defense against shame), but I find myself getting a little better each day. I keep the tools of A.A. on hand always.

Twelve Step work supports me in practicing acceptance of others and their behaviors.

My Twelve Step work helps me to forgive myself and, subsequently, forgive others.

I still feel the need to attack others, but today I stop and say a prayer more often.

**Question #15**

Have you ever used feelings of guilt (which focuses on something you did), in order to cover up feelings of shame (which focuses on what you are)?

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>Percent Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes:</td>
<td>84.6%</td>
</tr>
<tr>
<td>No:</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

**Question #16**

Do you choose relationships that reflect back your worth, or do you choose relationships and situations that reflect back your worthlessness?
<table>
<thead>
<tr>
<th>Total Responding</th>
<th>26</th>
<th>Percent Response</th>
<th>100.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worth</td>
<td>8</td>
<td></td>
<td>30.8%</td>
</tr>
<tr>
<td>Worthlessness</td>
<td>4</td>
<td></td>
<td>15.4%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>6</td>
<td></td>
<td>23.0%</td>
</tr>
<tr>
<td>Both</td>
<td>8</td>
<td></td>
<td>30.8%</td>
</tr>
</tbody>
</table>

Many respondents (84.6 percent) related to using feelings of guilt in order to cover up underlying feelings of shame. There were varied responses to Question #16, which focused on the choice of relationships as a reflection of individual worth. Almost a third of the respondents indicated that they chose relationships that reflected their worth while nearly a fourth said that they weren’t sure. Nearly a third stated that they chose both good and bad situations, and 15.4 percent said that they regularly made choices that reinforced feelings of worthlessness. Two individuals stated that they felt as though they were working towards more healthy relating, but one respondent was brutally and sadly honest:

I find women I can fix. That way, I can feel okay.

**Question #17**

Are you able to ask for what you want and need without feeling ashamed?

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>24</th>
<th>Percent Response</th>
<th>92.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12</td>
<td></td>
<td>50.0%</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td></td>
<td>8.3%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>10</td>
<td></td>
<td>41.7%</td>
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</tbody>
</table>
In response to Question #17, fifty percent of the respondents indicated that they were able to ask for what they wanted and needed without feeling ashamed. About forty percent said that they were able to achieve this sometimes. Eight percent of the respondents indicated that they were unable to ask for what they needed without resultant feelings of shame.

**Question #18**

How do you feel about openly confessing your flaws and limitations to other Twelve Step members? Can you connect spiritual healing with this kind of honesty? Do you regularly work the Eighth, Ninth and Tenth Steps as part of your recovery program? How does working these steps affect your feelings of self worth?

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>26</th>
<th>Percent Response</th>
<th>100.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Feelings about addressing flaws.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26</td>
<td>92.3%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>7.7%</td>
<td></td>
</tr>
<tr>
<td>B. Spiritual healing with honesty.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>C. Work eighth, ninth and tenth steps.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26</td>
<td>92.3%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>7.7%</td>
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</tbody>
</table>
D. Steps affect feelings of self-worth.

Yes  26  92.3%
No   0  7.7%

One hundred percent of the Twelve Step respondents said that they felt "okay" about confessing their flaws to other Twelve Step peers. The majority of respondents connected this tradition of honesty with spiritual healing. The survey also indicated that 100 percent of the respondents had worked eighth, ninth and tenth steps. There were also brief statements that connected the working of these steps with increased feelings of self-worth:

These are the most important steps. The more you do them, the more good comes back to you.

The more honest I allow myself to be, the better I feel about myself.

I know I'm only human, and that's okay.

I'm a more honest person.

I know that I'm a good person.

My self-worth increases in direct correlation with working these steps.

**Question #19**

What changes can you see occurring in your life as a result of Twelve Step participation? Do you perceive these changes as being predominantly inner or outer changes? Please explain briefly.
<table>
<thead>
<tr>
<th>Total Responding</th>
<th>26</th>
<th>Percent Response</th>
<th>92.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner Changes</td>
<td>26</td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>Outer Changes</td>
<td>0</td>
<td></td>
<td>0.0%</td>
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</tbody>
</table>

All of the respondents said that they perceived life changes as a result of Twelve Step work as being predominantly inner changes. Here are some of the comments:

I now have a reason for living.

I feel like I know who I am and what I need. I accept things and can be real with myself and others.

I have a lot more peace a lot more often.

I feel great today.

I like being sober. I like this way of life.

Nothing outside changes just because I’m in recovery, but I have serenity and inner peace. I know that I’m part of God’s master plan, and it’s okay for me not to know what part.

My self-esteem is improving. I’m setting goals and achieving. My shame has diminished.

Live what you can of the steps. You don’t have to do them perfectly. Whether you are an addict, alcoholic, or just an ordinary human being, living the steps will change your life.

I worry less about things that don’t really matter, which frees up my energy for the really important things. I enjoy life more. I feel gratitude for the smallest things—and joy. My inner peace helps me to heal my human relationships.

I focus on progress, not perfection, which allows me to make mistakes.

My self-esteem is better. I trust God and I trust life. I work the Twelve Step constantly. It’s an important part of my life.

I’m close to those I love—no longer hiding from the world or covering up feelings.
CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

This research explored the relationship of toxic shame, a feeling of unworthiness, to addictive behaviors. Further, it attempted to demonstrate how participation in the spiritually-based Twelve Step program effectively counteracted the psychological condition of shame.

Initially the researcher assessed impressions gained through group experiences without the knowledge of the group. Subsequently, a questionnaire containing nineteen key questions was mailed to twenty-six subjects with a cover letter which proposed a relationship between shame and addiction.

The questionnaire, which was designed to inventory both Twelve Step participation and shame-based behaviors, was constructed in a manner that would aid the respondent in making the appropriate connections between possible modification of shame-based responses and Twelve Step participation. At times, respondents were asked to identify feelings, which included shame, that were experienced as a result of working on individual steps. The results were then examined question by question.
Conclusions

The responses to the questionnaire shown indicate that many Twelve Step members are at least partially aware that the spiritual enrichment that they have experienced as the result of working a Twelve Step program has been effective in counteracting conditioned responses of shame. Further, that the psychological healing which has occurred during Twelve Step participation has effectively interrupted the cycle of shame and addiction so that the addictive behaviors are either diminished or eradicated.

Findings of the survey indicated that many of the subjects were aware of continuing to experience toxic shame and to exhibit shame-related behaviors in their interactions with others. The majority of respondents also indicated that they had experienced some release of shame as a result of Twelve Step work. All of the respondents were Twelve Step participants, with an average reported recovery time of 10.85 years. Over 75 percent of the respondents reported experiencing feelings of toxic shame, and over 75 percent felt that Twelve Step involvement had helped to heal that shame. Nearly two-thirds of the subjects reported a need to "numb out" with addictive behaviors when experiencing shame. Of these, over fifty percent said that by acting out the addiction, the feelings of shame increased. The subject's family was the most commonly identified source of shaming messages, while other relationships were rated second.

Many respondents indicated in the narrative that their Twelve Step work supported both the healing of shame responses and the modification of shame-based behaviors. All
of the subjects identified the Twelve Step tradition of rigorous honesty as a foundation for spiritual growth and emotional healing. Nearly 93 percent reported that working the eight, ninth, and tenth steps, which support that tradition, facilitated increased feelings of self-worth. One hundred percent of the subjects reported that they perceived life changes as a result of Twelve Step work as predominantly inner changes. The narrative responses to this question reported an improvement in the overall quality of life as a reflection of those inner changes.

**General Recommendations**

As additional evidence surfaces that confirms the relationship of shame to addiction, it becomes obvious that addictions treatment is incomplete without the inclusion of shame work and shame healing interventions. Although the Twelve Step program was not intentionally created for shame healing, it appears from the responses to the questionnaire that many of its steps, principles and traditions work towards that end.

Some therapists may be inadequately prepared to deal with a clients’s shame issues because of insufficient preparation in that area. There are two main reasons for this. The first is lack of education and training in the psychodynamics of shame. The second is the reluctance of some therapists to complete their own therapeutic shame work. When a therapist has failed to struggle through his or her own shame, he or she may be insensitive to the needs of the client who is getting in touch with shame related issues.
There are two recommendations for more effective shame therapy. The first is that the therapist must be willing to continue to confront the shamed part of himself/herself. The second is that counseling education must include thorough grounding in the area of shame, shame-based behaviors, and appropriate therapeutic interventions.

**Recommendations for Future Research**

Since the sample group was a small one, it is recommended that the group be expanded for a more accurate representation. In addition, the questionnaire needs to be modified in order to be implemented effectively for a larger population.
REFERENCES


ADDICTIONS RECOVERY QUESTIONNAIRE

QUESTION #1

Do you consider yourself someone who is recovering from some form(s) of addiction?

(Addiction is any substance, experience or process which has taken over our lives and over which we are powerless. Besides substance abuse, this would include eating disorders, codependency, love, sex and/or relationship addiction and debtor/spender behavior, to name a few.)

QUESTION #2

How long have you been active in your recovery process?

QUESTION #3

Is participation in a Twelve Step program a part of your recovery process?

QUESTION #4

Did you participate in a treatment program (hospital, public, or private) as a part of your recovery process?

QUESTION #5

If you did participate in a treatment program, did this program include Twelve Step work as part of the recovery process?

QUESTION #6

When working a First Step, (accepting your powerlessness over your addiction(s)), what feelings came up for you?

(Feelings might include anger, pain, loneliness, fear, shame, guilt, or joy.)
QUESTION # 7

Were you initially resistant to applying the Third Step (turning your life and will over to the care of God) as it pertained to your addiction? If so, please explain how your concept of God at that time influenced your response to that step. If you continue to experience conflict concerning this step, please briefly state why.

QUESTION # 8

Did you complete Fourth and Fifth Steps (personal inventory and sharing that inventory) as a part of your recovery? If you can, please identify the feelings that came up as a result.

QUESTION # 9

Can you relate to feelings of toxic shame (toxic shame is a feeling of worthlessness) as a part of your disease? In what ways did shame influence your attitude and behaviors? Has your Twelve Step work helped to heal some of your shame? If it has, please explain how this has occurred.

QUESTION # 10

When you do experience feelings of shame, do you also experience the temptation to "numb out" (relapse) with your drug of choice? If you have relapsed during your recovery, did the addictive behaviors increase your sense of shame?

QUESTION # 11

Were you ever ridiculed, blamed unfairly, humiliated, abandoned or treated with contempt by one or both parents? If you can recall such incidents, how do they affect your feelings about yourself now?

QUESTION # 12

Can you identify some of the sources of shaming messages that you have received about yourself? Some common sources include; family church, school, relationships and work.
QUESTION # 13

Do you continue to find yourself expressing shame related behaviors and attitudes such as the need to control, panic, rage, depression, numbness or indifference?

QUESTION # 14

Do you attack others as a defense against shame? Does your Twelve Step participation help reduce the need for this kind of aggression? If it does, please explain how or why?

QUESTION # 15

Have you ever used feelings of guilt (which focuses on something you did), in order to cover up feelings of shame (which focuses on what you are)?

QUESTION # 16

Do you choose relationships that reflect back your worth, or do you choose relationships and situations that reflect back your worthlessness?

QUESTION # 17

Are you able to ask for what you want and need without feeling ashamed?

QUESTION # 18

How do you feel about openly confessing your flaws and limitations to other Twelve Step members? Can you connect spiritual healing with this kind of honesty? Do you regularly work the Eighth, Ninth and Tenth Steps as part of your recovery program? How does working these steps affect your feelings of self worth?

QUESTION # 19

What changes can you see occurring in your life as a result of Twelve Step participation? Do you perceive these changes as being predominantly inner or outer changes? Please explain briefly.
Dear Friend In Recovery,

In the past two decades, there has been increased understanding of the relationship between toxic shame, which is a feeling of worthlessness, and a certain set of behaviors which those in recovery recognize as addiction. If you attend Twelve Step meetings, you are probably familiar with the slogan, "Keep coming back. It works". In the enclosed questionnaire, I am attempting to find out from you and other recovering people just how and why working a Twelve Step program helps to overcome and heal shame. I realize that the concept of shame and shame recovery may not be something that you have actually sat down and thought about, but that in itself does not mean that this kind of process has not occurred gradually within you as you continue to work a recovery program.

I would appreciate it if you would take the time to answer the questions and return them to me. If you do not understand a question or questions, I welcome your calls at 582-9684 and will return recorded messages promptly. If you feel uncomfortable with or unwilling to share concerning any questions, please simply state that. There will be no names or specific quotes used without your permission, and all responses will become part of a general survey. In addition, I am assured that all responses, however general, will be kept confidential by the small committee that reviews the results.

I have enclosed a stamped envelope, addressed to me, for your use. Again, thank you for your participation and willingness to share.

Sincerely,

Marilyn Paquette
BIOGRAPHICAL SKETCH

Marilyn Paquette was born in Manchester, Connecticut on August 5, 1939. She graduated from Manchester High School in 1957 and attended Colby College in Waterville, Maine for two years before marrying and moving to Arizona. She later attended Glendale Community College on a part-time basis as a communications major. She graduated with a B.A. in Psychology from Ottawa University in 1987. In 1989, she entered Ottawa University’s graduate program to obtain a Master of Arts degree in human resource development, later expanding that degree to a Master of Arts degree in professional counseling. Her clinical experience includes professional interaction with the mood and thought disordered, the elderly and terminally ill, addicted individuals, and the physically and sexually abused. She has also facilitated a shame recovery program of her own design and has lectured and made special presentations on psychological issues. Her four children are grown and she has five grandchildren.