

**Shame: Its impacts on the relationship between mothers with substance abuse  
disorders and child welfare social workers**

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*Abstract*

It is estimated that between one third and two thirds of all child maltreatment cases involve substance use (Child Welfare Information Gateway [CWIG], 2009). Studies indicate that child welfare social workers possess limited understanding and knowledge about substance abuse disorders (CWIG, 2009). Women, especially mothers with substance abuse disorders are often stigmatized which contributes to their experience of shame. Shame is a key part of addiction cycle. This study based on grounded theory explores the way shame affects the relationship between mothers with substance abuse disorders and child welfare social workers. The findings indicate that child welfare social workers have the ability to either ease or contribute to women's feelings of shame, which in return affects mothers' reactions to social workers and the success of the child welfare case. Mothers' feelings of shame display themselves through four distinct concepts: The Past, Family, Self-Worth and Hope. Understanding the dynamics of shame and treating mothers with substance abuse accordingly is crucial for well being of children and families in the child welfare system.

*Introduction*

This study reports on the unheard voices of substance abusing women in society by allowing them to tell their story and share how recovery helped them construct new knowledge. The research explores experiences of shame of mothers with substance abuse disorders and the way the shame influences their recovery. The ways in which social workers may contribute to or help feelings of shame in women's lives is of special

interest to the study.

Addiction is defined as “a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences” (National Institute on Drug Abuse [NIDA], 2007, p. 5). According to Dr. Nora Volkow (NIDA, 2007), addiction is comparable to other diseases that affect internal organs. In practice, substance abuse disorders are more commonly associated with crime, moral failure, or a simple matter of poor choice (Room, 2005). Individuals with substance abuse disorders are not viewed as patients who need medical attention; instead they are punished for their disease.

A national survey that “combined data from 2002 to 2007 indicated that over 3.4 million children lived with a mother who had a substance use issues” (SAMSHA, 2009). It is estimated that between one third and two thirds of all child maltreatment cases nowadays involve substance use (CWIG, 2009). However, studies indicate that social workers possess limited understanding and knowledge about substance abuse disorders (CWIG, 2009). Additionally, social workers are perceived to have negative attitudes and responses toward clients with substance abuse disorders, including stereotyping, failure to refer clients and pessimism about the clients’ prognosis (Amodeo & Fassler, 2000).

### *Literature Review*

This research was guided by the constructionist concept which purports that whatever is commonly considered as good, relevant or bad in society can be questioned because the judgments are merely creations of a society. Constructionists claim that anything can only exist within a contextual framework created by society (Parton & O’Byrne, 2000) and taken-for-granted beliefs about what is good or bad have historically

been defined and enforced by the governing class (Heiner, 2006). Social constructionism explores concepts of good and bad which underline the idea of stigma. Stigma contains “both extreme negative perceptions and social rejection of the marked individual” (Sallmann, 2010, p. 147). What something or someone is called by the dominant culture determines their very value and nature (Heiner, 2006).

By definition, stigma and shame are deeply connected. According to Gilbert and Andrews (1998), “stigma has to be related to social values and social good”, while shame can be experienced in private (p. 126). Mothers and pregnant women engaged in substance use are one of the most stigmatized groups in society (Murphy & Rosenbaum, 1999). It is a uniform societal view that a mother is supposed to care for her children and that the children’s needs should be her priority (Murphy & Rosenbaum, 1999). In contrast, the brain of a substance dependent individual has one goal, which is to find ways to maintain the addiction cycle (NIDA, 2007). Murphy and Rosenbaum (1999) state that for a woman to “be labeled an unfit mother has horrendous consequences of personal and social condemnation and social isolation” (p. 134).

Shame has become an intriguing and controversial subject of research (Brown, 2008). Shame and guilt are often mistaken and confused for one another. Though shame and guilt may arise from similar situations, each has a very distinct impact on individuals (Benetti-McQuid & Bursik, 2005). Most simply expressed, the difference between shame and guilt is that shame is an emotion of feeling poorly about one’s self, while guilt is an emotion of feeling poorly about something that one has done (Wiechelt, 2007). Tangney and Dearing (2002) state that when feelings of guilt are unaccompanied by feelings of shame, they can help build relationships, increase responsibility and promote socially

acceptable behaviors. Guilt moves people to action, toward restitution and making amends (Potter-Efron, 2002).

Unlike guilt, shame is a destructive and immobilizing emotion (Tangney & Dearing, 2002). It is paralyzing as it causes an individual to withdraw from society. Research shows that unlike guilt, shame often results in anger and interpersonal hostility (Tangney & Dearing, 2002). Anger and hostility can be directed toward self and can be directed at others who are perceived as judgmental and shaming.

Shame is “the master emotion because no other emotion plays such a central role in affective, cognitive, motivational, and behavioral experiences” (Turner & Schallert, 2001, p. 320). According to Brown (2008): “shame is an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging”. Shame is a deep personal concept and is experienced when one “fails to live up to socially prescribed behavior” (Efthim, Kenny, & Mahalik, 2001, p. 431). Habitual, internalized and chronic shame is linked to mental health problems, including substance abuse disorders, mood disorders, schizophrenia, and borderline personality (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008).

Shame is perceived as both a causal and a maintenance factor for the addiction cycle (Potter-Efron, 2002). Women are found to be more prone to shame and men are found to be more prone to guilt (Manion, 2003). Efthim et al. (2001) explain that a woman’s shame stems from personal sense of failing the internalized ideal related to gender role, as well as from social disapproval. The further an individual digresses from her socially prescribed role, the more shame she will experience.

Research indicates that many women with substance use problems were

victimized and brutalized from the earliest age (Miller & Downs, 1993). In the research on violence against women, shame is understood to be an intense, far reaching consequence of physical and sexual abuse (Buchbinder & Eisikovits, 2003). The unexpressed feelings of shame often cause women to seek escape in substance use (Potter-Efron, 2002). Substance abuse accompanied by domestic violence, prostitution, and child abuse and neglect further amplify shame (Murphy & Rosenbaum, 1999).

Lee and Wheeler (1996) state that “shame is an interactive occurrence”, which means that “potential for shaming is present in any relationship” (p. 315). As child welfare social workers and mothers with substance abuse disorders engage in interpersonal communication and relationships, “shame becomes an unavoidable occurrence” (Lee & Wheeler, 1996, p. 315). Women with substance abuse disorder often “bring to each interaction the accumulated history and reactivity known as transference” (Lee & Wheeler, 1996, p. 315). Clients can react in previously formed patterns of behavior ridden with shame and at the same time helping professionals can “themselves be instruments of shame” (Lee & Wheeler, p. 316), because of the power differential between the two.

### *Methodology*

The participants in the study are eight women, ages 20 to 50, with substance abuse disorders, who graduated from a residential substance abuse treatment program and have been in recovery for at least two years. The women are all staff members at a women’s substance abuse program in Central California. The staff’s position is unique due to the fact that they used to be recipients of substance abuse services and are now providers of these services. This creates the dual relationship with the child welfare

system, which enables them to develop the insider/outsider perspective (Louis & Bartunek, 1992). The participants were selected through a non-probability, convenience sample.

A qualitative grounded theory approach was chosen as the most appropriate means to accomplish the purpose of the study. Grounded theory is used to “generate or discover a theory, an abstract analytical schema of a phenomenon, that relates to a particular situation” (Creswell, 1998, p. 56). Upon the participant’s consent, the interviews were recorded using a voice recorder. The participants in the study were individually interviewed about their experiences of shame during the times of their active use and while in recovery. Some of the questions asked were: “How has shame affected your life during the times of your active drug use? In what ways have social workers contributed to or helped you with your feelings of shame? How did you respond to these social workers? How do you experience shame now that you are in recovery?”

After all the interviews were conducted, the researcher transcribed the recorded interviews. The researcher then made notes about the interviews during the process transcribing. The transcripts were re-read during the process of open coding, where the individual interviews were examined and compared to each other in order to capture dominant phenomena. Process of axial coding was used in order to connect the phenomena and organize them into categories or themes. This process was repeated until the researcher felt that all recurring themes were exhausted.

### *Findings*

The four distinct categories or themes weaved through all of the women’s testimonies are The Past, Family, Self-Worth and Hope. These themes dominate the

narratives and have a major impact on women's shame, their interactions with social workers and the course of their lives. The findings are presented in the following matrix, which emerged out of data analysis:

Major Themes	Data summary	Worker Behaviors/Attitudes that Provoke Shame	Negative Consequences for Client	Worker Behaviors/Attitudes that Diminish Shame	Positive Consequences for Client
The Past	Remembering regretful past events, previous child welfare cases	Social worker bringing back past digressions; doubting women's ability to succeed; not acknowledging present successes and progress.	Social worker is perceived as confrontational, social worker appears to work against woman, increase in shame followed by anger and hostility	Social worker not bringing back past digressions; believing in women's ability to succeed; acknowledging present successes and progress.	Decrease in shame followed by openness, trust and motivation to grow and improve self
Family	Feelings and memories associated with being a mother and a daughter	Social worker blaming woman for her family's circumstances; threatening women by using children	Increase in shame followed by anger and hostility, increased shame often results in relapse and/or increased drug use	Social worker not blaming woman for her family's circumstances; not reminding mother of the consequences her behavior had on children's lives	Decrease in shame followed by openness, trust and motivation for change and maintenance of recovery
Self-Worth	Feelings of worth, positive view of self, seeing self as valuable	Social worker blaming, not showing empathy; having dismissive attitude; not returning phone calls, being inattentive and preoccupied, interrupting, having negative facial expressions	Increase shame followed by anger, self-loathing, hostility, withdrawal, relapse	Social worker returning phone calls, visiting women, showing interest, having respectful and accepting attitudes	Decrease in shame, healing, followed by participation, empowerment and motivation to work toward recovery
Hope	Positive outlook, belief in better future	Social worker not encouraging woman	Increase in shame followed by surrendering, withdrawing, not progressing in CWS case	Social worker expressing hope, faith and trust in woman, working toward same goal	Decrease in shame followed by openness, trust and motivation to change, progress of CWS case

These data shows that when child welfare social worker constantly remind the women about their substance abuse disorder and the past, it is perceived as confrontational and increases their shame, thereby, widening the gap between the social worker and the women. This can make women with substance abuse disorders feel as if the social worker is working against them and not for them.

These data show that women with substance abuse disorders often increase their drug use in order to numb their feelings of shame over child removal. The hurt caused to families during mother's active use can become a weapon in hands of child welfare social workers. Mothers with substance abuse disorders whose children are dependents of the court are ashamed of their failed motherly roles and reminding them of it increases their shame. When social workers do not blame women for their families' circumstances the women are more open to change and recovery.

These data further reveals that the mothers with substance abuse disorders often lack self-worth. Social workers can either help to build up women's self-worth or to tear it down. Blaming is counterproductive as it only reassures women in their belief that they have no worth. On the other hand, treating mothers with substance abuse disorders with dignity and respect, allowing them the time to tell their stories, and getting to know them personally can help them rebuild the brokenness shame had caused. This also motivates and empowers the women toward recovery. Often the smallest of social worker's actions has a devastating effect on the self-worth of these mothers, such as social workers not returning phone calls, being inattentive or preoccupied, interrupting, or having negative facial expressions.

These data indicate that feelings of hope are crucial for women's healing,

recovery and reunification with their children. Perception that their child welfare social worker is not working for them can quickly erode women's hope and ability to progress in their child welfare case. Feeling that a child welfare social worker is compassionate, non-judgmental and warm gives women a sense of hope for the outcome of her case, encourages them to trust the system, and to apply themselves toward recovery.

The way shame impacts interaction between mothers with substance abuse disorders and their child welfare social workers is further illustrated by the map presented in the Appendix A.

### *Discussion*

An analysis of the data supports the premise that shame plays a major role in interactions between mothers with substance abuse disorders and their child welfare social workers. The study supports that shame often blocks the view, intercepts communication and stands in the way of interaction. The research indicates that child welfare social workers can help alleviate or worsen women's feelings of shame.

The women in the recovery program often cannot identify their feelings and motives of their behavior, especially shame. Mothers view child welfare social workers as sources of authority and power and they seek their approval, encouragement, and support. The findings suggest child welfare social workers need to demonstrate empathy, patience, acceptance and respect in order to be effective in working with women with substance abuse disorders. The findings indicate that child welfare social workers have a limited understanding of the concept of shame and this hampers recovery and the woman's ability to engage in CWS services.

### *Limitations and Future Research.*

The limitation of the study is in the small number of participants. All the interviewees are also staff of the same agency in California's Central Valley. This may limit range of applicability to the general field of social work. It would be beneficial to conduct a study with women from a larger randomized sample, different agencies, different geographic regions and at varying stages of recovery. Future research in the area of shame and women substance abusers and women in recovery should include child welfare social workers. The prevalence of substance abuse related problems in the child welfare system creates urgency for new research that will help social workers better understand individuals with substance abuse disorders. Shame, being a critical component of reality of substance abuse deserves a deeper exploration, especially the way it affects individual's interface with governmental systems.

#### *Policy/Practice Implications*

The study points to the importance of child welfare social workers having a comprehensive understanding of substance abuse disorders, its causes and effects, and the effects shame has on women's ability to recover and care for her children. This suggests that child welfare social workers need to learn about the concept of shame, how it affects their work and how they can identify and avoid stigmatizing and shaming women, who often are the primary recipients of child welfare services. Although more research is needed, this and other research suggest that a worker's ability to minimize shame and demonstrate behaviors that are perceived as more supportive, may lead to better outcomes related to recovery and the reunification of families in some cases.

In addition to incorporating the concept of shame into existing substance abuse training, child welfare agencies could create an aggressive anti-stigmatizing campaign in

order to reinforce to social workers what stigma and shame is and how it affects recipients of services. The agencies could also create a policy that condemns stigmatizing behaviors toward substance abusing women and promote anti-stigmatizing behavior as a value endorsed by the agency. Hiring procedure for child welfare social workers may need to be evaluated in order to ensure that they share the values of the agency and that clients receive the most beneficial and professional treatment. Lastly, mothers with substance abuse disorders are experts on their lives. Child welfare agencies should get input from women with substance abuse disorders when creating policies, programs and services geared toward them.

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## Appendix A

