

King D. and Proeve M. (2007) Shame, guilt, depression, anxiety, and substance use amongst professional counsellors in Australia, *Counselling, Psychotherapy, and Health*, 3(1), 88-103, May 2007.



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Shame, guilt, depression, anxiety, and substance use amongst professional counsellors in Australia

Abstract:

This co-relational research examined the relationship between proneness to shame and guilt, depression, anxiety, and substance misuse amongst professional counsellors in Australia. Shame and guilt have been argued to have unique implications for one's thoughts, feelings, and behaviours. Shame involves the harmful criticism of one's self, whereas guilt involves the more adaptive and prosocial criticism of one's actions. Trait shame and guilt have been reported to have direct links to psychopathological symptoms and may also be associated with substance misuse. The present study examined these two emotions within a counselling context. Eight hundred and seventy-six professional counsellors in Australia were recruited using a multiple mailing method (40.8% overall response rate). Results suggested that professional counsellors in Australia tend to more guilt-prone than shame-prone, exhibit low levels of depression and anxiety, and do not engage in harmful levels of alcohol, nicotine, and caffeine use.

KEYWORDS:

Shame, guilt, depression, anxiety, substance use

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Introduction

Shame and guilt have been the subject of increased interest over the past two decades (Tangney & Dearing, 2002). Empirical research has demonstrated that shame and guilt are distinct emotions that involve distinct cognitive, affective, and behavioural outcomes. Shame has been described as the affect of inferiority (Kaufman, 1989). This classification of the emotion is fitting in two respects: it embodies the intensely painful affective experience of shame and the cognitive appraisal of the self as being flawed (Tangney, Miller, Flicker, & Barlow, 1996). In terms of affect, shame is associated with myriad negative emotional states, including sadness, helplessness, and jealousy, and is characterised by submissive behavioural displays, such as lowering of the eyes, shrinking of body posture, and physically hiding the face. Further, the experience of shame will often motivate the individual to act in perpetually maladaptive ways. Some authors have suggested that shame entails the painful cycle of mentally “reliving” a past transgression in the absence of positive reappraisal, or attempting “to escape” self-evaluation by engaging in physical or mental withdrawal (Gilbert, 2003).

In contrast, guilt involves the negative evaluation of the behaviour which lead the individual to failure or wrongdoing (Tangney & Dearing, 2002). Because the self is not the subject of criticism, it is spared from feelings of worthlessness, defectiveness, and vulnerability. However, guilt can still elicit harmful feelings, but because these feelings are centred upon a person’s behaviour, the pain is often less intense and less enduring over time. For these reasons, some theorists have suggested that guilt is the quintessential moral emotion, its evolutionary function being to heighten self-awareness of one’s maladaptive behaviours (Caplovitz-Barrett, 1995). In doing so, an individual can recognise an act of wrongdoing and be motivated to pursue constructive or reparative action.

The phenomenological differences between shame and guilt have prompted investigation into their clinical correlates. One prominent finding in the clinical literature is that shame is associated with other psychopathological symptoms, including depression and anxiety. Tangney, Wagner and Gramzow (1992) administered the Self-Conscious Affect and Attribution Inventory (SCAAI), the Beck Depression Inventory (BDI), and the State-Trait Anxiety Scale (STAS) to two large groups of undergraduate students ($N_1 = 245$; $N_2 = 234$). They reported that shame-proneness was strongly related to psychological maladjustment, correlating .43 with depression and .34 with anxiety. By comparison, all correlations between guilt and depression or anxiety could be attributed to the shared variance between shame and guilt. Thus, guilt was unrelated to both depression and anxiety. More recently, Gilbert (2000) investigated the relationship between shame, depression, and social anxiety using a clinical sample and an undergraduate student sample. It was found that shame-proneness was significantly correlated with depression for both the clinical group ($r = .35$) and the student group ($r = .36$). Further, shame-proneness was equally and significantly correlated with social anxiety for both the clinical and undergraduate group ($r = .54$). As Gilbert had hypothesised, guilt-proneness was negligibly correlated with depression in both groups.

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Ang and Khoo (2004) provide additional empirical support for the shame-psychopathology relationship. They investigated the role of shame in depression and anxiety amongst 331 secondary school students. Participants completed the Behavior Assessment System (BAS) and the Internalized Shame Scale (ISS). Consistent with their predictions, those subjects who belonged to the “high-risk” category for both anxiety and depression reported significantly higher shame scores than those students who belonged to the anxiety-only, depression-only and control groups. Taken together, these empirical studies offer evidence that the experience of shame is associated with depression and anxiety.

The Shame-Addiction Spiral

The present study was guided by Potter-Efron’s (2000) model of the shame-addiction spiral. Within this framework, shame is identified as the central catalyst for the development of problematic thought processes, psychopathological symptoms and maladaptive substance use. The “shame spiral” is a spatial analogy which details a proposed chain of cognitive and behavioural events which lead a person to engage in increasingly risky substance use behaviours. The model may be briefly summarised as follows. The first stage of the spiral involves the painful awareness of one’s personal defects, real or imagined. This awareness generates negative self-appraisals symptomatic of shame, e.g. “I have disappointed my colleagues, I am not a very reliable person”. As a result, the person will feel motivated to escape or withdraw. To achieve this, the person may seek psychoactive substances which the person may believe will facilitate the disengagement of the “self” from one’s self-criticism. However, the escape created by the substance is only temporary, and continual use will be necessary to maintain the physiological release. The substance provides only a false haven of retreat from one’s negative self-evaluation, and as such the substance serves to further negative appraisal, e.g. “I can’t even go one day without a drink, I am so worthless”. By this circuitous process, the initial shame reaction leads to substance use, which, in turn, reinforces shame. Potter-Efron argued that once this “shame-spiral” has begun, the person’s feelings of shame and substance-taking behaviour will often increase until the person reaches a terminal stage of total cognitive and physical oblivion.

On face value, Potter-Efron’s (2000) theory of the shame-addiction spiral is compatible with existing models of shame in the clinical literature. However, few empirical studies have attempted to identify and delineate the presence of shame in both psychopathology and substance misuse. A study by Meehan et al. (1996) examined shame, guilt, and depression among 108 patients from an addiction rehabilitation clinic. They reported that clients recovering from addiction scored significantly higher on the Test of Self-Conscious Affect’s (TOSCA) measure of shame-proneness and BDI depression than control subjects. Whilst Meehan et al.’s findings highlighted the importance of studying the role of shame and psychopathology in substance misuse, their study did not utilise statistical analyses which could have controlled for the interacting effects of shame and psychopathology. Therefore, it was difficult to determine whether shame or psychopathology played a more significant role in addiction.

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More recently, Dearing, Stuewig, and Tangney (in press) examined the role of shame in substance use among 235 undergraduates and 332 prison inmates. For the undergraduate sample, partial correlations revealed that shame-proneness was positively correlated with alcohol ($r = .31$), and drug use ($r = .17$), whereas guilt was negatively associated with alcohol ($r = -.27$), and other drug use ($r = -.26$). Similar relationships between shame, guilt, and substance use were found amongst the prison inmate group. On the basis of these findings, Dearing et al. have argued that shame and guilt should be regarded as qualitatively different in relation to substance use treatment issues. However, future research was deemed necessary to determine whether shame and psychopathology operate confluent upon substance misuse behaviour, or whether one of these individual variables plays a more significant role in substance misuse. At present, this question represents a significant gap in the literature which the present study seeks to address in the context of the counselling profession.

The Counselling Profession

The present study investigated levels of shame, guilt, depression, anxiety, and substance use amongst professional counsellors in Australia. Whilst professional counselling has numerous intrinsic rewards, such as positive client outcomes (Osborn, 2004), many authors also recognise that counselling is, by nature, an emotionally demanding field of practice (Kesler, 1990; Skovholt & Ronnestad, 2003). However, few studies have sought to investigate counsellors' emotional wellbeing beyond the short-term "burnout" experiences of beginning or novice counsellors (Ross et al., 2002). Significant stressors in the counselling profession include: the experience of working alone (Hewitt & Wheeler, 2004), the lack of necessary experience (Skovholt & Ronnestad, 2003), the absence of adequate resources (Sowa & May, 1994), the event of client suicide and relapse (McAdams & Foster, 2000), having unreasonable expectations of oneself (Truell, 2001), and professional despair (Kottler, 2003). For some counsellors, occupational stress may cause severe disruption to their daily lives, including conflict with family and other relationships, a marked decrease in leisure activity, and various problematic behaviours (Smith & Sulsky, 1995). These issues are of paramount concern as counsellors' wellbeing can impact upon the quality of service delivery to those individuals who seek counselling, in addition to the overall prosperity of the counselling field.

Shame in a Counselling Context

Shame has been explored in relation to the client in psychotherapy (Farber & Hall, 2002), however its effects upon the therapist have not yet been examined. The authors of the present study contend that shame could manifest and create significant problems within a counselling context. In reference to Potter-Efron's (2000) model of the shame spiral, shame may initially arise from a minor act of self-criticism following a negative counselling experience. Arguably the most emotionally painful of all counselling outcomes is client suicide. In a sample of 376 counsellors, McAdams and Foster (2000) reported 23% had experienced the suicide of a client who was under their care. Within that group, they found that many counsellors had reported experiencing clinical symptoms of depression as a direct result. Following an intensely emotional event like suicide, feelings of shame can arise as a counsellor engages in self-criticism, e.g. "I have let down my client, I am not a very good counsellor". In these circumstances, shame-

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prone counsellors struggling to overcome feelings of depression and anxiety associated with their workplace may turn to substance use as a means of coping. This practice may become increasingly problematic.

Whilst there is at present little evidence to suggest that shame and substance use are in actual fact major problems among counsellors, there is an increasing awareness that substance misuse affects the lives of many individuals, including those with medical and health backgrounds, who are presumably aware of the risks associated with their own substance misuse (Brooke, Edwards, & Andrews, 1993). Winwood, Winefield and Lushington (2003) reported that alcohol misuse has been identified as problematic for many within the health profession, including physicians, psychiatrists, psychologists, and nurses. In their study of 312 dentists, high levels of Copenhagen Burnout Inventory (CBI) stress and burnout were associated with risky levels of alcohol misuse. Similarly, a review by Fowlie (1999) concluded that alcohol and drug use posed a serious threat to the quality of conduct and service delivery provided by the medical profession. These authors underscore the importance of studying alcohol and other substance use amongst health professionals, as these individuals may misuse these substances as a means of coping with the stressful occupational conditions they face on a continual basis.

It should be acknowledged that counsellors are trained to deal effectively with clients' emotional problems as well as their own emotions. As stated earlier, to experience guilt is to identify one's behaviour, not one's self, as the responsible agent for an act of transgression. Thus, in a counselling context, guilt-proneness may be an adaptive strategy for dealing with poor client outcomes and other negative experiences. By feeling guilt, the counsellor can reflect constructively upon his or her actions following a negative client outcome. Future clients and work-related issues will then benefit from the counsellor's deeper awareness of his or her abilities, realigned self-expectations and therapeutic goals. Therefore, it appeared reasonable to expect counsellors to score highly on a test of guilt-proneness.

This research aimed to investigate the level of substance misuse in professional counsellors, and to contribute to current psychological understanding of the relationship of substance misuse to shame and guilt.

Hypotheses

The present study set out to investigate the relationships between shame-proneness, guilt-proneness, depression, anxiety, and substance misuse in a sample of professional counsellors in Australia. Given guilt-proneness is widely considered to be an adaptive emotion, it was not expected to be related to either depression or anxiety, nor any of the three substance use variables. The following hypotheses were posed.

1. Shame-proneness will be positively correlated with depression and anxiety.
2. Shame-proneness, depression, and anxiety will be positively correlated with all three types of substance use: alcohol, nicotine, and caffeine.

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3. Controlling for depression and anxiety, shame-proneness will explain a significant portion of the variance in all three types of substance use: alcohol, nicotine, and caffeine.

Method

Participants

The surveyed sample consisted of professional counsellors who were registered with the Australian Counselling Association (ACA). Survey packages were mailed to 2313 counsellors. Of the 943 returned surveys, 20 (2.1%) could not be used due to unclear or incomplete responses, 8 (.8%) indicated the subject declined to participate, and 39 (4.1%) were returned to sender. The remaining sample consisted of 876 counsellors and represented an overall response rate of 40.8%. Within that group, 303 (34.6%) replied after the first mailing, 207 (23.6%) responded after the reminder postcard, and 366 (41.8%) responded after the second survey. These figures offer support for the effectiveness of a multiple mailing design in psychological research. Whilst the present study's return rate falls below the 60% return rate reported by Asch, Jedrzejewski, and Christakis (1997), this return rate is comparable with other multiple mailing studies of counsellors, such as McAdams and Foster's (2000) study. All participants were guaranteed anonymity and no compensation was offered for their involvement.

Of the 876 counsellors, there were 665 (75.9%) women, 192 (21.9%) men, and 4 (.5%) intersexed individuals. The ages of the participants ranged from 20 to 78 ($M = 48.6$, $SD = 10.3$). In terms of relationship status, 602 respondents (68.7%) indicated they were either married or in a current relationship, 102 (11.6%) were single, 127 (14.5%) were either divorced or separated, and 23 (2.6%) were widowed. In terms of ethnicity, 731 (83.4%) respondents were Caucasian, 29 (3.3%) were Asian, 19 (2.2%) were Indigenous Australian or Torres Strait Islander, and 25 (2.9%) were from a non-English speaking background.

In terms of occupational setting, 437 (49.9%) respondents worked within a solo context, 212 (24.2%) worked within a group setting, and 130 (14.8%) indicated a combination of both types. Specific work environments were also investigated: 392 (44.7%) worked within a private practice, 85 (9.7%) worked within a government agency, 21 (2.4%) worked within a university or TAFE environment, 152 (17.4%) worked within a community group, 36 (4.1%) worked in a spiritual group, and 109 (12.4%) indicated they worked in a non-specified occupational setting. The number of years each counsellor had spent providing counselling services ranged from zero to 45 years ($M = 7.3$, $SD = 8.1$).

Materials

Participants completed a survey package containing four sections: (a) demographic information; (b) Test of Self-Conscious Affect-3; (c) Depression Anxiety Stress Scales; (d) Substance Use Inventory. The demographic information section requested details of age, gender, ethnic background, occupational setting, practice type, and the number of years spent counselling. This demographic and educational information was of importance due to the variation of educational backgrounds of counsellors (Pelling & Whetham, in press). All questionnaires were presented in varied sequential order to counterbalance subject effects of fatigue, boredom, or any change in motivation.

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Test of Self-Conscious Affect-3 (TOSCA-3). The Test of Self-Conscious Affect-3 is a 16-item self-report, scenario-based instrument which assesses shame-proneness, guilt-proneness, externalisation, and unconcern (Tangney & Dearing, 2002). The TOSCA is a useful tool for measuring these variables because it distinguishes clearly between the experience of shame and guilt. Given that the TOSCA is composed of phenomenologically-based items, it has been suggested that the threat of social desirability bias is reduced (Tangney, 1991). Another benefit of the TOSCA is that it does not use the terms “shame” or “guilt”, and thus no requisite knowledge of shame or guilt is required or assumed. In the present study, the shortened version of the TOSCA-3 was employed. Fontaine et al. (2001) reported the TOSCA-3’s estimates of internal consistency for each of the four subscales were 0.46 for Guilt, 0.70 for Shame, 0.56 for Externalisation, and 0.64 for Unconcern. Whilst these figures are relatively low, they are consistent with Tangney and Dearing’s (2002) findings.

Depression Anxiety Stress Scales (DASS). The Depression Anxiety Stress Scales (DASS) is a 42-item, self-report measure which assesses the emotional states of depression, anxiety, and stress. The DASS is based upon well-established empirical scales, such as the Beck Depression Inventory (BDI), and has been used in numerous clinical studies to identify emotional disturbance. The present study has focussed specifically upon the depression and anxiety subscales of this instrument. Crawford and Henry (2003) reported the Cronbach’s alpha for the DASS’ subscales were .91 for depression, .84 for anxiety, and .90 for stress. In terms of validity, the DASS has good convergent validity with other well-recognised psychopathology measures; it has been correlated .74 with the BDI and .81 with the Beck Anxiety Inventory (Lovibond & Lovibond, 1995). Principal-components analysis has demonstrated the DASS possesses high construct validity, a finding which has been replicated in studies of clinical and general populations (Crawford & Henry, 2003).

Substance Use Inventory. Whilst there are obvious benefits associated with the use of empirically established measures, there were certain disadvantages to using these measures in the context of the present study. First, many exhibit a high degree of social desirability, particularly for items of a personal or sensitive nature, e.g. the behaviour of an intoxicated spouse (Kantor & Straus, 1989) and therefore may be unwelcoming or non-applicable for non-clinical populations. Second, there are currently no empirically validated measures of alcohol, nicotine, and caffeine use available for research in psychology. Given this lack of an appropriate measure, a 12-item measure of alcohol, nicotine, and caffeine use, which assessed frequency and duration of use, was devised for the present study.

This instrument was designed to assess type, intake, and frequency of use of alcohol, nicotine, and caffeine. For example, the item “On a typical day, what type of alcohol do you drink (i.e. beer, wine, spirits)?” indicated the type of alcohol that the individual typically drinks. The item “On a typical day, how many alcoholic drinks do you have?” measured an individual’s level of typical alcohol intake. The item “In a typical week, how many totally alcohol-free days do you have?” indicated a person’s level of alcohol frequency. An advantage of this measure is that scores are directly comparable with

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Australian national standards for substance use (Australia Bureau of Statistics, 2004). Level of substance dependency was not the focus of the present study and therefore items of this nature were not incorporated into the measure's design. A benefit of this devised measure is that it yields continuous data, making it suitable for parametric statistics.

Procedure

Data were collected using a multiple mailing survey method. This procedure comprised four stages. Firstly, the ACA posted an information letter inviting all 2313 of its registered members to participate in the present study. This letter informed potential subjects that a survey package which would include all necessary information would be sent to them within a week. Although the ACA did provide a mailing list of all its members' names and addresses, all survey packages were non-identifiable. Further, each survey included an anonymous reply paid envelope, thus ensuring the confidentiality of respondents. The second stage involved delivering the first survey package to all ACA members. One week after the first survey package was delivered, a postcard was sent to all 2313 counsellors, which reminded them about the study and requested they return their survey package. Because all survey packages were anonymous, reminders were sent to all of the names and addresses on the mailing list, irrespective of whether they had returned their first survey package. One week following the reminder postcard, a second survey package was sent out to the participants, requesting their participation or instructing them to disregard the package if they had already returned their survey. Data were collected over a four-week period.

Results

Reliabilities

Internal consistency analyses were conducted upon the Depression Anxiety Stress Scales (DASS) and the Test of Self-Conscious Affect (TOSCA). For the DASS, the Cronbach's alpha values were .93 for the Depression subscale, .87 for the Anxiety subscale, and .92 for the Stress subscale. For the TOSCA, the Cronbach's alpha values were .80 for the Shame subscale, .72 for the Guilt subscale, .62 for the Unconcern subscale, and .65 for the Externalisation subscale. Reliability analyses were not conducted upon the Substance Use Inventory because each of the 12 items measured qualitatively different aspects of substance use.

Descriptive Statistics

Preliminary analyses revealed positively skewed distributions for the DASS subscales. In terms of depression, 289 out of 838 subjects indicated scores of zero for the Depression subscale. A further 494 participants reported Depression scores below 10 out of 42, the cut-off value for "mild depression" on the DASS. Thus, 48 out of 838 subjects reported evidence of depressive symptoms ($M = 3.11$, $SD = 4.95$).

In terms of anxiety, 292 out of 841 subjects indicated scores of zero for the Anxiety subscale. A further 488 participants reported Anxiety scores below 8 out of 42, the cut-off value for "mild anxiety" on the DASS. Thus, 61 out of 841 subjects reported evidence of anxiety symptoms ($M = 2.39$, $SD = 3.80$). Scores on the DASS were not transformed

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for the purpose of parametric analyses because the very high prevalence of zeros in each variable meant it was likely that any transformation would make no difference.

Three types of substance use were examined: alcohol, nicotine, and caffeine. In terms of alcohol type, 61 (7.2%) subjects indicated they drank beer, 367 (43.2%) subjects indicated they drank wine, and 55 (6.5%) subjects indicated they drank spirits. For alcohol intake, 466 out of 849 participants (54.9%) reported drinking zero alcoholic units on a typical day. A further 375 subjects (44.4%) reported drinking less than six alcoholic units in any given day. Therefore, only three out of 849 participants indicated a harmful level of alcohol intake in any given day, as defined by the National Institute of Health and Welfare's 2005 guidelines. For alcohol frequency, 75 out of 876 participants (8.9%) reported having less than two alcohol-free days per week. By combining alcohol intake and alcohol frequency, a dichotomous variable was computed which represented harmful or non-harmful alcohol behaviour (National Institute of Health and Welfare, 2005). None of the 876 subjects met the criteria for harmful alcohol behaviour.

In terms of nicotine type, 747 (88.0%) subjects indicated they did not use any nicotine, 92 (10.8%) subjects indicated they used either cigarettes or cigars, and 8 subjects (.9%) used either patches or gum. For those who reported nicotine use, the number of nicotine units used on a typical day ranged from one to 35 ($M = 10.54$, $SD = 9.25$). For parsimony, one nicotine unit was defined as one cigarette or cigar, or one nicotine patch or piece of gum. In terms of frequency, cigarette and cigar smokers reported smoking every day of the week. Given that cigarette smoking is considered to be harmful at any level (National Institute of Health and Welfare, 2005), it was reasoned that 92 out of 848 subjects (10.8%) met the criteria for harmful nicotine use.

In terms of caffeine type, 476 (56.1%) subjects indicated they drank tea, 541 (63.7%) subjects indicated they drank coffee, and 25 (2.9%) indicated they drank carbonated caffeine drinks. Of the 767 participants who used caffeine, 558 (65.7%) subjects reported zero caffeine-free days per week. For caffeine intake, 91 out of 847 participants (10.7%) reported drinking zero caffeine units on a typical day. A further 657 subjects (77.8%) reported drinking between one and five caffeine units in a given day. Therefore, 120 out of 847 (14.2%) participants indicated a potentially harmful level of caffeine intake in a given day, or more than five cups of caffeinated drink in a typical day, as suggested by Nehlig (1999).

Comparisons with Normative Data

Scores on the DASS subscales were compared with normative data. Table 1 gives the means, standard deviations, and range of the Depression and Anxiety scores for the present study in comparison to Crawford and Henry's (2003) study of 1,771 adults from the general population of the UK. In addition, the percentage of individuals who met each category of harm has been presented. In terms of depression, the mean and standard deviation for the present study were considerably lower than the general population of the UK. Table 1 also shows that a greater percentage of the present study's sample belonged to the *normal* criteria for depression in comparison with UK normative data. Similarly, there were considerably fewer individuals in the "mild", "moderate", "severe", and

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“extreme” categories for depression in comparison to UK normative standards. A Chi-Square Test of Independence confirmed this observation, showing significantly fewer individuals in the present study reported evidence of depression than the UK general population ($\chi^2 = 70.03, p < .01$).

In terms of anxiety, the mean and standard deviation for the present study were slightly lower than the general population of the UK. Table 1 shows that a similar percentage of the present study’s sample belonged to the “normal” criteria for anxiety in comparison with UK normative data. A Chi-Square Test of Independence confirmed this observation, showing no significant difference between the two group percentage means. There were slightly more individuals in the “mild” anxiety condition, however there were fewer individuals in the “moderate”, “severe”, and “extreme” categories for anxiety in comparison to UK norms.

Table 1
Comparisons of counsellors’ Depression and Anxiety scores with UK normative data

	<i>M</i>	<i>SD</i>	Range	Percentage in each DASS category				
				Normal	Mild	Moderate	Severe	Extreme
<u>UK sample</u>								
Anxiety	3.56	5.39	0 - 40	94.4	2.0	3.8	2.0	3.2
Depression	5.55	7.48	0 - 42	81.7	6.2	6.3	2.9	2.9
<u>Present Study</u>								
Anxiety	2.39	3.80	0 - 40	93.5	3.6	1.7	.8	.8
Depression	3.11	4.95	0 - 36	93.9	2.6	1.8	.8	.7

Scores on the TOSCA subscales were also examined across studies. Fontaine et al. (2001) have administered the TOSCA to a sample of 891 adults, however their study did not provide TOSCA means or standard deviations, and therefore this data could not be reported. Table 2 shows the present study’s TOSCA means and standard deviations in comparison to Gilbert’s (2000) study of 109 students and 50 depressed patients. Given the present study used the short 11-item version of the TOSCA and Gilbert (2000) employed the full 16-item version of the TOSCA, all scores have been expressed as percentages for easier interpretation. The 11-item TOSCA has been reported to correlate .93 with the 16-item version (Tangney & Dearing, 2002), and therefore this conversion was judged to be appropriate. However, unfortunately, inferential statistics could not be conducted to test the differences between these means.

Two interesting observations were made of the three group TOSCA means. First, the sample of professional counsellors reported a lower mean level of shame-proneness than both the students and the depressed sample. Second, the counsellors reported a higher

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mean level of guilt-proneness than both the student and the depressed sample. These observations may suggest that counsellors differ from other known populations in levels of shame- and guilt-proneness.

Table 2
Counsellors' percentage means and standard deviations for the four TOSCA subscales compared with a student and clinical sample

	Counsellors (N = 876)		Students (N = 109)		Clinical (N = 50)	
	M	SD	M	SD	M	SD
Shame	48.78	13.41	57.26	16.47	63.75	17.95
Guilt	81.36	10.47	73.60	12.44	72.32	18.09
Externalisation	39.67	10.65	54.69	11.73	48.92	15.81
Unconcern	56.16	10.38	38.65	9.86	36.27	11.05

Levels of reported substance use were also compared with Australian normative data. In terms of alcohol, the counsellor sample reported a zero percent rate of harmful alcohol use. This was lower than the 10% of the general population of Australia who met the criteria for harmful alcohol use in 2004, as reported by the Australian Institute of Health and Welfare (2005). In terms of nicotine, the present study's sample reported a 10% rate of harmful nicotine use. This was lower than the 17% of the general population of Australia who reported harmful nicotine use in 2004 (Australian Institute of Health and Welfare, 2005). Normative data for caffeine use within Australia has not been published and therefore comparisons could not be drawn. In sum, these findings demonstrated the appropriateness of using the Substance Use Inventory for the present study. Clinically-oriented instruments which tend to measure levels of substance dependency, such as the Alcohol Use Disorders Identification Test (AUDIT), would have been unnecessary, as well as unsuitable, given the sample's below-average frequency of substance use.

Correlations

Table 3 shows the correlational relationship between all of the relevant continuous variables. Given the severely skewed distributions of the depression, anxiety and substance use scores, Spearman rank-order correlations were conducted. This statistical technique is appropriate for use when assumptions underlying parametric correlation can not be met adequately (Tabachnick & Fidell, 2001). Hypothesis 1 proposed that shame-proneness will be positively correlated with depression and anxiety. As Table 3 shows, this hypothesis was supported. Further, guilt-proneness was unrelated to both depression and anxiety.

Hypothesis 2 proposed that shame-proneness, depression, and anxiety would each be significantly correlated with all three types of alcohol use. Table 3 shows the Spearman rank-order correlations did not show any significant relationship between shame-proneness, depression, or anxiety and any of the continuous variables of substance use. Therefore, Hypothesis 2 was not supported. Guilt-proneness was unrelated to all substance use variables.

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Table 3
Correlations between Shame- and Guilt-Proneness, Depression, Anxiety, and Substance Use

Variable	1	2	3	4	5	6	7	8
1. Shame								
2. Guilt	.43**							
3. Unconc	-.05	.04						
4. External	.45**	.13**	.34**					
5. Depress	.32**	.05	-.07	.13**				
6. Anxiety	.29**	.06	-.07	.15**	.67**			
7. Alcohol	.02	.03	.02	.03	-.01	.05		
8. Nicotine	.05	-.01	-.01	-.04	.00	.02	.05	
9. Caffeine	.05	.02	-.03	.03	.02	.03	.02	.19**

** $p < .01$.

Hypothesis 3 composed of three parts. It was predicted that shame-proneness, controlling for depression and anxiety, would explain a significant proportion of the variance in three types of substance use: alcohol, nicotine and caffeine. Given none of the 876 participants met the criteria for harmful alcohol use, the proposed relationship between shame-proneness, depression, anxiety, and alcohol use could not be tested. Thus, part one of Hypothesis 5 was not tested.

Logistic regression analysis of shame-proneness, depression, and anxiety as predictors of group membership to harmful or non-harmful nicotine use was conducted. None of the predictor variables were able to predict group membership to harmful nicotine use any better than chance. The Omnibus Tests of Model Coefficients reported $\chi^2 = .89$, $p = .83$. Accordingly, the Nagelkerke R Square value was .00. In terms of the individual predictors; for shame, the odds ratio value was .99; for depression, the odds ratio value was .99; and for anxiety, the odds ratio value was 1.01. Thus, the second part two of Hypothesis 5 was not supported.

Logistic regression using shame, depression, and anxiety as predictors of group membership to harmful or non-harmful caffeine use was conducted. None of the predictor variables were able to predict group membership to harmful caffeine use any better than chance. The Omnibus Tests of Model Coefficients reported $\chi^2 = 2.55$, $p = .47$. Accordingly, the Nagelkerke R Square value was .00. In terms of the individual predictors, for shame, the odds ratio value was 1.01; for depression, the odds ratio value was .97; and for anxiety, the odds ratio value was 1.03. Thus, the third part of Hypothesis 5 was not supported.

Discussion

Few studies have examined the relationship between shame and guilt, psychopathology, and substance use (Dearing et al., in press; Meehan et al., 1996). Further, no published study has assessed individual differences on these variables using a sample of professional counsellors in Australia.

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The first hypothesis predicted that shame-proneness would be positively correlated with depression and anxiety. Consistent with the clinical literature (Harder, 1995; Meehan et al., 1996), this relationship was observed in the present study. Shame was positively correlated with depression and anxiety, whereas guilt was negligibly correlated with these two psychopathological variables. Thus, the first hypothesis was supported.

The second hypothesis predicted that shame-proneness, depression, and anxiety would be positively correlated with all three types of substance use: alcohol, nicotine, and caffeine. These relationships were not found in the present study. However, it should be stressed that the distributions of depression and anxiety and the substance use variables were extremely skewed. Professional counsellors tended to report levels of depression and anxiety below the lowest cut-off value. In addition, the counsellors reported levels of substance use well below the Australian national average. Nevertheless, the second hypothesis was not supported.

The third hypothesis stated that, when controlling for depression and anxiety, shame-proneness would explain a significant portion of the variance in all three types of substance use: alcohol, nicotine, and caffeine. Given the extremely low prevalence of psychopathology and substance use in the sample, it was not unexpected that shame, did not significantly predict the indication of depression, anxiety, or substance use in the present study. Thus, the third and final hypothesis was not supported.

Emotional Wellbeing

The results strongly endorse a positive picture of professional counsellors' emotional wellbeing. An overwhelming majority of counsellors reported zero to low levels of depression and anxiety. When compared with normative data, counsellors' depression scores were significantly lower than the general population of the UK. There are two possible explanations for this finding. First, it may have been that the high face validity of the DASS caused a social desirability effect. The counsellors in this study may have felt uncomfortable reporting those psychopathological symptoms, however mild, which are often presented by their clients. Similarly, these counsellors may have believed that irrespective of confidentiality their emotional problems may have been perceived unfavourably by their colleagues, media bodies, and the general population. However, given the large number of participants provided their personal details and wrote additional comments to support their general wellbeing on their survey, the authors regard this explanation as unlikely.

More credibly, the results suggested that professional counsellors in Australia are emotionally well-balanced and generally cope quite well with the stress inherent to their occupation. We speculate that a combination of counsellors' personality traits, education and training, and practical experience act as a protective buffer against the potential harm of client-related and other environmental stressors.

As anticipated, counsellors tended to score highly on the study's measure of guilt-proneness. This finding fits neatly within the view of the counsellor as an "empathetic listener", who offers positive regard for others whilst managing their own emotions.

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Given the current literature on the beneficial effects of guilt, notably that guilt-proneness has been linked with social responsibility (Zahn-Waxler & Robinson, 1995), this finding has positive implications. In the counselling context, guilt-proneness may be a useful emotional style for managing the stressors which have been documented to affect the wellbeing and quality of service of helping professionals. In an applied setting, educators may recognise that guilt-proneness can be an adaptive emotional style of significant value to those individuals who choose to undertake counsellor training.

Substance Use

The professional counsellors in this study reported generally healthy levels of substance use. Specifically, not one of the 876 surveyed counsellors reported a harmful level of alcohol use. Similarly, only 10.8% of counsellors were cigarette smokers, which was 7% lower than the national average. Interestingly, a large number of counsellors (N = 120) consumed more than five units of caffeine every day. Further, the majority of the sample (65.7%) reported using caffeine every day of the week. This finding is perhaps representative of the nationwide use of caffeinated products, and reflects the need to better understand the psychological effects of this predominant pattern of consumption.

Conclusion

The professional counsellors in this study tended to possess a high degree of the prosocial trait called guilt-proneness. In addition, the surveyed sample of counsellors reported low levels of non-harmful depression, anxiety, and substance use. These results suggest that professional counsellors in Australia cope very well with the occupational stress inherent to their occupational field. Counsellors' high emotional wellbeing may be related to a combination of factors, such as a general resilience to stress, specific counselling expertise, personality variables, or relevant practical experience. Further research may offer additional insights into the coping mechanisms employed by this unique professional body. In sum, this research presents a positive view of the counselling profession in Australia and, by extension, the quality of care this professional organisation offers society in general.

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