



Shame and guilt/self-blame as predictors of expressed emotion in family members of patients with schizophrenia

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ABSTRACT

Expressed emotion (EE) is a measure of the family environment reflecting the amount of criticism and emotional over-involvement expressed by a key relative towards a family member with a disorder or impairment. Patients from high EE homes have a poorer illness prognosis than do patients from low EE homes. Despite EE's well-established predictive validity, questions remain regarding why some family members express high levels of EE attitudes while others do not. Based on indirect evidence from previous research, the current study tested whether shame and guilt/self-blame about having a relative with schizophrenia serve as predictors of EE. A sample of 72 family members of patients with schizophrenia completed the Five Minute Speech Sample to measure EE, along with questionnaires assessing self-directed emotions. In line with the hypotheses, higher levels of both shame and guilt/self-blame about having a relative with schizophrenia predicted high EE. Results of the current study elucidate the EE construct and have implications for working with families of patients with schizophrenia.

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1. Introduction

Expressed emotion (EE) is a measure of the family environment that specifically assesses emotions articulated by a key relative towards a family member with a disorder or impairment (Hooley, 2007). EE was first measured by the Camberwell Family Interview (CFI; Leff and Vaughn, 1985). The CFI examines EE on three subscales – emotional over-involvement (EOI), criticism, and hostility. EOI is a composite rating of factors including a relative's exaggerated emotional response; over-identification with the patient; over-intrusive, over-protective, or overly self-sacrificing behaviors (e.g., "I no longer do anything for myself because taking care of his needs is now my top priority"); and excessive concern. (Barrowclough and Hooley, 2003). Criticisms are comments about the behavior and/or characteristics of a patient that a relative resents or finds irritating. Hostility refers to a more generalized version of criticism (e.g., "I can't stand John"). CFI studies have demonstrated that hostility is rarely seen in the absence of high-EE based on criticism. Thus, researchers using the CFI often combine these categories (e.g., Weisman et al., 1998, 2000; Lopez et al., 2009) and newer systems of rating EE, such as the Five Minute Speech Sample (FMSS; Magaña et al., 1986), do not measure hostility as a separate component; instead, it is combined with criticism. EE is important because it is a robust predictor of illness prognosis across a

broad range of psychiatric disorders (Wearden et al., 2000) and, with a few exceptions, across a range of cultures and ethnic groups (Weisman de Mamani et al., 2009). Thus, it is crucial to understand why some relatives respond to a loved one's illness in a critical or emotionally over-involved manner while others do not (Hooley, 2007).

In the current study, self-directed emotions were examined as predictors of EE because some scholars have proposed that both shame and guilt/self-blame may underlie the construct (Jenkins and Karno, 1992). Following Bentsen et al. (1998) who stated that "self-blame is an equivalent of guilt," the current study uses guilt and self-blame interchangeably. Shame and guilt/self-blame are both self-evaluative emotions (Tracy and Robins, 2006). Despite their similarities, however, they are distinct emotions, with different cognitive, affective, and behavioral components (Tangney, 1995). There is some empirical research to support this distinction. For example, Weisman de Mamani (2010) found that increasing shame proneness was positively associated with the general emotional distress (GED) of caregivers. However, increasing guilt proneness was negatively associated with GED.

While guilt/self-blame induces interpersonal engagement and reparation for wrongdoing, Silfver (2007) argues that guilt might be maladaptive, for example, when a person feels guilty for an uncontrollable event like an illness. Hatfield (1981) suggested that high EE is the consequence of guilt. Because guilt encourages reparative behaviors, relatives who feel excessively blameworthy regarding the patient's illness may resort to over-involvement or sacrificing conduct in order to mend behaviors and events for which they feel guilty. Indeed, Bentsen et al. (1998) found that high levels of guilt-

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proneness, or a tendency to engage in self-blame, were positively associated with the EOI component of EE. Thus guilt may induce reparative behaviors but simply the wrong kinds (those that are maladaptive).

Proneness to shame correlates with a tendency to blame others by making external attributions for shame-eliciting events (Tracy and Robins, 2006). These attributions provoke defensive criticism toward those involved in the shame-eliciting situation, as well as anger, rage, and hostility (Gilbert, 1998). Jenkins and Karno (1992) suggested that shame about having a family member with schizophrenia may underlie EE because shame motivates rage, hostility, anger, and criticism. Ryan (1993) carefully examined the interaction between a man with schizophrenia and his wife, and pointed to verbal and nonverbal evidence of feelings of shame in the patient's high EE spouse. Ryan concluded that relatives' criticism might be a consequence of shame. Low EE family members, on the other hand, may feel less shame about their relatives' symptoms and illness (Harrison and Dadds, 1992).

In a study examining EE in relatives of patients with bipolar disorder, McMurrich and Johnson (2009) found depressive symptoms to be a significant predictor of EE while both guilt-proneness and shame-proneness were not. However, having a relative with bipolar disorder may not be as shame-inducing as having a relative with schizophrenia because bipolar disorder is frequently associated with positive behaviors such as creativity (Santosa and Sachs, 1999) and achievement (e.g. Johnson, 2005). Therefore the experience of shame and guilt may not generalize between the two disorders.

Weisman de Mamani (2010) also examined the relationship of self-directed emotions in relatives of patients with schizophrenia using a dispositional measure of shame and guilt. Dispositional measures assess endorsements of shame and guilt that are trait-like, or inherent, rather than situation-based. However, in this study neither shame proneness nor guilt proneness predicted EE. It is important to note that dispositional measures do not take into account the fact that there are individual differences in the specific types of events and situations that elicit shame, even in people with comparable overall propensity towards experiencing shame. Thus, Weisman de Mamani (2010) recommended that future studies assess whether EE is associated with relatives' shame and guilt specifically related to their loved ones' illness. This study is building upon the recommendations of Weisman de Mamani to specifically assess self-conscious (referred to in the current study as self-directed) emotions about having a loved one with schizophrenia as predictors of EE.

Unlike the Weisman de Mamani (2010) and McMurrich and Johnson (2009) studies which both used generic proneness measures of self-directed emotions, in the current study we examined the relationships among EE and relatives' feelings of shame and guilt/self-blame as a direct consequence of having a relative with schizophrenia. Based on the literature reviewed above, it was hypothesized in this study that greater shame and guilt/self-blame about having a relative with schizophrenia would each predict the occurrence of high EE in relatives of patients with schizophrenia. On an exploratory basis we examined whether shame and guilt/self-blame predicted the specific components of EE. We expected to replicate Bentsen et al.'s (1998) findings of guilt/self-blame predicting EOI. Furthermore, based on Tangney's (1995) and Gilbert's (1998) views that shame triggers anger, rage, hostility, and criticism, as well as Ryan's (1993) qualitative findings, it was hypothesized in this study that greater shame would predict the occurrence of high EE-critical attitudes.

2. Method

2.1. Sample

The current study was part of a parent study evaluating the efficacy of a 15-week, culturally informed, family-focused treatment for schizophrenia (CIT-5) compared with a treatment-as-usual control condition (TAU). Patients and their family

member(s) were recruited from Miami and neighboring cities through the use of local radio, newspaper, and Miami's above-ground rail system advertisements, and community outreach activities (e.g., lectures at support groups for the mentally ill and their family members, hospitals). Participants met the following criteria: the family member(s) had a relative with schizophrenia or schizoaffective disorder, the family member(s) and patient shared at least one hour of contact per week, and participants spoke English or Spanish. Participants were given the option to be interviewed in English or in Spanish and 18 chose to be interviewed in Spanish, while 54 chose to be interviewed in English. An editorial board was used to translate all measures into Spanish. An editorial board approach is considered to be more effective than translation-back-translation and accounts for language variations between Hispanic subgroups (Geisinger, 1994). A native Spanish speaker initially translated all measures from English to Spanish. Next, an editorial board consisting of native Spanish speakers of Cuban, Puerto Rican, Nicaraguan, Colombian, Mexican, and Costa Rican descent, and a non-native Spanish speaker, individually reviewed the Spanish translations and compared them against the original English versions. After independently reviewing the translations, the individuals met as a group along with the original translator to discuss and reconcile discrepancies and concerns with the translations. Board members agreed that the language used in the final versions of all the Spanish measures was clear, comprehensible, and relevant for members of all Spanish-speaking ethnic groups.

Participants consisted of 72 family members of patients with schizophrenia or schizoaffective disorder who completed the baseline assessment of the parent study. In the parent study, there were some cases where more than one family member participated. To ensure the independence of observations, only data from the family member who reported the most contact with the patient were included in the current study.

2.2. Measures

2.2.1. Background information

A demographic sheet assessed respondents' gender, age, ethnicity, religion, educational level, and SES.

2.2.2. Diagnosis confirmation

The diagnosis of schizophrenia or schizoaffective disorder in patients was confirmed using the psychotic disorders module of the *Structured Clinical Interview for the DSM-IV Axis I Disorders, Version 2.0, patient edition (SCID-I/P)*. The *SCID-I/P* (First et al., 2002) is a semi-structured interview designed for diagnosing patients with Axis I disorders according to DSM-IV criteria. The *SCID-I/P* has been widely utilized and has demonstrated high inter-rater reliability on individual symptoms and overall diagnosis of schizophrenia (Ventura et al., 1998). For the current study, the Principal Investigator trained all graduate-student interviewers. To assess inter-rater reliability in the current study, the Principal Investigator and all interviewers watched six videotaped interviews and determined an overall diagnosis. Interrater agreement using Cohen's Kappa was 1.0. In other words, there was complete consensus regarding the presence or absence of diagnosis.

2.2.3. Expressed emotion

Expressed emotion was rated using the *Five Minute Speech Sample (FMSS; Magaña et al., 1986)*. While the CFI remains the gold standard for assessing EE, the more recently developed FMSS is the second most widely used method and is considerably shorter to administer and to code (Hooley, 2007). Family members spoke, without interruption, for five minutes about the patient, telling the interviewer what kind of person the patient is and how the two of them get along. Family members' responses were audiotaped in order to allow for later coding of their speech sample. Using the criteria of Magaña et al. (1986), family members received a high EE-critical rating if they made a negative initial statement about the patient or the relationship between the patient and themselves, if they reported a negative relationship with the patient, or if they expressed one or more criticisms about their patient. Family members received a high EE emotionally over-involved rating if there was evidence for self-sacrificing, overprotective, or lack of objective behavior toward the patient; an emotional display; or a combination of two or more of the following: a statement of attitude (i.e., feelings of love or willingness to do anything for the relative in the future), five or more positive remarks, or excessive detail about the patient's past. FMSS interviews were inaudible in four cases; therefore EE ratings were only available for 68 families. Of these, 19 were rated as high EE and 49 were rated as low EE. With respect to the specific components of high EE, 9 out of 68 family members received a high EE critical rating, while 11 out of 68 received a high EE-EOI rating.

An undergraduate research assistant and a graduate student participated in intensive didactic training sessions in the FMSS scoring system with a trained FMSS coder. During the training sessions, the trained coder thoroughly reviewed rating criteria and co-rated 10 training audiotapes with the trainees. The trainees then individually rated 10 additional audiotapes to assess their reliability with the trained coder. The kappa coefficient between the research assistant and the trained coder was 0.80 for rating high versus low EE, 0.86 for rating the critical component, and 0.74 for rating the EOI component. The kappa coefficient between the graduate student and the trained coder was 1.00 for rating high versus low EE, 1.00 for rating the critical component and 0.78 for the EOI component.

2.2.4. Shame and guilt/self-blame

The *Self-directed Emotions for Schizophrenia Scale* was created for the larger parent study described above. This scale is a two-item measure, with one item assessing

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