Psychiatry Research 216 (2014) 17–23

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Self-conscious emotions' role in functional outcomes within clinical populations

Rebecca MacAulay*, Alex Cohen

Louisiana State University, Department of Psychology, 236 Audubon Hall, Baton Rouge, LA 70803, U.S.A.

ARTICLE INFO

Article history:
Received 19 July 2013
Received in revised form
9 January 2014
Accepted 14 January 2014
Available online 22 January 2014

Keywords:
Pride
Shame
Neurocognition
Severe mental illness
Quality of life
Affect

ABSTRACT

Patients with severe mental illnesses (SMI) often experience dysfunction in their ability to efficiently carry out everyday roles and/or skills. These deficits are seen across many domains of daily functioning. We suggest that the "self-conscious emotions" of pride and shame play a role in these functional outcomes. Pride and shame appear to facilitate individuals' ability to evaluate their group status, detect social threats, and to adjust their behaviors accordingly. This study utilized an objective performance measure of functional capacity and a self-report of quality of life (QoL) to examine the respective roles of pride and shame in functional outcomes within two SMI patient groups (schizophrenia and affective disorder) and a community control group. The influence of neurocognition, affect and symptomatology on functional outcomes was also assessed. The patient groups did not differ in cognitive functioning, QoL, or shame. The schizophrenia group reported significantly higher pride and displayed worse objective performance than the other groups. Within each of the groups, shame had an inverse relationship with QoL, while pride positively associated with QoL. Shame associated with worse functional capacity in the schizophrenia group. Shame associated with better functional capacity, while pride associated with worse functional capacity within the affective disorder group.

1. Introduction

Patients with severe mental illnesses (SMI) frequently experience dysfunction in their ability to efficiently carryout everyday roles and/or skills. These deficits are seen across a multitude of domains, to include: independent living skills, vocational and financial responsibilities, and interpersonal relationships (Green et al., 2000, 2004). While there has been some success in attenuating patients' symptoms via current psychosocial and pharmacological interventions there remains notable impairments in patients' daily functioning skills (Bowie and Harvey, 2006). Thus, determining factors that significantly influence functional outcomes in clinical patients remains an important direction for research. Research suggests that affective traits, as well as neuro – and social cognitive dysfunction are associated with measures of functional outcomes in patients with a SMI (Horan et al., 2008; Fett et al., 2011; Keefe et al., 2004); however, a large proportion of variance in functional outcomes still remains unexplained by these factors. Moreover, while increased attention has been paid to the role of broad emotional factors (i.e., positive affect: PA and negative affect: NA) in functional outcomes, the emotions that comprise the domains of PA and NA are considerably heterogeneous in many regards (e.g., differences in their underlying neurobiological mechanisms and interpersonal functions). In the present paper, we propose that the "self-conscious emotions" of pride and shame, which are linked to distinct global, internal, and stable attributions about the self (Lewis, 2007; Tangney and Dearing, 2002; Tangney et al., 1992; Tracy and Robins, 2007b), are important to understanding how emotional factors influence functional outcomes both generally, as well as pathologically. Pride and shame were examined in terms of functional capacity (as measured by a brief version of the UCSD Performance-based Skills Assessment: UPSA-2; Patterson et al., 2001) and quality of life (QoL) within two SMI patient groups (schizophrenia and affective disorders), as well as a matched community control group. The independent contributions of neurocognition, affective traits and symptomatology on functional outcomes were also assessed.

Individual differences in the tendency to experience negative as compared to positive emotional states has been linked to an increased risk of developing a clinical disorder, as well as being found in patients with a SMI (Blanchard et al., 2001; Watson et al., 1988a, 1988b). Specifically, trait PA, defined as the tendency to experience positive emotions (e.g., enthusiasm and pride) is associated with improved QoL and better functional outcomes; whereas trait NA, defined as the tendency to experience negative emotions (e.g., anger and shame), is associated with worse community functional outcomes within schizophrenia (Blanchard et al., 1998; Horan et al., 2008). These relationships appear to be independent of cognitive impairment and symptomatology within schizophrenia

* Corresponding author. Tel.: +1 310 995 7620; fax: +1 225 578 4125.
E-mail address: rkmacaulay@gmail.com (R. MacAulay).

0165-1781/$ - see front matter © 2014 Elsevier Ireland Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.psychres.2014.01.022

patients. Similar relationships between QoL and affective traits have also been found within non-clinical populations (see Lyubomirsky et al., 2005). However, while there appears to be a link between emotional factors and functional outcomes, more research is needed to understand how such factors might influence outcomes. To address this issue, this study examined the emotions of shame and pride, which we believe to be more proximally related to functional outcomes. As we will discuss, shame and pride both have distinct neurobiological correlates, involve internalizing self-relevant attributions styles, play an important role in the development of self-esteem, and are related to one's ability to function within social groups.

Emotional experience is important to understanding pathology in that emotions have distinct underlying biological mechanisms that serve to differentially influence our behavioral and psychological responses in response to environmental challenges (see Damasio, 2004). Importantly, information regarding an emotion's functional role might be masked when solely focusing on the broad affective domains. For instance, the emotions of anger and shame are both included in the measurement of NA, yet the experience of anger often involves external attributions of other-blame, whereas the experience of shame involves the negative evaluation of oneself and attributions of self-blame (see Lazarus, 1993; Tracy and Robins, 2007b). Moreover, the experience of anger and shame appear to serve different functions as well as elicit different behavioral patterns (e.g., approach vs. avoidance).

As discussed, emotions play an important role in guiding social behaviors. In particular, the complex emotions of shame and pride appear to distinguish themselves from other emotions both biologically and behaviorally. Shame and pride appear to facilitate individuals' ability to evaluate their group status, detect social threats, and to adjust their behaviors accordingly. Pride is largely viewed as a positive emotion and is believed to reflect positive internal attributions that are both stable and centered on beliefs about ones' core competencies (Tracy and Robins, 2007b). Pride is activated in response to actions that promote group acceptance, and developmentally the experience of pride reinforces behaviors associated with obtaining positive group social status, which in turn serves to develop and maintain one's self-esteem (Tracy and Robins, 2007a). The experience of pride is also linked to perceptions of competence and warmth of one's social group members (see Harris and Fiske, 2007). Pride is linked to both less depression and trait anxiety, as well as greater relationship satisfaction (see Tracy et al., 2010). Conversely, shame is a negative affective state that involves the experience of negative evaluation of oneself and is linked to physiological changes (i.e., cortisol release) in response to psychosocial stress (see Dickerson and Kemeny, 2004). Shame can serve an adaptive function through shaping (i.e. discouraging) maladaptive behaviors (e.g., fighting or stealing), however the repeated experience of shame is associated with deleterious outcomes such as depression and a negative self-image, as well as having potential underlying biological mediators that heighten stress reactivity (e.g., heightened cortisol release and lowered serotonin) and increase behavioral avoidance (see Gilbert and McGuire, 1998; Gilbert, 2000; Gruenewald et al., 2004). Furthermore, while shame is significantly associated with negative attribution styles – it appears to make its own independent contributions to depression (Tangney et al., 1992). Shame has been linked to greater behavioral avoidance as well as severer pathology in both depression and schizophrenia (Gilbert and McGuire, 1998; Gilbert, 2000; Morrison, 1985) and has been found to mediate the relationship between perceived low social status and depression (Tracy and Robins, 2007a). Moreover, the experience of shame is associated with physiological responses to stress (stress induced cortisol) that are linked to pathology within both depression and schizophrenia (see Southwick et al., 2005 and Walker et al., 2008). Similar, stress-induced relationships with shame have been found in children (Lewis and Ramsay, 2002). Clinically speaking, shame may be an important treatment target to improving functional outcomes within SMI populations. Shame has proven to be an important and modifiable predictor of health-related quality of life in other highly stigmatized health conditions (HIV-positive individuals; Persons et al., 2010). In this regard, greater understanding of the role of shame, which is commonly reported by patients with a SMI, may help to inform treatment interventions (Miller and Mason, 2005; Morrison, 1985).

Pride and shame are also closely tied to the maintenance and development of self-esteem. Developmentally shame appears to contribute to the development and maintenance of negative beliefs about oneself (e.g., "I always fail because I am incompetent"), whereas the tendency to experience pride enhances one's self-image (Lewis, 2007). In this regard, individual differences in pride and shame would play a prominent role in the development of core competencies and the maintenance of such perceptions, which in turn would influence functional outcomes. Indeed, pride and shame have both been posited to be a mechanism by which the maintenance and enhancement of self-esteem may occur (see Tracy and Robins, 2007a). Consistent with this notion, Brown and Marshall (2001) found that pride and shame (as measured by single-item scales from the Positive and Negative Affect Schedule: PANAS; Watson et al., 1988a, 1988b) accounted for 83% of the variance in self-esteem scores, and they were the only emotions that significantly predicted self-esteem scores. In summary, self-conscious emotions appear to play a regulatory in social behaviors that influence functional outcomes.

Neuro- and social-cognitive factors appear to play a role in functional outcomes; however, as Fett et al. (2011) meta-analysis on the relationship between cognition and functional outcomes in schizophrenia illustrated, there remains a large proportion of unexplained variance in functional outcomes. Specifically, social cognition and neurocognition, which both appear to independently contribute to functional outcomes, leave approximately 75% of the variance in functional outcome measures unexplained (Fett et al., 2011). Similarly, while patient symptomatology has been linked to QoL, a large proportion of variance remains largely unaccounted for by symptomatology alone in patients with schizophrenia, schizoaffective and/or a mood disorder (Kuehner and Buerger, 2005; Ritsner et al., 2000). This research also suggests that psychosocial factors play an important role in the subjective QoL of patients with a SMI. Thus, studying pride and shame, which are predictive of such factors is an important direction for research that might help to inform future treatment interventions and research.

The expression of pride and shame in response to success and failure appears to be a cross culture phenomena that cannot entirely be explained by social learning processes, as the behavioral expression of these emotions in response to winning and losing are also evident in the congenitally blind (Tracy and Matsumoto, 2008). From a neurological perspective it is becoming increasingly evident that social cognitive and affective processes are reliant on similar systems and often appear to have an interdependent nature (e.g., emotional understanding and experience both play a critical role in social interactions; see Kennedy and Adolphs, 2012; Olsson and Ochsner, 2008). Shame and pride in particular have both been associated with regions of the brain associated with social cognition (particularly, the ability to make inferences about others intentions), as well as motivation systems. Specific neural activations within medial and inferior frontal gyrus have been found for shame as compared to guilt (Michl et al., 2012). Neural regions in the right posterior superior temporal sulcus and left temporal pole have been found to be activated in pride but not joy conditions (Takahashi et al., 2008), and although