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Guilt, shame and expressed emotion in carers of people with long-term mental health difficulties: A systematic review

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ABSTRACT

Expressed emotion (EE) is a global index of familial emotional climate, whose primary components are emotional over-involvement (EOI) and critical comments (CC)/hostility. There is a strong theoretical rationale for hypothesising that carers' guilt and shame may be differentially associated with their EOI and CC/hostility respectively. This systematic review investigates the magnitude of these theorised associations in carers of people with long-term mental health difficulties. Electronic searches (conducted in May 2016 across Medline, CINAHL, Embase, PsycINFO and ProQuest) were supplemented with iterative hand searches. Ten papers, reporting data from eight studies, were included. Risk of bias was assessed using a standardised checklist. Relevant data were extracted and synthesised narratively. EOI was positively associated with both guilt and shame, whereas CC/hostility was positively associated with shame. The strength of associations varied depending on whether or not guilt and shame were assessed within the context of the caring relationship. Based on these data, an argument can be made for the refinement, development and evaluation of systemic and individual interventions designed to target carers' guilt and shame. However, more research is needed to clarify the strength of these associations and their direction of effect before firm conclusions can be drawn.

1. Introduction

Expressed emotion (EE) is a global index of familial emotional climate, which encompasses family carers' attitudes, emotions and behaviours towards the person(s) to whom they provide care (Barrowclough and Hooley, 2003). Expressed emotion is usually defined in terms of its primary components: emotional over-involvement (EOI), critical comments (CC), and hostility (Barrowclough and Hooley, 2003). The term 'EOI' refers to overly self-sacrificing and/or intrusive behaviours and exaggerated emotional responses. Hostility and CC have a similar conceptual basis and often co-occur (Barrowclough and Hooley, 2003). As such, the term 'CC/hostility' is commonly used within the EE literature to refer to critical behaviour, character-focused statements and/or the presence or demonstration of negative attitudes towards service-users, including negative comments regarding their traits or personality (Barrowclough and Hooley, 2003).

Whilst not pathological in itself, EE is a robust predictor of prognosis across various psychiatric diagnoses (Butzlaff and Hooley, 1998; Weintraub et al., 2016). The negative association between EE, particularly EOI, and the mental health and well-being of carers is also widely noted (Brietborde et al., 2010; Jenkins and Karno, 1992). To this end, family interventions (FIs) have been developed to target and reduce aspects of EE whilst increasing carer support and raising awareness of factors contributing to EE (Pharoah et al., 2010). However, despite being recommended by clinical practice guidelines worldwide (American Psychiatric Association, 2004; Galletly et al., 2016; National Institute for Health and Care Excellence, 2014), FIs are poorly understood at the process level (Gracio et al., 2016). Furthermore, there exist a number of organisational, psychological and practical barriers to the dissemination and implementation of FIs within routine clinical practice (Bucci et al., 2016).

In an attempt to increase the precision and deliverability of current

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interventions, increasing research attention has focused on exploring both the psychological processes associated with EE and their mechanism of action (Barrowclough and Hooley, 2003). Cognitive approaches to understanding individual differences in carers' EE have mostly explored the utility of an attribution-based framework primarily focused on carers' attributions regarding the person affected by mental health difficulties (Barrowclough and Hooley, 2003; Kuipers et al., 2010). However, the attributions that carers make about their own roles in the development or maintenance of the illness are also likely to be of importance, as are the emotional states associated with such attributions (Jenkins and Karno, 1992; Robins and Schriber, 2009). Attributing one's own actions to internal, unstable and controllable causes is believed to engender guilt, whilst attributing them to internal, stable and uncontrollable causes is thought to result in shame (Tracy and Robins, 2006). This systematic review focuses on these two emotional states: guilt and shame.

Guilt and shame are self-evaluative emotions with distinct behavioural, affective and cognitive profiles (Tangney and Dearing, 2002; Tracy and Robins, 2006). Central to this distinction is the importance of the role of the self. Guilt reflects a judgement about one's behaviour or actions, resulting from the perception that a specific, transient and changeable aspect of one's behaviour has had a negative or undesirable effect upon another ('I did this bad thing'; Robins and Schriber, 2009). Guilt is thought to facilitate empathy and drive prosocial and reparative behaviours as a means of ameliorating feelings of responsibility for others' distress (Tangney and Tracy, 2012). To this end, guilt is often considered an adaptive emotion. However, guilt can become maladaptive when individuals develop an exaggerated or distorted sense of guilt for events that occur out of their control, or when reparation is not possible for a behaviour (Tangney and Tracy, 2012). As such, guilt may be an important factor to consider with respect to the development and maintenance of EOI. Carers experiencing guilt may engage in help-giving behaviours driven by a desire to make amends for an illness or specific challenging behaviours or difficulties for which they feel responsible (Hatfield, 1981). However, although initially adaptive and reparative, these behaviours may become maladaptive if they are perceived by carers to be ineffective or if carers assume disproportionate levels of responsibility for service-users' difficulties or behaviours (Tangney and Tracy, 2012). To this end, guilt may both lead to, and maintain, EOI behaviours. However, guilt is unlikely to be associated with CC/hostility as these behaviours serve no reparative function (Tangney and Tracy, 2012).

In contrast to guilt, shame reflects an enduring and stable judgement about oneself or one's character, arising as a result of real or perceived negative evaluation from others and/or negative self-evaluation ('I did this bad thing'; Robins and Schriber, 2009). In keeping with this differentiation, shame is often considered to be a maladaptive emotion, as individuals often defend against the painful negative feelings of shame by externalising blame onto others in the form of defensive criticism, hostility and aggression (Brown, 2004; Tracy and Robins, 2006). Shame may therefore be an important consideration with respect to CC/hostility, as it may drive carers to engage in defensive, regulatory anger-driven behaviours designed to protect their social image (Gausel et al., 2016; Jenkins and Karno, 1992).

If empirical evidence supports the theorised links between guilt and shame and components of EE, then they may represent potential targets for intervention (Gilbert and Irons, 2005). However, no systematic examination and synthesis of the current evidence-base regarding the relationships between the constructs has been conducted. This systematic review aimed to address this gap by using systematic review methodology to examine the associations among guilt, shame, EOI and CC/hostility.

2. Methods

2.1. Search strategy

The conduct and reporting of this review adheres to the general principles recommended by the Centre for Reviews and Dissemination (CRD, 2009) and the Meta-Analysis of Observational Studies in Epidemiology (MOOSE) guidelines[4] (Stroup et al., 2000). After several scoping searches, five electronic databases (Medline, CINAHL, Scopus, PsycINFO and ProQuest) were searched for relevant published and unpublished literature from their inception until October 2015. Searches were devised in collaboration with an information specialist[5] and contained no methodological search filters or disorder-specific keywords that would limit results to specific study designs or diagnostic groups. Table 1 details the search syntax used for each database. Conference proceedings and the authors' own files were then examined for additional relevant literature, followed by the reference lists of both included full-text studies and recent systematic reviews concerning the psychological factors associated with EE (Anastasiadou et al., 2014; Jansen et al., 2015). Finally, corresponding authors of included papers were contacted for information regarding studies in progress and unpublished research. Searches were repeated in October 2016 to identify any relevant new publications.

2.2. Study selection

Identified studies' titles and abstracts were simultaneously screened to assess their relevance to the review. Full-text copies of potentially relevant studies were then examined. Screening at both stages was done independently by two authors (MGC and JWR). Disagreement or uncertainty was resolved through consensus and the views of the wider research team were consulted where necessary. Studies were included if they: a) were published in English; b) reported data from family carers aged 18 years or over who provided care to relatives aged 18 years or over with long-term mental health difficulties; and c) reported quantitative data sufficient for computation of effect size(s) regarding the relationship(s) between guilt and/or shame and EOI and/or CC/hostility. The term 'long-term mental health difficulty' was defined as any non-organic mental health difficulty of ≥six months' duration (Barrowclough et al., 1998); specific diagnoses were not used as inclusion/exclusion criteria as EE is associated with outcome across a range of mental health difficulties (Butzlaff and Hooley, 1998).

2.3. Assessment of risk of bias

Risk of bias in included studies was independently assessed by MGC and JWR using a tool adapted from the Agency for Healthcare Research and Quality (Taylor et al., 2015; Williams et al., 2010). This tool allows for risk of bias to be assessed in nine specific areas, thus enabling comparability of specific issues across included papers (Jüni et al., 1999). Disagreement or uncertainty was resolved through consensus and/or arbitration by a third reviewer (PJT). In line with CRD (2009) guidance, no study was excluded based on the findings of the assessment of risk of bias.

2.4. Data extraction and analysis

Relevant demographic, methodological and summary data were extracted using a standardised data extraction form by MGC and independently checked for accuracy by JWR. Disagreement or uncertainty was resolved through consensus and the views of the wider

[4] A checklist designed to aid clear reporting of meta-analyses and systematic reviews of observational data.

[5] An individual with expert knowledge in bibliographic databases and information retrieval.