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The Role of Gender in Shame, Hostility, and Aggression Experienced by Caregivers for Patients With Dementia

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Abstract

The aim of this study was to investigate the differences between male and female caregivers for patients with dementia in the way they experience various psychosocial parameters such as shame, hostility, and aggression. The sample included 55 caregivers of patients with moderate and severe dementia, whereas the average age was 51 years. Female caregivers were found to experience significantly higher levels of external shame, measured by Other As Shamer scale, than male caregivers, t (53) = 2.54, $P < .01$. A significant difference was also found between the female and male caregivers regarding their recorded levels of internal shame, measured by Experience of Shame Scale, with female caregivers experiencing more internal shame than their male counterparts, t (53) = 2.11, $P < .01$. However, no significant differences were found in hostility and aggression between males and females. These results demonstrate the existence of gender differences in the levels of shame experienced by care providers for patients with dementia.

Keywords

gender, shame, dementia, caregiving

Introduction

Shame is generally characterized as an intense negative feeling, which involves feelings of incompetence and inferiority followed by the need to hide these perceived shortcomings.[1] There is also the added danger of internalizing the experience of shame causing the person to resort to behaviors (withdrawal from social activities, avoidance of social situations) that may provoke negative opinions from others regarding the person's personality.[2,3]

In regard to caregiving in dementia, shame can be caused by different reasons. The caregiver may feel shame about the patient's behavior (eg, wandering in the neighborhood, making sexual remarks in public), which is often socially incompatible, which means that the patient's behavior is absonant with the caregiver's social norms and values. The caregiver's thoughts about not doing enough to help the patient with dementia (PwD) may also be a cause of shame. Additionally, in the final stages of dementia, it is common for caregivers to feel emotionally exhausted. This may sometimes bring about thoughts of relief, which the patient's death would bring, which in turn makes the caregiver feel shame for having made this kind of thoughts about a loved person. Consequently, shame experience as well as the fear of being criticized by others' expectations can be associated with depression and fear of entrapment in the role of caregiving.[4,5] For that reason, further research has to be conducted in order to investigate what is more likely to cause increased levels of shame in caregivers.

On the other hand, feelings of hostility and aggression are also found in caregivers of PwD. Specifically, Razani et al[6] support that increased problems in activities of daily living found in PwD are positively related to increased levels of hostility and aggression in their caregivers. Additionally, according to Anthony-Bergstone et al,[7] anxiety as well as hostility levels were both increased in caregivers of PwD irrespective of gender.

It is noteworthy that according to Rudd et al,[8] gender is a strong predictor of the 4 psychological states of grief, that is, anxiety, sadness, anger, and guilt, in spousal caregivers of PwD. In more detail, caregiving wives had increased grief responses of anxiety, depression, anger, and guilt in

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comparison to caregiving husbands. Additionally, a significant meta-analysis from Thompson et al[9] highlights that male caregivers had significantly lower levels of depression, stress, and anger–hostility compared to women. However, due to the lack of studies identifying the role of gender in caregivers as regards the negative emotions toward the self, such as shame, as well as feelings of aggression and hostility, it is of great significance to investigate whether the aforementioned emotions really differ between males and females. Additionally, taking into account that feelings of shame and embarrassment along with the fear of being stigmatized when someone is diagnosed with dementia,[10] it is really important to investigate the factors associated with increased levels of shame in caregivers of patients with dementia.

Material and Method

The main objective of the study is to analyze gender differences on shame, hostility, and aggression. More specifically, we hypothesized that women would exhibit greater feelings of shame based on previous studies in which female caregivers were more prone to experience anxiety and depressive symptomatology, as well as caregiving burden compared to male caregivers.[11,12] However, according to our knowledge, there are no previous studies measuring shame, hostility, and aggression levels between male and female caregivers.

Participants

The study took place in "Saint John" Day Care Center for PwD, which is one of the day care centers that operates under the intendance of the Greek Alzheimer's Association. Eligible to take part in the study were individuals who were the main caregivers for a PwD. These caregivers were family caregivers and specifically spouses and children of the patients over the last 5 years. The total number of participants was 55 (34 females and 21 males), whereas the average age of the sample was 51 (standard deviation [SD] = 12.42) years.

Procedure

The caregivers had initially came to the day care center accompanying their patients who had their scheduled medical appointment. During their visit, they took part in the study after they had been informed about its scope and signed the informed consent. The ethics approval was given by the Greek Alzheimer's Association' Ethical Committee. The exclusion criteria for the study were depression diagnosis, whereas each participant should have been the main caregiver of the patient in the last 5 years.

Material

Other As Shamer Scale. External shame refers to evaluations, which are focused on the aspects that one believes others would reject or judge negatively if they became public. External shame, therefore, involves cognitions about how one thinks others view one's self. Internal shame is not always correlated with external shame, like in the case of someone who engages in an externally socially inappropriate and therefore shameful situation (eg, visiting prostitutes), which does not necessarily result in the person feeling internal shame due to these actions.[13] Other As Shamer (OAS) scale was developed by Goss et al[14] as an instrument of measuring external shame.[14] This is done by measuring the extent to which other people are seen as potentially shaming or derogating of one's self. Eighteen items, which assess subjective beliefs about what others think of the individual (eg, I think that other can see my shortcomings), are rated in a 5-point Likert scale ranging from 0 to 4 depending on how frequent each of the statements are experienced by the individual. Other As Shamer scale can be divided into 3 subscales: (1) inferior, (2) empty, and (3) mistakes. The score for each subscale is the sum of the scores on the corresponding questions, whereas the total score for the OAS is the sum of the scores on all the questions.[13,15] Paschou et al[15] have found the Cronbach alpha for the Greek version of the OAS to be 0.87. The OAS has been repeatedly used in a number of studies on shame.[15-18]

The Experience of Shame Scale. Internal shame has to do with one's negative self-evaluations and self-directed affects (eg, feeling disgusted with oneself) about one's self. In short, the person has negative feeling and views about one's behavior or physical and personality attributes. These negative feelings are related to cognitions and affects that the individual has concerning one's personality characteristics, behaviors, or attributes. Experience of Shame Scale (ESS) is a questionnaire consisting of 25 items that measure characterological shame (shame of personal habits, manner with others, sort of person one is, and personal ability), behavioral shame (shame about doing something wrong, saying something stupid, and failure in competitive situations), and bodily shame (feeling ashamed of one's body or any part of it).

The Symptom Checklist-90–Revised. The Symptom Checklist-90–Revised (SCL-90-R), which was created by Derogatis,[19] is a psychological assessment instrument that is widely used today by psychotherapists. It is commonly used as an aid in diagnosis, measurement of treatment outcomes, and gathering information for treatment planning. The checklist has been administered to clients with a variety of diagnoses, different demographic backgrounds, and in both inpatient and outpatient settings.[19] The instrument is composed of 90 items. These items describe the most commonly identified symptoms found in medical and psychiatric patients.[20] More specifically, the SCL-90-R includes 9 primary symptom dimensions and 3 global measures in order to represent symptomatic distress. The 9 symptom dimensions are somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism, whereas the global indices are Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total.[19] Symptom Checklist-90–Revised has been found to be both reliable and

Table 1. Demographic Data.

	Women	Men
Gender	34	21
Age, mean (SD)	50.16 (4.66)	52.52 (4.51)
Education, mean (SD)	10.11 (5.07)	9.03 (5.30)

Abbreviation: SD, standard deviation.

valid for the measurement of treatment outcomes when traditional methods of psychological instrument assessment were used.[21] For the purposes of the current study, only the dimension of aggression was assessed.

The Hostility and Direction of Hostility Questionnaire. The Hostility and Direction of Hostility Questionnaire (HDHQ) is a well-standardized self-rating scale comprised of 5 subscales, which assesses hostility and the direction of hostility. The combination of these subscales provides scores of Intropunitiveness (Self-Criticism and Guilt subscales) and Extrapunitiveness (Acting-Out Hostility, Paranoid Hostility, and Criticism of Others scales). Extrapunitiveness in particular has been found to have a significant correlation with expressed emotion.[22,23] Several studies have confirmed the validity of the HDHQ, while in regard to the Greek population, it has been applied to a sample of normal individuals, to individuals recovering from depression, and finally to somatic patients.[22]

Statistical Analyses

Independent samples *t* tests were performed for the examination of the differences between female and male participants regarding the following variables: OAS, ESS, HDHQ, and the aggression subscale of SCL-90-R. Finally, the Pearson *r* parametric statistical test was carried out for the examination of possible correlations between all the variables for the sample in total. An α value of .05 was used for all statistical analyses.

Results

The sample's demographic data are presented in Table 1, whereas mean scores and the SDs for the independent samples *t* tests for all variables are displayed in Table 2.

External and Internal Shame

The independent samples *t* test showed that female caregivers (mean [M] = 17.85, SD = 11.30) were found to experience significantly higher levels of external shame than male caregivers (M = 11.00, SD = 6.36), t (53) = 2.54, $P < .01$. A significant difference was also found between the female (M = 51.12, SD = 14.66) and male (M = 43.52, SD = 9.51) caregivers regarding their recorded levels of internal shame, with female caregivers experiencing more internal shame than their male counterparts, t (53) = 2.11, $P < .05$.

Table 2. Means (Standard Deviations) with *t* Differences.[a]

Psychological Parameters in Caregivers for PwD			
	Female n = 34	Male = 21	Differences
	Mean (SD)	Mean (SD)	*T*
OAS total (external shame	17.85 (11.30)	11.00 (6.36)	2.54[b]
ESS total (internal shame)	51.12 (14.66)	43.52 (9.51)	2.11[b]
HDHQ	15.91 (5.67)	17.43 (7.30)	−.86
Aggression (SCL-90-R)	3.85 (3.00)	3.62 (2.40)	0.30

Abbreviations: ESS, Experience of Shame Scale; HDHQ, Hostility and Direction of Hostility Questionnaire; OAS, Other As Shamer Scale; PwD, patient with dementia; SD, standard deviation; SCL-90-R, Symptom Checklist-90-Revised.
[a]n = 55.
[b]$P < .05$.

Table 3. Correlations Between Shame, Aggression and Hostility.

Variables	OAS	ESS	HDHQ	Aggression (SCL-90-R)
OAS (external shame)	–	.61[a]	.17	.11
ESS (internal shame)		–	.38[b]	.32[c]
HDHQ			–	.43[b]
Aggression (SCL-90-R)				–

Abbreviations: ESS, Experience of Shame Scale; HDHQ, Hostility and Direction of Hostility Questionnaire; OAS, Other As Shamer Scale; SCL-90-R, Symptom Checklist-90-Revised.
[a]$P < .001$.
[b]$P < .01$.
[c]$P < .05$.

Psychopathology (SCL-90), Aggression Subscale

No significant differences were observed as regard the aggression between males and females, t (53) = −.30, $P > .05$).

Hostility and Direction of Hostility Questionnaire

No significant differences between female and male caregivers were found regarding hostility as measured by HDHQ, t (53) = −.86, $P > .05$).

Correlations

Table 2 shows the correlations between the psychological scales that were used. According to the results, internal shame is positively related with aggression ($r = .32$, $df = 53$, $p < 0.05$) and hostility ($r = .38$, $df = 53$, $p < 0.01$), which means that an increase in the internal shame that is experienced by the caregiver is significantly associated with an increase in levels of aggression and hostility.

Discussion

The results of this study point to the fact that gender plays a significant role in the levels of both internal and external shame that are experienced by caregivers of PwD. This is in line with

our previous hypothesis that shame would be increased in females. More specifically, it has been shown that female caregivers were more prone than their male counterparts to feelings of shame when having to provide care for a PwD. What is more, female caregivers also experienced higher levels of internal shame, making them more vulnerable to their own feelings. Several theories have argued for the existence of dispositional tendencies, which make some people more prone to experience shame and guilt than others. These individual differences relate to a range of interpersonal and intrapersonal adjustment characteristics.[24,25] The present study showed that gender is also a factor that affects the experience of shame, at least in caregivers of PwD.

The results of this study highlight the vulnerability of female caregivers of PwD toward feelings of shame. Taking into consideration that female relatives constitute the majority of caregivers for this kind of patients, it becomes essential that professionals should work toward relieving them from a factor that may contribute in elevating their perceived psychological burden, which in turn may result in premature institutionalization for the PwD and psychological and physiological problems for the caregivers.

What is of great value is that according to the Stress Process Model, proposed by Pearlin et al,[26] the primary stressors which come from the daily demands of the caregiving, such as patients' behavioral disturbances, lead to secondary problems related to economic problems, family conflicts, and problematic self-perceptions about their role as caregivers. This is also supported by other studies[4,27] which found that caregivers are certain to develop one or more of negative feelings about the self, such as disappointment, guilt, frustration, hostility, and aggression, which can be probably regarded as symptoms of depression or anxiety.

In more detail, feelings of shame and guilt may come from the caregiver's self-criticism,[4] feelings of inadequacy that may have, and perception concerning the activities and the stressors, which derive from the provision of care. Consequently, it is of great importance to further study negative feelings toward the self, such as shame, as well as hostility and aggression, because there is less theoretical and empirical investigation on this.

Due to the lack of studies examining internal and external shame in comparison with caregiving in dementia, the present study may serve as a reference point for future research on the role of gender in the levels of shame felt by caregivers. Therefore, it is quite important to investigate the factors which can cause shame in caregiving of PwD. However, it seems that hostility and aggression do not differ between men and women. Further studies should focus on the relationship between shame and psychological burden. As regard the psychological factors of hostility and aggression, it seems that they are not affected by gender in the current study. Therefore, it is quite important to identify whether this finding will be confirmed by future research.

The results of this study are added to previous research data suggesting that shame levels are linked to lower levels of education, acculturation, and reduced knowledge about Alzheimer's disease.[28] Given that increased feelings of shame are associated with delayed access to health services, onset of treatment,[29,30] and the increasing burden for caregivers of PwD,[31] it is important to identify the factors involved in increasing the levels of shame in this population.

On the other hand, there are some significant limitations. At first, the size of the sample is relatively small compared to relevant studies. A second limitation has to do with the fact that certain variables such as the age of the caregiver, the stage of the PwD, and the relation (spouse and child) of the caregiver with the patient were not controlled for. A younger caregiver for example could feel less shame than an older one, because of the changes in society's acceptance of this disease in the recent years. Additionally, it would be of great significance to identify whether levels of shame are also higher in women who live in eastern cultures in order to confirm the generalizability of the study's findings. Finally, having depressive symptoms as a covariate variable of the study, we could investigate whether levels of shame would be also increased in female caregivers, irrespective of depressive symptomatology. Despite that in our study one of the exclusion criteria was depression diagnosis, the relationship between shame and depressive symptomatology in elders is very strong.[32] Therefore, it would be very useful to eliminate the impact of depressive symptoms, even if they are not so intense to set the diagnosis of depression.

Conclusions

These results demonstrate the existence of gender differences in the levels of shame experienced by care providers for PwD. Taking into account that except of dementia awareness, caregivers of patients with dementia have high levels of psychological burden,[33] it is really important to advance our understanding of shame and potentially use it as a point of therapeutic intervention in caregivers of patients with dementia, especially in women. Finally, this article addresses an issue that is under—studied in the caregiving literature—shame, as well as aggression and hostility, focusing on the crucial role of gender in caregivers of PwD.

Declaration of Conflicting Interests

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