Expressed Emotion: A Family Perspective

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Abstract

Although mental health professionals have shown much enthusiasm for the concept "expressed emotion (EE)," little critical analysis of the concept has appeared in the literature. Placing families in dichotomous categories of high EE and low EE amounts to stereotyping; such an approach does little to help professionals in understanding the complexities of family life with a mentally ill relative. High EE is seen as a factor that maintains mental illness in a relative. Once more, families feel hurt and alienated. Once more, families feel negatively labeled, but not empathically understood.

"Expressed emotion" is a relatively new concept to appear in the mental health literature. Since expressed emotion is a term used to describe families with a mentally ill relative, it is of considerable interest to members of the National Alliance for the Mentally Ill. The concept has never been fully defined, so we must infer its meaning from the way it is measured and from the way it is used in the literature. Expressed emotion is assessed by administering a series of psychological tests to family members at the time a patient is hospitalized or is receiving other treatment. How family members respond to these tests is used to characterize them as having high expressed emotion (high EE) or low expressed emotion (low EE). These family characteristics are thought by researchers to be related to the rates of relapse of the member who has schizophrenia (Brown, Birley, and Wing 1972; Vaughan and Leff 1976, 1981; Liberman et al. 1980; Falloon et al. 1982; Vaughan et al. 1982). There is a growing interest in EE on the part of mental health practitioners, who are developing various kinds of family treatment approaches based on this concept. This article explores the EE concept, its limitations, and some of the implications of its widespread use.

What Is Expressed Emotion?

Interest in EE has grown out of the work of Brown, Birley, and Wing (1972), British researchers who reported that certain family styles characterized by high EE influenced the course of schizophrenia, with high EE leading to the increased probability of exacerbation of symptoms or relapse. The EE level is inferred from a score on the Camberwell Family Interview, which is usually administered at the time the patient is admitted to the hospital (Brown and Rutter 1966; Rutter and Brown 1966). Snyder and Liberman (1981) explain the concept as follows:

The number of criticisms [made by family members to their ill member] together with the quality of emotional over-involvement expressed by relatives designates them as high or low EE. [Scores] of 6 or more criticisms or 4 or more on the 6-point emotional over-involvement scale place a family in the "high" EE category. Relatives with 5 or fewer criticisms and ratings of 3 or less on emotional over-involvement [make up] the "low" EE group.

It is clear from this definition that one critical comment more or less
can determine whether a family is categorized as a high EE family or a low EE family. If the family is determined to have high EE, professional intervention is recommended to protect the patient from relapse. Research attempting to establish that point is reviewed below. But first we must look at the EE concept to determine if it provides a useful way of looking at families.

Limitation of the Concept and Its Uses. As noted above, EE studies place all families into one of two categories: families with high EE and families with low EE. Moreover, one critical comment more or less can change a family’s designation. Writers in this area assume that families tend to be consistent in their characteristic level of EE over time unless there is professional intervention. In the light of these issues, the first question to be addressed is whether placing families in these either/or categories of high and low EE is valid. Human characteristics rarely, if ever, occur in either/or dimensions. Rather, they usually occur on a continuum, with different people showing amounts of a characteristic at different times and under different circumstances. For example, we do not label people as “hostile” or “not hostile.” Everyone has some potential for hostility, and hostility itself occurs on a continuum from mild to extreme. This must be equally true of expressed emotion. Dividing all families into high EE and low EE categories is a crude way of looking at families that is akin to labeling or stereotyping complex human interactions.

Much has been written about families’ feelings of alienation from mental health professionals (Hatfield 1983; Spaniol et al. 1984). Families often feel that professionals show little understanding of how families experience mental illness, its tremendous burdens, and its terrible sorrows. Professionals seem not to grasp the complexities of these families’ lives, and their advice is sometimes simplistic and inappropriate. The EE concept that guides much current practice does little to help professionals understand the family experience and perspective on mental illness in the family. Further, it tends to require that professionals look for the negative in families’ interactions, i.e., the high EE, to the exclusion of all that is positive in these families. This may increase the alienation between families and professionals and preclude effective partnership on behalf of the ill person. Professionals, having placed a label on families, may feel that they then understand the family and its dynamics, thus foregoing the kind of effort that must be made to achieve real understanding and empathy for each family’s struggles and needs.

As indicated above, the Camberwell Family Interview, which is used to establish EE level, is often done at the time of hospital admission. This is predictably a time of tremendous confusion and upset in the life of family members who have often been attempting to cope with their ill family member and the mental health system for a long period of time. That these family members might feel considerable frustration and anger at the time of admission is not surprising. However, it has not been established that the way a person behaves in an acute anxiety-provoking situation such as hospital admission is typical of his or her usual coping style in the natural home environment. Researchers assume that EE is a stable characteristic over time, but they have not demonstrated this fact through empirical research.

Finally, the extent to which EE is an artifact of culture must be addressed. In U.S. studies, more families with a schizophrenic relative show high EE (70 percent) than in British studies (45 percent). In India, almost all families were found to be low EE while Mexican-American families were midway between the English and Indian rates (12 percent). This wide diversity in EE responses may hold some promise for understanding cultural response to chronic mental illness.

Negative Labeling. It is important to emphasize that although research has shown an association between relapse of patients and high EE, it is a statistical relationship. It does not mean that high EE is the cause of relapse, although some families and some professionals interpret the relationship between the two factors in that way. It is possible that the family’s high EE and the patient’s relapse are both functions of other factors—the failure of the system to help, the lack of knowledge about mental illness and coping strategies to deal with it, the degree of the patient’s dysfunction and how it expresses itself, and other stresses and tensions in the larger environment.

Since high EE is seen as undesirable, then high EE families may justifiably feel that they have been labeled “bad families.” Once again, the focus is on family deficit and families are viewed negatively. Professionals seem unaware of the depth of family caring, the persistence of family members in the face of incredible odds, their creativity and inventiveness, and their heroic efforts to aid their family member when there is little positive in his or her life. There is, perhaps, more to be learned from studying the strengths of people rather than their frailties. It is upon their
strengths that alliances with professionals can be built. Yet the psychiatric profession continues to emphasize deficits over strengths.

Even though a causal relation between high EE and relapse has not been proved, there is a tendency to infer that the family causes relapse as noted in the following titles found in recent mental health journals: "Family Factors in Schizophrenic Relapse" (Vaughn et al. 1982); "The Influence of Family Life on the Course of Schizophrenic Disorders" (Brown, Birley, and Wing 1972); "Family Management in the Prevention of Exacerbation of Schizophrenia" (Falloon et al. 1982); and "Social and Family Factors in the Course of Schizophrenia" (Liberman et al. 1980). These titles suggest a linear relationship between family behavior and the ill member's psychiatric condition that is causal in nature. It is not surprising that families often feel that there is an element of blame in such writing.

Research in Expressed Emotion

In spite of these serious concerns about the usefulness of the EE concept, and its implications, research has shown that there is a clear relationship between what is measured on the Camberwell instrument and patient relapse. In the study of Brown, Birley, and Wing (1972), the relapse rate for patients in families exhibiting high EE was 21 percent compared to 26 percent for those families with low EE. While this is an important difference, it must be noted that 21 percent of those with high EE families did not experience relapse. This seems to suggest that some patients do well in spite of high EE or, possibly, because of it.

A number of research studies now report consistent findings of a relationship between EE levels and patient relapse (Brown, Birley, and Wing 1972; Vaughn and Leff 1976; Wing and Leff 1976; Wing 1972; Anderson, Hogarty, and Reiss 1981; Anderson, Hogarty, and Reiss 1980; Liberman et al. 1980; Falloon et al. 1982; Vaughn et al. 1982; Falloon, Boyd, and McGill 1984). In these studies, relapse ranged between 48 and 62 percent in high EE families and between 9 and 12 percent in low EE families, while one study found that patients relapsed more frequently in low EE families. Unfortunately, most of these studies had no control groups, were based on patients in a mixture of diagnostic groups, and varied in subjects' age, gender, and stages of schizophrenic illness. The time period for follow-up of the patient varied from 9 months to 2 years (Platman 1983).

A troublesome aspect of current research is its tendency to measure only one outcome variable—relapse or rehospitalization of patient. While relapse is a great concern of families, merely keeping people out of the hospital is not the only important factor. What is important is the long-term progress of the patient and the quality of life of patient and family. Too much focus on the negative aspects of stress may inhibit families from holding high enough expectations of their family member, with the consequence that families will protect him or her from the normal life stressors needed for growth. Families may avoid setting firm limits on behavior for fear of creating stress and thereby causing relapse. Too strong an emphasis on low EE may lead to apathy and withdrawal. High unexpressed emotion may lead to psychosomatic illnesses on the part of families or more indirect expressions of irritation at the patient. In any event, the stress of mental illness is felt not just by the mentally ill individual, but also by the other family members attempting to cope with their disabled relative. Where family members' capacities to manage the array of difficulties that accompany mental illness are strained to the limit, strong emotions are likely to occur. Stress, of course, can be a negative factor for persons who experience schizophrenia and other forms of mental illness, and some families may need help and support to keep the amount of stress down. Most families are quite aware that their ill relatives respond poorly to stressful situations and intuitively offer protection to them.

Research and professional opinion support the idea that there are biological explanations for the vulnerability to stress of persons with mental illnesses. Anderson, Hogarty, and Reiss (1980) indicate that people with schizophrenia have a deficit that interferes with the way they process stimuli. Such individuals have great difficulty in adequately screening out excessive stimuli and are easily overwhelmed by it. Stress creates anxiety, which further interferes with cognitive functioning. Given this understanding of mental illness, it is necessary to ask whether the critical comments and overinvolvement measured in the EE studies are necessarily the most likely stressors in mental illness. If the problem is cognitive processing under conditions of high stimulation, then stimulation from any number of sources could be stressful—too many people around, too fast and complicated communication, too much that is unexpected happening, and too many demands for high performance—all of which may raise the level of stress to intolerable limits. What is stressful also may vary widely from person to person. To focus so closely on critical comments seems shortsighted; more important sources of stress could be...
overlooked. It must be remembered
that psychiatric patients also relapse
when they are in staffed residences,
in psychosocial centers, and even in
hospitals. It is unfortunate that the
professional literature focuses al-
most exclusively on instances of pa-
tient relapse in the home. This leads
families to feel that they are selected
out for blame—that professional atti-
dudes really have not changed very
much and that new forms of bias are
being expressed in the EE measures.
If the Camberwell Family Interview
predicts relapse well, then logic dic-
tates that it should be used to assess
staff in clinics, hospitals, and other
patient services for their EE level
and its relationship to problems of
recovery.

Realistically, both families and
professionals know that many pa-
tients cycle through bad periods and
relapse even when there are no dis-
cernible changes in the environ-
ment. There are clearly unaccount-
able factors in many relapses, and it
is unfortunate if families or profes-
sionals must feel or attribute blame
for the existence of recurrent mental
illness. The baffling problem of re-
current illness is one that families,
patients, and professionals share.

EE and Family Intervention

The theory of EE does not lead to
any clear prescription for interven-
tion with families. A variety of ap-
proaches, usually called psy-
choeducation or family therapy, have
been developed, all of which have
the goal of lowering EE and preven-
ting relapse. When client outcome is
measured, irrespective of the design
of the program, the rate of relapse is
usually reduced. Nothing in the lit-

t
erature to date indicates which pro-
gram is best, or what factors or
combinations of factors in these in-
terventions actually make the dif-
ference. A sample of the elements of
treatment that vary from program to
program include:

- The presence or absence of 24-
  hour professional backup to deal
  with crises.
- The location of treatment,
  whether in the home, clinic, hospi-
  tal, or elsewhere.
- The involvement of the patient
  in a program of skill development
  or other treatment.
- The manner in which medica-
tion is monitored and controlled.
- The level of functioning of the
  patient.
- The length of the program, the
  training and background of the
  therapist, and his/her professional
  style.
- The content of the program and
  the relative emphasis on emotional
  support, communication skills,
  problem solving, and behavioral
  management.

It is fair to say that something is
working to reduce relapse in fam-
ilies participating in these programs,
but there is no clarity as to what the
key variables are that make an im-
pact. Simply having a better under-
standing of mental illness and
having some skills to deal with it
may improve coping, lower frustra-
tion, and lessen the tendency to be
critical. More efforts are needed to
tease out the important factors in
these complex interventions. Great
claims are being made about the
efficacy of psychoeducation, but
psychoeducation is not a standard
program; rather, it involves a variety
of approaches.

It is possible that none of the com-
ponents of programs mentioned
above are basic to the prevention of
relapse. In an interesting small
study, Byalon, Jed, and Lehman
(1982) reported that just making in-
formal home visits, offering support
and concern, and little else, to fam-
ilies with severely ill relatives re-
sulted in significantly lower relapse
rates. The common ingredient in
successful programs may be that
they inadvertently offer support to
families. On the other hand, it is
also possible that the one message
getting through to families is “under
no circumstances should the patient
be hospitalized.” The family, then,
may be bearing the brunt of coping
with a highly disordered patient in
the home. We simply do not know
what the salient factors are that re-
duce relapse.

A rapidly growing segment of
mental health professionals are
highly intrigued with the concept of
family EE. Many professionals are
looking at psychoeducational treat-
ments as a new panacea for the

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discussions of this policy issue and they will not easily accept someone else making a decision that affects them so deeply without themselves being involved. If a large cadre of professionals are trained in psychoeducational models, they will want the opportunity to apply their training. Thus, it will be to their advantage to have patients live at home, with the professional training families for the caregiving role. It has been widely stated that many mental health professionals do not like to work with severely disturbed people. Assigning this difficult task to families reduces the involvement of professionals in what some consider "unrewarding" work. A comment recently overheard by one of the authors (A.B.H.) illustrates the point: "It used to be that mental health professionals cared for the mentally ill and they failed," the mother said. "Now they have families doing caregiving so they can be the ones who fail." The National Alliance for the Mentally Ill (NAMI) must involve itself in this issue.

Conclusion

Although there is serious question about the use of EE as a conceptual framework, it has led to, or capitalized on, an existing trend of providing more information, support, and skill training to family caregivers. We believe that most families find this trend encouraging, with the skills and information generally useful. Since there is no clarity as to which of the many aspects of these programs is crucial in preventing relapse and since families often have many additional goals or needs, it seems logical that these family consumers should select the kind of help they need. Each family knows its own situation best.

The movement toward developing useful techniques for helping families cope with a disabled member need not depend on the problematic EE research. There are other theoretical frameworks (Hatfield 1985) that can be used and that neither label families negatively nor imply that families cause relapse. EE theory is not enough of a departure from traditional theories that blamed families for mental illness to overcome families' feelings of alienation from the mental health profession. The search for an alternative conceptual framework should be continued.

In a recent survey of NAMI affiliates, housing appeared at the top of legislative goals. There was no evidence that families were advocating more staff to train the family in caregiving skills. This clearly indicates that most families feel that their psychiatrically disabled member should live in community residences rather than in the family home. This goal is in conflict with the goals of those administrators and professionals who wish to make the families caregivers. While it is true that some families may want and need professional help to see them through the transitional period during which adequate residential alternatives are developed, families may not want to support heavy investment in family training to the extent that it diverts attention and money away from their primary goal, residential services for the disabled family member.

References


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