Explain how expressed emotion can influence outcomes in mental illness

Expressed emotion (EE) is a significant characteristic of the family milieu that has been found to predict outcomes in a wide range of mental disorders, (Brown et al., 1962; Butzlaff & Hooley, 1998). This essay will expound upon high and low expressed emotion, discuss the implications for outcomes, and review cultural limitations.

The interactions of high EE families are characterized by hostility, over-involvement, and critical comments toward the patient (Brown et al., 1962), which are measured via the Camberwell Family Interview (Vaughn & Leff, 1985). Hostility is conceptualized as generalized criticism of the patient and/or expressions of attitudes which are rejecting of the patient (Wearden et al., 2000). The hostility is generated from the family’s belief that the person is in control over the course of their illness which holds the patient accountable for adverse events (Mohapatra, 2013). Over-involvement reflects a feelings and behaviours of a family member towards the patient, indicating evidence of over-protectiveness or self-sacrifice; this is perpetuated by the idea that the patient is helpless and not able to do things for themselves (Barrowclough et al., 2001). Criticism is defined as comments about the behaviour or characteristics of the patients which the respondent clearly resents or is annoyed by (Pratibha et al., 2012).

Conversely, families characterized as low EE demonstrate positive regard and warmth (Vaughn & Leff, 1985). Positive regard comprises of remarks that express appreciation or support for patient's behaviour and verbal/nonverbal reinforcement by the caregiver (Brown et al., 1962). Warmth is based on kindness, concern, and empathy expressed by the caregiver while talking about the patient (Brown et al. 1962). It depends greatly on vocal qualities with smiling being a common accompaniment, which often conveys an empathic attitude by the relative (Mohapatra, 2013).

These family characteristics have been demonstrated to have impact on patient outcomes. Research has found that 87% of studies on EE found a significant association between high EE and patient relapse with a medium to large effect size (Butzlaff & Hooley, 1998). Furthermore, while EE has been extensively researched in schizophrenia, this study found that high EE also has high predictive reliability for mood and eating disorder relapse. Leff et al. (1985) found that families that engaged in therapy work to achieve low EE observed an 8% relapse rate as compared to 50% in the control group. This association may be explained by positioning EE within the diathesis-stress model of psychopathology, characterizing it as an environmental stressor that can potentially precipitate/cause relapse of psychosis among people with a genetic vulnerability (Hooley & Hiller, 2000).

EE has also been linked to alcohol use and relapse. Alcohol dependence is higher among people with mental illness (Regier et al., 1990). O’Farrel et al. (1998) showed that high EE families exacerbate drinking via constant criticism and cause relapse when a patient is attempting to achieve sobriety, whereas warmth facilitated recovery. Alcohol use in this population is associated with more physical illness, hostility, medication non-compliance, early hospital readmission, suicide, interpersonal and family problems, and homelessness (Whiteford et al., 2013). Thus, high EE indirectly worsens all these domains.

EE also has implications for learning. Learning is a challenge for individuals with developmental and/or learning disabilities even before any environmental obstacles are put into