

# Expressed Emotion: A Family Perspective

by Agnes B. Hatfield, Leroy Spaniol, and Anthony M. Zippie

## 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; Vaughn and Leff 1976, 1981; Liberman et al. 1980; Falloon et al. 1982; Vaughn 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

Reprint requests should be sent to Dr. A. B. Hatfield, Department of Human Development, College of Education, University of Maryland, College Park, MD 20742.

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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" (Lieberman 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 56 percent compared to 21 percent for those families with low EE. While this is an important difference, it must be noted that 44 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 rela-

tionship between EE levels and patient relapse (Brown, Birley, and Wing 1972; Vaughn and Leff 1976, 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 followup 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 at-

tempting 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 almost exclusively on instances of patient relapse in the home. This leads families to feel that they are selected out for blame—that professional attitudes 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 dictates 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 patients cycle through bad periods and relapse even when there are no discernible changes in the environment. There are clearly unaccountable factors in many relapses, and it is unfortunate if families or professionals must feel or attribute blame for the existence of recurrent mental illness. The baffling problem of recurrent 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 intervention with families. A variety of approaches, usually called psychoeducation or family therapy, have been developed, all of which have the goal of lowering EE and preventing relapse. When client outcome is measured, irrespective of the design of the program, the rate of relapse is usually reduced. Nothing in the literature to date indicates which program is best, or what factors or combinations of factors in these interventions 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, hospital, or elsewhere.
- The involvement of the patient in a program of skill development or other treatment.
- The manner in which medication 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 families participating in these programs, but there is no clarity as to what the key variables are that make an impact. Simply having a better understanding of mental illness and having some skills to deal with it may improve coping, lower frustration, 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 components 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 informal home visits, offering support and concern, and little else, to families with severely ill relatives resulted 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 reduce relapse.

A rapidly growing segment of mental health professionals are highly intrigued with the concept of family EE. Many professionals are looking at psychoeducational treatments as a new panacea for the treatment of prolonged mental illness. This trend is troubling when we realize that we really know so little about it.

Finally, from a family perspective, there is reason for being concerned about wholesale investment in psychoeducational training and research to the neglect of investment in residential alternatives and well-trained staff. What appears to be a de facto decision by practitioners and policy makers that families should serve as the major caregiving institution is certain to raise objections on the part of families. While the issue of family care versus community residential services has never been fully explored, there is a strong tendency for many professionals to act as though this question has been resolved in the direction of family responsibility and care. Family advocacy groups have never participated in high level dis-

cussions 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 psycho-educational 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 do 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.

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### The Author

Agnes B. Hatfield, Ph.D., is Professor of Education, Institute for Child Study, Department of Human Development, University of Maryland, College Park, MD, and Coordinator of Curriculum and Training, National Alliance for the Mentally Ill, Arlington, VA. Leroy Spaniol, Ph.D., is Associate Director, and Anthony M. Zipple, Sc.D., is Research Associate, Center for Rehabilitation Research and Training in Mental Health, Boston University, Boston, MA.