

Review

Revisiting Expressed Emotion in Psychiatric Disorders

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ABSTRACT

Background:

Expressed emotion (EE) refers to the emotional climate within a family, encompassing critical comments, hostility, and emotional over-involvement, as well as warmth and positive remarks. First identified in 1958 through relapse patterns among psychiatric patients discharged to different living arrangements, EE was formalised as a measurable construct with Michael Rutter in 1966.

Objective:

To revisit the construct of EE and examine its relevance to the course, relapse risk, and management of psychiatric disorders.

Methods:

This narrative review draws on existing literature on EE across psychiatric conditions, with particular focus on schizophrenia, and examines proposed mechanisms, caregiver burden, and intervention strategies.

Discussion:

EE has been studied most extensively in schizophrenia, but growing evidence links it to outcomes in depression, bipolar disorder, eating disorders, alcohol use disorder, and dementia. The stress-vulnerability model offers a mechanistic explanation, describing how EE interacts with biological vulnerability and life events to influence relapse. The review also considers the paradox of positive over-involvement, the burden EE places on caregivers amid deinstitutionalisation, and the modifiability of EE through psychoeducation, family therapy, and counselling, supported by validated instruments such as the Level of Expressed Emotion Scale and the Family Attitude Scale.

Conclusion:

Involving families in psychiatric management, while attending to caregivers' own well-being, remains central to improving long-term outcomes. Further research into strength-based family interventions is warranted.

KEYWORDS: Expressed emotion; Psychiatric disorders; Relapse; Family intervention; Caregiver burden; Schizophrenia.

INTRODUCTION

In 1958, Brown and colleagues observed that psychiatric patients discharged from hospital to live with parents or spouses relapsed at significantly higher rates than those who returned to siblings or independent living arrangements¹. This finding, drawn from a series of family-environment studies, gave rise to the concept of “expressed emotion,” which was formalised as a measurable index in collaboration with Michael Rutter in 1966².

As psychiatric research has advanced, Expressed Emotion (EE) has attracted growing attention for its role in the course and outcome of psychiatric illness³. EE refers to the emotional atmosphere within a family i.e. the relational climate that provides (or fails to provide) basic emotional support, comfort, and space for the patient's expression. Cultural and societal norms shape both the expression of these emotions and the impact they have on the patient².

The core dimensions of EE include critical comments, hostility, and emotional over-involvement, which together define a high-EE environment. In addition, warmth and positive remarks are assessed during EE evaluation and are generally considered protective factors associated with better clinical outcomes. High levels of criticism, hostility, and emotional over-involvement have consistently been associated with an increased risk of relapse, whereas warmth and positive remarks are associated with improved treatment adherence and recovery⁴.

The specific verbal and non-verbal traits caregivers display form the basis for assessing EE using various validated scales⁴.

Clinical Significance Across Disorders

EE has been studied most extensively in schizophrenia, but its relevance to major depression, mood disorders, eating disorders, alcoholism, dementia, and other chronic illnesses is now well supported by a growing evidence base⁴. The emotional valence of a patient's environment significantly affects outcomes across these conditions⁵. Among patients with bipolar disorder, EE also predicts symptom severity during both pharmacological and psychosocial treatment⁶. In alcohol use disorder, O'Farrell and colleagues found that relapse was more likely among patients whose family members displayed high EE compared with those in low EE households⁷.

Mechanism: The Stress-Vulnerability Model

EE is thought to influence relapse largely through its effect on the patient's emotional state and, in turn, on symptom control. The stress vulnerability model captures this process, incorporating biological vulnerability alongside a cycle of mutual influence between symptomatic behaviour, life events, and EE⁸.

The Role of the Family

The family plays a central role in the management of psychiatric illness. Among the many functions a family serves, communication, emotional support, and understanding of the patient's behaviour have the greatest bearing on outcome and relapse risk. Long term prognosis and recovery correlate closely with the quality and intensity of expressed emotion, which is why numerous family intervention programmes have been designed specifically to reduce EE and support full recovery while minimising relapse⁹.

A substantial body of evidence links the development, maintenance, and treatment response of many psychiatric illnesses to the quality of family relationships. Negative emotions expressed by family members often stems not from hostility toward the patient but from frustration, the prolonged course of treatment, caregiver burnout, and limited understanding of the illness. In this context, blame for a poor outcome is frequently placed on the patient, framed as wilful avoidance of responsibility rather than as part of the illness itself⁸.

The Paradox of Positive Over-Involvement

Excessive positive emotional involvement carries its own risks. It can manifest as over-protectiveness or self-sacrifice, disproportionate praise, and excuse-making that shields the patient from the consequences of their behaviour. Whether this pattern genuinely benefits long-term recovery or, like hostility and criticism, ultimately worsens relapse risk remains an open question. Patients may retreat back into illness as a way of coping with the pressure of being pitied, unable to sustain the disproportionate expectations or protectiveness directed at them. Conversely, recognising a patient's progress and treatment adherence can motivate continued engagement with maintenance treatment and active participation in non-pharmacological care. Unconditional acceptance strengthens the patient's self-respect and confidence⁸.

Deinstitutionalisation and Caregiver Burden

As psychiatric care has shifted from institutional settings toward home-based care, families have taken on far greater responsibility for relatives with mental illness. This added burden, compounded by poor cooperation from patients, produces a negative caregiving experience that fuels irritability and frustration and, in turn, heightens EE¹⁰.

Modifiability and Intervention

The most encouraging feature of EE is that it is modifiable. Because it involves environmental and personal factors, it responds well to psychoeducation, family therapy, and

counselling. Key targets for intervention include the stress of caregiving, faulty communication styles, and the development of constructive, healthy coping mechanisms. These interventions have been refined through extensive evaluation of caregivers using instruments such as the Level of Expressed Emotion Scale and the Family Attitude Scale¹¹⁻¹³.

Advances in EE research across diverse psychiatric populations and settings have shaped psychosocial intervention strategies for family caregivers. The various interventions which can be really helpful are psychoeducation for patients and caregivers, crisis management, skills training to tackle various issues, awareness and education about various myths and misconceptions, emotional support, and communication-skills training⁹.

Barrowclough and colleagues proposed two competing models of this education:

1. **THE DEFICIT MODEL**, which holds that inadequate knowledge of the illness drives negative behaviour and that disseminating information will foster more positive attitudes and behaviours.
2. **THE INTERACTION MODEL**, which holds that people construct their own explanations of illness, so that professionally provided information will be filtered and possibly rejected according to the person's existing beliefs and perceptions¹⁴.

Key Elements of Family Intervention

Ongoing research on EE has informed family-intervention strategies built around the following priorities:

- a) Reducing harsh, wounding communication and frequent critical comments;
- b) Avoiding over-involvement, possessiveness, and excessive control over the patient's activities;
- c) Setting progressive, realistic goals moving from simple to more demanding targets while maintaining steady, achievable expectations for the patient's recovery, employment, and finances alongside gradual gains in day-to-day functioning and
- d) Encouraging caregivers to maintain their own routines, physical and mental health, and social support networks, to guard against burnout and frustration.

CONCLUSION

Family expressed emotion has repeatedly been shown to predict outcome across a range of psychiatric disorders and cultural settings, making it one of the most thoroughly investigated psychosocial constructs in psychiatry. This underscores the importance of involving the family in overall management: educating them about the disease process and non-pharmacological treatment options, and the aspect most often neglected viz. attending to the caregivers' own well-being. Future research should focus on the feasibility and efficacy of strength-based interventions, delivered alongside ongoing psychosocial support at the individual and group level, to help patients and families across psychiatric disorders address the negative emotional climate within the family.

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