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The Role of Expressed Emotion on Post-Traumatic Stress Disorder

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INTRODUCTION

Expressed emotion (EE) is a term used to describe attitudes, emotions, and behaviors expressed by close family members or caregivers towards a patient[1]. The key components used to determine the degree of EE present in familial relationships includes emotional overinvolvement, critical comments, and hostility. Emotional overinvolvement refers to overly self-sacrificing or intrusive behaviors, and exaggerated emotional responses[1]. Critical comments refers to accusatory or blaming statements, while hostility refers to anger and negative remarks and attitudes[1]. Family members can be categorized as low EE or high EE, with high EE family members considered to be those that are emotionally over involved or are responsible for a significant amount of critical or hostile comments regarding the patient[2]. An environment with high levels of EE is predictive of symptom relapse in a variety of psychiatric illnesses, including schizophrenia, depression, anxiety disorders, and substance abuse[2].

EE was initially developed to assess the attitudes of family members toward patients with schizophrenia[3], and research has shown psychosocial interventions proved effective in reducing high EE and improving outcomes in schizophrenic patients[4]. EE has also shown potential for detecting and improving family interactions in cases of depression3. However, EE is an important area of research in other psychiatric illnesses as well, such as post traumatic stress disorder (PTSD), where social support has been shown to play a significant protective and therapeutic role[5]. Current literature has shown that EE, specifically the criticism and hostility components, can predict clinical outcome in PTSD, including worsening symptoms and decreased response to therapy[6]. Although 7-8% of the U.S. population experiences post-traumatic stress disorder (PTSD) at some point in their lives, there lacks a proportionate amount of research on the psychological toll this subgroup faces due to expressed emotion[7].

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CASE PRESENTATION

A patient with a past medical history of paraplegia and quadriparesis secondary to cervical spine fracture, presented to the Emergency Department with two days of fever and severe suprapubic pain. This was consistent with the patient's history of recurrent urinary tract infections and sepsis he/she experienced due to neurogenic bladder and due to chronic indwelling Foley catheter. He/she also struggles with constipation and ileus because of his/her injury. The patient was admitted to the medical floor of a community hospital for treatment, and Psychiatry was consulted for evaluation of his/her mood symptoms.

The patient reported a history of depression since his/her injury, however he/she had not received any prescription medical therapy for these symptoms. The patient did report use of medical marijuana for 5 years for chronic insomnia. He/she denied use of alcohol or other illicit substances for mood management. The patient has no history of psychiatric admissions, suicide attempts, manic or psychotic symptoms, abuse or childhood trauma, or psychiatric history within his/her family. He/she sees a community therapist semi-regularly, which he/she thinks has been helpful. The patient was employed prior to paralysis, but is now no longer working, and lives at home with his/her spouse and family.

His/her chief complaint was "I need someone to listen to me first." The patient discussed concerns about expressed emotions from immediate family members, specifically from his/her spouse. Although the initial injury occurred 7 years ago, the patient reported feeling sadder, due to a lack of support from his/her spouse and the spouse's "negative" attitude.

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The patient explained that his/her spouse invalidates the patient's emotions and that other family members, such as in-laws and siblings, minimize the patient's feelings by pointing out that "others have worse situations". These critical comments are a component of EE, judging the patient for grieving his/her loss and for not healing more quickly. In response to the criticism, the patient reported isolating behavior by locking himself/herself up in a room to get some space.

The patient also expressed concern over the spouse's intrusive behavior -- emotional overinvolvement -- by nagging the patient to heal more quickly, go to therapy more regularly, and spend less time in front of the television and more time with the family. According to the patient, his/her spouse emphasizes the spouse's role as both the breadwinner and the homemaker, contributing to the self sacrificial image of emotional overinvolvement. Hostility was a common theme in the stories told by the patient. His/her relatives often blamed the patient for the family's lack of financial security, for his/her spouse's own depression, and for any delays in development or misbehavior seen in their children. Throughout the conversation, the patient emphasized that he/she tries to maintain a positive attitude, but that the patient wants those around him/her to understand that what he/she is going through is difficult. The patient feels that these expressed emotions prevent him/her from getting better mentally.

Upon interviewing the patient's spouse privately, he/she expressed frustration by the patient's condition and its effect on both of their moods. The spouse reported that since the COVID-19 pandemic, they have been together 24/7 and that the patient needs someone else to talk to more often. These stressful circumstances and consistent close quarters may have also increased the spouse's hostility and overall EE towards the patient. The spouse stated that the patient speaks about going to an inpatient psychiatric facility and about his/her interest in suicide by euthanasia, but then admitted "I don't know if he/she is just trying to test me", a critical comment suggesting that when the patient shares his/her feelings, the spouse views it as a test rather than him/her seeking comfort. During a mediated conversation with both the patient and spouse together, the spouse was surprised to find out how strongly the patient was affected by the spouse's attitudes. The spouse did acknowledge some of his/her hostile comments and blaming of the patient during times of frustration as well.

Regarding the patient's mental status exam, he/she was alert and oriented to person, place, and time, dressed in a hospital gown, lying in a hospital bed. The patient appeared well groomed, speech was of normal rate and volume, and appropriate eye contact was maintained. The patient was cooperative and showed no psychomotor agitation or retardation. The patient reported anxious mood and displayed a constricted affect. He/she had a normal thought content and perception, denying obsessions, delusions, suicidal or homicidal ideation, and hallucinations. He/she had fair insight and judgment and his/her thought process was circumstantial. The patient had appropriate attention, concentration, memory, and fund of knowledge.

In response to a depression screening, the patient reported depressed mood, but maintains interest in activities like reading books and watching movies, where he/she reads the stories of survivors that make the patient feel less alone and motivated to help others in the same situation. The patient endorsed insomnia and admits to both initial and terminal insomnia, for which he/she uses medical marijuana. The patient denies feelings of guilt or worthlessness and does show hope that things can change. The patient reported decreased appetite attributed to medical conditions like ileus and constipation, and he/she denied trouble with concentration, energy, or psychomotor changes. Although the patient says he/she has not and would not attempt suicide, he/she has considered dying in a "dignified" manner by traveling to a state where euthanasia is legal. Based on this screening, the patient did not meet criteria for major depressive disorder.

Although the patient had not previously been diagnosed with PTSD due to minimal psychiatric care, his/her symptoms did meet DSM-5 criteria. The patient regularly had nightmares regarding the injury and experienced distress during the loud noises of his/her hospital stay, due to reminders of the hospitalization after his/her accident. The patient has avoided the location of the accident since it occurred and has experienced arousal symptoms such as difficulty sleeping and irritability. He/she has also had mood symptoms like intense fears of dying during sleep and feelings of detachment from his/her spouse and family. During periods of severe tension or arguments with his/her spouse, the patient's nightmares and mood symptoms worsen. Based on the assessment, the patient was diagnosed with PTSD, his/her symptoms likely exacerbated by EE in the forms of emotional overinvolvement, critical comments, and hostility.

The patient was not given any psychiatric medications during the five-day hospital stay but medically, he/she was treated with antibiotics for UTI, with

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Diazepam for sleep and Hydromorphone for pain. Upon discharge, the patient plans to continue seeing his/her community therapist and would like to increase the amount of psychological support he/she receives there. The patient is not planning to see a psychiatrist due to lack of interest in medications, however we suggested seeing a psychiatrist if he/she experiences worsening suicidal ideation or PTSD symptoms. Due to the prevalence of EE in the patient's daily life and its likely role in his/her worsening mood, we recommended family therapy. Improving the poor communication and understanding between the patient and his/her spouse will help the patient feel more supported, and awareness of EE will motivate the patient and his/her spouse to work together to minimize negative attitudes.

DISCUSSION

While the impact of expressed emotion on the management of post-traumatic stress disorder has not been thoroughly studied, there is extensive literature on the relationship between expressed emotion and several other psychiatric illnesses, including schizophrenia, eating disorders, and mood disorders[3]. One study assessed the EE of thirty-eight relatives of patients with PTSD, and examined the patient's PTSD symptoms at 6 and 12 months[6]. Critical and hostile relatives held the patient responsible for bad outcomes, including their mental health problems, as compared to low EE relatives[6]. The critical comments and hostility components of EE had a greater effect on outcomes than emotional overinvolvement did6. These findings are congruent with the generally accepted view that high expressed emotion hinders symptom resolution and is predictive of poor outcomes[8].

The study also found that interventions that helped relatives to develop a balanced perspective on the degree to which patients are able to control their symptoms were beneficial[6]. These findings were also seen in another study that showed that high EE relatives often attribute negative behaviors in the patient as internal, personal, or controllable whereas low EE relatives more often attribute these behaviors to external, universal, or factors that cannot be controlled[9]. As a result, family therapy models targeting EE in other disorders like schizophrenia have focused on psychoeducation about the disorder to improve understanding, teaching communication and effective problem-solving skills within the family to improve unproductive patterns of interaction and decreasing experiential avoidance[9]. Due to the similar impact of EE on various psychiatric conditions, these models show promise in the realm of PTSD[2]. This is especially relevant to our case where the patient's spouse did not recognize that he/she was attributing the patient's symptoms to his/her own control, until they had a mediated conversation. Incorporating such interventions would bring further awareness and understanding to our patient, and others in high EE environments.

It is also important to note that both the family members and the patient experience difficulties, and after years of struggling with PTSD, caregiver burnout can become apparent, especially when there are other dependents in the family. The needs of both parties need to be taken into consideration, further emphasizing the need for family and couple psychosocial therapies. One specific method of couples therapy shown to be effective is Cognitive Behavioral Conjoint Therapy (CBCT)[10]. CBCT for PTSD involves fifteen 75-minute sessions designed to educate about PTSD and its effect on relationships and teach communication skills with couple-oriented in vivo exposures to overcome behavioral and experiential avoidance[10]. The study showed evidence for both improved PTSD symptoms in the patient, and improved relationship satisfaction and partner mental health10. A study on family therapy showed that therapies which promote family member's understanding of PTSD symptoms might correct erroneous beliefs about interpersonal behavior and help reduce family conflict[11]. Family therapy can promote social support, creating a safe recovery environment where individuals can reprocess traumatic memories and learn to regulate associated negative affective states[11].

Based on these studies, CBCT and family therapy may provide promising treatment options to improve relationships and therefore minimize the negative effect of EE on patients, including ours.

While there is extensive research on the link between expressed emotion and disorders like schizophrenia, mood disorders, and anorexia nervosa[12,13,14], the literature pertaining to EE and post-traumatic stress disorder is meager. Published studies support the notion that family therapy and other therapeutic interventions that lower expressed emotion and reduce psychosocial stress are beneficial for patients suffering from the psychiatric illnesses discussed above[12,13,14]. Few studies have been undertaken to explore treatment options for patients with high expressed emotion and PTSD, and therefore larger randomized control trials determining the effect of various forms of family and couples therapy are warranted before definite recommendations can be made.

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CONCLUSION

In summary, our patient experienced worsening of his/her PTSD exacerbated by expressed emotion from close family members. While we acknowledge expressed emotion as a contributing factor to the state of this patient's mental health and were able to recommend psychotherapy based on the literature, additional research is needed to substantiate the relationship between expressed emotion and disorders like PTSD. This case study is an insightful example into how greatly patients with PTSD may be impacted by EE, and how strongly they may benefit from further studies examining solutions such as family therapy to minimize the effect of expressed emotion on patients. This is essential to improving the quality of life and decreasing the disease burden for both the patients and their families.

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