The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 6, Issue 4, DIP: 18.01.033/20180604
DOI: 10.25215/0604.033
http://www.ijip.in | October-December, 2018

The International Journal of INDIAN PSYCHOLOGY

Original Research Paper

Expressed Emotion and Its Relation with Anxiety in Caregivers of Psychiatric Patients

Hijam Naobi[1]*, Dr. Devi, W. R[2]

ABSTRACT

Expressed Emotion (EE) of the caregiver is one of the critical factors that contribute relapse of the psychiatric patient during and after treatment. Living with psychiatric patients could result in subjective burden and is usually associated with distress and stigma. Predisposing anxiety of the caregiver influences the recovery process of the mental illness. Less attention has been paid to the antecedent factors that contribute to EE of the family members. The present study was conducted to investigate the relationship between EE and anxiety, which in turn help to understand role of caregivers in the intervention process of psychiatric patients. ***Materials and Methods:*** Data were collected from 150 caregivers attending outpatient department of psychiatry, Regional Institute of Medical Sciences , Manipur, regarding socio-demographic characteristics (e.g., age, gender, domicile) using socio-demographic performa, followed by Family Attitude Scale and Taylor's Manifest Anxiety scale form caregivers of different psychiatric patients. Descriptive statistics such as mean and standard deviation (SD) and chi square for categorical data were used. ANOVA test was also applied to compare the means of different groups. ***Results:*** Among the socio-demographic variables, statistically significant difference (P=0.002) was between monthly family income and EE of caregivers. High significant relationship was also observed between EE and level of anxiety (p=0.000). Among the different psychiatric patients, highest mean score of EE was observed in Substance related disorders (mean=49.44) followed by Psychosis NOS (mean=39.6,and significant relationship was observed between different types of psychiatric illness and level of EE(p=0.002). Insignificant relationship was observed between the duration of illness and EE. ***Conclusion:*** An avenue has opened up to understand the role of family as an important resource towards intervention of psychiatric illness as well as the role of significant amount of EE and level of anxiety among caregivers indicates the need for psychosocial support to the family members for the mitigation in the EE and reduction of associated anxiety which in turn could reduce the number of relapse rates and facilitates the caregivers to manage and cope effectively with psychiatric illness.

[1] (M.Phil in Clinical Psychology, Deptt.of Clinical Psychology, RIMS, Lamphelpat-795004, Manipur, India)
[2] (Assistant Professor, Deptt. of Clinical Psychology, RIMS, Lamphelpat-795004, Manipur, India)
*Responding author

Received: September 17, 2018; Revision Received: October 20, 2018; Accepted: October 29, 2018

Keywords: *expressed emotion, anxiety, family members, psychosocial support, relapse.*

"Expressed emotion" (EE) refers to a global index of particular emotions, attitudes, and behaviours expressed by relatives about a family member diagnosed with psychiatric illness. It refers to communication of criticism, hostility or rejection about someone with a psychiatric illness, or reports of emotional over-involvement with them. It is a significant characteristic of the family milieu that has been found to predict symptom relapse in a wide range of mental disorders even though they may be on medication (Amaresha et al., 2012; Docherty et al., 2009; Kuipers et al., 2006;Bhugra et al., 2003; Haddock et al; 2001;). The concept of EE originated in the 1950s, following observation by George Brown in the interactions between patients with schizophrenia and their families (Brown et al., 1958). The concept of EE, now evidenced as a well validated predictor of relapse in schizophrenia.EE probably determines relapse through its effect on emotions and symptom control. Stress-vulnerability model of relapse is advanced that incorporates biological factors as well as cycles of mutual influence between symptomatic behaviour, life events, and EE (Barrowclough et al., 1997).

In contrast to the Western Culture, in India where there is family-centric culture, the primary kin network is the caregiver of the patient. The presence of a person with a severe mental disorder is often associated with a significant objective and subjective burden on the family members, especially for those who have a care giving role. High EE is characterised by high rating of criticality, hostility and emotional over involvement. Caregivers believe that illness is internal and can be controlled by the patient. The quantification of critical comments and hostility is greatly reliant on the way in which the respondent uses their tone of voice to convey their feelings (anger, rejection, irritability, ignorance, blaming, negligence etc.), while the judgment of over-involvement also takes into account on the basis of reported behaviour such as caregivers blaming themselves, sacrificing things, being overprotective of patients, excessively being concerned for patients, neglecting personal needs of self (i.e., caregiver's), and similar others (Amaresha, et. al., 2012;Sartorius et al., 2005). Contrary to the above case those relatives who have low EE are more conservative with their expression of emotion. Caregivers feel that the family members do not have control over the disorder and sympathize with them. The disorder is accepted to be external, not internal and out of the control of the patient and have warmth and positive regard for the patient. There is growing literature concerning the role of EE in psychiatric disorders. (Hooley et al., 1986; Miklowitz et al., 1988; Sabarese et al., 2002). Researches in this area make two things clear: a) rather than being a construct of interest solely with respect to schizophrenia, EE is a more general predictor of poor outcome across a range of conditions, and (b) EE is a construct that is modifiable. It is of interest to researchers and clinicians that EE predicts symptom relapse in patients and family based interventions reduce EE thereby reduces patients' relapse rates (Hogarty et al.,1986; Leff et al.,1982).

The interaction between EE and patient outcome is complex and dynamic. Previous studies have highlighted the role of EE as a paramount psychosocial stressor that has a direct

association with recurrence of illness. In particular, attitude of caregivers towards the patient and their understanding of the nature of illness are important. Caregivers can also play a key role as the informal care coordinator for a patient. Goossens et al. (2008) define an informal caregiver as "the person who, in the perception of the patient, is an important person in his or her life, who is not a professional and who delivers significant support and care for the patient". Misconception, fear and anxiety have been associated with persons with mental illness. Accordingly the response to mental illness is a sequence of denial, isolation and rejection. Predisposing anxiety in the caregivers influence EE. An understanding of the relation with anxiety as an underlying factor which might influence the EE of the family members would be useful. Cultural variation in the degree and type of EE has to be studied extensively and understood the principles of EE across different cultural groups and settings. Subjective burden, distress and stigma associated with the patient's condition could be understood by various factors including the socio-cultural perspective or personality of the caregiver. It will be helpful to know both the protective factors (Chadda et. al., 2010; Sartorius et al., 2005) as well as vulnerable factors to understand the construct of EE and its relationship with anxiety. Thereby, the present study attempts to explore the level of EE and anxiety and other relevant socio-demographic variables of caregivers which will bring attention to understand the intervention process.

MATERIALS AND METHODS

Prior to the initiation of the study, permission was sought from the authority of RIMS hospital for conduction of the study and the study was approved by Research Ethic Board, RIMS, Imphal. The study was a hospital based cross sectional study. The study was conducted in the Department of Psychiatry, Regional Institute of Medical Sciences (RIMS), Imphal, Manipur. Purposive sampling technique was adopted and data was collected through structured interview method. The study population contained caregivers of patients diagnosed with different psychiatric illness attending the outpatient department (OPD). Data were collected over a period of 5 months from October 2014 to February 2015.The inclusion criteria for the study were :(i) primary caregivers(parents/spouse/sibling/children) living with patients for at least 1 year; (ii) primary caregivers of patients suffering from psychiatric illness for at least 2 years and above diagnosed according ICD-10 (International Classification of Diseases and Related Health Problems − 10); (iii) age group of the caregivers were 20 years and above of both sexes who consented for the study. Exclusion criteria were caregivers without history of any psychiatric disorder, substance dependence, organic syndromes, intellectually disabled, or chronic physical illness. A separate informed consent was obtained from caregiver to participate in the study. Family members who are trained in the helping profession of mental health care service and those who had history of psychiatric disorder, substance dependence, organic syndromes, mental retardation, or chronic physical illness were excluded from the study. A separate informed consent was taken from the caregivers and approach to participate in the study. A total of 150 caregivers gave consent for the study thus represents the study population. Data were collected with the help Semi-structured socio-demographic performa to collect relevant information. Further, Family Attitude Scale (FAS) was used to assess the caregiver's level of criticism and hostility

(Kavanagh et al., 1997) which has 30 items in which the respondent is instructed to select one response out of the five options(every day, most days, some days, very rarely or neverly) for each items which is true about him/her towards the family member concern. The FAS is a reliable and valid indicator of relationship stress and expressed anger that has wide applicability. Taylor Manifest Anxiety Scale (TMAS) to measure the intensity of manifest anxiety (Taylor, 1953) using true/false response on 50 items. Construct validity of 0.72 and 0.75 and test retest reliability of 0.89 have been reported. The information obtained was scored manually using stencils. Further, it was sorted, classified, coded and entered in the computer. Descriptive statistics such as mean, standard deviation (SD), frequency and percentage were used for quantitative and categorical data respectively. Chi square test and ANOVA test were applied to analyse the data. Analysis was performed through the Statistical Package for the Social Sciences version 16.0 software (SPSS Inc., Chicago, IL, United States). The level of significance (alpha) was taken at 0.05.

RESULTS

Table 1 shows the relevant socio-demographic variables and related information for the study. Most of the caregivers were in the age group of 20-35years of age (36%)and it has been observed that female caregivers represent maximum with 62%.Further, most of the caregivers were married (88%) and educated up to higher secondary representing maximum with 38%. Analysis also indicated that most of the caregivers belong to nuclear family (56%) and considering the family size, big family more than 4 members represent maximum (64%).Unemployed caregivers (44.66%) with monthly income of below Rs. 10000 (60.66%) were the maximum in this category.

Table 1: Relationship between socio-demographic characteristics & other relevant information and expressed emotion of caregivers of patients with different psychiatric illness.

Subject / **Variables**	**No. of cases (N=150)**					
	Level of EE			χ^2	**d.f.**	**p-value**
	Low	**High**	**Total**			
Age Range						
20-35 Years	29	25	54(36%)	0.58	3	0.9
36-45 Years	19	14	33(22%)			
46-60 Years	24	15	39(26%)			
61 Years and above	14	10	24(16%)			
Total	86(57.3%)	64(42.7%)	150(100%)			
Gender						
Male	38	19	57(38%)	3.27	1	0.07
Female	48	45	93(62%)			
Total	86(57.3%)	64(42.7%)	150(100)			

Subject / Variables	No. of cases (N=150)					
	Level of EE			χ^2	d.f.	p-value
	Low	High	Total			
Marital Status						
Single	11	7	18(12%)	0.12	1	0.73
Married	75	57	132(88%)			
Total	86(57.3%)	64(42.7%)	150(100%)			
Educational Qualification						
No formal education	11	12	23(15.33%)	3.46	3	0.33
Primary	19	18	37(24.66%)			
High school-higher secondary	33	24	57(38%)			
Graduate-above	23	10	33(22%)			
Total	86(57.3%)	64(42.7%)	150(100%)			
Family Type						
Nuclear	48	36	84(56%)	0.003	1	0.96
Joint	38	28	66(44%)			
Total	86(57.3%)	64(42.7%)	150(100%)			
Family Size						
Big family-above 4 members	60	36	96(64%)	2.91	1	0.09
Small Family- 4 members and less	26	28	54(36%)			
Total	86(57.3%)	64(42.7%)	150(100%)			
Occupation						
Unemployed	39	28	67(44.66%)	0.204	2	0.9
Self employed	24	20	44(29.33%)			
Govt. employee	23	16	39(26%)			
Total	86(57.3%)	64(42.7%)	150(100%)			
Monthly family income						
Below Rs.10000	44	47	91(60.66%)	7.95	2	0.02
Rs.10000-Rs.25000	21	10	31(20.66%)			

Subject / Variables	No. of cases (N=150)					
	Level of EE			χ^2	d.f.	p-value
	Low	High	Total			
Rs.25001 above	21	7	28(18.66%)			
Total	86(57.3%)	64(42.7%)	150(100%)			
Domicile						
Urban	28	17	45(30%)			
Rural	58	47	105(70%)	0.63	1	0.43
Total	86(57.3%)	64(42.7%)	150(100%)			
No. of relapse						
Nil	26	19	45(30%)			
Once	10	5	15(10%)			
Multiple	37	27	64(42.66%)	1.12	3	0.77
No remission	13	13	26(17.33%)			
Total	86(57.3%)	64(42.7%)	150(100%)			
Frequency of OPD visit						
Weekly	5	9	14(9.33%)			
Fortnightly	12	9	21(14%)			
Monthly	46	34	80(53.34%)	3.681	3	0.298
Above	23	12	35(23.33%)			
Total	86(57.3%)	64(42.7%)	150(100%)			
Amount Expended on Treatment						
Below Rs.50,000	20	17	37(24.66%)			
Rs.50,000-Rs.100,000	34	26	60(40%)	0.374	2	0.829
Above Rs.100,000	32	21	53(37.33%)			
Total	86(57.3%)	64(42.7%)	150(100%)			

Furthermore it has been observed that caregivers residing in rural areas represent maximum with 70%. With regard to other relevant information for the study, it has been observed that multiple number of relapses represent maximum (42.66%) and monthly OPD visit were 53.34%. And the amount spent yearly on treatment range from Rs.50000-100,000 which represent maximum with (40%) in this category. Statistical analysis indicated that among the socio-demographic variables taken for the study, significant relationship has been observed between monthly family income and EE of caregivers (χ2=7.95,p=0.02).Other variables such as age (χ2=0.58,p=0.9), gender (χ2=3.27,p=0.07), marital status (χ2=0.119,p=0.73), educational qualification(χ2=3.461,p=0.326),family type (χ2=0.003,p=0.958), family size

(χ2=2.91,p=0.088), occupation(χ2=0.204,p=0.903),domicile (χ2=0.628,p=0.43), no.of relapse (χ2=1.115,p=0.773), frequency of OPD visit (χ2=3.681,p=0.829), amount spent on treatment (χ2=0.374,p=0.829) have been found statistically insignificant with EE of caregivers.

Table 2: Relationship between EE and level of anxiety of caregivers of patients with different types of mental illness.

Subjects / **Level of EE**	**Anxiety**			**χ2**	**d.f**	**p-value**
	Moderate	**High**	**Total**			
Low EE	67	19	86(57.33%)	43.92	1	0.000
High EE	12	49	64(42.66%)			
Total	82(54.7%)	68(45.3%)	150(100%)			

Table 2 shows the relationship between EE and level of anxiety of caregivers. It has been observed that out of 150 caregivers 86(57.33%) of them were having low EE and 64 were having high EE. Of the 86 caregivers with low EE, 67 caregivers exhibited moderate anxiety and 19 caregivers exhibited high anxiety. Further, it has also been observed that among 64(42.66%) caregivers with high EE, 15 caregivers exhibited moderate anxiety and 49 caregivers exhibited high anxiety. Statistical analysis indicated high significant relationship between EE and level of anxiety (χ2=43.92,p=0.000).

Table 3 shows the different types of psychiatric illness and its relation with the level of EE of caregivers. It has been observed that caregivers of Substance related disorders including Alcohol dependent syndrome, Alcohol abuse disorder, Cannabis dependent disorder and Poly-substance abuse disorder has the highest level of EE(mean ±S .D.=49±24.184) followed by Psychosis NOS (mean ±S .D.=49±24.184). Further analysis indicated statistically significant relationship between different types of psychiatric illness and EE of caregivers (f= 3.3972, p=0.002).

Table 3: Relation between different types of psychiatric illness and level of EE of caregivers

Subjects / **Types of Disorders**	**Mean±S.D.**	**f-value**	**p-value**
Substance Related Disorder	49.4 ±24.18	3.3972	0.002
Anxiety disorder	28.67±14.51		
Mood disorder	31.08±18.10		
Intellectually Disabled	31.33±16.96		
Schizophrenia	34.29±15.33		
Psychosis NOS	39.67±21.03		
Somatoform disorder	24.91±12.39		
Seizure	34.88±15.87		
Total	35.63±19.97		

Table 4: Relationship between Duration of Illness of Psychiatric and level of Expressed Emotion

Subjects / Duration of illness	Level of EE			$\chi 2$	df	p-value
	Moderate	High	Total			
2-4years	36	34	70(46.66%)	2.197	1	0.333
5-7years	20	14	86(57.33%)			
8 and above	30	16	64(42.66%)			
Total	86(57.3%)	64(42.7%)	150(100%)			

Table 4 shows the duration of the illness of different psychiatric patients and its relationship with EE. It has been observed that majority of patients with psychiatric illness of duration 5-7years represent maximum with 57.33% and maximum high EE has been observed in the 2-4 years of duration of illness. Further analysis indicated statistically insignificant relationship between duration of illness of patients and level of EE of caregivers ($\chi 2$=2.197,p=0.333).

DISCUSSION

This study was conducted on caregivers of patients with different mental disorders visiting OPD. Various socio demographic variables have been considered for the study. Among the variables undertaken for the study, high significant relationship with EE has been observed with monthly income of the family which signifies that lower the family income higher is the EE among the family members of the patients. The study also indicated insignificant relationship between socio-demographic variables namely age, education, gender, marital status, family, occupation, family type and residential area and type of family and EE. India being a country of lower socio-economic status as compared to the western countries, having a family member who is ill for two years and above put an additional pressure on the emotional environment of the family. Main caregivers are the person belonging to the patient's informal support system who takes the care and is responsible for the patient, and who commits most of his or her time to that task without receiving any economic retribution. The psychological state produced by the combination of physical work, emotional pressure, social restrictions, and economic demands arising from taking care for a patient as well is perceived as burden on relatives of patients which associated with an important reduction in their QOL, causing damage in caregiver's health condition (Fadden et al.,1987; Kuiper et al.,1992; Gutierrez et al.,2005)in turn resulting to high level of EE and subsequent relapse.

Furthermore, the present study confirmed that there is a significant relationship between the level of EE and anxiety among the family members of the patients. Previous study ascertained that anxiety may make family members particularly vulnerable to expressions of criticism which support the present finding of the study (Millman, 2011). Here, anxiety could be proposed as a contributory factor of EE which has a strong relationship with EE. In general, expressing emotions is beneficial and withholding emotions has personal and social costs. Yet, to serve social functions there are situations when emotions are withheld strategically (Kashdan et al., 2007). All persons are prone to anxiety and that anxiety is “an

inevitable part of life". At moderate levels, anxiety can be healthy. This is especially true when people have "the ability to vary anxiety levels in response to different situations". The earlier studies in this area indicate that anxiety is responsible for producing a propensity towards relapse and that could initiate a vicious cycle of 'Burden>Expressed emotion>Relapse' (Mohanty & Kumar, 2013). The finding of the present study could suggest of a postulate based on the finding as 'Burden>Anxiety>Expressed emotion>Relapse'. However, to have a postulate of such need longitudinal study for more exploration in the area to identify other contributing factors. A change in the level of anxiety results in the corresponding change of EE.

An attempt was made to analyse the different types of mental disorders with respect to EE and it has been observed in the study that caregivers of Substance related disorders have highest EE followed by Psychosis and other mental disorders. Further the study indicated significant relationship between different types of mental disorders and EE. Previous study ascertained that patients with high levels of EE in their family environment were more prone for relapse of alcohol use. High EE was associated with lesser time spent being abstinent from alcohol and more frequent relapses. Out of the components of EE studied, perceived criticism was associated with quicker and more frequent relapses, whereas emotional involvement was not associated with relapse (Mittal et al., 2015).EE was the strongest predictor of relapse during follow-up and its predictive effect remained in participants with early psychosis. (Pourmond, 2005). Similar findings indicated levels and types of caregiver strain are reported for those families caring for youth with Substance use Disorders (SUD) and those families caring for youth with other mental health problems (Heflinger & Brannan; 2006). However, the caregivers for patients with psychiatric disorders and co-occurring SUD have been reported significantly higher levels of anxiety than the caregivers for patients with psychiatric disorders but no SUD (Cleary et al., 2008). Moreover, it is indicated that the subjective well-being of caregivers for patients with developmental disabilities found below the normative score (Werner & Shulman, 2013).

In the present study, duration of the illness of different psychiatric patients and EE was considered. It has been observed that patient suffering from psychiatric illness with duration of 5-7years represent maximum with 57.33% and maximum high EE has been indicated with duration of 2-4 years although insignificant relationship was observed. It is believed that chronic burden of caregiving to a patient with psychiatric illness is likely to generate negative emotions. With the advent of deinstitutionalization, caregivers have increasingly assumed greater responsibility for the care of their mentally ill relatives, with the consequent negative caregiving experience a likely cause of stress manifested in heightened EE. It is a more general predictor of poor outcome across a range of conditions. However family can play an important role in helping in the recovery of a person with substance use disorders.

CONCLUSION

The primary aim of the study was to see the level of EE in relationship with anxiety among caregivers of patients with psychiatric illness. EE is considered to be a significant variable

contributing to the relapse in major psychiatric disorders. The study demonstrated that there is a strong relationship between the level of EE and anxiety of the caregivers. Amongst the socio-demographic variables, monthly family income has a significant relationship with high level of EE. This demonstrates that lower the family income, higher is the EE among the family members of the patients. The presence of significant amount of EE point out the need for psychosocial support to the family members for the mitigation in the EE and reduction of associated anxiety which in turn could reduce the number of relapse rates and facilitates the caregivers to manage and cope effectively with psychiatric illness. Socio-economic assistance during the treatment and psycho-education for the family members will help manage the family emotional climate on the clinical course and psychological adjustment of the patient and also facilitate to effectively cope and manage the ill family member.

LIMITATION AND IMPLICATION

Considering the importance of caregivers as partners in the care for patients with psychiatric disorders and their relatively high EE and anxiety may contribute to increase number of relapses. Assessment of EE and its relationship with anxiety of caregivers can therefore be recommended to quickly identify caregivers who are vulnerable and thus at a high risk for psychological problems themselves. The findings of the present study should be interpreted in light of few limitations. Sample size was relatively small so difficult to generalize the result. The study was a hospital based cross sectional study and random sampling was not taken. In view of the limitations of the study, future research could focus on programme for caregivers to cope and manage effectively with psychiatric illness. Nevertheless, the study could be an initiative to understand the intervention process, towards better mental health for the patient as well as the family members who are directly or indirectly involve in the care giving process.

REFERENCE

Amaresha, A.C., &Venkatasubramanian, G. (2012).Expressed Emotion in Schizophrenia: An Overview. Indian Journal of Psychological Medicine, 34(1), 12-20. doi:10.4103/02537176.96149

Barrowclough, C., & Parle M. (1997). Appraisal, psychological adjustment and expressed emotion in relatives of patients suffering from schizophrenia. British Journal of Psychiatry, 171, 26-30.

Bhugra, D. & McKenzie, K. (2003).Expressed emotion across cultures.Advances in Psychiatric Treatment, 9, 342-8. doi:10.1192/apt.9.5.342

Brown, G.W., Carstairs, G.M., & Topping, G. (1958). Post hospital adjustment of chronic mental patients. The Lancet, 2 (7048), 2,685–689.

Chadda, R.K., Singh, T.B., &Ganguly, K.K. (2010).A prospective study of relationship of caregivers' mental Health with the perceived burden and coping in schizophrenia and bipolar affective disorder.Indian Journal of Social Psychology.26(1-2), 52 - 51.

Cleary, M., Hunt, G. E., Matheson, S., & Walter, G. (2008). The association between substance use and the needs of patients with psychiatric disorder, levels of anxiety,

and caregiving burden. Archives of Psychiatric Nursing, 22(6), 375–385. doi: 10.1016/j.apnu.2008.02.001.

Docherty, N.M., St-Hilaire, A., Aakre, J.M., Seghers, J.P., McCleery, A., &Divilbiss, M. (2009). Anxiety Interacts With Expressed Emotion Criticism in the Prediction of Psychotic Symptom Exacerbation. Schizophrenia Bulletin. 37(3), 611–618.

Fadden, G., Bebbington., P., &Kuipers, L.(1987): The burden of care: The impact of funtional psychiatric illness on the patient's family. British Journal of Psychiatry, 150, 285–292.doi: 10.1192/bjp.150.3.285.

Goossens, P. J. J., Van Wijngaarden, B., Knoppert-Van Der Klein, E. A. M., & Van Achterberg, T. (2008). Family caregiving in bipolar disorder: caregiver consequences, caregiver coping styles, and caregiver distress. International Journal of Social Psychiatry, 54(4), 303–316. doi: 10.1177/0020764008090284.

Gutiérrez-Maldonado, J., Caqueo-Urízar, A., & Kavanagh, D.(2005): Burden of care and general health in families of patients with schizophrenia. Social PsychiatryPsichiatric Epidemiology, 40, 899–904. doi 10.1007/s00127-005-0963.

Heflinger, C. A., & Brannan, A. M. (2006). Differences in the experience of caregiver strain between families caring for youth with substance use disorders and families of youth with mental health problems. Journal of Child & Adolescent Substance Abuse, 15(3), 83–104. doi: 10.1300/J029v15n03_06.

Hogarty, G.E., Anderson, C.M.,& Reiss, D.J. (1986). Family psycho-education, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia.Archives of General Psychiatry. 43 (7), 633–642.

Hooley, J.M., Orley, J., & Teasdale, J.D. (1986).Levels of expressed emotion and relapse in depressed patients.British Journal of Psychiatry.148, 642- 647.

Kashdan, T.B., Volkmann, J.R., Breen, W.E., & Han, S. (2007). Social anxiety and romantic relationships: The costs and benefits of negative emotion expression are context-dependent. Journal of Anxiety Disorder. 21(4), 475–492.

Kavanagh, D.J., O'Halloran, P., Manicavasagar, V., Clark, D., Piatkowska, O., Tennant C. & Rosen A. (1997). The family attitude scale: reliability and validity of a new scale for measuring the emotional climate of families. Psychiatry Research. 70(3), 185–195.

Kuipers, L., Lef,f. J., & Lam, D.(1992): Family work for schizophrenia: a practical guide. London: Gaskell.

Kuipers, E., Watson, P., Bibbington, P., Dunn, G., Fowler, D., Freeman, D.,Garety, P. (2006). Influence of carer expressed emotion and effect on relapse in non-affective psychosis. The British Journal of Psychiatry.188 (2), 173-9. DOI: 10.1192/bjp.bp.104.007294.

Leff, J., Kuipers, L., Berkowitz, R., Eberlein-Fries, R., & Sturgeon, D. (1982).A controlled trial of social intervention in the families of schizophrenic patients.The British Journal Psychiatry. 141 (2) 121-134. DOI: 10.1192/bjp.141.2.121

Miklowitz, D.J., Goldstein, M.J., Nuechterlein, K.H., Snyder, K.S., & Mintz, J. (1988).Family factors and the course of bipolar affective disorder.Archives of General Psychiatry.45, 225- 231.

Millman, Z.B. (2011). Expressed Emotion and Levels of Family Psychopathology in Parents of Bipolar Adolescents, Dissertation thesis. Department of Psychology and Neuroscience. University of Colorado, Boulder.

Mittal, S., Koganti, C.T., Yadiyal, A., Rao, P., &Chandini. (2015): Expressed Emotion and Relapde of Alcohol use disorders. International Journal of Scientific & Research Publication.5(4),1-5.

Mohanty, S., & Kumar, S. (2013).Burden of care and expressed emotion in spouses of chronic schizophrenic patients.Indian Journal Clinical Psychology. 40 (1), 49-54.

Pourmand,D., Kavanaugh, D.J., & Vaughan,K.(2005): Expressed Emotion as predictor of relapse in patients with comorbid Psychoses and Substance use disorders.39(6),473-478. doi.org/10.1080/j.1440-1614.2005.01606.

Sabarese, J., & Todman, M.W. (2002). Intellectual disabilities, Residential Care and Expressed Emotion: Functional Costs. Journal of Developmental Disabilities. 11(2), 69-78.

Sartorius, N., Leff, J., L´opez-Ibor, J.J., Maj, M., & Okasha, A. (2005). Families and Mental Disorders: From Burden to Empowerment. England: John Wiley & Sons Ltd. 217-235.

Taylor, J.A. (1953). A personality scale of manifest anxiety. The Journal of Abnormal and Social Psychology. 48, 285–290.

Werner, S., & Shulman, C. (2013). Subjective well-being among family caregivers of individuals with developmental disabilities: the role of affiliate stigma and psychosocial moderating variables. Research in Developmental Disabilities, 34(11), 4103–4114. doi: 10.1016/j.ridd.2013.08.029.

Acknowledgments

The authors profoundly appreciate all the people who have successfully contributed to ensuring this paper is in place. Their contributions are acknowledged however their names cannot be able to be mentioned.

Conflict of Interest

There is no conflict of interest.

How to cite this article: Naobi, H & Devi, W. R (2018). Expressed Emotion and Its Relation with Anxiety in Caregivers of Psychiatric Patients. *International Journal of Indian Psychology*, *6*(4), 127-138. DIP:18.01.033/20180604, DOI:10.25215/0604.033