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Research Paper

A Study to Assess and Compare the Expressed Emotions in Caregivers of Patients of Bipolar Affective Disorder and Obsessive Compulsive Disorder

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ABSTRACT

Introduction - Psychiatric illnesses are not only a chronic, despairing, stigmatized situation for the sufferers, but also produce a lot of physical, mental, emotional, social and financial burden for the family, specially the primary caregiver. This study was undertaken to assess and compare the level of Expressed Emotion (EE) among caregivers of patients of Bipolar Affective Disorder (BPAD) and Obsessive Compulsive Disorder (OCD). **Methodology** – 100 patients, 50 of BPAD (25 of Mania and 25 of Depression) and 50 of OCD were selected after screening. Their primary caregivers (100) were then included in the study. A socio-demographic profile and LEE (Level of Expressed Emotion scale) questionnaire were filled by each caregiver. The scores on the 60 questionnaire format of LEE scale were then assessed and compared between groups. Four sub-sets of EE were analyzed, namely Intrusiveness, Critical Attitude, Emotional Involvement and Tolerance of caregivers towards their patient. **Results** – Analysis showed that caregivers of patients of BPAD had higher level of EE than caregivers of patients of OCD. In the group of BPAD, higher EE was observed in caregivers of patients of BPAD with Mania than patients with BPAD Depression. Higher EE was indicated by more Intrusive and Critical Attitude and less Emotional Involvement and Tolerance. **Conclusions** – Mostly elderly, males, from rural, low socio-economic groups were the primary caregivers. Probably, patients of BPAD and especially with manic episodes were more negative and hostile because of their unpredictable and relapsing nature of illness, which in turn produced more frustration and negativity in their caregivers. Further studies are required to see the correlation between high EE of caregivers and patient outcomes.

Keywords: *Expressed Emotion, caregivers, patients, Bipolar Affective Disorder (BPAD), Obsessive Compulsive Disorder (OCD)*

Psychiatric illnesses not only spell despair and hopelessness for patients, but they are also plagued with stigma and ostracisation. Moreover, they become a physical, mental, emotional and financial burden for the whole family. In such a family, the

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patient is emotionally and or physically dependent on the caregiver.

More chronic and incapacitating the illness more becomes the responsibility of the caregiver. Since, in majority of cases, the illness is considered a social taboo, the caregivers receive no social support, which adds up to a greater burden on their psyche and emotions.

Expressed Emotions (EE) refers to a global index of particular emotions, attitudes and behaviors expressed by relatives, about a family member diagnosed with a psychiatric illness. [1] This has now become the "measure" of the family's emotional and functional environment. There is vast majority of evidence that the quality of family relationships is closely related to the development, maintenance, treatment response and relapse rates of psychiatric disorders. [2]

EE includes assessment of intrusiveness, critical comments, hostility, emotional over-involvement, positive remarks and warmth of the family members towards the patient. [3-8] Family members showing high EE tended to be more intrusive, hostile, critical and intolerant towards the patient.

Taking care of a patient with a psychiatric illness for days and years is likely to generate negative emotion, which further leads to negative interaction between patient and caregiver. [9] Research says that 1/3rd to 1/2 of these caregivers suffer psychological distress and experience higher rates of mental ill health, than general population. [10, 11]

Caring for a mentally ill relative is not a static process since the needs of the care recipient alters as their condition changes. Role becomes more demanding and difficult if patient's mental disorder is associated with behavioral problems or physical disabilities. [10, 11]

Also, caregiver’s responsibilities have markedly increased, as due to de-institutionalization, more than 90% of patients are now managed at home. [12] Their burden is exacerbated by multiple issues such as poverty and illiteracy. [13] They have to simultaneously provide physical, psychological, emotional, medical, social and financial care. [14]

In the face of these increasing challenges and responsibilities, caregivers often feel tired, isolated and overwhelmed because they lack support, training, information and a sympathetic ear. They may have to miss work, or even take early retirement to provide care, which leads to added financial burden. [15, 16]

Most of the studies conducted so far, have been focused on caregivers of patients of Schizophrenia. [17-19] of late, research has been initiated in the role of EE in other psychiatric and neuron-degenerative disorders too. [20-23]

Hence, the objective of the present study was to assess the EE and compare the same, in caregivers of Bipolar Disorder and Obsessive Compulsive Disorder patients. These two illnesses also have prolonged nature and are equally taxing for the family. Moreover, EE in Indian population may be different from literature available from Western population, as there is marked difference in culture, socio-economic setups, emotional attachments, priorities, commitments and in general basic outlook towards familial relationships.

MATERIALS AND METHODS

Trial Design and Participants

Study Design- Observational, Cross-sectional, Analytical and Comparative, Clinical Study.
Setting- Tertiary Health Care Center (Geetanjali Medical College and Hospital, Udaipur, Rajasthan, India).

Study Duration- April 2017-August 2018.

Selection and Description of Participants-

- Patients were examined by a consultant psychiatrist and underwent screening and assessment, using ICD-10 symptom checklist.
- 100 patients (50 each of Bipolar Affective Disorder and Obsessive Compulsive Disorder) were selected.
- They included both men and women with ages ranging from 18-65 years.
- Patients with co-morbid psychiatric illnesses or other medical co-morbid conditions were excluded.
- Participants of this study were the primary caregivers of the above selected 100 patients.

Ethics- Approval was obtained from the Institutional Ethics Committee [Ref: GU/HREC/EC/2017/1380 dated 28th February 2017] and written informed consent was taken from all subjects (the caregivers).

This study was in accordance with the guidelines provided by World Medical Association Declaration of Helsinki on Ethical Principles for Medical Research Involving Humans.

Tools

Socio-demographic proforma was filled in details for both patients and their caregivers.
Diagnosis of psychopathology was done by using ICD -10 Symptom Checklist.

Severity of the illness was assessed by using Young Mania Rating Scale (YMRS), Hamilton's Depression Scale (HAM-D) and Yale Brown Obsessive Compulsive Scale (YBOCS).

Expressed Emotion was measured by using Level of Expressed Emotion (LEE) Scale. [24]

LEE Scale comprises of a 60 item questionnaire with a true or false format. The items are based on the four sub-sets of EE, mainly, Intruisiveness, Emotional Response, Attitude towards Illness and Tolerance and Expectations. The Scale generates a score for overall level of EE as well as score for each of the four response sub-sets.

All questions were first translated from English to Hindi, for better understanding and conversation with the subjects. Numbers of questions in each sub-set were - Intruisiveness - 15, Emotional Response - 16, Critical Attitude towards Illness - 13 and Tolerance - 16.

Intruisiveness and Critical attitude were considered as indicators of high EE, whereas Emotional response and Tolerance as markers of low EE.

Since, no literature was available to denote a cut-off point for scoring, our study considered 50% or more as cut-off.

Out of 28 items (indicating high EE), positive responses to 14 or more was considered high EE. Similarly, out of 32 items (indicating low EE), positive answers to 16 or more was considered as low EE.

Thus, 14 or more positives in first two sub-sets AND/OR less than 16 positives in last two sub-sets - were labeled as HIGH EE.

Procedure

After briefing the subjects and taking written informed consent, they were each given a proforma for socio- demographic details and the LEE scale questionnaire. For illiterate caregivers, assistance was provided for explaining the question and noting down their response.

Statistical analysis

Data obtained from the subjects were subjected to one way ANOVA, Student's t test and Karl Pearson Coefficient of Correlation. Then they were analyzed with the Statistical Package for Social Sciences, version 16.0 for Windows (SPSS Inc., Chicago, IL, USA).
$p < 0.05$ was considered as statistically significant.

RESULTS

Characteristics of Subjects

Among the 100 subjects, 75% were males & 25 % females, their age ranging from 20-64years with majority between 30- 50 years. Most of the caregivers were poorly educated (primary school) or even illiterate. Male caregivers were mostly farmers or shopkeepers, earning less than 50000 per month, female caregivers were all homemakers. There was no significant socio-demographic difference between caregivers of either groups.

Patient characteristics

In Bipolar Manic patients 68%, in Bipolar Depressives 44% and in OCD patients 58% were males. 44 % of Bipolar Manic patients were in the younger age group (21-30 years) whereas in Bipolar Depressives – 28% were between 21-30 years and 32% were between 31-40 years. OCD patients showed 50% between 21-30 years and 26% in 31-40 years.

Patients of OCD were educated better (mostly till 10^{th} and 12^{th} standard) as compared to Bipolar patients who were either illiterate or had primary education. Most patients were either at home or assisting in farming. Only 14% of the total were studying.

Majority of the patients (>60%) and their families were from rural background. But overall, the patients in both groups did not differ significantly in their demographic profiles.

Comparison of Expressed Emotion

From the LEE scale questionnaire filled by the 100 caregivers, comparison of total scores and individual subset scores was done.

Positive answers for Intruisiveness and Critical Attitude were done individually and then these were added (to see the score for high EE). Similarly positive answers were totaled for

Emotional Involvement and Tolerance separately then combined (to see the score for low EE).

Table No. 1. Comparison of EE between caregivers of BPAD and OCD patients.

Parameters	Type2	N	Mean	Std. Deviation	Std. Error Mean	Mean Diff	't'	P value
INT	BPAD	50	5.28	1.051	.149	.560	2.065	.042*
	OCD	50	4.72	1.604	.227			
CRIT	BPAD	50	5.58	1.372	.194	.580	2.327	.022*
	OCD	50	5.00	1.107	.156			
INT + CRIT	BPAD	50	10.86	1.959	.277	1.140	2.753	.007**
	OCD	50	9.72	2.176	.308			
EOI	BPAD	50	10.74	1.688	.239	1.140	3.297	.001**
	OCD	50	11.88	1.769	.250			
TOL	BPAD	50	10.84	1.167	.165	.740	2.651	.009**
	OCD	50	11.58	1.592	.225			
EOI + TOL	BPAD	50	21.60	2.000	.283	1.860	3.990	.000**
	OCD	50	23.46	2.620	.371			

(p < 0.05 significant) (**p < 0.01 highly significant)*

INT = Intruisiveness, CRIT = Criticism, EOI = Emotional Over Involvement, TOL = Tolerance,

There was significant difference in all four subsets of EE between the caregivers of BPAD and OCD patients. Intruisiveness and Criticism were higher in caregivers of BPAD patients, indicating a higher EE. At the same time, they also showed lower scores for Emotional Involvement and Tolerance again favoring a high EE.

Thus, caregivers of BPAD patients had significant higher EE than caregivers of OCD patients.

ANOVA and Karl Pearson Correlation Coefficient calculations also substantiated the above.

Table No. 2. Comparison of EE between BPAD Mania and BPAD Depression caregivers.

Parameters	Type1	N	Mean	Std. Deviation	Std. Error Mean	Mean Diff	't'	P value
INT	BPAD Mania	25	.96	1.837	.367	.880	2.091	.042*
	BPAD Depression	25	1.84	1.028	.206			
CRIT	BPAD Mania	25	4.00	1.323	.265	1.520	4.965	.000**
	BPAD Depression	25	2.48	.770	.154			
INT + CRIT	BPAD Mania	25	4.96	2.908	.582	.640	.987	.329
	BPAD Depression	25	4.32	1.435	.287			
EOI	BPAD Mania	25	15.12	.881	.176	.120	.586	.561
	BPAD Depression	25	15.24	.523	.105			
TOL	BPAD Mania	25	14.16	.850	.170	.840	4.938	.000**
	BPAD Depression	25	15.00	.000	.000			
EOI + TOL	BPAD Mania	25	29.28	1.400	.280	.960	3.212	.002**
	BPAD Depression	25	30.24	.523	.105			

(p < 0.05 significant) (**p < 0.01 highly significant)*

INT = Intruisiveness, CRIT = Criticism, EOI = Emotional Over Involvement, TOL = Tolerance

Critical Attitude showed statistical significance (higher for caregivers of patients of BPAD Mania). Intruisiveness was found to be more in caregivers of patients of BPAD Depression. But the combined scores of indicators of high EE failed to achieve statistical significance between the two groups.

Scores for Tolerance parameter was significantly higher for caregivers of BPAD Depression patients and summation of Emotional Over Involvement and Tolerance was also significantly higher, showing that caregivers of BPAD Depression had lower EE.

Thus, caregivers of patients of BPAD Depression showed more Tolerance and Warmth (low EE) as compared to caregivers of BPAD Manic patients who were more critical (high EE).

DISCUSSION

In this study, 100 patients (50 of BPAD and 50 of OCD) were selected from outpatient and inpatient settings of the Psychiatry department of a tertiary care level hospital. And their respective primary caregivers were chosen to participate as subjects. Majority of the patients were males, 56% of BPAD and 58% of OCD, but this could be because more males seek treatment than females in this conservative rural community. It was strangely observed that majority of caregivers in both categories were also males (76% and 74%). Though generally in most situations, females are the primary caregivers, [25] but the number of increased male care providers could be because, in these rural parts, women are not allowed to go out of their homes, even to attend to hospitalized family members. Caregivers in BPAD patients were more in their 30s and 40s, but the caregivers of OCD patients were more beyond 40 years of age. This again substantiates earlier observations, that in our country, the responsibility of caregiving seems to be more with the older family members. [25]

Most patients and caregivers were poorly educated and seemed to be mainly engaged in farming, labor work and domestic duties. Patients and their families fell in the rural low socio-economic group as affluent urban families probably preferred to seek consultation privately to avoid the social stigma.

Although, there is less literature on impact of level of EE of caregivers on patients of neurotic disorders, but in the last two decades, most studies point towards the negative correlation between caregivers and their patients, which in turn, modifies the patient outcomes too.

In this study, the level of Expressed Emotion of the caregivers were assessed and compared between those for BPAD and OCD patients.

Moreover, comparison was also done between caregivers EE between the two subgroups of BPAD, namely – Mania and Depression.

Our study found that the caregivers of BPAD patients had significantly higher EE as compared to caregivers of OCD patients. These caregivers (mostly spouses and parents) were more critical towards their patient and less warm and less tolerant.

Between the two sub groups of BPAD patients it was found that caregivers of patients of Mania were higher on EE than the caregivers of patients of Depression.

Our present study did not include the relationship of caregivers EE level with that of patient outcomes. But earlier studies have shown that patients of BPAD, whose key relatives had high EE, had more relapses thereby needing more hospitalizations. [26, 27]

Patients of BPAD having unresolved residual symptoms (eg – depression, irritability, hypomania etc) contribute to his or her intensity of reactions towards their caregivers, who in turn react with frustration, hostility, negativity, intolerance and hopelessness. [28, 29] The higher EE of caregivers could also be because of the helplessness of the chronic relapsing nature of illness and unpredictability of symptoms of Mania.

On the other hand, caregivers of patients of OCD, though also frustrated and helpless, may be showing lower EE, due to the predictable and persistent nature of their patients' illness, leading to a chronic, anticipated tolerance to the situation and more level of acceptance.

The limitations of our study arose due to some basic cultural and social differences of our population. Our society, being more conservative and showing stronger family ties with close knit bonding, tends to have low EE towards a sick family member. Thus, our data will definitely differ from the Western literature (since the same LEE scale questionnaire is being used for scoring). Moreover, due to societal and familial restrictions our people cannot express absolute freedom of speech. Thus, it is questionable whether the answers given by the caregivers were a true expression of their thoughts and feelings. To add to this, psychiatric illnesses themselves are still a huge social stigma in these parts. Some questions in the LEE questionnaire could be perceived as "Intruisive" by Western population but may mean "care and concern" in the Asian population. e.g. – "Do you enquire when and where he/ she is going?" Different set of questions should be prepared, depending on the ethnicity, socio-cultural backgrounds etc. [30]

Lastly LEE scores would vary at different time-points – e.g. Interviewing during manic episode or depressive episode. Similarly, so many factors of the individual caregiver like age, health status, relationship with patient, duration of caregiving etc would also alter the level of EE.

CONCLUSIONS

The caregivers of the selected patients were mostly males, in older age groups, belonging to rural, low socio-economic strata, with poor education, and mainly involved in agriculture or domestic work.

Caregivers of patients of BPAD had higher levels of EE than caregivers of patients of OCD. Among BPAD patients, caregivers of patients of manic episodes had higher EE as compared to those with depression.

Thus, such caregivers with high EE were more Intruisive and Critical but less Tolerant and less Emotionally Involved with their patients.

Future Directions

Further multi-centric studies with large sample size are required along with structured questionnaire pertaining to our socio-cultural set-up. There is also a need to check the correlation between negative emotions of caregivers and outcomes of their patients on subsequent follow-ups.

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Conflict of Interest
No conflict of interest declared.

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