A Study of Expressed Emotion in Psychiatric Nurses and Its Relation to the General Role and Effects of Emotions in Nursing

Lauren AnneMarie Buck

A Senior Thesis submitted in partial fulfillment
of the requirements for graduation
in the Honors Program
Liberty University
Fall 2011

Acceptance of Senior Honors Thesis

This Senior Honors Thesis is accepted in partial fulfillment of the requirements for the graduation from the Honors Program of Liberty University.

_____

Lynne Sanders, Ed.D.
Thesis Chair

_____

Tamra Rasberry, M.S.N.
Committee Member

_____

Chad Magnuson, Ph.D.
Committee Member

_____

James H. Nutter, D.A.
Honors Director

_____

Date

Abstract

Nurses play a vital role in the health and care of a patient. Through that care, the nurse has the ability to improve the patient's experience or ruin it. A vital component influencing the care provided are the emotions the nurse displays toward her coworkers, patients, and patients' family members. The emotions of a nurse may positively or negatively impact a patient. The studies that examine the impact of the nurse's emotions on patient's outcomes are varied and few. The communication and emotion of nurses are likely to impact their care and, from that, the patient's outcome; however, there is little solid research on the specific effects, be they positive or negative. A connection might be found in studies of Expressed Emotion in psychiatric patients. Expressed Emotion (EE) refers to the negative emotions the patients' family, and in newer research, that the patient's nurses, display to psychiatric patients that can lead to relapses in their condition. Correlations between emotion and outcome are strongly evidenced in EE research. Examining the empirical research that shows the impact of EE on patient outcomes may give insight on the impact of a nurse's attitude on patient outcomes as a whole.

A Study of Expressed Emotion in Psychiatric Nurses and Its Relation to the General Role and Effects of Emotions in Nursing

It is relatively easy to find studies on Expressed Emotion in the psychiatric clinical setting. In the same respect, it is commonplace to find research on the emotional work that is so intricate a part of nursing practice. The difficulty, however, comes in building a relationship between the two that spans atmosphere and patient background. Examining the roles of nurses, the history of Expressed Emotion, and the newer studies on the Expressed Emotion of nurses, suggests that there is a valid correlation between nurse's emotions and patient's outcomes in extended-stay wards.

Role of Nurses

General

Young, old, or somewhere in the middle, the vast majority of people living in the United States have been in or have a family member who has been in the care of a nurse. According to Scott (2011), "The role of the nurse is socially sanctioned in our society. Broadly speaking the function of this role is to promote the health and well-being of the patient" (p. 124). Be it in a hospital, nursing home, outpatient facility, clinic, or doctor's office, nurses all have the similar role of keeping patients in the best possible health for their condition. Nursing in practice should meet patients needs, comfort them in struggle, empower them as they recover, and advocate for their best interest. With this practice comes the responsibility to act in the interest of the patient, not to impose the nurse's own opinion of care (Benner, 2000). There is a balance that is required between strengthening and liberating patients, and confining and restricting them. Nurses work to enhance patient outcomes and are rated on their ability to do so.

Healthcare/medical facilities rely on the nursing staff to be the front line and support system. When patients come into the hospital for care or treatment, they may see a doctor, but they spend most of their time in the care of a nurse. Based on the time commitment involved, the nurse has the ability to improve patient experience or ruin it. Nurses' influence on patient's experiences relies heavily on the emotions they expresses or elicits. P. Anne Scott (2000) states, "I suggest that an aspect of being a good nurse is having an emotional sensitivity to other human beings (patients), because this emotional sensitivity allows the nurse to perceive more accurately the context and perspective of the patient" (p. 123). Therefore the role of a nurse is very much *emotion work*.

Emotion Work

Bandaging wounds, feeding, changing linens, starting IVs, performing exercises, and administering medications are only a select few components of the job of a nurse. Another aspect is to be emotionally on call for various types of patients, who all have their own unique stories. Scott (2000) states, "The engagement that can potentially occur between the practitioner and the patient has a strong emotional element. A patient may elicit compassion, concern, pity or indeed anger or frustration" (p. 125). Patients and nurses alike have a variety of emotions. Because of this factor, the nurse's work can well be considered *emotional labor,* which stresses that the job of a nurse is not only the technical or physical tasks, but also the nurse's ability to create a proper emotional climate (Bolton, 2000).

Emotions can be displayed through many outlets: facial expressions, gestures or body language, words, or tone of voice (Rafaeli, 1987). Any combination of these expressions can create a reassuring or demeaning response in a patient. The key is to

control the emotions that are outwardly expressed. A nurse must be kind and caring while remaining calm and detached (Bolton, 2000). Her capacity to take an awkward, embarrassing, or scary situation and create calm or understanding from it is a gift. A nurse will often dole out excessive amounts of care and emotion without ever receiving it in return (Bolton, 2000), which can lead to burnout among nurses. The emotional aspects of nursing can be the most rewarding part of the job and also the most stressful.

To control the negative reactions that come from constantly expressing emotions, some institutions have tried teaching the nurses how to respond to emotionally demanding situations. Other institutions have tried implementing rules referred to as *display rules* (Brotheridge & Grandey, 2002). The rules give guidelines as to the degree of emotion the nurse should show or hide in order to meet the expectations of employee performance. There have been varied results from the implementation of emotion teaching and established guidelines. In some cases, nurses made to display an expected emotion felt their psychological well-being was damaged by being made to act like a puppet. While in other instances, nurses who were able to professionally control emotions stated that the teaching "helps them to continue performing effectively" (Rafaeli, 1987, p. 31).

In either situation, the nurse is required to separate true feelings from expression. This difference between feeling and expression is called *emotional dissonance* (Brotheridge & Grandey, 2002). A very basic example of the difficulty in controlling feelings and expressions is seen in the outcome of accidental injury. For example, if one individual steps on another's toes while stepping forward in a grocery store line, the most common immediate *feeling* to have is frustration over the pain. The hurt person might

feel anger over the unwarranted pain, but express understanding and forgiveness to the accidental injury. It seems quite often, then, that most people, including nurses, work to control their emotions in an effort to better function in an ever-changing society.

In relation, the skill and professionalism of a nurse is found in her ability to care for a patient within a variable setting (Brotheridge & Grandey, 2002). While this is certainly a positive trait found in the emotional labor that is nursing, it can be damaging over time, especially if the nurse is frequently engaging in *surface acting*. This is used in many professions to hide or enhance emotional expression and is a direct contrast to *deep acting*, where nurses truly control their thoughts and feelings to rationally deal with a situation (Brotheridge & Grandey, 2002). In surface acting, the emotion is fake and forced, which, when done constantly, can distance nurses from their true feelings. In the process, nurses can become hard, detached from the feelings of others, and may experience depersonalization (Brotheridge & Grandey, 2002). As a result, nurses must keep their emotions in careful check, making sure not to fabricate a reaction, but rather construct a more open opinion to the situation. Truly seeking to understand a patient's condition or feelings can enhance the chances of a nurse being able to express her true, newly-remodeled emotions.

Understanding and properly expressing emotions is vital to the nurse's work because unlike zoologists or paleontologists, the science of nursing deals directly with vulnerable human beings. Nurses are noted to be care-providers and health promoters to patients and with that role comes respect and an expectation of morality (Scott, 2000). Nurses have many moral decisions to make on a daily basis, which require them to be clinically competent, as well as patient advocates. A nurse's "clinical judgment cannot

be separated from ethical reasoning because each clinical judgment judges what good is at stake and what to do in each particular situation" (Benner, 2000, p. 16).

Scott (2000) outlined two vital elements in regard to making moral judgments: cognitive activity and emotional activity or empathy. In order to treat a patient's pain the nurse must be able to sense emotions (cognitive) and respond accordingly (emotional). Without due caution, a nurse's emotions can too closely reflect the emotions of her patient. A problem arises when the nurse does mirror the emotions of her patient in a setting where that is highly inappropriate. According to Benner (2000), "For example, a strict communication technique of reflecting back the patient's expressed emotion would be unwarranted in a situation of trauma where the patient was flooded with emotion and experiencing terror" (p. 12). The nurse can also allow her emotions to harm the clinical relationship by displaying countertransference to her patient. Countertransference is the tendency of the nurse to place the feelings she has toward a person in her past onto the patient (Varcarolis & Halter, 2010). This often occurs when a patient's attitude, characteristics, or habits resemble someone close to the nurse. Nurses should be careful to guard against this type of emotional response because it can create distrust and discomfort. Emotions must remain in check in any clinical situation because they shadow the event with either distress or positivity. Good nurses are sensitive to the emotions of their patients. Emotional sensitivity helps them to step into the shoes of their patients to better understand their perspective (Scott, 2000). It also allows the nurse to protect the patient from unmerited harm that may follow an outburst of emotion.

As mentioned above, understanding the patient makes it easier for the nurse to express positive emotions without feeling as if she is acting. Patients can pick up on

those expressed emotions of the nurse whether she means to convey them or not; therefore, being controlled, but genuine seems the most effective.

Expressed Emotion

Meaning of Expressed Emotion

The theory of Expressed Emotion (EE) was coined in Great Britain the 1960s by George Brown and his colleagues to describe "a global index of particular emotions, attitudes, and behaviors expressed by relatives about a family member diagnosed with schizophrenia" (Jenkins & Karno, 1992, p. 9). Expressed Emotion focuses mostly on the negative emotions family members displayed toward another family member with a mental disorder, usually schizophrenia, that can cause relapses in their condition (Katsuki, Goto, & Someya, 2005). More succinctly, EE measures relatives' tolerance, intrusiveness, and flexibility in responding to patient's problems (Forster et al. , 2003).

In Expressed Emotion research, emotions are classified as *critical*, *emotionally over-involved,* or *hostile* (McDonagh, 2005). Relatives who exhibit critical emotions are being degrading toward the patient or his disorder. Relatives who exhibit emotional over-involvement often blame themselves for the illness and become too involved and overbearing, showing pity toward the patient. Finally, relatives that show hostile attitudes blame the patient for his condition and even the problems of the family as a whole.

The three types of Expressed Emotion are compiled and a rating is given to the caregiver or relative that is either high or low. The higher the EE the more negative emotions are displayed, while the lower the EE the less prevalent the negativity. It is the

higher EE which has shown to correlate with relapse. Further information regarding EE measurement will be discussed below.

Expressed Emotion History of Leading to Relapses in Psychiatric Patients

In psychological disorders such as schizophrenia, alcoholism, child learning disabilities, and bipolar disorder, relapse is one of the greatest fears of both the patient and the care-provider. A relapse can stem from a variety of causes, but one of the leading contributors is EE (McDonagh, 2005). In fact, EE originated from studies done on patients leaving psychiatric settings to return to their households. The research showed a clear link between "the emotional atmosphere of the household and the course and relapse of psychosis" (Dennis & Leach, 2007, p. 267). In the past, nearly all EE work has been performed on schizophrenic patients.

Schizophrenic patients, by nature of the condition, have abnormal or exaggerated emotional responses (Varcarolis & Halter, 2010). Based on this knowledge, schizophrenic patients tend to amplify the emotional reactions of healthy patients making it more likely that they will relapse due to their strong perception of negative EE.

Only more recently has research has extended to the general psychiatric population and even into the employed caregivers of that group (Dennis & Leach, 2007). Studies have been done on EE in the following areas: depression, bipolar, dementia, anorexia nervosa, asthma, stroke, obesity, childhood epilepsy, autism, Parkinson's disease, and inflammatory bowel disease (Jenkins & Karno, 1992). The majority of conditions in the list are not even issues that require the patient to stay in a psychiatric unit or institution. The studies reaching beyond psychiatric conditions to non-psychiatric

conditions are much fewer in number, but show similar relationships of high EE and relapse or worsening.

A research study by Simpson (1989) demonstrated a distinct correlation between high Expressed Emotion levels and readmission rates. Over 9 months, there was a 13% readmission rate in schizophrenics with low EE families, while the readmission rate in high EE families was 51%. Additionally, the turnover rate of residents living in a hostel with staff with 57% high EE was much greater than the hostel with staff with 20% high EE (Dennis & Leach, 2007). The relationship of EE and relapse or readmission rate is unavoidable; as EE decreases, the patient's length of time away from the hospital increases, and vice versa.

Ways to Discover or Rate Expressed Emotion

The original method of discovering the presence and quality of Expressed Emotion was through conducting the tedious, time-consuming Camberwell Family Interview (CFI). The CFI, created by Rutter and Brown in 1966, initially lasted approximately five hours and contained a series of well-planned, open-ended questions regarding the feelings and attitudes of the family members towards the patient. Interviewees are asked about the development of the patient's illness, symptoms, and the type of relationship they have with the patient (Berry, Barrowclough, & Haddock, 2010). The interview was taped to watch both the verbal and non-verbal reactions of the family members to the questions asked (McDonagh, 2005). A trained rater then reviewed the interview and scored the relative interviewed according to 5 scales: critical comments, hostility, positive remarks, emotional over-involvement, and warmth. The results from the CFI were compiled to determine the EE of relatives and classify the interviewed family member as having high EE or low EE. The higher the score, the more likely the

interviewee was to express criticalness, hostility, or emotional over-involvement and overall negativity. Extensive use of the CFI among families and patients found it to be accurately predictive of EE and it has since been condensed into a shortened one-hour interview.

Though the Camberwell Family Interview is suggested to be effective in rating expressed emotion, even the condensed assessment takes anywhere from 60 to 90 minutes to administer, not including the time needed for analysis, making it unfeasible for regular use (Katsuki et al. , 2005). Other scales such as the Five-Minute Speech Sample (FMSS) and Family Attitude Scale (FAS) are quicker and equally effective measurement tools as well (Kavanagh, et al. , 1997).

The Five-Minute Speech Sample is the most frequently used alternative to the Camberwell Family Interview (Berry et al. , 2010). This scale measures EE based on a five minute, uninterrupted recording of a family member discussing the patient in question. The recording is then reviewed and the relationship between patient and relative is rated as positive, neutral or negative. In 89. 7% of cases reviewed, the CFI and the FMSS shared compatible results, building confidence for its use in the clinical setting (Berry et al. , 2010). The FMSS has also become popular for its ease of use and quick rater training, as it does not require that the reviewer be strongly experienced.

Expressed Emotions and Nurses

As discussed previously, high Expressed Emotion leads to increased patient readmission rates. The studies on EE mentioned above focused on relapses caused by familial EE; however, there are also nurse-specific factors that directly affect the EE score and patient readmission rates. These include the following: “nurses’ attitudes,

nurses' behavior, ward atmosphere, institutionalization, social therapy, and patient outcome" (Simpson, 1989, p. 459). Before delving into the above factors, there are several scales that are useful in measuring EE in nurses specifically.

Measuring Expressed Emotion in Nurses

There are many scales to rate Expressed Emotion or components of Expressed Emotion in psychiatric nurses, the foremost being the Adjective Check List (ACL), the Nurse Attitude Scale (NAS), the five-minute speech sample (FMSS), and the Patient Rejection Scale (PRS). To assess the reliability of each scale, they were compared to a shortened version of the aforementioned, clinically-sound Camberwell Family Interview (CFI). The CFI itself was not used because the length of time it takes to administer is not practical in a nursing setting, thus a briefer instrument was developed to correlate with the CFI and comparatively measure EE (Arthur, 2002).

The Adjective Check List reviews nurses' use of positive and negative adjectives when describing themselves, situations, or patients in order to determine their Expressed Emotion. It is done using by asking the nurse, family, and patient to rate the behavior of themselves and the respective others using 10 preset negative and 10 preset positive adjectives using an 8-point Likert scale. Implementing the ACL, the nurses with high EE saw themselves as being more negative, but saw their patients as being less negative (Arthur, 2002). The ACL was less consistent and reliable than the FAS overall.

The Nurse Attitude Scale is an adaptation of the Family Attitude Scale (FAS). As the findings of the FAS have shown to correlate well with the findings of the abbreviated CFI, Katsuki, Goto, and Someya (2005) created the Nurse Attitude Scale (NAS) in hopes of emulating the FAS results. The original FAS was a 30-item self-report inventory to

measure the EE of a patient's family members. In a similar format, the NAS is a 30-item self-report inventory to measure the EE of psychiatric nurses. Later, a short form of the NAS was created in Japan to establish a tool to measure staff EE that had fewer questions, but was still valid and dependable (Katsuki, et al. , 2008). The short form NAS contained only 12 items compared to the 30 used in the original NAS. The short form proved to be quicker and equally reliable (Katsuki et al. , 2008).

As discussed briefly above, the Five-Minute Speech Sample is an interview of sorts where participants discuss a certain patient for five minutes without interruption (Forster et al, 2003). The original scale, when applied to family members, focused around answering the following: *What kind of person is the patient and how do you get along together* (Arthur, 2002, p. 193)? When applied to nursing staff, these short speech samples were recorded and reviewed to determine EE levels from the amounts of criticism and over-involvement stated by the nurse (Finnema, Louwerens, Slooff, & Bosch, 1996). The FMSS, when compared to the other measuring tools, is the most difficult to judge because the perceived EE collected from the patients was institution – specific, applying only to the staff in that particular setting (Forster et al. , 2003).

In addition to these, there is also a Patient Rejection Scale (PRS), an 11-item self-report done by the nurse to assess for hostility and rejecting responses (Berry et al. , 2010). Studies done using the PRS found increased rejection toward patients with more symptoms and found that the older the staff member, the higher the rejection scores. The studies done on the application of the PRS are varied and few, however, and have not shown to be generally reliable to hospital staff. Collectively, research seems to validate

the use of the FMSS and the NAS for its reliability and reliability among family members and staff alike (Berry et al. , 2010).

EE and Nurse Attitudes and Behavior

In one study the most common expressed emotion shown by staff members was criticism (Katsuki et al. , 2005). The nurse knows the "proper" way for a patient to act or react to certain treatment or care and when the patient's actions are contrary to the supposed norm, it is easy for the nurse to be critical of those actions. The display of critical emotion does not only affect the patient, but also that nurse and those surrounding her. In fact, Katsuki et al. (2008), found a link between EE as measured by the NAS short form and the results of a Maslach Burnout Inventory (MBI) administered to that same nurse population. Hostility and Criticism on the NAS short form were positively correlated with Emotional Exhaustion and Depersonalization on the MBI. In contrast, Positive Remarks measured by the NAS short form were positively correlated to Personal Accomplishment on the MBI. The nurses who displayed hostility and criticism towards their patients had complaints of emotional burnout. The effects then of EE were not limited to causing poor outcomes in patients, but poor outcomes in themselves. Either result is unbeneficial and could lead to greater EE problems in the future.

When the Camberwell Family Interview was applied to nurses, nurses who had nurturing and sympathetic attitudes had lower Expressed Emotion, while overly authoritarian staff had higher Expressed Emotion (Simpson, 1989). A similar study was performed using an extended version of the American Opinions about Mental Illness (OMI) scale (Simpson, 1989). The study was done on 76 schizophrenic patients over the two weeks that followed their admission into a psychiatric setting. Using the scale, the researchers discovered that "'staff authoritarianism' was negatively correlated with

improvement and 'protective benevolence' – here seen as a friendly, non-punitive, *laissez-faire* approach to patient – was positively correlated with improvements" (Simpson, 1989, p. 461). In simpler terms, a controlling persona negatively impacted patient outcome, while a kind, caring persona enhanced patient outcome. From this perspective, it seems evident that emotions play a large role in patient outcomes in the psychiatric setting.

In addition, Simpson (1989) recorded a study that found a correlation between the time of patient contact and expressed emotion score. The more junior nurses who spent more time in contact with their patients had lower EE scores, despite the fact that they had fewer years of experience. The longer length of daily contact time allowed the nurse to develop a relationship with each patient and a deeper understanding of his actions/reactions. In a similar manner, nurses with more years of experience were shown to have lower EE scores. The more experienced nurses were more familiar with a great variety of conditions, people-types, and effective emotional outlets to help them work with their psychiatric patients (Simpson, 1989). The low EE score did not depend on the experience in these cases, but rather the length of time that the nurses got to spend developing patient relationships.

Expressed Emotion in Ward Type, Institutionalization, and Therapy

Another contribution affecting Expressed Emotion scores in psychiatric nurses and patients was the type of ward that they worked in or stayed in respectively. In psychiatric hospitals there are both long-stay and short-stay wards. The Ward Atmosphere Scales (WAS) reviews different types of hospital wards to measure the "consensual environmental press" of a psychiatric ward (Simpson, 1989, p. 426).

Subsections of the WAS were classified as *relationship*, *treatment*, and *administrative*. The findings of the WAS revealed that over a 6-month period, the wards with low *relationship* and *administration* had a greater number of dropouts. In contrast, wards with high *relationship* and *treatment* took longer to discharge their patients; however, they were able to keep them out of the hospital for longer as a result (Simpson, 1989). The efforts that were put forth within the hospital gave the patient more time to stay out of the hospital. The extra work that nurses did in building relationships and using patient-focused treatments created lower EE scores and less relapses. In other words, the positive atmosphere created in the ward was directly related to the enhanced outcome of its patients.

Another study done on a locked psychiatric unit had surprising results from observing the nurse's interaction with patients (Brooker, 1990). In the study, *all* of the nurses took the time to acknowledge the patient's outlook, understand their condition, and redirect the patient toward a purposeful activity. In this locked setting the patient and nurse developed a unique relationship based on the amount of time spent together and the inability for the patient to foster relationships outside the closed ward. According to Dennis and Leach (2007), "Locked environments, limited family contact and restricted community access further enhance the centrality of staff relationships" (p. 268). For these patients, the hospital becomes a home and the nursing staff, a family. The nurse has the ability to improve or worsen patient outcome even more so in such a setting because she has a central role in the patient's life.

Educating Nurses About Expressed Emotion

One of the most effective ways to improve Expressed Emotion scores is through teaching the medical staff how to better handle their emotions and expression of emotion. Surface and deep acting was mentioned prior to this in a discussion of emotion control alone. Those forms of emotional control – deep acting specifically – are extremely applicable as they can be used to instruct nurses across a wide variety of backgrounds. When it relates to EE in the psychiatric population specifically, education is the key to knowing exactly how to reach the psychiatric patient.

Willets and Leff (1997) created a staff-training program to teach nurses how to interact with families, increase their knowledge of psychiatric illness, and give them strategies for managing difficulties. The training program was employed at five community care facilities and consisted of nine, two-hour sessions over 10 weeks. The instructors provided examples, role-play, formal teaching, and feedback during the sessions. Those enrolled in the class had their EE measured before and after to assess for differences. At the completion of the class, there was a relatively insignificant decrease in EE, but in two of the facilities the change was significant. Among *all* participants and facilities, the presence of emotional over-involvement and hostility disappeared after the program (Willets & Leff, 1997). Education in this instance proved beneficial if only to decrease the EEs of over-involvement and hostility. While they are not as prevalent as high criticism EE scores among patients, removing their presence in the unit through teaching can only improve patient status.

A study of Expressed Emotion education on long-stay wards generated similar results (Finnema, Louwerens, Slooff, & van den Bosch, 1994). An educational program was put into effect at six Dutch psychiatric hospitals with long-stay wards. The program was intended to increase staff knowledge of mental illness in order to decrease EE towards patients with those conditions through understanding. Following the class, there was not a significant or measureable decrease in nurses' EE; however, there was a decrease in ward rules and instances of submitting patients to locked seclusion. The changes to ward climate after the teaching provided an environment where patients could have more autonomy over their belongings, decisions, and movement in and out of the ward. The educational program created significant benefits for the patient although the EE results had little fluctuation.

Providing nurses with education on the presence and proper use of Expressed Emotion seems to create an improvement in their dealings with patients. The positive results from that EE instruction will likely continue as more research and effort is put into the implementation of such programs. Just as nurses are taught the skills needed to care for a patient's physical needs, providing additional training to care for the patient's mental and emotional needs is vital. Holistic care treats body and spirit; therefore, any training that incorporates both physical and spiritual aspects can improve patient outcome for the long haul.

Ties Between Expressed Emotion Work and General Emotions

In general, the studies done on Expressed Emotion, whether they are done on nurses or family members, have shown a strong link between negative emotions and patient relapses, and positive emotions and patient improvements (Simpson, 1989).

While these EE studies focus primarily on the psychiatric patient, emotional expression is important to any aspect of nursing care. The psychiatric patient population is a good starter, because those patients are more likely to be visibly effected by emotions due to the mental and chemical differences in the brain (Varcarolis & Halter, 2010). However, the work should be applicable to nearly anyone, because the core concepts and presence of emotion are universal across all peoples (Jenkins & Karno, 1992).

The above stated, a summary of past Expressed Emotion research and the emotions of the general patient population is important to understanding the present correlation. To start, criticism was found to be the highest EE in nurses according to the NAS performed by their patients (Katsuki et al. , 2005). Their critical comments were correlated to poor patient outcome, negative symptoms, and socially abnormal behaviors (Dennis & Leach, 2007). By example, an overly critical atmosphere correlates to poor patient outcome, inside or outside the ward. Next, the Ward Attitude Scale (WAS) discussed previously linked emotion work in psychiatric units with improved patient outcome (Simpson, 1989). It suggested that the nurse's emotions and time benefited the patient and improved outcome. In the locked psychiatric setting, negative EE, by definition, had little to do with the patient's outcome, but more to do with the absence of a positive relationship (Dennis & Leach, 2007). The more the nurse built a relationship with the patient, the better the outcome became. Surely those results must be universally applicable because positive relationships should be built in any clinical interaction not just those interactions with a psychiatric patient.

The locked setting also provides more time for patient contact, which is a key factor in improving emotions. As mentioned previously, the longer amount of time a

nurse spends with the patient, the lower the likelihood of relapse or ratings of perceived high EE in that nurse (Simpson, 1989). To be cliché, time is truly one of the greatest gifts to give, and again the benefits of quality time are not simply experienced by those on a psychiatric ward. Most people appreciate the attention given to them: the child in the emergency room, the man with Parkinson's disease, the elderly lady with schizophrenia, or the nurse discussing care with a doctor. Unfortunately, many settings do not allow for such extended time windows or focused care; therefore, increasing the time for patient contact or decreasing patient load could also be beneficial to improving nurses' emotions and patients' outcomes.

The difficulty between linking a general patient population and a psychiatric patient population comes with the differences in mental status and the length of patient stay. Nurse interaction time was shown to affect patient outcome in the psychiatric setting because many of those nurses spend weeks, sometimes months or years with the same patients (Simpson, 1989). This is not the case in general medical floors, where patients move in and out of the unit on a daily, and rarely, weekly basis. If a direct connection were to be made, the research of EE on a non-psychiatric population would likely need to be performed in a long-term care facility where the extended outcomes could be analyzed. However, regardless of the setting, emotions play a factor in any clinical or personal relationship. This includes the atmosphere of a unit as well, which can so easily be influenced by the emotions of the nurses working there. All in all, creating any variety of emotional outcomes is unavoidable.

Emotional Outcomes

People enjoy feeling loved and cared for; they enjoy positive emotional expression (Safilios-Rothschild, 1976). That is likely why sales go up so significantly on holidays and anniversaries, because people appreciate an outward expression of an inward love (Belk & Coon, 1993). If this is true in everyday life and it is true based on the results of EE studies, then why should the same not be true of all patient populations? A smile, extra moment, thoughtful gesture, added precaution, or quick word of encouragement could mean the world to a patient. Those expressions of emotion reflect a sort of compassion to the patient that might be just the ticket to keep him out of the hospital. The *quality* of care truly does impact the recovery and lower the readmission rate (Dennis & Leach, 2007).

To summarize with an example, a patient comes into the hospital because he has had an infection in his elbow for nearly two months without treatment. The patient also has diabetes mellitus type II, hypertension, and has smoked one pack per day for 55 years. He has no family in the area and has just been told that the infection, which started in his elbow, has spread to his blood stream causing sepsis. This patient is not on a psychiatric floor, but there is no doubt he is having some mental issues with the news of his poor health, hospital stay, and lack of emotional support. Then the ill patient's nurse walks into the room with a smile, calls him by name, and expresses empathy to him in the small way she knows how. Her positive emotions – or low EE, as it would be called for the psychiatric patient – in that instance, made the patient's day.

The situation may vary slightly from case to case; however, similar stories of emotional stressors that often generate pessimism go on every day in hospitals across the world. In those patients who do not have support from family or friends during their period of illness, interaction with the nurse may be their only outlet. Because of this, the nurse should be able to provide some amount of emotional relief. It does not need to be an extra task or hours more time spent with the patient, but could simply be a few brief moments talking about the patient's feelings while changing the bed linens. Expressing empathy, using non-verbal language such as a facial expression, and treating the patient like a human, not a job, are all ways to improve patient outcome through emotion. There may be times when the staff can do little to make that patient feel better, but having the mindset of controlling personal emotions and expressing them appropriately can create a trend that may be the perfect experience for the patient the next room over.

Learning from the Correlation

Emotional expression can be seen on subways, in art museums, in pieces of literature, in a classroom, in the home, restaurant, park, or grocery store, so why should emotions not also be in the clinical setting? Emotions are almost inseparable from everyday life; because of this, emotional expression needs to be controlled and possibly learned. This is not to imply that nurses are incapable of taming their feelings, but rather that there may be more efficient and generally applicable ways of doing that. In fact, as education of the nursing staff was provided or increased, patients perceived lower EE (Forster et al. , 2003). The patient could tell a change had occurred in the nurse's

expression just from education on the best ways to handle feelings towards or situations with their patients (Brooker, 1990).

As this applies to the education performed in a psychiatric setting, so it can be used to advocate for teaching among nurses in general. In fact, even beyond the medical field, almost anybody could grasp some small piece of helpful information regarding emotional expression control and coping with others' expression. These teachings could include teaching on the following: methods of separating emotion from feelings and nonverbal expression; the impact of facial expression on patient impression; the above influences of emotion related to EE in the psychiatric setting; and methods of deep acting (Brotheridge & Grandey, 2002). Further study needs to be done on the most effective types of teaching depending on setting, patient population, adequate staffing, and cultural influences.

Future Research/Implications

Culture influences emotional expression. Western cultures, where much of this research was done, have different ways of expressing their emotions than other Eastern or Third-World cultures (Arthur, 2002). A culture's unique form of expression must be factored into the future measurements of EE or any emotion study. It is important that culture is taken into consideration because the known emotional characteristics of each culture can provide a general baseline to which the patient's psychopathology can be compared (Jenkins & Karno, 1992). This analysis, therefore, should only be applied to those nurses working in a Western Culture. Further study into the emotions of various

other cultures should be done in order to determine whether emotional expression and patient outcome could be correlated in any culture.

It would also be beneficial to do a broad study of the predicted conclusions found in this analysis of the literature. Though it seems logical that emotions *should* impact patient outcome, it is not reliable unless tested by research. That said, a form of the NAS or FMSS using additional categories of emotions could be created and then applied to patients beyond the psychiatric realm. The results from such a study could lead hospitals to require instruction on emotional control if it is shown to improve patient outcome.

Finally, research regarding the validity of applying Expressed Emotion to the general patient population must be done. Can a connection between long-stay psychiatric patients and medical patients truly be correlated? Such a study may find that EE effects only apply in settings where the patient is staying for more than one to seven days. If this were the case, then EE may only be seen to apply to long-term intensive care units and/or long-term care facilities. Nurses work in these settings as well; therefore, even in the event that EE research and emotion training is only applicable to that narrowed patient population, the results would still breed a well-equipped, well-rounded nurse.

In the end, the goal of any study should be the improvement of patient outcome and the better understanding of the emotional labor that is nursing. No matter the country, state, unit-type, or age group, emotional work goes far beyond EE and should be considered as a valuable part of the nursing field.

References

Arthur, D. (2002). The validity and reliability of the measurement of the concept "expressed emotion" in the family members and nurses of Hong Kong patients with schizophrenia. *International Journal of Mental Health Nursing*, *11*(3), 192-198. Retrieved from CINAHL Plus with Full Text.

Belk, R. W. , & Coon, G. S. (1993). Gift giving as Agapic love: An alternative to the exchange paradigm based on dating experiences. *Journal of Consumer Research, 20*(3), 393-417.

Benner, P. (2000). The roles of embodiment, emotion and lifeworld in nursing practice. *Nursing Philosophy, 1,* 5-19.

Berry, K. , Barrowclough, C. , & Haddock, G. (2010). The role of expressed emotion in relationships between psychiatric staff and people with a diagnosis of psychosis: A review of the literature. *Schizophrenia Bulletin*, *162,* 1-15.

Bolton, S. C. (2000). Who cares? Offering emotion work as a "gift" in the nursing labour process. *Journal of Advanced Nursing, 32*(3), 580-586.

Brooker, C. (1990). The application of the concept of expressed emotion to the role of the community psychiatric nurse: A research study. *International Journal of Nursing Studies, 27*(3), 277-285.

Brotheridge, C. M. , & Grandey, A. A. (2002). Emotional labor and burnout: Comparing two perspectives of "people work. " *Journal of Vocational Behavior, 60,* 17-39.

Crawford, M. J. , Adedeji, T. , Price, K. , & Rutter, D. (2010). Job satisfaction and burnout among staff working in community-based personality disorder services. *International Journal of Social Psychiatry, 56*(2), 196-206.

Dennis, A. M. , & Leach, C. (2007). Expressed emotion and burnout: The experience of staff caring for men with learning disability and psychosis in a medium secure setting. *Journal of Psychiatric and Mental Health Nursing, 14,* 267-276.

Edwards, D. , Burnard, P. , Coyle, D. , Fothergill, A. , & Hannigan, B. (2000). Stress and burnout in community mental health nursing: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 7,* 7-14.

Ewers, P. , Bradshaw, T. , McGovern, J. , & Ewers, B. (2001). Does training in psychosocial interventions reduce burnout rates in forensic nurses? *Journal of Advanced Nursing, 37*(5), 470-476.

Finnema, E. J. , Louwerens, J. W. , Slooff, C. J. , & ven den Bosch, R. J. (1996). Expressed emotion on long-stay wards. *Journal of Advanced Nursing, 24,* 473-478.

Forster, J. , Finlayson, S. , Bentall, R. , Day, J. , Randall, F. , Wood, P. ,…Healy, D. (2003). The perceived expressed emotion in staff scale. *Journal of Psychiatric and Mental Health Nursing, 10,* 109-117.

Jenkins, J. H. , & Karno, M. (1992). The meaning of expressed emotion: Theoretical issues raised by cross-cultural research. *American Journal of Psychiatry, 149,* 9-21.

Katsuki, F. , Fukui, S. , Niekawa, N. , Oshima, I. , Setoya, N. , Ninomiya, S. , …Tsukada, K. (2008). Development of the Nurse Attitude Scale short form: Factor analysis in a large sample of Japanese psychiatric clinical staff. *Psychiatry and Clinical Neurosciences*, *62*(3), 349-351. Retrieved from MEDLINE with Full Text.

Katsuki, F. , Goto, M. , & Someya, T. (2005). A study of emotional attitude of psychiatric nurses: Reliability and validity of the Nurse Attitude Scale. *International Journal of Mental Health Nursing*, *14*(4), 265-270. doi:10. 1111/j. 1440-0979. 2005. 00391. x.

Kavanagh, D. J. , O'Halloran, P. , Manicavasagar, V. , Clark, D. , Piatkowska, O. , Tennant, C. , & Rosenberg, 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.

Langdon, P. E. , Yaguez, L. , & Kuipers, E. (2007). Staff working with people who have intellectual disabilities within secure hospitals. *Journal of Intellectual Disabilities, 11*(4), 343-357.

McDonagh, L. A. (2005). Expressed emotion as a precipitant of relapse in psychological disorders. Retrieved from http://www. personalityresearch. org/papers/mcdonagh. html

Rafaeli, A. , & Sutton, R. I. (1987). Expression of emotion as part of the work role. *Academy of Management Review, 12*(1), 23-37.

Safilios-Rothschild, C. (1976). A macro- and micro-examination of family power and love: An exchange model. *Journal of Marriage and Family, 38*(2), 355-362.

Scott, P. A. (2000). Emotion, moral perception, and nursing practice. *Nursing Philosophy, 1,* 123-133.

Simpson, R. (1989). Expressed emotion and nursing the schizophrenic patient. *Journal of Advanced Nursing*, *14*(6), 459-466. Retrieved from CINAHL Plus with Full Text database.

Varcaolis, E. M. & Halter, M. J. (2010). *Foundations of psychiatric mental health nursing: A clinical approach*. (6th ed). St Louis, MO: Saunders.

Willetts, L. E. , & Leff, J. (1997). Expressed emotion and schizophrenia: The efficacy of a staff training programme. *Journal of Advanced Nursing, 26,* 1125-1133.