

A Phenomenological Study: Family Experience in Expressed Emotion in Providing Care for Client with Risk of Aggressive Behavior

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Abstract

Aggressive and violent behaviors are among the symptoms manifested in individual with schizophrenia. The relationship between caregiving and mental disorder can be assessed through expressed emotion (EE). This study aimed to identify family experience in expressing emotion when providing care for client with risk of aggressive behavior. The design of the study was qualitative and it employed a phenomenological approach. Six participants were involved in an in-depth interview about their experiences in expressing emotion in providing care for client with risk of aggressive behavior. The findings identified three themes. These are; psychological responses followed by physical responses as manifested by family response, hostility as reflection of family's negative emotion, and positive interaction within family to meet psychological need. The findings may be used as a reference for nurses and families to consider EE when providing care for client with risk of aggressive behavior. The result emphasized that psychiatric nurses should consider EE when providing psychosocial interventions as this predicts the course of illness.

Keywords: Expressed emotion, family, risk of aggressive behavior

Introduction

Hostility and aggressive behaviors are among the most prominent symptoms of schizophrenia. They are a result of the lack of impulse control. An aggressive behavior is a behavior that may cause harm for oneself, others, or environment. The violence may be manifested as verbal threat, physical aggression, armed assault, vandalism, and burning goods. The aggression may cause physical injury; thus, it requires medical attention [1].

Families may experience burden in providing care for client with risk of aggressive behavior. Twenty-six percent and 31 % of caregivers experienced at least one incident of severe and one incident of minor physical assault respectively. Forty-four percent and 64 % of caregivers experienced at least one incident of severe and one incident of minor psychological aggression respectively. Aggressive behavior committed by a client with schizophrenia shows a positive relationship with the level of burden experienced by the family [2]. Another study reported that 40 - 60 % of the patients with schizophrenia returned to their homes and relied on their family in meeting their daily needs. Patients with schizophrenia are not capable of meeting their daily needs and of interacting with people. A study stated that 68.6 % of the patients with schizophrenia were indulged in activities while 31.4 % of them did not participate in any activities. Patients' high dependency on their family leads to restriction of time, energy, and attention which results in caregiving burden. In other words, family's behavior, interaction manner, and expectation affected patient's mental state [3].

The relationship between caregiving and psychiatric illness is measured by EE. Several studies have established EE as a highly reliable psychosocial predictor of psychiatric relapse in patients with schizophrenia in a variety of cultural and social contexts [4]. Expressed emotion is a measurement to

evaluate family's milieu and the quality of relationship between them and the patients with mental disorder. There are five EE that play a pivotal role in schizophrenia pathway. The expressions include low EE which is characterized by warmth and positive remarks and high EE which is manifested by critical comment, hostility, and emotional over-involvement. A study on EE that focused on high EE studies reported the absence of significant correlation between low EE and treatment outcome of patient with schizophrenia [5].

Bogojevic, Ziravac & Zigmund [6] conducted a study which focused on family's EE to a patient with schizophrenia who had been admitted in the hospital for a long term and investigated on how it affected treatment outcome. The retrospective study involved 112 patients with schizophrenia and their families. The result indicated that 71.4 % of the families had a high level of EE, especially the biological parents which represented 62.5 % of it. The patients of the families who had a lower EE appeared to have a better prognosis. Considerable data indicate that high levels of EE among caregivers predict high rates of relapse among patients with schizophrenia which is one of the relapse symptoms in aggressive behavior [7].

There are many studies that have addressed the EE phenomenon in other countries. However, there are only a few studies addressing the phenomenon in Indonesia. A cross sectional study in Indonesia showed that 67.8 % felt the burden of care, 49.2 % had high EE at 50.8 % had lower EE and the burden of care showed a significant relationship to EE [8]. Studies on this topic in Indonesia are mostly quantitative which require qualitative approach to explore family experience in caregiving for client with risk of aggressive behavior comprehensively. The novelty of this study was supported by Indonesia traditional influence on family response in providing care for client with risk of aggressive behavior. Research showed that for Indonesians, especially Javanese people, emotions mean negative, so they must be well controlled so as not to influence relationship with others and to maintain harmony [9]. There has never been a qualitative study on family experience of expressing emotion in caregiving for client with risk of aggressive behavior. Thus, the aim of this study was to find the depiction of family experiences in expressing their emotions when providing care for patient with risk of aggressive behavior.

Materials and methods

The study design used was qualitative that employed phenomenological approach. Phenomenological approach was applied to describe the general perception of particular group on experiencing a concept or phenomenon of interest [10]. Qualitative method was employed in this study as authors intended to thoroughly understand and investigate on family experiences in expressing their emotions when providing care for patient with risk of aggressive behavior. The study applied descriptive phenomenological approach which consisted of four stages, including bracketing, intuiting, analyzing, and describing [11].

This study used purposive sampling technique which was a technique in selecting participants based on the study purposes and individual experience related to the phenomenon of interest [11]. Participant's information was obtained from a report of medical visit in outpatient department of RSJ Grhasia. A total of 6 participants were then screened with assessment of The Positive and Negative Syndrome Scale-Excited Component (PANSS-EC). PANSS-EC has been tested for validity, reliability and sensitivity by Kusumawardhani and the Medical Faculty of Universitas Indonesia in 1994. PANSS-EC aimed to evaluate agitation symptom of family members with risk of aggressive behavior. The PANSS-EC consists of 5 items: excitement, tension, hostility, uncooperativeness and poor impulse control. The 5 items from the PANSS-EC are rated from 1 (not present) to 7 (extremely severe); scores range from 5 to 35; mean scores 20 clinically correspond to severe agitation [12]. The result of PANSS-EC score was ≤ 20 which indicated that patient with risk of aggressive behavior was not required to be admitted to the hospital. The signs and symptom of risk of aggressive behavior include; feelings of anger, resentment, spoke harshly and tense expression. Participant selection was based on the criteria related to the study purposes, which included a) Families who provided direct care for a family member with risk of aggressive behavior. Patient with such risk of aggressive had PANSS-EC score ≤ 20 , b) Families who lived under the same roof with a family member with risk of aggressive behavior c) Families who were able to express the

experience properly d) Families who deliberately consented to be involved in the study by signing the form.

An in-depth interview using voice recorder was conducted in the participants' own houses to observe the interaction between family and family member with risk of aggressive behavior. After the first interview with the first participant was completed, the data was processed into a transcript for analysis purposes. The analysis was carried out by all of the research team. The interview was conducted to another participant until data saturation was achieved. The report was prepared from early January until early June 2017. The method used in the analysis process was Colaizzi's approach: 1) to create verbatim version out of result of interviews with participants and re-read participants' descriptions based on the phenomenon to gain perceptions of their experience and to produce a general understanding of the experience; 2) extract significant statements which is directly related to the phenomenon researched; 3) formulate the definition of significant results in pursuit to find the hidden meanings; 4) categorize significations in theme group and confirm consistency between the findings and the story of the participants without disregarding unfit data; 5) integrate findings with a comprehensive description of phenomenon that are researched, describe keywords which include text segments as a topic, comparing consistent theme topics, relate themes of consistent significations which seemingly forming themes; 6) validate findings by going back to the participants to ask general descriptions which then be compared to their personal experience; and 7) incorporate the changes participants stated in the final description of the phenomenon [13].

The participants of this study were family members who provided direct care for patients with risk of aggressive behavior. The authors complied with the principles of research ethics to protect participants when conducting the study, which included principles of autonomy, beneficence, non-maleficence, anonymity and justice [11]. Autonomy means participants independently in making decision whether to be involved or not to be involved in this study without any coercion. Principle of beneficence was implemented by avoiding questions which may put participants at unease. Researchers implemented non-maleficence principle by reducing harmful risk for participants through providing detailed information so participants were able to understand and kept away from potential harms. Anonymity principle was fulfilled by removing participant's name and initial and assigning code of P1 for the first participant, P2 for the second participant, and so forth. Justice implies that all participants were provided with equal treatment and right to participate in this study [14].

Results and discussion

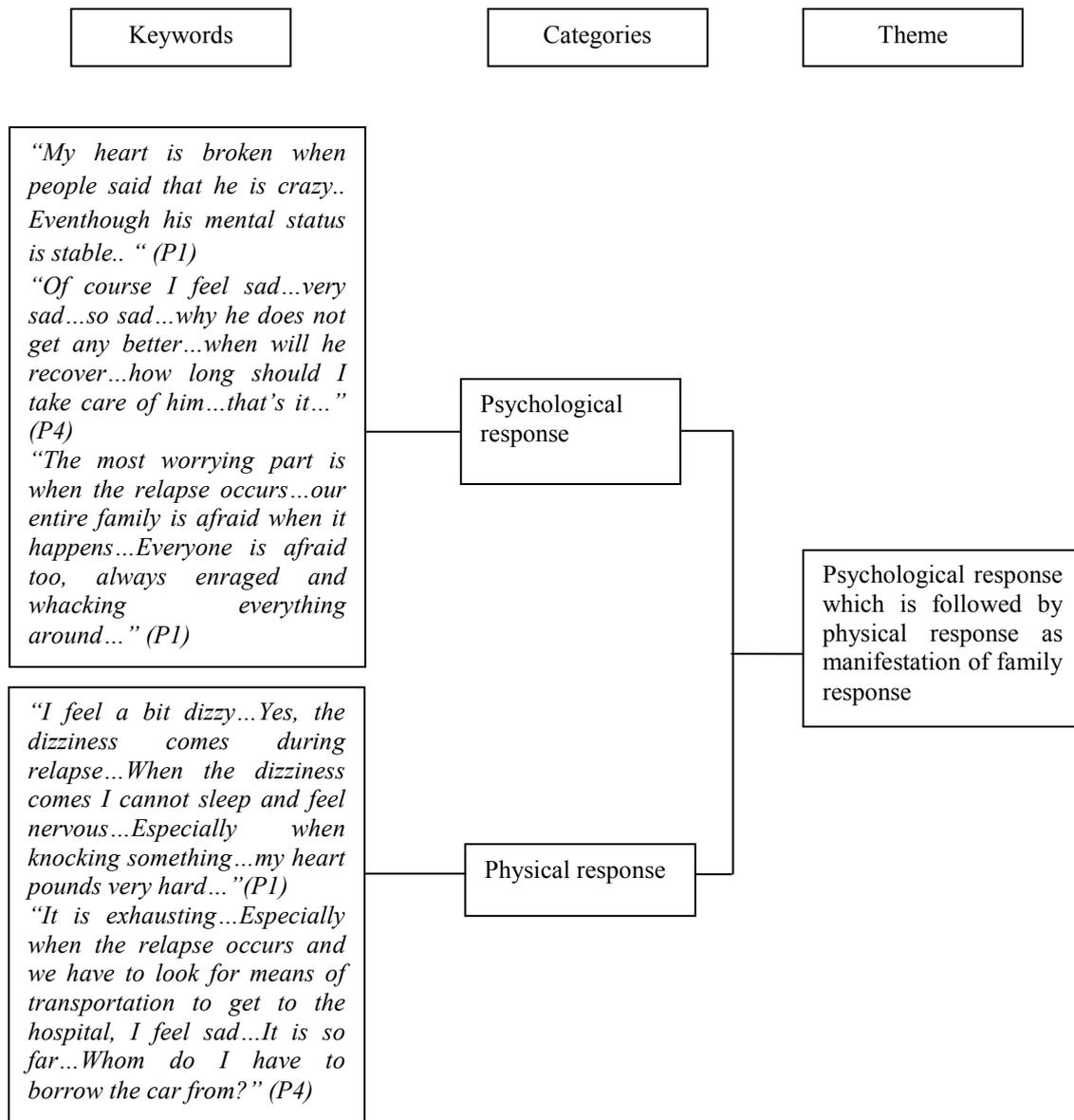
There were 6 participants who were involved in this study. All of them were female with age ranged from 45 years old as the youngest and 73 years old as the eldest. All of them were Javanese Moslems. The educational attainment of participants varies from middle school graduate to bachelor's degree holders. The participants include; two housewives, two merchants, and two entrepreneurs. The participants were the main caregiver of the patient and had been providing care for patient from 10 to 28 years.

The family members with risk of aggressive behavior characteristic were 25 years old as the youngest to 45 years old as the eldest. Four of them were males and the rest were females. They had been hospitalized for 1 to 17 times. Data collection by in-depth interview was performed from April, 10th to May, 12th 2017.

This study identified 3 themes related to family EE when providing care for patient with risk of aggressive behavior. The themes included:

1) Psychological response which followed by physical response as manifestation of family response.

The theme had 2 categories, psychological and physical response. Participants' quotes which represent this theme included:



The result suggested that participants demonstrated psychological responses such as compassion, sadness, fear, and anxiety. Cognitive approach describes that individual's emotion is resulted from appraisal of the stressful situation. Individual with positive appraisal of situation will develop positive emotional response. On the other hand, individuals with negative appraisal of situation will develop negative emotional response as well [15]. Emotions perceived by family during provision of care for patient with risk of aggressive behavior were affected by family's evaluation of patient's condition which became a stimulus for family.

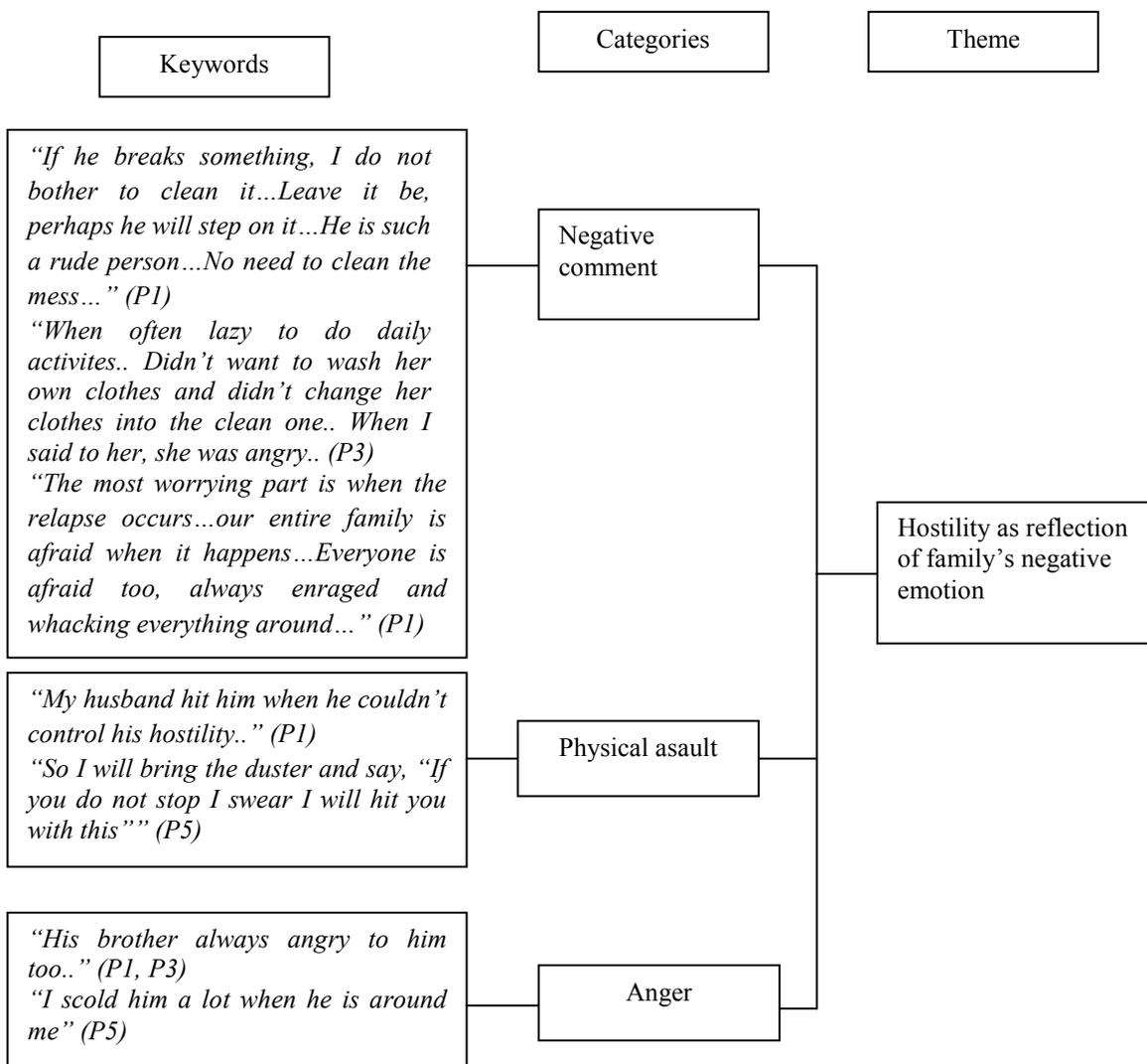
Emotional responses toward stress included fear, phobia, anxiety, depression, sadness, and anger [16]. The statement coincided with the result of the study that indicated that when a family member with risk of aggressive behavior was developing the symptoms, the other family members experienced fear, anxiety of the prognosis and uncertainty of patient's condition, and sadness. Even though the maximum

effort for the treatment had provided to the patients, the expected outcome was not met. In addition, by seeing aggressiveness of patient with mental disorder, anger of another family member was stimulated also.

Participants of this study reported physical responses such as fatigue, dizziness, and insomnia. Negative symptoms of schizophrenia affected family's burden, particularly in longer term of treatment. This study revealed that EE was correlated with family's burden and well-being. A family with high EE tends to have a poor health condition and higher subjective and objective burdens when compared to family with low emotional expression. Burden perceived by family in providing care for patient also led to negative effects, such as physical and mental disorder, frustration, solitude, and anger [17]. Another study claimed that high EE was associated with family burden and aggravating anxiety and depression [18].

2) Hostility as reflection of family's negative emotion

The theme was derived from three categories, which included negative comment, physical assault, and anger, as stated by participants below:



A study demonstrated that families of patient with schizophrenia perceived physical, social, and emotional burden as well as incapability of managing patient's behavior which contributed to family's impatience [19].

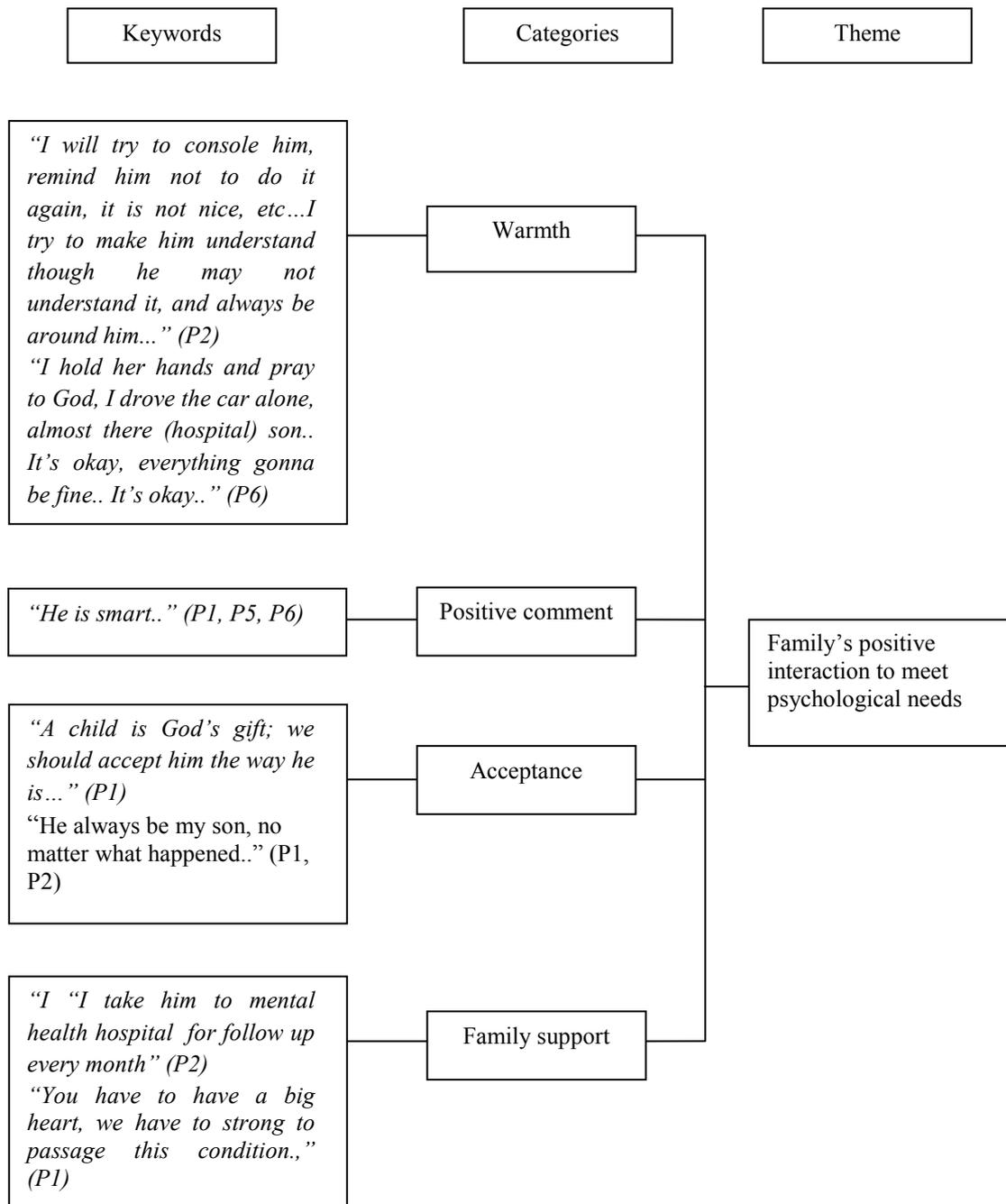
Kymalainen and Weisman [20] stated that cultural difference contributed to high EE toward patient's functionality. Cultural values, belief, and behavior may affect family's interaction. It may be especially difficult for family members to communicate coherently and in a less critical manner when focusing on patient's inability to sustain particular cultural norms and values that are endorsed by their family and ethnic background. In general, studies conducted in Western cultures document higher rates of EE (Nuechterlien *et al.*, 1986) than those conducted in Asian cultures (Azhar & Varma, 1999; Wig, 1987). However, Asian studies report high variability, for example, extremely low rates (23 %) of EE have been reported from India (23 %), while considerably high EE rates were found among other Asian cultures like in Pakistan (75 %), Iran (56 %), Egypt (55 %), Japan (46 %) and China (42 %; Ikram, Suhail, Jaferi & Singh, 2011; Kamal, 1995; Mino, Inoue, Tanaka & Tsuada, 199; Mottaghipour, 2001; Wig, 1987) [10].

Participants' attribute of Javanese culture had inclination to suppress and control their emotions so they would not express it excessively in front of other persons. Javanese also tended to avoid expressing uncontrolled emotion and beginning fight [21]. Internalization of negative emotion without assertive expression may increase the burden perceived by family of patient with risk of aggressive behavior.

The study result showed that family experienced stigma as they provided care for family members with risk of aggressive behavior. People with schizophrenia are often viewed as being potentially violent and individuals tend to desire greater social distance from them. The result corresponded with Koschorke, *et al.*'s study [22] which described that 21 % of families were experiencing stigma when they were caregiving for family member with mental disorder. The stigma was affected by positive symptoms of schizophrenia, severity of disability, younger age of patient with mental disorder, education degree, and study location. Another study revealed that there was a correlation between EE and stigma. Families with high EE were more likely to have a poor support system, higher score of depression, and higher stigma. Families with low EE were more likely to have a better support system, lower score of depression, and lower stigma [17].

3) Family's positive interaction to meet psychological needs.

This theme consisted of four categories, including warmth, positive comment, acceptance, and family support, as expressed by participants in the following statements:



The result suggested positive interactions which demonstrated by families with patients with risk of aggressive behavior. These positive interactions include; warmth, positive comment, acceptance, and family support. A study revealed that parent's warmth had a great impact on child's development and may determine the onset of mental disorder. Lack of warmth by parents was associated with psychopathology in adolescent, such as anxiety and depression disorder. Warmth in family indicated a

healthy mental state and proper family's functioning [23].

Family support is defined as internal and external service of support provided by family. Internal family support includes support from husband, wife, or sibling. External family support includes support from other members of a nuclear family [24]. An individual with lack of family support is more likely to be burdened by negative evaluation of problems and would experience difficulty in solving problem.

Javanese is widely known to have *rila* (willingness), *nrima* (accepting), and patience traits. *Rila* is willingness to get rid of selfishness leading to be in harmony with environment. *Nrima* means capable of accepting the ill fate peacefully without complaining and mutiny and with conviction that the misery will end eventually. The *Nrima* attitude allows Javanese to enjoy everything they have and live their lives composedly. It was also associated with the concept of *ngrasakke* and *rumangsa* in which a person also shares another's misery [21]. Moreover, the value of *ngemong* is a fundamental dimension of Javanese culture for recuperation of patient with mental disorder in community. *Ngemong* implies tolerance, considerate, compassion, and positive acceptance of patient's impulsive and aggressive behavior toward family and society.

Schaffer [25] explained that a family was responsible for providing support in positive interaction, effective communication, and information to reduce stress and ignorance. A family should fulfill health management tasks, such as creating a conducive family environment, reducing stressors which may trigger the aggressivity, guiding family member's behavior and ensuring continuity of the treatment and medication.

Conclusions

This study identified three themes which consisted of 9 categories regarding family experience in EE when providing care for patient with risk of aggressive behavior. The themes included psychological response which followed by physical response as manifestation of family response, hostility as reflection of family's negative emotion and family's positive interaction to meet psychological needs. Family members with risk of aggressive behavior required family support to maintain their condition. The family needs to understand that interaction process and family member's manner in expressing some feelings may affect the mental state of the patients with mental disorder. The study implies that nurses should be more empathetic in understanding family's experience as they provide care for family members with risk of aggressive behavior. The result recommended that psychiatric nurses should emphasize the significance of EE during psychosocial interventions such as family psycho-education and to form self-help group for families so they may share experiences and solutions. The researchers suggested that future studies should investigate family experience in EE in other nursing problems, such as hallucination and social isolation.

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