PROVIDING INFORMATION TO RELATIVES AND PATIENTS ABOUT EXPRESSED EMOTION AND SCHIZOPHRENIA IN A COMMUNITY SUPPORT SETTING: A RANDOMISED, CONTROLLED TRIAL

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KEY WORDS:

Schizophrenia, Expressed Emotion, Psychoeducation, Attributions.

Abstract — This study investigated the impact of a brief, community-based psychoeducational program for clients with schizophrenia and their family members. The treatment provided information about schizophrenia and expressed emotion (EE) and assessed whether participants' knowledge about the illness and EE levels changed over time. Findings are noteworthy in that they suggest that brief interventions in a community setting may not only increase knowledge, but may also be useful for reducing EE. This finding is interesting in that it goes against many earlier studies which found no benefit from similar treatments on EE scores when assessed in highly controlled research settings.

Introduction

Instead of staying in an outpatient facility, chronically mentally ill clients now tend to be released as soon as possible. However, this can create a 'revolving-door' pattern of admission and discharge. Research shows rehospitilization rates of 40-50% after one year and 75% upwards after two years. This can add to an increasing burden for families, as studies have found that between 46% and 65% of those hospitalized with schizophrenia return on discharge to live with their families.

The return of the client can cause a major upheaval in both his or her life and in those of the family. Those with schizophrenia may feel hurt, angry or resentful for not being understood, helped or for being admitted to hospital. Relatives may feel anxious or helpless because they do not know what to expect. Additionally, clients and family members may feel stigmatized or ashamed and socially isolate themselves.

Combined with all of this is the fact that the client with schizophrenia generally has an intrinsic vulnerability or lower tolerance for stress. Returning to the same environment, particularly in those families with high Expressed Emotion (EE), is quite likely detrimental for both the client and the family. Hostility, criticism and emotional over-involvement may exacerbate symptoms, and potentially contribute to the client's relapse. As a response to such outcomes, preventive interventions aimed at reducing stress and increasing adaptive communication have been developed.

Family Interventions

There have been a large number of psychoeducational programs focusing on behavioural problem solving, family communication and support as well as crisis management over the past 20 years, they have been well researched and many have been manualised.

A continuing problem with this modality, not unlike that experienced by other family treatments for hard to treat populations, is that there tends to be problems with successful dissemination from research to applied settings. One major problem with these comprehensive programs is that they require much in the way of time and resources with training and supervision, thus, their availability and use in routine clinical practice is limited.

Family Education Programs

An integral part of psychoeducational programs is the dissemination of information for clients and family members on the nature of schizophrenia, diagnosis, symptomology, etiology, course of illness, treatment, including medication, family management, prognosis and management strategies designed to lower the emotional climate of the home to which the patient is likely to be discharged, including links to available resources and support services.

Family Education Programs—Continued

Studies have found that providing such information has the effect of decreasing relatives' reported levels of burden, self-blame, distress, anxiety and EE as well as lower unreasonable expectations. Improvements have also been seen in patients' personal functioning and social adjustment.

Objective

The present research assessed the merits of a brief education program, designed to retain the effectiveness of programs used more often in research settings. However, it was carried out in a community setting that could support its philosophy on an everyday basis over the longer term to assist and reinforce any gains produced. It was expected that providing information about the disorder and its management to patients and family members would result in increased knowledge in family members and lower expressed emotion compared to a randomly assigned control condition.

Method

People with schizophrenia were recruited into the study along with family members. These family members were the people who were seen by the client to be the most influential and important people in their lives and to be the main provider of emotional support on a regular basis. Relatives and clients were then randomly allocated to a treatment group or a wait-list control group.

Trained, independent assessors (Schizophrenia Fellowship employees) carried out a multi-method assessment gathering demographic information and measuring the knowledge about schizophrenia held by the family members [KASI], and the level of Expressed Emotion in a household (LEE Scale).

Education Program

The education program itself was administered over two sessions by the first author and provided information on diagnosis, symptomology, etiology, medication, and course and prognosis of schizophrenia as well as Management strategies that can help both the client and relatives, and 10-15 minutes of relaxation training.

The intervention incorporated aspects of programs by Barrowclough and Tarrier, and Falloon and colleagues. Additional information drawn from the literature about expressed emotion was provided with techniques on how to help maintain a low stress and stimulus environment in the home. Information was also provided to the community support centers to provide ongoing support for patients and families.

Results

The analyses conducted were selected to address the two main hypotheses of the study. Namely, as a result of attending a brief educational program, a) participants' knowledge would increase and b) the level of expressed emotion in the family would decrease compared to the control condition.

Analyses showed that knowledge increased significantly after the intervention and was maintained at a three-month follow-up. The control condition reflected no changes in knowledge (see Table 1). Other results showed that both relatives' and clients' EE ratings significantly decreased from pre- to post-test. Changes in total EE scores improved after treatment by over twice the magnitude compared to the control condition. All gains were maintained at the three-month follow-up, with continuing improvement seen in family members' attitudes (see Table 2).

Discussion

Previous short education programs have shown that education alone does not reduce EE, but that it can produce increases in relatives' knowledge and general coping and to an extent alleviate relatives' burden and distress. This study supported the changes reported in earlier studies but also found additional positive effects. Over the course of the current study, there were definite reductions in EE and initial changes on EE were either maintained or, continued to improve over a three-month follow-up interval. Here, particularly with respect to family members' attitudes, reductions in EE appeared to be due largely to education.

Limitations of the Study

The results of the study are qualified by limitations that included a relatively small sample size which was drawn from the Schizophrenia Fellowship who likely reflected increased levels of motivation by virtue of their willingness to participate.

Conclusions

The effectiveness of this brief program was demonstrated, particularly in terms of knowledge and family members' knowledge and attitudes towards the illness. This is encouraging and supports the value of these programs in recovery and community support settings.

Table 1: Means and Standard Deviations for the KASI

	Treatment		All Clients	Wait-list Control		
Measures	Pre-test	Post-test	Follow-up	Pre-test 1	Pre-test 2	Post-test
Diagnosis						
M	3.00	3.00	3.00	2.88	3.13	3.13
SD	0.00	0.00	0.34	0.64	0.35	0.60
Range	0.00	0.00	2-4	2-4	3-4	2-4
Symptomology						
M	3.00	3.83	3.61	2.88	3.13	3.63
SD	1.13	0.37	0.70	0.84	0.84	0.70
Range	1-4	3-4	2-4	2-4	2-4	2-4
Aetiology						
M	2.42	3.08	3.28	2.25	2.13	3.25
SD	0.67	0.76	0.75	0.46	0.35	0.66
Range	2-4	2-4	2-4	2-3	2-3	0.33
Medication						
M	2.50	3.58	3.78	2.75	2.50	3.88
SD	1.45	0.95	0.55	1.28	1.07	0.33
Range	1-4	1-4	2-4	1-4	1-4	3-4
Course & Prognosis						
M	2.17	2.67	3.11	2.75	2.75	3.13
SD	1.03	0.85	0.68	1.28	1.03	0.78
Range	1-4	1-4	1-4	1-4	1-4	2-4
Management						
M	2.92	3.25	3.22	2.50	2.50	3.25
SD	0.52	0.60	0.81	0.76	0.76	0.66
Range	2-4	2-4	2-4	1-3	1-3	2-4
Total Score *M*	16.00	19.58	20.00	16.00	16.13	20.25
SD	3.10	2.22	1.91	3.74	3.04	2.39
Range	12-21	15-22	16-23	10-19	11-29	15-23

Table 2: Means and Standard Deviations for the LEE Scale – Relative's Version

Level of Expressed Emotion Scale – Relative's Version						
	Treatment		All Clients	Wait-list Control		
Measures	Pre-test	Post-test	Follow-up	Pre-test 1	Pre-test 2	Post-test
Intrusiveness						
M	3.33	2.33	1.72	4.38	4.13	3.13
SD	3.87	4.09	2.44	2.56	2.64	1.76
Range	0-14	0-15	0-8	1-8	0-7	0-6
Emotional Response						
M	3.83	3.08	3.06	3.88	3.75	2.75
SD	3.38	2.60	2.41	2.36	2.66	1.56
Range	1-9	1-10	1-8	1-8	1-9	1-6
Attitude Toward Illness						
M	0.66	0.58	1.33	2.13	2.13	0.88
SD	0.84	1.11	1.85	2.36	2.36	1.05
Range	0-3	0-4	0-7	0-7	0-7	0-3
Tolerance/Expectations						
M	1.92	1.50	1.39	1.50	1.25	1.00
SD	2.47	2.40	2.15	1.20	1.28	0.50
Range	0-9	0-9	0-7	0-3	0-3	0-2
Total EE score						
M	9.58	7.50	7.50	11.88	11.25	7.75
SD	9.34	8.92	7.87	4.30	6.36	3.38
Range	2-32	2-35	1-29	4-19	1-19	1-12

Table 3: Means and Standard Deviations for the LEE Scale – Client's Version

Level of Expressed Emotion Scale – Client's Version						
	Treatment		All Clients	Wait-list Control		
Measures	Pre-test	Post-test	Follow-up	Pre-test 1	Pre-test 2	Post-test
Intrusiveness						
M	4.46	3.36	3.63	5.63	5.38	5.38
SD	4.50	4.27	3.34	3.42	3.34	3.20
Range	0-12	0-13	0-11	0-10	0-10	0-9
Emotional Response						
M	4.81	3.82	4.19	4.50	4.00	2.25
SD	4.85	4.15	4.29	3.59	3.46	2.17
Range	0-13	0-12	0-12	0-9	0-9	0-6
Attitude Toward Illness						
M	2.27	1.64	2.44	2.88	2.38	1.25
SD	2.20	1.82	2.66	3.04	2.88	1.56
Range	0-7	0-5	0-10	0-10	0-9	0-5
Tolerance/Expectations						
M	3.73	3.46	3.69	4.00	3.75	2.88
SD	3.90	3.85	4.08	2.27	2.32	2.20
Range	0-12	0-12	0-12	1-7	1-7	1-6
Total EE score						
M	15.27	12.18	12.59	17.00	15.50	11.75
SD	13.89	13.48	12.01	8.75	8.90	8.15
Range	1-41	1-39	1-41	6-31	6-28	1-22