



Research report

Dyadic view of expressed emotion, stress, and eating disorder psychopathology

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ABSTRACT

Prevailing models of the association between expressed emotion (EE) and relapse conceptualize EE as a form of stress for patients. In eating disorders (ED), there is no research addressed to evaluate the degree to which patients feel stress due to their relatives' EE. It has been neither investigated how the EE and the subsequent stress relate to disordered behaviours and attitudes neither. Using a sample of 77 inpatients with ED, this study aimed to: (1) evaluate patients' reported level of stress as it relates to their caregivers' EE, particularly as associated with carer's criticism, emotional overinvolvement and warmth; (2) examine the associations of stress with the patients' perceptions (self-reported) and the caregivers' perspective (assessed by the Camberwell Family Interview) of the EE; and (3) study how the two views of EE (patients' and caregivers') and the stress due to EE relate to the ED symptoms. The findings indicate that patients judged their carers' critical stance as the most stressful, followed by emotional overinvolvement. Secondly, patients' perceptions of EE, whereas none of the interview indices focused on the caregivers' perspective, were associated to the stress and to the ED symptomatology. Additionally, the patients' stress due to criticism was positively related to the ED symptoms, while the stress associated with emotional overinvolvement and warmth was not. Clinical and research implications are discussed. Findings suggest attention to the ED patients' view of their family environment and support the utility of assessing their appraisals of EE.

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The family emotional climate, as assessed by the construct Expressed Emotion (EE) (Hodes & Le Grange, 1993; Hooley, 2007), is associated with the course of serious mental illness including eating disorders (ED). EE refers to the emotional nature of the relationship between the patient and a significant other and is comprised of five indices: criticism, hostility, emotional overinvolvement (EOI), warmth, and positive remarks (Leff & Vaughn, 1985). Patients with different chronic illnesses living in a high-EE environment (high in criticism, hostility and/or EOI) have significantly more risk of relapse than do patients in a low-EE environment (low in criticism, hostility and EOI; Wearden, Tarrier, & Barrowclough, 2000). The amount of time the patient and caregiver spent together also predict the relapse rate (Bebbington & Kuipers, 1994). A meta-analysis of EE and relapse studies reported a medium (large) effect size ($\varphi = .51$) among a handful of studies of ED (Butzlaff & Hooley, 1998). Moreover, family-based treatments that reduce EE have also improved ED symptomatology (Le Grange & Eisler, 2009; Sepúlveda, Lopez, Todd, Whitaker, & Treasure, 2008).

Most studies of EE apply the Camberwell Family Interview (CFI; Vaughn & Leff, 1976) or a similar instrument, which directly measure the caregiver's degree of EE (e.g., criticism) directed at the ill relative. For example, van Furth et al. (1996) found that caregiver's critical and overinvolved attitudes were associated with a worsening of the patient's symptoms. In addition, van Furth et al. found that a lower degree of positive affect (less presence of positive remarks) was associated with a longer duration of treatment.

Although most studies of EE use the objective measure of caregiver's actual criticism and EOI, there is a small but growing literature examining patient's perception of caregiver's EE, particularly the patient's perception of their caregiver's level of criticism. For example, perceived maternal criticism was associated with patients' lower desire to involve their relatives in therapy (Perkins et al., 2005). We believe that including both measures of caregivers' actual level of their criticism and EOI and patients' perceptions of their caregivers' emotional stance can enrich our understanding of the role of family processes and the course and treatment of ED. Doing so provides a balanced assessment of the dyad, not just the caregiver's or patient's perspective.

Furthermore, past assessments of the patient's perspective have been limited by focusing on only negative affective stances

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(criticism and EOI). Recently, family investigators have developed a perceived EE measure that includes both negative and positive affective stances (Keefe, López, Tiznado, Medina-Pradas, & Mendoza, submitted for publication; Medina-Pradas, Navarro, López, Grau, & Obiols, in press). In the present study, we apply both the objective measure of caregiver's EE (the CFI and its specific indices) and the newly developed patient perception measure. By examining both perspectives we can examine how perspective (relatives' or patients') is associated with ED symptomatology. Moreover, we can also examine which index of EE is particularly related to clinical functioning.

In addition to examining how the perspective of caregivers' emotional stance is related to clinical functioning, we also examine the role of patients' perceptions of the stress associated with the caregiver's expressed emotion. EE is thought to predict the course of severe psychiatric disorders because of the stress that patients feel given their caregiver's emotional stance (Hooley, 2007; Hooley & Gotlib, 2000). Several studies support the notion that high-EE, especially critical, environments are stressful for patients (Cutting & Docherty, 2000; Cutting, Aakre, & Docherty, 2006; Hooley & Teasdale, 1989; Miklowitz, Wisniewski, Miyahara, Otto, & Sachs, 2005). The presence of warmth, on the other hand, may help reduce the patient's stress level (Lopez et al., 2004). These studies, however, were carried out with other disorders, not ED. Although previous studies have reported an association between perceived stress and disordered eating (e.g. Laugero, Falcon, & Tucker, 2011; Shatford & Evans, 1986), we do not know how stress is associated with EE or with clinical symptoms in patients with ED.

To examine the patients' levels of stress associated with their caregivers' EE, we expanded past measures of perceived stress due to caregiver's criticism (Cutting et al., 2006; Hooley & Teasdale, 1989; Miklowitz et al., 2005) to include perceived stress due to caregiver's EOI and warmth.

The overall goal of the present study is to understand the associations among EE, stress, and ED symptoms. Our specific aims were: (1) evaluate patients' levels of stress as it relates to their caregivers' EE, determining which of the EE indices (criticism, EOI, or warmth) was more stressful for the patients with ED, (2) determine how the levels of stress were related to the traditionally used EE indices of the CFI (that takes into account the key relatives' perspective) and to the patients' perceptions, and (3) analyse the relationships among the different perspectives of EE (relatives' and patients'), the levels of stress, and the different cognitions and behaviours related to the eating symptomatology.

Methods

Participants

Seventy-seven patients with diagnosis of ED according to DSM-IV-TR (American Psychiatric Association, 2002) and their key relatives were consecutively recruited at the time of admission to an inpatient ED specialist centre (Eating Disorders Institute, Barcelona, Spain). Patient's inclusion criteria were a primary ED diagnosis by clinicians, and having a key relative who was both accessible and willing to participate. The key relative was defined as the person who was involved in the patient's health care, and the family member with whom the patient had the most contact. Patient's exclusion criteria were psychosis, any neurological or somatic illness that could interfere with the psychiatric diagnosis, and/or moderate to severe mental retardation. The sample was comprised of patients with a diagnosis of anorexia nervosa (AN, 46.7%), bulimia nervosa (BN, 31.2%), and non-specified ED (EDNOS, 22.1%). The average illness history from first contact with mental health services was 8.8 years (SD = 6.6, range = 0.1–35.7). The sample was almost exclusively women (93.5%), with a mean age of

26.4 years (SD = 7.3, range = 13–50). Some 3.9% had completed primary school, 23.4% junior school (until 14 years of age), 28.6% secondary school, 9.1% professional school, and 35% college or postgraduate training. Most patients were single (72.7%) and were either studying (49.3%) or working (14.3%). The rest were either on sick leave (16.9%), unemployed (14.3%) or permanently disabled (5.2%). Most were living with their carers (79.2%).

The majority of the caregivers were women (72.7%), with a mean age of 48.2 years (SD = 10.1, range = 24–70). Over 80% were married or cohabiting and 80% were employed. They were predominantly the ill relatives' mothers (70.1%) with the remaining caregivers being their partners (23.4%), fathers (5.2%), or others (1.3%).

Measures

The patients' levels of stress from influential others' criticism, EOI, and warmth were measured with the *Perceived Stress due to Expressed Emotion* (PSEE). It was based on the Hooley and Teasdale's (1989) Perceived Criticism scale item concerning patients' level of upset in response to criticism. The items are: (1) when "x" criticizes you, how upset/stressed do you get? (2) When "x" protects you too much, how upset/stressed do you get? (3) When "x" talks to you warmly, how upset/stressed do you get? Each item was rated using a 10-point Likert scale, anchored with the words 'not at all upset/stressed' at the end '0' and 'very upset/stressed indeed' at the '9'. The scores on upset due to criticism exhibited convergent validity with another self-report measure of general sensitivity to criticism and anxiety, divergent validity with scores on a measure of depression, and strong evidence of predictive validity (Steketee, Lam, Chambless, Rodebaugh, & McCullouch, 2007; White, Strong, & Chambless, 1998).

The patients' perceptions of their caregivers' criticism, EOI, and warmth were assessed with three instruments. The first is the Spanish expanded patient version of *The Brief Dyadic Scale of Expressed Emotion* (BDSEE; Keefe et al., submitted for publication; Medina-Pradas et al., in press). It is comprised of 3 subscales: 'Perceived Criticism' (4 items), 'Perceived EOI' (6 items), and 'Perceived Warmth' (4 items). They were designed to determine the extent to which patients perceived their influential others to be critical, overprotective and overanxious, or warm towards them. Items are scored on a 10-point Likert scale. The second instrument is the *Parental Bonding Instrument* (PBI; Parker, Tupling, & Brown, 1979) in its Spanish version (Gómez-Beneyto, Pedrós, Tomás, Aguilar, & Leal, 1993), a 25-item questionnaire with a 4-point rating scale ranging from "very like" to "very unlike". The version adapted into the present was used (Baker, Helmes, & Kazarian, 1984). Two scales, termed 'Overprotection' and 'Care', reflect the carers' attitudes as perceived by the patients. The third instrument was the *Family Emotional Involvement and Criticism Scale* (FEICS; Shields, Franks, Harp, McDaniel, & Campbell, 1992). The FEICS is a widely used scale that measures recipients' perception of influential others' criticism and emotional involvement. We used only the criticism score for this study, which was drawn from the Colombian version of the scale (Restrepo et al., 2004). We slightly modified its wording for use in Spain. These three instruments have adequate psychometric properties in the original studies and with the present sample (see Medina-Pradas et al., in press for more details).

Patients were also administered the *Eating Disorder Inventory-2* (Garner, 1991; TEA, 1998), the *Beck Depression Inventory* (Beck, Steer, & Brown, 1996; Sanz, García, Espinosa, Fortún, & Vázquez, 2005), the *Rosenberg Self-Esteem Scale* (Rosenberg, 1965; Vázquez, Jiménez, & Vázquez-Morejón, 2004), and the *State-Trait Anxiety Inventory* (Spielberger, Gorsuc, & Lushene, 1970; TEA, 1982).

Finally, the abbreviated version of the *Camberwell Family Interview* (Montero & Ruiz, 1992; Vaughn & Leff, 1976) was used to

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