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Psycho-education in bipolar disorder: effect on expressed emotion

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Abstract

In a waiting-list controlled study on a multi-family psycho-educational intervention in bipolar disorder, key relatives in the treatment group showed a significant change from high to low levels of expressed emotion (EE) compared with the control group. In addition, patients with low-EE key relatives had a significantly lower number of hospital admissions compared with those living with high-EE key relatives. The multi-family groups were well received by the participants, and there were only a few drop-outs. © 1997 Elsevier Science Ireland Ltd.

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1. Introduction

Psycho-education has been shown to play an important role in reducing the level of expressed emotion (EE) in family members and thereby reducing the relapse rate in schizophrenia (Anderson et al., 1986; Berkowitz et al., 1990). Bipolar disorder is a chronic disorder that imposes a psycho-social burden on family members comparable to that associated with schizophrenia (Anderson et al., 1986). The influence of family interactions on the course of chronic illness, whether psychiatric or somatic, is well established. EE reflects the extent to which rela-

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tives of patients express critical, hostile, or emotionally overinvolved attitudes towards their disturbed family member.

High EE in family members proved to be a predictor of relapse in schizophrenia (Parker and Hadzi-Pavlovic, 1990), recent onset mania (Miklowitz et al., 1987), bipolar disorder (Priebe et al., 1989; O'Connell et al., 1991), and unipolar disorder (Hooley and Teasdale, 1989). Interventions designed to reduce levels of EE in family members include psycho-education and training in communication skills and problem solving. These interventions have been shown to lower the levels of EE in key relatives of schizophrenic patients (Leff et al., 1982; Hogarty et al., 1986; Tarrier et al., 1988). Psycho-educational programs have also been developed for bipolar disorder (Anderson et al., 1986) and major depressive disorder (Glick et al., 1994), as well as for specific treatment modalities such as a videotaped educational program for patients being treated with lithium (Peet and Harvey, 1991). Exposure to such programs is associated with improved outcome (Glick et al., 1994), but increased medical knowledge, per se, has not been shown to be effective (Berkowitz et al., 1990), as patients cannot apply textbook psychiatry to their individual cases. Although education will certainly help those involved to overcome their general misinformation and fear related to the illness, psycho-educational programs have broader aims than merely imparting information. They are designed to provide both patients and key relatives with a neutral but engaging introduction to a therapeutic relationship. To date, little information is available about the effects of psycho-educational programs on the level of EE of key relatives in bipolar disorder.

The EE assessment instrument used in this study is the Five-Minute Speech Sample (FMSS; Magaña et al., 1986). In this procedure, the key relative (not in the presence of the patient) is asked to speak without interruption for 5 min about what kind of person the patient is and how they get along together. The FMSS is a simple and valid instrument for the measurement of EE. Its scores show a high degree of correspondence with those of the more time-consuming Camberwell Family Interview (Magaña et al., 1986; Leeb et al., 1991; Malla et al., 1991; Stark and Buchkremer, 1992), although ratings derived from the FMSS show some underestimation of high-EE scores (Malla et al., 1991).

In our clinic, the first author developed a psycho-educational program for bipolar disorder (Hofman et al., 1992; Honig et al., 1995). This program focuses on the provision of illness-related information, on methods of coping more effectively with the illness, and on the recognition of the need for support by both patients and family members.

The hypothesis tested in this study was that psycho-education would lower EE levels of key relatives in the treatment groups and not in the waiting-list control group. In addition, it was hypothesized that this type of intervention would fulfil a need of both patients and key relatives.

2. Methods

All patients were recruited from the Social Psychiatric Unit of the Community Psychiatric Centre Maastricht, the lithium out-patient clinic of the attached psychiatric hospital (PMS Vijverdal), and the psychiatric in-patient and day patient clinic of the Academic Hospital Maastricht. All patients fulfilled DSM-IV criteria (American Psychiatric Association, 1994) for bipolar disorder based on information from the referring psychiatrist, the medical record, and descriptive data from other family members. The population consisted predominantly of patients with long-standing psychiatric histories (mean = 11 years), many relapses (mean = 9), and multiple hospital admissions (mean = 3). Relapse was defined as a period of recurrence or increase of symptoms warranting increased psychiatric care and a change in medication. The mean age in the treatment group was 43.8 years (S.D. = 13.0) for patients and 47.1 years (S.D. = 13.7) for key relatives. All but five patients in the treatment group and also all but five in the control group were taking lithium as a prophylactic.

EE levels of key relatives were measured by