

An Acceptance-Based Psychoeducation Intervention to Reduce Expressed Emotion in Relatives of Bipolar Patients

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Expressed emotion (EE) is a robust predictor of outcome in bipolar disorder. Despite decades of research, interventions to reduce EE levels have had only modest effects. This study used an expanded model of EE to develop an intervention. Research has demonstrated a strong link between attributions and EE in families of patients with psychiatric disorders. There is also substantial research to suggest that anger can drive blaming attributions. Combining these ideas, this study built on previous psychoeducation interventions through the addition of an acceptance component designed to decrease anger and blaming attributions among family members of those with bipolar disorder. Twenty-eight family members attended a 1-day or 2-evening multifamily group workshop and completed a follow-up assessment 1 week later. At follow-up, participants demonstrated more knowledge about bipolar disorder. Anger, blaming attributions, and number of criticisms remained unchanged. Results of this study are consistent with others in that it is difficult to change EE. Implications for future clinical research in this area are addressed.

THE CONSTRUCT of expressed emotion (EE) is defined as critical, hostile, or emotionally overinvolved (EOI) attitudes toward a relative with a psychiatric disorder (Hooley, Rosen, & Richters, 1995). EE has been linked with poor patient outcome for several psychiatric disorders (Barrowclough & Hooley, 2003; Butzlaff & Hooley, 1998). Butzlaff and Hooley (1998) found a meta-analytic effect size of $r = .39$ across six studies that examined the relationship between EE and relapse within mood disorders. More recent research suggests that, although EE was unrelated to manic relapse, high EE was related to a five-fold increase in the odds of a depressive recurrence, even after controlling for symptom severity (Yan, Hammen, Cohen, Daley, & Henry, 2004). Criticism has been found to be the most important element of EE for understanding the course of mood disorders (Hooley et al., 1995) and for bipolar depression (Kim & Miklowitz, 2004). Thus, EE has an influence on bipolar relapse, more specifically for depression.

What drives high levels of criticism? According to Weiner's (1995) attribution-affect model, attributions influence the way people experience emotion. In particular, when an individual perceives that another person is in control of his or her behavior, this leads to a judgment that the other person is responsible for his or her behavior. A judgment that the other person is responsible elicits anger and criticism. High EE relatives who are critical have a tendency to view symptoms of mental illness as behaviors that are within the patient's control (Barrowclough, Johnston, & Tarrier, 1994). Because high EE relatives believe the patient is in control of his or her behavior, they believe the patient must also be capable of modifying this behavior. Thus, relatives struggle to normalize the patient's behavior through negative feedback and controlling behavior of their own (Hooley & Campbell, 2002).

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Several studies of schizophrenia and depression have shown that high EE is related to personal, internal, and controllable attributions (Barrowclough et al., 1994; Brewin, MacCarthy, Duda, & Vaughn, 1991; Hooley & Licht, 1997; Wendel, Miklowitz, Richards, & George, 2000). Wendel et al. (2000) found that high EE relatives made more personal and controllable attributions than low EE relatives, whereas stability and internality of attributions were not related to EE. Attributions of control were particularly related to the criticism and hostility components of EE. In sum, family beliefs that a patient's symptoms are personal and controllable appear related to criticism. As such, unfairly blaming attributions may lead to poorer patient outcomes.

Weiner's attributional theory has been the foundation for many family psychoeducation programs in schizophrenia and other psychiatric disorders (Dixon, Adams, & Lucksted, 2000). The purpose of psychoeducation is to reduce family members' guilt, confusion, helplessness, and sense of overresponsibility. The ultimate goal is to enable family members to be less critical of their ill relative by addressing misattributions for illness (Lefley, 1996).

Several studies have demonstrated that family psychoeducation programs can increase knowledge about the illness, increase familial support, reduce family burden, increase self-efficacy, and reduce relapse rates in psychiatric disorders (Abramowitz & Coursey, 1989; Cozolino, Goldstein, Nuechterlein, & West, 1988; Dixon et al., 2000; Honig, Hofman, Rozendaal, & Dingemans, 1997; Pitschel-Walz, Leucht, Baeuml, Kissling, & Engel, 2001; Solomon, Draine, Mannion, & Meisel, 1996). In bipolar disorder, family, couple, and parent psychoeducation programs also have significantly improved nonverbal interactions, caregiver knowledge of the disorder, patient understanding of the illness, positive family interactions, caregiver distress, coping, attributions, patient functioning, and patient medication adherence (Bland & Harrison, 2000; Brent, Poling, McKain, & Baugher, 1993; Clarkin, Carpenter, Hull, Wilner, & Glick, 1998; Fristad, Goldberg-Arnold, & Gavazzi, 2003; Simoneau, Miklowitz, Richards, Saleem, & George, 1999; van Gent & Zwart, 1991).

These psychoeducation programs, however, were developed with the aim of reducing EE. Whereas they have attained positive effects on many outcomes, the results are less uniform when considering EE levels. Specifically, these programs failed to improve negative verbal interactions (Fristad et al., 2003; Simoneau et al., 1999). To date, we can identify only one study that documented significant reductions in EE with treatment compared to control (Honig et al.,

1997). Honig et al. reported a significant change in EE for a treatment group compared to a control group: results of a six-session multifamily psychoeducational intervention showed that 31% of relatives of patients with bipolar disorder in the treatment group changed from high EE to low EE, compared to none of the relatives in the control group. The authors, however, did not report if changes to EE were specific to criticism or overinvolvement. Taken together, findings suggest that currently available interventions have achieved only limited success with the core goal of reducing EE.

One way to improve interventions might be to consider other variables driving EE. Substantial literature suggests that emotions provide fuel for quick heuristic judgments of behavior that match a person's mood state. For example, anger triggers attributions that blame people rather than the situations people face (Keltner, Ellsworth, & Edwards, 1993; Lerner & Keltner, 2001; Smith & Ellsworth, 1985). Longer-lasting mood states also guide appraisals (Siemer, 2005). Given that anger would be expected to lead to attributions of responsibility for behavior and, as noted above, that attributions of responsibility for behavior can increase anger, it is important to consider a bidirectional relationship between attributions of responsibility and angry mood.

As described above, traditional psychoeducation programs were based on the notion that the provision of accurate information about the illness would modify attributions and thereby decrease EE. However, attributions of blame might be intensified by anger, and traditional psychoeducational programs do not address anger. In this study, basic psychoeducation was augmented by targeting anger in order to reduce blaming attributions.

To reduce anger, materials from Christensen and Jacobson's integrative behavioral couple therapy (IBCT) were adapted for this intervention (Christensen & Jacobson, 2000). IBCT was designed to decrease negative interactions among partners by emphasizing emotional acceptance (Christensen et al., 2004). In contrast to traditional behavioral couple therapy (TBCT), which seeks to change behavior of spouses, the goal of IBCT is to help spouses accept, without promoting resignation, aspects of their partners that were previously unacceptable (Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000). Christensen and Jacobson (2000) define acceptance as the ability "to tolerate what you regard as an unpleasant behavior of your [relative], probably to understand the deeper meaning of that behavior, certainly to see it in a larger context, and perhaps even to appreciate its value and importance in your relationship" (p. 124).

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