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Linking family cohesion and flexibility with expressed emotion, family burden and psychological distress in caregivers of patients with psychosis: A path analytic model



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ABSTRACT

The present study aimed to evaluate a path analytic model accounting for caregivers' psychological distress that takes into account perceived family cohesion and flexibility, expressed emotion and caregiver's burden associated with the presence of mental illness in the family. 50 first-episode and 50 chronic patients diagnosed with schizophrenia or bipolar disorder (most recent episode manic severe with psychotic features) recruited from the Inpatient Psychiatric Unit of the University Hospital of Heraklion, Crete, Greece, and their family caregivers participated in the study. Family functioning was assessed in terms of cohesion and flexibility (FACES-IV), expressed emotion (EQ), family burden (FBS) and caregivers' psychological distress (GHQ-28). Structural equation modelling was used to evaluate the direct and indirect effects of family dynamics on caregivers' psychological distress. The results showed that neither family cohesion nor family flexibility exerted significant direct effects on caregivers' psychological distress. Instead, the effect of flexibility was mediated by caregivers' criticism and family burden indicating an indirect effect on caregivers' psychological distress. These results apply equally to caregivers of first episode and chronic patients. Family interventions aiming to improve dysfunctional family interactions by promoting awareness of family dynamics could reduce the burden and improve the emotional well-being of family caregivers.

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1. Introduction

Given the family's central position in patient care and psychosocial rehabilitation, research on psychosis within the context of the family is critical. From a systems perspective, which considers the family as a closely interconnected social unit, dysfunction or illness in one family member is bound to affect the other members (Friedman et al., 2003). Families both affect and are affected by a mentally ill member through a dynamic process impacting patterns of communication, interactional styles, family responsibilities, and family roles as the family adapts to the physical and psychological demands of managing the illness.

The majority of studies on family emotional atmosphere of patients with psychosis have focused on the construct of expressed emotion (EE), which is considered an important measure

of family environment and reflects the extent to which the patient's family members express critical comments (CCs), hostility, and/or emotional over-involvement (EOI) toward him/her. CCs convey dislike or disapproval of the patient's behavior; hostility reflects disapproval or rejection of the patient as a person; EOI entails an exaggerated or overprotective attitude towards the patient, as evidenced by intrusive behaviors and evident emotional distress of the carer. As hostility greatly overlaps with CC, EE classification of caregivers is based mainly on CC and EOI (Wiedemann et al., 2002). Although EE has been established as a highly reliable psychosocial predictor of relapse in psychosis (Butzlaff and Hooley, 1998; Cechnicki et al., 2013; Hooley, 2007), it remains unclear what accounts for high EE among families. Some studies have shown that high EE in family caregivers is associated with parental disengagement and reduced connectedness (Wuerker et al., 2001, 2002), as well as greater burden of care (Sczufca and Kuipers, 1996, 1998). Thus, rather than a cause of relapse, parental attitudes toward the patient may be part of a more complex and dynamic phenomenon reflected in the family emotional environment.

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Family burden (FB) refers to the negative impact of a member's mental disorder on the entire family (Biegel and Schultz, 1999; Schene, 1990) typically associated by the addition of caregiving responsibilities to existing family roles (Schene, 1990). The origins of EE and FB have received little research attention, and their mutual interactions are not yet well understood. There is evidence that EE and FB are interacting phenomena such that, for instance, caregivers experience higher level of burden when they are more strongly emotionally involved (Alvarez-Jimenez et al., 2010; Gonzalez-Blanch et al., 2010; Moller-Leimkuhler and Obermeier, 2008; Perlick et al., 2004). Moreover, it has long been established that caregivers of patients with psychosis experience high levels of burden which adversely impacts their health and quality of life (Caqueo-Urizar and Gutierrez-Maldonado, 2006; Gutierrez-Maldonado et al., 2005). Additionally, recent findings suggest high levels of burden and psychological distress among caregivers of patients experiencing their first episode of psychosis (FEP) (Boydell et al., 2014; Jansen et al., 2015a; McCann et al., 2011).

Family systems theory, as operationalized by the Circumplex Model of Marital and Family Systems (Olson et al., 1979), provides useful insights into the intrafamilial relationships of patients with psychosis. The Circumplex Model conceptualizes family cohesion, flexibility, and communication skills as three central variables that define family interactions (Olson, 2000). Family cohesion is defined as the emotional bonding that family members have toward one another (Olson, 1993), whereas family flexibility relates to the quality and expression of leadership and organization, role relationship, and relationship rules and negotiations (Olson and Gorall, 2006). Communication encompasses the positive skills used by the family members to convey information (Olson and Gorall, 2006) and it is viewed as a facilitating dimension that helps families negotiate cohesion and flexibility issues (Olson et al., 2007). Within the Circumplex Model, cohesion may vary along a curvilinear continuum from disengaged (very low levels of cohesion) to enmeshed (very high levels of cohesion). Similarly, flexibility ranges from rigid (very low levels of flexibility) to chaotic (very high levels of flexibility (Olson and Gorall, 2006)). Optimal functioning requires balanced levels of cohesion and flexibility (indicated by mid-range values), whereas family dysfunction is characterized by values at either end of the continuum (Craddock, 2001).

Even though family cohesion and flexibility are considered to play an important role in patient recovery from psychosis, these dimensions of family functioning remain relatively under-researched. Studies on chronic patients with schizophrenia and bipolar disorder have yielded mixed findings, some confirming (Chang et al., 2001; Friedmann et al., 1997; Phillips et al., 1998; Romero et al., 2005; Sun and Cheung, 1997) and others failing to confirm (Miller et al., 1986) the association between psychiatric disorders and family dysfunction, whereas empirical data in the context of FEP are scarce. A very recent study (Koutra et al., 2014a) found that families of FEP patients experienced higher levels of dysfunction in terms of cohesion and flexibility as compared to families of healthy controls, whereas they presented more balanced levels of cohesion and flexibility than families of chronic patients.

In Greece, the limited resources of community care result in insufficient support of patients with psychosis, which is mostly provided by family members. Previous research has identified specific characteristics in Greek families that may influence the type of care they provide. Although the Greek family is seemingly a nuclear family (Georgas, 1999; Katakis, 1998; Papadiotis and Softas-Nall, 2006; Softas-Nall, 2003), in reality it functions as an extended one (Georgas, 1999, 2000) characterized by cohesiveness and tight knit bonds and interactions. Strong family values in Greek families contribute to the sense of concern and obligation

that family members have to care for their identified patient. In Greece, the family is considered a pillar of society, and thus, problems are expected to be solved by the whole family. This type of family has been called "extended urban family" (Georgas, 2000). In this regard, illness in one family member may affect family dynamics and result in substantial burden for the entire family.

In their recent review, Jansen et al. (2015b) emphasized that there seems to be a scarcity of psychological models accounting for variations in caregiver's psychological distress in early psychosis. Furthermore, most of the research on family functioning in psychosis focuses on unidimensional constructs, such as EE, which do not fully capture its complexity. In light of the aforementioned limitations, we hypothesized that a new theoretical perspective which embraces a broader view of family functioning would appear more useful (Koutra et al., 2014b). In this regard, family functioning, as conceptualized by the Circumplex Model, is examined as a potential new approach to provide an improved understanding about the determinants of caregivers' psychological distress in psychosis. Although the Circumplex Model is well established in many other clinical fields, such as bipolar disorder (Robertson et al., 2001), eating disorders (Vidovic et al., 2005), etc., it has not been widely applied to the psychosis research. King and Dixon (1996) were the first to examine the application of the Circumplex Model on the development of the family's level EE and the association between EE and patients' social adjustment. Although cohesion and flexibility were found to be useful in their models of symptom type and social adjustment, they did not appear to underlie either CC or EOI components of EE.

The concept of EE has been of considerable importance in the development of family interventions in psychosis. There is growing evidence that the two components of EE are uncorrelated and related to different factors (van Os et al., 2001), with EOI being more closely related to caregiver's distress than CC (Alvarez-Jimenez et al., 2010). EOI has been considered as an understandable reaction to a crisis and also a sign of care and willingness from the part of the caregiver to be engaged in treatment and support (van Os et al., 2001), whereas CC has been considered to be a trait marker in caregivers associated with poor prognosis, often being developed as a reaction to frequent psychotic episodes (Alvarez-Jimenez et al., 2010; van Os et al., 2001).

The aim of the present study was to test a path analytic model accounting for caregivers' psychological distress that takes into account perceived family cohesion and flexibility, emotionally charged behaviors toward the patient (EE), and caregiver's sense of burden associated with the presence of mental illness in the family (FB). To our knowledge, this is the first systematic attempt in the literature to examine the interplay of family dynamics (indexed by cohesion and flexibility) with caregiver's EE, FB, and psychological distress in patients with psychosis. The study considers characteristic features of family functioning (cohesion and flexibility) as exerting direct effects on caregivers' psychological distress as well as indirect effects by affecting both their behavior (EE) and perceived burden. We hypothesized that when caregivers view their family as functional their behavior toward the patient will be positively affected (as indexed by low levels of EE). Conversely, when the family is viewed as dysfunctional their behavior will be negatively affected resulting in high levels of EE. Furthermore, strong (negative) EE behaviors toward the patient, will likely be associated with stressful interpersonal interactions and conflict, enhancing the sense of burden. In addition, increased levels of EE are expected to further enhance the psychological burden of experienced by caregivers leading to higher levels of psychological distress. The hypothesized multiple mediator relationship is depicted in Fig. 1. Finally, in view of differences between families of patients experiencing their first episode of psychosis (FEP) and chronic patients with psychosis reported by our group on a variety

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