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Cross-cultural adaptation and validation of the Greek version of the Family Questionnaire for assessing expressed emotion

Katerina Koutra[a,b,*], Marina Economou[c,d], Sofia Triliva[e], Theano Roumeliotaki[b], Christos Lionis[b], Alexandros N. Vgontzas[a]

[a]Department of Psychiatry and Behavioural Sciences, Faculty of Medicine, University of Crete, Heraklion, Greece
[b]Department of Social Medicine, Faculty of Medicine, University of Crete, Heraklion, Greece
[c]1st Department of Psychiatry, Medical School, Eginition Hospital, University of Athens, Athens, Greece
[d]University Mental Health Research Institute, Athens, Greece
[e]Department of Psychology, University of Crete, Rethymnon, Greece

Abstract

Expressed emotion (EE) has proved to be an established factor in short-term relapse in schizophrenia. The aim of the present study was to examine the psychometric properties of the Greek version of the Family Questionnaire (FQ), a brief self-report questionnaire measuring the EE status of relatives of patients with schizophrenia in terms of criticism (CC) and emotional overinvolvement (EOI). The translated and adapted 20-item FQ was administered to 176 family caregivers of patients with schizophrenia and bipolar disorder. Caregivers' burden (Family Burden Scale) and psychological distress (General Health Questionnaire-28) were also evaluated. The findings indicated that the Greek version displays a two-factor structure with two subscales of EE—CC and EOI—with 10 items each, similarly to the original version. The convergent validity of the subscales was highly supported by correlations with caregivers' burden and psychological distress. The Cronbach's α coefficient measuring internal consistency for the two scales were 0.90 for CC and 0.82 for EOI. The test–retest correlation coefficients measuring reproducibility were 0.99 and 0.98 for CC and EOI, respectively. The Greek version of the FQ appears to be a valid and reliable instrument to be used in both research and clinical assessment of family EE.

1. Introduction

Expressed emotion (EE) is an indicator of aspects of emotional behavior within a family; more specifically, it refers to patterns of communication between a patient and his or her family. It has long been studied as an index of family stress in relation to the course of psychiatric illness [1]. EE comprises five components [2]: i) Criticism (CC), which refers to critical comments made by a family member about the patient's behavior; ii) Hostility (H) remarks, which reflect disapproval or rejection toward the patient; iii) Emotional Overinvolvement (EOI), referring to an exaggerated and disproportionate emotional response toward the patient, as reflected by the intrusive style of the relationship with the patient and evident emotional distress by the carer; iv) Warmth (W), which denotes expressions of empathy, understanding, affect and interest toward the patient; and v) Positive Remarks (PR), which refer to expressions of approval, positive appraisal or appreciation of the patient and/or his/her behavior. However, in most studies family level of EE is obtained only through aggregating scores from the CC, H, and EOI components, which have shown to bear the highest predictive value in relation to relapse [3].

Several decades of research have established EE as a highly reliable psychosocial predictor of psychiatric relapse in schizophrenia [4–6]. Researchers have positioned EE within the diathesis–stress model of psychopathology, conceptualizing it as an environmental stressor that can potentially precipitate/cause relapse of psychosis among people with a genetic vulnerability [7]. Relatives and carers exceeding threshold levels of EE generally communicate using negative language or interaction patterns toward

* Corresponding author at: Department of Psychiatry and Behavioural Sciences, Faculty of Medicine, University of Crete, PO Box 2208, Heraklion, 71003 Crete, Greece. Tel.: +30 2810324999; fax: +30 6977357108.
E-mail address: koutra.k@gmail.com (K. Koutra).

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patients [8–10], which, in turn, may lead to interpersonal stress and may yield risk factors associated with psychotic and other disorders [11]. In a similar vein, patients from high-EE environments are more disruptive; presenting odd and troublesome behavior, such as being disagreeable or critical, while interacting with family members, in comparison to patients from low-EE environments [12–14]. In addition to research conducted on family members, EE has been studied in relation to professional carers [15].

A variety of measures have been developed in order to assess EE in patient–relative relationships. Among these, the main instrument employed is a semi-structured interview especially designed to identify the presence of EE, the Camberwell Family Interview (CFI) [16], based on the work of G.W. Brown [17]. However, the time-consuming administration (between 1 and 2 hours) and coding limits (approximately 3 hours) has led researchers to look for an alternative. In this manner, the Five-Minute Speech Scale (FMSS) [18] was developed, which is a more feasible tool, though it still requires coding by a qualified rater. Although the FMSS requires less time to administer (approximately 5 minutes) and score (approximately 20 minutes) as compared to the CFI, the primary disadvantage of using this instrument involves inflated Type II error rates.

Difficulties with measurement limit the clinical utility of the EE, and in response to this, researchers have developed several shorter methods for measuring EE. Several self-report questionnaires have been developed to assess EE experienced by either relatives or patients. A recent review of EE instruments [19] has identified nine valid alternative measures, which has facilitated the clinical and research utility of EE. Although self-report questionnaires cannot be expected to provide the depth of information yielded by the CFI, they do constitute a time- and cost-effective way of eliciting attitudes germane to the EE index and they dispense with the dichotomous high/low measure of the CFI that has previously been criticized [20].

More recently, Wiedemann and colleagues [21] have developed the Family Questionnaire (FQ), a brief questionnaire that enables accurate assessment of CC and EOI. The FQ is easier to administer and less time consuming than the CFI or the FMSS, although it is at least equivalent to the FMSS in terms of validity. Furthermore, the FQ is suitable for repeated administration, there is no need for any training before its use, and the time needed for administration and evaluation is minimal [21]. The preliminary version of the FQ included 130 items derived from three different sources, such as clinicians' reports about common statements made by family members about a relative with schizophrenia and common ways of behaving with such a relative, EE-related concepts or existing EE questionnaires. Items were generated for the areas of "intrusiveness," "emotional response," "attribution of illness" and "coping skills," whereas items relating to attitude and behavior areas recorded in the CFI were also included. Finally, a number of items reflecting the CFI evaluation criteria [16] were generated for the areas of CC and EOI. All items were evaluated for breadth of coverage, ease of understanding and acceptance by a team of EE experts. The next step included the selection of 30 items that had the highest correlations with the CC or EOI subscales of the CFI. The final version of the FQ was produced after the deletion of 10 items resulting in a shorter version of a 20-item questionnaire consisting of two scales—CC and EOI—with 10 items each [21].

During the last decades, the construct of family EE has been a key area of interest for mental health professionals who provide family interventions. The family's EE has been shown to be predictive of outcome in mental and physical illnesses in a variety of cultural settings [22]. Apart from its predictive value, EE has been extremely productive, in that it has led to the development of family interventions capable of modifying the family behavior patterns that underlie it [23]. Thus, it has been useful in both structuring and evaluating the effectiveness of psychosocial treatment in psychosis. With the rapid development of family therapy and interventions in Greece, there has been an increasing need for a standardized assessment tool of family EE in the Greek population. The main objectives of the present study were to translate, adapt and examine the psychometric properties of the FQ in a Greek sample of caregivers of patients with psychotic disorders in order to determine whether it is a useful tool for the study of family EE in Greece. The FQ was chosen for being translated and adapted to the Greek population since it has been shown to be a research-applicable alternative measure of EE in psychotic disorders with good psychometric properties in both research and clinical contexts. Within this study, we also described the socio-demographic and clinical characteristics associated with family EE, and assessed the extent to which family burden and caregivers' psychological distress may affect family EE.

2. Methods

2.1. Participants

A total of 180 participants recruited from the Psychiatric Clinic of the University Hospital of Heraklion, Crete, Greece, and the University Mental Health Research Institute of Athens, Greece, were contacted and informed about the purpose of the present study during a 12-month period (December 2010–December 2011). In Heraklion, family caregivers of 125 patients consecutively admitted to the Psychiatric Clinic were selected from the hospital's electronic database; in Athens, the family caregivers of 55 patients who participated in four psychoeducational groups which took place during a 1-month period in the University Mental Health Research Institute of Athens were, also, selected. Finally, 176 (response rate = 97.7%) family members agreed to participate and returned usable data (n = 121 from Heraklion and n = 55 from Athens). The key caregiver was defined as the person who provides the most