



Relatives' expressed emotion, distress and attributions in clinical high-risk and recent onset of psychosis



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ABSTRACT

It has been well-demonstrated that Expressed Emotion (EE) in caregivers of schizophrenia patients is related to their illness attributions, but little is known about relatives' cognitive and emotional appraisals at early stages of psychosis. This study examined differences on the relationships of EE with distress and illness attributions in 78 relatives of At-Risk Mental States (ARMS) and First-Episode of Psychosis (FEP) patients, and which of those variables better predicted EE. Criticism and Emotional Over-Involvement (EOI) were associated with distress and with several illness attributions in both groups. Anxiety was more strongly associated with criticism in ARMS than in FEP-relatives, and it was associated with EOI in the ARMS but not in the FEP-group. No differences on the relationships of EE with depression or attributions were found. Furthermore, distress and attributions of blame toward the patients predicted criticism. Attributions of control by the patient and emotional negative representation about the disorder predicted EOI. Findings highlight the need to focus on early family interventions that provide proper information and psychological support in accordance with the illness stage, to help relatives improve their understanding of the disorder, handle difficult thoughts and emotions, reduce negative appraisals, and prevent high-EE over the psychotic process.

1. Introduction

Adapting to life with a relative affected by a mental disorder is often a stressful experience that creates a sense of subjective burden and distress in family members (Jungbauer and Angermeyer, 2002). There is substantial evidence in the literature demonstrating that the responsibility of caring for a family member with a psychotic disorder can lead to show elevated levels of distress, anxiety, and depression in caregivers (Barrowclough et al., 1996; Jansen et al., 2015a, 2015b). In the early stages of psychosis, caregivers face a number of issues, such as shock, grief, poor understanding of illness and the psychiatric system (Onwumere et al., 2011). In fact, Martens and Addington (2001) have reported higher levels of distress in relatives of early psychosis patients than those of individuals who have a more chronic course of illness.

Some studies have found that distress in caregivers of persons with First-Episode of Psychosis (FEP) seems to be more related to their subjective appraisal of the impact of illness and over-involvement than to variations in the patients' symptomatology and overall functioning in the early phase of illness (Addington et al., 2003). However, little is known about the psychological underpinnings of caregiver distress in early psychosis and further research could improve our understanding of the trajectory of distress early in the course of illness and assist in developing strategies for preventing long-term distress in caregivers and supporting recovery in the whole family (Jansen et al., 2015a, 2015b).

In relation to family caring role, one of the most influential concepts in psychosocial research on psychosis has been Expressed Emotion (EE), a measure of the family emotional environment comprised of

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stances expressed by relatives towards an ill family member (Vaughn and Leff, 1985). Given that high-EE, defined by the presence of elevated levels of criticism, hostility and/or Emotional Over-Involvement (EOI), has consistently shown to be an important predictor of relapse in schizophrenia (Brown et al., 1972; Butzlaff and Hooley, 1998), much research has focused on trying to understand the psychological factors that underlie this construct.

For instance, the attributional model (Barrowclough and Hooley, 2003) postulates that relatives' EE attitudes are related to their beliefs about the causes and nature of the mental disorder. Several studies have shown that, in the absence of adequate information about the disorder, caregivers are likely to make attributions that psychotic symptoms are under the patient control or are their responsibility. In consequence, relatives who believe that patients might control over their behaviours or blame them for their symptoms may react with criticisms in an attempt to reduce those behaviours (Weisman et al., 1998). On the other hand, it has been suggested that emotionally overinvolved relatives tend to believe that they have somehow contributed to the patient's problems, so they usually present self-blaming attributions (Bentsen et al., 1998).

Most EE and related factors studies in the field of psychosis have been carried out with patients with chronic psychosis or schizophrenia (Kavanagh, 1992; Hooley, 2007), although the recent focus of research on early stages of the psychotic continuum has led to an increasing interest in the study of EE, in order to prevent the entrenchment of high-EE and relapses. Preliminary research have found that high-EE is present in approximately the half of the relatives of FEP patients (Bachmann et al., 2002; Heikkilä et al., 2002) and is also present even in relatives of persons at-risk for psychosis (O'Brien et al., 2006; Schlooser et al., 2010). In addition, recent findings indicated that caregivers of patients with early psychosis presented significant emotional problems and, that higher levels of EE are related with caregivers' burden and with elevated levels of anxiety and depression at these early psychosis stages (Tomlinson et al., 2014; Boydell et al., 2014; Barrowclough et al., 2014).

In a prior study, our team investigated the prevalence of EE indices in relatives of both FEP and At-Risk Mental States (ARMS) patients, and we demonstrated that illness attributions mediate the relationship of EE with clinical and functional symptoms at these stages (Domínguez-Martínez et al., 2014). Furthermore, some studies have shown that relatives' cognitive representation of psychosis may play an important role in their emotional appraisals even at early stages of the disorder (Onwumere et al., 2008) and that critical relatives of FEP patients are also more likely to believe that the problematic behaviours are controlled by the patient (McNab et al., 2007; Vasconcelos et al., 2013). Nevertheless, far less is known about psychological characteristics associated to relatives' levels of EE in early psychosis phases and more research is need at this regard, especially in ARMS population. In addition, both groups of FEP and ARMS relatives have been rarely compared in these questions (Domínguez-Martínez et al., 2014; Meneguelli et al., 2011), so it remains unclear if the nature of relatives' EE, distress and illness beliefs differs from a subclinical to a recent stage of psychosis.

Considering the crucial role of family environment in the prognosis of psychosis and the benefits that early family intervention could provide in preventing the development of misguided beliefs and negative emotions in relatives at these early stages of the psychotic process, it would be necessary to improve our understanding of the relatives' psychological factors that could be related to their levels of EE, such as distress and illness beliefs, as well as to examine whether these family factors predict in some way the EE. Thus, the following aims were addressed at this study: 1) To describe and compare the levels of EE (criticism and EOI), distress (levels of anxiety and depression), and several illness attributions in relatives of ARMS and FEP patients; 2) To examine the associations of EE with relatives' distress and illness attributions, as well as differences of these

associations between ARMS and FEP groups; and 3) To explore whether relatives' distress and illness attributions predict EE in both groups. Based on the attributional model and on previous findings, we hypothesized that: a) FEP-relatives would show higher levels of EOI, depression and both self-blame and self-control attributions than ARMS-relatives, who would show higher levels of criticism, anxiety and attributions of control and blame towards the patients than FEP-relatives; b) In both groups, EOI would be associated with anxiety and depression, attributions of self-blame and self-control, as well as with negative emotional representation of the disorder, whereas criticism would be associated with relatives' belief that patients can control their symptoms and with the attribution of blame toward the patient; and c) illness attributions would predict EE in all the relatives. In particular, beliefs of self-blame, self-control and negative emotional representation of the disorder would predict EOI, while beliefs of control and blame toward the patient would predict criticism.

2. Methods

2.1. Participants

This study comprises 78 relatives, 41 of ARMS and 37 of FEP patients. They were recruited within the Sant Pere Claver-Early Psychosis Program conducted in Barcelona, Spain (Domínguez-Martínez et al., 2011), if they had regular contact and/or the most significant relationship with the patient. Patients met ARMS criteria as assessed by the Comprehensive Assessment of At-Risk Mental States (CAARMS) (Yung et al., 2005) or FEP criteria according to DSM-IV-TR (American Psychiatric Association, 2002).

All participants provided written informed consent. The project was developed in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) and has been approved by the local ethical committee.

2.2. Measures

EE was assessed with the Family Questionnaire (FQ) (Wiedemann et al., 2002), which comprises 20-items equally distributed in two subscales (criticism and EOI) scored on a 4-point scale ranging from 'never/very rarely' to 'very often'. The Depression and Anxiety subscales of the Symptom Checklist (SCL-90-R) (Derogatis and Cleary, 1977) were used to assess relatives' distress. The SCL-90-R is a psychiatric self-report inventory intended to measure symptom intensity on a five-point scale from 0 'not at all' to 4 'extremely'. Illness Attributions were assessed with the Illness Perceptions Questionnaire for Schizophrenia-Relatives' version (IPQS-R) (Lobban et al., 2005), a measure of relatives' beliefs about the disorder whose items are rated from 1 'strongly disagree' to 5 'strongly agree'. For the purposes of this study we used the following subscales: cause (personal ideas about the cause of the disorder), timeline acute/chronic and timeline cyclical (perception of the pattern and duration of the disorder), consequences for both patients and relative (the expected effects and outcome of the disorder), personal control-patient and personal control-relative (control over the disorder), personal blame-patient and personal blame-relative (blame toward the patient or self-blame about the disorder), treatment control/cure (usefulness of treatment), illness coherence (a coherent understanding of the disorder) and emotional representation (negative emotions about the disorder including sense of fear, frustration, anger, loss, worry). In order to explore causal attributions more in depth, individual items of the cause-subscale were also ranked in terms of strength of belief as indicated by their authors.

2.3. Statistical analyses

First, descriptive data were analyzed (means and standard deviations or percentages, depending on the nature of the variables). Second,

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