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Validity of the Brief Dyadic Scale of Expressed Emotion in Adolescents

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Abstract

Purpose: Perceived expressed emotion is a valuable predictor of clinical outcome in psychiatric and community samples, but its assessment is limited to few instruments. A recent development to briefly assess expressed emotion from the patient's perspective is the 14-item Brief Dyadic Scale of Expressed Emotion (BDSEE). Although psychometric properties of the BDSEE have been provided for adult eating disorders, validity for adolescents is still lacking. In this study, BDSEE's factorial, convergent, and divergent validity was tested in an adolescent sample with binge-eating disorder and a matched community sample.
Methods: For validation, well-established self- and mother-report questionnaires and adolescent's Five Minute Speech Sample were used.
Results: Confirmatory factor analysis on the German BDSEE replicated the proposed three-factor structure in adolescents. BDSEE's convergent validity with the Five Minute Speech Sample and construct-related questionnaires was shown. Divergent validity was documented with BDSEE subscales being unrelated to socio-demographic and clinical characteristics. Further, BDSEE subscales were unrelated to measures of maternal distress.
Conclusions: While the results underline that the BDSEE is a valid self-report measure for assessing perceived expressed emotion in adolescents with and without binge-eating disorder, the evaluation of its predictive validity is still in need.
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1. Introduction

Although perceived expressed emotion (EE) is a valuable predictor of clinical outcome in psychiatric and community samples, e.g., [1–3], its assessment is limited to few instruments that measure EE from the patient's perspective. A recent promising development to assess perceived EE in adult eating disorders is the Brief Dyadic Scale of Expressed Emotion (BDSEE) [4] that has been demonstrated to be reliable and valid in Spain. The current study sought to provide evidence for its psychometric properties in a German sample of adolescents with and without binge-eating disorder (BED).

For more than 50 years, research on expressed emotion (EE) evidenced that individuals living in high emotionally involved homes are reliably at risk for the onset and relapse of a range of mental disorders and psychopathology [5,6]. EE refers to the extent to which a close relative talks about the patient in a critical, hostile, warm, or emotionally overprotective manner. There is evidence that beyond EE which has been assessed through the relative for a long time, patients' views are central in the processing of EE [7]. Notably, the measure of "how much criticism is getting through to the patient" [1, p.234] was shown to be a more proximal indicator of the impact of EE on the patient than the number of relative's critical comments about the patient. Indeed, perceived EE has been found to predict clinical relapse [1,2,9] and treatment outcome [10] in adult patients, and is associated with psychopathology in adolescents from clinical [11] and non-clinical samples [3,12].

The assessment of perceived EE is primarily based on self-report questionnaires. High predictive validity was particularly found for the Perceived Criticism Scale (PCS) [1] and the Level of Expressed Emotion Scale (LEE) [13,14]. However, these instruments only measure negative components of EE, while there is growing interest on the impact of positive emotional attitudes on the course of illness, particularly in youth [15,16]. Regarding validation, all these measures on perceived EE have been validated with

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the Camberwell Family Interview (CFI) [17], the gold-standard measure for EE from the relative's perspective, although the association between perceived EE and the relative's *true* EE was found to be only low to moderate [18,19]. The results on the PCS and the LEE were mostly gathered in samples with depression and schizophrenia, but may not generalize to samples of eating disorders. When applied to patients with eating disorders, the LEE showed inconsistent predictive validity [20] and an exceptionally high rate of high perceived EE (89%) [21].

The latest development to assess perceived EE is the Brief Dyadic Scale of Expressed Emotion (BDSEE) [4] that was designed to measure three core components of EE: the extent to which patients perceive their close relative as being critical, emotionally over-involved, and warm towards them. In a sample of 77 patients with eating disorders, Medina-Pradas et al. [4] demonstrated good to excellent reliability, factorial validity, and convergent validity with the CFI and self-report questionnaires. In a recent study on the most prevalent eating disorder in adolescents [22], binge-eating disorder (BED) [23], included in the fifth revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [23] as its own diagnostic entity, the BDSEE was specifically applied to adolescents for the first time [11]. The results indicate BDSEE subscales to discriminate between adolescents with and without BED, but evidence on further validity criteria is lacking.

In this context, the aim of the present study was to provide a psychometric evaluation regarding the factorial, convergent, and divergent validity of the German BDSEE in adolescents with and without BED.

2. Materials and Methods

2.1. Participants

A sample of one hundred four 12- to 20-year-old adolescents were included in the study. The sample comprised 52 (50.0%) adolescents with sub- and full-threshold BED (DSM-5) [23] (DSM-IV-TR) [24] with adaptation according to age, i.e., including both objectively and subjectively large binge-eating episodes [25,26], who sought cognitive-behavioral treatment (BED group) [27]. In addition, 52 (50.0%) adolescents from the community without an eating disorder diagnosis were recruited school- and population-based (HC group). Both samples were stratified with respect to age, sex, weight status, and socio-economic status. Diagnostic items of the Eating Disorder Examination (EDE) [28,29] were used to ascertain diagnostic status.

Initially, adolescents were screened by telephone for eligibility and then invited to a face-to-face diagnostic visit onsite. Inclusion criteria for the total sample were an age between 12 and 20 years, and the written informed consent of parents and assent of adolescents. Participants were excluded when they had current psychotic disorder, intake of antipsychotic drugs, psychotherapy, or suicidal ideation, see [27]. Ethical approval for this study was granted through the local ethics committee.

The total sample had a mean age of 15.0 (±2.6) years, was predominately female (n = 86, 82.7%), and had a mean standard deviation score of the body mass index (BMI-SDS) of 1.7 (±1.0). The sample was mostly classified as social middle class (12.1 ± 4.5) as indicated by the Winkler Social Class Index [30], ranging from 0 to 21. Mothers of adolescents had a mean age of 45.6 (± 6.2) years. The majority of mothers were married (n = 46, 45.5%) or separated (n = 44, 43.6%), respectively. Most adolescents lived with the whole family (n = 47, 46.1%) or with mothers only (n = 42, 41.2%) while a minority lived on their own (n = 10, 9.8%) but reported regular contact to the mother. Based on mother-report, the amount of contact mothers spend with their child was about 35.4 (±24.3) hours per week. The BED and HC group did not differ with respect to socio-demographic and anthropometric characteristics (all $p > .05$).

2.2. Measures

The *Brief Dyadic Scale of Expressed Emotion* (BDSEE) [4] assesses three core components of EE: perceived criticism (4 items; e.g., "How critical is … of you?"), perceived emotional over-involvement (EOI, 6 items; e.g., "… does not let me do things on my own."), and perceived warmth (4 items; e.g., "How warm is … towards you?"). The 14 items are scored on a 10-point Likert scale from 1 = *not at all*/*never* to 10 = *very*/*always*. Sum scores are calculated, with higher scores indicating more perceived criticism, EOI, or warmth. The German version of the BDSEE was translated from the English version of the BDSEE (see [4]) by the first author and back-translated by a certified translator, followed by a congruence check of the back-translated and English version of the BDSEE. Internal consistencies for all subscales of the German BDSEE were good-to-excellent ($.83 \leq \alpha \leq .90$).

2.2.1. Measures for convergent validation

The *Five Minute Speech Sample* (FMSS) [31–33] was administered in a patient version in order to obtain speech-based data on perceived EE. Individuals were asked to speak for five minutes about their thoughts and feelings about their mother and how they get along together. The recorded speech was coded by trained raters who were blind to diagnostic status. Based on the FMSS manual [33], the Manual for Coding Patient's Perceptions of their Relative's EE [8], and BDSEE, the coding system operationalized perceived criticism, perceived EOI, and the quality of relationship. Perceived criticism included any statement or critical tone indicating that the adolescent felt criticized, disapproved of, or disliked by the mother with respect to his/her behavior or characteristics. Perceived EOI was defined as any statement indicating that the adolescent found the mother excessively involved in his/her life,

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