vention and demonstrate the necessity and efficacy of a family-based therapeutic approach in the treatment of schizophrenia.

Social Network and Expressed Emotion

Angermeyer[1] has summarized research results on the social network of schizophrenic patients as follows: 1. Prior to onset: The density of the social network is normal to slightly diminished. 2. In the early stage of illness: social network is mainly composed of family members. 3. In the late stage: social network very impoverished, mainly composed of fellow-patients and non-family caregivers. Surely, it is generally agreed that the situation described in statement 3 is neither desirable nor can it be understood as meaning that patients are doomed to their fate for the rest of their lives. At the early onset of the illness, the "family" as a natural resource functions as the nucleus of the patient's social network while underpinning interconnecting threads, and does so more than any other form of therapy offered. The transition from Stage 2 to Stage 3 is often characterized by a long process resulting in the loss of the "family" resource, usually brought about after family members have suffered a long series of disappointments and often by "burn out" on the part of the family members providing care. Psychiatric institutions with their diverse resources are called on to replace the patient's missing or overtaxed natural resources. However, it has become apparent that there are limits to financing substitute living quarters and caregiving regimens, and here too these capacities are quickly exhausted when striving to attain a standard of living for their patients which is as close to "normal" as possible. The objective of family therapy and therapeutic family intervention, one of the best studied forms of therapy, is to retain the family (resp. other members with close ties to the patient) as a resource in order to optimize therapy, rehabilitation and stability of the social network. To be sure, family-related factors, as research on expressed emotion (EE) has shown, can have anti-therapeutic effects.

Butzlaff and Hooley[2] demonstrated in a meta-analysis of relevant literature that the following assertions are now based on solid empirical grounds: EE is a robust relapse-predictor in schizophrenia. EE is more evident in chronic patients than in patients in the early stages of illness. Effect sizes are larger in affective disorders and in eating disorders than in schizophrenia. Further studies on the influence of EE on relapse rates in schizophrenia will not produce new evidence. Given the broad empirical basis now available it is important to work towards a new understanding of the EE phenomenon which operates independently of the initial observations of the first describers.

We recommend that when speaking of the "EE" phenomenon the following adapted perspective be applied: EE is a characteristic of interactions that can also be measured as an attitudinal variable. The interactional perspective is more relevant to the process and the therapy applied than the attitudinal perspective.

This leads to the following assumptions: Characterization of interactions should not be restricted to a dichotomous approach but be based on a wide range of categorized interactions. It is inappropriate to characterize interactions as uni-directional. Therapy should, if possible, be directed towards the most important partners participating in disturbed interactions.

Based on this interpretation of EE interactivity Hahlweg[3] was able to show that it is not the occurrence of negative interactions itself that is characteristic of High EE but the unrestrained length of the sequence of negative interactions (up to 20 interactions, compared to 5 in Low EE families) (Fig. 1). A close examination of what appears to be Low EE reveals that this behavior cannot be simply described as a lack of High EE characteristics. Low EE, provided it is not just an expression of resignation, can be characterized as a suitable and desirable form of behavior towards a schizophrenic patient. Contrasting characteristics in interactive styles are depicted in the table below (Table 1).

As early studies on EE had individualized EE status as well as time of contact with High EE families as a relapse predictor, this led to the assumption that a reduction in the time of contact between the patient and his family should be part of the recommended therapeutical treatment. Given the information available, this recommendation can no longer be propagated (Fig. 2). As demonstrated in Fig. 2, decreasing contact density in High EE families results merely in a slight reduction

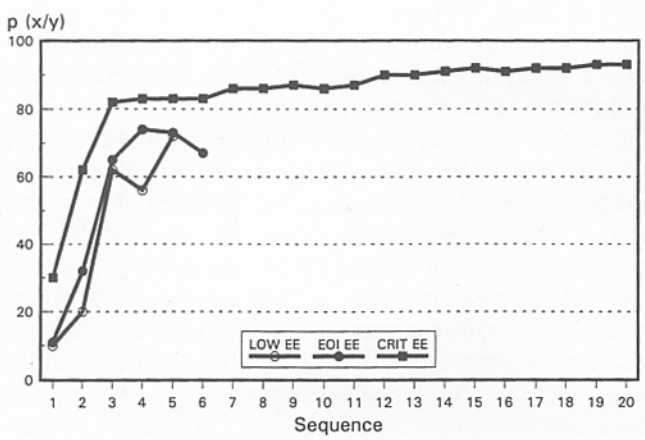

Fig. 1 Negative interactive sequences in High EE and Low EE (after Hahlweg[3]). EOI: emotional overinvolvement, CRIT: critical.