Table 1 Interactive Styles in High EE and Low EE Families (modified after Hubschmid and Zemp 1989)

High EE	Low EE
Profuse and generalizing criticism	Little criticism, specific and target-oriented
Pessimistic view of illness outcome	Optimistic view of illness outcome
"Behavior is controlled by patient"	"Behavior is partially illness-related and only partially controllable"
Family members battle to control patient's behavior	Behavioral limits are set
Aggressive self-assertion on the part of the patient due to negative emotional background	Flexible self-assertion on the part of the patient
Commands	Proposals
Behavioral style: rigid, conflict-directed, polarizing	Behavioral style: de-escalating
Effects: relapse likelihood increased	Effects: relapses are prevented
In general non-acceptance of rehabilitative schemes	Rehabilitative measures are accepted

EE: expressed emotions.

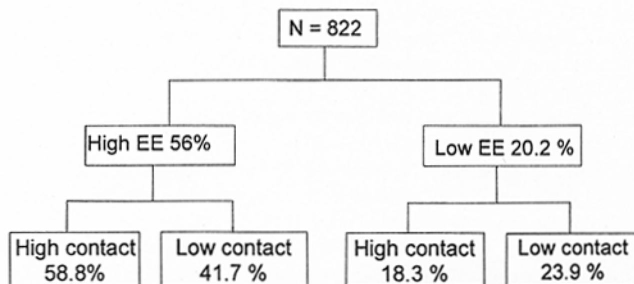

Fig. 2 Relapse rate in relation to EE status and duration of contact (after Bebbington and Kuipers 1994[5]).

whereby the level of relapse risk remains still very high (our studies have shown this to be attributable to persistent High EE interactions with other caregivers). It is much more promising to create, by means of family therapy, a climate of Low EE interactions with relatives and other caregivers. In this case, higher density of interaction even results in a lowering of the relapse risk.

Studies on Family Intervention: Where Science Stands Today

Family intervention studies on schizophrenic patients,[6–9] which since the beginning of the 80s have gained in significance not only with respect to scientific results but also to practicability, are founded on a number of common assumptions: 1. Schizophrenia is considered to be an illness. 2. The family environment is not considered to cause the illness. 3. Therapy is supportive in nature and sees the family as a therapeutic agent. 4. Therapy consists of a "treatment package" which entails drug treatment and outpatient clinical management. Whereby statements 1–3 clearly differentiate family intervention from the psychoanalytic and systemic therapies discussed above, statement 4 expresses that together with the therapeutic family sessions a program comprising the implementation and the coordination of multimodal treatment ingredients has to be established.

Family intervention studies have in common high practical relevance and some methodological problems. The studies compare "therapeutic packages" and are hardly in a position to test hypotheses as to the differential efficacy of the therapeutic components. It will be up to individual studies on the respective therapeutic modality to produce relevant results. Psychosocial studies on intervention practices greatly vary in methodological stringency. Conclusively, expert opinion on the eligibility of these studies for meta-analytic investigations varies greatly.

This is exemplified in the meta-analysis based on 12 studies by Mari and Streiner[10] and the analysis by Falloon and collaborators (unpublished observations) of 38 studies. This may help to explain the contrast in the conclusions drawn in each study: Mari is very tentative whereas Falloon is assertive. According to Mari and Streiner,[10] family interventions reduce relapse and hospitalization frequency, compliance and vocational opportunities improve. Expressed emotion and family burden, however, do not decrease. At least 6 patients must undergo treatment, in order to prevent a single relapse. This would result in an unfavorable cost-benefit-ratio. Cardin's[11] and our own cost-analysis[12] do not support this assumption.

Let me briefly summarize the most important results of Falloon's meta-analysis which to date has not been published: 38 controlled studies +6 in preparation; 6826 cases; 16 studies with good resp. excellent methodology; 13 studies with adequate resp. good methodology; 9 studies with poor methodology.

Factors not associated with outcome: methodological quality of the studies; duration of treatment (less/more than 6 months); severity of disorder; type of session (single family/family group).

Factors associated with a favorable outcome: strength of treatment ($\chi^2 = 18,3; p = 0,0002$); type of treatment strategy ($\chi^2 = 566; p = 0,0001$). The effect of strength of treatment (stringency and adherence to the treatment) is depicted in Fig. 3. The relationship between treatment gains and therapeutic strategy applied (Fig. 4). As to reduction of the family burden, average effect size when applying cognitive-behavioral family-