Relationship Between Empathic Family Attitude and Relapse in Schizophrenia: A 2-Year Followup Prospective Study

by Manuel Girón and M. Gómez-Beneyto

Abstract

Empathy plays a central role in social relationships, and lack of empathy has been suggested as part of expressed emotion in the relatives of patients with schizophrenia. The aim of this research is to measure empathy in the relatives of schizophrenia patients and to establish the relationship between lack of empathy and relapse. Eighty schizophrenia patients were followed up in a 2-year prospective cohort study. Relatives’ empathy, defined as the ability to perceive the patient’s mood state, was measured at the beginning of the study with a questionnaire given after a 10-minute interaction between the patient and his or her relative. Several other attitudinal, clinical, and social variables were also measured. A significant relationship was found between poor empathic attitude and relapse. Lack of treatment compliance, negative symptoms, unemployment, and poor premorbid adjustment were also associated with relapse. In a multivariate analysis, the association between poor empathic attitude and relapse was maintained. Statistical control of the relatives’ critical attitude showed that each kind of attitude predicts relapse independently.

Key words: Outcome, empathy, family attitudes, cohort study, relapse.


Empathy has been defined as the capacity for knowledge of the emotional state of another person regardless of one’s own emotional state (Ivey et al. 1993). While it seems obvious that empathy should play a central role in understanding people, and hence in the management of relationships, it is not clear how and to what extent it does. Some early reports quoted by Gage (1953) underlie the importance of empathy in marital relationships, leadership, teaching, and clinical work. The role played by empathy in psychotherapy was the object of attention in the 1960s, particularly for those studying the client-centered approach. Empathy, warmth, and self-congruence were considered “necessary and sufficient” facilitative conditions for client growth (Rogers 1957) and, hence, for a positive therapeutic outcome. An empathic style in psychotherapy has also been described as non-threatening support (Rogers 1961) that helps reduce psychophysiological arousal in the patient during the interaction (Dittes 1957). Interest in empathy has been heightened by the conviction that empathy can improve with training (Truax and Carkhuff 1967).

In relation to schizophrenia, Leff and Vaughn (1984) reported that empathy forms part of the attitudinal repertoire of relatives with low emotional expressiveness. Family attitudes are one of the most powerful predictors of clinical relapse in schizophrenia (Kavanagh 1992). However, unlike criticism and emotional over-involvement, empathy has received little attention, possibly because of the complex conceptual and methodological issues involved in measuring it.

In the first published attempt to measure empathy in a standardized way, Dymond (1949) asked a sample of students to predict how others would rate themselves on each of six personality traits (self-confidence, superior-inferior, selfish-unselfish, friendly-unfriendly, leader-follower, and sense of humor). An empathy score was derived from the number of predictions that coincided exactly with the actual rating. Dymond’s experiment was replicated by two later studies using different personality scales (Bender and Hastorf 1950; Notcutt and Silva 1951). However, Hastorf and Bender (1952) noted that when a person predicted the scores of two other people, these predictions were much more highly related to each other and to the predictor’s own scores than they were to the scores of the people pre-
dicted for. This finding suggested to the authors that projection was playing a role in the prediction task. Several subsequent studies attempted to obtain an empathy score independent from projection (Bender and Hastorf 1953; Norman and Ainsworth 1954; Cronbach 1955; Gage and Cronbach 1955).

In the present study, empathic attitudes of patients' relatives are evaluated by measuring their ability to predict patient answers to a mood questionnaire depicting mood states, rather than personality traits, which were the focus of previous attempts to measure empathy. Mood is a situational state that must be captured by cues present at the moment of testing. This task may therefore be independent of previous knowledge about the person being evaluated and hence closer to real empathy than the task of describing personality traits.

The primary aim of this project is to establish whether relatives' poor empathic attitude, defined as the ability to guess the patient's answers to a mood questionnaire, predicts clinical relapse in schizophrenia. A second aim is to determine whether the association between lack of empathy and relapse is maintained after controlling for the effect of other factors related to the course of the illness, including relatives' critical attitude, an attitudinal factor associated with relapse (Girón and Gómez-Beneyto 1995).

Methods

The sample consisted of consecutive admissions to the Psychiatric Hospital of Alicante between December 1985 and December 1986. Patients fulfilled the following selection criteria: schizophrenic or schizophreniform disorder according to DSM-III criteria (American Psychiatric Association 1980), 15–50 years old, living with a relative for at least 15 days of the 3 months preceding admission, and a minimum hospitalization time of 1 week following admission.

The initial measurements were made during the hospitalization period. The followup measurements were obtained monthly for the first 9 months, at any readmission, when there was reason to suspect relapse, and, in all cases, at the end of the 2-year followup. Information was collected by research assistants.

To objectively measure relatives' empathy, we developed the Questionnaire of Empathy (QUEM). The QUEM is composed of 32 items describing affective states. The first 20 items correspond to the items of the State-Trait Anxiety Inventory (STAI) state questionnaire (Spielberger et al. 1970) and the remaining 12 items describe mood states not included in the STAI-state (upset, bored, frustrated, sad, suspicious, amused, shy, cross, unsatisfied, confused, involved, indifferent). The question, "How do you feel now, at this very moment?" was answered by rating each item on a 3-point scale (none, a little, a lot).

The procedure was as follows: The relative was asked to maintain a conversation with the patient for at least 10 minutes to determine his mood state. After this interaction, the questionnaire was administered separately to the relative and to the patient. Once they had each filled in the questionnaire according to their own mood state, the relative was asked to answer the same questions according to what he thought the patient was feeling. Thus, for each item of the questionnaire there are three scores: one provided by the patient on himself (score P) and two provided by the relative, one on himself (score R) and another on how he thinks the patient is feeling (score RP).

To separate the effect of projection, empathy is considered to be present only if the relative's rating of the patient's mood (RP) matched the patient's self-rating (P) and is different from his own (R). This procedure helps ensure that all scored matches are caused by empathy by excluding matches that may be caused by projection. Each rating is classified as a hit or a failure: A hit (H) is any item in which R ≠ RP and RP = P; a failure (F) is any item in which R ≠ RP and RP ≠ P. Poor empathic attitude is defined as \( (\sum H + \sum F) / (\sum R + \sum P) \).

The QUEM has good internal consistency: Cronbach's alphas were 0.93 for P score; 0.95 for R score; and 0.94 for RP score.

The patient's QUEM global score (the sum of the individual items) showed a significant correlation with the depression scale (Pearson \( r = 0.25, p = 0.031 \)) and the anxiety scale (Pearson \( r = 0.33, p = 0.004 \)) of Krawiecka's Psychiatric Assessment Scale (PAS; Krawiecka et al. 1977), which were administered during the last week of the initial hospitalization, but did not correlate with positive or negative symptoms.

During the last 3 days of the initial hospital stay, family members who could potentially be considered "key" relatives (always including spouse and both parents) were evaluated. Given that face-to-face contact between patients and relatives potentiates the effect of relatives' negative attitude on the probability of relapse (Bebbington and Kuipers 1994), face-to-face contact was evaluated monthly during the first 9 months of followup. If the patient's home included more than one relative, the relative with more face-to-face contact with the patient was considered the "key" relative for further analysis.

Other factors measured to predict relapse were the following:

1. Critical attitude of the relative, measured by seven scales of the Semantic Differential (Osgood et al. 1957) grouped into three dimensions: negative evaluation, passivity, and weakness. Critical attitude was rated in a graduated three-step scale based on the negative evaluation...
and passivity scales. Details of this measure are described in a previous article (Girón and Gómez-Beneyto 1995).

2. Compliance with neuroleptic treatment, evaluated using Falloon et al. (1985) criteria monthly and prospectively over the first 9 months of followup. Compliance was considered irregular if the dose taken by the patient was less than 75 percent of the prescribed amount during 1 month or if the treatment was interrupted for 1 month or more. At the end of the 2 years, assessment was made retrospectively for the past 15 months, considering compliance irregular if the patient had failed to take medication for 4 weeks or more.

3. Positive symptoms in the last week of initial hospitalization, evaluated by means of the Spanish version of the PAS (Krawiecka et al. 1977; Pérez-Fuster et al. 1989). The sum of the hallucinations, delusions, and incoherence scales was used as a global score.

4. Negative symptoms during hospitalization, evaluated by means of the Spanish version of Andreasen's Negative Symptoms Assessment Scale (SANS; Andreasen 1982; Obiols et al. 1985). The sum of the global scores was used.

5. Premorbid social adjustment evaluated using the Premorbid Adjustment Scale of Cannon-Spoor et al. (1982), in the Spanish version by Alvarez et al. (1987). A poor adjustment rating was assigned when the score was in the lower quartile of the Premorbid Adjustment Scale score distribution.

6. Occupational and social functioning in year before the episode that led to admission were evaluated using the Strauss and Carpenter Outcome Scales (1972). Unemployment was rated as present if the patient had not been able to keep a job for more than 3 months in the past year. Social relationships were considered deficient if the frequency of social contacts with friends was less than once a month or if the patient had maintained only casual contacts.

7. Other factors registered were sex, age, marital status (married vs. unmarried), schooling (more than 7 years vs. fewer than 8 years), length of illness from onset to last admission measured in years, and number of previous psychiatric hospitalizations.

The procedure employed by Vaughn et al. (1984), along with the Spanish version of Krawiecka’s PAS, was used to identify and evaluate relapse. The severity of psychotic symptoms at discharge was compared with that at followup. Using hallucinations, delusions, and incoherence scales of the Krawiecka’s PAS, we defined two types of relapse: Type 1 is a change from total remission of psychotic symptoms at the initial discharge to presence of them at followup. Type 2 is a change from persisting symptoms at the initial discharge to a significant exacerbation at followup (Vaughn et al. 1984).

All patients were followed up monthly during the first 9 months. If relapse was suspected, a psychiatrist visited the patient at home and carried out a clinical assessment. During months 10 to 24, patients were evaluated if they were hospitalized, if they were attended by an emergency service, or if the family contacted the research team. An evaluation of all patients, including those who did not relapse, was carried out at the end of month 24.

Sample. During the intake period, 91 patients were admitted to the hospital, but 3 were excluded from the study because their initial hospital stay lasted less than 1 week. Of the 88 patients who fulfilled the selection criteria, 8 were excluded: 6 refused to take part, 1 committed suicide, and 1 was transferred to a long-stay unit. Four patients were diagnosed with schizophreniform disorder and 76 with schizophrenic disorder. The majority were male (67.5%), young (27.8 ± 7.5 years), and single (75%). Most (65%) were readmissions, and the average duration of illness was 6.9 years (standard deviation [SD] = 6.6).

The average Global Assessment Scale (Endicott et al. 1976) score on admission was 21.9 (SD = 7.1) rising to 38.0 (SD = 11.1) at the time of discharge (Wilcoxon p = 0.008). Positive psychotic symptoms measured with the PAS also improved significantly, from an average score of 8.0 (SD = 2.3) on admission to 4.9 (SD = 2.6) on discharge (Wilcoxon p = 0.000). During admission, each patient received over 400 mg per day chlorpromazine equivalent. The average hospital stay was 21.6 days (SD = 16.5).

During the 2-year followup, patients were treated by their psychiatrists, received the standard care (i.e., they were seen at monthly intervals in an outpatient clinic and treated with support and medication), and were not included in specific rehabilitation or reinsertion programs.

Key Relatives. After being discharged from the hospital, all patients lived continuously with key relatives throughout the 2-year followup. The distribution of the key relatives was 52 mothers (65%), 14 fathers (17.5%), 6 husbands (7.5%), 5 wives (6.25%), 2 siblings (2.5%), and 1 aunt (1.25%). The average age for the key relatives was 55 years (SD = 13; range 28–78). In 33 of the 49 households that had two key relatives it was possible to administer the QUEM to both. The relatives selected as key and those who were not showed a low concordance in poor empathic attitude (PEA) (intraclass correlation coefficient = 0.08), but their group means were not significantly different (Mann-Whitney U test p = 0.329).

Course and Clinical Relapse. During the 2-year followup, 43 patients (53.75%) relapsed at least once. Of these relapses, 28 were Type 1 (from complete remission
on discharge to relapse) and 15 were Type 2 (from persistent symptoms to marked clinical exacerbation). Six patients who showed severe persisting positive symptoms throughout the followup period were excluded from the analyses.

**Results**

**Relatives’ PEA and Relapse.** The QUEM was administered to 71 of the 74 key relatives. Table 1 shows the relation between the relatives’ attitudes measured by the QUEM and relapse. Hits, failures, and PEA scores are associated with the presence of relapse.

Patients living with relatives with PEA (PEA ≥ 0.50) relapsed 2.6 times more often than those living with relatives with good empathic attitude (PEA < 0.50). Sixty-seven percent (35/52) of patients living with relatives with PEA and 26.3 percent (5/19) of those living with relatives with good empathic attitude relapsed (Yates corrected chi-square test = 7.9, df = 1, p = 0.005, odds ratio [OR] = 5.8, 95% OR confidence interval = 1.8, 18.7).

Table 2 shows the relation between PEA and relapse according to face-to-face contact status. The relationship between PEA and relapse reached a statistically significant value in both high- and low-contact homes. The correlation coefficient between PEA and relapse was 0.4 in both cases.

**Other Prognostic Factors and Relapse.** Patients who relapsed show a higher unemployment rate (79.1% vs. 38.7%, Yates corrected chi-square test = 10.8, df = 1, p = 0.001), more irregular treatment compliance (76.7% vs. 51.6%, Yates corrected chi-square test = 4.0, df = 1, p = 0.045), a poorer premorbid adjustment rate (34.9% vs. 9.7%, Yates corrected chi-square test = 4.9, df = 1, p = 0.026), a higher score on negative symptoms (12.47 ± 5.64 vs. 9.68 ± 6.11, Mann-Whitney U test, p = 0.053), and a higher critical attitude rate in their relative (76.7% vs. 48.4%, Yates corrected chi-square test = 5.2, df = 1, p = 0.023). Details of this univariate analysis are described in a previous article (Girón and Gómez-Beneyto 1995).

Table 3 shows the Pearson correlation between PEA and other prognostic factors. Positive symptoms, unemployment, and lack of social contacts are associated with PEA.

**Multiple Logistic Regression Models.** Table 4 presents the result of the estimation of a logistic regression model initially containing all the variables. The forward stepwise procedure (p value to enter = 0.15; p value to remove = 0.20) selected eight variables: poor occupational functioning, poor premorbid adjustment, good level of schooling, shorter course of illness, number of previous hospitalizations, irregular compliance, critical attitude, and PEA. Using the dichotomized version of the PEA rating, their OR in the multivariable model is 6.4 (95% OR confidence interval = 1.2, 35.1).

Given that both critical attitude (CA) and PEA showed an association with relapse, a composite rating combining CA and a dichotomized version of the PEA rating, was also used. This new dimension, termed negative attitude, was rated in a graduated three-step scale:

**Table 1.** Mean (standard deviation) of Questionnaire of Empathy scores according to relapse status (Mann-Whitney U test)

<table>
<thead>
<tr>
<th>Relapse</th>
<th>Nonrelapse</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hits</td>
<td>5.35 (3.89)</td>
<td>7.16 (3.76)</td>
</tr>
<tr>
<td>Failures</td>
<td>9.95 (4.98)</td>
<td>7.13 (3.32)</td>
</tr>
<tr>
<td>Poor empathic attitude</td>
<td>0.66 (0.16)</td>
<td>0.50 (0.17)</td>
</tr>
</tbody>
</table>

**Table 2.** Mean (standard deviation) of poor empathic attitude according to face-to-face contact and relapse status (Mann-Whitney U test)

<table>
<thead>
<tr>
<th>Face-to-face contact</th>
<th>Relapse</th>
<th>Poor empathic attitude</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (≥ 35 hrs)</td>
<td>Yes</td>
<td>0.64 (0.18)</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0.48 (0.18)</td>
<td></td>
</tr>
<tr>
<td>Low (&lt; 35 hrs)</td>
<td>Yes</td>
<td>0.67 (0.15)</td>
<td>0.025</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0.54 (0.11)</td>
<td></td>
</tr>
</tbody>
</table>

**Table 3.** Pearson correlations between poor empathic attitude and other prognostic factors (n = 71)

<table>
<thead>
<tr>
<th>Poor empathic attitude</th>
<th>Critical attitude</th>
<th>Positive symptoms</th>
<th>Negative symptoms</th>
<th>Employment</th>
<th>Social contacts</th>
<th>Irregular compliance</th>
<th>Premorbid adjustment</th>
<th>Course of illness in years</th>
<th>Hospitalizations</th>
<th>Female sex</th>
<th>Age</th>
<th>Married</th>
<th>Schooling ≥ 8 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.181</td>
<td>0.260</td>
<td>0.149</td>
<td>0.305</td>
<td>-0.265</td>
<td>0.180</td>
<td>0.137</td>
<td>0.109</td>
<td>0.109</td>
<td>0.016</td>
<td>0.038</td>
<td>0.072</td>
<td>0.033</td>
</tr>
</tbody>
</table>

1p < 0.05.
2p < 0.01.
3Dichotomous variable: 0 = no, 1 = yes.
Table 4. Results of stepwise multivariate logistic regression analysis predicting relapse (n = 71)

<table>
<thead>
<tr>
<th>Step (independent) variable</th>
<th>Coefficient (standard error)</th>
<th>Odds ratios (95% confidence interval)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Poor empathic attitude, %</td>
<td>0.059 (0.023)</td>
<td>1.06 (1.02, 1.11)</td>
<td>0.009</td>
</tr>
<tr>
<td>2. Unemployment¹</td>
<td>2.562 (0.937)</td>
<td>12.97 (2.06, 81.33)</td>
<td>0.006</td>
</tr>
<tr>
<td>3. Critical attitude²</td>
<td>1.076 (0.490)</td>
<td>2.93 (1.12, 7.66)</td>
<td>0.028</td>
</tr>
<tr>
<td>4. Course of illness, yrs</td>
<td>-0.217 (0.095)</td>
<td>0.81 (0.67, 0.97)</td>
<td>0.022</td>
</tr>
<tr>
<td>5. Good schooling level¹</td>
<td>2.123 (0.914)</td>
<td>8.35 (1.40, 50.07)</td>
<td>0.020</td>
</tr>
<tr>
<td>6. Poor premorbid adjustment¹</td>
<td>1.944 (0.958)</td>
<td>6.98 (1.07, 45.86)</td>
<td>0.043</td>
</tr>
<tr>
<td>7. Irregular compliance¹</td>
<td>1.418 (0.787)</td>
<td>4.13 (0.89, 19.31)</td>
<td>0.072</td>
</tr>
<tr>
<td>8. Hospitalizations, n</td>
<td>0.171 (0.117)</td>
<td>1.19 (0.94, 1.49)</td>
<td>0.143</td>
</tr>
<tr>
<td>Constant</td>
<td>-10.363 (2.703)</td>
<td>47.0 (df = 8, p = 0.000)</td>
<td></td>
</tr>
</tbody>
</table>

Cases correctly classified, %       81.69

Note.—Dependent variable: relapse (0 = no, 1 = yes).

¹0 = no, 1 = yes.
²0 = no poor empathic attitude (PEA), no critical attitude (CA), 1 = PEA or CA, 2 = PEA and CA.

Discussion

The characteristics of the sample studied are similar to those of psychiatric patients who are admitted to short-stay units in Spain (Muñoz et al. 1988) and also to those of a Spanish sample of schizophrenia patients in a study examining the influence of expressed emotion on relapse (Montero et al. 1992). Furthermore, PAS scores at the start of followup and rate of relapse were almost identical in both samples. Therefore according to the characteristics of the sample, the ecological validity of our findings appears sound.

Table 5. Results of stepwise multivariate logistic regression analysis predicting relapse (n = 74)

<table>
<thead>
<tr>
<th>Step (independent) variable</th>
<th>Coefficient (standard error)</th>
<th>Odds ratios (95% confidence interval)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unemployment¹</td>
<td>2.978 (0.895)</td>
<td>19.65 (3.40, 113.55)</td>
<td>0.001</td>
</tr>
<tr>
<td>2. Negative attitude²</td>
<td>1.405 (0.571)</td>
<td>4.07 (1.33, 12.48)</td>
<td>0.014</td>
</tr>
<tr>
<td>3. Course of illness, yrs</td>
<td>-0.145 (0.069)</td>
<td>0.87 (0.76, 0.99)</td>
<td>0.037</td>
</tr>
<tr>
<td>4. Poor premorbid adjustment¹</td>
<td>2.215 (0.884)</td>
<td>9.16 (1.62, 51.81)</td>
<td>0.012</td>
</tr>
<tr>
<td>5. Good schooling level¹</td>
<td>1.834 (0.784)</td>
<td>6.26 (1.35, 29.10)</td>
<td>0.019</td>
</tr>
<tr>
<td>6. Irregular compliance¹</td>
<td>1.223 (0.679)</td>
<td>3.40 (0.90, 12.84)</td>
<td>0.072</td>
</tr>
<tr>
<td>Constant</td>
<td>-7.943 (2.201)</td>
<td>41.3 (df = 6, p = 0.000)</td>
<td></td>
</tr>
</tbody>
</table>

Cases correctly classified, %       81.08

Note.—Dependent variable: relapse (0 = no, 1 = yes).

¹0 = no, 1 = yes.
²0 = no poor empathic attitude (PEA), no critical attitude (CA), 1 = PEA or CA, 2 = PEA and CA.
In relation to its psychometric characteristics, the QUEM is an objective test that does not require previous training for its use and allows for quick and inexpensive administration. The QUEM has good internal consistency and good face and concurrent validity. Nevertheless, further psychometric research to establish external validity and test–retest stability should be pursued. However, the object of this psychometric analysis should not be the QUEM, which in itself is a rather straightforward questionnaire, but the whole procedure to measure PEA. The reliability and validity of PEA scoring should be the focus of future psychometric studies.

One problematic issue of PEA measurement is that in trying to control the effect of projection in the assessment of empathy, some matches caused by empathy may be missed because of their coincidence with the relative’s own rating. Nevertheless, a re-analysis of our own data shows that similar results are obtained when the relative’s own ratings are ignored, that is, when projection is not controlled for.

As we have seen, PEA presents an association with other variables related to relapse. Therefore a multivariate analysis is appropriate to estimate PEA’s independent prediction power. To this end we fitted a multivariate logistic model containing the QUEM score as well as other well-known prognostic factors. The model fits well (chi-square = 47, df = 8, p = 0.000) and correctly classifies 82 percent of the cases (see table 4). Unemployment, course of illness (years of duration), good schooling level, poor premorbid adjustment, irregular compliance, and hospitalizations are the best predictors of relapse. The results are consistent with expectations, except the positive relationship between good educational level and relapse. High self-expectations may be associated with ongoing frustration and predisposition to relapse. In any case, we do not know of any other perspective study predicting relapse that includes educational level and premorbid adjustment in a multivariate analysis. This finding therefore needs replication.

Relatives’ attitudes—PEA and critical attitude—significantly and independently predict relapse, and the power of this prediction improves when both types of attitudes are incorporated into a single rating—negative attitude. The fit of this second model is similar and requires fewer variables.

We have found the existence of a significant association between relatives’ PEA and relapse; this relationship between attitude and relapse is maintained in a statistically significant way after controlling for the effect of other prognostic factors.

The connection between relatives’ empathy and relapse in schizophrenia was introduced in the work of Leff and Vaughan (1984) on expressed emotion (EE). These authors described empathy related to low EE, although they did not specifically expand on the topic. The results of our research are in accordance with those of Kuipers et al. (1983), who showed that high-EE relatives display less active listening skills than low-EE relatives. However, our results show that PEA is related to relapse in both high and low face-to-face contact homes. If we accept that the method used to measure face-to-face contact is correct, this finding questions the existence of a direct dose–response relationship between relatives’ PEA and relapse, and, hence, the causal nature of this relationship, at least conceptualized as a face-to-face communication problem. Three alternative hypotheses could explain this link.

First, it has been suggested that inadequate empathy is the primary defect in schizophrenia and is also shown by schizoid personalities. Therefore, it should not be surprising that relatives of schizophrenia patients are low in empathy. Perhaps the link between the relatives’ attitude and relapse may be explained by a variable related to the severity of the illness and transmitted within the family. In this sense, Strauss and Carpenter (1981) have proposed an interactive development model in which the relatives’ attitudes and the patient’s dysfunctions could be related to the same genotypic vulnerability. This hypothesis could be approached by investigating if relatives with schizotypal personality disorder, a personality disorder closely related to schizophrenia and highly prevalent among relatives of schizophrenia patients (Kety et al. 1975; Kendler et al. 1981), are also lacking in empathy.

The basis for the second hypothesis centers on one of the main diagnostic cues for the diagnosis of psychosis in the old German phenomenological school—the impossibility of “empathizing” with the patient’s inner experience. In fact, psychosis was thought to be due to an interruption of the continuity of normal psychological processes. It could be argued that the positive association between PEA scores and the tendency to relapse detected in this study is not a causal one but the result of severe psychotic affective disintegration. Patients with the most severe psychosis, and hence with the worst prognosis, may be the most difficult to understand even by their relatives, either because of their profound affective disintegration or because of their inability to express themselves. Should this argument be correct, low PEA scores would not reflect true lack of empathy from the relative, and the correlation between PEA scores and the tendency to relapse could be a spurious correlation related to the severity of the psychosis. However, in this study, we did not find a significant relationship between either the patient’s QUEM score and relapse or the patient’s QUEM score and prognostic factors. In consequence, this proposition can be ruled out.
Out of these hypotheses, the relatives’ low empathic ability, the patient’s incomprehensible inner life, or both, we think that the latter may be closer to the truth and a more fruitful hypothesis to investigate further.

Finally, it may be that the relationship between empathy and relapse is genuinely non-linear. As one of our reviewers put it: “Perhaps too little or too much empathy is a problem.” Poor empathy may cause relatives to misunderstand the needs of the patient, which may in turn lead to tension and the patient’s altered behavior. On the other hand, too much empathy may induce indulgence, overprotection, and the relative’s inability to set limits, which may also lead to the patient’s altered behavior.

We believe we have opened a line of research that may contribute to knowledge on the way relatives and schizophrenia patients interact and how this interaction may influence the course of the illness. Other interesting questions, pertaining to the relationship between empathy, schizophrenia, and schizophrenia spectrum personality disorders may also be pursued now.

Our findings may also be useful in relation to therapy. The ability to be accurately attuned to the actual emotional state of the patient could restrain the tendency to overgeneralize and to make incorrect attributions of the patient’s behavior. As in psychotherapy, empathy from relatives could contribute to a facilitating climate that helps the patient lessen emotional inner conflicts and focus on problem-solving behavior. Empathy has been mentioned as a component of family intervention programs for the prevention of relapse in schizophrenia (Falloon et al. 1984; Kuipers et al. 1992). Role playing and role reversal are mentioned as useful strategies to improve empathy. However, the efficacy of these techniques has not yet been proven. To test their efficacy with relatives of schizophrenia patients, they should be adapted to take into account the severe cognitive difficulties that some patients may have in expressing and communicating overgeneralize and to make incorrect attributions of the patient’s reaction to therapist’s permissiveness. Research on empathy and relapse is genuinely non-linear. As one of our reviewers put it: “Perhaps too little or too much empathy is a problem.” Poor empathy may cause relatives to misunderstand the needs of the patient, which may in turn lead to tension and the patient’s altered behavior. On the other hand, too much empathy may induce indulgence, overprotection, and the relative’s inability to set limits, which may also lead to the patient’s altered behavior.

We believe we have opened a line of research that may contribute to knowledge on the way relatives and schizophrenia patients interact and how this interaction may influence the course of the illness. Other interesting questions, pertaining to the relationship between empathy, schizophrenia, and schizophrenia spectrum personality disorders may also be pursued now.

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References


Announcement

A farewell conference for Prof. Dr. M. Romme will be held in Maastricht, The Netherlands, January 14-15, 1999. The conference will be held in both Dutch and English and will include oral presentations, debates, and workshops in the field of Social Psychiatry.

The theme of the conference, “Coping with Psychoses, from Object to Subject,” will open on Thursday with presentations on “Worlds Apart, Possible to Surpass,” “Proper Choices, Steps to Recovery,” and “To Live with Impossible Choices.” The afternoon workshops include topics on recovery from psychoses, rehabilitation, ego-documents and bookmarks, user participation, advocacy and patient rights, self-harm, hearing voices, and networking. On Friday, there will be a presentation on “Schizophrenia, a Scientific Delusion” and a public debate that will concentrate on the question of how to stimulate, organize, and mobilize social integration of a marginalized minority into society. There will be a parallel session with rational and objective professionals on one side and clients and users on the other that will concentrate on “Changing Paradigms in the Treatment of Psychoses and User Influence.” The workshops in the afternoon include “Does the Illness Concept Have a Scientific Basis?” “Experience Sampling,” “Charities and Their Goals,” and “Children Hearing Voices.”

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