INTRODUCTORY REMARKS

Interest in the interactional styles of patients with affective disorders has been greatly stimulated by the great success of the expressed emotion research paradigm in schizophrenia. The very consistent finding that schizophrenic patients in HEE families show a higher relapse rate compared to those in LEE families (Kavanagh 1992) was connected with the vulnerability stress model of schizophrenia. Tarrier’s group (Tarrier et al. 1979) could demonstrate that psychophysiology and neuropsychology change when patients start communicating with HEE key relatives, i.e. increased affective load raises autonomic arousal beyond the vulnerability threshold and the chain basic symptoms/transitional states/manifest psychosis can be set off.

Compared to this field the expressed emotion findings in affective disorders are much more inconsistent and inconclusive. Furthermore the very elusive theoretical vulnerability-stress model cannot be transferred straightforwardly to the affective disorders. The situation is more complicated here. We are confronted with a variety of competing pathogenetic models, focusing on temperament and affect regulation, autonomic instability, cognitions, self-image and self-esteem, and deficits in social competence and social network (Mundt 1998).

Hence, apart from the expressed emotion paradigm, other methodological approaches may have contributed more to our knowledge concerning about the impact of interactional styles on the development and course of affective disorder.
We briefly go through these methodological fields and report on the main results before presenting those of our own study.

**Expressed emotion studies**

There are seven studies which included bipolar patients when using the expressed emotion paradigm. All of them used the full Camberwell Family Interview (CFI); one in addition used the abbreviated form, the Five Minute Speech Sample (FMSS). The cut-off for critical comments as the principal criterion for the determination of high expressed emotion varied between seven in the Okasha *et al.* (1994) study and two in the Priebe *et al.* (1989) and Goring *et al.* (1992) studies. Hence it is difficult to compare the prevalence of HEE families among affective disorders across the studies, since the cut-off was obviously used to gain reasonable variance between HEE and LEE families. The follow-up period covered usually 9–12 months; only the study of Greil *et al.* (1992) followed up their patients for 5 years. This study was also the largest one, including more than 100 bipolar and schizoaffective patients, whereas the others worked with small samples which restricted their statistical power considerably. Four of the six follow-up studies – one was a cross-sectional-one only – found the EE index predictive for the 9-month course, one more found the patient’s but not the partner's HEE status predictive, one found no prediction at all. The finding of Göring *et al.* (1992), that the actual partner EE was not predictive but the patient EE was, is an argument against the so-called “victimization” hypothesis of expressed emotion. The only study which found EE not predictive at all is the one with the longest follow-up. This supports a notion of many groups that the predictive power of the EE status depends on the stage of the illness when it was taken. It seems to be more influential if taken and applied at the beginning of the patient’s career rather than in residual stages of the illness. This at least has been clearly demonstrated for schizophrenia by Schulze-Mönking (1993).

To sum up the results of EE studies one may assume that, for the very short-term course, there is a trend of the EE index to be predictive for the short-term course of bipolar disorder. The inconsistencies of the results compared to those of families with schizophrenic patients are discussed in literature with regard to the following factors. The assessment instrument may play a role. The application of a full CFI gains a higher rate of high EE families than the abbreviated form of the FMSS. However, the Heidelberg group developed a more sensitive FMSS form which used the criterion of “covert criticism” which made this instrument more sensitive for high EE families (Leeb *et al.* 1993). The cut-off score for critical comments may also influence the predictive value, as well as the reliability of the