

Family Psychoeducational Support Groups in Spain: Parents' Distress and Burden at Nine-Month Follow-Up

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Forty-one mothers and twenty-seven fathers agreed to participate in a 6-week, low-cost, multiple-family psychoeducational intervention in Spain. Their knowledge acquisition, subjective distress, annoyance at patient's behavior, perception of social impact of the patient's illness, expectations about patient's recovery, and family burden were measured before and after the intervention and at 9-month follow-up. Ninety-three percent of the fathers and 78% of the mothers attended four or more classes. Although parents acquired a significant amount of knowledge about the illness, no significant score differences were found immediately after the intervention or at follow-up in the other measures. However, significant father-mother differences were revealed. Compared with mothers, fathers were more optimistic throughout the study about the outcome of the illness, became more aware of the social and financial impact of the illness on the family, and reported feeling less annoyed by the patient's behavior at follow-up. The results indicate that low-cost psychoeducational multiple family groups alone do not decrease family distress and burden. These findings also suggest that psychoeducational interventions need to consider differences in gender and family roles and underline the importance of engaging fathers in treatment.

KEY WORDS: Family psychoeducation; parent distress; burden; support groups; Spain.

INTRODUCTION

Over the last four decades, as a result of the deinstitutionalization movement and the psychopharmacological management of schizophrenia, the burden of patient care has fallen heavily on the patient's family. In the United States, between 30 and 65% of the mentally disabled live with other family members (1). In Spain, where residential care alternatives are virtually nonexistent, most discharged

psychiatric patients return to live with their families (2). The results of a European survey indicate that in Spain 84% of chronic mental patients live with their family, while the percentages for England and Sweden are 21 and 38%, respectively (3).

Living with a relative who suffers from schizophrenia can cause significant family distress (4). Caring for a mentally ill family member affects the caregiver's well-being, finances and social relationships (5). Caregivers often have difficulty understanding illness behaviors and become annoyed most frequently by the patient's negative symptoms (6). In addition, relatives may also feel overburdened by their own beliefs concerning the likelihood of improvement and the effectiveness of treatment (7).

Six of seven family psychoeducation controlled trials demonstrated that family treatment, combined with maintenance antipsychotic medications, decreased patients' relapse rates and caregivers' burden (8). These model interventions included,

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among other components, education about schizophrenia and nonblaming family therapy. The success of these intensive, long-term family interventions (weekly to biweekly sessions from 3 to 6 months and monthly sessions for an additional 6 to 9 months, with an average duration of treatment of 1 year) prompted the development of brief, low-cost multiple-family psychoeducational groups (from 1 2-hr session to 15 1.5-hr sessions, with an average of six sessions). Low-cost family interventions increased participants' knowledge about schizophrenia however, their effects on family members' distress and burden have been debated (8, 9).

A culturally adapted long-term family intervention has been utilized in China with similar results (10), yet except for our preliminary report (11), no study, to our knowledge, has investigated the impact of long-term or brief psychoeducation on family distress and burden in Spain. This is the first study to determine the effects of low-cost psychoeducation on relatives' subjective distress in Spanish culture and the only report on parents of schizophrenia patients, exclusive of other relatives. In a previous paper (11) we indicated that 41 mothers and 27 fathers agreed to participate in the intervention. This article reports the effects of the program on fathers' and mothers' knowledge acquisition of schizophrenia, subjective distress, and family burden at the 9-month follow-up visit. The research used a repeated-measures design to evaluate the relationship of participation in the intervention on parents' acquisition of knowledge about schizophrenia and perceptions of subjective distress and family burden associated with their child's illness. Effects on patients' fathers and mothers were analyzed separately.

MATERIALS AND METHODS

The study was conducted at the Hospital Clínico San Carlos de la Universidad Complutense de Madrid, Spain. Patients who met the following inclusion criteria were invited to participate in the research project: (i) age, 18 to 45; (ii) living with their parents; (iii) living within the hospital's catchment area; (iv) consecutive admissions to the inpatient unit; and (v) DSM-III-R diagnosis of schizophrenia based on personal interview using a DSM-III-R symptom checklist.

Subjects

Patients

The patient sample consisted of 30 males and 15 females with an average age of 26 years. All were single with the exception of one female who was separated from her husband and living with her parents. Although 67% had completed high school and 36% had at least a year of university education, only 7% had been employed 6 months prior to index hospitalization. Their mean age at illness onset was 20 years and they had, on average, three previous hospitalizations. Further details about the characteristics of the patient sample may be found in Table 1.

Parents

The parents of 45 patients were invited to participate in the study. Ten fathers and one mother in this group were deceased. The parents of two patients were divorced, and the fathers were absent

Table 1. Demographic Characteristics

| | Patients (%) | Mothers (%) | Fathers (%) |
|-----------------------|--------------|-------------|-------------|
| <i>n</i> | 45 (100) | 41 (60) | 27 (40) |
| Age (range) | 26 (18–44) | 58 (37–79) | 59 (44–69) |
| Male | 30 (67) | | |
| Married | | 29 (71) | 26 (96) |
| Single | 44 (98) | | |
| Separated/divorced | 1 (02) | 2 (05) | |
| Widowed | | 10 (24) | 1 (04) |
| Elementary education | 15 (33) | 32 (76) | 17 (63) |
| High school education | 30 (67) | 10 (24) | 10 (37) |
| Employed | 3 (07) | 7 (16) | 14 (52) |
| Retired | | 3 (07) | 9 (33) |

from the family. Only six fathers and three mothers refused to participate in the study. Thus 27 fathers and 41 mothers participated in the study. Further details about the characteristics of the sample may be found in Table 1.

Procedures

Patients were interviewed by members of the research team within 1 week after admission. Parents of patients who met inclusion criteria were contacted by telephone and invited to participate in the study. Parents were assessed before the psychoeducational course started, immediately upon completion of the last lecture, and at 9-month follow-up. Each parent completed a series of self-report questionnaires designed to evaluate the following parameters: knowledge acquisition, subjective distress, perceived social impact of patient's illness, annoyance with patient's behavior, and expectations about patient's recovery.

Psychoeducational Group

The psychoeducational course consisted of six weekly classes with a duration of 1.5 hr each. The target group was the patients' parents and patients did not attend the course. Other relatives, without being part of the study, were allowed to participate as parents' companions. Three courses were given during the study period, to allow a maximum of 15 sets of parents per course. The classes were held in one of the medical school classrooms adjacent to the hospital. Evening hours were chosen to allow working parents to attend.

The course was taught by a psychiatrist (J.M.C.) and a psychiatric resident (J.S.F.) as coteacher and trainee. Each class started with a didactic lecture, illustrated with slides, lasting about 45 min. This initial presentation was followed by another 45 min of led group discussion. Each lecture was preceded by a review of the material discussed in the previous class. Summaries of the lectures printed on different colored paper were distributed after the review. A programmed text (available on request) and a set of slides were developed to ensure the same content. The teachers established themselves as role models of effective communication through their clear enunciation,

good eye contact, and exposition of material in simple terms.

Measures

Knowledge Acquisition

The assessment instrument designed by McGill and collaborators (12) to measure knowledge about schizophrenia was utilized in this study. To facilitate scoring, the initial 6 open-ended questions of the original questionnaire were deleted, and only the 14 multiple-choice questions were preserved. The instrument was translated by the research team following the translation-back-translation procedure.

Subjective Distress

The somatization, obsessive-compulsive, interpersonal sensitivity, depression, and anxiety subscales of the Symptom Checklist (SCL-90) (13) were utilized to measure subjective distress.

Parents' Perceptions of the Social Impact of Patient's Illness

This consists of a 5-point four-question scale (1 = lowest/5 = highest) assessing separately parents' isolation from relatives, isolation from friends, guilt feelings, amount of leisure time, and financial hardship (11).

Parents' Annoyance with Patient's Behavior

Parents' annoyance with the patient's behavior was determined through five 4-point scales (1 = lowest/5 = highest) that separately assessed parents' understanding of the patients' behavior, shame, attribution of laziness, and perceptions of the patients' dangerousness to self or others (11). These questions are a modified version of those utilized by Smith and Birchwood (14).

Parents' Expectations about Patient's Recovery

A set of five separate questions was asked to rate parents' expectations about patient's recovery.

ery. Each question was scored on a 4-point scale (11).

Data Analysis

Since mothers and fathers may influence each other, the repeated measures were analyzed by computing differences between mothers and fathers at each time period and computing paired difference *t* tests across time periods. For comparing post-baseline and follow-up to baseline measurements, Bonferroni corrections were performed by dividing alpha by two. Pearson product-moment correlation was utilized to establish relationships between variables.

RESULTS

Course Attendance

Twenty-five of 27 (93%) fathers attended four or more psychoeducational sessions. Of the 41 mothers who initially agreed to participate in the study, 32 (78%) attended four or more sessions. Follow-up data were available on 18 fathers (67%) and 24 mothers (59%).

Knowledge Acquisition

Parents' schizophrenia knowledge scores, measured immediately after the psychoeducational intervention, differed significantly from their baseline scores ($t = 4.62$, $df = 57$, $p < 0.001$). At 9-month follow-up, both fathers' and mothers' schizophrenia knowledge scores were lower than the scores obtained at the end of the intervention but still significantly different from the preintervention scores ($t = 3.18$, $df = 37$, $p = 0.005$). Mothers' and fathers' scores did not differ significantly from each other at any time period (Table 2). Mothers' years

of education related to knowledge scores before ($r = 0.375$, $p = 0.02$) and after ($r = 0.334$, $p = 0.06$) intervention, while fathers' education did not relate to knowledge scores prior to ($r = 0.231$, $p = 0.3$) or immediately after ($r = 0.317$, $p = 0.1$) the psychoeducational course.

Subjective Distress

The psychoeducational group did not have a significant effect on any of the measures of subjective distress (all p 's > 0.10) (Table 3). However, before and after the intervention, mothers' scores were significantly higher than fathers' scores on the somatization, obsessive-compulsive, depression, and anxiety subscales of the SCL-90. At follow-up, mothers' scores remained significantly higher than fathers' scores on the obsessive-compulsive, depression, and anxiety subscales (Table 4).

Parents' Perceptions of the Social Impact of Patient's Illness

The educational intervention did not have a significant effect on parents' perceptions of the social impact of the patient's illness (all p 's > 0.10) (Table 5). Before the intervention, the fathers' mean scores (3.17 ± 2.21) were lower than the mothers' scores (3.89 ± 3.26), a nonsignificant statistical trend (Table 6).

Parents' Annoyance with Patient's Behavior

No significant change on the annoyance measure was noticed at the end of the psychoeducational course or at follow-up (all p 's > 0.10) (Table 5). Compared with mothers', fathers' annoyance decreased more from preintervention to postintervention, although this difference did not reach statistical significance ($t = 1.96$, $df = 30$, $p = 0.06$). Mothers'

Table 2. Knowledge Acquisition: Number of Subjects, Mean Scores, and Standard Deviations

| | Before | | | After | | | Follow-up | | |
|--------|----------|------|------|----------|-------|------|-----------|-------|------|
| | <i>n</i> | Mean | SD | <i>n</i> | Mean | SD | <i>n</i> | Mean | SD |
| Father | 27 | 15.9 | 7.54 | 25 | 22.4* | 7.20 | 18 | 21.4* | 6.29 |
| Mother | 39 | 16.6 | 7.03 | 32 | 23.1* | 6.82 | 24 | 18.7* | 7.43 |

* $p < 0.01$ for comparisons to baseline (before). Significance determined with respect to $\alpha = 0.05/2 = 0.025$ by a Bonferroni correction.

Table 3. Subjective Distress: Number of Subjects, Mean Scores, and Standard Deviations

| Variable | Father | | | Mother | | |
|----------------------------------|----------|------|------|----------|------|------|
| | <i>n</i> | Mean | SD | <i>n</i> | Mean | SD |
| Somatization | | | | | | |
| Before | 27 | 0.45 | 0.37 | 41 | 1.06 | 0.77 |
| After* | 25 | 0.58 | 0.52 | 32 | 1.12 | 0.65 |
| Follow-up* | 18 | 0.62 | 0.69 | 24 | 1.11 | 0.72 |
| Obsessive-compulsive | | | | | | |
| Before | 27 | 0.66 | 0.45 | 41 | 1.03 | 0.67 |
| After* | 25 | 0.65 | 0.47 | 32 | 1.08 | 0.74 |
| Follow-up* | 18 | 0.59 | 0.56 | 24 | 1.20 | 0.91 |
| Interpersonal sensitivity | | | | | | |
| Before | 27 | 0.27 | 0.25 | 41 | 0.64 | 0.61 |
| After* | 25 | 0.37 | 0.39 | 32 | 0.67 | 0.68 |
| Follow-up* | 18 | 0.32 | 0.36 | 24 | 0.78 | 0.78 |
| Depression | | | | | | |
| Before | 27 | 0.66 | 0.41 | 41 | 1.21 | 0.80 |
| After* | 25 | 0.74 | 0.46 | 32 | 1.24 | 0.72 |
| Follow-up* | 18 | 0.67 | 0.74 | 24 | 1.22 | 0.76 |
| Anxiety | | | | | | |
| Before | 27 | 0.34 | 0.32 | 41 | 0.76 | 0.71 |
| After* | 25 | 0.39 | 0.41 | 32 | 0.73 | 0.62 |
| Follow-up* | 18 | 0.29 | 0.44 | 24 | 0.73 | 0.72 |

*All *p*'s > 0.1 for comparisons to baseline (before).

Table 4. Mother–Father Differences in Subjective Distress:^a Number of Pairs, Mean Scores, Standard Deviations, *t* Values, Probabilities, and Degrees of Freedom

| Variable | <i>n</i> couples | Mean difference | SD | <i>t</i> | <i>p</i> | df |
|----------------------------------|------------------|-----------------|------|----------|----------|----|
| Somatization | | | | | | |
| Before | 25 | 0.58 | 0.69 | 4.22 | 0.001 | 24 |
| After | 23 | 0.55 | 0.79 | 3.34 | 0.005 | 22 |
| Follow-up | 14 | 0.33 | 0.90 | 1.38 | 0.2 | 13 |
| Obsessive-compulsive | | | | | | |
| Before | 25 | 0.39 | 0.85 | 2.30 | 0.05 | 24 |
| After | 23 | 0.45 | 0.88 | 2.46 | 0.05 | 22 |
| Follow-up | 14 | 0.71 | 0.87 | 3.02 | 0.01 | 13 |
| Interpersonal sensitivity | | | | | | |
| Before | 25 | 0.32 | 0.70 | 2.41 | 0.05 | 24 |
| After | 23 | 0.28 | 0.76 | 1.76 | 0.1 | 22 |
| Follow-up | 14 | 0.32 | 0.70 | 1.69 | 0.1 | 13 |
| Depression | | | | | | |
| Before | 25 | 0.49 | 0.72 | 3.36 | 0.005 | 24 |
| After | 22 | 0.56 | 0.78 | 3.37 | 0.005 | 21 |
| Follow-up | 14 | 0.53 | 0.74 | 2.67 | 0.02 | 13 |
| Anxiety | | | | | | |
| Before | 25 | 0.36 | 0.70 | 2.58 | 0.05 | 24 |
| After | 23 | 0.36 | 0.57 | 3.03 | 0.01 | 22 |
| Follow-up | 14 | 0.38 | 0.64 | 2.20 | 0.05 | 13 |

^aPaired comparisons of mean differences between mothers' and fathers' scores before and after a 6-week psychoeducational course and at 9-month follow-up.

Table 5. Family Burden Measures: Number of Subjects, Mean Scores, and Standard Deviations

| Variable | Father | | | Mother | | |
|----------------------------------|----------|-------|------|----------|------|------|
| | <i>n</i> | Mean | SD | <i>n</i> | Mean | SD |
| Social impact | | | | | | |
| Before | 23 | 3.17 | 2.21 | 28 | 3.89 | 3.26 |
| After* | 23 | 3.00 | 2.04 | 31 | 3.71 | 2.60 |
| Follow-up* | 17 | 3.47 | 2.76 | 21 | 4.00 | 2.95 |
| Behavioral annoyance | | | | | | |
| Before | 23 | 6.22 | 2.49 | 30 | 5.70 | 2.59 |
| After* | 23 | 4.65 | 2.12 | 32 | 5.59 | 2.37 |
| Follow-up* | 17 | 5.06 | 2.22 | 21 | 6.04 | 2.60 |
| Recovery expectations | | | | | | |
| Before | 26 | 8.38 | 2.79 | 39 | 7.33 | 2.78 |
| After* | 25 | 8.40 | 2.25 | 31 | 7.68 | 2.02 |
| Follow-up* | 18 | 8.78 | 1.86 | 22 | 7.95 | 2.79 |
| Family burden^a | | | | | | |
| Before | 26 | 0.65 | 4.60 | 37 | 2.97 | 5.45 |
| After* | 25 | -0.80 | 4.12 | 31 | 1.64 | 5.04 |
| Follow-up* | 18 | -0.33 | 5.03 | 22 | 1.82 | 6.46 |

^aFamily burden is a combined measure of social impact, behavioral annoyance, and recovery expectations. For details refer to text.

*All *p*'s > 0.1 for comparisons to baseline (before)

Table 6. Mother-Father Differences in Family Burden Measures:^a Number of Pairs, Mean Scores, Standard Deviations, *t* Values, Probabilities, and Degrees of Freedom

| Variable | <i>n</i> couples | Mean difference | SD | <i>t</i> | <i>p</i> | df |
|------------------------------|------------------|-----------------|------|----------|----------|----|
| Social impact | | | | | | |
| Before | 21 | 1.57 | 3.53 | 2.04 | 0.06 | 20 |
| After | 19 | 0.84 | 2.34 | 1.57 | 0.13 | 18 |
| Follow-up | 13 | 0.31 | 2.36 | 0.47 | 0.65 | 12 |
| Behavioral annoyance | | | | | | |
| Before | 23 | 0.34 | 3.61 | 0.46 | 0.65 | 22 |
| After | 20 | 1.10 | 3.49 | 1.41 | 0.18 | 19 |
| Follow-up | 13 | 2.15 | 2.38 | 3.27 | 0.01 | 12 |
| Recovery expectations | | | | | | |
| Before | 22 | 0.50 | 1.71 | 1.37 | 0.19 | 21 |
| After | 18 | 0.61 | 2.38 | 1.09 | 0.29 | 17 |
| Follow-up | 13 | 0.85 | 2.38 | 1.28 | 0.22 | 12 |
| Family burden | | | | | | |
| Before | 20 | 2.15 | 6.04 | 1.59 | 0.13 | 19 |
| After | 18 | 2.78 | 6.34 | 1.86 | 0.08 | 17 |
| Follow-up | 13 | 3.31 | 4.17 | 2.86 | 0.01 | 12 |

^aPaired comparisons of mean differences between mothers' and fathers' scores before and after a 6-week psychoeducational course, and at 9-month follow-up.

annoyance score was higher at follow-up (6.04 ± 2.60) than at baseline (5.70 ± 2.59), while fathers' average score was lower at follow-up (5.06 ± 2.22)

than at baseline (6.22 ± 2.49). At follow-up fathers' annoyance scores were significantly lower than mothers' scores (Table 6).

Parents' Expectations about Patient's Recovery

Mothers' and fathers' mean recovery expectations scores increased from baseline to postintervention and from postintervention to follow-up, however, these changes did not reach statistical significance (all p 's > 0.10). Although no significant differences were found between mothers' and fathers' mean scores (Table 6), mothers' mean recovery expectations score were consistently lower than fathers' at baseline, at course termination, and at follow-up (Table 5).

Parents' Perception of Family Burden

Correlation analyses, for both mothers and fathers, revealed a positive association between social impact and annoyance ($r = 0.311, p < 0.001$), a negative association between social impact and recovery expectations ($r = 0.255, p < 0.001$), and a negative association between annoyance and recovery expectations ($r = 0.145, p = 0.06$). A single measure of family burden was derived from scores on the measures of social impact, annoyance and expectations about recovery. The psychoeducational family group did not have a significant effect on this measure at course termination or at follow-up (all p 's > 0.10) (Table 5). Length of patient's illness was associated with mothers' perception of burden before ($r = 0.412, p = 0.01$) and after ($r = 0.550, p = 0.002$) the intervention, but not at follow-up ($t = 0.273, p = 0.2$). However, length of patient's illness was not associated with fathers' perception of burden preintervention ($r = 0.003, p = 0.98$), postintervention ($r = 0.300, p = 0.2$), or at follow-up ($r = 0.131, p = 0.6$). A trend at postintervention indicating that mothers perceived a higher level of burden compared with fathers became statistically significant at follow-up (Table 6).

DISCUSSION

Low-cost psychoeducational programs have been used in the United States, Canada, and Great Britain to decrease the family burden experienced by the relatives of psychotic patients. Given the centrality of the family among Spaniards, the adolescents' late age of emancipation (15), and the high percentage of schizophrenic patients who live with their families of origin (Confederación de Familiares

y Enfermos Mentales, 1995), family psychoeducation may play a highly important role in the treatment of schizophrenia and in the development of family support programs. This study was designed to examine the effects of a psychoeducational intervention on the parents of patients with schizophrenia in Spain and to investigate possible differences between fathers and mothers.

Knowledge Acquisition

That parents significantly increased their knowledge about schizophrenia immediately after the intervention and at the 9-month follow-up is not surprising. With the exception of Cozolino *et al.*'s study (16), all other cited investigators have reported a gain in relatives' schizophrenia knowledge following the educational course.

Subjective Distress and Burden

The lack of impact of this low-cost psychoeducational intervention study on parents' subjective distress and burden appears to agree with the conclusion reached by Lam (8) in his review of the relevant literature. Two low-cost multiple-family psychoeducational approaches, by Smith and Birchwood (14) and Abramowitz and Coursey (17), have reported a reduction in relatives' distress and burden, while Cozolino *et al.* (16) and Posner *et al.* (9) failed to find significant changes. On the other hand, the inability of this treatment to decrease family burden among Spaniards could be related to the lack of cultural adaptation of the intervention, since at least two similar studies have reported positive results (14, 17).

It is also possible that parents of schizophrenia patients in Spain, compared with their counterparts in Anglosaxon societies, perceive lower levels of distress and burden secondary to caring for their mentally ill child, allowing no room for significant change. The apparent lower prevalence of high expressed emotion found among families of schizophrenia patients in Spanish studies (18–20), compared with similar studies among Anglo families seem to corroborate this impression. From a different perspective, families of Spanish background in the United States place a high value on providing care to an ill family member (21). Thus, culturally patterned parental expectations may encourage de-

nial of distress and burden, thus allowing parents to focus better on their caregiving role.

Mother-Father Differences

A comparison of fathers' and mothers' participation reveals that a larger percentage of fathers attended four or more psychoeducational sessions. Fathers' high degree of participation is especially notable compared to fathers' low enrollment in other psychoeducational programs. Fathers' participation in psychoeducational programs, if reported, has been minimal. While women comprised 67 and 83% of the experimental and control group samples, respectively, in the Abramowitz and Coursey study (17), only three fathers participated in Cozolino's research (16). In contrast, in our study 25 of the 27 fathers enrolled attended more than four classes. Fathers' high attendance rate in this study may be explained by their adherence to the traditional functions of husband and father in Spanish society, which include protecting and providing for one's family (22). Other possible explanations for this finding include the increased availability of the retired and unemployed fathers and the influence that high-status physician presenters may have had on fathers' participation.

Mothers report significantly more subjective distress than fathers at baseline, immediately after the intervention, and at follow-up. The significant differences in subjective distress found between mothers and fathers, although not unexpected, are noteworthy. Gender differences in subjective distress have been found in patient and nonpatient populations in the United States (23). Though not reaching statistical significance, mothers perceive a greater degree of social impact from the patient's illness than fathers. This could be related to the mothers' higher degree of involvement in the care of their mentally ill children.

Mothers' level of annoyance is significantly higher than fathers' at follow-up. In addition, mothers' annoyance scores increase from baseline to follow-up, while fathers' scores decrease, although these changes do not reach statistical significance. Mothers' expectations about recovery are lower than fathers at all three times measured, but the differences do not reach statistical significance. Moreover, mothers' perceived family burden at follow-up is significantly higher than fathers' burden. These findings suggest that the psychoeducational intervention

affects fathers and mothers differently. The association between length of patient's illness and perception of burden found for mothers and not for fathers may be related to mothers' higher degree of contact with the patient, probably dictated by culturally established differences in familial roles. That this association between length of illness and mothers' burden is not found at follow-up suggests that psychoeducation may have increased mothers' acceptance of the chronicity of the illness.

Limitations of the Study

Nine (24%) of 38 patients who completed the study were hospitalized during the 9-month follow-up period, however, readmissions were not associated with family distress and burden in this sample. The lack of a control group in the study may raise some questions about the validity and generalizability of the findings. In analyses of differences among preintervention, postintervention, and follow-up measures, parents served as their own controls. Changes in the measured variables could have occurred spontaneously due to the time elapsed between pre- and posttest. Since the duration of the educational course was only six weeks, it is hard to conceive that significant score changes could have occurred during that time period. Answering the questionnaires at baseline may have influenced subjects' scores postintervention but may have little effect on the 9-month follow-up scores.

Practical Implications

Psychoeducational multiple-family groups are well accepted by parents of schizophrenia patients in Spain. Spanish fathers may be more amenable to participate in psychoeducational interventions compared with fathers of schizophrenia patients from samples taken in the United States, Canada, and Great Britain. However, this psychoeducational intervention did not significantly decrease family distress and burden, suggesting that low-cost psychoeducational multiple-family groups alone do not decrease family distress and burden. Alternatively, this finding may suggest that culturally adaptive interventions need to be developed to decrease the burden of Spanish families, since two low-cost family interventions among Anglos (14, 17) did demonstrate a positive effect. Regardless of overall effi-

cacy, further studies addressing specific aspects of family burden should be pursued.

These findings also suggest that psychoeducational interventions need to consider differences in gender and family roles and underline the importance of engaging fathers in treatment. Furthermore, the significant father/mother differences can be utilized to positively affect outcomes of mothers when joint therapies are pursued, since including fathers in the intervention may balance out mothers' overwhelming feelings of distress and burden. The applicability of these findings to Hispanic minority groups in the United States, who may adhere to similar cultural values and family patterns, needs to be explored.

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