Family Psychoeducation for Latino Populations with Mental Illness Living in the United States

Mary Sauceda

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University of Medicine and Dentistry of New Jersey

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Dr. Craig Scanlan – Instructor

Dr. Amy Spagnolo – Advisor
Family Psychoeducation is considered an Evidence Based Practice (EBP) that produces positive outcomes for families and their loved ones with mental illness. (Pratt, Gill, Barrett & Roberts, 2007). Despite its benefits, only a small percentage (9.6%) receives these services (Torrey & Gorman, 2005). For Spanish speaking Latinos living in the United States these services are even more limited due to cultural barriers and because most of the mental health services are delivered in the English language (Lopez, Lara, Kopelowicz, Foncerrada & Aguilera, 2009; Weisman, 2005).

There are different models of Family Psychoeducation. Most of the modalities of Family Psychoeducation aim to provide education and support to family members and caretakers of persons with mental illness (Bertrando 2006; Glynn, Cohen & Noosha, 2007; Murray & Dixon, 2005; Pratt et al., 2007). The main interventions include mental illness education, problem solving, stress reduction, long-term services, and family and consumer involvement (Murray & Dixon, 2005; Pratt et al., 2007; Valencia, Rascon, Juarez, Escamilla, Saracco, et al., 2010). These interventions, when added to pharmacological treatment, have shown positive outcomes such as reduction in relapse, decrease in hospitalization, improvement of family understanding of mental illness and its management, improvement of problem solving, decrease in stress level, and family recovery. (Murray & Dixon, 2005; Pratt et al., 2007; Valencia et al., 2010). These outcomes have a threefold benefit; the ill person gains stability, the caretaker’s burden is decreased, and the mental health system reduces costs as a result of less hospitalizations (Gutierrez, Caqueo & Ferrer, 2009; Murray & Dixon, 2005; Pratt et al., 2007).
The Family Psychoeducation EBP has been implemented in foreign countries such as China, Spain, Scandinavia, Britain and Latin America; all of them showing positive outcomes (Gutierrez, et al., 2009; Murray & Dixon, 2005; Valencia et al., 2010). Family Psychoeducation has also been tried among Hispanics in the United States (Breitborde, Kopelowicz, Zarate, Gonzalez, Mintz & Liberman, 2003; Lopez & Kopelowicz, 2010; Lopez et al.; Magana, Ramirez, Hernandez & Cortez, 2007; Murray & Dixon, 2005). However, the research studies conducted are very limited (Magana et al., 2007).

Latinos, also called Hispanics, form the largest minority group living in the United States. They are estimated to be approximately forty seven million persons, which is more than 15% of the country’s population (Census, 2007-2009; Weisman, 2005). In addition to speaking the Spanish language, Latinos have specific cultural characteristics that impact the way mental illness is perceived and care for. An important cultural feature is that family members are expected to take care of their loved ones with diseases or disabilities; therefore they have the ill person living in the same household (Breitborde et al., 2003; Kopelowicz, Zarate, Gonzalez, Mintz & Liberman, 2003; Lefley, 2000; Magana, Ramirez, Hernandez & Cortez, 2007). Also, Latinos have lower levels of Expressed Emotion and seem more accepting of the loved ones with mental illness (Valencia et al., 2010; Weisman, 2005). Yet another characteristic is that among Latinos, confidentiality is not as important as in other cultures; consequently family matters related to mental illness can be discussed openly (Valencia et al., 2010). Additionally, among Latino immigrants, the level of integration into the American culture or the length of time they have been living in the United States has an effect on how they seek mental health services (Lopez et al., 2009; Murray & Dixon, 2005).
In order to provide culturally competent services for Latinos/Hispanics, all of the above noted features have to be taken into account. Besides these features, it is also recommended that the service providers are bilingual/bicultural (English and Spanish) to be able to offer a choice of language. They should be able to deliver at elementary school level language as well. These aspects are important because Latino immigrants have different levels of language acquisition, acculturation, and literacy. (Breitborde et al. 2010; Kopelowicz, et al., 2003; Lopez et al., 2009; Magana et al., 2007). Moreover, the service providers should be trained to use an informal, interpersonal style of communication, have familiar conversations during encounters, and share food (Kopelowicz et al., 2003, Lopez et al., 2009).

Although existing practice guidelines specify the inclusion of minorities, families and caregivers in the provision of mental health services (APA, 2004), family psychoeducation interventions are not regularly offered to Latinos in a culturally sensitive fashion including services in Spanish (Weisman, 2005). Nevertheless, in recognition that language and cultural background are barriers for persons with mental illness to have access to services (Torrey & Gorman, 2005), there have been some attempts to offer family psychoeducation interventions to minority populations living in the Unites States (Murray & Dixon, 2005). The present literature review seeks to look at studies done to evaluate the application of family interventions among Latinos in order to answer this question: Do Latino Spanish speaking families of persons with severe and persistent mental illness have a decrease in the Family Concerns Score and decrease in consumer relapse when Family Psychoeducation EBP is delivered in the Spanish language and in the Latino culture sensitive fashion? The results reported by the reviewed studies are grouped in three categories: First, the effect on the families and the Family Concerns Score
measure; second, the effect on the persons with mental illness (consumers), and third, outcomes related to the issue of Expressed Emotion.

Methods

The literature search was done using several electronic databases. First, the Cochrane Library and TRIP Database were accessed to investigate if there was any Evidence-Based review. Several Family Psychoeducation reviews were found, the most relevant were New Challenges in family interventions for schizophrenia (Glynn, Cohen and Noosha, 2007), and Family Interventions for Bipolar Disorder (Justo, Soares and Calil, 2007). However, there were no reviews that addressed Family Psychoeducation for Hispanic/Latinos. Second, Evidence-Based Clinical Trials were sought at the Cochrane Library and TRIP Database. As a result five studies were found but only two of them were available in full text (Kopelowicz et al., 2003; Gutierrez et al., 2009). Copies of the other three were ordered. Third, the National Guideline Clearinghouse was accessed. Four guidelines for Psychoeducation practice were found, however, none of them related to Spanish/Latino populations; nevertheless some stated the importance of including minorities and families/caretakers in the interventions (APA, 2004). Fourth, an original (primary) articles research search was done using Ovid and Medline (PsycINFO) and applying the inclusion/exclusion criteria (Table 1).

Table 1

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<tr>
<th>Criteria for Latino/Hispanic Family Psychoeducation Primary Literature Search</th>
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<td>Criteria</td>
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Severe and persistent mental illnesses (Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder)

Families/caregiver with adult loved one with mental illness (18 years or older)

Latino- Spanish speaking families

Cultural and ethnic considerations related to families of persons with mental illness

Psychoeducation/skills interventions

Caregiver burden

Languages: English and Spanish

Studies done in the United States and/or internationally

Exclusion

Organic Brain Disorders (i.e. Dementia)

Families/Caregivers with children less than 18 years old

Families that are not of Latino-Spanish speaking origin

Cultural considerations not related to families of persons with mental illness

Mental Health in Latinos not related to family/caregiving

The words used in the search were: Mental disorders, psychoeducation, family therapy, group psychotherapy, psychosocial care, health education, Latin, Hispanic Americans, relative, caregiver, family health, caregiver burden, community mental health services, disease management, quality of life, schizophrenia, bipolar disorder, Expressed Emotion, adult, humans. These words were mapped into the subject headings with the purpose of finding all possible key words. In order to connect the clinical terms with Hispanic/Latino ethnicities and with adult
Family members, the Boolean language AND/OR was used. A first search was not productive, and a second search in the PsycINFO Database produced twenty primary articles related to Family Psychoeducation for Hispanic/Latinos. However, most of them were eliminated because they did not meet the inclusion criteria. The search resulted in only six original articles, three of them being RCTs (Table 2). The reference lists from the pertinent articles were reviewed as a snowball activity. Relevant citations were obtained and some articles from journals and books were obtained for background and support information. However, there were no more primary source RCTs available in full text.

Table 2

<p>| Search History for Latino/Hispanic Family Psychoeducation Literature Search |</p>
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<th>Type of filter</th>
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<td>Adults with Mental illness</td>
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**Review of Literature**

The literature reviewed evaluated different aspects of the family experience and Family Psychoeducation interventions among Latino populations with mental illness. Gutierrez et al. (2009) and Magana et al. (2007) studied the impact on the family, and Valencia et al. (2010)
evaluated the effects on the persons with mental illness (the consumer), while and Kopelowicz et al. (2003) researched both. The issue of Expressed Emotion was examined by Breitborde et al. (2010) and Valencia et al. (2010). Lopez et al. (2009) introduced an innovative educational instrument to teach Family Psychoeducation. Four of the studies were done among Latinos living in the United States (Breitborde et al., 2010; Kopelowicz et al., 2003; Lopez et al., 2009; Magana et al., 2007) and two were done in Latin American countries (Gutierrez, et al., 2009; Valencia et al., 2010). All of them were done in the Spanish language and delivered in a culturally sensitive fashion. Nevertheless, the studies done in the United States offered the persons and their families to choose the language because some Latinos growing up in the United States do not have good command of the Spanish language (Breitborde et al. 2010; Kopelowicz, et al., 2003; Lopez et al., 2009; Magana et al., 2007).

Effect of Family Psychoeducation Interventions on the Family

Having a loved one with a mental illness brings concerns and difficulties for the family. The families have to deal with their own preconceptions about mental illness, the burden of caring for a disabled member, the added stress, communication problems, and financial constrains. All these factors can have a detrimental effect on the caretaker’s physical and mental health (Pratt et al., 2007; Lefley, 2007). The impact on the family can be stronger among Latinos because of the cultural conceptions and barriers. The family is expected to take care of disabled members while access to services is limited by the language and the lack of culturally competent services (Weisman, 2005). Previous studies have demonstrated relative benefits of Family Psychoeducation interventions for the family but very few of them have included Hispanic minorities (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006). In
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a research review of six Psychoeducational Multifamily Groups studies, SAMHSA (2006) reported that only two studies included Hispanics, which had a representation of 4.7 and 5.9% of the sample. The literature review done found five studies (Breitborde et al., 2010; Gutierrez et al. 2009; Kopelowicz et al., 2003; Lopez et al., 2009; Magana et al., 2007) that discuss how the Latino family is affected by mental illness and the impact of culturally competent family interventions on them. The Gutierrez et al. study was done in Arica, Chile, and the others were done in the United States.

Gutierrez et al. did a RCT in Chile in which the experimental group participated in an 18-week multifamily psychoeducational program. The goal of the intervention was to change the attitudes and health perceptions of the caregivers of persons with mental illness. The psychoeducation program had 5 modules: (1) The family experience of schizophrenia, (2) Psychoeducation, (3) Skills to improve communication, (4) Relatives’ self-care, and (5) Evaluation of the intervention. Assessments were done before and after the intervention using standardized questionnaires that were translated to Spanish and adjusted to the Latino culture. The questionnaires evaluated three components of attitudes: cognitive, behavioral, and affective. In addition, another questionnaire evaluated the general health. The control group received standard treatment consisting of monthly appointments with a psychiatric nurse. The participants were 41 family members/caregivers of persons with schizophrenia that receive health services at a community clinic. Along with the family/caregivers, their respective loved ones were included in the study. The outcomes reported that the experimental group showed lower scores (meaning improvement) on the attitude questionnaire after the intervention (83.9, SD 10.2) compared with the control group (109.4, SD 13.4), p=.007; the interaction between the groups, evaluation time and the gender of the caregiver indicated that the intervention was more
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effective among females caregivers (F= 4.703, p=.037); the experimental group showed improvement on the behavioral component (F=8.80; p=.005), in the cognitive component (F=12.99, p=.001), and in the affective component (F=3.59, p=.06), compared with the control group which did not show improvement in any. There was no effect on the caretaker perception of general health as the difference in scores were not statistically significant (p=.116). This study’s strength consists of it being a RCT in which standardized questionnaires were used, and several statistic tests were applied including repeated measures designs, between and within subject factor, and ANOVA. The weaknesses of the study are notable for being a small sample, the CI was not reported, the blinding was not addressed, neither the impact of attrition. The intervention period was short, and multiple biases are a concern including instrument, insensitive measure, expectation and attention bias. This study has low internal and external validity which limits its applicability to practice and comparison with other researches. However, it represents an effort to learn about family interventions done in a Latin country and it is worth replication with an improved design.

Magana et al., 2007 did an observational study in which they examined the relationship between caregivers’ mental health and perceived burden and stigma. The participants were 85 “dyads” (p.379) of Latinos composed by the caregiver and the ill family member. The ill person had either schizophrenia or schizoaffective disorder receiving treatment either at an outpatient community mental health center in El Paso, Texas (N-45) or in Milwaukee, Wisconsin (N-27). The caregivers had a mean age of 55.1 SD 13.3 with 85% female. The patients had a mean age of 38.9 SD 11.5 and 75% were male. The outcome reported that psychiatric symptoms, stigma and burden were significantly related to depressive symptoms suffered by the caregiver. The strengths of this study include that it was an observational study that offered direct data from the
participants, and used standardized tests that are available in the Spanish language. However, there are concerns of volunteer bias as the participants may not be representative of the population. Therefore, practical application is not advisable. Yet, if replicated with a more controlled design it can be valuable in learning how the family is affected emotionally by the burden of caring for someone with mental illness.

Kopelowicz et al. included in their study an evaluation of the caregiver burden but did not find pre-post differences. They attribute this finding to limitations on the design, consequently no extrapolations can be made base on this section of their study. Additionally, Breitborde et al. did an observational study and included the aspect of the physical health status of the caregivers. They found that the caregivers and ill relative were in poor health compared with the overall population of the United States even before the study: 26th percentile for mental health, 19th percentile for physical health, and 21st for general health. While this observation is important, it is not conclusive at whether the poor health is related to having a mental illness or caring for someone with mental illness.

Lopez et al. conducted a pre-post test study to validate an innovative family psychoeducational instrument: a 35-minutes psychoeducational program presented to community residents. The program had the goal of increasing Spanish-speaking persons’ literacy of psychosis. The program called “La CLAve” was delivered in the Spanish language with typical Latino cultural features. It had 4 components: (1) Knowledge of psychosis, (2) Efficacy beliefs that one can identify psychosis in others, (3) Attributions to mental health, and (4) Professional help-seeking. A pre-test was done before the intervention and a post-test after. A follow-up was done 3 weeks later in which another test was done to evaluate the gains. The participants were 95 Spanish-speaking subjects, out of which 38 (experimental group) were caregivers of persons
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with schizophrenia or schizoaffective disorder from a heavily Latino populated area in Los Angeles, California, and 57 were community residents (control group). The community residents had a mean age of 36.54 years (SD 10.65), a mean of 8.8 years of education, 59% unemployed, 95% female; they were selected from two parenting classes at local schools, and from a health fair at a local church. The caregivers had a mean age of 49.92 years (SD 12.21), a mean of 7.6 years of education, 50% unemployed, 61% female; they were recruited from an ongoing multifamily group study from three local outpatient psychiatric clinics. The outcomes included an increase of the family members’ perception that they can identify mental illness but the training did not increase the caregivers’ illness attributions or help-seeking. The strengths of this study include that multiple appropriate statistical analyses was done, along with follow-up, and that it introduces a novel, non-traditional tool for psychoeducation. The weaknesses were the caregivers’ group was smaller than the control, there were important differences between the two groups in age and gender, and the program and the evaluation involved reading and writing skills that may have not matched the literacy level of the subjects. Additionally the Confidence Interval and Beta were not reported, and there are concerns for Selection, Instrument, Expectation, Memory, Co-Intervention Biases as well as Hawthorne Effect. The study lacks internal and external validity. Therefore it is not advisable to extrapolate the results. However, it would be good to continue the validation of the educational instrument as it is culturally competent.

The five studies reviewed touch on significant concerns for caretakers. They also provide important observations that come from primary sources. However, due to the limitations of these studies, no conclusions can be inferred for practical purposes. It is advisable to encourage further research on this area among Hispanics.
The Family Concerns Score is an instrument used in Family Psychoeducation programs in New Jersey to evaluate the family burden related to caring for a loved one with mental illness. The above mentioned factors (preconceptions about mental illness, burden of caring for a disabled member, added stress, communication problems, and financial constrains) are measured with a questionnaire that is applied pre-intervention and then periodically to monitor the impact of the services provided (Intensive Family Support Services [IFSS], n.d.).

The literature reviewed revealed that each of the five studies used different types of scales and measures to evaluate family burden. All of them claimed having more than adequate internal consistency and validity when used among Latino populations. Breitborde et al. (2003) used the RAND-36 Item Health Survey to evaluate physical, mental and general health. Gutierrez et al. (2009) developed their own questionnaire based on several known instruments and added their new questions to evaluate culturally appropriate family attitudes and opinions; they also used the SF-36 General Health Questionnaire to evaluate the physical and mental health. Kopelowicz et al. used the Family Burden Interview Scale. Lopez et al. created several instruments that were specific to evaluate their educational product. Magana et al. used the Zarit Burden Scale. Out of the above mentioned instruments, the one used by Kopelowicz et al. is the closest to the one used in the programs in New Jersey. Even so, not having a unified scale along with weak research designs makes it difficult to evaluate the results and points out to the need for systematization of family services for Hispanics.

Effects of Family Psychoeducation Interventions on the Consumer

Previous studies done across different cultures have demonstrated that Family Psychoeducation interventions, when added to pharmacotherapy, result in positive outcomes for
consumers (NAMI Multicultural Action Center, 2008). These outcomes are decrease in relapse, decrease hospitalizations, and increasing adherence to treatment (Glynn et al., 2007; Murray & Dixon, 2005; Pratt et al., 2007). The literature review generated two studies; one by Valencia et al. (2010) and one by Kopelowicz et al. (2003) which had findings consistent with previous research. These two studies were done with Latino consumers and their families or caretakers. The Valencia study was done in Mexico City and the Kopelowicz’s was done in Los Angeles, California.

Valencia et al. did a Level I RCT with 107 subjects with schizophrenia and their caretakers. The interventions consisted of psychosocial skills training with family psychoeducation, in addition to customary care given during 12 months. The interventions were delivered in the Spanish language and in the Latino cultural fashion. The customary care consisted of 20-minute monthly appointments for pharmacotherapy. The results showed statistically significant (p< .05) positive outcomes for the consumers in that there was 12.8% relapse on the experimental group compared with 33.3% on the control group; 2.1% of the experimental group was re-hospitalized compared with 14% of the control group. Adherence with medication was 91.5% for the experimental group and 77.8% for the control group. Adherence to scheduled appointments was 82.5% in the experimental group and 70% in the control group. This study had strong internal validity because blinding was carefully maintained, the groups were well randomized even after attrition, statistical analysis made utilizing a variety of appropriate tests, including independent chi square to compare groups for demographics, Student t tests to verify there were no differences in groups at baseline, ANOVA for pre-post difference within and between groups, and Cohen’s d for effect sizes. However, this study did not report the Confidence Interval (CI) and Volunteer and Attention Bias could be concerns.
Another important consideration is that in this study, there was no separation between the several psychosocial interventions and the family interventions. Therefore, the impact of the family psychoeducation alone cannot be evaluated.

Kopelowicz et al. did a Level II RCT with 92 Latino subjects with schizophrenia spectrum disorders and their respective family/caretaker. In addition to receiving the standard care at a community mental health center, the subjects participated in skills training group sessions for 90 minutes, four times a week during 3 months. They were trained on Medication Management and on Symptom Management. The family/caretakers were trained as coaches for their ill family member. They were also informed about the skills the subjects were learning. The training was done in the Spanish language and in a culturally sensitive manner. Assessments were done at baseline, at the end of the intervention (3 months) and at 6 month follow-up. The comparison group received standard care only. The outcomes showed that the experimental group had notable improvement in their Medication Management skills through the 9 month follow up \(F=46.38, \text{df}=1, 81, p<.0001\); the experimental group also showed improvement in Symptom Management; and the re-hospitalization rate among the experimental group was lower (5.1%) than control group (22.2%). The strengths of this study consist of being a RCT in which Randomization and blindness were carefully maintained. Also attrition was counted for and follow-up was done. The study was weak in that the CI and Beta were not reported, it was a small sample, and there are concerns of Volunteer and Attention bias. This study has the advantage that the outcomes are more related to the family interventions; however, the internal and external validity is not as strong as the Valencia et al. study.

Despite the limitations of these two studies, they offer a glimpse into the possibility that family interventions can be beneficial for Latinos with mental illness. The benefits for consumers
overflow to the families/caretakers and to the mental health system, as a better control of symptoms reduces the family burden and the cost of hospitalizations. The review of these articles makes evident the need for more research that directly correlates the family interventions with the consumer outcomes.

Expressed Emotion

Expressed Emotion (EE) refers to the way the family communicates with their loved ones with mental illness. The family members who express criticism, hostility and are over-involved in the care of the ill person are considered having high EE. Those who express acceptance and understanding have low EE (Glynn et al., 2007; Murray & Dixon, 2005; Weisman, 2005). Previous research indicates that high EE contributes to relapse of symptoms and rehospitalization of persons with mental illness (Glynn et al., 2007; Murray & Dixon, 2005; Weisman 2005). These researchers explain that there are EE variations among cultures. They have noticed that Latino families tend to have low EE as they are more accepting of their loved one’s disease (Glynn et al., 2007; Weisman, 2005). The literature review done resulted in only one original research study of EE among Mexican-Americans done by Breitborde et al. (2010).

Breitborde et al. conducted an Observational study. They used sixty subjects with schizophrenia or schizophrenia related disorders and their respective sixty caregivers living in California. Part of the research was to investigate the relationship between caregivers’ expressed Emotion (EE) and the mental health of the consumer and the caregiver. The assessment was done at baseline and 12.7 months later. The outcomes showed that Higher Emotional Overinvolvement (a subset of EE) at baseline was correlated with worsening in mental health at follow-up (B=-2.06, p-rep=.91, p=.03). This study’s strengths were that it was an Observational
Study that produced direct observation data, and that made use of standardized tests available in Spanish to do the evaluations. The weaknesses were that the sample size was relatively small, there was high attrition that required statistical adjustments, due to the attrition, the subjects that remained in the study are more stable and may have not be representative of the population. Also Non responders’ bias and withdrawal bias are concerns because the subjects that left the study might be representative of a population with high EE. The findings of this study are consistent with previous studies which show a connection between high EE and worsening of psychiatric symptoms. The study also shows a relationship between EE and the caregiver’s health. However, the validity of this study is low which limits is applicability.

**Implications or Unresolved Questions**

This literature review shows there is a dearth of robust research in Family Psychoeducation for Latinos. The RCTs are scarce, and there is not a unified criterion, unified set of measures or fidelity scale to follow. There is palpable need to conduct more RCTs to evaluate specific interventions, and their short and long term impact. There is also need to explore the family burden and the role of Expressed Emotion among Latinos with mental illness and their families. Additionally, the instruments to measure family burden that have been translated into Spanish need further validation and refinement.

The studies reviewed share important features with the population I intend to investigate. They have similar cultural background, language, mental illness, and style of caretaking. Nevertheless, there are differences. These studies include mostly persons with schizophrenia while I would like to include a wider spectrum of mental illness. The studies done in Latino countries are valuable; however, they do not totally represent the population in my study which
would comprise Latinos of several nationalities who are immigrants to the United States. Additionally, they may have rural or urban background, and differing levels of education. All these aspects need to be taken into consideration when doing research with Latinos.

**Conclusions**

In looking back to the research question: *Do Latino Spanish speaking families of persons with severe and persistent mental illness have a decrease in the Family Concerns Score and decrease in consumer relapse when Family Psychoeducation EBP is delivered in the Spanish language and in the Latino culture sensitive fashion?* It becomes evident that the literature review does not answer it. Moreover, the review of these studies reveals that Family Psychoeducation is an underdeveloped intervention when it is applied to Latino populations in the United States and abroad. Nevertheless, the production of standardized instruments, materials and tests translated into the Spanish language represents progress made. Another important advance is the efforts done to adjust the interventions to the Latino/Hispanic culture.

Despite their limitations, the studies showed important lessons. First, the great need to provide psychoeducation to Latino families is evident, as the people with mental illness and caretakers are suffering physically and emotionally. Second, there were promising positive outcomes such as decrease in family burden and decrease in relapse and hospitalization of the consumer. Third, there exist some standardized instruments in Spanish that can be used to measure family burden. Most of all, they attest to the feasibility of the provision of culturally competent services for Latino minorities. This review showed a glimpse that the research question originally made could be answered in the positive because Family Psychoeducation for Latinos is a worthwhile effort.
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