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Original article

Dyadic adjustment in parents of schizophrenics

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Abstract

Objective. – To study the dyadic adjustment in couples with a schizophrenic offspring.

Method. – 140 married couples, 67 with a children with schizophrenia, and two control groups: 41 couples without pathology and 32 couples with pathology, were assessed with the Dyadic Adjustment Scale, the Beck Depression Inventory and the Self-Rating Anxiety Scale.

Results. – The couples with a schizophrenic offspring evidenced significantly worse dyadic adjustment than did the normal controls, especially low consensus and cohesion in husbands, and low cohesion and satisfaction in wives. Anxiety and depression in mothers of schizophrenics is significantly higher than in mothers of controls.

Discussion. – These findings suggest that the poor dyadic adjustment of the parents with a schizophrenic offspring could be an effect of the burden.

Conclusion. – The treatment on the schizophrenia should be supplemented by interventions aimed at parents' dyadic adjustment, and mothers' anxiety and depression, so that they can be in better conditions to help their child.

Keywords: Schizophrenia; Dyadic adjustment; Parents

1. Introduction

The poor dyadic adjustment in parents of children with some kind of pathology has been pointed out by some authors [30,46]. Aquilino [4] found that the children of couples with low cohesion and affectional expression perceived worse parental support, whereas Stoneman et al. [42] found that parental depression, conflict, and marital unhappiness had negative implications for the relationship between mothers and children. Velligan et al. [45] found that maternal communication deviance, associated with prediction of schizophrenia [37,47], was higher in families in which fathers were dissatisfied with their marital relationship. Hibbs et al. [19] found a worse marital adjustment in mothers of children with disruptive behaviour disorders than controls, and that low expressed emotion, associated to relapse in schizophrenia [23], was related to a better dyadic adjustment. In other work in which we studied the relationship between expressed emotion and dyadic adjustment in parents of schizophrenic patients we found that in both parents criticism was negatively related to consensus in the couple and that critical mothers perceived less cohesion in the couple.

Family therapists have suggested that the bad dyadic relationship could be an etiological factor in the pathology of their children [17,29,36]. Other authors have underlined the burden that a family has to support for having a relative with a psychiatric illness. Objective burden refers to practical problems, such as disruption of family relationship, constraints in social activities, and financial difficulties. Subjective burden refers to the psychological reactions that family members experience, e.g. depression, anxiety and feeling of loss. The burden implies couple difficulties that lead to a rise in the divorce rate [8,10,14,16,18,24,27,28,33].

Some family therapists have remarked the bad relationship existing in parents of schizophrenic patients, and the negative influence that it has on the development of the illness [17,26]. However, Klinck and Waring [20] found no evidence that the quality of a marriage of parents of a schizophrenic child was worse than that of controls, and criticised the judgemental language used in describing the parents of schizophrenics.

The aim of this report was to study the dyadic adjustment, and its relationship with anxiety and depression in parents of

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a schizophrenic offspring, compared with two control groups: with and without pathology.

2. Subjects and methods

The sample consisted of 140 married couples: 67 with a child (58 males and 9 females) who presented schizophrenia. The 67 families were sent to us by the Health Public Service. The diagnosis of schizophrenia was performed according to criteria from the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, (DSM-IV) [1]. The criteria for selecting the experimental sample were: having a child with schizophrenia, age of the children between 15 and 25 years old, single and living in the family home, and not having received any kind of family or couple therapy.

The other 73 couples were recruited from the general population as a control group that was homogenous with the experimental group in the socio-demographic variables such as sex, age, environment, economical level, occupation and studies. The presence of severe physical or mental disorder in any of the members of the nuclear family was cause of exclusion. The control group was also divided into two groups: control group without pathology (CN) ($n = 41$) and control group with pathology (CNP) ($n = 32$). In this second group someone of the dyad presented a score higher than 6 on the General Health Questionnaire (GHQ-28) [15], or higher than 10 on the Beck Depression Inventory (BDI) [7], or higher than 44 on the Self-Rating Anxiety Scale (SAS) [48]. The sample was divided in three groups: schizophrenia, CN and CNP, homogeneous in sociodemographic variables.

The socio-demographic characteristics of the 140 couples were: the mean age of the husbands was 57.56 ± 6.34 years; the mean age of the wives was 54.38 ± 6.13 years; the mean age of the children was 21.61 ± 3.34 years; the mean number of children of the couple was 2.56 ± 0.93; the 90.7% of the couples lived in an urban environment. The socio-economic level was low in the 22.9%, medium in the 48.6% and high in the 28.6% of the couples. The 60% of the husbands and the 71.4% of the wives had primary studies. The 84.7% of the husbands and the 22.8% of the wives had a professional range from medium degree to qualified worker, and the 72.9% were housewives. The 93.6% of the husbands and the 95% of the wives were catholic.

The clinical characteristics of the schizophrenic patients were: the mean age at onset was 19.54 ± 4.01. The mean duration of the illness was 2.75 ± 3.34 years. The mean number of hospitalisations was 2.04 ± 2.20. The type of schizophrenia was: paranoid, 31 (46.3%), disorganized, 15 (22.4%), undifferentiated, 11 (16.4%), and residual, 10 (14.9%).

2.1. Instruments

- Sociodemographic variables, age at onset, duration of illness and hospitalisations, were recollected with an "ad hoc scale".
- Symptoms of the patients were assessed with the Brief Psychiatric Rating Scale—Expanded (BPRS-E) [25]. Scale for the Assessment of Positive Symptoms (SAPS) and the Scale for the Assessment of Negative Symptoms (SANS) [2].
- The BDI [7], a 21-item self-report questionnaire. The cut-off score used was 10.
- The SAS [48], a 20-item self-report questionnaire with statements on a 4-point scale of severity. The cut-off score used was 44.
- General Health Questionnaire (GHQ-28) [15]. A 28 item self-report with four options of answer that is designed to assess the general mental health state. The cut-off score used was 6. It was only administered to the families of the CN and CNP groups.
- The Dyadic Adjustment Scale (DAS) [3,39,40]. The scale is a 32-item questionnaire designed to measure relational adjustment and satisfaction in intimate couples. The scale measures dyadic adjustment along the following four components: degree of consensus, cohesion, general relational satisfaction and affectional expression. Dyadic consensus is the degree of agreement that couples hold on issues of importance such as handling family finances or making major decisions. Dyadic cohesion refers to how often a couple engages in companionate activities. Affectional expression concerns how often a couple expresses love for each other. Dyadic satisfaction examines the degree of happiness in the relationship, plus the frequency of conflicts experienced in the relationship. A global quality measure in dyadic adjustment for each member of the couple was used, with the cut-off score of 107 proposed by Crane et al. [12] as an indicator of distress and nondistress for married individuals. We evaluated the quality of the couple adjustment following the criteria of to average the individual scores to determine a couple score [13].

2.2. Procedure

We got in touch with the Health Public Service, in order to request their collaboration in the study financed by the University. We informed them about the selection criteria and gave them information for the patients' relatives. The families that were interested were sent to us by with the Health Public Service, contacting directly with us after a first telephone call in which they were given a date to verify the diagnosis and the selection criteria. If they passed the selection criteria, then the study variables were evaluated.

A unit formed by a psychiatrist and three clinical psychologists, trained in the administration of the assessment measures, evaluated the families. The procedure of evaluation had a fixed structure. Once the family (parents and child) were cited, three members of the unit presented themselves and gathered socio-demographic and family data. Afterwards, they went to different rooms, each member of the unit with a member of the family. The psychiatrist of the unit interviewed the patient to gather information about the his-

Table 1
Correlations among DAS, its subscales, SAS, and BDI in the total sample (n = 140)

	hcon	hsa	hae	hcoh	wcon	wsa	wae	wcoh	hdas	wdas	hsas	wsas	hbdi
hsa	0.442**												
hae	0.556**	0.635**											
hcoh	–0.101	0.252**	0.117										
wcon	0.374**	0.188*	0.243**	–0.166*									
wsa	0.245**	0.383**	0.324**	0.182*	0.628**								
wae	0.288**	0.323**	0.423**	0.128	0.567**	0.577**							
wcoh	0.021	0.280**	0.207*	0.503**	0.089	0.399**	0.233**						
hdas	0.764**	0.798**	0.738**	0.444**	0.249**	0.395**	0.392**	0.340**					
wdas	0.323**	0.362**	0.359**	0.152	0.839**	0.881**	0.697**	0.528**	0.425**				
hsas	0.021	–0.238**	–0.157	–0.095	–0.022	–0.124	0.001	–0.220**	–0.134	–0.124			
wsas	0.119	–0.123	–0.063	–0.132	–0.083	–0.320**	–0.044	–0.238**	–0.038	–0.238**	0.294**		
hbdi	0.065	–0.188*	–0.138	–0.170*	–0.209*	–0.344**	–0.115	–0.275**	–0.118	–0.331**	0.644**	0.359**	
wbdi	0.120	–0.079	0.032	–0.129	–0.106	–0.386**	–0.081	–0.238**	–0.006	–0.278**	0.269**	0.671**	0.392**

DAS, dyadic adjustment scale; hcon, husbands consensus; hsa, husbands satisfaction; hae, husbands affectional expression; hcoh, husbands cohesion; hdas, total das in husbands; mcon, wives consensus; wsa, wives satisfaction; wae, wives Affectional expression; wcoh, wives cohesion; wdas, total das in wives; hsas, self-rating scale in husbands; hbdi, beck depression inventory in husbands; wsas, self-rating scale in wives; wbdi, beck depression inventory in wives.

** $P < 0.01$.

* $P < 0.05$.

tory of the illness, and to administer the scales of symptoms. The questionnaires to evaluate the study variables were also administered to the parents in a separate way.

The control group was recruited from the general population, informing them previously that we were performing a study in the University about the impact of the illness in the families and that we needed families without physical or psychical pathology as a control group. If they wanted to participate, they were given a date in witch we could see if they passed the selection criteria and if it was so, we proceed to evaluate the study variables as we did with the experimental group. Subjects participated voluntarily after informed consent was obtained.

The statistical analyses used were: multivariate analysis of variance (MANOVA), univariate analysis of variance (ANOVA) with Scheffe's multiple comparisons post hoc, univariate analysis of covariance (ANCOVA), Chi-square test, t-test, logistic regression and Pearson correlations. Before performing the tests, the distribution of the variables was proved to be normal by the Kolmogorov-Smirnov test. The analyses were conducted with the Statistical Package for the Social Sciences (SPSS) V. 10.

3. Results

The Cronbach's alfa coefficient for the whole sample (n = 140 couples) on the total DAS was $\alpha = 0.86$ for the husbands and $\alpha = 0.89$ for the wives. These findings are similar to those of other studies [9,39–41]. The rest of the scales showed a good internal consistence.

No differences were found in DAS scores related to sociodemographic variables (age, number of children, studies, profession, medium, and socio-economic status).

3.1. Correlations

In Table 1 we can see that there are positive correlations in the scales of DAS, except between consensus and cohesion in both spouses, and between cohesion and expression of affect in the husbands. With regard to SAS and BDI, we see that both scales correlate negatively with satisfaction in both spouses and with cohesion and total DAS of wives. We also see that the more depressed the husbands are, the worse cohesion they notice and their wives notice worse consensus, satisfaction and cohesion. The wives notice worse cohesion and satisfaction the more anxious or depressed they are. The more depressed or anxious the husbands are, the more depressed or anxious the wives are and vice versa. When we make correlations controlling the SAS and the BDI, the relationship in the DAS and its subscales is kept.

In the schizophrenia group (n = 67) we made correlations among the DAS, its subscales, patients' symptoms (BPRS, SANS, SAPS), hospitalisations and months of illness. In the husbands, we found negative correlations, statistically significant, between months of illness and expression of affect (r = –0.265, P = 0.030) and satisfaction (r = –0.249, P = 0.042); between hallucinations (SAPS) and satisfaction (r = –0.242, P = 0.048), and between cohesion and disorientation (r = 0.264, P = 0.031), hyperactivity (r = –0.257, P = 0.036), and distraction (r = 0.305, P = 0.012). In the wives we found negative correlations between satisfaction and hostility (r = –0.282, P = 0.021), and positive correlations between cohesion and suicide (r = 0.247, P = 0.044). When we correlated the SAS and the BDI of the parents with symptoms and history of illness of the patient, we found a negative relation between anxiety in the mother and the scale of aboulia of the SANS (r = –0.261, P = 0.033).

3.2. Comparison among groups

A MANOVA was conducted on the DAS and its scales. Overall group effect was significant when introducing the group variable as an inter-group factor (Wilks' Lambda = 0.637, $F(18,258) = 3.625$, $P < 0.0001$). When we

Table 2
Comparison in DAS and its subscales among the three groups

	Group	*n*	Mean	d.f.	*F*(d.f.,2)	Sig.
Husbands consensus	Schizophrenia	67	56.33	8.30		
	CN	41	52.56	6.79		
	CNP	32	54.09	5.54		
	Total	140	54.71	7.45	3.519	0.032
Husbands satisfaction	Schizophrenia	67	39.97	5.45		
	CN	41	41.73	3.69		
	CNP	32	40.41	3.74		
	Total	140	40.59	4.66	1.869	0.158
Husbands affectional expression	Schizophrenia	67	9.76	2.49		
	CN	41	10.00	1.45		
	CNP	32	9.94	1.90		
	Total	140	9.87	2.09	0.185	0.831
Husbands cohesion	Schizophrenia	67	11.52	5.10		
	CN	41	15.00	5.14		
	CNP	32	13.75	4.70		
	Total	140	13.05	5.22	6.495	0.002
Wives consensus	Schizophrenia	67	54.66	11.29		
	CN	41	52.93	5.80		
	CNP	32	52.56	7.21		
	Total	140	53.67	9.09	0.766	0.467
Wives satisfaction	Schizophrenia	67	37.49	7.77		
	CN	41	41.44	4.30		
	CNP	32	39.53	4.59		
	Total	140	39.11	6.45	5.141	0.007
Wives affectional expression	Schizophrenia	67	9.76	2.70		
	CN	41	9.80	1.63		
	CNP	32	9.47	1.68		
	Total	140	9.71	2.21	0.244	0.784
Wives cohesion	Schizophrenia	67	10.18	5.55		
	CN	41	14.56	4.58		
	CNP	32	11.25	5.02		
	Total	140	11.71	5.46	9.328	0.000
Husbands total DAS	Schizophrenia	67	117.58	14.31		
	CN	41	119.29	12.60		
	CNP	32	118.19	12.10		
	Total	140	118.22	13.27	0.209	0.812
Wives total DAS	Schizophrenia	67	112.09	22.24		
	CN	41	118.73	10.55		
	CNP	32	112.81	13.18		
	Total	140	114.20	17.73	1.938	0.148

DAS, dyadic adjustment scale; CN, control; CNP, control with pathology group.

repeated the MANOVA separately, we found the following for the husbands (Wilks' Lambda = 0.826, $F(8,268) = 3.360$, $P = 0.001$), and this for the wives (Wilks' Lambda = 0.764, $F(8,268) = 4.830$, $P < 0.0001$).

A ANOVA was performed in order to study if there were differences statistically significant among the three groups on the DAS and its scales. Table 2 indicates the existence of differences among groups on some scales. Multiple comparisons using Scheffé's "post hoc" test showed the following significant differences in the husbands: in the consensus ($P = 0.037$) and cohesion scales ($P = 0.003$) between schizophrenia and CN groups, with less consensus and cohesion in the schizophrenia group. In the wives, the differences were in

Table 3
Espouses with anxiety and depression in schizophrenia and control with pathology groups (CNP) ($n = 99$)

	Schizophrenia group $n = 67$		CNP group $n = 32$	
	Husbands	Wives	Husbands	Wives
SAS (> 44)	7 (10.4%)	17 (25.4%)	0	0
BDI (> 10)	20 (29.9%)	43 (64.2%)	7 (21.9%)	12 (37.5%)

SAS, self-rating anxiety scale; BDI, Beck depression inventory; CNP, control with pathology group.

satisfaction between schizophrenia and CN groups ($P = 0.008$) and in cohesion between schizophrenia and CN groups ($P < 0.0001$), and CN vs. CNP groups ($P = 0.027$), with lower means in schizophrenia and CNP groups.

Since some authors [32,38] suggest that anxiety and depression can influence the dyadic adjustment, we performed an ANCOVA to study if there were significant differences between groups in the DAS and its factors, considering BDI and SAS as concomitant variables. Since it has been proved that there are no interactions between BDI, SAS and group, the results show that there are no statistically significant differences on the satisfaction scale in wives among groups, controlling the BDI. In the rest of the scales the SAS and the BDI did not influence, maintaining so the results of the ANOVA.

We compared the dyadic adjustment quality of the husbands and wives separately among the three groups (nondistress, DAS > 106/distress < 107), and we found statistically significant differences between them in wives ($\chi^2 = 6.718$, d.f. = 2, $P = 0.035$). Pairwise group comparisons were also performed using Bonferroni correction, alfa level was set at $P = 0.017$ (0.05/3), finding significant differences between schizophrenia and CN groups ($\chi^2 = 16.613$, d.f. = 1, $P = 0.008$), with worse adjustment in the schizophrenia group. No differences were found among groups in husbands and in the couples' quality of the DAS.

We have studied the differences in anxiety and depression between the schizophrenia group and CNP, and we have found differences statistically significant in the SAS ($\chi^2 = 9.803$, d.f. = 1, $P = 0.001$), and the BDI ($\chi^2 = 6.243$, d.f. = 1, $P = 0.011$) of the wives, with greater percentage of depression and anxiety in the schizophrenia group (see Table 3).

3.3. Intragroup analysis

To study if having or not depression and anxiety could influence on the DAS and subscales, we have compared, by means of t-test, the couples in which some of their members suffered from anxiety (SAS > 44) and/or depression (BDI > 10) with the ones that did not suffer from anxiety or depression. When making the comparisons in the group schizophrenia ($n = 67$), we found no differences statistically significant, in the DAS and its subscales, between the couples with anxiety and/or depression ($n = 49$) and the ones that do not suffer from anxiety or depression ($n = 18$). Whereas in the group CNP ($n = 32$) we found differences in the scale of consensus of the wives ($F(30) = 1.704$, $P = 0.012$), with worse consensus in the couples with anxiety and/or depression ($n = 20$). When we compared, in schizophrenia and CNP groups joined ($n = 99$), the good or bad dyadic adjustment of each spouse, between couples without anxiety nor depression ($n = 30$) vs. couples with anxiety and/or depression ($n = 69$), we did not find differences statistically significant, using the chi square test.

In the schizophrenia group we compared spouses with distres/nondistress (DAS < 107/ >106) in: SAS, BDI, and clinical characteristics of the patients (BPRS, SANS, SAPS, number of hospitalisations and duration of illness), and we found that wives with distress had higher BDI means than nondistressed ones ($t(65) = 2.296$, $P = 0.025$).

3.4. Regressions

Finally, we carried out a logistic regression considering group as a dependent variable, and DAS and its subscales as independent variables. The results showed that the assignment to the schizophrenia group was influenced by husbands' cohesion ($B = -0.135$, $P = 0.043$), and the wives' satisfaction ($B = 0.172$, $P = 0.006$), predicting in a correct way the 85.1% of the couples from the schizophrenia group. The assignation to the CN group was influenced by wives' cohesion ($B = -0.128$, $P = 0.033$), being correctly classified the 58.5% of the couples in the control group without pathology.

4. Discussion

The anxious and depressed symptomathology found in the mothers of schizophrenics can be related to the family burden. Kuipers [21] found that one-third of relatives have elevated levels of anxiety or depression connected with the caring role. Salleh [34] found that the 23% of the carers developed neurotic disorders resulting from the stress, nearly half of them had neurotic depression. This author found also that neurotic carers had more subjective burden and distress, and that the number of problem behaviours and previous admissions were significantly correlated with the severity of burden. Barrowclough et al. [5] found that the depression of the relatives was related to the chronicity of the pathology, which could be due to a feeling of having failed in the management of the illness.

Some authors found that the burden was associated with the female sex of the relatives, long duration of illness, negative symptoms, disturbing behaviour and a greater number of hospitalisations [14,27,28,35]. The correlations found among DAS, symptoms and duration of illness could be associated with the burden. The finding that cohesion of

Table 4
Espouses and couples with poor dyadic adjustment in the three groups

	Schizophrenia group $n = 67$	CN group $n = 41$	CNP group $n = 32$
Husbands (DAS < 107)	10 (14.9%)	2 (4.9%)	3 (9.4%)
Wives (DAS < 107)	16 (23.9%)	2 (4.9%)	7 (21.9%)
Couples (DAS < 107)	10 (14.9%)	2 (4.9%)	5 (15.6%)

DAS, dyadic adjustment scale; CN, control group; CNP, control with pathology group.

fathers correlated positively to disorientation, hyperactivity, and distraction, suggests that they perceive that the couple is joined to face the symptoms that could do the patient more unpredictable. The mothers, on the contrary, perceive more cohesion when there exist more risk of suicide in the children. These findings suggest that the pathology has a strong relation with the parents' dyadic adjustment.

In the intergroup comparisons we see that the fathers of schizophrenic patients perceive less consensus and cohesion and the mothers less cohesion, satisfaction and quality of adjustment than parents of CN group. This suggests that the poor dyadic adjustment is due to other causes. The differences found in the scale of satisfaction in mothers between the schizophrenia and control groups, disappear when we control the BDI. This suggests that insatisfaction is closely related to depression, but we cannot assert if it was previous or posterior to the schizophrenia in the child (Table 4).

Anyway, when we compare people with and without anxious and depressed pathology in the schizophrenia group, we do not find differences in DAS scores. This suggests that the poor dyadic adjustment of some parents of schizophrenic patients can be due to other factors, different from anxiety and depression. Stravynski et al. [43] did not find differences in the DAS in couples with and without depression; while others [33,38] found worse adjustment in couples in which there was depression. This coincides with the worse consensus found in the wives, in couples with anxiety and/or depression, of our group CNP.

In the schizophrenic group, the low cohesion in both parents, the low consensus of fathers and the less satisfaction of the mothers (joined to depression), are characteristics that difference them from controls without pathology. The poor dyadic adjustment in the parents of the schizophrenic patients is not related to the clinical characteristics of the patients, nor the anxiety of both parents, nor depression of fathers. Just the mothers with worse couple adjustment sow more depression.

Logistic regression results showed that low cohesion in husbands and low satisfaction in wives was significantly associated with the schizophrenia group. Whereas high cohesion in mothers was associated with the CN group. Dyadic cohesion refers to how often a couple engages in companionate activities, and a low cohesion would be related to some distance in the couple. Perhaps the husbands notice that the wives are less available for them, maybe due to the time they devote to the schizophrenic child or to the depression. Low satisfaction in mothers, as we have seen, is related to depression.

Our results about parents of schizophrenic patients having worse dyadic adjustment than controls, are in concordance with the descriptions of family therapists [17,26,36]. These authors suggested that the poor dyadic adjustment of parents would favour the appearance of transgenerational lapses, which would difficult the development of the child and would favour the appearance and maintenance of the schizophrenic symptomathology. Another explanation for our results, perhaps more realistic since we did not know how the couple relationship was before the child became schizophrenic, is that the burden of having a schizophrenic patient damages the couple relationship, which in turn could impair the child in a circular way. Kruesi and Lenane [19] found a worse marital adjustment in mothers of children with disruptive behaviour disorders than in mothers of controls. They also found that low expressed emotion [23] was related to a better dyadic adjustment.

5. Conclusion

Affirming today that schizophrenia is due to the poor adjustment in the parents is, at least, irresponsible. On the one hand, apart from not having a scientific basis, it blames the parents adding stress to people who suffer from important subjective and objective burden. On the other hand, seeing the difficulties the children have, it is necessary that the parents help each other to face the problems, offering the ill child a coherent and solid position that gives him or her security.

Parents who are distressed could have more difficulties to implement effective parenting strategies and, consequently, could contribute to an increase in their children's behaviour problems. Also, children who perceive their parents to be emotionally distressed express their own anxiety in the form of increasing symptoms, or responding to a lack of parental supervision and discipline by parents preoccupied with marital or personal difficulties.

Families of schizophrenics can easily feel overburdened and exploited because of a lack of community alternative. Relatives need provision of information and advice, emotional support and respite care; but, *in most countries*, receive little help from professionals in the management of difficult behaviours. Our results suggest that the mothers of schizophrenics need to be helped in their anxiety and depression, and the couples in their dyadic adjustment, especially cohesion. Far from blaming the families, interventions oriented to helping parents in his dyadic adjustment and symp-

tomathology would improve their life quality and would let them be in better conditions to help their child.

Numerous studies confirmed the efficacy of family interventions in schizophrenia to reduce the relapse rate and the *symptomatology*, to improve the social adjustment and the relatives' attitudes toward the patients [6,11,22,31,44]. But the effect of these interventions in the dyadic adjustment of parents has not been sufficiently studied.

Future research with interventions aimed at improving these variables will allow us to prove if they are accompanied by an improvement in the pathology of the schizophrenic patient, and in the quality of the life in patients and relatives.

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