The Development of a Culturally Informed, Family-Focused Treatment for Schizophrenia

AMY WEISMAN†
EUGENIO DUARTE†
VAMSI KONERU†
STEPHANIE WASSERMAN†

With the changing demographics in the United States, there is an increasing need for psychotherapy interventions that have been tailored for and empirically evaluated with culturally diverse groups. This article discusses the development and evaluation of a family-focused, culturally informed therapy for schizophrenia (CIT-S) that is currently being pilot tested at the University of Miami. Case examples of CIT-S with participating families are provided, along with a discussion of interesting and challenging cultural issues that we have encountered during the pilot phase of this treatment study

Keywords: Culture; Schizophrenic; Family Therapy

The demographics in the United States are rapidly changing. By the year 2050, it is expected that 50% of the population will belong to ethnic or racial minorities (Kagawa-Singer, 2001). With this changing demographic comes a need for health and psychological services that are tailored to and appropriate for diverse populations. In this article, we will provide an overview of a new, culturally informed therapy for schizophrenia (CIT-S) that has been developed in both English and Spanish and is currently being pilot tested at the University of Miami.

OVERVIEW

The need for treatments for schizophrenia is clear. This illness is considered one of the most severe of mental disorders and is marked by an insidious and chronic course (Saunders, 2003). The illness occurs in all ethnic populations, with prevalence rates ranging from 1.4% to 4.6% worldwide (see Jablensky, 2000). Schizophrenia not only takes its toll on patients, but it is also clearly a family process, dramatically impacting patients' relatives and loved ones as well (Weisman, 2005).

†University of Miami.

Correspondence concerning this article should be addressed to Amy Weisman, Ph.D., University of Miami, Department of Psychology, P.O. Box 248185, Coral Gables, FL 33124-0751. Tel: (305) 284-3477, Fax: (305) 284-3402. E-mail: aweisman@miami.edu

Family psychoeducation is an evidenced-based practice that has consistently been shown to reduce relapse rates for schizophrenia (Dixon, Adams, & Lucksted, 2000; Lehman & Steinwachs, 1998; Miklowitz & Goldstein, 1997). For instance, a meta-analysis by Pitschel-Walz, Leucht, Baeuml, Kissling, and Engel (2001) strongly indicates that relapse rates for patients with schizophrenia can be drastically reduced if patients' family members are included in the treatment. However, most mental health facilities still lack family treatments of any type (Lefley, as cited in McFarlane, 2002). Furthermore, few studies have examined efficacy of family treatments for schizophrenia with minority populations.

In the United States, members of ethnic minority groups neither receive nor provide psychotherapy in proportion to their numbers (Bernal & Scharrón-del-Rio, 2001). The attrition rates for minorities in psychotherapy are also considerably higher than those for Whites. For instance, 50% of Hispanics, compared with 30% of White patients, drop out of therapy after their first session (Fraga, Atkinson, & Wampold, 2004). Minorities may be more likely to seek psychotherapy, and attrition rates might be reduced if treatments were tailored to their unique language and cultural needs.

The above notwithstanding, a growing body of literature indicates that certain sociocultural characteristics common in many minority families from traditional[1] societies may be beneficial to patients with schizophrenia. This hypothesis stems from the results of several individual studies (Weisman & Lopez, 1997; Weisman, Lopez, Karno, & Jenkins, 1993) and the International Pilot Study of Schizophrenia (IPSS), a large multisite study conducted by the World Health Organization (WHO; 1973, 1992). The original WHO study and the later follow-up used standardized procedures in nine different countries and found that patients from the developing nations of Nigeria, India, and Colombia had a more favorable course than patients from industrialized countries such as Denmark, Czechoslovakia, the United Kingdom, the Soviet Union, and the United States.

What might account for the better course of illness for patients from traditional cultures, and how can we capitalize on these factors in treatment programs? Researchers are beginning to identify a few characteristics of family members from these societies that may underlie better prognoses for patients. Some of these characteristics include the expression of fewer critical/hostile (high-EE) attitudes and less blameworthy attributions toward patients, greater support and cohesion, and stronger spiritual/religious resources in the family. We now provide a summary of the literature regarding each of these characteristics and a discussion of how incorporating this knowledge into family-focused treatment programs may be beneficial for minority and Anglo families alike.

Expressed Emotion

Expressed emotion is a widely used measure of the emotional climate of a household, specifically assessing relatives' critical, hostile, and emotionally overinvolved (intrusive and excessive self-sacrificing behavior) attitudes toward patients (Woo, Goldstein, & Nuechterlein, 2004). Not surprisingly, a mounting body of research indicates that the course of schizophrenia is highly correlated with the family

---

[1] The term *traditional cultures* is used here to imply societies that are tradition oriented. These societies tend to have fairly strict and clear codes for behavior and tend to have a worldview that emphasizes harmony and cooperation with others over individual needs and desires (Smith, 2004).

atmosphere (Bebbington & Kuipers, 1994). Numerous individual studies (Goldstein, Rosenfarb, Woo, & Nuechterlein, 1994; Moline, Singh, Morris, & Meltzer, 1985) and several review articles (e.g., Butzlaff & Hooley, 1998; Kavanagh, 1992) have now strongly indicated that patients returning to hostile, critical, or emotionally overinvolved environments (high-EE homes) are significantly and substantially more likely to relapse within a 9-month period, as compared with patients returning to low-EE homes. Furthermore, these studies found that high or low EE status could not be fully explained by patient characteristics such as severity of illness. Thus, this body of research suggests that the emotional climate of the home may affect illness course, even for a disorder that has strong biological determinants (Kendler & Diehl, 1993).

Furthermore, the link between emotional environment and prognosis has been tested in over 40 countries around the world and, with a few exceptions, seems to hold up remarkably well across cultures. That is, regardless of where a patient is from, patients who live in high-EE environments do not fare as well (Weisman, 2005). However, relating this back to culture and prognosis, several studies around the world have also shown that family members from more traditional ethnic or cultural groups (e.g., Asians, Hispanics) tend to express fewer critical/hostile or high-EE attitudes about their ill family members as compared with less traditional groups, such as the British and Anglo Americans (Jenkins, Karno, De La Selva, & Santana, 1986; Telles et al., 1995). In fact, in a study currently under review for publication, Weisman and colleagues (Weisman, Kymalainen, & Armesto, under review) recently found that Anglos were five times more likely to be rated as high EE using the 5-minute speech sample method of assessment (Magaña, Goldstein, Karno, & Miklowitz, 1986) when compared with Latinos, and three times more likely when using another instrument called the Camberwell family interview (CFI; Vaughn & Leff, 1976). Because high EE appears to be toxic for patients with schizophrenia, regardless of culture, family treatments that directly target critical, hostile, and overinvolved attitudes seem warranted.

Why might some relatives be more accepting toward family members suffering from a mental illness and express fewer critical, hostile, and emotionally overinvolved attitudes when talking about their loved one? Some research suggests that low-EE relatives may possess certain personality characteristics, such as greater flexibility (Hooley, 1998) and greater problem-solving abilities (Chambless, Bryan, Aiken, Steketee, and Hooley, 2001), which may aid them in coping with schizophrenia in a loved one in a more adaptive and supportive manner. A growing body of research also points to causal attributions about the illness as another variable that may underlie EE. Attributions toward the illness have also been found to vary by ethnicity and may account for some of the cultural patterns observed in EE and schizophrenia outcome research. We examine this body of research.

Attributions

Attributions refer to one's causal perceptions about an event (Weiner, 1986). Attributions are important in relationships in that they have been found to be strongly linked to the perception of blame and negativity toward others in the event of adversity (Peterson & Docherty, 2004). In general, people are more critical and less empathic when the cause of another person's misfortune appears to be something that the person could have prevented or controlled.

Attributions appear to be useful in understanding the connection between EE and schizophrenia prognosis. For example, several researchers (Brewin, MacCarthy, Duda, & Vaughn, 1991; Weisman et al., 1993; Weisman, Nuechterlein, Goldstein, & Snyder, 1998) have argued that high-EE attitudes may develop when relatives perceive that the symptoms of schizophrenia are, at least to some degree, controllable by the patient. In the past few decades, this hypothesis, first developed by Jill Hooley (1987), has been tested and supported in numerous studies with both White (Brewin et al.; Weisman et al., 1998) and non-White (Weisman et al., 1993) samples. These studies found that relatives designated as low EE tended to make more external and uncontrollable attributions for their ill family member's behavior (e.g., ''I think Juan's avoiding us is all part of his illness—that's what this disorder does to a person''), whereas the attributions of relatives designated as high EE tended to be more internal and blameworthy (e.g., ''My view of things is that Marta acts that way so my wife doesn't give her any responsibilities around the house'').

The differences in percentages of high-EE families between Hispanic/Latino and Anglo Americans seem to parallel qualitative data regarding the attributions that the two groups make for their relative's disorder. Weisman and López (1997) tested for cultural differences in attributions between Mexicans residing in Mexico and Anglo Americans living in the United States. In this study, Mexicans were found to be much more external in their perceptions of control and less blaming in their attributions about schizophrenia than were Whites. This study suggests that cultural differences observed in family members' reactions to schizophrenia may shed light on the WHO's observations that patients from many developing societies have quicker and more complete recoveries than do patients from more industrialized societies. This phenomenon may stem from cultural differences in attributions and from the emotional responses that follow. However, attributions are unlikely to explain the whole story. We now turn to two other factors that may underlie the lower rates of high EE and the better course of illness observed in more traditional societies.

Spirituality/Religion

There is growing evidence that spirituality is associated with both mental and physical health. For example, several studies have linked greater spirituality with better self-esteem, greater personal adjustment, less alcohol and drug abuse, and less sexual permissiveness and suicide (Waite, Hawks, & Gast, 1999; Pargament, Kennell, Hathaway, Grevengoed, Newman, & Jones, 1988; Pargament, Koening, Tarakeshwar, & Hahn, 2004). In a comprehensive meta-analysis, McCullough, Hoyt, Larson, Koenig, and Thoresen (2000) found that greater religious involvement was associated with much lower odds of dying prematurely.

Despite the great heterogeneity within Hispanic culture, Hispanics frequently have been observed to have a strong religious faith, which shapes their conceptualization of both physical and mental illness (Musgrave, Allen, & Allen, 2002). In one study with a sample of highly unacculturated Hispanic Americans living in Los Angeles who were almost exclusively (91%) rated as low EE, Weisman, Gomes, and López (2003) found that almost half of the participants made reference to spirituality in their making sense of the illness. That is, 40% of the sample made at least one reference to God or religion in discussing the cause of the relative's illness or coping with said illness. Furthermore, in nearly all these comments, religion and spirituality appeared to be

used primarily as an aid to better understand and come to terms with the illness rather than to blame patients for the illness (which might also be expected from religious relatives).

We want to point out that there is definitely the potential to apply religion, to the detriment of patients with schizophrenia. Relatives could, for example, see the illness as God's punishment for wrongdoing. However, in the Weisman et al. (2003) study, there was no evidence of blaming or otherwise detrimental attributions of a religious/spiritual nature. Stemming from this and other research, in the current article, we propose that for many patients and family members from traditional cultures, having a religious or spiritual worldview may help them make sense of adversity, including mental illness, and may actually aid in coping with or recovering from schizophrenia. In other words, a strong religious/spiritual stance may be related to the better observed prognosis for schizophrenia observed in traditional societies.

Family Cohesion

Another factor that we speculate may contribute to the observed better course of illness in traditional societies is the tendency for families to be more unified and cohesive in traditional cultures and to play a more central role in patients' lives (Lefley, 1990; Weisman, 1997, 2005). In a recent study, Weisman et al. (2005) found that greater perceptions of one's family as cohesive and supportive were associated with better general emotional well-being for both patients and family members (i.e., less reported stress, anxiety, and depression). For patients, perceived family cohesion was also associated with fewer specific psychiatric symptoms. In other words, patients who perceived their family environment as supportive displayed less severe symptoms, including delusions, hallucinations, and disorganization in speech.

Although most cultures around the world strongly value family and family relationships, including Anglo Americans, people from traditional cultures appear to have a more interdependent sense of themselves as they relate to others, particularly their family members (Singelis, 1994). We hypothesize that, to some degree, this collectivistic identity may make them more invested in the care of an ill relative and more supportive of and attuned to the patient's needs. Thus, we hypothesize that helping families who are coping with mental illness relate to one another in a more supportive and low-key fashion will allow both patients and family members to cope more effectively.

DEVELOPMENT AND EVALUATION OF CIT-S

Over the past few years, the first author of this article (A. Weisman) and her research team have integrated findings from earlier studies and developed a culturally informed therapy for schizophrenia (CIT-S). This treatment combines techniques that, in prior studies, have demonstrated success in helping families with schizophrenia, along with cultural components hypothesized to enhance the treatment for minorities and Anglos alike. CIT-S was developed in English and Spanish. It is composed of five segments, each lasting three sessions.

CIT-S Treatment Segments

Family collectivism. The first module of CIT-S is family collectivism. This segment is aimed at fostering a strong sense of family unity and helping members to see

themselves as a team working toward a mutual goal. Within these three sessions, specific focus is placed on deflecting the blame from any one member of the family. In the first session, family members are praised for attending treatment and reminded that their attendance is indicative of a strong commitment to the patient and to the family. During this session, the therapist thoroughly describes CIT-S and answers questions that families may have about the treatment. The aim is that families leave the first session having understood the nature of the treatment and, most important, how it will help their relative. As part of this segment, the therapist asks participants what they hope to gain from the treatment and points out commonalities among the family members. For instance, most family members and patients will likely report that they hope to see improvement in their ill family member's functioning.

As with all segments of CIT-S, the discussion of collectivism is guided using a series of handouts.[2] The first is called the collectivism handout. Specific topics covered during this section are (1) what the concept of family means to each member; (2) each family member's perception of his or her role in the family; (3) how family members view generational and gender roles; (4) whether family members see a clear hierarchy within the family; and (5) whether family members see any significant conflicts or alliances between members. For homework, participants prepare narratives that can be written or audiotaped to share in treatment. These narratives illustrate how each member feels that he or she might contribute differently to improve family functioning.

In addition, the therapist encourages family members to point out specific behaviors of other members that they appreciate and feel enhance family well-being, and other behaviors that they would like to see increased, decreased, or modified to benefit the family as a whole. These narratives help elucidate how each member contributes to and influences the family system, and they also aid in generating ideas about potentially improving family functioning. They can further assist the therapist in guiding discussions and highlighting commonalities among family members and can also be used to deemphasize family differences.

Following is an example from one of our CIT-S cases that illustrates how the collectivism segment can be used effectively to help break down dyadic alliances that were causing significant conflict in the household. The family was of Cuban origin and included a married couple who lived with the wife's mother, a common situation among Hispanic families. In this family, the wife (the identified patient) was clearly allied with both family members. However, she was caught between the husband and mother, who were constantly bickering about several topics, one of which was how to properly care for the wife. The patient reported being very stressed and overwhelmed by the constant squabbling. In treatment, a significant amount of time was spent discussing how, although both family members appeared to nurture the daughter, the constant fighting between the mother and son-in-law was actually working against the family's shared goal of helping the patient to remain in remission. We discussed the fact that the high level of conflict and stress were only causing more difficulties for their already ill loved one. At the conclusion of these three sessions, the son- and mother-in-law had begun to have calmer discussions, which were motivated by their mutual goal of helping the patient remain stable and avoid relapse.

---

[2] All handouts can be obtained by contacting Amy Weisman at aweisman@miami.edu.

Education. The second module, education, is based on the earlier psychoeducational programs of Falloon, Boyd, and McGill (1984) and Miklowitz and Goldstein (1997). Handouts that guide this segment were modified for schizophrenia, but similar ones for bipolar disorder can be found in Miklowitz and Goldstein's book. During the education phase, the known causes of schizophrenia and its exacerbating factors are addressed, including genetics, neurochemistry, life stress, and biological, interpersonal, and social factors. Families are also provided with information about ways in which family and social interactions influence the patient's mood, thoughts, and behavior.

Special attention is paid to the role of high-EE attitudes and attributions, which, as discussed, appear to be related to relapse and illness course. In this segment, we thoroughly discuss the signs and symptoms of the illness, and patients and family members are taught to quickly and accurately recognize prodromal symptoms of new episodes. This knowledge allows for more aggressive relapse prevention and intervention. We further aim to identify family members who may be experiencing feelings of guilt over beliefs about having caused the disorder. We make a special attempt to disabuse and alleviate these and other faulty misperceptions.

In this segment, we also educate participants about the role of stress in exacerbating the illness and discuss how environmental factors can interact with a person's genetic and biological vulnerabilities/predispositions to trigger the disorder. Strong emphasis is placed on educating participants about the detrimental effects of substance abuse on relapse and prognosis. There exists approximately 59% comorbidity between schizophrenia and substance abuse (Margolese, Malchy, Negrete, Tempier, & Gill, 2004). Research findings demonstrate that integrating education on substance abuse into treatment results in a more effective intervention (Bellack & Gearon, 1998; Clark & Mueser, 2003; Layne, 2002). On the other hand, if substance abuse is ignored, clinical outcome for substance users is poor (Carey, 1995). We also emphasize that substance abuse is often responsible for triggering the onset of the illness, relapse, exacerbation of symptoms, and suicide (Jerrell, 1996; Ries, 1994).

The following example illustrates how the education module of CIT-S was used to address the exacerbating effect of substance abuse on schizophrenia. In this family, the patient was a high-functioning, educated young Hispanic woman in the early stages of the illness. She was pursuing a master's degree at the time, and achieving her degree was a primary goal. Unfortunately, she regularly consumed marijuana. In treatment, we spent a good deal of time reviewing and emphasizing the link between marijuana use and impairment in cognitive abilities and memory. This information was particularly relevant and salient for this client because she was very motivated to function at her highest potential to advance through graduate school.

In therapy, we emphasized that her drug use was likely to take her away from her educational goals and that cognitive and memory effects worsened exponentially when interacting with substance abuse. The patient's family members noted that she was, in fact, far more symptomatic and more cognitively impaired following marijuana consumption. We discussed that, although drug use seemed rewarding at the moment, it was only impeding her goals. Her family members were encouraged to serve as a support system whenever the patient felt tempted to consume drugs. Although this client did not, unfortunately, remain drug free, she was very impacted by this knowledge and did report a significant reduction in her use and a future goal of quitting altogether.

Before concluding the education segment, we reiterate to families that although no one factor or person is solely responsible for the disorder, family members can do several things to help the patient cope with the illness. First, we reassure family members that they have already begun the process of helping the patient by deciding to participate in the treatment. We then review other ways to be helpful, such as encouraging medication adherence, helping patients refrain from substance abuse, and helping to maintain a low-key and supportive home environment. We remind participants of the strong evidence indicating that living in a supportive and empathic environment appears to result in better patient outcome.

Spiritual coping. The third phase of treatment, spiritual coping, is aimed at helping participants tap into spiritual or existential beliefs that help them productively conceptualize and come to terms with the illness. This phase begins by eliciting from clients a detailed spiritual history that includes an exploration of each family member's spiritual beliefs and values. Specifically, clients are asked to discuss their beliefs (or disbeliefs) about God or another supreme being, their notions of morality, and the meaning or purpose that they attribute to life. They are also asked to outline their participation in spiritual or religious communities and to discuss any spiritual sources of support (e.g., priests, rabbis) that they currently have or would like to have in their lives. They are asked about spiritual practices (e.g., prayer, meditation, attending religious services) that they currently use or would consider using. Practices such as forgiveness, empathy, and appreciation are at the heart of a spiritual treatment approach (Sperry, 2001).

These concepts are discussed, role-played, and encouraged both inside and outside the treatment setting. Homework for this module includes conducting a spiritual or philosophical genogram, reading spiritual bibliotherapy, and bringing in for discussion spiritual writings that appear relevant to coping with mental illness. Clients are also encouraged to engage in spiritual practices outside treatment that they identify as personally relevant and potentially therapeutic (e.g., prayer, meditation) and to discuss these experiences in the following session. During therapy, clinicians have the opportunity to reframe participants' maladaptive uses of religion, such as believing that the patient's mental illness is God's punishment for some wrongdoing.

The family is guided in reframing these types of negative attributions using more adaptive religious teachings, such as, "God uses struggles to build virtue and patience." Another example of a maladaptive use of spirituality is a client who passively turns to God to resolve his or her problems without attempting to take an active role in coping with life's adversities. In this aim, therapists refer to religious scriptures, such as "God helps those who help themselves," to redirect clients to use their spiritual beliefs more adaptively.

The spiritual coping phase of treatment is completed with all clients, regardless of religious orientation (or lack of a religious orientation). Based on previous research, we expect that approximately 10% of clients will report that they do not believe in God. We also expect that an additional 5%–10% may report that they believe in God but are uncomfortable or uninterested in a religiously based treatment. For this reason, no attempt is made to steer clients toward adopting a religious stance in treatment. These clients are asked to complete very similar exercises, but rather than focusing on specific religious beliefs, we explore their philosophical beliefs about right and wrong, empathy, and life's meaning. As with religious clients, nonreligious participants are

encouraged to engage in existential exercises, such as meditation and philosophical readings, and to practice the same spiritual notions of forgiveness, empathy, and appreciation.

Within families, some members may identify as religious and choose to focus on their spiritual beliefs in treatment, while others may not. Regardless of religious orientation, all participants are encouraged to respect one another's beliefs. In fact, it is important that this ground rule for therapy be established during the first session and reinforced during each module. If establishing reciprocal respect proves problematic for family members, the clinician refers back to the collectivism module and applies these concepts in helping members reconcile spiritual differences. Clearly, spirituality is a highly complex construct, and a religious intervention may not be indicated for some families (e.g., patients who appear to be experiencing religious delusions). In these cases, clinicians are instructed not to target religious beliefs and values and instead target philosophical or existential beliefs that are more secular in nature. In addition to helping families come to terms with the illness, the spirituality segment can be used in a more practical manner. For instance, we treated one Hispanic family for whom Catholicism was an important part of life. The family included the patient and his biological parents. In this family, the patient presented with some positive symptoms (i.e., hallucinations and delusions), but his most pronounced symptoms were negative and included diminished interest in activities, limited facial expressions, and lack of desire to interact with others. For this family, we used religion as part of a behavioral intervention to target the patient's withdrawal and lack of engagement with others. For homework, we asked the patient to resume attending church on Sundays, a behavior rooted in his cultural background that he highly valued but had not been doing since he became ill. He was also assigned the task of attending the social functions following mass and talking with others. He reported viewing church as a safe, accepting environment where he could try out his social skills with people who were less likely to reject him than were strangers. This segment appeared to work very well for this client. We were able to draw on a culturally valued behavior (i.e., church attendance) to get him out of the house on weekends, which is when he tended to isolate himself the most. This client successfully completed the assignment and, in the following session, reported feeling much better about himself and more confident. His family was also pleased that he was engaging again in behaviors that were highly valued by their culture and reported being satisfied that they now had an activity (i.e., going to church) that the family could enjoy together as a group.

Communication training and problem solving. The last two segments, communication training and problem solving, are drawn largely from Falloon et al. (1984) and from Miklowitz and Goldstein (1997). Handouts used to guide these segments can be found in Miklowitz and Goldstein's book. These approaches have strong empirical support for helping families cope more effectively with mental illness (Miklowitz, George, Richards, Simoneau, & Suddath, 2003; Simoneau, Miklowitz, Richards, Saleem, & George, 1999). Because these skills have been described extensively in the literature, here we give only a brief overview and then describe their use with one of our clinical cases. In the communication training segment, family members are taught skills to help them communicate and provide support to one another more effectively. Specific skills that we focus on include expressing warmth, giving positive feedback to other family members, active listening, and making positive requests for behavioral

change. The primary aim of this segment is to foster a low-key, supportive home environment that research suggests is strongly associated with a better course of illness.

Following, we illustrate how the communication segment was implemented with one of our CIT-S cases. This case involved a Jewish family, which included the identified patient, her husband, and their daughter. The family's pattern of interacting often consisted of more than one member, or all members, talking at the same time, with members frequently interrupting one another. This pattern was an obstacle in therapy and in their home life together. Heated arguments frequently ensued, and members often lost focus of the goals that they had set at the beginning of the session. For this reason, learning to actively listen to one another and make positive requests for change was especially salient for this family. For example, when the active listening skill was first introduced, the daughter, who was usually the most dominating in conversations, immediately identified with the utility of this skill and said, ''I think I should learn to do that, I probably do need to listen more.'' Through role-plays, along with reciprocal feedback and the therapist's coaching, members learned to take turns speaking and actively listening to one another, which in turn helped them understand each other's different perspectives and promoted greater harmony and cohesion.

The last phase of treatment, problem-solving skills, was also developed by colleagues and has been widely discussed elsewhere (e.g., Falloon et al., 1984; Miklowitz & Goldstein, 1997). In short, this phase teaches family members techniques to enhance their problem-solving capacities. Families are taught to identify problems, agree on their definition, ''brainstorm'' possible solutions, and develop strategies for testing out and deciding upon optimal solutions and how to best implement them.

In one of our CIT-S cases, the identified patient resided in an assisted living facility (ALF) approximately 20 minutes from his mother, father, and older sister. Although the patient's family enjoyed spending as much time with him as possible, the patient's psychiatrist had recently advised the family not to remove the patient from the ALF because such outings often made the patient hyperactive and difficult to control upon returning to the ALF. The participants were frustrated because, consistent with their Peruvian heritage, Sunday afternoons had always been a time for the family to attend church and have dinner together. The psychiatrist discouraged the family from spending time with the patient outside the ALF, and members disagreed about whether to heed the psychiatrist's advice.

The problem-solving phase was used to help members agree on a shared conceptualization of the problem: finding a way to maintain close ties with the patient while preventing the patient from experiencing stress and agitation. After proposing and evaluating several alternatives, the members agreed that the best solution consisted of ordering Peruvian food every Sunday from a nearby restaurant and having dinner with the patient at the ALF. The family successfully implemented their solution, and the patient was very happy that his family made such an effort to spend time with him.

Evaluation of CIT-S. We are currently evaluating CIT-S in a pilot study that is under way at the University of Miami. To date, we have enrolled approximately 20 families in the treatment study and have completed pilot testing of our baseline measures and treatment with several of these families. In this study, our primary hypothesis is that families who receive this 15-week, five-segment treatment will fare better than those that receive a three-session treatment-as-usual family psychoeducation intervention.

(If CIT-S proves effective in the pilot study, we plan to then test it against another empirically supported treatment that is matched in length.) We expect both patients and their relatives to experience mental health benefits resulting from participating in CIT-S, both in terms of decreased psychiatric symptoms for patients and better general emotional well-being (less depression, anxiety, and stress) for patients and relatives alike.

Cultural Challenges Encountered in Treatment

Throughout this pilot study, we have encountered three interesting cultural challenges that merit acknowledgment. The first issue deals with how ethnicity is defined and coded. More specifically, in our study, participants are asked to identify the ethnicity that they believe best describes them from the following list: Caucasian, African American, Native American, Hispanic, Asian American, or Other. In rare instances, participants may struggle between two categories. For example, Cubans, Puerto Ricans, and Dominicans of African descent sometimes identify as both African American and Hispanic. This issue can be problematic for coding and analyzing data. In such a circumstance, we ask participants to discuss their heritage and to reflect on which ethnic category most strongly reflects their values, beliefs, behaviors, and physical and genetic attributes. To date, after engaging in such discussion, all our study participants have appeared to have little difficulty selecting the ethnic category that best captures their ethnic heritage. In addition, so far, patients' self-reports of their ethnicity have been in agreement with assessors' own perceptions of participants' heritage. However, in an earlier study conducted by the first author (Weisman, Rosales, Kymalainen, & Armesto, 2005), one study participant identified himself as Asian American when his appearance and other information available to the researchers indicated that he was of African American heritage. Given that this patient was also prone to delusions, the researchers consulted with one of the patient's family members (with the patient's permission), also a participant in the study, who confirmed that the patient was in fact African American.

Although this is a delicate issue, the CIT-S treatment protocol dictates that if we encounter instances in which data obtained from participants are inconsistent with other information available to us, we attempt to verify the information with outside sources and record the data that appear to be most valid (e.g., the relative's report of the patient's ethnicity in the preceding example). However, if any reasonable concerns remain regarding the accuracy of a data point, our protocol is to drop the data point in question from the study. Fortunately, discrepancies in self-reported ethnicity, such as the example described above, appear to be quite rare.

The second issue encountered frequently in our treatment study deals with variability of English language fluency within Spanish-speaking families. Initially, before we began enrolling families in the treatment study, our research protocol dictated that we interact with families in the language that was best understood collectively by all members of the family. When in doubt, we planned to follow the ideas of Santisteban and Szapocznik (1994) by selecting the language of the oldest members of the family, so as not to upset the hierarchy in families by giving more power to younger members (Szapocznik, Rio, Perez-Vida, & Kurtines, 1986). However, in practice, we found this to be a more complicated problem than we had anticipated, and one best resolved based on judgment and the specifics of each case.

In one of our CIT-S cases, the family included a mother who understood English extremely well but reported feeling comfortable speaking only Spanish, and her two children who were young adults raised primarily in the United States. The children understood Spanish very well but reported being uncomfortable speaking it. In this case, the family actually recommended to the therapist that she direct the mother in Spanish and the children in English, and that family members would each respond in their dominant language. As this was a pilot case, we agreed to try the approach requested by the family and found that it worked extremely well. Everyone was able to speak in the language that they were most at home in and comfortable speaking. In fact, this approach appeared to strengthen the bond between the therapist and the family.

Strict adherence to the original treatment manual would have prescribed speaking in Spanish with the family because it is the eldest member's (the mother) dominant language. In hindsight, however, we believe that using Spanish exclusively would have proved less effective with this particular family. This example highlights the importance of balancing treatment adherence and treatment competence. Data from our pilot study suggest that flexibility with respect to language and accommodating to the particular family constitutes a more competent approach than following a specific formula dictating language for all families.

In the same vein, another more challenging difficulty is that families with schizophrenia are often disorganized, and getting them in regularly and on time for their appointments has been a struggle. This challenge has been especially pronounced with some of our Hispanic families. In fact, research suggests that the notion of time is somewhat more fluid among Hispanics than Anglos (Queralt, 1984), which may account for our observations. Our experience in the pilot study has led us to believe that, to run a successful treatment study, flexibility in scheduling assessments and treatment is key. For example, our staff now schedule appointments using more open blocks of time (and never back to back) and bring work to do while waiting for participants to arrive. These subtle changes have increased our efficiency and decreased frustration within the CIT-S research team. Thoroughly explaining to participants the importance of time and education about how the clinic functions has also proved helpful in reducing tardiness. Again, flexibility is key. As noted, modeling good flexibility skills may have an added clinical benefit in that flexibility is a personality trait that has been found to be associated with low EE (Hooley, 1998).

Maintaining Treatment Gains

There is strong empirical support for family and other types of treatments for Axis I disorders (Falloon et al., 1984; see Chambless & Ollendick, 2001 for review). However, even for ''treatment responders,'' relapse rates are still quite high, and many patients continue to have pronounced residual symptoms (Westen & Morrison, 2001). To address this concern, we are planning to offer monthly drop-in multifamily groups for all participants who have completed the treatment and all follow-up assessments. Although the drop-in group will be primarily of a support nature, the group leader will introduce or reinforce techniques from all five CIT-S modules as needed. This idea is motivated by concerns for cost-effectiveness and by evidence in the literature that strongly supports multifamily groups (Lehman & Dixon, 1995; McFarlane, 2002). We believe that the number, nature, and complexity of skills presented in CIT-S would

be difficult to learn in a group format, but this approach appears to be ideal for sustaining treatment gains and may be particularly useful for Hispanics and other ethnic groups that greatly value community and collectivistic healing methods.

CONCLUSION

CIT-S is a 15-session treatment program that is strongly grounded in the literature. It is aimed at creating home environments that are supportive and shaping beliefs by encouraging relatives to recognize that even when patients are actively trying to manage their illness, some disruptive symptoms are likely to persist or recur. CIT-S is expected to result in lower rates of high EE, increased perceived collectivism and family cohesion, and the use of more adaptive religious, spiritual, and philosophical coping mechanisms. We hypothesize that CIT-S will result in significant decreases in schizophrenia symptoms for patients and will also help to improve general emotional and mental health for both patients and family members. Although we do not have outcome data yet, consumer satisfaction ratings on our completed cases average above 6 on a 7-point scale for how effective or helpful family members find CIT-S. Although self-report satisfaction/efficacy ratings are no substitute for other efficacy evaluations (e.g., clinical interviews), our early satisfaction ratings are encouraging indicators.

REFERENCES

Bebbington, P., & Kuipers, L. (1994). The predictive utility of expressed emotion in schizophrenia: Aggregate analysis. *Psychological Medicine*, *24*, 707–718.

Bellack, A.S., & Gearon, J.S. (1998). Substance abuse treatment for people with schizophrenia. *Addictive Behaviors*, *23*, 749–766.

Bernal, G., & Scharrón-del-Río, M.R. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural Diversity and Ethnic Minority Psychology*, 7, 328–342.

Brewin, C.R., MacCarthy, B., Duda, K., & Vaughn, C.E. (1991). Attribution and expressed emotion in the relatives of patients with schizophrenia. *Journal of Abnormal Psychology*, *100*, 546–554.

Butzlaff, R.L., & Hooley, J.M. (1998). Expressed emotion and psychiatric relapse. *Archives of General Psychiatry*, *55*, 547–552.

Carey, K. (1995). Treatment of substance use disorders in schizophrenia. In L.B. Dixon & A.F. Lehman (Eds.), *Double jeopardy: Chronic mental illness and substance abuse disorders* (pp. 85–108). Langhorne, PA: Harwood Academic.

Chambless, D.L., Bryan, A.D., Aiken, L.S., Steketee, G., & Hooley, J.M. (2001). Predicting expressed emotion: A study with families of obsessive-compulsive and agoraphobic outpatients. *Journal of Family Psychology*, *15*, 225–240.

Chambless, D.L., & Ollendick, T.H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685–716.

Clark, R.E., & Mueser, K.T. (2003). Progress in research on dual disorders. *British Journal of Psychiatry*, *183*, 377–378.

Dixon, L., Adams, C., & Lucksted, A. (2000). Update on family psychoeducation for schizophrenia. *Schizophrenia Bulletin*, *26*(1), 5–20.

Falloon, I.R.H., Boyd, J.L., & McGill, C.W. (1984). *Family care of schizophrenia: A problem solving approach to the treatment of mental illness*. New York: Guilford Press.

Fraga, E.D., Atkinson, D.R., & Wampold, B.E. (2004). Ethnic group preferences for multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology*, *10*, 53–65.

Goldstein, M.J., Rosenfarb, I., Woo, S.M., & Nuechterlein, K.H. (1994). Intrafamilial relationships and the course of schizophrenia. *Acta Psychiatrica Scandinavica*, *90*(Suppl.), 60–66.

Hooley, J.M. (1987). The nature and origins of expressed emotion. In K. Hahlweg & M. Goldstein (Eds.), *Understanding major mental disorder: The contribution of family interaction research* (pp. 176–194). New York: Family Process Press.

Hooley, J.M. (1998). Expressed emotion and locus of control. *Journal of Nervous and Mental Disease*, *186*, 374–378.

Jablensky, A. (2000). Epidemiology of schizophrenia: The global burden of disease and disability. *European Archives of Psychiatry and Clinical Neuroscience*, *250*, 274–285.

Jenkins, J., Karno, M., De La Selva, A., & Santana, F. (1986). Expressed emotion in cross-cultural context: Familial responses to schizophrenic illness among Mexican-Americans. In M.J. Goldstein, I. Hand, & K. Hahlweg (Eds.), *Treatment of schizophrenia* (pp. 33–49). New York: Springer.

Jerrell, J.M. (1996). Cost-effective treatment for persons with dual disorders. In R.E. Drake & K.T. Mueser (Eds.), *Dual diagnosis of major mental illness and substance abuse: Recent research and clinical implications* (Vol. 2, pp. 79–91). San Francisco: Jossey-Bass.

Kagawa-Singer, M. (2001). From genes to social science: Impact of the simplistic interpretation of race, ethnicity and culture on cancer outcome. *Cancer Supplement*, *91*, 226–232.

Kavanagh, D. (1992). Recent developments in expressed emotion and schizophrenia. *British Journal of Psychiatry*, *120*, 601–620.

Kendler, K.S., & Diehl, S.R. (1993). The genetics of schizophrenia: A current, genetic-epidemiologic perspective. *Schizophrenia Bulletin*, *19*, 261–285.

Layne, G.S. (2002). Schizophrenia and substance abuse. In E. Beyer & D. O'Connell (Eds.), *Managing the dually diagnosed patient: Current issues and clinical approaches* (pp. 287–316). New York: Haworth Press.

Lefley, H.P. (1990). Culture and chronic mental illness. *Hospital and Community Psychiatry*, *41*, 277–286.

Lehman, A.F., & Dixon, L.B. (Eds.). (1995). *Double jeopardy: Chronic mental illness and substance use disorders*. New York: Harwood Academic Publishers.

Lehman, A.F., & Steinwachs, D.M. (with the coinvestigators of the PORT Project). (1998). At issue: Translating research into practice: The Schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations. *Schizophrenia Bulletin*, *24*(1), 1–10.

Magaña, A.B., Goldstein, M.J., Karno, M., & Miklowitz, D. (1986). A brief method for assessing expressed emotion in relatives of psychiatric patients. *Psychiatry Research*, *17*, 203–212.

Margolese, H.C., Malchy, L., Negrete, J.C., Tempier, R., & Gill, K. (2004). Drug and alcohol use among patients with schizophrenia and related psychoses: Levels and consequences. *Schizophrenia Research*, *67*, 157–166.

McCullough, M.E., Hoyt, W.T., Larson, D.B., Koenig, H.G., & Thoresen, C. (2000). Religious involvement and mortality: A meta-analytic review. *Health Psychology*, *19*, 211–222.

McFarlane, W. (2002). *Multifamily groups in the treatment of severe psychiatric disorders*. New York: Guilford Press.

Miklowitz, D.J., George, E.L., Richards, J.A., Simoneau, T.L., & Suddath, R.L. (2003). A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry*, *60*, 904–912.

Miklowitz, D.J., & Goldstein, M.J. (1997). *Bipolar disorder: A family focused treatment approach*. New York: Guilford Press.

Moline, R.A., Singh, S., Morris, A., & Meltzer, H. (1985). Family expressed emotion and relapse in schizophrenia in 24 urban American patients. *American Journal of Psychiatry*, *142*, 1078–1081.

Musgrave, C.F., Allen, C.E., & Allen, G.J. (2002). Spirituality and health for women of color. *American Journal of Public Health*, *92*, 557–560.

Pargament, K.I., Kennell, J., Hathaway, W., Grevengoed, N., Newman, J., & Jones, W. (1988). Religion and the problem-solving process: Three styles of coping. *Journal for the Scientific Study of Religion and Spirituality*, *27*, 90–104.

Pargament, K.I., Koenig, H.G., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. *Journal of Health Psychology*, *9*, 713–730.

Peterson, E.C., & Docherty, N.M. (2004). Expressed emotion, attribution, and control in parents of schizophrenic patients. *Psychiatry: Interpersonal and Biological Processes*, *67*, 197–207.

Pitschel-Walz, G., Leucht, S., Baeuml, J., Kissling, W., & Engel, R.R. (2001). The effect of family interventions on relapse and rehospitalization in schizophrenia: A meta-analysis. *Schizophrenia Bulletin*, *27*, 73–92.

Queralt, M. (1984). Understanding Cuban immigrants: A cultural perspective. *Social Work*, *29*, 115–121.

Ries, R. (1994). *Assessment and treatment of patients with coexisting mental illness and alcohol and other drug abuse*. Rockville, MD: U.S. Department of Health and Human Services.

Santisteban, D.A., & Szapocznik, J. (1994). Bridging theory, research and practice to more successfully engage substance abusing youth and their families into therapy. *Journal of Child and Adolescent Substance Abuse*, *3*, 9–24.

Saunders, J.C. (2003). Families living with severe mental illness: A literature review. *Issues in Mental Health Nursing*, *24*, 175–198.

Simoneau, T.L., Miklowitz, D.J., Richards, J.A., Saleem, R., & George, E.L. (1999). Bipolar disorder and family communication: Effects of a psychoeducational treatment program. *Journal of Abnormal Psychology*, *108*, 588–597.

Singelis, T.M. (1994). The measurement of independent and interdependent self-construals. *Personality and Social Psychology Bulletin*, *20*, 580–591.

Smith, T. (2004). *Practicing multiculturalism: Affirming diversity in counseling and psychology*. Boston: Pearson Education.

Sperry, L. (2001). *Spirituality in clinical practice: Incorporating the spiritual dimension in psychotherapy and counseling*. Ann Arbor, MI: Sheridan Books.

Szapocznik, J., Rio, A., Perez-Vida, A., & Kurtines, W. (1986). Bicultural effectiveness training: An experimental test of an intervention modality for families experiencing intergeneration/intercultural conflict. *Hispanic Journal of Behavioral Sciences*, *8*, 303–330.

Telles, C., Karno, M., Mintz, J., Paz, G., Arias, M., & Tucker, D., et al. (1995). Immigrant families coping with schizophrenia: Behavioral family intervention v. case management with a low-income Spanish-speaking population. *British Journal of Psychiatry*, *167*, 473–479.

Vaughn, C., & Leff, J. (1976). The measurement of expressed emotion in the families of psychiatric patients. *British Journal of Social and Clinical Psychology*, *15*, 157–165.

Waite, P.J., Hawks, S.R., & Gast, J.A. (1999). The correlation between spiritual well-being and health behaviors. *American Journal of Health Promotion*, *13*, 159–162.

Weiner, B. (1986). *An attribution theory of motivation and emotion*. New York: SpringerVerlag.

Weisman, A. (2005). Integrating culturally based approaches with existing interventions for Hispanic/Latino families coping with schizophrenia. *Psychotherapy: Theory, Research, Practice, Training*, *42*, 178–197.

Weisman, A., Kymalainen, J., Rosales, G., & Armesto, J. (under review). Expressed emotion and collectivism in White and Latino/Hispanic family members of patients with schizophrenia.

Weisman, A.G. (1997). Understanding cross-cultural prognostic variability for schizophrenia. *Cultural Diversity and Mental Health*, *3*, 2–13.

Weisman, A.G., Gomes, L., & López, S.R. (2003). Shifting blame away from ill relatives: Latino families' reactions to schizophrenia. *The Journal of Nervous and Mental Disease*, *191*, 574–581.

Weisman, A.G., & López, S.R. (1997). An attributional analysis of emotional reactions to schizophrenia in Mexican and Anglo cultures. *Journal of Applied Social Psychology*, *27*, 224–245.

Weisman, A.G., López, S.R., Karno, M., & Jenkins, J. (1993). An attributional analysis of expressed emotion in Mexican-American families with schizophrenia. *Journal of Abnormal Psychology*, *102*, 601–606.

Weisman, A., Nuechterlein, K.H., Goldstein, M.J., & Snyder, K. (1998). Expressed emotion, attributions, and schizophrenia symptom dimensions. *Journal of Abnormal Psychology*, *107*, 355–359.

Weisman, A.G., Rosales, G., Kymalainen, J., & Armesto, J. (2005). Ethnicity, family cohesion, religiosity and general emotional distress in patients with schizophrenia and their relatives. *Journal of Nervous and Mental Disease*, *193*, 359–368.

Westen, D., & Morrison, K. (2001). A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies. *Journal of Consulting and Clinical Psychology*, *69*, 875–899.

Woo, S.M., Goldstein, M.J., & Nuechterlein, K.H. (2004). Relatives' affective style and the expression of subclinical psychopathology in patients with schizophrenia. *Family-Process*, *43*, 233–247.

World Health Organization. (1973). *Report of the international pilot study of schizophrenia*, *Volume 1*. Geneva, Switzerland: Author.

World Health Organization. (1992). *Schizophrenia: An international follow-up study*. New York: Wiley.