

INTEGRATING CULTURALLY BASED APPROACHES WITH EXISTING INTERVENTIONS FOR HISPANIC/LATINO FAMILIES COPING WITH SCHIZOPHRENIA

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Evidence suggests that schizophrenia is highly responsive to the sociocultural and emotional atmosphere of the family. Therapies have shown an improvement in schizophrenia symptoms following family-oriented interventions.

However, most programs are developed and offered in English only, and few are culturally informed. Existing programs may fail to meet the needs of minorities, particularly Hispanics/Latinos, the largest minority group in the United States. In this article, a broad literature is reviewed, which strongly supports the integration of culturally based treatment approaches with existing psychoeducational family-focused interventions to enhance treatment programs for Hispanic/Latino patients and families coping with schizophrenia. On the basis of this conceptual integration, an intervention titled "culturally informed therapy for schizophrenia" is described.

Schizophrenia, a debilitating mental illness, appears to occur in all populations, with remarkably similar prevalence rates worldwide (ranging from 1.4% to 4.6%; see Jablensky, 2000, for a review of the epidemiology of schizophrenia). This illness has a dramatic impact not only on those who suffer from it but also on their family members. The past several decades have wit-

nessed a dramatic increase in the number of individuals with schizophrenia who reside with relatives (Goldstein & Miklowitz, 1995). Furthermore, with greater managed care restrictions and less availability of services and supported housing for those with severe mental illness, families bear an even greater responsibility for the care of these individuals (Mueser & Glynn, 1999). It is crucial for those dealing with severe mental disorders to understand factors that contribute to better patient and family functioning.

Although there are clearly biological underpinnings for schizophrenia, mounting evidence now suggests that the course of illness is also highly responsive to the patients' psychosocial and home environment. For instance, more than 30 years of international research in an area known as expressed emotion (EE) strongly indicates that patients with schizophrenia who are in close contact with relatives who express a large number of critical, hostile, or emotionally overinvolved attitudes toward them (designated as high EE relatives) have greater risk of relapse than do patients whose relatives express fewer of these attitudes (designated as low EE relatives; Hooley & Hiller, 2000). Moreover, the link between EE and relapse has been replicated across diverse cultural groups (i.e., British, Mexican American, and Asian Indian). Studies confirming the connection between EE and schizophrenia relapse are numerous and have been reviewed extensively elsewhere (e.g., Butzlaff & Hooley, 1998; Kavanagh, 1992).

These studies indicate a strong need to target EE and other sociocultural factors that relate to the course of illness in family-focused intervention programs. In addition, existing programs have overlooked important sociocultural models that may enhance their efficacy with minorities. Hispanics/Latinos now represent the largest United States minority group. Thus, culturally informed programs in Spanish are especially needed. The aim of this article is to describe a culturally informed therapy for schizophrenia

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(CIT-S) program that was recently developed in English and in Spanish and is currently being pilot tested at the University of Miami.

This article begins with a review of the literature that provides a rationale for the specific areas targeted by CIT-S. In particular, the article explains why addressing attributions, expressed emotion, family cohesion, and religiosity/spirituality in treatment may be effective in assisting Hispanic/Latino patients and their relatives to cope with schizophrenia. Next, the article provides an overview of each segment of CIT-S, and clinical examples of a hypothetical family are provided. The article concludes with a brief delineation of how CIT-S will be evaluated, and important directions for future research are discussed.

Culture and Schizophrenia

Expressed Emotion

As discussed earlier, the prognosis of schizophrenia is strongly predicted by the important construct referred to as expressed emotion. Despite the approximately equivalent prevalence rates of schizophrenia worldwide and the cultural robustness of EE as a predictor of outcome, international research in psychopathology indicates that empathy and support patterns toward mentally ill relatives vary dramatically across national and ethnic groups. In general, relatives of patients from developing or “traditional” cultures tend to be rated as high EE less often than do their more industrialized counterparts. In this article, I follow Smith (2004) in using the term *traditional* to describe cultures that are tradition oriented. These societies tend to have fairly strict and clear codes for behavior and to have a worldview that emphasizes harmony and cooperation with others over individual needs and desires.

Variability in the course of schizophrenia among cultures of different developing statuses has been observed even within nations such as the United States. For example, in one study, the prevalence of high EE in families in the Los Angeles area was found to be 3 times greater in Anglo American families than in Hispanic/Latino families (Jenkins, Karno, De La Selva, & Santana, 1986) and 10 times higher in another study (Telles et al., 1995). In recent research using a cross-national sample (Weisman, Rosales, Ky-malainen, & Armesto, 2005), the authors found

EE rates to be approximately 4.5 times higher in Anglo Americans compared with Hispanics/Latinos using the Five Minute Speech sample method of rating EE and 3 times higher using The Camberwell Family Interview, an alternate approach.

Differences in the prevalence of high EE levels appear to form a generalized cultural pattern in terms of schizophrenia relapse rates. The results of the International Pilot Study of Schizophrenia (IPSS) suggest that patients from the developing nations of Nigeria, India, and Colombia had a more favorable course than did patients from industrialized countries such as Denmark, Czechoslovakia, the United Kingdom, the USSR, and the United States (World Health Organization [WHO], 1992). Although schizophrenia appears to be negatively influenced by high EE universally, the outcome and the course of the disorder seem to be significantly influenced by unique sociocultural forces.

It is important to point out that the IPSS’s (WHO, 1992) finding of a better course of illness in traditional/developing societies, and its attribution that “culture” is at the root of the observed differences, has not gone unchallenged. Some critics argue that methodological problems in the IPSS make the evidence for a more favorable course in developing societies inconclusive. It has also been purported that “noncultural” mechanisms such as societal differences in economics, exposure to diseases, and access to mental health centers may also contribute to observed differences in course of illness. (See Edgerton and Cohen [1994] for a critique of the IPSS and the conclusions drawn from the study.)

Attributions

Attributions appear to be one fruitful construct in better understanding EE and schizophrenia prognosis. Hooley (1987) was among the first to propose a relationship between EE and a relative’s perception of the patient’s control over his or her disorder. In line with a more general attribution–affect conceptual framework developed by Weiner (1986, 1995), Hooley hypothesized that high EE attitudes develop when relatives perceive that the symptoms of schizophrenia are, at least to some degree, controllable by the patient. In the past two decades, Hooley’s (1987) hypothesis regarding the link between attributions and EE has been tested and supported

in numerous studies and with both Caucasian (Brewin, MacCarthy, Duda, & Vaughn, 1991; Weisman, Nuechterlein, Goldstein, & Snyder, 1998) and non-Caucasian (Weisman, López, Karno, & Jenkins, 1993) samples. Consistent with attribution theory, these studies found that attributions about the controllability of schizophrenia differed between high EE and low EE relatives. Low EE relatives tended to make more external and uncontrollable attributions for the family member's behavior (e.g., "I think Victor's avoiding us is all part of his illness; that is what this disorder does to a person"), whereas the attributions of high EE relatives who expressed criticism and hostility tended to be more internal and blameworthy (e.g., "My view of things is that Maria acts that way so my wife doesn't give her any responsibilities around the house"). Finding the EE-attribution link with different ethnic groups suggests that attribution theory may have broad utility for better understanding expressed emotion.

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. Jenkins et al. (1986) noted that high EE Mexican Americans appeared less accepting of the illness-based view of the disorder than did low EE Mexican Americans (Jenkins et al., 1986). On the whole, however, Mexican Americans were much more likely than Anglo Americans to view the problem as one of illness, irrespective of EE status. Jenkins (1984) found that Mexican American key relatives were far less likely to criticize symptom behaviors than were their Anglo American counterparts. In addition, Mexican Americans often associated the illness with one's nervous or mental condition or some other legitimate problem. The authors noted that belief in the legitimacy of schizophrenia as an illness was linked to views that symptom behaviors generally lie outside the patient's personal control.

More recently, Weisman and López (1997) directly tested for cultural differences between Mexicans residing in Mexico and Anglo Americans living in the United States. In this study, Mexicans were much more external in perceptions of control, and less blaming in their attributions about schizophrenia, than were Anglo Americans. Anglo Americans in this group also reported feeling more intense unfavorable emo-

tions toward a person with schizophrenia. The research reviewed above suggests that cultural differences observed in family members' reactions to schizophrenia may shed light on the puzzling observation made by the WHO (1992). On the basis of its multisite international pilot study on schizophrenia, the WHO concluded that patients from many developing societies have a quicker and more complete recovery than do patients from more industrialized societies. It seems plausible that this stems from cultural differences in attributions and from the emotional responses that follow.

Collectivism and Family Cohesion

For at least the past decade, researchers (e.g., Lefley, 1990; Weisman, 1997) have begun to speculate that strong family values and a collectivistic orientation may be additional factors that underlie the lower rates of high EE among traditional cultures and the more benign course observed for schizophrenia patients from these societies. *Collectivism* refers to individuals and societies that put group goals above their own individual goals and who, from birth onward, are integrated into strong cohesive in-groups, which continue to protect them throughout their lifetime in exchange for unquestioning loyalty and support (Kim, Triandis, Kagitcibasi, Choi, & Yoon, 1994).

Research by Singelis (1994) suggests that, compared with a strong value placed on independence and uniqueness in mainstream American culture, many cultural groups emphasize collectivism, or interdependence and connectedness with others. The perception of being interconnected with another may lead to empathy for his or her problems and, in turn, to more supportive reactions. This may be particularly true for individuals sharing genetic ties. In Hispanic/Latino cultures, as is true for many traditional cultural groups, the family is considered to be the single most important social unit for the individual (Murillo, 1976). It seems reasonable that individuals with strongly familistic identities might be motivated to view odd or disruptive behavior of a loved one in a more benign way to preserve the solidarity of the family. Believing that the relative with schizophrenia is unable to control disruptive behavior may help justify and facilitate continued acceptance of the ill relative in the household.

In this article, the abbreviation H/L (Hispanic/Latino) is used from this point forward to refer to both men and women in the United States who have come from or have ancestry from Mexico, Puerto Rico, the Dominican Republic, Cuba, El Salvador, Nicaragua, Colombia, Venezuela, Ecuador, Honduras, and other Latin American countries. Though the definitions are controversial, generally, the term *Hispanic* is defined as relating to the people, speech, or culture of Spain, whereas the term *Latino* does not necessarily include reference to Spain. I am aware that neither term is accepted by all groups and that there is a trend for some groups to prefer one term over the other. For example, Cuban Americans living in Miami generally report a preference for the term *Hispanic* over *Latino*, whereas Mexican Americans and Central Americans, living in Los Angeles, generally report a preference for the term *Latino* over *Hispanic*. Even within subgroups, there are differences of opinions, and some individuals prefer no collective term (neither *Hispanic* nor *Latino*) and instead prefer to be identified by country of origin or ancestry (e.g., Mexican or Cuban), as both terms fail to identify significant within-group racial and cultural variability and the influence of indigenous peoples (D. W. Sue & Sue, 1990).

In the same vein, it is also important to point out that, in this article, no differentiation is made among H/L Americans from diverse cultural backgrounds. Despite historical and cultural ties, however, H/Ls represent a vastly heterogeneous group of people who come from different countries with different cultural and sociopolitical histories (Zea, Mason, & Murguía, 2000), and some variability in beliefs and values among different H/L groups (e.g., Puerto Rican Americans, Dominican Americans, Salvadoran Americans) does occur. Despite widespread within-group differences, previous research suggests that H/Ls from various countries of origin do share many commonalities, including language, and several of the primary variables discussed in this article (e.g., strong family unity, strong religious faith, and sense of oneself as highly connected with others; Garcia-Preto, 1996). Hence, whereas variability in responses may occur between and among different H/L groups, as a whole, these groups are expected to endorse several beliefs and values that are more similar to one another than to those of Anglo Americans.

Drawing from prior research, I speculate that

strong family values and a tendency to externalize blame may be two factors underlying the greater compassion and lower rates of criticism from H/L relatives (and perhaps other minority groups) toward their loved ones with schizophrenia. It is further proposed that strengthening these values and beliefs in treatment programs may help patients and their relatives cope better with mental illness.

Religion/Spirituality

I also speculate that certain traditional values common in many developing societies may lend themselves to conceptualizing mental illness symptoms in a family member in a less stigmatizing and blameworthy fashion. In turn, this may lead to lower levels of criticism and animosity toward the ill relative. For many individuals from traditional cultures, religion/spirituality provides a reference point for the meaning of many events and behaviors (Lefley, 1990).

In this article, no distinction is made between the terms *religion* and *spirituality*, and for the remainder of the article, the initials R/S are used to represent both constructs and all forms of the words (i.e., *spiritual*, *spirituality*; *religion*, *religiosity*). In some contexts, however, *religion* is used to refer to a shared belief system (dogma) and communal ritual practice (liturgy), and *spirituality* is used to refer more to one's search for meaning and belonging and the core values that influence one's behavior (Sperry, 2001, p. 4).

These heuristics are useful, and it is important for researchers conducting empirical research to differentiate between these constructs in the future. In this article, however, they are not separated, mainly because, until recently, religion and spirituality were measured by global indices (e.g., frequency of church attendance, self-report of spirituality and religiousness), and most of the empirical studies reviewed in developing the viewpoints expressed in this article did not formerly distinguish between these constructs. Thus, it would be difficult to tease apart one from the other when interpreting the findings. Whereas I believe it would be beneficial to examine these constructs separately in future studies, it should also be pointed out that some investigators actually oppose a bifurcation (e.g., Hill & Pargament, 2003).

Research examining the relationship of both religion and spirituality to serious mental illness

offers evidence that these constructs may relate to the supportive and generally low EE attitudes observed in many studies with H/L families. In predominately Catholic H/L societies, for instance, attitudes toward illness are frequently governed by the premise that God controls our lives and often works in mysterious ways (Bachy-Rita, 1982). Many H/Ls also practice, or are exposed to, folk religions or healing practices such as Curanderismo, Espiritismo, and Santeria (Harris, Velásquez, & White, 2004). In these practices, common symptoms of mental illness, such as paranoia, anxiety, or irritability, are often attributed to external or uncontrollable sources such as spirit possession or a hex imposed by an enemy. External control perspectives from both Catholicism and folk healing religions may send the message that individuals are not at fault for their adversities (e.g., symptoms of mental illness) and that what happens to others can also happen to oneself. This worldview likely impresses upon H/Ls the need to be more compassionate, understanding, and tolerant of other people's conditions such as schizophrenia.

In a recent study, Weisman, Gomes, and López (2003) found that 40% of a sample of relatively unacculturated H/Ls living in the Los Angeles area made at least one reference to God or R/S in discussing their relative with schizophrenia. Nearly all of these comments reflected use of R/S in a supportive manner. The following is one example from the Weisman et al. (2003) study (translated from Spanish): "I only ask God to give us patience to bear all this. To survive what comes up, right. What can we do? It is out of our hands. So, we have to be cool and calm to get through it" (p. 578). Another relative said,

What I do is ask God, my God, since I was little, my parents raised me in, in an environment to have faith in everything to . . . trust God for everything. And that is what I say, "My God, without you we are nothing. You are the one who has to help us. If you sentence us, you know the reasons. But you also have to help us survive them, right?" (p. 578)

Relatives did not appear to use R/S in a passive, resigning manner. Instead, they often used R/S actively to cope with the illness. The following excerpt captures this: "We give him advice and tell him to go to church, you see? At church he gets a lot of comfort and listens to the priest" (p. 579). Another stated, "What I do is ask God for help, and I ask God for protection" (p. 579). In other words, results suggest that H/Ls use R/S as an aid to better understand and come to terms

with the illness and as a mechanism to help the patient and the family cope with the disorder.

In the Weisman et al. (2003) study described in the preceding paragraph, the authors did not provide data concerning references to R/S among more acculturated H/Ls or among Anglo Americans. However, in another analog study in which college students in the United States and in Mexico read vignettes about a hypothetical family member with schizophrenia, Weisman and López (1996) found direct evidence that Mexicans report holding more intense R/S beliefs and values than do Anglo Americans. Whereas this study did not assess EE, the authors found that Mexicans were much more external in attributing blame toward the fictional patient and were much less likely to report feelings of frustration and anger toward the patient.

Recent research (e.g., Turner & Gil, 2002; Vega, Alderete, Kolody, & Aguilar-Gaxiola, 2000; Vega & Sribney, 2003) indicates that, for H/Ls, as length of stay in the United States increases, mental health outcomes become worse, suggesting an inverse relationship to acculturation. For instance, Vega and Sribney (2003) found that, among Mexican American immigrants, social and cultural assimilation into U.S. culture, as indicated by English language use and year in the country, increases vulnerability to alcohol addiction. In line with the research reviewed above, it is plausible that as H/Ls acculturate, they assume more individualistic values, make more attributions to person, and may have less access to family, R/S, and community networks that could help them deal with serious mental illness.

Family Treatments for Schizophrenia and Other Severe Mental Disorders

Several studies have shown that family interventions are efficacious in treating adults with psychiatric disorders. Family-focused treatments, which provide psychoeducation, enhance coping skills, and improve family adaptation, have shown power in the treatment of schizophrenia (Falloon, Boyd, & McGill, 1984; Goldstein & Miklowitz, 1995). Family treatments have also been effective for bipolar disorder. Miklowitz et al. (2000) and Rea, Tompson, Miklowitz, & Goldstein (2003) have found that bipolar patients given family-focused therapy and routine pharmacotherapy had lower relapse rates than did

patients in a comparison group who received less family education and routine pharmacotherapy. Overall, these interventions have focused on providing psychoeducation about the disorder and on building communication and problem-solving skills in a family context.

Despite knowledge that family-oriented interventions can be effective for severe psychopathology, most mental health facilities still lack family treatments of any type (Lefley, as cited in McFarlane, 2002). This is likely due to the costs of implementing expensive and lengthy treatments. In addition, over the years, a number of researchers and scholars have pointed to the paucity of social science research on ethnic minority populations and the lack of attention to cultural variables in the research (S. Sue & Sue, 2003). For example, Rogler, Malgady, Constantino, and Blumenthal (1998) strongly argued for the need to render traditional treatments more accessible to H/Ls by extracting elements from H/L culture and using them to modify traditional treatments. Family therapy might be an especially logical approach with H/Ls and other ethnic minorities, given the interpersonal emphasis in many minority communities (Nagayama-Hall, 2001).

Although extremely little research has been conducted on the outcome of treatment with H/Ls, Organista and Muñoz (1996) suggested that there are clear cultural and economic reasons for advocating for psychoeducational and cognitive-behavioral treatments (CBT) for H/L families. They suggested that the expectations of many H/L patients include immediate symptom relief, guidance and advice, and a problem-centered approach. The authors argued that the didactic style of CBT is well suited to H/L patients, in that it quickly orients patients to treatment by educating them about mental illness and how the intervention can be used to treat their problems. Organista and Muñoz argued that this type of treatment is useful for "demystifying psychotherapy, while still being consistent with role preparation in which patients unaccustomed to therapy are taught what they can expect and what will be expected of them in the attempt to prevent drop-out and enhance treatment" (p. 259).

Given that psychotherapy is often associated with stigma in H/L culture, Organista and Muñoz (1996) further contended that use of therapy manuals, homework assignments, and chalkboards help H/Ls to think of therapy as more of a class, which alleviates stigma. Furthermore, a large

proportion of minority families, including H/Ls, live below the poverty line. Organista and Muñoz have suggested that CBT, with its short-term, directive, and problem-solving orientation, may be more consistent with the expectations of low-income groups whose pressing life circumstances frequently demand immediate attention and interfere with long-term treatment.

Whereas a few studies (e.g., Comas-Diaz, 1981; Roselló & Bernal, 1999; Szapocznik, Rio, Perez-Vida, & Kurtines, 1986) offer reason to expect that cognitive behaviorally oriented family treatments will be effective for H/Ls, most currently existing programs are offered in English only. They therefore fail to meet the needs of numerous H/Ls who do not speak English fluently. This is particularly a need in some U.S. cities such as Miami, Los Angeles, and San Antonio, where H/Ls represent the largest ethnic group and many residents are monolingual Spanish speakers. Research is clearly needed to assess the impact of family therapy among minorities. In addition, existing programs have overlooked important sociocultural models that may enhance their efficacy with minorities and Anglos alike. On the basis of previous research, I speculate that efforts to increase a sense of unity and collectivism in the family and incorporating existential and R/S dimensions into treatment may make family interventions more appealing and relevant to Hispanics.

Addressing Family Cohesion/Collectivism in Therapy

The ecological validity of psychosocial treatment outcome research can be improved by incorporating a culturally sensitive perspective (Bernal, Bonilla, & Bellido, 1995). As stated earlier, the importance placed on individualism in the United States is not shared by most other cultures and U.S. minority groups, which often emphasize humility, anonymity, and a submission of the self to the welfare of one's group (both the family and the community). According to Aponte and Johnson (2000), the intense focus on the individual that is typical of mainstream U.S. therapies is alien to these worldviews. They caution that a lack of sensitivity to the discomfort induced in ethnic or cultural minorities by such factors can lead to ineffective treatment and early termination.

The strength of the family, in particular, has

often been regarded as especially salient for individuals from traditional cultures. For H/Ls, the family holds an extremely important and valuable role in their lives (Acosta, 1982). Recent research found that the family (*La familia*) is still a focal point in the lives of H/Ls ("Latinos in America," 2000). The Latinos in America study, which was based on interviews with 2,417 Latinos, suggests that the findings are generalizable, as the sample involved immigrants from first through third generation and representatives of all H/L backgrounds. Thus, although there are certainly differences among H/Ls of different countries of origin, the importance of the family seems to be a commonality among them. Thus, for clinicians to establish credibility and trust when working with H/Ls, they must respect and incorporate the members of the extended family and understand important aspects of family relations. For example, using younger family members to serve as language translators for older members could upset power balances and could violate important age hierarchies common in H/L cultures.

In treating H/Ls, Arredondo and Perez (2003) argued that clinicians need to drop the medical model that presumes pathology, with the illness or malady typically viewed as emanating from the individual without sufficient attention to various contexts that influence psychological well-being. Forces that shape the H/L worldview include survival through cooperation, collaboration, and learning of new skills. Clinicians need to be aware of the interdependent thinking and behavior that has become the infrastructure for survival. In sum, it is crucial with H/Ls and other minorities that clinicians think about collectivistic value orientations such as allocentrism, personalismo, and familismo¹ (Arredondo & Perez, 2003). These value systems have widely been touted as helping H/Ls and other minorities endure difficult circumstances such as discrimination, poverty, and even mental illness in the family.

However, it is also important to keep a watchful eye for potential cultural patterns that may in fact be detrimental to individual members within H/L families. For example, excessive or pathological machismo (the notion that males must live up to the dictates of being stronger, smarter, and better than women; Flores Niemann, 2004) may lead H/L wives, daughters, and female siblings to be viewed and to view themselves as inferior to their male counterparts. This cultural practice has

the potential to result in unfair treatment of females in the family and to detrimentally impact their self-esteem. Marianismo, the cultural view that "good" H/L women are family and home oriented, nurturing, self-sacrificing, and submissive (Flores Niemann, 2004), may also lead some H/L women to make life choices that are detrimental to their own well-being (e.g., a daughter who opts not to finish high school or go to college in order to stay home and take care of her father and brother). Clinicians need to guard against maladaptive behaviors and practices in family functioning, even if the practices are common and widespread in the culture of the family. Explaining to families how certain cultural beliefs and practices may be harmful to their loved ones, and suggesting viable alternative viewpoints and ways of behaving, is sometimes critical to avoid perpetuating maladaptive cultural norms.

These caveats aside, it appears that some H/L traditions and practices, such as family collectivism, are associated with better well-being. For example, Weisman, Rosales, Kymalainen, and Armesto (in press) recently found that increasing perceptions of family cohesion for H/L patients with schizophrenia is associated with decreasing general emotional distress and fewer psychiatric symptoms. In addition, in this same study, Weisman et al. (in press) found that greater perceptions of family cohesion also had a protective effect against emotional distress for the H/L family members of the patients in the study.

It is surprising that, despite frequent calls by researchers and clinicians for recognizing the importance of valuing the family and using it as a resource in treatment, few studies have empirically assessed the impact of targeting familism or collectivism as a direct treatment goal in therapy. In addition, few specific techniques of family therapy currently exist for working with minorities. There is some evidence, however, that family-oriented, interdependent approaches may be particularly effective with H/Ls. Perhaps the best example comes from research by Szapocznik and associates (e.g., Szapocznik & Kurtines,

¹*Allocentrism* refers to the tendency to give precedence to group goals over individual goals. *Personalismo* is a Spanish word that describes the mind-set that values human relationships over formal rules and regulations. *Familismo*, also a Spanish word, signifies the pervasive influence and importance of the family (Smith, 2004).

1993), primarily with Cuban American families. Szapocznik and colleagues have developed specific techniques to treat a variety of problems and disorders (e.g., adolescent drug abuse, depression in the elderly, HIV-infected gay H/L males) using a systems approach that incorporates Cuban values. In a landmark article, Szapocznik and Kurtines (1993) described viewing clients' problems within a contextualist paradigm. *Contextualism* refers to the view that behavior cannot be understood outside of the context in which it occurs. Contextualism is concerned with the interaction between the organism and the environment.

In their 1993 article, Szapocznik and Kurtines expanded contextualism in two important ways. First, they argued that, particularly for H/Ls, the individual needs to be understood in the context of the family, and the family needs to be understood in the context of the culture. Stemming from these beliefs, the authors developed a treatment called Bicultural Effectiveness Training (BET). This is a 12-session family-oriented intervention that aims to enhance bicultural skills in all family members. In particular, they emphasized that parents and children need to manage problems and cultural differences within the family and successfully function in a pluralistic society. Treatment strategies used include temporarily detouring the conflict away from any one family member and instead focusing on intergenerational and intercultural differences. Families are provided with a transcultural perspective that emphasizes communalities among the family members and deemphasizes differences or re-frames them as strengths.

Szapocznik and colleagues (Szapocznik & Kurtines, 1993; Szapocznik et al., 1986) developed modes of interventions for a variety of problems that they tailored for use with Cubans, but which are based loosely on Minuchin and Fishman's (1981) Structural Family Therapy. This work is especially valuable because it has a strong theoretical base, is derived from actual clinical observations, and takes into account the complexities of real-life family interactions. One example is that they caution therapists to respect the authoritative role of the father, even when this role seems unreasonable (see Martinez, 1993). Szapocznik et al. said that, before attempting to change patterns of interacting, it is essential to form alliances. Although H/L families are often supportive, Szapocznik et al. were clear to address in treatment how family processes such as enmeshment can also be destructive. In these treat-

ments, the researchers place particular emphasis on understanding family power balances based on traditional role expectations and then working within the context to improve family functioning.

Incorporating R/S Into Family-Based Treatment for Schizophrenia

The large majority of Americans (approximately 90%) report that they believe in God (e.g., Wiggins Frame, 1996). One in three Americans avows a firm R/S commitment (Gallup, 1989). Thus, R/S is a significant component of many contemporary U.S. lives, particularly in ethnic minorities. With this in mind, it seems important that mental health practitioners prepare themselves to make use of R/S in the therapeutic setting (Nagayama-Hall, 2001).

Wiggins Frame (1996) argued that R/S faith and psychotherapy intersect. Both focus on a transformation of the mind and emotions. Stander, Piercy, MacKinnon, and Helmeke (1994) further purported that R/S and family therapy are especially overlapping. Both foster a sense of identity, give meaning to life, and provide social support networks and rituals that can facilitate positive change in individuals and enhance the physical and emotional welfare of their members. Because of the similarities between R/S and family therapy, Stander et al. (1994) argued that clinicians may enhance treatment by viewing themselves as partners with R/S in enhancing meaning, functioning, and life satisfaction for clients.

Although incorporating R/S into family therapy for schizophrenia may be helpful for most families, it might be particularly helpful for minorities who already tend to rely on R/S for conceptualizing and coming to terms with adversity. As discussed earlier, many H/Ls with schizophrenia or with an afflicted relative draw comfort and cope with mental illness by turning to R/S (Weisman et al., 2003). Thus, it is likely that when treating R/S clients, incorporating R/S into the intervention may make the treatment appear especially relevant and palatable. Organista and Muñoz (1996) suggested that, when working with H/Ls, reinforcing church attendance and prayer as part of the behavioral and cognitive activities of the intervention may help alleviate stress and negative mood states.

Recently, even some mainstream psychotherapy interventions have begun to incorporate R/S

elements into treatment. Nielsen, Johnson, and Ellis (2001) argued that Rational Emotive Behavior Therapy (REBT) is well suited for R/S individuals. For example, organized religions typically instill beliefs, strengthen these beliefs, or attempt to correct beliefs that conflict with the dogma. In REBT, the fundamental goal is to change irrational and dysfunctional beliefs. Thus, Nielsen et al. believe that many of these techniques for changing beliefs may seem familiar, straightforward, and even comforting to R/S clients.

There is some evidence that R/S is associated with better physical and mental health. McCullough, Hoyt, Larson, Koenig, and Thoresen (2000) conducted a meta-analysis of 42 independent studies of the association of R/S involvement with all-cause mortality. Results from this analysis strongly indicated that people high in R/S involvement were significantly more likely to be alive at follow up than were people lower in R/S involvement. In a meta-analysis exploring how R/S relates to mental health, Payne, Bergin, Bielema, and Jenkins (1991) found R/S to be associated with better well-being, self-esteem, and personal adjustment, and less alcohol and drug abuse, sexual permissiveness, and suicide. In another study assessing R/S beliefs in marital functioning, Abbott, Berry, and Meredith (1990) found that the majority of R/S individuals (selected from 20 major U.S. regions) reported that R/S was helpful to family life. This was primarily reported in the form of enhancing the family's social network and by encouraging family members to petition God for help with family problems.

The findings reviewed above are correlational and do not necessarily imply that increasing clients' R/S or incorporating R/S into treatment will enhance therapeutic efficacy. It could be that R/S individuals have a host of other qualities (optimism) and opportunities (social interaction) that are associated with positive mental health. However, a few studies indicate that integrating R/S elements into treatment may improve patient functioning. In one study, Propst, Ostrom, Watkins, Dean, and Mashburn (1992) compared two versions of CBT of equal length, one with R/S content and one with a standard cognitive-behavioral protocol. Only patients who met *DSM-III* criteria for depression and identified themselves as R/S and of Christian faith were included. The authors found that, at the end of

treatment, patients receiving therapy with a R/S component had lower posttreatment depression and better adjustment than did patients receiving a similar but non-R/S treatment or no treatment (wait-list controls).

However, at least a few studies have not found that incorporating R/S into treatment enhances efficacy. In one study, Koenig, George, Blazer, Pritchett, and Meador (1993) found that, after controlling for confounding variables such as gender, health, life events and socioeconomic status, the relationship between prayer interventions and anxiety disappeared. In a two-part study, Lingren and Coursey (1995) entered 30 clients who were interested in R/S into a four-session, highly structured psychoeducational program designed to help clients utilize their R/S beliefs to foster better mental health. All participants were already engaged in a psychosocial research program and were described by the authors as seriously mentally ill. Whereas Lingren and Coursey did find significant pre-post increases on a R/S support scale, they did not find differences in depression, hopelessness, self-esteem, or purpose in life. However, it does not seem surprising that a group with a duration of only four sessions would have much impact on powerful negative emotions and entrenched personal beliefs about one's worth and one's life meaning.

A fundamental issue that has kept R/S and the clinical fields in relatively separate compartments is the legitimate concern of some clinicians and researchers that R/S is sometimes used maladaptively. Organista and Muñoz (1996) offered the example of patients reporting that they "just pray" instead of adhering to their treatment regimen (e.g., taking medication, doing the week's homework assignment). They suggested methods of challenging patients who use R/S in a non-healthy manner. Their approach to this type of situation is to ask clients to share the exact content of their prayers. Commonly, clients state that they ask God to help them with their problems. Organista and Muñoz reported that they try to help clients shift their prayers in a more active direction with techniques such as the saying "Ayúdate, que Dios te ayudará," which translates to English as "God helps those who help themselves." They also encourage therapists to model for patients and ask them to recite prayers in which they ask God for support and courage in trying out new behaviors. They illustrate this

point with the example of a woman suffering from panic disorder with agoraphobia who, through treatment, begins to pray for support in her efforts to leave her house, attend therapy, and do things by herself.

Complications of R/S may be particularly important for patients with schizophrenia. Delusions of a R/S nature are found in almost half of patients with schizophrenia, and it is widely known that clergy are frequently consulted by patients with the disease (Torrey, 1995). The onset of the disorder usually occurs around the same period of life when philosophical and R/S beliefs are developing and in flux. Thus, R/S can be incorporated into a patient's psychopathology. During the onset of the disorder, many patients undergo intense heightened awareness and conclude that their R/S experiences (sometimes in the form of R/S delusions or hallucinations) indicate a unique and special relationship with God. Clinicians need to take into account that R/S may sometimes be used dysfunctionally and must guard against maladaptive uses in therapy.

That being said, like most human beings, people with schizophrenia may benefit from relating to God and may have a strong need to relate to a God or a philosophical worldview that allows them to place themselves and their lives within a larger context. Adding a R/S component to therapy with patients with schizophrenia may make the treatment appear more relevant and palatable. Because R/S is very important to most people, including patients with schizophrenia, to ignore it in treatment may be akin to denying the person. Of course, when working with patients and families with schizophrenia, clinicians should be exceedingly careful to help them channel their R/S beliefs and coping mechanisms in productive and healthy ways.

Integrating Culture Into Existing Treatment Programs for Schizophrenia

There is a strong need for psychotherapies for ethnic minorities that are both empirically supported and culturally sensitive (Nagayama-Hall, 2001). It is essential that researchers construct theories of psychotherapy and evaluate treatments grounded in the realities and experiences of ethnic minority populations (Bernal & Scharrón-Del-Río, 2001). I (with assistance from my graduate students) am presently developing a first-stage manual and pilot testing a treatment

program designed specifically to be relevant and effective for H/L families coping with schizophrenia. This family treatment program, called culturally informed therapy for schizophrenia (CIT-S), is informed by the research reviewed above. The intervention combines cognitive-behavioral techniques with demonstrated efficacy with cultural components hypothesized to enhance this treatment for minorities and Anglos alike. The cognitive-behavioral components are drawn primarily from adult family-focused treatments for schizophrenia (Falloon et al., 1984; Miklowitz & Goldstein, 1995) and bipolar disorder (Miklowitz & Goldstein, 1995), which have been shown to reduce symptoms in patients with serious mental illness. This treatment program is outlined below.

An important first goal of CIT-S is to enter the worldview of the family rather than unvaryingly applying a set of techniques and theoretical concepts to every family. This, of course, requires gaining a clear picture of the families' own sense of their organization and transactional patterns as well as understanding important historical, political, economic, and social realities that impact them. This approach aids in *joining* the family, a term coined by Minuchin (1974) that refers to accepting and accommodating families to win their confidence and circumvent resistance (Nichols, 2004). Joining the family and forming alliances makes it considerably more likely that any family will accept the therapist and be compliant in treatment; after all, people generally are not eager to accept advice from someone whom they feel does not really understand them (Nichols, 2004). Collecting information in the early stages of treatment, which allows the therapist to view the family members through their own lens, will assist the therapist in moving from the role of distant observer to that of family ally. Joining and forming alliances may be particularly important with H/L families, which tend to value personalismo above and beyond more structured and formal relationships.

Treatment Stages

The following five segments of treatment are proposed for CIT-S: family cohesion, education, spiritual coping, communication training, and problem solving. Each segment has a suggested length of approximately three treatment ses-

sions.² Examples from a hypothetical family (the Diaz family), which include the patient (Juan), his mother, and his grandparents, are used to help illustrate examples of how each segment may play out in therapy.

The first proposed segment of treatment, family collectivism, is aimed at fortifying a strong sense of family unity and helping members to view themselves as a team working toward a mutual goal. In the first session, each family member should be commended for coming to treatment. This should be framed as indicating a real commitment to the patient and to the family. Participants should be asked what they hope to gain from the treatment. Commonalities should be pointed out (most family members and patients will likely report that they hope to see improvement in patient functioning). Family members should also be asked to describe their perception of their role in the family; that is, they should be asked to discuss their beliefs about how they contribute to the family, both in terms of enhancing family well-being and possibly contributing to family problems. Data gathering in this fashion assists the therapist in conceptualizing the family from the family members' own vantage point, which is necessary for joining or forming a strong alliance with the family (Nichols, 2004).

In this segment, participants should be encouraged to view themselves as a system of interdependent and interrelated individuals whose behaviors necessarily affect other family members. Differences in generational and gender roles should be discussed. For homework, participants should be asked to write a narrative (or prepare one to be delivered orally, if they are uncomfortable or unable to write) that they will share in treatment. This narrative should describe how family members feel that they might contribute differently to improve family functioning. In addition, they should be asked to point out specific behaviors in other members that they appreciate and feel enhance family well-being and other behaviors that they would like to see increased or modified to better benefit the family as a whole. These narratives should be utilized in the early sessions, primarily to help families get a clearer picture of how each member contributes and influences the family system and to generate ideas about potentially improving family functioning. These narratives will likely generate some feelings of anger as participants identify problem

behaviors in other family members. Families should be provided with a transcultural perspective that emphasizes commonality between members and deemphasizes differences. Attempts should be made to deflect the blame for family problems away from any one individual (e.g., the patient). However, families should not be formally instructed to implement any changes to their behavior on the basis of these narratives until the fourth (communication training) and fifth (problem-solving) segments of treatment, when the ideas generated from the narratives are revisited.

Hypothetical example from Segment 1. The therapist has asked each member of the Diaz family to respond to the following question: "From your own perspective, why are you in treatment and what do you hope to get out of it?" Each family member's response, and the therapist's reply, appear below:

- Juan:* No disrespect to you doc, but to be honest, I'm here because my mom and grandma insisted. I know the medication helps me think better, but I'm not really into the psychotherapy stuff. [Juan smiles] I'm also here because my favorite mall is across the street from here. I love to stroll around with mama and my grandparents there. It should be easy to convince them to go if we are so close.
- Mom:* Well that is an easy question for me. I'm here because my son is sick and I'd do whatever it takes to help him get better.
- Grandmother:* Ditto.
- Grandfather:* Like Juan, I'm not so sure that this will help us, but we're a family. That is what families do. They stick together. When someone is sick or in need, all of us should do our share to help out. My daughter and wife think this will help, so I'm here. That is all there is to it.

²Handouts that accompany CIT-S can be obtained by contacting Amy Weisman.

Therapist: Well, everyone may not agree that psychotherapy is the best way to help Juan, but I am really impressed at how each of you is clearly very concerned about Juan and willing to try this out. Coming to weekly therapy is a big commitment and that says to me that you really care deeply about Juan. [Therapist to Juan]: And it is great that you are taking charge of your illness by trying new things even if you are a bit skeptical that they will work. It is also great that you like to spend time shopping and hanging out with your family. You are all clearly a team here and that is reassuring because we find that patients from families who are committed to one another and spend time together seem to have a better course of illness.

The second proposed segment, education, is drawn largely from earlier psychoeducational programs (e.g., Falloon et al., 1984; Goldstein & Miklowitz, 1995). This segment should provide information about the known causes and exacerbating factors of schizophrenia, including genetics, neurochemistry, life stress, and other biological, interpersonal, and social factors. Biological and psychosocial treatments found to be effective should be reviewed. Whereas it is stressed that families do not cause schizophrenia, the emphasis is on ways in which family members can work together to overcome its symptoms. Families should be provided with information about the ways in which family and other social interactions affect mood, cognition, and overall behavioral functioning. In this module, attributions (blameworthy) and attitudes (high EE) known to be associated with a poor course of illness should be directly targeted. Participants should be taught about the detrimental effects of negatively charged home environments on both patients and their relatives. Families should also be taught to develop balanced and realistic attributions regarding the amount of control that patients

have over the illness and the associated symptoms.

Hypothetical example from Segment 2. The therapist has presented the Diaz family with handouts and information about the causes of schizophrenia. Juan's mother's response and the therapist's reply appear below:

Mother: I did not realize that heredity plays such a strong role. It is a little reassuring, actually, because my brother also had some of the same features that I see in Juan. Growing up, we would sometimes find my brother alone, talking out loud. He would say that he was talking to spirits. They [pointing toward her parents] would tell me that my brother had mal de ojo [the evil eye]. Dad thought my brother's weird behavior was caused by a hex put on him from our neighbor. My dad and this neighbor had a long-standing feud over ownership of some fruit trees growing between our yards. I do not really believe in hexes or any of that folk stuff, especially now that I am an adult, but I do often wonder if Juan's illness might have something to do with the way I raised him. You know, we learn things from our parents and grandparents, and Juan always spent a lot of time around them too [pointing to her parents]. I guess, in a way, I wondered if the way my parents and I raised Juan might have made him sick, like my brother.

Therapist: Wow, I imagine that believing that Juan's illness was caused by the way you and your family raised him must have been quite a burden. [Therapist looking at the grandfather] I imagine it was equally stressful for you to think your son's symptoms were caused by your difficult relationship with your neighbor. As I said earlier, there is no evidence that family environment or family behavior can cause schizophrenia. In other words, I want to be very clear that you and your family did nothing to bring on Juan's illness. On the other hand, research does show that people with

this illness do function much better in supportive and low-key environments, so the way you relate to Juan now can have a major impact on the course of his illness. Together we will work on communication and problem-solving techniques that I hope will help you to all interact in a way that will be beneficial to Juan and his illness and, hopefully, to the rest of you as well.

The third proposed segment of treatment, religious/spiritual coping, should be aimed at helping participants tap into R/S and/or existential beliefs that may aid them in productively conceptualizing and coming to terms with the illness. This segment should begin with a detailed R/S history, which will include an exploration of each family member's R/S beliefs and values. Specifically, clients should be 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 should also be asked to outline their participation in R/S communities and to discuss any R/S supports (e.g., priests, rabbis) they currently have or would like to have in their lives. They should be asked about R/S practices (prayer, meditation, attending R/S services) that they currently use or would consider using. Practices such as forgiveness, empathy, and appreciation are at the heart of a R/S perspective (Sperry, 2001). These concepts should be discussed, role-played, and encouraged, both inside and outside of the treatment setting. Homework for this module should include conducting a R/S or philosophical genogram, reading R/S bibliotherapy, and bringing in for discussion R/S writings that appear relevant to coping with mental illness. Clients should also be encouraged to engage in R/S practices outside of 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 should reframe maladaptive uses of R/S, such as believing that the patient's mental illness is "God's punishment for some wrongdoing." The family should be helped to reframe this type of negative attribution with more adaptive R/S teachings, such as "God uses struggles to build virtue and patience." Another example 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 should refer to R/S scriptures, such as "God helps those who help themselves," in redirecting clients to use their R/S beliefs adaptively. The R/S coping segment of treatment can and should be completed with all clients, regardless of R/S orientation (or lack of R/S orientation). On the basis of previous research (Gallup, 1989; Nagayama-Hall, 2001; Wiggins Frame, 1996), it can be expected that approximately 10% of clients will report that they do not believe in God, and an additional 5%–10% may report that they believe in God but are uncomfortable or uninterested in a R/S-based treatment. No attempt should be made to steer clients toward adopting a R/S stance. This subgroup of clients should still be asked to complete very similar exercises, but rather than focusing on specific religious beliefs, their philosophical beliefs about right and wrong, empathy, and life's meaning should be emphasized. As with R/S clients, these participants should also be encouraged to engage in existential exercises such as meditation and existential readings and to practice the same R/S notions of forgiveness, empathy, and appreciation. Within families, some members may identify as R/S and choose to focus on their R/S beliefs in treatment, whereas others may not. Regardless of R/S orientation, all participants should be encouraged to respect one another's beliefs (this ground rule for therapy should be established during the first session and reinforced during each module).

Hypothetical example from Segment 3. The Diaz family is discussing R/S and their view of how it may relate to Juan's illness:

Mom:

Well, I'm definitely a believer; I go to church once a week and I pray to the Virgin of Guadalupe every night that she give me the strength to carry on and be the best parent that I can be to Juan. I do not know if it helps any, but it makes me feel better for at least trying. I also find praying and going to church relaxing and soothing too. I haven't been since Juan's last relapse two months ago. I guess I've been too busy and stressed out.

Grandfather: Yeah. We've all been too busy and stressed to go. I miss it though. I looked forward to Sundays when we'd all go to church together, then we'd go out to eat. I have to say, I'm not a purist; I'm Catholic, but I still have some beliefs in the spirits. My great grandfather was one of the best Curanderos from the barrio where we grew up. I guess it is hard to admit, but my wife and I also both feel a little angry at God lately. Juan is such a nice boy, as is our son, and it does not seem fair that they should have this terrible illness. We just do not quite understand that. We both still have a strong faith, but I guess we're a little angry.

Therapist: Well, I've certainly heard people from other families say similar things, so you are not alone in that feeling. It sounds as if you all enjoyed some elements of your faith, such as going to church together and you [therapist now looking at Juan's mom] seemed to get some comfort from praying too. I'd really encourage you to continue those things, perhaps even more so when times are stressful. Taking time for yourself and finding ways to calm down will certainly help you interact in a calmer and more effective manner with Juan, and this is really likely to help him get better. [Therapist now looking at the grandparents] I know you are both a little angry at God, but I'm wondering if, and how, you might use your faith to make sense of the illness.

Grandmother: Well, like my mom would tell me when things would go wrong, sometimes God throws blocks in the road to make us stronger. I have to give God that Juan's illness and my son's illness have

definitely brought my family closer together. [Looking at her husband] I guess, in a weird way, we should be thankful for that.

The fourth proposed segment, communication training, drawn largely from earlier psychoeducational programs (e.g., Falloon et al., 1984; Goldstein & Miklowitz, 1995), teaches family members skills that will enable them to communicate and provide support to one another more effectively. This segment may be particularly important yet challenging for H/L families because indirect, implicit, or covert communication is often emphasized, whereas expressions of differences, direct requests, and assertiveness are often viewed as rude or insensitive to others (Falicov, 1996). It is important to convey to families that patients with schizophrenia often have disruptions in their receptive and expressive language skills and that interacting with them in an indirect, circumscribed, or ambiguous manner may exacerbate their symptoms. It is also important to reassure H/L families that clear and direct communication can be conveyed respectfully. Because Latino families put great emphasis on interpersonal relationships and *simpatía*, families may have difficulty expressing negative emotions. *Simpatía* has been defined as a general tendency toward achieving harmony in interpersonal relations, avoiding personal conflict, and deemphasizing negative behaviors and emotions toward others (Marín & Marín, 1991). Various aspects of the *simpatía* script have been documented by researchers, including avoidance of confrontation and deemphasizing negative emotions and behaviors likely to lead to conflictive situations (Kagan, Knight, & Martinez-Romero, 1982). Thus, it is especially important to reassure H/L families that, with the right communication skills, even dissatisfaction, anger, and frustration can be conveyed in a manner that is productive. It should be underscored that when dissatisfaction and anger are expressed in an honest and appropriate manner in close family relationships, it often results in bringing family members closer together.

During the communication segment of treatment, family members should be taught to converse more clearly with one another. Specific skills taught should include giving positive and negative feedback to other family members, ac-

tive listening, and making requests for behavioral change. Role-playing, behavioral rehearsal, and homework assignments should be used to help shape these behaviors. The therapist should actively model good communication skills and provide verbal reinforcement to family members during this process. Families should be shown pictorial examples of escalating cycles of both positive and negative family communication, and families should be asked to identify similar patterns within their own families. Normalizing these difficulties is important at this stage to reduce blame. The focus of the session should not be to assign responsibility for the problems but rather to identify the patterns that families tend to get into when someone is mentally ill and to engender hope that family members can have some positive impact on the individual with schizophrenia.

Hypothetical example from Segment 4. Juan's grandmother remarks angrily about Juan's poor hygiene and form of dress.

Grandmother: [Smirking] With that matted hair of his and those old clothes, he'll never find a girlfriend. Nobody wants to be with a slob.

Therapist: It sounds like you are concerned about Juan's future, and that is very nice. It seems that you want him to be in a satisfying relationship and that you think that his appearance and hygiene may be hurting his chances of finding a partner. Last week I introduced some techniques for expressing negative feelings and for making requests from one another in a way that is less likely to make the other person defensive and instead is more likely to make the person want to comply with your request. [The therapist hands the grandmother two handouts titled "expressing negative feelings" and "making a positive request"] Can you try conveying your feelings again? But this time, I'd like you to speak directly to Juan and to use the communication techniques that we practiced in here last week.

Grandmother: Oh, sorry, sometimes I slip. [Grandmother now looking at Juan] Juanito, my love, I would really appreciate it if you would wash your hair and wear cleaner and nicer clothes each day. I'd be happy to help you wash your clothes and pick them out if you like. I think that might help you find a girlfriend. That would definitely make me happy, and I bet you'd be happier too.

The fifth proposed segment, problem-solving skills training (also drawn largely from earlier psychoeducational programs such as Falloon et al., 1984, and Goldstein & Miklowitz, 1995), teaches family members techniques to enhance their problem-solving capacities. Families should be taught to identify problems, to agree on their definition, to brainstorm possible solutions, to decide on the optimal solution, and to effectively implement the solution. The therapist should actively present the family with the steps of problem solving, aid in defining the problem and evaluating the solutions, and review the relative success of the solution. Family problems that tend to generate "stressed out" or counterproductive feelings should be the focus during this segment. The final session should also focus on solving the specific problem of how family members can best continue to benefit from the techniques they have learned in therapy. Specifically, the session should address how families can best continue to (a) use one another as partners in the healing process, (b) use the R/S coping techniques learned in therapy, and (c) use their new communication and problem-solving techniques after termination of the intervention.

Hypothetical example from Segment 5. The Diaz family is arguing about whether they should remain in Miami or move back to Mexico after CIT-S is complete.

Therapist: [Handing the family the problem-solving worksheets] Ok, so this is clearly an important issue. Juan, do you want to take a stab at summarizing the problem in a way that all can agree?

Juan: Yeah, mis viejos [referring to his grandparents] want to go back to Mexico.

Therapist: Why is that a problem?

Juan: Because mom and I like it better here, and my psychiatrist is here, and the services for me are better here.

Therapist: Ok, so the problem is that some of you want to move back to Mexico, whereas others do not. Does everyone agree that that is the issue? [All nod] This is a tough one. Let us begin by discussing several possible solutions. I'd like each of you to identify at least two possible ways of resolving this, without evaluating any at this point. Just to give you an example, one solution might be that you could live in Mexico part of the year and in Miami the other part, or some of you can go back and others can stay. I'm sure there are several other possible solutions as well.

The family is then instructed to discuss and weigh the pros and cons of each solution that is offered and is encouraged to discuss them and to come to consensus regarding which solution makes the most sense for everyone. Combining solutions is also permitted and encouraged. For example, this family may decide that the grandparents will move back to Mexico permanently and that Juan and his mother will make regular visits.

It is important to point out that these Diaz family vignettes provided are just examples of how CIT-S might play out with an actual family. They are in no way intended to caricaturize H/L families. For example, whereas many H/Ls do believe in folk religions, many others do not. As discussed earlier, it should be underscored that H/Ls are an extremely heterogeneous group, and one treatment approach will not fit all H/L families. It is also important to point out that the word *family* is defined broadly in CIT-S for both practical reasons (to maximize real-world generalizability) and theoretical reasons (I believe the aims and structure of CIT-S can benefit a wide range of families). One might wonder how the same treatment could benefit very different constellations of families, such as a 40-year-old patient and his or her 13-year-old daughter versus a 40-year-old patient and his or her 75-year-old parents. Clearly, these two types of families would likely face very different issues. In this case, the focus of the topics addressed in treatment might vary greatly between these two fam-

ilies. The structure of treatment (the administration of the five treatment modules and their accompanying handouts to guide the treatment) would be quite similar, however. For example, in the family collectivism segment, the aim would be to help members of both sets of families feel more connected and united with one another, like a team working toward a common goal. Questions from the handouts used to guide this segment would probe participants about several aspects of their actual and ideal family life, including their current and idealized roles in this family. In the first-case scenario, the ill mother might define her idealized role as matriarch of the family yet report feeling that she is letting her daughter down by being ill or undependable. When the daughter is asked to describe her mother's role from her perspective, she would likely be able to identify some aspects in which the mother is able to competently fulfill her parenting role (e.g., helping with homework or setting reasonable curfews for the daughter) and others in which she is not. The therapist might then brainstorm with the family about how the daughter and mother could work together to help the mother come closer to her idealized role and to help both family members to live in a household closer to their family ideal. In the second family, the 40-year-old son may view his actual role in the family as "scapegoat for family problems because of his illness." His idealized role might instead be that of a helpful son who assists his aging parents. As in the first example, the therapist might help the family brainstorm ways in which each member might help the patient achieve his idealized role, therefore benefiting the entire family unit. For example, the son may be more proficient in English than his parents and may therefore be able to serve as an asset to them in situations where knowledge of English is necessary. Thus, as is the case with most manualized treatments, the content in CIT-S sessions would likely vary greatly from family to family (this is likely the case even for families with the same or similar constellations of members); however, the process of CIT-S is expected to benefit many types of H/L families.

Summary of CIT-S, Goals, and Expected Outcomes

As discussed above, the primary aims of CIT-S are to create home environments that are em-

pathic; to lower levels of critical and hostile attitudes; and to shape attributions by encouraging relatives to recognize that, even for patients actively attempting to take control of their illness (by taking medications, attending therapy sessions, managing stressors, etc.), some disruptive symptoms are likely to persist or recur. Similar to previously successful interventions for schizophrenia (Falloon et al., 1984) and bipolar disorder, this intervention will also be aimed at teaching families effective communication and problem-solving skills, which will be encouraged as the mode of interacting during treatment and at home. Drawing from the sociocultural research reviewed above, the proposed treatment intervention will also be aimed at fortifying a strong sense of family unity by encouraging relatives to view themselves as interconnected, tapping into families' R/S and/or existential beliefs, and using these to more productively conceptualize and come to terms with their loved one's illness.

Specifically, this treatment is expected to result in significant decreases in schizophrenia symptoms for patients and to improve general emotional and mental health for both patients and family members. CIT-S is also hypothesized to lower rates of high EE, increase perceived collectivism and family cohesion, and result in the use of more adaptive R/S and philosophical coping mechanisms.

In the pilot phase, CIT-S is currently being evaluated against a treatment as usual (TAU) intervention, which involves only the education segment of CIT-S. Random regression models will be used to examine the hypothesis that patients' psychiatric symptoms, emotional well-being, and quality of life will improve more in CIT-S than in a TAU intervention. Likewise, we will test the hypotheses that patients and family members in the CIT-S condition will report using more effective general coping strategies, more R/S coping, and increased perceived collectivism/family cohesiveness. If CIT-S appears effective and outperforms TAU, in subsequent stages, a full-scale clinical trial will be conducted comparing CIT-S with a traditional family-focused therapy that is matched in length.

In closing, this article offers CIT-S as one potential model for integrating culture with existing family-oriented psychosocial treatment programs for serious psychopathology. Although current theory and research provide a strong case for this conceptual integration, CIT-S is in the

initial stages of evaluation, and the result of a controlled clinical trial is clearly needed to test its efficacy. If CIT-S proves effective, more research will be needed to examine mechanisms of change and to determine whether variables specifically targeted in treatment (e.g., EE, R/S, family cohesion) actually make unique contributions to patient and family member outcome.

It will also be important in future research to clarify the association between mental health and religious versus spiritual beliefs and behaviors. As stated earlier, some researchers oppose a bifurcation (e.g., Hill & Pargament, 2003). However, there is some evidence to suggest that religion and spirituality may impact mental health differently (Jones, 1999). Thus, in future research, it will be essential to assess not only whether a person is R/S but also how he or she is R/S. In other words, it will be important to pinpoint specific spiritual and/or religious beliefs and practices that may be associated with better mental and emotional health and others that may be injurious. Likewise, research is needed that examines how different H/L subgroups may react to CIT-S and to other family treatments. Whereas there are clearly some commonalities among H/L subgroups, there are often key differences as well (Garcia-Preto, 1996; Zea et al., 2000). Thus, studies with large and diverse samples of H/Ls are also needed to evaluate the efficacy of family treatments across H/L subgroups.

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