Chapter 12
Family-Focused Psychoeducational Programs for Minorities with Serious Mental Illness

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Overview

This chapter will provide an overview of family-focused psychoeducational programs for minorities with serious mental illness. Psychoeducation refers to treatments that impart information about mental and physical health by way of didactic and structured methods (Rummel-Kluge & Kissling, 2008). Psychoeducation for serious mental disorders typically involves providing specific information on the symptoms of the illness, the biological and psychosocial processes contributing to the development of an illness, factors impacting the course of the illness, coping, and problem-solving strategies, as well as information on available treatments and resources for ongoing care for patients and family members coping with the disorder (Goldstein & Miklowitz, 1995). Family-focused psychoeducational approaches are useful in a variety of settings and with a variety of clients, but they appear to be particularly well-suited for minorities, as researchers consistently recommend including the family in mental health treatments for minorities (Flaskerud, 1986; Szapocznik, 1994; McGoldrick, Giordano, & Garcia-Preto, 2005).

This chapter will address how psychoeducational interventions can be tailored to better serve minorities. By way of example, we will describe a family-focused, culturally informed therapy for schizophrenia, that was developed by the first author and which is currently being pilot tested at the University of Miami.

Background

Why is family psychoeducation important in mental illness? Over the last several decades, managed care restrictions have increased, leaving families with a greater responsibility for the care of their ill relatives (Goldstein &

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Miklowitz, 1995; Mueser & Glynn, 1999). This responsibility is especially pronounced for many minorities in the U.S., who are even more likely to take on the care of an ill relative, often with fewer economic resources and social service options and more limited housing alternatives (Guarnaccia & Parra, 1996; Snowden, 2007). In addition, minorities are often socially isolated.

Psychoeducation for mental illness appears to work best when offered as a family affair (Magliano et al., 2005). In this format, families are educated on how best to assist the patient while also attending to their own needs in order to prevent burnout and counteract common strains. The stress and burden of caregiving should not be underestimated as the impact on the family is often far-reaching, with caregivers reporting high rates of depression, anxiety, and stress (Magliano, Fiorillo, Malangome, De Rosa, & Maj, 2006). Some common challenges include limited access and time for social activities, feelings of loss and isolation, and drainage of emotional and financial support (McFarlane, Dixon, Lukens, & Lucksted, 2003). Minorities often face additional burdens including racial discrimination, challenges of acculturation and assimilation, as well as language barriers. Psychotic spectrum mental illnesses (such as schizophrenia) present further challenges in that family members frequently become the focus of a patient's symptoms (particularly paranoid delusions). As a result, individuals with severe mental illness may refuse to participate in family-based treatments and may express strong convictions that their family members be kept out of their psychiatric care. Minorities may be particularly distressed by this because family trust is often paramount in many traditional ethnic cultures (Triandis, McCusker, & Hui, 1990). Thus, minorities may be even more vulnerable to feelings of hurt and despair if feared or shunned by a mentally ill relative.

While biological/genetic factors are clearly involved in the development and course of schizophrenia and other severe disorders such as bipolar illness (e.g., Torrey, Bowler, Taylor, & Gottesman, 1994), the patient's family and psychosocial environment also largely impacts the course of the illness (Mueser, Torrey, Lynde, Singer, & Drae, 2003; Dixon et al., 2001; Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001). For example, when individuals with schizophrenia are in close contact with family members who express critical, hostile, or emotionally overinvolved attitudes (defined as high expressed emotion, or high EE) about them, they have a substantially greater risk for psychiatric relapse than do patients whose relatives are designated as low EE. This finding is based on 40 years of research in multiple countries and cultures (Hooley & Hiller, 2000) and will be addressed further below.

On the positive side, research has indicated that the effects of mental illness sometimes pose beneficial effects on patients, individual family members, and the entire family system. For example, helping a loved one can result in greater self-esteem and self-worth and successfully coping with mental illness can result in a feeling of enhanced personal resilience and a reassessment of life's priorities (Chen & Greenberg, 2004; Marsh & Lefley, 1996). Families often rally together,

and this frequently has the effect of increasing perceived family unity. This may be particularly important for minorities. Weisman, Rosales, Kymalainen, and Armesto (2005) found that for Black and Latino/Hispanic families with schizophrenia, increased perceived family cohesion was associated with lower levels of depression, anxiety, and stress for both patients and family members and fewer psychiatric symptoms for patients.

Family-focused, psychoeducational treatments can be an excellent resource for increasing the likelihood of these positive consequences, as well as decreasing the negative sequalae often associated with mental illness in the family. The importance of including family members in the treatment of mental illness has been well documented, with reviews demonstrating that family treatments can reduce relapse rates for schizophrenia by 20–50% (Pitschel-Walz et al., 2001; McFarlane et al., 2003). Meta-analyses and reviews of the literature on family psychoeducation have shown the following benefits: reductions in family member perceived burden, greater family member well-being, increased employment and participation in vocational rehabilitation for patients, change in EE behaviors, increased knowledge of illness, better treatment and medication adherence, better social functioning and adjustment for patients, increased quality of life, reduced medical costs, reduced psychiatric relapse, and less severe psychiatric symptoms (Pitschel-Walz et al., 2001; McFarlane et al., 2003). As the domains for improvement are so varied, it is important to think of psychoeducation as more than just a means to reduce hospitalization rates. Furthermore, treatment gains from family psychoeducation have been shown in diverse cultures, including the U.S. (Goldstein & Miklowitz, 1995), China (Ling et al., 1999), Spain (Muela Martinez & Godoy Garcia, 2001), Scandinavia (Rund et al., 1994), and Britain (Barrowclough et al., 2001).

Unfortunately, very few families of any ethnicity who are coping with severe mental illness receive family psychoeducation or therapy, with estimates ranging from .7% to 8% receiving formal help depending on the sample and method of data collection (Dixon et al., 1999). Furthermore, in general, there are disparities for ethnic minorities. First, minorities tend to utilize services less frequently. (For an in-depth discussion of utilization, see the chapter by Koroukian in this volume.) Second, when they do utilize services, they appear to receive poorer quality care (National Institute of Mental Health, 1999). For example, a large-scale study with 4,249 patients with schizophrenia found only a 17% utilization rate of case management services among Blacks and a 19% utilization rate for Latinos/Hispanics. Utilization rates for Whites were at 30% (Barrio et al., 2003). Efforts to close the gap in health care disparities are sorely needed.

Including family members in treatment may help in this aim. Members of ethnic minorities tend to have a more interdependent and interconnected view of family (Weisman de Mamani, Kymalainen, Rosales, & Armesto, 2007; Oyserman, Coon, & Kemmelmeier, 2002). Additionally, research shows that Blacks and Latinos/Hispanics with serious mental illness turn to other family members for advice more so than do non-Hispanic Whites. Whites are more

likely to seek help from mental health professionals (Guarnaccia & Parra, 1996). Thus, family treatments may be more culturally syntonic for these ethnic groups. This may make minorities more willing to enroll and attend family therapy than they might for more individually oriented treatment approaches.

Structured family treatments can provide specific skills and information that are critical in managing a severe mental illness. The following three sets of skills have been found to be invaluable for both patients and families dealing with mental illness: education about illness, communication training, and problem solving (for schizophrenia: Falloon, Boyd, & McGill, 1984; for bipolar disorder: Goldstein & Miklowitz, 1995; Miklowitz et al., 2000). These components are also well suited to minorities, particularly low socioeconomic status (SES) families, as problem-focused and didactic styles of therapy appear to be more culturally sanctioned and less threatening (Organista & Muñoz, 1996).

In addition to education and skills training, therapists should also include information about supplementary resources available to families (in clients' preferred languages, if possible). These include support groups, consumer-run meetings, or membership in national organizations. In our experience, the National Alliance on Mental Illness (NAMI) has been a particularly helpful resource for many of our clients coping with severe mental illness. In many cities, groups are available in Spanish and other languages. Additional information about this organization can be found at www.nami.org/multicultural.

Culturally Relevant Domains of Psychoeducational Intervention

Successful family-focused programs for mental illness tend to focus on educating the family about the illness, improving communication and expressing negative feelings more effectively, teaching problem-solving skills and active listening, and helping family members develop more realistic expectations for the patient (Goldstein & Miklowitz, 1995). Below we use a multicultural perspective to discuss significant factors that impact the course of mental illness.

Expressed Emotion (EE)

EE is both a universal and a culturally bound construct. The majority of cross-cultural studies have supported the predictive validity of EE (Hashemi & Cochrane, 1999). A relative is rated as high EE if he/she expresses high degrees of criticism, hostility, or emotional overinvolvement (e.g., overly self-sacrificing behavior) toward a relative with a mental illness. However, the different components of EE predict outcome differentially across cultures and are moderated by culture (López et al., 2004). For example, criticism is significantly less prominent in collective cultures. Also, it is important to note that what is

considered critical, hostile, or emotionally overinvolved varies across cultures (Jenkins & Karno, 1992). White family members tend to criticize undesirable, individual personality traits that violate norms of autonomy. Latino/Hispanic relatives and Black relatives, on the other hand, appear more likely to condemn behaviors that disrespect and shame other family members and defy collectivism and interdependence (Jenkins, Karno, de la Selva, & Santana, 1986; Kymalainen, Weisman, Rosales, & Armesto, 2006).

In general, Latinos/Hispanics and other minorities appear to have significantly lower rates of high EE and better course of illness when compared to their White counterparts (Weisman de Mamani et al., 2007; Karno et al., 1987). Less blameworthy attributions, greater reliance on adaptive religiosity/spirituality, high degrees of family cohesion, and the suppression of negative affect may begin to explain lower rates of high EE among Latin Americans (Jenkins, 1991; Weisman & López, 1996; Weisman, Gomes, & Lopez, 2003; Weisman, Duarte, Koneru, & Wasserman, 2006). Family member warmth has also been found to predict relapse for Latinos/Hispanics and may be an even better predictor than high EE in this ethnic group (López, Nelson, Snyder, & Mintz, 1999; Kopelowicz et al., 2002; López et al., 2004). This is not surprising given that family affection and harmony are highly prized among Latinos/Hispanics (Marín & Marín, 1991). Thus, high degrees of warmth from a loved one may be especially soothing to Latino/Hispanic patients with a mental illness.

The study of EE has also been exported to several Asian countries, and in most studies appears to be associated with poor course of illness. For example, studies in China and Japan indicate that patients from high EE homes relapse sooner and more frequently than those from low EE homes (Mino et al., 1995; Ng, Mui, Cheung, & Leung, 2001). However, base rates of high EE may be lower in Asian countries. In India (Leff et al., 1987) and in China (Ran, Leff, Hous, Xiang, & Chan, 2003) only about a quarter of relatives were rated as high EE, compared to approximately 67% of non-Hispanic Whites in the U.S. (Vaughn, Snyder, Jones, Freeman, & Falloon, 1984). The comparatively low base rates of high EE may be due to the centrality of collectivism, conformity, modesty, and suppression of negative emotions among traditional cultures (Ran et al., 2003). Low occurrence of high EE and these protective values may explain why patients with schizophrenia living in developing countries have a better prognosis than do patients living in more developed countries (Saravanan et al., 2007; Murphy & Raman, 1971; Wing, 1978).

Blacks are one of the only cultural groups for which high EE has not been found to predict poorer prognosis for schizophrenia. (Moline, Singh, Morris, & Meltzer, 1985; Tompson et al., 1995). In fact, criticism may serve as a protective factor against relapse in this ethnic group. Rosenfarb, Bellack, and Aziz (2004) found that the more critical Black relatives were, the less likely their ill relative was to relapse. Weisman, Rosales, Kymalainen and Armesto's (2006) found no association between the number of relatives' criticisms toward patients rated from the Camberwell Family Interview (to assess EE) and Black patients' own perception of their relatives' criticism. This may explain why high EE does not

predict relapse among Blacks. It may be that conversations perceived as angry and aggressive by Whites are experienced as culturally syntonic by Blacks (Tompson et al., 1995), whose communication patterns are often characterized as effusive and emotionally and physically expressive (Millhouse, Asante, & Nwosu, 2001). Moreover, Blacks may feel that their relatives' critical statements are reflective of engagement, affection, caring, and support (Rosenfarb et al., 2004). Although criticisms as traditionally measured by EE instruments do not predict relapse among Blacks, Black patients' perceptions of relatives as critical may be predictive (Tompson et al., 1995). Because criticisms may actually serve as a buffer against relapse (they are thought to be perceived as statements of care and concern), interventions that attempt to reduce relatives' criticisms may inadvertently increase the risk of relapse in Black patients with schizophrenia. Instead, patients' perceptions of criticism may be particularly important to address in psychotherapy with Black families. Psychosocial programs aimed at lowering EE in most ethnic groups, and perceived criticism in Blacks are important.

Attributions

Attributions address causal worldviews and are inherently cultural. Some evidence exists for cross-cultural differences in attributions and affect toward relatives with schizophrenia that may account for some of the cultural differences observed in base rates of high EE and in illness prognosis. In line with this, Weisman and Lopez (1997) found that Mexicans were more likely to perceive the negative behavioral symptoms of schizophrenia as less controllable than were Whites. In turn, Whites expressed much more intense unfavorable emotion (anger, frustration) toward a person described to meet the criteria for schizophrenia.

This research suggests that a less blaming view of schizophrenia and the associated symptoms may lead to lower levels of negative emotion and high EE (Weisman & Lopez, 1997). There is a fair amount of evidence to support this view in Whites and minorities alike. For example, in a Mexican American sample (Weisman, Lopez, Karno, & Jenkins, 1993) and again in a non-Hispanic White sample (Weisman, Nuechterlein, Goldstein, & Snyder, 1998), Weisman and colleagues found that relatives designated as high EE were more likely to perceive the patient's illness and the associated symptoms as within the patient's personal control. In other words, they were less likely to buy into the notion that the patient was genuinely ill and that the symptoms were an unintended side effect. Others (e.g., Brewin, Maccarthy, Duda, & Vaughn, 1991, Hooley and Campbell, 2002) have found similar results. When family members attribute patients' symptoms to external (e.g., a biochemical/organic disease), rather than to internal controllable factors (e.g., laziness), they are less likely to blame them for their symptoms. Thus, increasing knowledge about the causes

of serious mental illness, as well as fostering a more realistic understanding regarding the extent of a patient's ability to control his or her symptoms, should be a major aim of psychoeducational programs.

Stigma

Stigma is an another important construct to explore in family-focused treatment for severe mental illness because it sometimes prevents patients and their relatives from fully accepting the illness and taking steps to treat it (Kravetz, Faust, & David, 2000). It is interesting and important to note that persons from minority ethnic groups with severe mental illness may experience a double stigma. Primarily, these individuals face stigma as a result of belonging to a cultural minority group and may further face discrimination due to the fact that they have a serious mental illness. Terms such as *nervios* and *fallo mental* among Latinos/Hispanics and neurasthenia among Asians are frequently supplemented to decrease perceived stigma (Guarnaccia, Parra, Deschamps, Milstein, & Arqiles, 1992). These terms have been used to describe a variety of common and not so common experiences and symptoms such as heart palpitations, anxiety, depression, panic attacks, and schizophrenia (Guarnaccia et al., 1992). These terms can be useful in diminishing feelings of embarrassment and disgrace, but they can also have the effect of decreasing the likelihood that patients and families will seek and/or remain in treatment. Thus, it may be particularly important to target feelings of stigma when conducting psychoeducational interventions with minority groups.

Family Collectivism

While strong family ties are likely beneficial to everyone, as discussed above, perceived family collectivism appears to be especially important to the emotional well-being and symptom severity of minorities with schizophrenia (Weisman et al., 2005). While there is substantial heterogeneity between and within minority groups in the United States, one factor that stands out to differentiate certain minority cultures from the mainstream is the emphasis on interdependence over individualism. In a meta-analysis of cross-national studies and studies within the U.S., Oyserman et al. (2002) found that European Americans are both more individualistic and less collectivist than others. In many ways, mainstream American culture is founded on the ideals of individualism; these ideals include a focus on self-expression, direct communication, and the promotion of one's own goals (Singelis, 1994). Collectivists, by contrast, share a number of opposing defining attributes, which include the belief in a common fate, emotional dependence, and the desire to maintain harmony within groups (Triandis et al., 1990; Brewer & Chen, 2007). It is, therefore,

essential for therapists to be aware that many minorities living in the U.S. may come from cultures that ascribe to a more collectivist orientation with an emphasis on family values and interdependence.

This may pose unique challenges to the therapeutic alliance. One contentious issue that is likely to arise at the beginning of treatment with minorities, for example, is the intense focus on individual thoughts and feelings in mainstream U.S. therapy. This can be highly uncomfortable for families from collectivist cultures (Aponte & Johnson, 2000). A culturally conscious therapist should ease this discomfort by understanding and applying the concept of contextualism. In their work on family therapy with minority clients, Szapocznik and Kurtines (1993) define contextualism as a system for understanding an individual as embedded within the context of the family, which is itself embedded within the context of the culture. In this way, the therapist begins to understand the contextual factors working on family and individual issues. Educating the family about ways to capitalize on their collectivist orientation is a main goal of psychoeducation in family therapy.

Spirituality

Spirituality/religion is another critical component to consider when helping families to conceptualize and cope with mental illness (Weisman et al., 2006). The issue of whether or not to address spirituality and religiosity in the treatment of individuals with serious mental illness has been hotly debated among mental health professionals. On one hand, it has been argued that addressing these issues might lead to increased religious delusions in patients with schizophrenia, which are already highly common and distressful (Getz, Fleck, & Strakowski, 2001; Torrey, 1995). Others, however, have argued that ignoring spiritual issues in treatment provides a disservice to those patients who are religiously oriented (Fallot, 1998; Pargament, 1997).

Whether or not a therapist decides to address spiritual or religious issues in treatment often depends on the patient's particular personality and symptom profile. For example, a religious intervention would likely be contraindicated for a patient who is highly opposed to one or for a patient with frequent religious delusions. In general, however, there is a growing body of evidence highlighting the benefits of religion. For example, a meta-analysis conducted by McCullough, Hoyt, Larson, Koenig, and Thoresen (2000) found a strong association between religious involvement and lower mortality rates. Furthermore, a review article by Koenig, Larson, and Weaver (1998) summarizes the breadth of data showing that religious individuals have lower rates of depression, less alcohol and drug abuse, and lower rates of anxiety disorders.

Another benefit of religion that is more specific to minorities is the accessibility and centrality of the religious community. In many minority cultures,

churches and religious communities play a central role in the lives and coping processes of their members. In Latino/Hispanic cultures, for example, strong religious beliefs inform the conceptualization of both physical and mental illness (Musgrave, Allen, & Allen, 2002). Furthermore, where access to mental health care is limited, as it is for many minorities of lower SES, individuals often turn to religious coping for strength and support (Pargament, 1997; Lincoln & Mamiya, 1990). This is because adaptive uses of religion may share many of the same functions as psychotherapy. Some of these overlapping functions include providing meaning to life, utilizing social support networks, and facilitating positive change (Stander, Piercy, Mackinnon, & Helmeke, 1994). Educating clients about the overlap between religion and psychotherapy and providing information regarding how to use faith to access positive therapeutic processes can be very effective in religious patients. It is important to note that spirituality education is indicated for nonreligious clients as well, as the main focus is on the development of empathy, forgiveness, and appreciation, all of which are essential therapeutic processes (Sperry, 2001).

Language

While there are many issues to take into consideration when working with ethnic minority clients, one of the most obvious barriers to treatment is language use. Of course, it is ideal if mental health practitioners are able to provide services in the client's preferred language. If both the therapist and clients are bilingual, some researchers suggest using the language preferred by older family members (Santisteban & Szapocznik, 1994) so as to respect the common age hierarchy in many minority families (Szapocznik, Rio, Perez-Vida, & Kurtines, 1986). If translators are needed, it is critical to select a person with training in mental health interpretation, rather than drafting a family member or friend into this role (Leung & Boehnlein, 2005, p. 370). This can be problematic because informal translators may provide incorrect or insufficient information important for diagnosis and treatment, increase mistranslations or omissions of the therapists' questions, and supply shortened or misconstrued representations of the clients' responses (Monroe & Shiranzian, 2004).

In our work with families with schizophrenia at the University of Miami, we have found that flexibility is more important than following a specific formula dictating which language to use. The first author of this chapter has described this with a case example in Weisman et al. (2006, p. 182):

In one of our 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.

As Weisman and colleagues (2006) describe, strict adherence to their original treatment manual would have prescribed speaking in Spanish with the family. In hindsight, however, we believe that following strict guidelines to use the mother's dominant language would have proven less effective with this particular family. Thus we believe this demonstrates the importance of flexibility with respect to language and accommodating to a particular family's style and wishes.

Culturally Informed Therapy for Schizophrenia (CIT-S)

We will now describe an example of one treatment that has been informed by the literature and developed specifically so as to be relevant for minority families coping with schizophrenia. Culturally Informed Therapy for Schizophrenia (CIT-S) is a 15-session family therapy currently being pilot tested at the University of Miami. Specifically, the treatment is broken into five 3-session modules on the following topics: Family Collectivism, Education, Spiritual/ Religious Coping, Communication Training, and Problem Solving. The Education, Communication Training, and Problem-Solving modules are based on the work of Falloon et al. (1984) and Miklowitz and Goldstein (1997). Although we believe CIT-S will be effective for many minority and majority groups, it has been especially designed to be relevant for people of Latino/Hispanic decent. All assessment and therapy tools and procedures have been developed in both English and Spanish. Handouts are used to guide each session. For more information or copies of handouts, please email the first author (Dr. Amy Weisman de Mamani, aweisman@miami.edu). The treatment is also described in more detail in Weisman, Duarte, Koneru, and Wasserman (2006).

Family Collectivism

The first module of CIT-S is family collectivism. The overarching objective of this segment is to foster or enhance family unity and help family members to see one another as team members working toward shared goals. Furthermore, blame for the patient's illness is deflected off of any one individual. Initially, family members are praised for attending treatment; the therapist frames their attendance as indicative of a commitment to the patient and to the family unit. To further highlight family cohesion, the therapist asks participants about their expectations for treatment and points out commonalities among the family members. Specific topics covered during this segment, with the aid of handouts,

include what the concept of family means to each member, each family member's perception of his or her role in the family, each family member's perception of other family members' roles in the family, how family members view generational and gender roles, whether family members see a clear hierarchy within the family, and whether family members see any significant conflicts or alliances between members.

An example from one of our CIT-S cases illustrates how the collectivism segment can be used to examine and improve individual family member's roles and contributions to the family unit and dissipate conflicts. The family members were recent Cuban immigrants and consisted of the mother of the patient and the adolescent brother of the patient. Upon discussing each member's role, it became clear that the mother held all the responsibility for the family's well-being and felt very overburdened. Her son, and the patient's brother, had largely withdrawn from the family unit and from assisting his mother because of the resentment he harbored toward his sibling, the identified patient. This was evidenced by his silence and animosity during the initial session. During the collectivism sessions, we reframed the brother's potential contribution as assisting the mother and the family as a whole and discussed ways in which each family member might contribute more equally. As treatment progressed, the mother and brother of the patient became a more cohesive unit. The brother of the patient became highly involved during the sessions. He regularly contributed ideas as to how he might help his mother in caring for the patient and often aided his mother in obtaining services for the patient.

Education

In this segment of CIT-S, therapists present information on the symptoms of schizophrenia, the factors contributing to the development of the illness, exacerbating factors, warning signs of a relapse, and ways to create an environment that is protective against relapse. The role of high-EE attitudes and attributions and its relationship to psychiatric relapse is emphasized. This didactic approach is especially well suited to Hispanic and other minorities who may expect therapy to provide more immediate information, advice, and problem-solving techniques. Additionally, minority families may associate a large amount of stigma regarding therapy, and a more information-oriented approach may help make therapy more concrete and less daunting (Organista & Muñoz, 1996).

One particular challenge during the education module is if the patient becomes defensive about symptoms of the illness. For example, we worked with one family in which the patient had difficulty accepting his diagnosis of schizophrenia. He was upset by the focus of the sessions on his symptoms and as a reaction would minimize his experiences or provide alternative explanations for his symptoms involving esoteric religious beliefs he formed after developing

the illness. To diffuse this defensiveness, the therapist asked other family members to discuss their experiences with some of the symptoms within their own lives (e.g., periods of poor hygiene, lack of motivation, distrusting others, etc.). Once the focus was less directly on the patient's own symptoms, he seemed to feel more comfortable discussing his symptoms without relying on the religious explanations as a defense.

Spiritual/Religious Coping

The spirituality module begins with a discussion of the family's spiritual and religious history. Family members are encouraged to discuss beliefs about God, morality, and the meaning of life, as well as more behavioral components of religion, such as attendance of religious services or private prayer. In therapy, the clinician helps family members cultivate important spiritual practices, including emotional wisdom through forgiveness and empathy. Outside therapy, families are encouraged to utilize the available social support inherent in most religious congregations to help cope with the illness and to continue their spiritual growth. Therapists also suggest that patients and family members read spiritual/religious texts and find passages that may provide inspiration for more active ways to manage or come to terms with the illness, such as "God helps those who help themselves."

It is important to note that within families, individuals often present with very different spiritual beliefs and practices. This can be viewed as a point of contention or, preferably, as a jumping-off point for a rich and meaningful conversation about beliefs and purpose. In one of our cases, we saw a Cuban American patient and his mother. The patient had been diagnosed with schizophrenia but also exhibited a number of obsessive-compulsive symptoms, including a fear of being in a car and driving to new locations. During the spirituality module, it was established that going to church was a culturally sanctioned behavior that the highly religious mother desired to share with her son. The patient felt positively about attending church but had been limited because of his symptomology. Over the course of these three sessions, the patient and mother agreed to try driving to church with the ultimate goal of attending services. The religious underpinning of this behavioral intervention proved useful in that it provided a meaningful goal for the family to meet together. By the end of treatment, the patient had driven to church with his mother and was optimistic about attending services in the future.

Communication Training

The communication training segment of treatment aims to enhance the quality and effectiveness of the family's verbal interactions. Communication training

involves teaching the families four basic skills: expressing positive feelings, active listening, making positive requests for change, and expressing negative feelings about specific behaviors. Role playing is the primary technique used to teach these skills. These skills are drawn largely from the work of Falloon, Boyd, and McGill (1984) and from Miklowitz and Goldstein (1997). Using this method, family members practice new ways of communicating in a setting that is safe and nonjudgmental.

In one of our CIT-S cases, we had a family from Panama, including the son (identified patient), his mother and his father. During the communication training module, we noticed a pattern whereby the mother frequently served as the primary spokesperson for the entire family. She would often talk over other family members and they would often collude by yielding the floor to her. Furthermore, when the son did speak he would often look to his mother for confirmation that what he was saying was acceptable. Through the use of role playing, the mother became a much more conscientious communicator. She was better able to refrain from interrupting when others spoke, maintain eye contact, and demonstrate that she understood what her relatives were saying by paraphrasing the information back in her own words. This change appeared to have many benefits. For example, the mother reported enjoying learning more about her son's and husband's perspective on things. Moreover, the son appeared to gain confidence in expressing himself more clearly and directly. This is a skill that will serve him well when interacting with doctors and mental health counselors in managing his illness and eventually in other areas of his personal and professional life.

Problem Solving

This module teaches family members more concrete ways of discussing problems, brainstorming strategies to address problems, discussing the pros and cons of each idea, agreeing on a solution, and implementing the plan. Family members work through several examples with the therapist and use homework to practice the techniques between sessions. As this is the final module in CIT-S, families practice a "relapse drill," where they use problem-solving strategies to develop a detailed course of action in the event of a psychiatric relapse.

Culture can play a huge role in relapse-prevention strategies, particularly when family members have different levels of acculturation. For example, one Hispanic family we worked with consisted of a couple and their adult son, who was the patient. The patient, who was more acculturated to U.S. culture than his parents, was returning to college and desired more independence. The mother, however, wanted to call and visit the patient frequently in order to monitor his symptoms and be more involved in his life. These behaviors made the patient feel like his parents did not trust him to manage his own illness and expected him to relapse. The problem-solving module provided an opportunity

to come to a solution that was decided on by all family members in which the patient agreed to take more initiative to call his parents and keep them informed of his symptoms so they felt connected to his life, but he felt more in control.

While data collection for the CIT-S project is still underway, preliminary analyses using a 7-point scale (1 = "Very Dissatisfied"; 7 = "Very Satisfied") have indicated a very high degree of consumer satisfaction with the treatment for both family members ($M = 6.26$, $SD = .88$) and for patients ($M = 5.75$, $SD = 1.27$). Furthermore, in a recent study we have found that greater therapist competence/adherence to the various modules of CIT-S is strongly associated with greater treatment retention and greater consumer satisfaction for family members (Dunham & Weisman de Mamani 2007).

Conclusions

In conclusion, the use of psychoeducational programs in the treatment of schizophrenia and other serious mental illness is essential for reducing relapse and improving quality of life for minority and nonminority patients and their family members. Including techniques that emphasize family collectivism, adaptive spiritual/religious coping techniques, as well as tailoring discussions of constructs such as EE, attributions, and stigma may increase the effectiveness of psychoeducational approaches when working with ethnic minorities. Of course, more work needs to be done to eliminate the language and other cultural barriers to treatment that minorities often face.

References

Aponte, J. F., & Johnson, L. R. (2000). The impact of culture on the intervention and treatment of ethnic populations. In J. F. Aponte & J. Wohl (Eds.), *Psychological intervention and cultural diversity* (pp. 18–39). Boston, MA: Allyn and Bacon.

Barrio, C., Yamada, A. M., Hough, R. L., Hawthorne, W., Garcia, P., & Jeste, D. V. (2003). Ethnic disparities in use of public mental health case management services among patients with schizophrenia. *Psychiatric Services, 54*, 1264–1270.

Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S. W., Moring, J., O'Brien, R., et al. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *American Journal of Psychiatry, 158*, 1706–1713.

Brewer, M. B. & Chen, Y. (2007) Where (who) are collectives in collectivism? Toward conceptual clarification of individualism and collectivism. *Psychological Review, 114*, 133–151.

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

Chen, F., & Greenberg, J. S. (2004). A positive aspect of caregiving: The influence of social support on caregiving gains for family members of relatives with schizophrenia. *Community Mental Health Journal, 40*, 423–435.

Dixon, L., Lyles, A., Scott, J., Lehman, A., Postrado, L., Goldman, H., & McGlynn, E. (1999). Services to families of adults with schizophrenia: From treatment recommendations to dissemination. *Psychiatric Services*, *50*, 233–238.

Dixon, L., McFarlane, W., Lefley, H., Luckstead, A., Cohen, C., & Falloon, I. (2001). Evidence-based practices for services to family members of people with psychiatric difficulties. *Psychiatric Services, 52*, 903–910.

Dunham, R., & Weisman de Mamani, A. (2007). Therapist competence and adherence as a predictor of treatment efficacy in families enrolled in Culturally Informed Therapy for Schizophrenia. Poster presented at the annual meeting of the Society for Research in Psychopathology, Iowa City, IA.

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.

Fallot, R. D. (1998). The place of spirituality and religion in mental health services. *New Directions for Mental Health Services, 80*, 3–12.

Flaskerud, J. H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal, 22*, 127–141.

Getz, G. E., Fleck, D. E., & Strakowski, S. M. (2001). Frequency and severity of religious delusions in Christian patients with psychosis. *Psychiatry Research, 103*, 87–91.

Goldstein, M. J., & Miklowitz, D. J. (1995). The effectiveness of psychoeducational family therapy in the treatment of schizophrenic disorders. *Journal of Marital and Family Therapy, 21*, 361–376.

Guarnaccia, P. J., & Parra, P. (1996). Ethnicity, social status, and families' experiences of caring for a mentally ill family member. *Community Mental Health Journal, 32*, 243–260.

Guarnaccia P. J., Parra, P., Deschamps, A., Milstein, G., & Arqiles, N. (1992). Si Dios quiere: Hispanic families' experiences of caring for a seriously mentally ill family member. *Culture, Medicine and Psychiatry, 16*, 187–215.

Hashemi, A., & Cochrane, R. (1999). Expressed emotion and schizophrenia: A review of studies across cultures. *International Review of Psychiatry, 11*, 219–224.

Hooley, J. M., & Campbell, C. (2002). Control and controllability: beliefs and behaviour in high and low expressed emotion relatives. *Psychological Medicine, 32*, 1091–1099

Hooley, J. M., & Hiller, J. B. (2000). Personality and expressed emotion. *Journal of Abnormal Psychology, 109*, 40–44.

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. Goldstein, I. Hand, & K. Hahlweg (Eds.), *Treatment of schizophrenia: Family assessment and intervention* (pp. 35–49). New York, NY: Springer-Verlag.

Karno, M., Jenkins, J., De La Selva, A., Santana, F., Telles, C., Lopez, S., et al. (1987). Expressed emotion and schizophrenic outcome among Mexican-American families. *Journal of Nervous and Mental Disease, 175*, 143–151.

Koening, H. G., Larson, D. B., & Weaver, A. J. (1998). Research on religion and serious mental illness. *New Directions for Mental Health Services, 80*, 81–95.

Kopelowicz, A., Zarate, R., Gonzalez, V., Lopez, S., Ortega, P., Obregón, N., et al. (2002). Evaluation of expressed emotion in schizophrenia: A comparison of Caucasians and Mexican-Americans. *Schizophrenia Research, 55*, 179–186.

Kravetz, S., Faust, M., & David, M. (2000). Accepting the mental illness label, perceived control over the illness, and quality of life. *Psychiatric Rehabilitation, 23*, 323–332.

Kymalainen, J. Weisman, A., Rosales, G., & Armesto, J. (2006). Ethnicity, expressed emotion, and communication deviance in family members of patients with schizophrenia. *The Journal of Nervous and Mental Disease, 194*, 1–6.

Leff, J., Wig, N., Ghosh, A., Bedi, H., Menon, D., Kuipers, L., et al. (1987). Influence of relatives' EE on the course of schizophrenia in Chandigarh. *British Journal of Psychiatry, 151*, 166–173.

Lueng, P. K., & Boehnlein, J. K. (2005). Vietnamese families. In M. McGoldrick, J. Giordano, & N. Garcia-Preto (Eds.), *Ethnicity and family therapy* (pp. 363–373). New York: Guilford Press.

Lincoln, C. E., & Mamiya, L. H. (1990). *The Black church in the African American experience*. New York: Duke University Press.

Ling, S., Zhao, C., Yang, W., Wang, R., Jin, Z., Ma, T., et al. (1999). Efficacy of family intervention on schizophrenics in remission in community: Result of one year follow-up study. *Chinese Mental Health Journal, 13*, 325–327.

López, S., Hipke, K., Polo, A., Jenkins, J., Karno, M., Vaughn, C., et al. (2004). Ethnicity, expressed emotion, attributions, and course of schizophrenia: Family warmth matters. *Journal of Abnormal Psychology, 113*, 428–439.

Mak, W. W., & Wu, C. F. (2006). Cognitive insight and causal attribution in the development of self-stigma among individuals with schizophrenia. *Psychiatric Services, 57*, 1800–1802.

Magliano, L., Fiorillo, A., Fadden, F., Gair, F., Economou, M., Kallert, T., et al. (2005). Effectiveness of a psychoeducational intervention for families of patients with schizophrenia: Preliminary results of a study funded by the European Commission. *World Psychiatry, 4*, 45–49.

Magliano, L., Fiorillo, A., Malangome, C., De Rosa, C., & Maj, M. (2006). Patient functioning and family burden in a controlled, real-world trial of family psychoeducation for schizophrenia. *Psychiatric Services, 57*, 1784–1791.

Marín, G., & Marín, B. V. (1991). Research with Hispanic populations. *Applied social research method series*, 23. Newbery Park, CA: Sage Publications.

Marsh, D. T., & Lefley, H. P. (1996). The family experience of mental illness: Evidence for resilience. *Psychiatric Rehabilitation Journal, 20*, 3–12.

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. R., Dixon, L., Lukens, E., & Lucksted, A. (2003). Family psychoeducation and schizophrenia: a review of the literature. *Journal of Marital and Family Therapy, 69*, 3–12.

McGoldrick, M., Giordano, J., & Garcia-Preto, N (Eds.). (2005). *Ethnicity and family therapy*. New York: Guilford Press.

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

Miklowitz, D. J., Simoneua, T. L., George, E. L., Richards, J. A., Kalbarg, A., Sachs-Ericcson, et al. (2000). Family focused treatment of bipolar disorder: 1-year effects of a psychoeducational program in conjunction with pharmacotherapy, *Biological Psychiatry, 48*, 582–592.

Millhouse, V. H., Asante, M. K. & Nwosu, P. O. (2001). *Transcultural realities: Interdisciplinary perspectives on cross-cultural relations*. Thousand Oaks, CA: Sage.

Mino, Y., Tanaka, S., Inoue, S., Tsuda, T., Babazono, A., & Aoyama, H. (1995). Expressed emotion components in families of schizophrenic patients in Japan. *International Journal of Mental Health, 24*, 38–49.

Moline, R., Singh, S., Morris, A., & Meltzer, H. (1985). Family EE and relapse in schizophrenia in 24 urban American patients. *American Journal of Psychiatry, 142*, 1169–1177.

Monroe, A. D., & Shiranzian, T. (2004). Challenging linguistic barriers to health care: Students as medical interpreters. *Academic Medicine, 79*, 118–122.

Muela Martinez, J. A., & Godoy Garcia, J. F. (2001). Family intervention program for schizophrenia: Two-year follow-up of the Andalusia Study. *Apuntes de Psicología, 19*, 421–430.

Mueser, K. T., & Glynn, S. M. (1999). *Behavioral family therapy for psychiatric disorders* (2nd ed.). Oakland, CA: New Harbinger.

Mueser, K. T., Torrey, W. C., Lynde, D., Singer, P., & Drae, R. (2003). Implementing evidence based practices for people with severe mental illness. *Behavior Modification, 27*, 387–411.

Murphy, H. B.M. & Raman, A. C. (1971). The chronicity of schizophrenia in indigenous tropical peoples: Results of a 12-year follow-up on Muritius. *British Journal of Psychiatry, 118*, 489–497.

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.

National Institute of Mental Health. (1999). *Strategic plan on reducing health disparities*. Rockville, MD: Author.

Ng, R., Mui, J., Cheung, H., & Leung, S. (2001). Expressed emotion and relapse of schizophrenia in Hong Kong. *Hong Kong Journal of Psychiatry, 11*, 4–11.

Organista, K. C., & Munoz, R. F. (1996). Cognitive behavioral therapy with Latinos. *Cognitive and Behavioral Practice, 3*, 255–270.

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin, 128,* 3–72.

Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, and practice*. New York: Guilford Press.

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

Ran, M., Leff, J., Hou, Z., Xiang, M., & Chan, C. (2003). The characteristics of expressed emotion among relatives of patients with schizophrenia in Chengdu, China. *Culture, Medicine and Psychiatry, 27*, 95–106.

Rosenfarb, I., Bellack, A., & Aziz, N. (2004). Race, family interventions and patient stabilization in schizophrenia. *Journal of Abnormal Psychology, 113*, 109–115.

Rummel-Kluge, C., & Kissling, W. (2008). Psychoeducation in schizophrenia: new developments and approaches in the field. *Current Opinions in Psychiatry, 21*, 168–172.

Rund, B. R., Moe, L., Sollien, T., Fjell, A., Borchgrevink, T., Hallert, M., et al. (1994). The Psychosis Project: Outcome and cost-effectiveness of a psychoeducational treatment programme for schizophrenic adolescents. *Acta Psychiatrica Scandinavica, 89*, 211–218.

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.

Saravanan, B., Jacob, K. S, Johnson, S., Prince, M., Bhugra, D., & David, A. S. (2007). Assessing insight in schizophrenia: East meets West. *British Journal of Psychiatry, 190*, 243–247.

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

Snowden, L. R. (2007). Explaining mental health treatment disparities: Ethnic and cultural differences in family involvement. *Culture, Medicine and Psychiatry, 31*, 389–402.

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

Stander, V., Piercy, F. P., Mackinnon, D., & Helmeke, K. (1994). Spirituality, religion and family therapy: competing or complementary worlds? *The American Journal of Family Therapy, 22*, 27–41.

Szapocznik, J. (Ed.). (1994). *A Hispanic/Latino family approach to substance abuse prevention*. Rockville, MD: Center for Substance Abuse Prevention.

Szapocznik, J., & Kurtines, W. M. (1993). Family psychology and cultural diversity: opportunities for theory, research, and application. *American Psychologist, 48*, 400–407.

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.

Tompson, M., Goldstein, M., Lebell, M., Mintz, L., Marder, S., & Mintz, J. (1995). Schizophrenic patients' perceptions of their relatives' attitudes. *Psychiatry Research, 57,* 155–167.

Torrey, E. F. (1995). *Surviving schizophrenia: A manual for families, consumers, and providers* (3rd ed.). New York: Harper Perennial.

Torrey, E. F., Bowler, A. E., Taylor, E. H., & Gottesman, I. I. (1994). *Schizophrenia and manic-depressive disorder*. New York: BasicBooks.

Triandis, H. C., McCusker, C., & Hui, C. H. (1990). Multimethod probes of individualism and collectivism. *Journal of Personality and Social Psychology, 59,* 1006–1020.

Vaughn, C. E., Snyder, K. S., Jones, S., Freeman, W. B., & Falloon, I. R. (1984). Family factors in schizophrenic relapse: Replication in California of British research on expressed emotion. *Archives of General Psychiatry, 41,* 1169–1177.

Weisman, A. G., Duarte, E., Koneru, V., & Wasserman, S. (2006). The development of a culturally informed, family focused treatment for schizophrenia. *Family Process, 45,* 171–186.

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

Weisman de Mamani, A. G., Kymalainen, J., Rosales, G., & Armesto, J. (2007). Expressed emotion and interdependence in White and Latino/Hispanic family members of patients with schizophrenia. *Psychiatry Research, 151,* 107–113

Weisman, A. G., & Lopez, S. R. (1997). An attributional analysis of emotional reactions to schizophrenia in Mexican and Anglo American cultures. *Journal of Applied Social Psychology, 27,* 223–244.

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

Weisman, A., 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 & Mental Disease, 193,* 359–368

Weisman, A. G., Rosales, G. A., Kymalainen, J. A., & Armesto, J. C. (2006), Ethnicity, expressed emotion, and schizophrenia patients' perceptions of their family members' criticism. *The Journal of Nervous and Mental Disease, 194,* 644–649.

Wing, J. K. (1978). Social influences on the course of schizophrenia. In L. C. Winny, R. L. Cromwell, & S. Matthysse (Eds.), *The nature of schizophrenia* (pp. 599–616). New York: Wiley.