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Culturally Adapted Psychosocial Interventions for Schizophrenia: A Review

Jessica Maura and Amy Weisman de Mamani, *University of Miami*

Recent research examining the potential efficacy of culturally adapted interventions for various mental disorders illustrates increasing interest in the integration of cultural perspectives into mental health systems. Despite recent evidence demonstrating that culturally adapted interventions may be more effective than a one-size-fits-all approach, few psychosocial treatments for schizophrenia consider cultural factors that may enhance their efficacy with diverse populations. The aim of this review is to discuss the empirical evidence examining the potential utility of culturally adapted group interventions for schizophrenia, as a means to encourage further work and expansion in this area. Specifically, this article provides an in-depth review of the empirical literature on culturally adapted psychosocial interventions for individuals with schizophrenia and their family members, with a focus on group-based interventions. This review is followed by a discussion of a few cultural constructs that may impact patient and family member functioning, and therefore may be important to address in psychosocial treatments for schizophrenia. Finally, we end this review with a broad discussion of research limitations and potential areas for additional research, clinical implications for adapting EBTs to better address cultural concerns, and a case vignette to illustrate how cultural considerations can be integrated into a traditional multifamily group therapy approach.

Schizophrenia is a chronic and disabling psychiatric disorder that occurs in roughly 1 in every 100 individuals (Silverstein, Moghaddam, & Wykes, 2013). Schizophrenia imparts substantial impacts on patients' social, psychological, and vocational functioning (Freeman et al., 2014; Pinkham et al., 2012) and is associated with significant psychological distress among family members (Mitsonis et al., 2012). While antipsychotic medications have been shown to be effective in preventing future relapse and reducing positive symptoms of schizophrenia (e.g., hallucinations, delusions, disorganized speech), psychosocial outcomes, including family functioning and social adjustment—which also influence relapse—are less amenable to psychopharmacological interventions (Bustillo, Lauriello, Horan, & Keith, 2001).

In recent years, group therapy has attracted interest as it has been deemed more time- and cost-effective, allows a greater number of individuals to be treated simultaneously, efficacious, and promotes greater interpersonal relationships than other psychotherapeutic interventions (Lockwood, Page, & Conroy-Hiller, 2004; Perkins & Repper, 2003; Segredou et al., 2012). Further, with the ever-expanding ethnic diversity of the United States, integrating cultural perspectives into mental health systems has become an important social initiative (Hall, 2001; Huntington, 2004; Stepick, Stepick, & Vanderkooy, 2011). However, while group-based psychosocial treatments have been found to provide benefits to patients and family members alike (for comprehensive reviews, see Lyman et al., 2014; Segredou et al., 2012), to date very few culturally informed group treatments for schizophrenia exist. Further, of those that are available, even fewer programs attend to the needs of both patients and family members and can be adapted for use with individuals of diverse cultural backgrounds. The aim of this review is to discuss the empirical evidence examining the potential utility of culturally adapted group interventions for schizophrenia, as a means to encourage further work and expansion in this area. To accomplish this goal, we first detail the empirical literature examining group-based psychosocial interventions for schizophrenia, with a focus on culturally adapted approaches. As a means to expand upon this literature, we will then identify and discuss two cultural constructs, collectivism and spiritual/religious coping, which may impact patient and family member functioning, and therefore may be important to address in psychosocial treatments for schizophrenia. Finally, we outline research limitations and potential areas for additional research, clinical implications for adapting EBTs to better address cultural concerns, and provide a case vignette to illustrate how cultural considerations can be integrated into a traditional multifamily group therapy approach.

In order to synthesize the available evidence examining culturally adapted interventions for schizophrenia, we

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have attempted to conduct a comprehensive narrative review. We chose a narrative review over a meta-analysis or other type of review because narrative approaches are well suited to summarizing broad areas of the literature base as a means to draw conclusions and generate areas for future work (Dochy, 2006; Green, Johnson, & Adams, 2006). We utilized PsycINFO, MEDLINE, CINAHLPlus, and PUBMED databases, with no limitations on year of publication. Key search terms included schizophrenia and/or psychosis, group, CBT/cognitive behavioral therapy, psychoeducation/psychoeducational interventions, MFGT/multifamily group therapy, and culture/culturally adapted. In our discussion of collectivism and spiritual/religious coping, we also included the terms collectivism, familism, family cohesion, spiritual/spirituality, and religion. Studies that discussed culturally adapted interventions for patients and/or family members of patients with schizophrenia were included in the current review, including outcome studies and qualitative descriptions of cultural adaptations. We excluded studies that used samples without psychosis or a diagnosis of schizophrenia, or which were not available in English. No further exclusion criteria were used.

Group Therapy for Schizophrenia

Various group-based psychosocial treatments have been developed for schizophrenia. The most prominent and well validated of these include cognitive behavioral therapy, psychoeducational therapy, and multifamily group therapy (Hyde & Goldman, 1992; McDonell, Short, Hazel, Berry, & Dyck, 2006; Segredou et al., 2012).

A large body of literature has examined the effectiveness of group cognitive behavioral therapy (CBT) for individuals with schizophrenia. CBT for schizophrenia focuses on cognitive processes that may exacerbate the salience of hallucinations and delusions (Maher, 1988). While some literature has reported promising effects of group-based CBT, including lower levels of depression (Gledhill, Lobban, & Sellwood, 1998), anxiety (Gaynor et al., 2011), improved quality of life (Bechdolf et al., 2010), and reductions in positive symptoms of schizophrenia (Granholm, Holden, Link, & McQuaid, 2014; Zanello, Mohr, Merlo, Huguelet, & Rey-Bellet, 2014), findings regarding the efficacy of group CBT for schizophrenia appear somewhat mixed. Barrowclough et al. (2006) tested the efficacy of a group-based CBT protocol and found no differences in symptoms, functioning, or relapse between the CBT group and a treatment-as-usual control condition. Relatedly, Bechdolf, Köhn, Knost, Pukrop, and Klosterkötter (2005) found that while participation in a group CBT program appeared to reduce rehospitalization rates among patients with schizophrenia at a 6-month follow-up, these results did not persist over time and no significant effects were found at a 2-year follow-up. Lawrence, Bradshaw, and Mairs (2006) conducted a meta-analysis examining the efficacy of group-based CBT for schizophrenia and reported concerns regarding the methodological quality of the studies reviewed, the inconsistency of study findings, and the maintenance of improvements in symptoms over time. Similarly, a recent paper by Owen, Speight, Sarsam, and Sellwood (2015) conducted a review of group-based CBTp outcome studies to assess the acceptability and effectiveness of group based CBTp among inpatients with schizophrenia. The authors suggest that while group-based CBTp appears acceptable to patients and may have the potential to reduce distress and improve quality of life, limitations in the methodological quality of the studies reviewed highlight the need to interpret these findings with caution (Owen et al., 2015). Further, to our knowledge, only one study has examined the potential impact of group CBTp for family members. Landa and colleagues (2015) tested a group- and family-based CBT program for youth at risk for psychosis and found that family members involved in the group program demonstrated improved family communication and greater confidence in their ability to help their loved one. However, research examining family outcomes for group-based CBTp is sparse and additional work in this area is required to confirm these findings. Thus, it appears that while CBT for individuals with schizophrenia appears to demonstrate some benefits for patients and family members, study results are inconsistent and it is unclear whether these effects persist over time.

Group-based psychoeducation is another well-established treatment for individuals with schizophrenia and their families. Psychoeducational therapy focuses on increasing knowledge about the illness, identifying symptoms of relapse, highlighting the importance of psychopharmacological treatment, and teaching coping skills (Segredou et al., 2012). Group-based psychoeducation programs have shown effectiveness at improving subjective quality of life (Bechdolf et al., 2010), functioning (Chien & Wong, 2007), medication nonadherence (Lyman et al., 2014), and reducing rates of rehospitalization (Goldstein, 1995; Herz et al., 2000; Pitschel-Walz et al., 2006) among patients with schizophrenia. Multifamily psychoeducational groups have also been found to improve problem-solving ability and reduce burden among family members of individuals with schizophrenia when compared to control groups (Khoshknab, Sheikhona, Rahgouy, Rahgozar, & Sodagari, 2014; Lyman et al., 2014). However, mixed findings regarding the efficacy of psychoeducation have also been reported. Lincoln, Wilhelm and Nestoriuc (2007) completed a meta-analysis of the effectiveness of psychoeducational programs for individuals with schizophrenia and found that while psychoeducation produced a medium effect size for relapse and a small effect size for knowledge at treatment termination, it had no effect on symptom severity, functioning, or medication adherence.

Similarly, Sin and Norman (2013) conducted a review of psychoeducational interventions for family members of individuals with schizophrenia and found improvements in knowledge about the illness and coping, but reported less consistent findings regarding the impact of psychoeducation on family burden and expressed emotion, a measure of criticism, hostility, and emotional overinvolvement within the family environment. Despite promising findings on the impact of group-based psychoeducation on patient and family member functioning, these interventions also appear limited as very few programs include both patients and family members in treatment simultaneously (Dixon, Adams, & Lucksted, 2000; McFarlane, Dixon, Lukens, & Lucksted, 2003). Further, Lyman et al. (2014) report that adapting psychoeducational programs to address cultural beliefs, attitudes, and norms may improve outcomes for both patients and family members, and therefore research in this area is warranted.

Multifamily group therapy (MFGT) integrates psychoeducation, relapse prevention, social skills and vocational development, and problem-solving sessions in a multiple-family group format (McFarlane, 2002). MFGT has been found to be associated with lower perceived stress (Rotondi et al., 2005), improvements in negative symptoms (Dyck et al., 2000), reduced relapse and rehospitalization rates (Dixon et al., 2000; McDonell et al., 2006; Pitschel-Walz, Leucht, Bäuml, Kissling, & Engel, 2001) and improved social functioning (Montero et al., 2001; Rotondi et al., 2005) among patients with schizophrenia. MFGT has also been found to improve family member well-being (McFarlane et al., 2003). Hazel et al. (2004) found that family caregivers of individuals with schizophrenia who participated in a MFGT program reported reduced psychological distress across a 2-year treatment period when compared to a standard care control condition. While the benefits of MFGT have been well-established in the literature, less literature exists examining the effectiveness of MFGT across different ethnic and cultural groups (Stuart & Schlosser, 2009). Relatedly, McFarlane et al. (2003) reported the need to test MFGT programs that have been modified in content and outcome to meet the needs of various cultural groups.

Culturally Adapted Psychosocial Interventions for Schizophrenia

The call for examining the potential efficacy of culturally adapted psychotherapeutic interventions for schizophrenia has recently gained traction (APA, 2013; Ferrer-Wreder, Sundell, & Mansoory, 2012; U.S. Department of Health and Human Services, 2003; Vega et al., 2007). A major criticism underlying each of the abovementioned evidence-based models (CBT, psychoeducation, MFGT) is that they subscribe to Western-based models of mental illness, and therefore do not consider the cultural context that may impact service delivery and outcomes among individuals from different cultural backgrounds (Barrio & Yamada, 2010; Benish, Quintana, & Wampold, 2011). As a result, recent efforts have been made to examine empirically the potential efficacy of modifying evidence-based approaches to better consider the cultural context in which mental illness is perceived, interventions are delivered, and participants respond to treatment (Castro, Barrera, & Steiker, 2010; López, Barrio, Kopelowicz, & Vega, 2012; Pearson & Burlingame, 2013; U.S. Department of Health and Human Services, 2003; Vega et al., 2007).

Cultural adaptation refers to "The systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). Specific cultural constructs that have been identified in the literature as important to consider when adapting interventions include collectivism, spirituality, and discrimination (Hall, 2001). Typical cultural adaptations applied to existing EBTs include explicit discussions of culture, racial/ethnic matching of therapists and clients, use of the client's preferred language during therapy, incorporating cultural values into the treatment protocol, discussing spirituality, and reaching out to culturally relevant services and community leaders (Griner & Smith, 2006). Recent meta-analyses evaluating the effectiveness of cultural adaptations to EBTs have demonstrated promising evidence that culturally adapted interventions may be more effective than a one-size-fits-all approach (Benish et al., 2011; Griner & Smith, 2006). However, research examining group-based cultural adaptations geared towards individuals with schizophrenia and their family members is sparse.

The bulk of the available literature examining the efficacy of culturally adapted psychosocial interventions for schizophrenia focuses on individual and family-based approaches. Recent research has focused on the development of a culturally adapted CBT for psychosis (CaCBTp) that incorporates culturally based patient health beliefs and attributions to psychosis (e.g., previous wrongdoing, supernatural beliefs), help-seeking behaviors (e.g., mistrust of health-care providers), racism and discrimination, and the role of religion and spirituality into a traditional CBT framework (Rathod, Kingdon, Phiri, & Gobbi, 2010). Research indicates promising findings regarding the efficacy of CaCBTp. Naeem et al. (2015) tested a brief CaCBTp for outpatients with schizophrenia in Karachi, Pakistan, which consisted of 6 therapy sessions inclusive of the patient and primary caregiver, and one family therapy session. This program combined a traditional CBTp framework, including psychoeducation about schizophrenia and the stress

vulnerability model, cognitive work in testing delusions and hallucinations, and skills to manage negative symptoms (Kingdon & Turkington, 2005), with culturally specific components such as the inclusion of the primary caregiver in treatment planning, discussions of spirituality, and the use of Urdu phrases and folk stories to clarify the content of the protocol (Naeem et al., 2015). The authors found that this program was effective in reducing positive and negative symptom severity when compared to a medication management treatment-as-usual control condition (Naeem et al., 2015). Further, this group of researchers uncovered similar findings, including lower levels of symptom severity and improved insight, when testing this protocol within inpatient populations in Pakistan (Habib, Dawood, Kingdon, & Naeem, 2015). Another group of researchers (Rathod et al., 2013) similarly examined the efficacy of CaCBTp among Black British, African Caribbean/Black African, and South Asian Muslim patients with schizophrenia living in the U.K. This intervention involved 16 individual therapy sessions and modified traditional CBTp, as developed by Kingdon and Turkington (2005), to flexibly allow for discussions of spirituality/religiosity, as well as how cultural attitudes, beliefs, values, and norms may influence symptomatology and perceptions of the causes of mental illness (Rathod et al., 2013). The authors found that the described treatment protocol was effective in reducing levels of overall symptom severity, when compared to a comparison condition consisting of pharmacotherapy and monitoring by a multidisciplinary team (Rathod et al., 2013). Finally, Edge and colleagues (2014) are currently developing a culturally adapted family intervention (CaFI) for African Caribbeans with schizophrenia and their family members, which focuses on psychoeducation, problem solving, and stress management; however, specifics of the cultural adaptation and pilot data are not yet published.

Several studies have also examined the efficacy of culturally adapted psychoeducational programs for Chinese patients with schizophrenia and their family members. Culturally adapted components of these psychoeducational family interventions include focus on the value of collectivism, strong family ties, orientation to the mental health system, and discussions of stigma towards mental illness (Bae & Kung, 2000; Yang & Pearson, 2002). These protocols have also shown promise and have demonstrated improvements in relapse and rehospitalization rates among patients (Ran et al., 2003), lower levels of family burden (Xiong et al., 1994), as well as improvement in illness knowledge and functioning (Li & Arthur, 2005) among Chinese patients with schizophrenia and their family members.

López and colleagues (2009) developed and tested La CLAve, a 35-minute culturally adapted psychoeducational program for Spanish-speaking community residents and family members of individuals with schizophrenia in Los Angeles. The program aimed at increasing psychosis literacy through the use of popular cultural icons derived from music, art, and videos to describe symptoms of psychosis and address illness attributions and help-seeking behaviors. The program was successful in improving knowledge, efficacy beliefs, illness attributions, and help-seeking behaviors among community residents, and symptom knowledge and efficacy beliefs among caregivers (López et al., 2009). Valencia et al. (2010) developed a culturally adapted psychosocial skills training and psychoeducational program for Mexican outpatients with schizophrenia. Cultural adaptations to the program included beginning sessions with *platica* (small talk) to build trust, and therapist self-disclosure to create a sense of *personalismo* (personal orientation). The program was found to improve medication adherence, symptom severity, social functioning, and relapse and rehospitalization rates (Valencia et al., 2010).

Weisman and colleagues (2006) developed a family-focused therapy for schizophrenia, known as Culturally-Informed Therapy for Schizophrenia (CIT-S). CIT-S incorporates discussions of collectivism and spirituality/religion into the family-focused treatment developed by Falloon, Boyd, and McGill (1984) and Miklowitz and Goldstein (1997). Weisman de Mamani and colleagues (2014) tested the CIT-S treatment protocol against a three-session psychoeducation (PSY-ED) treatment condition. The authors found that the CIT-S protocol outperformed the PSY-ED control condition in reducing patient symptom severity with a medium effect size (Weisman de Mamani et al., 2014) and in decreasing caregiver burden with a large effect size (Weisman de Mamani & Suro, 2016). Fewer studies exist examining the impact of culturally informed group therapies for individuals with schizophrenia and their family members. The literature on this topic, with programs organized by the cultural group to which they were developed for, is reviewed below.

Asians

Chien and Wong (2007) tested a culturally sensitive family psychoeducational group program for patients and family members of individuals with schizophrenia in China. The program included psychoeducation and family role and strength rebuilding within a collectivistic and familistic value orientation. The standard care control group consisted of monthly medication management, brief family education, and counseling if requested. The authors found that family members participating in the experimental group reported greater family functioning, reduced burden of care among family members, and lower rehospitalization rates among patients than those in the control condition. The authors reported that increasing interdependence in a psychoeducational program may help to improve family functioning and reduce patient relapse and rehospitalization (Chien & Wong, 2007). Guo and colleagues (2010) tested the effectiveness

of a culturally adapted psychosocial intervention for individuals with schizophrenia and their family members against a medication-only control condition at 10 clinical sites in China. The psychosocial intervention consisted of monthly group-based psychoeducation, family intervention, skills training and CBT over the course of 1 year. Culturally relevant components of the treatment protocol included a focus on family involvement, collaboration within the family, and the inclusion of family members in the treatment program. The authors found that patients randomized to the psychosocial intervention demonstrated lower rates of rehospitalization and symptom severity, and increased insight, social functioning, activities of daily living, and quality of life when compared to the medication-only control group (Guo et al., 2010).

Shin and Lukens (2002) developed and tested a 10-week culturally sensitive psychoeducational group therapy program for Korean Americans with schizophrenia receiving services at an outpatient center in New York. Patients in the experimental condition received both the culturally sensitive psychoeducational group and supportive individual therapy, whereas the control group received supportive individual therapy only. Cultural adaptations to the psychoeducational program included consideration of Korean values when providing psychoeducation, a biopsychosocial model that places less emphasis on affective symptoms, the clinician role as a cultural broker in which they discuss and interpret cultural differences and provide culturally informed services within the community, as well as a didactic rather than interactive format, which places less emphasis on self-disclosure and therefore may be more acceptable to individuals of Korean descent (Shin & Lukens, 2002). The authors found that patients assigned to the group therapy program showed reduced symptom severity, lower perceptions of stigma and greater coping skills at termination, when compared to the control group. In a later study, Shin (2004) tested the culturally sensitive psychoeducational group against an individual supportive therapy program among a sample of Korean American parents of patients with schizophrenia. Results indicated that parents assigned to the culturally sensitive psychoeducational program demonstrated lower levels of stigma, more coping skills and increased family empowerment when compared to those assigned to the control condition. Though the literature is limited, the abovementioned studies demonstrate various benefits for culturally adapted programs for individuals of Asian descent with schizophrenia and their family members.

Hispanics/Latinos

Kopelowicz, Zarate, Gonzalez Smith, Mintz, and Liberman (2003) tested the effectiveness of a culturally adapted skills training program for Latino outpatients with schizophrenia. The primary cultural adaptations were the inclusion of the patient's key relative in treatment as generalization agents, the translation of training materials and worksheets, and the use of bilingual and bicultural therapists. Patients and their key relative participated in the 3-month skills training group. Compared to patients who completed a customary outpatient care group, patients in the skills training group demonstrated greater skill acquisition and generalization, and lower rates of rehospitalization. In a later study, Kopelowicz et al. (2012) tested a culturally adapted multifamily group therapy (MFGT) for Mexican American individuals with schizophrenia aimed at improving medication adherence against a non-culturally adapted MFGT, and a treatment-as-usual control condition which consisted of medication management and individual, family, and group therapy as needed. The culturally adapted MFGT incorporated principles from the theory of planned behavior (Ajzen, 1991), which emphasizes subjective norms and perceived behavioral control. The authors found that patients in the culturally adapted MFGT demonstrated higher rates of medication adherence and lower rates of hospitalization than the standard MFGT or treatment-as-usual control conditions.

Barrio and Yamada (2010) developed a 16-session culturally based MFGT for Spanish-speaking Latino families with a relative diagnosed with schizophrenia and compared it to a usual-care control condition that consisted of medication management, as well as case management and family, individual, and group therapy. Cultural components of the intervention include discussions of specific strengths and culturally based coping strategies for each family member, the concept of familism, spirituality/religiousness, as well as the potential impact of cultural attributions and bicultural experiences on patients and family members. Additionally, psychoeducation and problem-solving training was provided. The authors found that family members participating in the culturally adapted MFGT demonstrated improved knowledge about the illness and lower levels of family burden when compared to those in the usual-care condition.

Patterson and colleagues (2005) developed and tested *Programa de Entrenamiento para el Desarrollo de Aptitudes para Latinos* (PEDAL; Program for Training and Development of Skills in Latinos), a 24-session group therapy aimed at improving everyday living skills of middle and older-aged Latino individuals with chronic schizophrenia against a friendly support group. The intervention was delivered in outpatient community clinics in San Diego and focused on improving medication management, social skills, communication skills, organization, transportation, and financial management from a CBT framework. Cultural adaptations to the program included translation of materials, bicultural and bilingual assessors and group leaders, incorporation of

Latino icons, sayings, and activities into the treatment, the emphasis of *simpatia* (polite social relations), *personalismo* (warm relationships), and *respeto/formalidad* (respect/formality). Further, intervention materials were modified to more appropriately serve this population; for example, when discussing finances, emphasis was placed on cash rather than checks and credit cards; when discussing transportation, emphasis was placed on working with family members rather than travelling independently; and when discussing medication management, the benefits of adhering to a medical regimen as a means to contribute to the family was discussed. The authors found that participants in the PEDAL program demonstrated improvements in everyday living skills at 6- and 12-month follow-ups when compared to the support group control condition.

Blacks

Research examining the potential of culturally adapted interventions for individuals with schizophrenia of African descent is limited. Carter and Jordan (1972) conducted a culturally adapted reality-oriented group therapy for Black inpatients with paranoid schizophrenia at a psychiatric hospital in North Carolina. The group consisted of 16 Black male patients, was led by a Black psychiatrist, and focused on "solving here-and-now problems" (Carter & Jordan, 1972). Cultural adaptations to the group consisted of discussions of identity, specifically being Black in a predominantly White society, and the presence of feelings of inadequacy and worthlessness when comparing oneself to other members of society. The authors reported that after 6 months, over half of the patients had been released from the hospital, and the majority of the remainder were preparing for discharge. The authors report that an understanding of the patients' culture, lifestyle, and value system is of utmost importance when working with this population (Carter & Jordan, 1972).

Baker, Stokes-Thompson, Davis, Gonzo, and Hishinuma (1999) tested the efficacy of a psychosocial rehabilitation program for Black patients with chronic mental illness living in an urban, predominantly black Baltimore community. The program consisted of daily transportation to and from the mental health center, classes in personal grooming, housekeeping, cooking, office and computer skills, vocational rehabilitation, and weekly group meetings to discuss and plan weekend activities (e.g., church services). The authors found improvements in level of functioning, including improvements in rehospitalization rates, social relationships, personal hygiene, and work and leisure activities (Baker et al., 1999). A handful of studies examining the impact of psychosocial interventions for individuals with schizophrenia in Africa have been conducted and are described below.

Asmal, Mall, Emsley, Chiliza, and Swartz (2014) examined the feasibility and acceptability of a bimonthly MFGT in an urban community in South Africa. The MFGT protocol consisted of psychoeducation, discussions of stress and expressed emotion, communication skills, problem solving, and crisis planning. In addition, the groups discussed cultural factors that may influence attendance and implementation of the intervention. Four groups consisting of patients and family members were run, three of which were conducted in Afrikaans and one in English. Key emergent themes included the impact of stigma, patient vulnerability to exploitation and violent victimization (the study was conducted in a particularly violent area of South Africa), the impact of multiple stressors on caregivers (e.g., poverty, lack of social support, health conditions, community violence), and the impact of substance use (Asmal et al., 2014). The authors report that the incorporation of the abovementioned topics into a traditional model of family therapy may be particularly relevant for individuals with schizophrenia and their family members living in South Africa.

Agara and Onibi (2007) examined the impact of a 4-session culturally adapted group psychoeducational program for individuals with schizophrenia and depressive disorders in Nigeria. The group psychoeducational program was conducted 4 weeks prior to the patient's discharge from the hospital, and patients were followed for 9 months following treatment termination. Cultural adaptations to the treatment protocol included a module on cultural aspects of the disorder, which focused on discussions of religious practices and beliefs, such as the common belief that mental illness is spiritual in nature and therefore not amenable to medical treatment. The authors found that patients who underwent the culturally adapted psychoeducational program were consistently more compliant with scheduled clinic appointments than those who did not receive the group psychoeducation program (Agara & Onibi, 2007).

Pooe et al. (2010) compared the effectiveness of a traditional group-based psychoeducational program versus a culturally adapted group-based psychoeducational program in inpatients and outpatients diagnosed with schizophrenia in South Africa. The original psychoeducational group consisted of 3 sessions discussing signs and symptoms of the illness, as well as illness course and prognosis. The culturally adapted psychoeducational group included simplified and illustrated explanations of the subject material, and used language, phrases, and examples specific to the cultural group. The authors found that individuals in the culturally adapted group fared better in terms of comprehension and retention of the material provided, demonstrated greater insight, and were better able to relate to their illness than individuals in the traditional group (Pooe et al., 2010).

Cultural Constructs

The literature reviewed above indicates that culturally adapted interventions for schizophrenia provide benefits to patients and family members alike. However, a large majority of the abovementioned interventions are somewhat narrow in scope, in that they typically target patients or family members only, or are directed towards a singular ethnic or cultural group. Further, when family members are included in the treatment protocol, it is often with the purpose of improving patient outcomes (Lucksted et al., 2012). Given that very few individuals with schizophrenia or family members of individuals with schizophrenia receive any mental health services at all (Dixon et al., 1999; Drake & Essock, 2009), a need exists for inclusive, culturally sensitive treatments aimed at improving outcomes for both patients and family members of various ethnic backgrounds. The proceeding sections outline the literature that informed the selection of collectivism and spirituality/religiosity as constructs that may influence patient and family member functioning.

Literature from The World Health Organization (Jablensky, Sartorius, Ernberg, & Anker, 1992; Sartorius et al., 1986) multisite studies and other literature (Haro et al., 2011; Hopper & Wanderling, 2000; Kulhara, Shah, & Grover, 2009) indicates that patients with schizophrenia from developing countries may display a more benign course of illness than patients from developed countries. A body of literature has examined certain socio-cultural variables, including spirituality/religiosity and the value placed on family, as factors that may be implicated in these findings. Literature examining the impact of these factors on patients with schizophrenia and their family members is reviewed below.

Collectivism

The emphasis of the family as a priority above the self is considered one construct that is prominent in developing nations that tend to be more collectivistic or interdependent in nature (Triandis, 1993). The tendency to value social ties, or the family structure, over individual needs, wants and desires, has been identified in several different cultural groups, though different terminology has been utilized among them. Among individuals from African descent, communalism, where social relationships are prioritized over individual achievements, has been regarded as an important cultural value (Wallace & Constantine, 2005). Among Hispanics/Latinos, familism, where the family is prioritized over the self and warm, close family relationships are emphasized, has similarly been identified in the literature as an important cultural value (Campos, Ullman, Aguilera, & Dunkel Schetter, 2014). Likewise, among individuals of Asian descent, filial piety, which refers to honoring one's family, as well as deference, compliance, and support in familial relationships, has been identified as a strongly held cultural value (Yeh & Bedford, 2003). While the abovementioned terms are specific to the cultural group in which they originated, they all share a common theme regarding the importance of the family, and social ties broadly, above individual wants and needs. In the current study, we refer to this construct as collectivism. The literature regarding the impact of familial bonds and interconnectedness on mental health is reviewed below.

Schwartz et al. (2010) found that communalism, familism, and filial piety clustered onto a single factor they referred to as family/relationship primacy, and that this factor was associated with positive psychological functioning. Utilizing a diverse university sample, Campos and colleagues (2014) found that the impact of familism on better psychological health is mediated by greater closeness to family members and greater perceived social support, regardless of ethnicity or cultural background. Relatedly, family warmth and a sense of familism has been linked to better mental well-being (Mulvaney-Day, Alegría, & Sribney, 2007; Rodriguez, Mira, Paez, & Myers, 2007; Schwartz et al., 2010) and lower relapse rates among Mexican-American patients with schizophrenia (López et al., 2004). Weisman, Rosales, Kymalainen, and Armesto (2005) found that for patients and family members of Hispanic and African American descent, increased perceptions of family cohesion were associated with lower ratings of depression, anxiety, and stress, as well as fewer psychiatric symptoms among patients. A study by Weisman and López (1996) found that increasing perceptions of familial unity and cohesion among White and Mexican undergraduates led to more favorable emotional responses to vignettes describing a hypothetical relative with schizophrenia. Similarly, among caregivers, familism has been linked to less distress and better psychological health (Magaña, 1999; Magaña & Smith, 2006) as well as lower levels of subjective burden (Weisman de Mamani & Suro, 2016). The abovementioned literature indicates that a greater sense of collectivism may play a protective role and provide various benefits to both patients and family members alike.

Spirituality/Religiosity

In traditional cultures, spirituality/religiosity is a fairly prominent construct which serves to provide meaning to many life events and behaviors (Lefley, 1990). While religion and spirituality can be considered separately, with religion referring to specific behavioral and social practices and shared belief systems, and spirituality referring to broader transcendent considerations of life's meaning (Mohr, Brandt, Borras, Gilliéron, & Huguelet, 2006), for the purposes of this review we consider both constructs

together as they are related, not independent, and are typically not distinguished from one another in the literature base (Hill & Pargament, 2008). The use of one's spiritual or religious beliefs to cope with symptoms of schizophrenia and the ongoing recovery process may provide benefits to patients with the illness as well as their family members. The literature on this topic is discussed below.

Shah et al. (2011a; 2011b) found that spirituality/religiosity was associated with more active and adaptive coping and better quality of life among patients diagnosed with schizophrenia. Relatedly, Verghese et al. (1989) found that patients with schizophrenia in India who spent more time engaging in religious activities had better prognosis at a 2-year follow-up. However, research indicates that the type of spiritual/religious coping may influence the potential impact of spirituality/religiosity on patient functioning. Rosmarin, Bigda-Peyton, Öngur, Pargament, and Björgvinsson (2013) found that among patients with schizophrenia, positive religious coping (e.g., seeking spiritual connection, benevolent religious reappraisals) was associated with lower depression and anxiety and higher well-being, whereas negative religious coping (e.g., spiritual discontent, demonic reappraisals) was associated with increased depression, anxiety, suicidal ideation, and lower well-being. Mohr et al. (2006) found that positive religious coping among individuals with schizophrenia was associated with lower psychiatric symptoms, and higher subjective ratings of hope, comfort and meaning in life, whereas negative religious coping was associated with increased guilt, anger, despair, psychiatric symptoms, and substance use. In a follow-up study, Mohr et al. (2011) followed the prior sample and found that patients who endorsed helpful religion and placed high importance on spirituality had fewer negative symptoms, and better clinical global impression, social functioning and quality of life at a 3-year follow up.

Though the relationship between spirituality/religiosity and patient functioning has been well established, less research has been conducted examining the role of spiritual/religious functioning among caregivers with schizophrenia. Rammohan, Rao, and Subbakrishna (2002) examined 60 caregivers of individuals with schizophrenia in India and found a positive association between strength of religious belief and well-being. Murray-Swank et al. (2006) assessed 83 caregivers of individuals with serious mental illness participating in the Family to Family Education Program of the National Alliance on Mental illness. The authors found that religiosity in caregivers was associated with less depression and greater self-esteem and self-care (Murray-Swank et al., 2006). Similarly, Duarte (2010) found that increases in general religiosity and religious coping over time were related to higher self-report ratings of quality of life for caregivers of individuals with schizophrenia.

Prior literature reports that as many as 80% of patients with schizophrenia report to rely on spirituality/religion as a method of coping with their illness (Loewenthal, 2007; Tepper, Rogers, Coleman, & Malony, 2001). Further, Kulhara, Avasthi, and Sharma (2000) report that individuals with schizophrenia who identify as religious are more likely to seek religiously based (rather than medical) treatments for their symptoms. Thus, given the high number of patients with schizophrenia who report a religious or spiritual affiliation, an intervention that incorporates spirituality/religion into the treatment program may be particularly engaging. While very few studies have examined the effectiveness of spiritually/religiously based interventions for individuals with schizophrenia, studies examining the impact of these interventions show promising results.

Phillips, Lakin, and Pargament (2002) developed a 7-week psychoeducational program for individuals with severe mental illness that focused on personal and community spiritual resources, spiritual goals, spiritual struggles, forgiveness, and hope. Participants reported benefits of the group including an open space in which they could discuss and explore religious and spiritual beliefs in a nonjudgmental manner. Revheim, Greenberg, and Citrome (2010) found that patients with schizophrenia who participated in a spirituality-based group therapy program, which focused on the use of spiritual beliefs to cope with one's illness, reported higher self-efficacy for positive symptoms, negative symptoms and social functioning, and higher self-rated hopefulness than patients who did not attend the spirituality group. While the results of these studies are promising, research in this area is sparse, and further development and examination of spiritually/religiously oriented treatments that attend to the needs of both patients and family members is needed.

Clinical Implications

Various clinical and ethical implications for the use of culturally adapted treatment programs have been discussed in the literature. Specifically, Trimble and Fisher (2006) state that mental health professionals have a moral and ethical responsibility to deliver treatments that consider cultural contexts and values that may impact client well-being. Further, research indicates that ethnic minorities are more likely to underutilize mental health services (Ayalon & Young, 2005) and that incorporating cultural values and beliefs increases utilization among these groups (Bernal et al., 2009; Flaskerud, 1986). Thus, the literature reviewed indicates that culturally adapted interventions may not only be effective, but may be more appealing and engaging for ethnically diverse clients.

Several broad cultural components have been identified in the literature as important to consider when adapting EBTs for schizophrenia. These include the provision of the therapy protocol in one's preferred language, the use of culturally specific phrases or metaphors to enhance understanding and clarify content, discussions of spirituality/religiosity and how these factors may be used adaptively to cope with the stress associated with mental illness, a focus on the familial support system and improving family dynamics, as well as broad discussions of how cultural beliefs, behaviors, and attitudes may influence attributions of mental illness, symptom expression, and help-seeking behaviors. Thus, when adapting EBTs to better consider culture, it is recommended that these components be considered.

To further illustrate how the inclusion of these components may look in clinical practice, we describe how the major elements of a well-established EBT for schizophrenia, CBTp, may be culturally adapted. First and foremost, a primary cultural adaptation to CBTp may include the provision of services in the client's preferred language, when possible, to assist in understanding of the intervention material, as well as to enhance engagement and foster the therapeutic alliance (APA, 2013). Further, when providing psychoeducation, it may also be useful to discuss cultural views regarding the causes of mental illness and approaches to treatment. These discussions may highlight misinformed attributions regarding the causes of mental illness (e.g., mental illness is punishment from God for a prior wrongdoing) and provide opportunities to not only discuss etiological models but to practice thought challenging and cognitive restructuring. Attention to culture may also provide a more thorough clinical picture and assist in case conceptualization. For example, identification of culturally specific perpetuating factors (e.g., stigma/discrimination) or protective factors (e.g., spirituality/religiosity, familial support) may provide opportunities to address factors that make recovery more difficult and strengthen factors that may aid in recovery (Kingdon & Turkington, 2005). Finally, as culture appears to play a role in the phenomenology of schizophrenia symptoms (McLean et al., 2014), these factors may also be important to consider when targeting symptomatology. According to Kingdon and Turkington (2005), understanding how and why a delusional belief developed is crucial for later examination and challenging of such delusional thought content. Thus, a detailed understanding of culturally relevant events, beliefs, and images that may have contributed to delusional thought content may assist in discussing and debating delusions. Further, discussions of culturally relevant beliefs about the origins of hallucinatory experiences (e.g., spirits are talking to me) may prove useful when engaging in reattribution of hallucinations.

Case Illustration

To further illustrate how these adaptations may look from another framework, we provide a case illustration which incorporates discussions of family collectivism and spirituality/religiosity into a traditional MFGT.

Berta, a 47-year-old housewife enrolled in a culturally adapted MFGT for schizophrenia with her husband, Mauricio, her son Alfredo (age 19), and her two daughters (ages 15 and 17). Both Mauricio and Berta had emigrated from Cuba approximately 22 years ago. Alfredo had his first psychiatric break 2 years ago and was diagnosed with schizophrenia. Berta and Mauricio were once active members of the Cuban-American community but they had stopped attending political and cultural events and reported feeling somewhat disconnected from this community since Alfredo became ill. Prior to Alfredo's illness, the family had also attended church together weekly yet they had not managed to do so for over a year. Recently most of Berta's time was spent looking after Alfredo and driving him to therapy appointments.

During the group intervention, the role of the family was discussed. During this discussion, Berta shared with the group her concern that her younger children would resent the disproportionate attention given to Alfredo. She also expressed concern that she was neglecting her husband, and that he would no longer find her physically attractive because she did not have the time and energy to exercise and attend to other aspects of her physical appearance. Berta also reluctantly acknowledged that, at times, she resented Alfredo. This, in turn, made her feel guilty because she cared deeply for him and the resentment conflicted with her intensely ingrained Cuban values that children and family come first. Berta's admission resonated with other family members in the group, who reported similar difficulties adapting to caregiver roles and managing feelings of guilt, shame, and stigma. This discussion served to normalize these common caregiver experiences for Berta, and set the stage for a supportive and accepting atmosphere among group members.

After hearing his mother's perspective, Alfredo reported that he understood why his mom felt burdened and revealed that he also felt remorseful that his mom was pushed into a perpetual parental role, despite the fact that he was no longer a minor. At this time, other patients shared similar struggles with balancing needs for independence and familial support, a discussion that Alfredo indicated made him feel less alone. Berta reported being unaware of Alfredo's difficulty adapting to the "sick" role and indicated that hearing other patients' perspectives provided her greater insights into her son's struggle. Throughout this discussion, patients simultaneously provided support to one another, while also considering their

family member's perspectives, which in turn facilitated greater appreciation and understanding regarding the impact of the disorder on the family unit as a whole. Mauricio reported feeling surprised to learn about Berta's insecurity about her appearance and her other roles in the family. He voiced appreciation and gratitude for all she does for their ill son and the family. He expressed the view that she was beautiful inside and out and referred to her as the glue that held the family together. Mauricio and her children reassured Berta that they do not feel abandoned or slighted by her attention to the patient, though they wished for her own well-being that she would attend more to her own needs. Learning that the family felt this way reduced some of Berta's guilt. This discussion also hit home with an African American mother of a patient, who reported pride in her matriarchal role, but indicated that that like Berta, she often struggled with finding time for herself. This discussion prompted group discussion of strategies to encourage self-care among patients and family members alike.

The role that spirituality/religiosity played in group member's coping with the illness was also discussed. Mauricio and Berta were encouraged to reconnect with the local Cuban-American society and reengage with their religious activities. They slowly resumed playing dominos with their friends from the group on Friday evenings and reengaged with political activities that were important to them and that they believed kept them closely tied to their Cuban roots. Discussions of other group member's spiritual supports and practices (e.g., yoga, meditation) also prompted interest among Berta's daughters, who began attending yoga together weekly as a means to manage stress associated with the illness. By the end of the group intervention, the family had resumed going to church together every Sunday and recommenced some of their other religious rituals (e.g., prayer before meals). Several group members also began a weekly bible study in which they shared spiritual/religious readings, psalms, and hymns with one another that had been helpful in coping with the illness. Berta reported that relying more on her faith gave her strength. Instead of perceiving it as a catastrophe, she began viewing Alfredo's illness as a challenge for the family to solve together with God's assistance. While managing Alfredo's illness was indeed stressful at times, she and Mauricio acknowledged that the illness resulted in a treatment that was bringing the family closer than they had been in years. Reconnecting with their Cuban roots made them feel more grounded and secure in their identities. Alfredo had begun taking on more responsibility for his own care and his siblings began doing more to help him and their mother around the house. At treatment termination, the family was working more collectively to manage the illness and this appeared to reduce burden and stress in all members.

Study Limitations and Conclusions

Though the literature reviewed indicates promising findings regarding the efficacy of culturally adapted EBTs, there are several limitations of the empirical literature discussed in this review that should be noted. A primary limitation includes the significant variability of components of the interventions that designated them to be "culturally adapted" (e.g., language translations, community/family involvement, direct discussions of cultural components that may impact treatment). This variability makes it difficult to identify which specific cultural modifications are associated with outcomes. Use of dismantling studies may provide insight into which modifications are associated with improved efficacy. Additionally, the literature reviewed indicates that very few culturally adapted interventions for schizophrenia attend to the needs of both patients and family members and can be adapted for use with individuals of diverse cultural backgrounds. Given that very few individuals impacted by schizophrenia receive any mental health treatment, further development and testing of patient- and family-member-inclusive, culturally versatile treatment approaches may provide more accessible and comprehensive treatment options for clients and clinicians. Finally, it is important to note the limitations of the current review. As discussed previously, a narrative review was selected as it appeared to most accurately capture the goals of the current paper. However, we did not systematically evaluate effect sizes or other methodological aspects of the studies described. Thus, we cannot speak to their quality or their methodological rigor. Using meta-analytic or similar approaches in the future may be helpful in this regard. Furthermore, though considerable efforts were made to include all relevant literature in our review, some pertinent studies (e.g., those that were in languages other than English or in nonpsychotic spectrum clinical populations) may have been missed. As such, the results of the current review should be interpreted with caution.

Overall, the literature reviewed above indicates that culturally adapted psychosocial interventions for schizophrenia demonstrate promise; however, further work is needed in this area to identify specific cultural components that may influence efficacy, and to develop treatment approaches that are inclusive of patients of family members, and can be adapted for use with individuals of various cultural backgrounds. As a means to expand upon the current literature, we have identified two broad cultural constructs, collectivism and spiritual/religious coping, associated with better mental health in schizophrenia. These are adaptable for use with individuals of various ethnic backgrounds and may be useful to target in future interventions. Due to the cost-effective nature of group-based programs, we recommend further work and expansion in this area. However, it is important to note that we

view culturally specific group interventions as a compliment to, rather than a replacement of, established family-based and individualized approaches, and recognize that diversity in treatment modality is as valuable as the integration of diversity within the therapeutic intervention.

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Address correspondence to Jessica Maura, M.S., 5665 Ponce De Leon Blvd., Coral Gables, FL 33146; e-mail: Jmaura2@gmail.com.

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