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NOTES: IV. Psychopathology Chapter 20
In this chapter, we address serious mental disorders among multicultural populations that have psychosis (unusual thinking, distorted perceptions, and odd behaviors), mania (mood that is abnormally high), or both as hallmark symptoms. We focus on the two most common forms of serious mental illness, schizophrenia and bipolar disorder. Schizophrenia is characterized by severe disorganization in behavior, perception, and thought, and bipolar disorder is characterized by episodic manic episodes that are frequently followed by depressed mood. Bipolar disorder is often further differentiated into bipolar I, which refers to full-fledged mania that alternates with episodes of major depression, or bipolar II, characterized by hypomania that alternates with episodes of major depression (Beidel, Bulik, & Stanley, 2010). Both disorders have worldwide lifetime prevalence rates of around 1% of the population (prevalence rates reported across numerous studies have generally ranged from 0.2% to 2%).

We begin this chapter with a review of cultural differences in the prognosis and manifestation of serious mental illness. Next, we present research on important factors to consider when working with multicultural populations with mental illness. We then review three existing treatments designed specifically for culturally diverse patients with mental illness and their families. We conclude the chapter with a case illustration from our own research and some specific recommendations to consider when researching and treating populations with serious mental illness from diverse backgrounds.

CULTURAL DIFFERENCES IN COURSE AND MANIFESTATIONS OF SERIOUS MENTAL ILLNESS

Despite roughly comparable worldwide prevalence rates for serious mental illnesses such as schizophrenia and bipolar disorder (which both affect roughly 1 in 100 people universally), mounting evidence has indicated that cultural factors relate strongly to the course and manifestations of these disorders. The most widely cited set of studies on this topic comes from the World Health Organization (1973, 1979, 1994). These studies used standardized assessment procedures and included numerous sites around the world over a period of several decades. The resiliency of the World Health Organization’s findings are striking.

Prognosis

Results consistently showed that patients with schizophrenia and other psychotic spectrum disorders who reside in the industrialized West had less favorable outcomes than their counterparts who reside in developing countries. Despite a few critics (e.g., Edgerton & Cohen, 1994), most scholars accept the World Health Organization’s findings of cross-cultural differences in the course of serious mental illness as valid. However, the reasons that may account for these cultural patterns are still hotly debated (e.g., Hopper, 2004).

Drawing from prior research, in this chapter we invoke the following three hypotheses as potential explanations for why patients with serious mental illness from developing or traditional cultures may
have a better illness course. First, these cultures have a tendency for more integrated and supportive family systems. Second, they have a greater propensity to rely on religious and other adaptive spiritual and existential mechanisms for coping with adversity. Third, they have a worldview that tends to shift blame away from patients for their illness and the associated symptoms. We give more attention to these three areas in later sections of the chapter.

Manifestations
A few studies have also examined cultural differences in manifestations of severe mental illness. For example, in line with their hypotheses, Weisman et al. (2000) found on one hand that Anglo American, compared with Mexican American, patients with schizophrenia reported experiencing greater frequency of several psychiatric symptoms on the Present State Exam, including persecutory delusions, nervous tension, and blunted affect. On the other hand, Mexican Americans were more likely to report physical symptoms than their Anglo American counterparts. Weisman et al. described cultural factors that may explain these differences in symptom presentation and concluded that even a very biologically determined disorder such as schizophrenia can be shaped by sociocultural factors.

Brekke and Barrio (1997) examined cross-ethnic symptom differences in schizophrenia in three ethnic groups: African Americans, Whites, and Latinos. In line with their expectations, they found that Whites demonstrated greater symptom severity than did minorities (Blacks and Latinos). They further found that empathy and social competence were two strong statistical mediators of nearly all symptom differences observed between the ethnic minority and nonminority groups. These authors suggested that empathy and social competence might be part of a sociocentric cultural mechanism that can help to explain cross-ethnic symptom differences in schizophrenia.

Not all research has pointed to a better prognosis for minority patients or those from more traditional or developing cultures. For example, in a sample of adult inpatients with psychotic symptoms, Arnold et al. (2004) found that African American men exhibited significantly higher total psychotic symptoms than did European American men. These results were consistent regardless of whether psychosis ratings were derived from unblinded audiotaped interviews or from a transcription in which all cues indicating patient ethnicity were removed.

Similarly, Kennedy, Boydell, Os, and Murray (2004) examined ethnic differences in the presentation of bipolar disorder among African Caribbean, African, and White European patients experiencing their first manic episode. All patients were drawn from an ethnically diverse area of southeast London, England. In this study, Caribbean and African groups were found to have an earlier onset of mania and bipolar disorder and a more severe clinical presentation at first mania than their White counterparts. They were also more likely to experience psychotic symptoms at first mania. Kennedy et al. offered a number of possible explanations for their findings. First, they may reflect genuine ethnic differences, whether genetically or environmentally determined, in the clinical presentation of bipolar disorder. Alternative explanations offered by these authors were that African Caribbean and African patients may be less inclined to look for services because of differences in beliefs about the acceptability of seeking professional help for symptoms of mental illness. We should note, however, that DeCoux Hampton, White, and Chaifetz (2009) examined clinical records and interviews from four community-based randomized clinical trials and found that African Americans with severe mental illness were as likely as Whites to consent to and remain in clinical research studies.

DeCoux Hampton (2007) carefully reviewed the literature in an attempt to identify explanations for the greater symptom severity and overdosage of schizophrenia in African Americans (relative to Whites). From her review emerged a variety of potential factors. Among these factors are higher usage of psychotomimetic substances (drugs that mimic the symptoms of psychosis), underdetection of depression, provider bias, miscommunication between patient and provider, and misinterpretation of cultural mistrust as paranoia. Another potential factor that emerged from this review is African Americans' tendency to use acute care and emergency services
more often than their White counterparts. DeCoux Hampton surmised that African Americans may be more likely to be assessed in an acute phase of illness, thus increasing the likelihood of a schizophrenia diagnosis.

RESEARCH AND PRACTICE PERSPECTIVES RELEVANT TO WORKING WITH MULTICULTURAL POPULATIONS WITH SERIOUS MENTAL ILLNESS

Numerous factors should be considered when working with multicultural populations with serious mental illness. In this section, we discuss four areas that our own research and that of colleagues suggest may be particularly beneficial to take into account when working with minorities: family involvement, religion and spirituality, therapist–client match in culture and worldview, and language choice.

Family Involvement

Family involvement in treatment is likely to benefit most patients with severe mental illness (Weisman de Mamani, Dunham, Aldebot, Tuchman, & Wasserstein, 2009), in part because greater restrictions in managed care have left families, many of whom know little about mental illness, with more day-to-day responsibility for their ill loved ones. This responsibility appears even more pronounced for many U.S. ethnic minorities, who are even more likely to assume care for an ill relative, often with fewer economic resources to assist them (Guarnaccia & Parra, 1996; Snowden, 2007).

The importance of including family members in the treatment of mental illness has strong empirical support in the literature. Benefits include reductions in family member perceived burden, increased employment and participation in vocational rehabilitation for patients, increased knowledge of illness, better treatment and medication adherence, better social functioning for patients, increased quality of life, reduced medical costs, reduced psychiatric relapse, and less severe psychiatric symptoms, to name only a few (McFarlane, Dixon, Lukens, & Lucksted, 2003; Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001). Moreover, treatment gains from family psychoeducation have been demonstrated in diverse cultures, including the United States (Goldstein & Miklowitz, 1995), China (Ling et al., 1999), Spain (Muela Martínez & Godoy García, 2001), Scandinavia (Rund et al., 1994), and the United Kingdom (Barrowclough et al., 2001).

Studies have indicated that very few families coping with serious mental illness receive any family psychoeducation or therapy, regardless of ethnicity, despite its demonstrated efficacy. Estimates have ranged from 0.7% to 8% (Dixon et al., 1999). Furthermore, minorities tend to use services less frequently and, when they do, they appear to receive poorer quality of care (National Institute of Mental Health, 1999). Including family members in treatment may improve this statistic. For example, ethnic minorities tend to have a more interdependent and interconnected view of family (Oyserman, Coon, & Kemmelmeier, 2002; Weisman de Mamani, Kymalainen, Rosales, & Armesto, 2007). Additionally, Blacks and Latinos–Hispanics with serious mental illnesses turn to other family members for advice more often than do non-Hispanic Whites, whereas Whites are more likely to seek help from mental health professionals (Guarnaccia & Parra, 1996). Hence, family treatments may be more culturally syntonic for minorities and may make them more receptive to family therapy over individually oriented treatment approaches.

Another reason for incorporating families into treatment for serious mental illness is that Weisman, Rosales, Kymalainen, and Armesto (2005) found that greater perceptions of one's family as cohesive and supportive were associated with better general emotional well-being for both patients and family members (i.e., less reported stress, anxiety, and depression); for patients, perceived family cohesion was also associated with fewer specific psychiatric symptoms. In other words, patients who perceived their family environment as supportive displayed less severe symptoms, including delusions, hallucinations, and disorganization in speech. Thus, improving perceptions of family cohesion in households dealing with a severe mental illness may be an important treatment goal. It is worth noting that families tend to be more unified and cohesive in traditional cultures, and they play a more central role in patients' lives than do their White counterparts.
(Lefley, 1990; Weisman de Mamani et al., 2009), which may contribute to the better course of illness that has been observed in traditional societies.

Religion and Spirituality

The United States is a country with rich religious and spiritual beliefs and traditions (Rosmarin, Pargament, & Robb, 2010). Despite heterogeneity in the form that religion and spirituality take, we should note that 93% of people in the United States report a belief in God or a higher power (Gallup Poll, 2007–2008). Thus, ignoring religion and spirituality in research and treatment disregards a central meaning and social system that most Americans report as vital to who they are, how they think, and how they relate to others.

The importance of incorporating religion into treatment has been well documented in prior research. For example, a review article by Koenig, Larson, and Weaver (1998) showed that among other benefits, religious individuals have lower rates of depression and anxiety and are less prone to alcohol and drug abuse. A meta-analysis conducted by McCullough, Hoyt, Larson, Koenig, and Thoresen (2000) further found a strong association between religious involvement and lower all-cause mortality rates. In general, research has suggested that those who are religious are healthier and happier than their nonreligious counterparts (see Rosmarin et al., 2010, for a review).

The benefits of incorporating religion and spirituality into treatment for nonpsychotic individuals have generally been well documented (see Rosmarin et al., 2010). Much more controversy exists regarding whether to address spirituality and religiosity in the treatment of patients with serious mental illness. Some researchers have argued that this might lead to increased religious delusions in patients with psychosis (Getz, Fleck, & Strakowski, 2001; Torrey, 1995). Others, however, have argued (and we agree) that ignoring spiritual issues in treatment is a disservice to those patients who are religiously oriented (Fallot, 1998; Pargament, 1997).

Weisman de Mamani, Tuchman, and Duarte (2010) wrote a critical review article on the topic of incorporating religion and spirituality into treatment for serious mental illness. Although the literature is somewhat mixed, the preponderance of evidence has suggested that incorporating adaptive religious and spiritual practices into treatment for patients with a serious mental illness is likely to be beneficial for most patients. However, there is one important exception. Research has suggested that a religious intervention is not indicated for patients who are currently experiencing religious delusions and hallucinations. In general, directly challenging any psychotic thought or behavior is counterproductive. By definition, psychosis is not rational. Most clinicians who work with patients with severe mental illness will attest to the fact that more often than not, the result of directly confronting a psychotic thought or behavior is to reinforce that symptom (see Weisman de Mamani et al., 2010, for a more thorough review of incorporating spiritual approaches into therapy with psychotic patients).

Integrating religion and spirituality into treatment with minorities may be especially vital. Religious communities and churches often play a central role in the lives of Black (Black & Jackson, 2005), Latino and Hispanic (Musgrave, Allen, & Allen, 2002), and other minority groups and often inform the conceptualization of both physical and mental illness. Additionally, access to mental health care is often limited for many minorities of lower socioeconomic status. Thus, these individuals often turn to religious coping for strength and support (Lincoln & Mamiya, 1990; Pargament, 1997). Religion actually shares many of the same functions as psychotherapy, such as providing meaning to life, using social support networks, and facilitating positive change (Stander, Piercy, Mackinnon, & Helmeke, 1994). Thus, not only are religious and spiritual approaches likely to be culturally sanctioned for minorities living in the United States, the greater use of these approaches in traditional and developing societies may also explain, in part, the better course of illness observed in patients who live in these nations. It is important to note that we believe that spirituality treatments are indicated for nonreligious clients as well, because the primary focus is on the development of empathy, forgiveness, appreciation, and other existential practices (Sperry, 2001) that are likely to be beneficial to most individuals who are experiencing distress.
Therapist–Client Match in Culture and Worldview

Most psychotherapy interventions for severe mental illness were developed by and tested on people of White European origin. Furthermore, most therapists are not familiar with the cultural backgrounds and lifestyles of various ethnic minority groups and have received training primarily developed for Anglo, or mainstream, Americans (Bernal & Padilla, 1982; Chun, Dunston, & Ross-Sheriff, 1983; Sue & Zane, 2009; Wyatt & Parham, 1985), which has several potential drawbacks. First, therapists may have less credibility and may function less efficiently with clients with whom they do not share a common worldview. Furthermore, many individuals may shy away from practitioners who they do not believe will validate their views. For example, Rungeangkulkij and Chelsa (2001) reported that most Thai families believe that karma and supernatural forces are the cause of serious mental illness. Accordingly, Rungeangkulkij and Chelsa explained that Thais tend to shun the professional mental health system and instead turn to folk therapies in which shamans use healing rituals and negotiate with supernatural forces to alleviate illness. Differences in perceptions of illness may explain why Asians living in the United States delay seeking professional help when ill (Sue, 1994) and why, when they do, it is often for much more serious disturbances (Rungeangkulkij & Chelsa, 2001).

Cultural differences in worldview have also been examined extensively with respect to the attributions that family members make for severe mental illness. Some evidence has suggested that family members from minority and other traditional cultures hold attributions toward loved ones with a mental illness that are less blaming of them for their symptoms and their disorder as a whole. For example, Weisman and López (1997) found that Whites were more likely than Mexicans to perceive the negative behavioral symptoms of schizophrenia as controllable. In turn, Whites expressed much more intense unfavorable emotions (anger, frustration) toward a person described as meeting the criteria for schizophrenia. Weisman de Mamani et al. (2007) also found that Latinos and Hispanics were less likely than Whites to express critical and hostile attitudes (known as high expressed emotion). In brief, expressed emotion is a measure of the family environment reflecting the amount of criticism, hostility, and emotional overinvolvement expressed by a key relative toward a family member with a disorder or impairment (Hooley, 2007). The construct is important because decades of research have indicated that patients whose relatives are rated as high in expressed emotion (critical, hostile, or emotionally overinvolved) have a poorer illness prognosis than those whose relatives are rated as low in expressed emotion (see Butzlaff & Hooley, 1998, for a review). Weisman de Mamani et al. (2009) postulated that a less blaming worldview of mental illness, lower levels of frustration, and fewer expressed critical and hostile attitudes toward patients may, in part, explain the better course of illness for patients from traditional or developing cultures.

Language

According to the U.S. Census Bureau (Shin & Kominski, 2007), approximately 20% of the U.S. population speaks a language other than English at home. Language barriers can present numerous challenges in psychotherapy. The following is an example of a language-related miscommunication that Amy Weisman de Mamani observed through videotape when supervising a graduate student clinician. The client, although fluent in English, possessed a strong accent that sometimes prevented the therapist and the supervisor from understanding what he said. A primary goal of therapy for this client was to seek help in finding and retaining a romantic partner. The therapist asked the client to list the qualities that were most important to him in an ideal partner. The client’s first response was a one-word answer that appeared to be “feet.” After several minutes of trying to decipher why feet were so salient for this client and trying to uncover whether they had some deeper symbolic meaning, it became clear that the client had really said “fit.” He explained that he was hoping to find a girlfriend who was physically fit. Basically, the therapist (and the supervisor watching the videotape) had been barking up the wrong tree. The miscommunication appeared to stem purely from phonetic factors associated with the client’s accent (this client was not a psychotic client). The
misunderstanding was easily cleared up, and the consequences of the miscommunication appeared to be innocuous. However, it is easy to see how this and similar language misinterpretations could lead to grave misunderstandings in therapy. This problem intensifies exponentially with patients whose thought and language processes are compromised by severe mental illness.

The topic of psychosis and language has received surprisingly sparse attention in the literature. More than 40 years ago, Del Castillo (1970, p. 242) commented on the lack of consideration of this area: “The possible influence of the relationship between thinking and speaking on a person's mental health has been neglected by scholars because it is on the borderline between various disciplines.” Del Castillo clarified this comment by stating that linguists generally know too little about psychiatry and psychiatrists know too little about language to study the topic competently. However, he went on to describe several examples in his own clinical practice in which he observed clients demonstrating psychotic symptoms when interviewed in their native tongue but not when interviewed in English. He offered the following proposition:

It seems that the intellectual effort of expressing oneself in a foreign language in which one lacks fluency is equivalent, from the psychologist's viewpoint, to certain stimuli that are apt to awaken a sleeping person and to arouse his unconscious towards exhorting that type of vigilance that is either absent during sleep or other forms of mental relaxation or that assumes different forms such as distortion or symbolic disguise. Or it may be that when speaking in a foreign language the speaker is simply more on guard. (Del Castillo, 1970, p. 242)

In a letter to the editor, Schoeman, Southwood, Chiliza, and Emsley (2008) reported observations similar to those of Del Castillo (1970). They conducted an in-depth case study during which they administered a set of structured clinical interviews to a bilingual South African man in his first episode of schizophrenia in two languages an hour apart. After that they performed a structured linguistic analysis. Similar to Del Castillo, they observed that this client also displayed markedly more psychosis in his native language. More systematic research in this area is needed to determine whether bilingual patients do indeed display greater psychosis in their native versus non-native language. These observations have clear research and practice implications. They suggest that when bilingual patients present for therapy or research participation, interviewing them in both native and non-native languages (when feasible) may provide a more comprehensive and useful understanding of their thought processes. These observations also raise the question as to whether research data collected in English from monolingual English speakers are comparable to those collected in English from non-native English speakers or to data that have been collected in languages other than English.

NOVEL CULTURAL INTERVENTIONS FOR SERIOUS MENTAL ILLNESS

Several well-designed studies have tested previously established psychotherapy interventions with minority populations (e.g., Kopelowicz, Zarate, Gonzalez Smith, Mintz, & Liberman, 2003; Telles et al., 1995). However, few treatments have specifically been designed to meet the needs of ethnic and cultural minorities coping with serious mental illness. In this section, we review three novel intervention approaches that either modified or developed new services specifically designed to be congruent with or inclusive of cultural values and beliefs of many minorities in the United States. Two of these interventions were designed for Spanish-speaking populations. The third is an approach intended to tap into participants' own cultural beliefs, values, and practices. As such, this intervention can easily be tailored to any ethnic, racial, or cultural group.

The first intervention we review was developed by López et al. (2009) and is called La CLAve. The primary goal of this psychoeducational approach is to increase Spanish-speaking individuals' literacy regarding psychosis. The second intervention that we discuss was developed by Aviera (1996) and is called dichos therapy, which is a group treatment
that uses proverbs with Spanish-speaking inpatients with serious mental illness. The third intervention, culturally informed therapy for schizophrenia (CIT–S), was developed by Amy Weisman de Mamani (see Weisman de Mamani et al., 2009, for a review). CIT–S is a family-focused intervention for patients with schizophrenia and their loved ones.

La CLAvE
López et al. (2009) have recently developed and tested a 35-minute psychoeducational program aimed at improving knowledge of psychosis among Spanish-speaking individuals. López et al. chose to focus on psychosis literacy because psychosis is found in several disorders (e.g., schizophrenia, bipolar disorder, major depression) and because research has shown that it is associated with considerable burden to family caregivers (Magaña, Ramirez García, Hernández, & Cortez, 2007). Psychotic phenomenology can at times be distressing to observe. Rather than simply telling participants the key symptoms of psychosis, these authors used a creative approach that allowed them to illustrate symptoms in a culturally relevant and memorable manner that they surmised would be less distressing to participants.

The La CLAvE approach (López et al., 2009) uses popular cultural icons from art, music, and videos to describe psychotic symptoms. López et al. (2009) helped participants to remember key psychotic symptoms with a creative mnemonic device. The Spanish word clave translates to clue in English. The first three letters depict the central classes of psychotic symptoms: C stands for the Spanish word creencias, which translates to beliefs in English (e.g., delusions); L stands for lenguaje in Spanish and translates to the word language in English (e.g., neologism, poverty of speech); and A stands for alucinaciones, which in English means “hallucinations.” This category is further clarified by the small letters v and e to depict that hallucinations can be seen or heard. Specifically, the English infinitives to see and to hear translate, respectively, to ver and escuchar in Spanish.

The following example illustrates how López et al. (2009) incorporated popular Latino culture into their psychosis literacy program. They used the song “El Muelle de San Blas” to illustrate delusions (false beliefs). This song depicts a young woman who lives at a pier waiting for her lover to return. As the story of the song unfolds, it describes psychiatric personnel coming to retrieve la loca del muelle (the crazy woman from the pier). As the song is playing, the researchers present the lyrics to help participants follow the content more easily. In addition, they add a visual component with paintings. For example, they depict delusions by showing Rufino Tamayo’s painting “El Diablo” (the devil). This painting gives them an opportunity to explain that those suffering from delusions often believe that some being is trying to harm them (the devil being a relatively common theme in actual delusions).

López et al. (2009) tested the efficacy of the La CLAvE approach and found that it was successful in increasing symptom knowledge and efficacy beliefs in community residents and in Latino caregivers of patients with schizophrenia. Latinos have been well documented to underuse professional mental health services for severe mental illness (e.g., Barrio et al., 2003). Programs such as La CLAvE may be useful in educating Latinos about mental illness in a culturally sanctioned, nontraditional, and low-stress environment that may better equip those with less exposure to mental illness to know when and how to seek help when confronted with mental illness in themselves or a loved one. Although López et al. did not mention this in their article, this style of artistic approach to education about psychosis appears to be easily adapted to other ethnic and cultural groups (e.g., Asians, African Americans) to increase their literacy of psychosis as well.

Dichos Therapy Group
One impediment to treatment among foreign-born clients with serious mental illness is a language barrier. Language is one’s primary means of transmitting information about beliefs and cultural traditions (Santiago-Rivera & Altarriba, 2002). Such barriers can both discourage patients from seeking help and contribute to reduced or deleterious outcomes (Aviera, 1996). Aviera (1996) developed a clever approach that incorporates Spanish proverbs (dichos) into group therapy for hospitalized patients with psychotic spectrum disorders. Although never tested empirically, Aviera developed his treatment
on the basis of clinical observations published by Zuñiga (1991, 1992) and others, who noted that dichos can be used in therapy to undercut resistance, reframe perspectives, make points, and essentially transform a potentially foreign experience into one that is culturally palatable.

At the time of publication, Aviera (1996) had been running his dichos group for 3 years. All group members carried a psychotic spectrum diagnosis, and most were described as suffering from a chronic course. The dichos group ran weekly for 60 minutes. Groups were initiated by having patients share their understanding of what dichos are and how and why they are used to convey ideas, beliefs, and values. Group members were asked to recall dichos and share their understanding of the message of the dicho, the circumstances under which it would apply, and any emotional reaction or memories stimulated by the adage. The therapist played an active role in structuring discussions; soliciting thoughts, feelings, and reactions; and redirecting tangential or delusional thoughts.

Although Aviera (1996) did not empirically evaluate the dichos intervention, he did offer in-depth clinical observations and examples for the group's utility in the following areas: building rapport, focusing attention, enhancing motivation, building self-esteem, exploring and articulating feelings, developing insight, and exploring cultural values and identity. We briefly summarize Aviera's observations in a few of these areas.

Building rapport. On the basis of his clinical observations, Aviera (1996) noted that participants in dichos therapy appeared to become more natural and relaxed in social interactions. Aviera reported that meeting participants on familiar ground facilitated trust and encouraged a sense of openness. For example, he described one patient who experienced extreme suspiciousness on entering the group. When the client was asked whether she knew any dichos, the client replied with the proverb "caras vemos, corazones no sabemos," which in English translates loosely to "faces we see, but what is in hearts we don't know." Aviera explained that although the patient was unable to describe feelings of uneasiness directly related to the group, she was very receptive to discussing her more general feeling of the unknown. Aviera's perception was that through this discussion the client became visibly more animated and at ease with the group.

Exploring cultural experiences, values, and identity. According to Aviera (1996), discussion of cultural issues is something that occurs naturally in the process of exploring dichos. Because the adages presented in therapy come from participants' own native language, experiences, and culture, Aviera hypothesized and observed clinically that they help participants construct bridges to their past identity, to their loved ones, and to their heritage. Dichos reflect a wide range of cultural values and mores. A central feature of dichos is that they offer messages about how people should live their lives. Psychotic patients often present with disturbances in their identity, their beliefs and values, and their place in the world. Aviera reported that without proverbs, many of his patients had difficulty processing and responding to requests to articulate their principles and morals. Rather than directly providing clients with imposed values, Aviera noted that when participants were asked their thoughts regarding a particular dicho, what generally emerged was the person's own experience or position on the topic. In other words, exploring dichos often gave participants the opportunity to clarify and solidify their own beliefs and perspectives. Aviera provided the example of one of his patients who offered the following proverb: "estar como perro en barrio ajeno" ("to be like a dog in a foreign neighborhood"). This proverb stimulated a discussion of differences between life in patients' native countries and life in the United States, which offered group members the opportunity to discuss the many challenges inherent in adapting to a new country, feelings of rejection and being out of place, and experiences with discrimination and racism. Another proverb offered in response to the same topic was "el que no arriesga, no gana" ("he who does not risk, does not gain"). In addition to allowing patients the opportunity to discuss the risks taken in immigrating to the United States, they were also afforded the opportunity to discuss and appreciate all they had gained since moving to the United States. Although Aviera did not explicitly
mention this, this proverb would also appear to lend itself to the discussion of the pros and cons of seeking professional help as a way of coping with serious mental illness. On one hand, patients who are more active and involved in their treatment are more likely to achieve their treatment goals (e.g., O’Farrell, Fals-Stewart, Murphy, Stephan, & Murphy, 2004). On the other hand, they also put themselves at risk for a variety of stressors including loss of anonymity, lack of independence, and disappointment if they do not view their treatment as successful.

In short, dichos therapy appears to be an innovative way of facilitating open discussions of issues common to many Spanish-speaking patients with severe mental illness. The intervention offers a non-intrusive tool for overcoming barriers to treatment that are often encountered when working with ethnic minority patients with severe mental illness. Adages are used in most cultures around the world to convey attitudes and morals. It appears that this approach could readily be tailored to any language to assist a variety of multicultural populations with severe mental illness.

Culturally Informed Therapy for Schizophrenia

Stemming from research findings discussed in earlier sections of this chapter, Amy Weisman de Mamani and her research team recently developed and are currently pilot testing a treatment called CIT-S. This intervention has been discussed in prior publications (see Weisman de Mamani et al., 2009, 2010, for a more in-depth overview). Therefore, we review it only briefly in this chapter. CIT-S includes five modules, each of which consists of three sessions. It occurs over 15 weekly 60- to 75-minute sessions and is delivered in family format. Every module is guided by a series of detailed handouts. The approach was developed in both English and Spanish, and all materials are available in both languages. The approach is not tied to any specific ethnic or cultural group (discussed further in the following paragraphs) but was primarily developed with Hispanics, the largest and most rapidly growing ethnic group in the United States, in mind (Bridges, de Arellano, Rheingold, Danielson, & Silcott, 2010; Takeuchi, Alegria, Jackson, & Williams, 2007).

The first module, family collectivism, has the overarching aim of fostering or enhancing family unity and helping family members to see one another as a team working toward shared goals. A few of the specific topics covered during this segment include family members’ perspective of what the concept of family means to them; their views of their current family and their ideal family; gender, generational, and other roles or hierarchies that exist within their family; and significant conflicts or alliances between members. In this segment, 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 (therapists can almost always count on family members agreeing that they would all like to reduce tension in the household and that they would like to see improvement in the patients’ symptoms and functioning). As noted earlier, we strongly believe that a segment on increasing perceptions of family cohesion is necessary because prior research has clearly indicated mental health benefits for patients with schizophrenia and their loved ones who view their families as more united (Weisman et al., 2005), and family-focused treatments for mental illness have been found to be superior to individually oriented approaches (Pitschel-Walz et al., 2001).

The second module, education, is largely drawn from the work of Falloon, Boyd, and McGill (1984) and Miklowitz and Goldstein (1997). In this segment, information is presented on the symptoms of schizophrenia, the etiology of the illness and exacerbating factors, ways to create an environment that is protective against relapse, and relapse prevention drills should the warning signs emerge. This didactic approach is especially well suited to minorities who may expect therapy to provide more immediate information, advice, and problem-solving techniques (Wen-Shing & Strelitzer, 2001).

The third module, spirituality, begins with a discussion of the family’s spiritual and religious history. Participants are asked to discuss beliefs about God, morality, and the meaning of life. They are also
asked to describe more behavioral components of religion, such as attendance at services or private prayer. The aim in treatment is to help family members cultivate important spiritual practices, including emotional wisdom through forgiveness and empathy. Outside of therapy, families are encouraged to tap into support systems inherent to many religious congregations to help cope with the illness. Participants are also directed to read spiritual or 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.” The rationale for this module was discussed in some detail in earlier sections of the chapter.

The remaining two modules, communication training and problem solving, were also drawn largely from the work of Falloon et al. (1984) and Miklowitz and Goldstein (1997) and have strong empirical support in the literature. Module 4, communication training, focuses on enhancing the quality and effectiveness of the family’s verbal interactions. Participants are taught a variety of communication skills, including 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. This method allows family members to practice new ways of communicating in a setting that is safe and nonjudgmental.

The final module, problem solving, teaches participants concrete ways of discussing and resolving their problems. The methods include brainstorming strategies, discussing the pros and cons of various ideas, 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. Because this is the concluding module of CIT-S, families practice a relapse drill, in which they use problem-solving strategies to develop a detailed course of action in the event of a psychiatric relapse.

Although not yet published and derived from small samples, our current pilot data are promising and suggest that this treatment (when compared with a randomly assigned psychoeducation-only comparison control condition) may be effective for reducing symptom severity in patients and in alleviating family member anxiety and distress (Weisman de Mamani, 2011).

CASE ILLUSTRATION

Following is a brief vignette drawn from our CIT-S treatment study that demonstrates how some of the topics discussed previously (e.g., religion, family, and client-therapist match on culture and worldview) can emerge in therapy with multicultural populations. In this chapter, we do not give a breakdown of specific CIT-S modules because they are illustrated elsewhere (e.g., Weisman de Mamani et al., 2009).

The family presented includes two middle-aged sisters, Roberta and Cynthia, and Roberta’s son, Robert, 32, who was diagnosed with schizophrenia more than 10 years ago (note that we have used aliases to protect participants’ identities). The family sought treatment after Robert’s most recent hospital admission. According to the sisters, Robert did not take his medication as prescribed, and his relapses were frequent and occasionally severe. All family members were Black and of Bahamian descent. They were seen by a biracial-biethnic therapist of White-Hispanic descent.

During the first session of family therapy, they were asked what they expected and hoped to get out of treatment. Cynthia and Roberta reported that they were experiencing increasing difficulties in helping Robert manage his illness and comply with taking his medication. Although they had some ideas about how to help him, they were hoping that the therapist would provide additional education about schizophrenia and some specific tips on how best to help Robert improve his functioning. Robert also wanted to manage his symptoms better and to be less burdensome to his family.

The participants described their family as exceptionally close knit, including more than 20 relatives who all lived in close proximity. Relatives in this family were said to provide primary emotional, economic, and social support to one another. Cynthia and Roberta expressed particular gratitude for the help they received from relatives in caring for Robert, especially when he was in the midst of a psychotic episode. Robert expressed appreciation to the
therapist for her willingness to work with them in a family format because they were accustomed to addressing their problems as a unit. As such, Robert revealed that he would not have been interested in pursuing any form of individual therapy.

In the early stages of treatment, Robert, Cynthia, and Roberta were all polite and, at least on the surface, appeared engaged in therapy. However, the therapist observed that responses from all three members were often short and factual, and they seemed to be somewhat guarded. The therapist pointed out that family members appeared to be holding back. Robert and Roberta voiced being somewhat uncomfortable discussing personal problems outside of the family. The therapist asked whether anything about her background made it difficult to divulge information to her. As part of this conversation, the therapist directly asked whether participants had concerns about her being of a different race and culture and whether this made it difficult for them to confide in her. All three members appeared to appreciate her candor, which appeared to open the door for them to express some concerns that they did have. Roberta and Cynthia revealed that since moving to the United States, they had found it difficult to find treatment providers who respected their views of mental illness. Family members acknowledged concern that not being of Bahamian descent, the therapist might dismiss their views and perceive their methods of coping with Robert’s illness as bizarre.

The therapist attempted to maintain a welcoming and nonjudgmental stance toward the family and their views. With time, Roberta and Cynthia reluctantly shared that they perceived Robert’s mental illness to stem from evil spirits. They explained that beliefs about evil spirits are consistent with the teachings of their religion, a sect of Pentecostal Christianity that is common on their native island in the Bahamas. They discussed how they often took Robert to church, where members of the congregation would recite special passages to him to remove the spirits. They also shared that they had formed a close connection with members of the church and with the religious leader, who would often come to their house to place olive oil on Robert’s head and pray for him to be freed from the evil within him.

Although these methods were not sufficient to cure his illness, family members did perceive that they and Robert received a great deal of benefit from the rituals.

Throughout treatment, the therapist attempted to maintain an open and validating stance. She pointed out that the religious rituals that the family was using appeared to be relaxing and soothing to them. She acknowledged that religion often helps people make meaning out of adverse events and suggested that the family appeared to be using their religion to make sense of and cope with Robert’s mental illness. She also commented that the family appeared to feel a strong sense of camaraderie with and support from members of the church. The therapist explained that all of these practices (social support, stress reduction techniques, meaning-making coping) are beneficial to mental health and commended them for using them to cope with Robert’s symptoms. She further commented that despite these helpful healing techniques, the family still appeared to be grappling with Robert’s illness. She reassured the family that most people dealing with serious mental illness (even those coping well) benefit from professional help, and she suggested that the interventions she offered in therapy might complement those that the family was already using.

The therapist worked with the family in an open and collaborative manner that conveyed respect for them and for their belief system. This approach appeared to help the family become less guarded. Over time, they became much more receptive to the information and intervention techniques that she provided in treatment. The family appeared to embrace learning more about schizophrenia, particularly its biochemistry and the important role that family can play in helping to maintain a loving and low-key environment that is conducive to mental health. The family seemed reassured that the therapist encouraged them to continue to draw support from their church and their religion.

Toward the end of therapy, Robert was able to acknowledge that his lack of medication adherence was likely contributing to his relapses and to the stress that his mother and his aunt were enduring. He made a commitment to try harder to take his medication as prescribed and to be less defensive.
when his aunt and mom reminded him to do so. Through communication training and problem solving, the family learned to talk to one another in a more direct and effective manner. Connecting with the therapist (someone whom they may have identified as an inherent part of the mainstream U.S. mental health care system) appeared to give them hope that their culture and ways of life could be respected and valued by practitioners in the United States. They appeared reassured that they could practice the new techniques they learned in therapy and help Robert to function better without having to renounce or radically alter the beliefs and practices that they valued from their native country. We anticipate that this validating experience will make it more likely that this family will continue to collaborate with mental health professionals in the future to help manage Robert’s illness.

CONCLUSIONS

In brief, from our review of the literature and our own clinical and research experiences, we put forth the following recommendations for working with multicultural populations with serious mental illness:

1. Incorporate the family whenever possible.
2. Use adaptive religious and existential beliefs and practices when helping families manage mental illness.
3. Elicit and discuss cultural differences in beliefs and values and recognize and respect those that differ from one’s own.
4. Stay attuned to language-related factors in bilingual patients that may make researchers and clinicians susceptible to errors when estimating psychopathology.

In line with research reviewed throughout this chapter and consistent with commentary by Juckett and Rudolph-Watson (2010), we conclude by encouraging clinicians and researchers to also consult Appendix I of the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision; American Psychiatric Association, 2000). This appendix highlights the importance of considering the interface of culture-bound syndromes and serious mental illness among culturally different clients and provides a Cultural Formulation model that can help practitioners explore their patients’ cultural identities, explanatory models, and cultural barriers to treatment. It is intended to supplement the multiaxial diagnostic assessment and to address difficulties that may be encountered when applying the manual’s criteria in a multicultural environment.

References


Weisman de Mamani, A. G. (2011, May). *Culturally informed therapy for schizophrenia*. Presented at the psychiatry grand rounds, Bedford Veteran’s Association Medical Center, Bedford, MA.


