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The Role of Collectivism and Spiritual/Religious Coping on Patient and Family Member Functioning in Schizophrenia and the Feasibility of a Culturally Informed Group Therapy for Schizophrenia

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UNIVERSITY OF MIAMI

THE ROLE OF COLLECTIVISM AND SPIRITUAL/RELIGIOUS COPING ON
PATIENT AND FAMILY MEMBER FUNCTIONING IN SCHIZOPHRENIA AND
THE FEASIBILITY OF A CULTURALLY INFORMED GROUP THERAPY FOR
SCHIZOPHRENIA

By

Jessica L. Maura

A THESIS

Submitted to the Faculty
of the University of Miami
in partial fulfillment of the requirements for
the degree of Master of Science

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The Role of Collectivism and
Spiritual/Religious Coping on Patient and
Family Member Functioning in
Schizophrenia and the Feasibility of a
Culturally Informed Group Therapy for
Schizophrenia

Abstract of a thesis at the University of Miami.

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Research suggests that group based psychosocial treatments for schizophrenia provide benefits to patients and family members alike. However, few of these existing treatments consider cultural factors that may enhance their efficacy with diverse populations. The current study examined the potential impact of two cultural constructs, collectivism and spiritual/religious coping on patient and family member functioning in order to assess the relative importance of addressing these constructs in psychosocial treatments for schizophrenia. We first examined whether collectivistic ideals and use of spiritual/religious coping strategies related to psychiatric and psychological functioning among 113 patients and 50 family members of patients with schizophrenia. We hypothesized that higher self-report ratings of collectivism and adaptive spiritual coping would be associated with better psychiatric and psychological functioning among patients and family members at baseline. We then examined the feasibility of a group based Culturally Informed Therapy for Schizophrenia (CIGT-S), which incorporates collectivistic principles and spiritual coping into the treatment protocol. The feasibility of the group protocol was tested by examining its impact on patient symptom severity, as well as its impact on patient and family member self-report ratings of depression, anxiety,

and stress. For these analyses, baseline data was compared to group termination data from 12 patients and 11 family members. We also conducted between groups analyses by comparing waitlist termination data from 20 patients and 13 family members to group termination data from 12 patients and 11 family members. Finally, we examined participant satisfaction with the group protocol, including qualitative reports on components of the protocol that participants deemed most valuable. Results indicated that for patients, neither collectivistic self-construals nor positive religious coping were significantly related to symptom severity or depression, anxiety, and stress. Rather, higher independent self-construals were associated with lower symptom severity. Among family members, results indicated that positive religious coping was not significantly associated with depression, anxiety, and stress, but that greater collectivistic self-construals were associated with greater depression, anxiety, and stress. Results examining the feasibility of the CIGT-S protocol indicated that patients demonstrated lower levels of symptom severity upon completion of the CIGT-S program, however no other significant effects were found. Finally, results examining overall patient and family member satisfaction with the treatment protocol indicated that patients and family members both reported being highly satisfied by the treatment program. This was also represented in participant's open ended responses to our satisfaction questionnaire. These findings demonstrate the potential of a culturally adapted group intervention inclusive of patients with schizophrenia and their family members to impart positive impacts on patient symptom severity.

Keywords: schizophrenia, culture, group therapy

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Chapter 1

Introduction

Schizophrenia is a chronic and disabling psychiatric disorder that occurs in roughly one in every 100 individuals (Silverstein, Moghaddam, & Wykes, 2013). Schizophrenia imparts substantial impacts on patient's 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., 2011). 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. To address

this gap, the current study examined whether collectivism and spiritual/religious coping (cultural constructs which have been identified as relevant to individuals of various ethnic backgrounds) related to patient and family member functioning and therefore may be important to address in psychotherapeutic interventions. Further, we examined the feasibility of a group based psychosocial intervention which directly addresses these factors. We adapted a Culturally Informed Therapy for Schizophrenia (CIT-S; Weisman, Duarte, Koneru, & Wasserman, 2006; Weisman de Mamani, Weintraub, Gurak, & Maura, 2014) to a group format, which included both patients with schizophrenia and family members of patients with schizophrenia. To test the feasibility of the group protocol, we examined its impact on patient's symptom severity, as well as its impact on patient and family member self-report ratings of depression, anxiety, and stress. We also examined participant satisfaction with the group protocol, including qualitative reports on components of the protocol that participants deemed most valuable.

In this thesis, I first briefly review the literature on group based psychosocial interventions for schizophrenia, followed by an in-depth review of the literature on culturally adapted psychosocial interventions for individuals with schizophrenia and their family members. This review aims to provide relevant background information on currently available treatments and rationale for the utilization of the cultural constructs that informed the development of the current protocol. This is followed by a review of the literature that pinpoints collectivism and spirituality/religiosity as culturally relevant factors that may influence patient and family member functioning. The current treatment protocol, a Culturally Informed Group Therapy for Schizophrenia (CIGT-S) is then introduced, followed by study hypotheses and an analytic plan for testing study

hypotheses. Finally, the results and conclusions of the current study are examined and discussed.

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., 2011).

A large body of literature has examined the effectiveness of group cognitive behavioral therapy (CBT) for individuals with schizophrenia. While CBT was originally developed to treat symptoms of depression and anxiety (Beck et al., 1979; 1985) it was later adapted to treat psychosis (Zubin & Spring, 1977) and focuses on cognitive processes that may exacerbate the salience of hallucinations and delusions (Maher, 1988). 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, & Philippe, 2014). However, the 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, Kohn, Knost, Pukrop and Klosterkotter (2005) found that while participation in a group CBT program appeared to reduce re-hospitalization 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 et al. (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 regarding impact on positive symptoms, and the maintenance of improvements in symptoms over time. The authors concluded that the effectiveness of group CBT for schizophrenia has yet to be established and requires further research. Thus, while CBT for individuals with schizophrenia appears to demonstrate some benefits for patients, study results are inconsistent and it is unclear whether these effects persist over time. Further, few group based CBT treatment programs aim to address the needs of family members of individuals with schizophrenia.

Group based psychoeducation is another well-established treatment for individuals with schizophrenia and their families. Psychoeducational therapy was originally developed by Lazell (1921) and Marsh (1933) and focuses on increasing knowledge about the illness, identifying symptoms of relapse, highlighting the importance of psychopharmacological treatment, and teaching coping skills (Segredou et al., 2011). Group based psychoeducation programs have shown effectiveness at improving subjective quality of life (Bechdolf et al., 2009), functioning (Chien & Wong, 2007), 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). Lyman et al. (2014) reviewed research articles, meta-analyses and

research reviews from 1995 to 2012 examining the evidence for psychoeducational programs for individuals with severe mental illness. The authors found evidence for the effectiveness of psychoeducation in improving medication nonadherence and relapse and rehospitalization among patients, as well as improved problem solving and burden among family members of individuals with schizophrenia (Lyman et al., 2014). 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. Additionally, the authors found that interventions that included family members were more effective at reducing symptoms and relapse at follow-up. 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. However, the authors 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 (Sin & Norman, 2013). Despite promising findings on the impact of group based psychoeducation on patient and family member functioning, 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, particularly for underserved populations, and therefore research in this area is warranted.

Multifamily group therapy (MFGT) was originally established by Laburt and Morong (1964) and later refined and adapted by McFarlane (1994; 2002) to address the needs of individuals with severe mental illness. 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 reduce relapse and rehospitalization rates (Dixon, Adams, & Lucksted, 2000; McDonell, Short, Hazel, Berry, & Dyck, 2006; Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001) and improve social functioning (Montero et al., 2001) among patients with schizophrenia. Rotondi and colleagues (2005) examined the feasibility of a multi-family online psychoeducational group therapy program and found that patients reported lower perceived stress and a trend towards higher perceived social support following the intervention. Dyck and colleagues (2014) found that individuals with schizophrenia undergoing MFGT demonstrated less negative symptoms after one year when compared to a standard care control group. 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 two 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 (2003) reports 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, & Mansoor, 2012; US 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; Lopez, Barrio, Kopelowicz, & Vega, 2012; Pearson & Burlingame, 2013; US 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, Quintana, & Wampold, 2011; Griner & Smith, 2006). However, research examining group based cultural adaptations geared towards individuals with schizophrenia and their family members is sparse and additional work is needed in this area. The literature examining culturally adapted psychotherapeutic interventions for schizophrenia is discussed below.

The bulk of the 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) which 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). CaCBTp has shown efficacy in reducing symptom severity among patients of Black British, African Caribbean/Black African, South Asian Muslim (Rathod et al., 2013), and Pakistani (Habib, Dawood, Kingdon, & Naeem, 2015; Naeem et al., 2015) descent. 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. Further, culturally

adapted psychoeducational family interventions which 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) 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-min 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).

The current group protocol was adapted from a previously established family-focused therapy developed by Weisman and colleagues (2006). This treatment protocol, known as Culturally-Informed Therapy for Schizophrenia (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 et al., 2014) and in decreasing caregiver burden with a large effect size (Weisman de Mamani & Suro, 2015). 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 ten clinical sites in China. The psychosocial intervention consisted of monthly group based psychoeducation, family intervention, skills training and CBT over the course of one 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 which places less emphasis on affective symptoms, the clinicians 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: Recent research has highlighted the call among consumers, family members and providers to integrate cultural concepts, such as *familismo* (centrality of the family), *respeto* (respect in interpersonal relationships) and *personalismo* (warmth in interpersonal relationships), into treatments for Hispanic/Latino individuals with schizophrenia (Hackethal et al., 2013). Research examining the impact of culturally adapted group programs for Hispanics/Latinos is discussed. 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 which 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, saying, 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, life style 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.

Kritzinger, Swartz, Mall, and Asmal (2011) report a need for studies examining the potential of family based and psychoeducational approaches to treatment, as well as logistical and cultural issues that may impact treatment among individuals with

schizophrenia in South Africa. In a later study, 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 amendable 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). Poee 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 (Poee et al., 2010).

Cultural constructs utilized in the current study

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, and led to the development of the Culturally Informed Group Therapy for Schizophrenia (CIGT-S).

Literature from The World Health Organization (Jablensky et al., 1992; Sartorius et al., 1986) multi-site 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, Alegria, & Sribney, 2007; Rodriguez, Mira, Paez, & Myers, 2007; Schwartz et al., 2010) and lower relapse rates among Mexican-American patients with schizophrenia (Lopez 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 Lopez (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, 2015). 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. To expand upon this literature, the current study assessed the relationship between collectivistic values and psychiatric symptoms and psychological functioning among patients with schizophrenia and their family members. Further, the current study assessed the feasibility of targeting collectivism and interconnectedness as a direct therapeutic goal, as was done in the CIGT-S program. *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, Borrás, Gillieron, & Huguelet, 2006), for the purposes of this study 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, Ongur, Pargament and Bjorgvinsson (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. To further clarify and expand upon this literature, the current study examined the relationships between spiritual/religious coping and psychiatric and psychological functioning among both patients with schizophrenia and their family members.

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, Rodgers, Coleman, & Maloney, 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 spiritually/religiously oriented treatments that attend to the needs of both patients and family members are needed. . In the current study, which included both patients and family members, engagement in spiritual/religious beliefs and practices was a treatment goal and therefore was directly implemented into the treatment protocol.

A culturally informed group therapy for schizophrenia (CIGT-S)

The literature reviewed above indicates that both psychoeducation and multi-family group therapy have resulted in positive outcomes for both patients and family members. However, a need exists for group treatments that include both patients and family members, and consider the cultural context in which mental illness is perceived, interventions are delivered and participants respond to treatment. The current study aimed to address this gap, by providing a culturally adapted psychoeducational multi-family group therapy program that permitted both patients with schizophrenia as well as family

members of patients to participate. The current study aimed to address the needs of both patients and family members by decreasing self-report ratings of depression, anxiety, and stress, fostering collectivistic values, and increasing spiritual/religious coping in both groups, as well as reducing symptom severity among patients. Further, CIGT-S intended to meet the needs of individuals of various ethnic and cultural backgrounds, as the treatment protocol was designed to access individual beliefs, values and behaviors that may be adaptive in coping with the illness. As a result, the protocol can be tailored for use in various ethnic and cultural backgrounds.

The fully manualized treatment protocol consisted of five modules, each lasting three weeks, for a total of fifteen weeks. Sessions occurred on a weekly basis and lasted approximately 90 minutes. The treatment protocol combined techniques that have previously been found to be effective within this population, such as psychoeducation, communication training, and problem solving, with culturally specific components, including collectivism and spiritual coping, which have also been predictive of positive mental health outcomes (Krok, 2014). The treatment modules include family collectivism, psychoeducation, spiritual coping, communication training, and problem solving. Detailed descriptions of each treatment segment are provided below.

Family collectivism: The primary aim of the family collectivism module is to fortify a strong sense of unity and cohesion, and to help group members view each other as members of a team working towards a unified goal (Weisman, 2005; Weisman, Duarte, Koneru, & Wasserman, 2006; Weisman de Mamani, Weintraub, Gurak, & Maura, 2014). In the first session, all participants are commended for coming to treatment, an action that indicates their commitment to their own and their loved one's

wellbeing. Group members are then asked to share their goals in attending therapy, and commonalities, such as improving the patient's well-being, improving family functioning, and gaining a better understanding of the illness, are pointed out. Group members then share in a discussion of their perceptions of their role within their family, including how they contribute to their family system, and discuss their current satisfaction or dissatisfaction with that role. Any relevant generational and gender roles or hierarchies within the family are also discussed and shared within the group setting. During this module, several homework assignments are given to group members, including writing and sharing personal narratives regarding one's role and how they would like to adapt or alter their role to improve family functioning, as well as preparing discussions of specific behaviors in family members that enhance family functioning, and behaviors that may be altered to improve family functioning. Throughout these sessions, the commonalities between family members, and group members as a whole, are identified, and differences are deemphasized, as a means to enhance unity within the family system and the group.

Psychoeducation: The second module, psychoeducation, was largely pulled from prior work by Falloon, Boyd, and McGill (1984) and Miklowitz and Goldstein (1997). The purpose of this module is to provide information regarding the symptoms of schizophrenia, the known causes of the illness (including genetic, neurobiological and environmental factors), established treatments for the disorder, and the impact of the family environment and stress on illness progression (Weisman, 2005; Weisman et al., 2006; 2014). In this segment, the construct of expressed emotion, a measure of the family environment characterized by criticism, hostility and emotional overinvolvement, and its

detrimental impact on patient prognosis is discussed. The harmful effect of substance use on relapse and prognosis is also discussed. Throughout these discussions, care is taken to assess any feelings of guilt members may have regarding their role in causing the disorder. Through psychoeducation, therapists work to refute any misconceptions regarding their role in causing the disorder and shift focus to ways family members can help patients cope with the illness, such as encouraging medication adherence, discouraging substance use, and maintaining a low stress home environment (Weisman, 2005).

Spiritual Coping: The aim of the spiritual coping module is to foster spiritual or existential beliefs that may aid in coping with the illness (Weisman, 2005; Weisman et al., 2006; 2014). Throughout these sessions, group members share their spiritual/religious beliefs (or disbeliefs), notions of morality, and their perceptions of the meaning of life. Group members also discuss participation in spiritual/religious communities, support networks, and practices that they have or would like to engage in. Practices such as kindness, empathy, forgiveness and appreciation are also discussed in these sessions. Homework assigned in this module includes engaging with a spiritual/religious practice (e.g., attending a religious service, meditation, volunteering, and prayer) and selecting a spiritual/religious reading relevant to coping with mental illness to share with the group. During these sessions, therapists work to reframe any maladaptive uses of spirituality/religion, such as the belief that mental illness is a punishment from God for a prior wrongdoing. In these instances, the therapists guide group members to use their spiritual/religious beliefs adaptively and may share sayings such as, “God uses struggles to build virtue and patience” (Weisman, 2005). In these sessions, therapists do not

attempt to steer group members towards any particular spiritual/religious orientation. At the beginning of this module, all group members are asked about their spiritual/religious identification. In the event that a group member identifies as non-religious, a parallel set of handouts that focuses on philosophical beliefs and spiritual practices is utilized, and homework assignments are adapted similarly. Relatedly, among patients with spiritual/religious delusions, the parallel existential handouts are utilized.

Communication Training: The fourth module, communication training, was also largely pulled from prior work by Falloon, Boyd, and McGill (1984) and Miklowitz and Goldstein (1997). The aim of this module is to teach group members skills that will allow them to communicate clearly and efficiently as a means to foster a low key supportive home environment. Specific communication skills including active listening, expressing positive feelings, making positive requests and expressing negative feelings about specific behaviors. In session, discussion and role-play are utilized to teach skills, and group members are asked to rehearse the skills learned outside of the group setting for homework.

Problem Solving: The fifth and final module, problem solving, was similarly adapted from prior work by Falloon, Boyd, and McGill (1984) and Miklowitz and Goldstein (1997). The goal of this module is to teach group members specific techniques to assist them in improving their problem solving abilities. Group members are taught to identify and agree upon the problem at hand, brainstorm several possible solutions to the problem, discuss the pros and cons of each solution, and choose the best solution (or combination of solutions). Group members are asked to plan and carry out their chosen solution(s) for homework, and to come to group prepared to discuss the success of the

solution, or any issues that arose. Through this module, group members are provided the opportunity to work through problems that have been identified in the earlier sessions, and to view these challenges as external problems that through teamwork are amendable to change.

The Current Study

The current study aimed to examine whether collectivism and spiritual/religious coping related to patient symptom severity, and patient and family member depression, anxiety, and stress cross-sectionally. Next, the current study aimed to examine the feasibility of the CIGT-S protocol by examining differences in patient symptom severity and patient and family member depression, anxiety, and stress after completion of the group program. Finally, we examined participant satisfaction with the group protocol, including qualitative reports on components of the protocol that participants deemed most valuable.

The relationships between collectivism and spiritual/religious coping on symptom severity and depression, anxiety, and stress were examined cross-sectionally using baseline data from patients and family members. The feasibility of the CIGT-S protocol was examined by looking at differences in symptom severity and self-report ratings of depression, anxiety, and stress both within (comparing baseline and termination data) and between groups (comparing group termination and waitlist termination data).

Hypotheses

Based on the research reviewed above, the current study tested the following two main sets of research questions:

1)! The first set of analyses examined cross-sectionally the relationships between collectivism and spiritual/religious coping on patient symptom severity, and patient and family member psychological well-being.

Baseline data were used in these analyses. We hypothesized that higher levels of collectivism and positive spiritual/religious coping at baseline would be associated with lower levels of symptom severity among patients, and lower levels of depression, anxiety, and stress among patients and family members. Conversely, we hypothesized that lower levels of collectivism and negative spiritual/religious coping at baseline would be associated with higher levels of symptom severity among patients, and higher levels of depression, anxiety, and stress among patients and family members.

2)! The second set of analyses examined the impact of the CIGT-S protocol on patient symptom severity, and patient and family member depression, anxiety, and stress.

These analyses were examined in two ways. First, baseline data was compared to waitlist termination data and group termination data. We hypothesized that patients who completed the CIGT-S protocol would demonstrate lower levels of symptom severity and lower levels of depression, anxiety, and stress compared to their functioning at baseline. Similarly, we hypothesized that family members who completed the CIGT-S protocol would demonstrate lower levels of depression, anxiety, and stress compared to their functioning at baseline. However, we expected no changes in functioning between baseline and termination scores for patients and family members assigned to the waitlist condition. Second, we compared the CIGT-S treatment group and the waitlist group at termination (controlling for baseline scores). We hypothesized that patients who

completed the CIGT-S protocol would demonstrate lower psychiatric symptoms, and that patients and family members would demonstrate lower levels of depression, anxiety, and stress compared to patients and family members assigned to the waitlist control condition.

Chapter 2

Methods

Procedures

The current study was part of a larger project which examined the efficacy of the Culturally Informed Treatment for Schizophrenia (CIT-S; Weisman, 2005; Weisman et al., 2006; 2014). During enrollment for the CIT-S family therapy program, a need was recognized to provide longer term treatment to individuals with schizophrenia and their family members. Given that group programs are considered not only effective but financially efficient, adapting the CIT-S program to a group format represented an opportunity to test the feasibility of a broader program that could be run indefinitely and utilized in community settings. This adaptation also allowed us to provide treatment to individuals who did not qualify for the family treatment, which required that patients or family members attend therapy with at least one other relative. These considerations led to the development of the group treatment protocol, which while identical to CIT-S in content, allowed individuals without a relative to receive treatment within a group setting. Patients and family members were both eligible for the group protocol, and most commonly included patients with no local relatives or relatives interested in participating, or family members with patients who were hospitalized or otherwise unable to attend treatment. Participants were recruited via advertisements on Miami's above ground rail station, local newspapers, radio advertisements, and local hospitals. An initial phone screen was completed with all participants to assess eligibility. To be eligible, patients had to be diagnosed with schizophrenia or schizoaffective disorder, and to not have been hospitalized for psychiatric reasons within the previous 3 months. Family members were

eligible if they had regular contact (defined as a minimum of 1 hour or more per week over the last 3 months) with a patient diagnosed with schizophrenia or schizoaffective disorder. Family members were defined as a biological relative, step-relative, or a significant other. If participants appeared to be eligible, they were scheduled to complete a baseline assessment interview at the University of Miami Psychological Services Center. At the initial meeting, all participants read and signed an informed consent form in which they were informed of the study process and randomization procedure, as well as their right to discontinue participation in the study at any time without penalization. At this time, patients' diagnosis of schizophrenia or schizoaffective disorder was confirmed with the Structured Clinical Interview for the DSM-IV, Patient Edition (SCID-I/P, First, Spitzer, Gibbon, & Williams, 2002). Assessments lasted approximately 3 hours and were conducted in the participant's preferred language (English or Spanish), which was identified during the initial phone screen. Trained bilingual graduate students or undergraduate research assistants completed the assessments in interview format (all measures were read to participants) to control for differences in reading proficiency. All participants were compensated with \$25 for their time.

Upon completion of the baseline assessment, participants were randomized to enter the CIGT-S program immediately, or were randomized to a 15-week waitlist control condition. Participants randomized to the waitlist control condition were permitted to join the group program after completing a waitlist termination assessment. All participants completed a termination assessment after completing 15 weeks of the CIGT-S treatment protocol. Participants who completed the group termination

assessment were permitted to continue attending the group, however additional data was not collected beyond the termination assessment.

Assessments were conducted in English or Spanish, depending on the participant's preference. An editorial board was utilized to translate all measures from English to Spanish. Members of the editorial board included the principal investigator (Amy Weisman de Mamani), a non-native Spanish speaker, and native Spanish speakers of Cuban, Nicaraguan, Costa Rican, Columbian, Mexican and Puerto Rican descent. First, all measures were translated to Spanish by a native speaker of Cuban descent. Then, all members of the editorial board independently reviewed and compared the translations to their original English versions. The editorial board then discussed any discrepancies in the Spanish translations that were identified, and worked together to create language-generic versions of the measures that would be understood by a wide range of Spanish speaking individuals. All measures were reviewed again by the editorial board, and additional discrepancies were discussed until a consensus was reached that all measures were language generic, captured the constructs intended by the measures, and were analogous to the English versions (Weisman de Mamani et al., 2014).

Sample

A total of 163 participants were enrolled in the CIGT-S program, including 113 patients with schizophrenia (69%) and 50 family members of patients with schizophrenia (31%). Patients were primarily male (75.2% male, 24.8% female) with a mean age of 43.5 ($SD = 10.02$). Patients self-identified their ethnicity as Caucasian (17.7%), African American (51.3%), Hispanic (26.5%), or Other (1.8%). Three patients had missing data for ethnicity (2.7%). Family members were mostly female (46% male, 54% female) with

a mean age of 49.22 ($SD = 13.48$). Family members self-identified their ethnicity as Caucasian (30%), African American (20%), Hispanic (38%), Asian American (2%), or Other (6%). Two family members had missing data for ethnicity (4%). Family members identified themselves as mothers (32%), fathers (16%), significant others (6%), children (14%), siblings (18%), or other relatives, such as aunts or nephews (14%). Waitlist Termination data was collected on 33 participants, including 20 patients (61%) and 13 family members (39%). Group Termination data was collected on 23 participants, including 12 patients (52%) and 11 family members (48%).

Measures

Though participants completed various questionnaires during the baseline and follow up assessments, only the measures relevant to the current study will be discussed. All measures utilized in the current study are described in detail below and included in the appendix.

Demographics: All participants completed a demographics questionnaire in which they provided information including age, gender, racial/ethnic background, and years of formal education.

Diagnostic Confirmation: The Structured Clinical Interview for DSM-IV, Patient Edition (SCID-I/P, Version 2.0), Psychotic Symptoms Module (First et al., 2002) is a semi-structured diagnostic interview that was used to confirm lifetime criteria for a schizophrenia or schizoaffective disorder diagnosis. The SCID-I/P has demonstrated high inter-rater reliability and diagnostic accuracy (Ventura, Liberman, Green, Shaner, & Mintz, 1998). In the current study, inter-rater reliability was determined by having all interviewers and the study's principal investigator (Amy Weisman de Mamani) watch

and independently rate six videotaped SCID-I/P interviews to determine an overall diagnosis. Inter-rater agreement using Cohen's Kappa was 1.0, indicating perfect agreement among all interviewers regarding the presence or absence of a schizophrenia/schizoaffective disorder diagnosis.

Symptom Severity: The Brief Psychiatric Rating Scale (BPRS; Lukoff, Nuechterlein, & Ventura, 1986; Overall & Gorham, 1962) is a 24-item semi-structured interview that was used to determine the severity of patient symptomatology at baseline and termination assessments. The BPRS evaluates the following areas: unusual thought content, hallucinations, conceptual disorganization, depression, suicidality, self-neglect, bizarre behavior, and hostility. Items are assessed using a 7-point Likert rating scale with 1 indicating "Not Present" and 7 indicating "Extremely Severe". Total BPRS scores are obtained by summing patient scores on all 24 items, with higher overall scores indicating greater symptom severity. The BPRS has demonstrated high inter-rater reliability by the scale's creators (Ventura, Green, Shaner, & Liberman, 1993) and good inter-rater reliability in a prior study done by the principal investigator, with a Cronbach's alpha ranging from .74 to 1.00 on all scale items (Weisman et al., 2005). The principal investigator (Amy Weisman de Mamani) demonstrated reliability with the creator of the BPRS, Dr. Joseph Ventura, after completing a BPRS training and quality assurance program at the University of California, Los Angeles. Dr. Weisman de Mamani trained all graduate student interviewers. In the current study, inter-rater reliability was determined by having all interviewers code six training tapes selected by Dr. Joseph Ventura. Intraclass correlations between interviewers and consensus ratings of Dr.

Ventura ranged from .79 to .98 for total BPRS scores (Weisman et al., 2014). In the current study, the BPRS demonstrated good reliability (Cronbach's $\alpha = .81$).

Depression, anxiety, and stress: The Depression, Anxiety, and Stress Scale (DASS; Lovibond & Lovibond, 1995) is a 42-item scale that was used to measure patient's and family member's overall levels of depression, anxiety, and stress. Items are rated using a 4-point Likert scale, with 0 indicating "Did not apply to me at all" and 3 indicating "Applied to me very much, or most of the time". Total DASS scores were obtained by summing scores on all 42 items, with higher overall scores indicating greater self-reported depression, anxiety, and stress. Items capturing ratings of depression include, "I felt sad and depressed," and, "I couldn't seem to experience any positive feeling". Items capturing ratings of anxiety include, "I felt scared without any good reason," and, "I felt that I was using a lot of nervous energy". Finally, items capturing ratings of stress include, "I found it difficult to relax," and, "I found it hard to wind down". Prior literature in schizophrenia has demonstrated high overall (Cronbach's $\alpha = .96$ for family members, .97 for patients) and individual subscale (depression Cronbach's $\alpha = .94$, anxiety Cronbach's $\alpha = .89-.90$, stress Cronbach's $\alpha = .91$) reliability estimates for the DASS (Weisman et al., 2005). In the current study, the DASS demonstrated high overall reliability estimates for both patients (Cronbach's $\alpha = .98$) and family members (Cronbach's $\alpha = .97$).

Collectivism: The Self-Construal Scale (SCS; Singelis, 1994) is a 24-item scale that measures independent and collectivistic self-construals. Items are rated using a 7-point Likert scale, with 1 indicating "Strongly disagree" and 7 indicating "Strongly agree". Items capturing an independent self-construal include, "I enjoy being unique and

different from others in many respects,” and, “My personal identity independent of others is very important to me”. Items capturing a collectivistic self-construal include, “It is important for me to maintain harmony within my group,” and, “I often have the feeling that my relationships with others are more important than my own accomplishments”. The SCS provides two subscales, independent and collectivistic, and scores were coded such that higher scores on these subscales indicated greater independent/collectivistic self-evaluations. The scale’s creator (Singelis, 1994) reported adequate internal reliability for the independent (Cronbach’s $\alpha = .69$) and collectivistic (Cronbach’s $\alpha = .73$) subscales of the SCS. In the current study, the SCS demonstrated adequate overall reliability estimates (Cronbach’s $\alpha = .77$ for patients, $.74$ for family members), and adequate reliability for the independent (Cronbach’s $\alpha = .70$ for patients, $.61$ for family members) and collectivistic subscales (Cronbach’s $\alpha = .73$ for patients, $.77$ for family members).

Spiritual/Religious Coping: The Religious Coping Activities Scale (RCAS; Pargament et al., 1990; Watson, 1999) is a 29-item scale that was used to assess the extent to which patients and family members turned to spiritual/religious beliefs and behaviors to cope with the stress associated with having schizophrenia/having a relative with schizophrenia. Items are rated using a 4-point Likert scale, with 1 indicating “Not at all” and 4 indicating “A great deal”. The RCAS evaluates six types of spiritual/religious coping: Spiritually Based Activities (e.g., “God showed me how to deal with the situation”), Good Deeds (e.g., “Led a more loving life”), Discontent (e.g., “Felt angry with or distant from God”), Interpersonal Religious Support (e.g., “Received support from the clergy”), Plead (e.g., “Bargained with God to make things better”), and

Religious Avoidance (e.g., “Prayed or read the Bible or other religious text to keep my mind off my problems”). The scale’s creators (Pargament et al., 1990) found internal consistency reliabilities for the individual scales of the RCAS to range from low to high (Spiritually Based Activities Cronbach’s $\alpha = .92$; Good Deeds Cronbach’s $\alpha = .82$; Discontent Cronbach’s $\alpha = .68$; Interpersonal Religious Support Cronbach’s $\alpha = .78$; Plead Cronbach’s $\alpha = .61$; Religious Avoidance Cronbach’s $\alpha = .61$). Lower reliability estimates for the Discontent, Plead, Interpersonal Religious Support, and Religious Avoidance subscales have been linked in part to the small number of items for each scale (2-3 items each). To correct for this, prior literature has combined Spiritually Based Activities, Good Deeds, Interpersonal Religious Support, and Religious Avoidance to comprise one factor, “Positive Religious Coping”, and Discontent and Plead to comprise one factor, “Negative Religious Coping” (see Anderson, Marwit, Vandenberg, & Chibnall, 2005). Using this method, Anderson et al. (2005) found improved internal consistency reliability estimates (Positive Religious Coping Cronbach’s $\alpha = .95$; Negative Religious Coping Cronbach’s $\alpha = .77$). The current study replicated this approach and examined the overall factors Positive Religious Coping and Negative Religious Coping. In the current study, the RCAS demonstrated high overall reliability estimates (Cronbach’s $\alpha = .95$ for patients, .95 for family members), as well as high reliability estimates for the positive (Cronbach’s $\alpha = .96$ for patients, .96 for family members) and adequate reliability for the negative (Cronbach’s $\alpha = .73$ for patients, .63 for family members) subscales.

Consumer Satisfaction: At the end of each group session, a 7-point Likert scale, with 1 indicating “Very dissatisfied” and 7 indicating “Very Satisfied” was given to

assess participant's satisfaction with each individual group therapy session. Satisfaction ratings from each group therapy session were averaged and overall means were analyzed to examine consumer satisfaction with the treatment protocol. In addition, participants provided open-ended responses to the following questions: "What did you think of today's session? What would you like to focus on in the next session? Please provide any additional comments if you wish?"

Statistical Analyses

Preliminary analyses: All statistical analyses were conducted using SPSS Statistics software, Version 22. All study variables were examined for normality and outliers. Normality was examined using Kline's (2005) criteria, such that a variable was deemed to have a non-normal distribution when the absolute value of the skew index is greater than 3 and the absolute value of the kurtosis index is greater than 8. Variables examined in the current study were calculated such that higher scores represented higher levels of the specified construct (e.g., greater symptom severity, greater depression/anxiety/stress, higher collectivism, more religious coping). Relationships between demographic variables (e.g., age, gender, and ethnicity) and dependent variables (symptom severity, depression/anxiety/stress, collectivism, religious coping) were examined as potential covariates prior to conducting primary analyses. The categorical demographic variables of gender and ethnicity were dummy-coded. An independent samples t-test was used to test gender differences and a one-way ANOVA was used to test differences between ethnic groups on variables of interest. For the continuous demographic variable (age), a Pearson correlation coefficient was calculated and tested

for significance. If any demographic variable was determined to be significant, it was statistically controlled for in the primary analyses.

Primary analyses: The first set of analyses aimed to examine, cross-sectionally, whether collectivism and spiritual/religious coping relate to patient and family member functioning at baseline. Partial correlations, controlling for any significant demographic variables, were conducted between independent/collectivistic self-construals, positive/negative religious coping, depression/anxiety/stress, and patient symptom severity, to determine whether greater collectivistic self-construals and positive religious coping were associated with lower patient symptom severity and lower patient and family member depression/anxiety/stress.

The second set of analyses aimed to examine the impact of the CIGT-S protocol on patient symptom severity, and patient and family member psychological well-being. A series of one-way analysis of covariances (ANCOVAs), controlling for any significant demographic variables, was used to evaluate differences in means on patient symptom severity and patient and family member depression/anxiety/stress both within (mean difference between baseline and group termination assessments) and between (mean differences between group termination and waitlist termination) groups (controlling for baseline scores). Dependent variables for patients included symptom severity and dependent variables for patients and family members included overall ratings of depression, anxiety, and stress.

Chapter 3

Results

Preliminary analyses

All study variables were examined for normality and outliers. All variables were within normal limits (see Table 1). Missingness within the primary outcome variables was assessed to determine whether missing data was missing at random. All missing data was found to be missing completely at random, indicating that no systematic missingness existed within the data, Little's MCAR test Chi-Square = 2272.39 (df = 21.92, $p = .113$). Relationships between demographic variables (e.g., age, gender, and ethnicity) and dependent variables (symptom severity, depression/anxiety/stress, collectivism, religious coping) were then examined as potential covariates prior to conducting primary analyses. Results indicated that age was significantly associated with positive religious coping among patients, $r = .186$, $p < .05$, such that older age in patients was associated with higher levels of positive religious coping. Among family members, age was significantly associated with negative religious coping, $r = -.29$, $p < .05$, and independent self-construals, $r = -.28$, $p < .05$, such that older family members utilized less negative religious coping and endorsed lower independent self-construals. Further, a significant relationship between gender and negative religious coping was found among patients, $t(140) = 2.86$, $p < .01$, such that male patients ($M = 13.49$, $SD = 4.37$) endorsed higher levels of negative religious coping than did female patients ($M = 11.13$, $SD = 4.59$). Finally, ethnicity was found to be significantly related to positive religious coping among patients $F(4, 135) = 8.721$, $p < .001$. Bonferroni post-hoc analyses revealed that Caucasian patients endorsed utilizing positive religious coping significantly less than

African American patients (M difference = -17.27, $SE = 4.09$, $p < .001$). Among family members, ethnicity was found to be significantly related to independent self-construals, $F(5, 67) = 3.26$, $p < .05$. Bonferroni post-hoc analyses revealed that Caucasian family members endorsed lower independent self-construals than did African American family members (M difference = -10.23, $SE = 2.81$, $p < .01$). As age, gender, and ethnicity were all determined to be significantly related to the dependent variables among patients, these variables were statistically controlled for in all primary analyses specific to patients. Among family members, age and ethnicity were found to be related to dependent variables, and therefore these variables were statistically controlled for in all primary analyses specific to family members.

Patients and family members who were randomized to either enter the group immediately or enter the group after the waitlist period were designated as “non-completers” if they attended at least one group session but did not complete the treatment or termination assessments. Results indicated that there was a significant amount of attrition (50% of patients, 46% of family members) within the current sample. However, among patients, a chi square test indicated that no significant differences existed between the treatment groups on attrition, with 18 (53%) patients dropping out of the group condition and 10 (45%) patients dropping out of the waitlist condition, $\chi^2(1) = .29$, $p = .58$. With respect to family members, a chi square test also indicated no significant differences between the treatment groups on attrition, with 9 (41%) family members dropping out of the group condition, and 16 (53%) family members dropping out of the waitlist condition, $\chi^2(2) = 1.94$, $p = .38$.

Primary analyses

The first set of primary analyses aimed to examine, cross-sectionally, whether collectivism and spiritual/religious coping related to patient and family member functioning at baseline. First, patient data is discussed. Partial correlations, controlling for age, gender and ethnicity, were conducted between independent/collectivistic self-construals, positive/negative religious coping, depression/anxiety/stress, and patient symptom severity, to determine whether greater collectivistic self-construals and positive religious coping were associated with lower patient symptom severity and lower patient depression/anxiety/stress. Contrary to study hypotheses, results indicated that patient collectivistic self-construals were not significantly related to patient symptom severity ($r_p = -.15, p > .05$) or depression/anxiety/stress ($r_p = -.09, p > .05$). Similarly, positive religious coping was not significantly related to patient symptom severity ($r_p = -.09, p > .05$) or depression/anxiety/stress ($r_p = -.15, p > .05$). However, results indicated that independent self-construals among patients were significantly associated with symptom severity ($r_p = -.21, p < .05$), suggesting that higher independent self-construals were related to lower symptom severity. See Table 2 for a full correlation matrix for patient data.

Next, family member data is discussed. Partial correlations, controlling for age and ethnicity, were conducted between independent/collectivistic self-construals, positive/negative religious coping, and depression/anxiety/stress to determine whether greater collectivistic self-construals and positive religious coping were associated with lower family member depression/anxiety/stress. Contrary to study hypotheses, results indicated that among family members, greater collectivistic self-construals were

associated with greater depression/anxiety/stress ($r_p = .31, p < .05$), and positive religious coping was not significantly associated with family member depression/anxiety/stress ($r_p = .04, p > .05$). However, results indicated that negative religious coping was associated with depression/anxiety/stress ($r_p = .45, p < .01$) such that higher levels of negative religious coping was associated with higher self-reports of depression/anxiety/stress. See Table 3 for a full correlation matrix for family member data.

As multiple family members within one family unit were permitted to join the group, to assess the potential influence of non-independence of data, these analyses were also run examining only data collected from the primary caregiver. For the purposes of this study, the primary caregiver was operationalized as the relative who had the most contact with the patient. No significant differences emerged when examining outcomes using family member or primary caregiver data. Specifically, among primary caregivers, greater collectivistic self-construals were associated with greater depression/anxiety/stress ($r_p = .34, p < .05$), and positive religious coping was not significantly associated with family member depression/anxiety/stress ($r_p = .08, p > .05$). Similarly, negative religious coping remained significantly associated with depression/anxiety/stress ($r_p = .43, p < .01$) such that higher levels of negative religious coping was associated with higher self-reports of depression/anxiety/stress.

The second set of primary analyses examined the impact of the CIGT-S protocol on patient symptom severity, and patient and family member depression/anxiety/stress. A series of one-way analyses of covariances (ANCOVAs), controlling for significant demographic covariates (age, gender, ethnicity for patients; age and ethnicity for family members) were conducted. First, an ANCOVA was used to evaluate the differences in

means on patient symptom severity both within (mean difference between baseline and group termination assessments) and between (mean differences between group termination and waitlist termination) groups. Importantly, analyses comparing differences in patient symptom severity between groups also controlled for patient's levels of symptom severity at baseline.

Results indicated that there was a significant mean difference in patient symptom severity within groups, such that patient symptom severity scores decreased between the baseline ($M = 55.16$, $SE = 1.28$) and group termination ($M = 46.59$, $SE = 3.79$) assessments (M difference = 8.57, $SE = 4.02$, $p < .05$) with a medium effect size (Cohen's $d = .66$). Though not significant, results examining mean differences in patient symptom severity between groups indicated that patient symptom severity was lower at group termination ($M = 46.59$, $SE = 3.79$) than at waitlist termination ($M = 53.23$, $SE = 2.99$). Again, while the mean difference between these groups was not significant (M difference = -6.64, $SE = 4.83$, $p > .05$) a medium effect size was observed (Cohen's $d = .51$) indicating that non-significant results may have been due to limited power associated with a small sample at follow up. Next, an ANCOVA was used to evaluate the differences in means on patient depression/anxiety/stress, again examining differences both within (mean difference between baseline and group termination assessments) and between (mean differences between group termination and waitlist termination) groups. Though not significant, results indicated that patient depression/anxiety/stress decreased from baseline ($M = 47.54$, $SE = 3.54$) to group termination ($M = 30.91$, $SE = 10.37$). Again, while the mean difference was not significant (M difference = 16.64, $SE = 10.98$, $p > .05$) a medium effect size was observed (Cohen's $d = .47$). Patient

depression/anxiety/stress was lower at group termination ($M = 30.91$, $SE = 10.37$) than at waitlist termination ($M = 46.01$, $SE = 8.18$) with a small to medium effect size (Cohen's $d = .43$), however the mean difference between these groups was not significant (M difference = -15.10 , $SE = 13.20$, $p > .05$).

Finally, an ANCOVA was used to evaluate the differences in means on family member depression/anxiety/stress, both within and between groups. Results indicated that family member depression/anxiety/stress did not differ from baseline ($M = 19.4$, $SE = 3.17$) to group termination ($M = 20.69$, $SE = 7.2$; M difference = -1.29 , $SE = 8.02$, $p > .05$; Cohen's $d = .06$). Further, between groups analyses indicated that while family member depression/anxiety/stress was lower at group termination ($M = 20.69$, $SE = 7.2$) than at waitlist termination ($M = 28.6$, $SE = 6.02$), the mean difference between these groups was not significant (M difference = -7.91 , $SE = 9.33$, $p > .05$, Cohen's $d = .37$). See Table 4 for an overview of these findings. Again, as multiple family members within one family unit were permitted to join the group, to assess the potential influence of non-independence of data, these analyses were re-run examining only data collected from the primary caregiver. Once again, no significant differences emerged when examining outcomes using family member or primary caregiver data. Specifically, family member depression/anxiety/stress did not differ from baseline ($M = 20.32$, $SE = 3.72$) to group termination ($M = 20.45$, $SE = 8.48$; M difference = $-.13$, $SE = 9.46$, $p > .05$; Cohen's $d = .01$). Further, between groups analyses indicated that while family member depression/anxiety/stress was lower at group termination ($M = 20.45$, $SE = 8.48$) than at waitlist termination ($M = 30.02$, $SE = 6.81$), the mean difference between these groups was not significant (M difference = -9.56 , $SE = 10.85$, $p > .05$, Cohen's $d = .42$).

Exploratory analyses were also conducted to examine overall patient and family member satisfaction with the treatment protocol, utilizing both quantitative and qualitative measures. The quantitative measure of consumer satisfaction asked participants to rate how satisfied they were with each session, where “Very Dissatisfied” represented a 1 and “Very Satisfied” represented a 7. Results indicated that, patients ($M = 6.18$, $SD = 1.17$) and family members ($M = 6.38$, $SD = .57$) both reported being highly satisfied by the treatment program. Qualitative data (*What did you think of today’s session? What would you like to focus on in the next session? Please provide any additional comments if you wish?*) was also examined to identify specific aspects of the program that participants reported as most valuable. A comprehensive list of this data, containing all comments provided across every session, is included in Appendix B. Broadly, qualitative results suggest that patients viewed the CIGT-S group as a forum in which they could learn new concepts and discuss concerns in an open, validating environment (e.g., “*Good open dialogue; Allowed me to share some things with my family; It really gave me time to debrief; It brought me peace of mind to share what was on my mind; I look forward to having a place to go over my problems*”). Patients also reported that the group provided a sense of comfort in knowing they are not alone in their illness (e.g., “*It was very helpful to find people that are going through the same situation as me. People who have experience some of the things that I have experience; I enjoyed the session today. It feels good to know I’m not alone in my illness; I have met really good people here. A family of sorts in itself*”). The CIGT-S group also appeared to be a place for patients to gain insights not only into their own experiences, but into the experiences of other family members (e.g., “*Very good, gave me quite an insight; Very*

interesting, all aspects, parent, caretaker, patients perspective; It brought me a lot: insight, understanding, etc. I can't wait for next session”).

Similarly, qualitative data indicated that family members viewed the group as safe and non-threatening (e.g., *“It was a very comfortable atmosphere; I liked it. It was very safe and comfortable; Very non-threatening environment”).* Further, family members appeared to be satisfied with the content of the group discussions (e.g., *“Good - discussing family dynamics is important; Great topic! Family plays a very important role in mentally ill people; Good to review symptoms of schizophrenia with family members present; I think the spirituality discussion helped me better get to know the group better; Very informative and helpful to trigger an interest to learn about spiritual development and applying it to more mental health”).* Family members also discussed how including patients and family members in the CIGT-S program allowed them to gain different perspectives into both patient and family member experiences (e.g., *“It was interesting because I saw things (family and relationships) from a different perspective; It was good to meet other people who have the illness and family members; It was very interesting to hear different perspectives on how to balance family involvement”).* Further, family members shared significant insights gained as a result of the CIGT-S experience (e.g., *“I learned I need to treat my mentally ill son with more respect and dignity - as I would any other adult; Very revealing while difficult. Made me think and reflect; Helped me think about...need for having more patience to myself and other - also adjust my expectations with myself and others”).* Finally, family members discussed the most helpful components of the CIGT-S group, including encouraging communication and sharing experiences (e.g., *“I think it was helpful in getting (Patient) and I to talk; It was great!*

Everyone sharing their experiences is very helpful; Parents sharing about their personal experiences is tremendously helpful”).

Qualitative data also provided useful information regarding ways to improve upon the CIGT-S program. Patients described additional topics that may be useful to incorporate into the program, (e.g., *“Stigma, labels; Self-esteem; Invasion of privacy. Discrimination. Violation of right”*). Additionally, patients reported interest in continued discussion of specific family related issues that may be useful to address in depth within the group setting (e.g., *“Family goals; On the love of my family - but feeling judged; Feeling included by my family”*). Finally, patients also discussed specific skills that they would like to work on in the group, including emotional expression and future planning (e.g., *“Life planning on how to be able to handle the anxiety of dealing with daily life such as making a living; Expressing my feelings”*).

Family members also provided additional topics that may be helpful to address in the program, including concrete (e.g., *“Concrete planning, like budgets; Where to find resources”*) and emotional (e.g., *“Anger and letting go; Ways to cope with stressful situations as caregivers”*) skill building. Family members also highlighted the importance of the family dynamic (e.g., *“More about family interaction; More on family dynamics”*), and requested continued in depth discussions regarding how to best support their ill relative (e.g., *“How to improve our roles; How family can provide support; How to deal with SZ in loved one. Discuss ways to help the person with SZ; Family and how we can continue to support our mentally ill person”*). Another theme that arose for family members included ways to support continued independence of the patient (e.g., *“More on independence of family member; How to set "realistic" expectations; Problem solving to*

work toward independence”). Finally, family members requested longer group sessions (e.g., “*Extend the session to 15 more min. Thank you, you guys are great :)*”).

Chapter 4

Discussion

The current study had two primary aims. First, we aimed to examine whether collectivism and spiritual/religious coping related to patient symptom severity, and patient and family member depression, anxiety, and stress. Secondly, we aimed to examine the feasibility of the CIGT-S protocol by examining differences in patient symptom severity and patient and family member depression, anxiety, and stress after completion of the group program. On an exploratory basis, we also aimed to examine participant satisfaction with the group protocol, including qualitative reports on components of the protocol that participants deemed most valuable.

With respect to our first aim, results indicated that for patients, neither collectivistic self-construals nor positive religious coping were significantly related to patient symptom severity or depression, anxiety, and stress. These findings are inconsistent with previously reviewed literature indicating that collectivistic ideals and positive religious coping may serve as protective factors among patients and have positive impacts on the recovery process (Castelein, Bruggeman, Davidson, & van der Gaag, 2015; Mohr et al., 2006; Mohr et al., 2011; Suttajit, & Pilakanta, 2015).

Alternatively, results indicated that higher independent self-construals were associated with lower symptom severity among patients. These results may indicate that components of individualistic attitudes (e.g., reliance on the self, importance of personal identity) may be adaptive among patients with schizophrenia. This finding is consistent with literature which indicates that self-efficacy, characterized by one's expectations regarding their abilities to perform various behaviors or tasks (Kurtz, Olfson, & Rose, 2013), has been

linked to mental health in schizophrenia. Specifically, higher rates of self-efficacy have been linked to better social functioning (Hill & Startup, 2013), whereas low levels of self-efficacy have been found to be linked to higher rates of negative symptomatology, specifically avolition (Avery, Startup, & Calabria, 2009), as well as higher rates of internalized stigma (Hill & Startup, 2013) among patients. Thus, some components of individualism as assessed by the SCS (e.g., “*Being able to take care of myself is a primary concern for me*”) may reflect a sense of self-efficacy and therefore be associated with better mental health. Consequently, future research aimed at identifying the specific components of individualistic self-construals that may drive positive patient prognosis may further tease apart the adaptive and maladaptive components of individualism in schizophrenia and may subsequently inform future treatment approaches. Relatedly, among family members, results indicated that positive religious coping was not significantly associated with family member depression, anxiety, and stress, but that greater collectivistic self-construals were associated with greater depression, anxiety, and stress. Thus, it may be that families who are more involved and invested in their relative’s care may experience more distress when faced with adversity related to their loved one’s illness. This is consistent with literature which has found that stress associated with the patient’s illness has been linked to overall caregiver stress ratings (Laidlaw, Coverdale, Falloon, & Kydd, 2002). Thus, it may be that in the short term collectivistic self-construals, which emphasize the family as a priority above the self, may be linked to more depression, anxiety, and stress among caregivers. However, over time collectivistic self-construals may serve an adaptive role, as this distress combined with a commitment to the relative with schizophrenia may lead family members to seek

treatment options that could ultimately benefit the patient and family as a whole. Future research identifying which features of collectivism may have adverse versus adaptive effects on the family unit may provide insights regarding identification of those at risk, and development of relevant therapeutic interventions. Additionally, more use of negative religious coping was related to higher patient symptom severity, and higher patient and family member self-report ratings of depression, anxiety, and stress. These findings suggest that negative religious coping (e.g., bargaining with God, feeling angry with or distant from God) may be particularly relevant to patient and family member psychological well-being. Therefore, the identification of negative religious coping styles and the provision of education in more adaptive coping strategies may be important components to consider when engaging in treatments targeted towards individuals with schizophrenia and their family members.

Regarding our second study aim, results indicated that patients demonstrated lower levels of symptom severity upon completion of the CIGT-S program, supporting study hypotheses. Additionally, trends in the data indicated that patients who completed the CIGT-S program demonstrated lower levels of symptom severity than those who had been assigned a waitlist control condition, indicating that improvements in patient symptom severity do not appear to be the result of mere passage of time. This suggests that the CIGT-S treatment program was effective in reducing patient symptom severity. This effect is in line with the outcome of the CIT-S individual family therapy protocol (Weisman de Mamani et al., 2014) which uses the same intervention modules within a single family setting (not a multi-family group). Furthermore, family member ratings of depression, anxiety, and stress, while not significant, were lower at group termination

than they were in the waitlist control condition (with a small to medium effect size), indicating that engagement in the CIGT-S program may also have benefits for family members of individuals with schizophrenia. These findings demonstrate the potential of a culturally adapted group intervention, inclusive of patients with schizophrenia and their family members, to impart positive impacts on patient and family member psychological well-being. Thus, it appears that CIGT-S may be an avenue in which to address the paucity of programs which are culturally informed, attend to the needs of both patients and family members, and can be adapted for use with individuals of diverse cultural backgrounds. As very few individuals with schizophrenia or family members of individuals with schizophrenia receive any mental health services (Dixon et al., 1999; Drake & Essock, 2009), this practical and flexible approach to treatment may serve as an effective means to expand upon the availability of services within this population.

Finally, on an exploratory basis, we examined overall patient and family member satisfaction with the treatment protocol. Results indicated that patients and family members both reported being highly satisfied by the treatment program. This was also represented in participant's open ended responses to our satisfaction questionnaire (see Appendix B for a complete list of comments). Generally, it appeared that respondents viewed the group as a safe and open environment in which new concepts could be learned and concerns could be discussed. Patients reported the group was helpful in allowing them to share their experiences, meet others with similar experiences, and gain insights regarding the perspectives of other patients and family members. Family members discussed their satisfaction with the group content, and reported greater understanding and insight regarding patient experiences. Regarding ways to improve

upon the program, patients added additional topics to explore (e.g., stigma, self-esteem) and specific skills they would like to work on in the group setting, including emotional expression and future planning. Family members reported interest in concrete (e.g., finding resources) and emotional (e.g., ways to cope with stress) skill building, as well as ways to support the independence of the patient. Both patients and family members highlighted the importance of discussing the family dynamic and ways to support the family as a whole.

There were various limitations within the current study. First, patients within the current sample were primarily African American men. Therefore, results regarding the effectiveness of the CIGT-S program on patient symptom severity may not generalize to a broader sample of patients. Follow up research with a more ethnically diverse sample may provide more insights regarding the impact of this program on individuals of various ethnic backgrounds. Additionally, our first set of primary analyses utilized cross-sectional data, therefore preventing us from making cause-effect inferences regarding the impact of collectivism/independence and positive/negative spiritual religious coping on patient and family member well-being. Longitudinal studies, which allow the investigation of the potential impact of these constructs over time would provide greater insights regarding the causal nature of these variables. Another limitation of the current study was the lack of an active comparison condition. Future research examining the differential effect of the CIGT-S program compared to a matched length family focused treatment would provide both an active comparison condition as well as allow for insights as to whether the culturally adapted modules (family collectivism, spirituality) are driving change above and beyond the otherwise identical traditional family focused treatment. Finally,

there was a high degree of attrition within the current study which may have impacted our ability to detect significant effects within the CIGT-S outcome data. While high rates of attrition are fairly common in psychotherapy research for schizophrenia (Hamilton, Moore, Crane, & Payne, 2011) future research examining patient and family member factors which may impact attrition rates in group therapy may provide insights into who may benefit most from treatment, as well as guide the development of strategies to prevent attrition in those who appear to be at high risk for drop out.

In summary, findings from the current study indicate that independent self-construals were associated with better patient prognosis, collectivistic self-construals were associated with poorer family member well-being, and that negative religious coping was associated with poorer patient prognosis and poorer family member well-being. Thus, it appears that these cultural constructs have the potential to impact psychological functioning and therefore may be important to address within a therapeutic intervention. Further, the current study found that patients who completed the CIGT-S program demonstrated improved symptom severity, and that patients and family members were highly satisfied with the protocol. These findings indicate that the CIGT-S program is indeed feasible, and may serve as a model of a patient and family member inclusive, culturally adapted, group intervention which can be flexibly applied to individuals of various ethnic backgrounds.

Table 1
Skewness and Kurtosis for Continuous Outcome Variables

Variable	Skewness	Std. Error	Kurtosis	Std. Error
BPRS_IP	-.01	.20	-.49	.40
DASS_IP	.37	.21	-1.15	.42
DASS_Fam	1.76	.29	3.32	.56
RCAS_Positive_IP	-.33	.21	-.95	.41
RCAS_Positive_Fam	.19	.29	-1.11	.58
RCAS_Negative_IP	.45	.20	-.35	.40
RCAS_Negative_Fam	.88	.28	.06	.56
SCS_Collectivistic_IP	-.26	.20	.09	.40
SCS_Collectivistic_Fam	-.33	.29	-.19	.56
SCS_Independent_IP	-1.15	.21	2.40	.41
SCS_Independent_Fam	-.17	.28	-.10	.56

Key: IP = Patient; Fam = Family Member; BPRS = Brief Psychiatric Rating Scale; DASS = Depression, Anxiety, and Stress Scale; RCAS_Positive = Religious Coping Activities Scale Positive Domain; RCAS_Negative = Religious Coping Activities Scale Negative Domain; SCS_Collectivistic = Self Construal Scale Collectivistic Orientation; SCS_Independent = Self Construal Scale Independent Orientation

Table 2
Patient Correlations (controlling for age, gender and ethnicity)

	SCS_ Collectivistic	SCS_ Independent	RCAS_ Positive	RCAS_ Negative	DASS	BPRS
SCS_ Collectivistic	1	.36**	.44**	-.02	-.09	-.15
SCS_ Independent	.36**	1	.15	-.07	-.08	-.21*
RCAS_ Positive	.44**	.15	1	.28**	-.15	-.09
RCAS_ Negative	-.02	-.07	.28**	1	.19*	.20*
DASS	-.09	-.08	-.15	.19*	1	.69**
BPRS	-.15	-.21*	-.09	.20*	.69**	1

Note: * Indicates significant at $p < .05$, ** Indicates significant at $p < .01$

Key: BPRS = Brief Psychiatric Rating Scale; DASS = Depression, Anxiety, and Stress

Scale; RCAS_Positive = Religious Coping Activities Scale Positive Domain;

RCAS_Negative = Religious Coping Activities Scale Negative Domain;

SCS_Collectivistic = Self Construal Scale Collectivistic Orientation; SCS_Independent =
Self Construal Scale Independent Orientation

Table 3
Family Member Correlations (controlling for age and ethnicity)

	SCS_ Collectivistic	SCS_ Independent	RCAS_ Positive	RCAS_ Negative	DASS
SCS_ Collectivistic	1	.22	.38**	.19	.31*
SCS_ Independent	.22	1	.16	.12	.02
RCAS_ Positive	.38**	.16	1	.22	.04
RCAS_ Negative	.19	.12	.22	1	.45**
DASS	.31*	.02	0.4	.45**	1

Note: * Indicates significant at $p < .05$, ** Indicates significant at $p < .01$

Key: DASS = Depression, Anxiety, and Stress Scale; RCAS_Positive = Religious Coping Activities Scale Positive Domain; RCAS_Negative = Religious Coping Activities Scale Negative Domain; SCS_Collectivistic = Self Construal Scale Collectivistic Orientation; SCS_Independent = Self Construal Scale Independent Orientation

Table 4
Baseline, Waitlist Termination, and Group Termination Means for Primary Variables

Variable	BL Mean	WL_Term Mean	Group_Term Mean	Mean Difference
<i>Within groups</i>				
BPRS	55.16		46.59	8.57*
DASS_IP	47.54		30.91	16.64
DASS_Fam	19.4		20.69	-1.29
<i>Between groups</i>				
BPRS		53.23	46.59	-6.64
DASS_IP		46.01	30.91	-15.10
DASS_Fam		28.6	20.69	7.9

Note: * Indicates significant at $p < .05$

Key: BL = Baseline; WL_Term = Waitlist Termination; Group_Term = Group Termination; BPRS = Brief Psychiatric Rating Scale; DASS_IP = Patient Ratings on Depression, Anxiety, and Stress Scale; DASS_Fam = Family Member Ratings on Depression, Anxiety, and Stress Scale.

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APPENDIX A: Measures

THE ROLE OF COLLECTIVISM AND SPIRITUAL/RELIGIOUS COPING ON
PATIENT AND FAMILY MEMBER FUNCTIONING IN SCHIZOPHRENIA AND
THE FEASIBILITY OF A CULTURALLY INFORMED GROUP THERAPY FOR
SCHIZOPHRENIA

Demographic Questionnaire

1. Age (years) _____ Birthdate _____
mon. day year
2. Gender _____ male _____ female
3. What is your background?
_____Caucasian _____African American _____Native American
_____Hispanic _____Asian American _____Other
4. What is your primary language? _____
5. What is your marital status?
_____Married _____Divorced _____Single _____Separated
6. How much formal education do you have? Circle that which best applies:
 1. Advanced Degree – M.A., M.D., Ph.D.
 2. College Degree – B.A.
 3. Some college
 4. High school graduate
 5. Some high school beyond grade 8
 6. Grade 8 completed
 7. Below grade 8
7. What is your current occupation? _____
What other occupational experiences have you had? _____
8. Where do you live? _____
How many years have you lived in the U.S.? _____
Where else have you lived? _____ For how long? _____
9. Growing up, who was the primary bread winner in your family? _____
How much formal education does/did this person have? Circle that which best applies:
 1. Advanced Degree – M.A., M.D., Ph.D.
 2. College Degree – B.A.
 3. Some college

4. High school graduate
5. Some high school beyond grade 8
6. Grade 8 completed
7. Below grade 8

What was this person's primary occupation? _____

Other occupational experiences of this person? _____

10. Growing up, where did your family live? _____

11. Are you involved in any support groups?

If yes, how many? _____ What kinds of groups? _____

How long have you been involved in each? _____

12. What religion are you? _____

13. What medications are you/is your relative (if relative interview) currently taking?

14. (for family member) On average, how many hours per week do you have contact with the patient? (e.g., email, telephone, face to face)

15. Have you/your relative been hospitalized in the last 3 months/ since your last assessment?

If yes, When _____, for how long?

Reason for hospitalization? _____

Brief Psychiatric Rating Scale (BPRS), Version 4.0

Description and Administration of the BPRS

The Brief Psychiatric Rating Scale (BPRS) provides a highly efficient, rapid evaluation procedure for assessing symptom change in psychiatric patients. It yields a comprehensive description of major symptom characteristics. Factor analyses of the original 18-item BPRS typically yields four or five factor solutions. The Clinical Research Center's Diagnosis and Psychopathology Unit has developed a 24-item version of the BPRS.

This manual contains interview questions, symptom definitions, specific anchor points for rating symptoms, and a "how-to" section for problems that arise in rating psychopathology. The purpose of the manual is to assist clinicians and researchers to sensitively elicit psychiatric symptoms and to reliably rate the severity of symptoms. The expanded BPRS includes six new scales added to the original BPRS (Overall & Gorham, 1962) for the purpose of a more comprehensive assessment of a wider range of individuals with serious mental disorders, especially outpatients living in the community (Lukoff, Nuechterlein, & Ventura, 1986).

This manual will enable the clinician or researcher to conduct a high quality interview adequate to the task of eliciting and rating the severity of symptoms in individuals who are often inarticulate or who deny their illness. The following guidelines are provided to standardize assessment. Please familiarize yourself with these methods for assessing psychopathology.

- (1)! Using all sources of information on symptoms.
- (2)! Selecting an appropriate period or interval for rating symptoms.
- (3)! Integrating frequency and severity in symptom rating: the hierarchical criterion.
- (4)! Rating the severity of past delusions for which the patient lacks insight.
- (5)! Rating symptoms when the patient denies them.
- (6)! Using a standardized reference group in making ratings.
- (7)! Rating symptoms that overlap two or more categories or scales on the BPRS.
- (8)! Rating a symptom that has no specified anchor point congruent with its severity level.
- (9)! "Blending" ratings made in different evaluation situations.
- (10)! Resolving apparently contradictory symptoms.

1.! USING ALL SOURCES OF INFORMATION ON SYMPTOMS

The rating of psychopathology should be made on the basis of all available sources of information about the patient. These sources include behavioral observations and interviews made by treatment staff, family members, or other caregivers in contact with the patient, available medical and psychiatric case records, and the present interview of the patient. The interviewer/rater is encouraged to seek additional sources of information about the patient's psychopathology from others to supplement the present interview—this is particularly important when the patient denies symptoms.

2.! SELECTING AN APPROPRIATE PERIOD OR INTERVAL FOR RATING SYMPTOMS

The duration of the time frame for assessment depends upon the purpose for the rating. For example, if the rater is interested in determining the degree of change in psychopathology during a one month period between pharmacotherapy visits, the rating period should be one month. If a research protocol aims to evaluate the emergence of prodromal symptoms or exacerbation of psychotic symptoms, it may be advisable to select a one week interval since longer periods may lose accuracy in retrospective recall. When a study demands completeness in identifying criteria for relapse or exacerbation during a one or two year period, frequent BPRS assessments will be necessary. Rating periods typically range from one day to one month. Retrospective reporting by patients beyond one month may suffer from response bias, retrospective distortions, and memory problems (which are common in persons with psychotic and affective disorders). When resources and personnel do not permit frequent assessments, important information can still be captured if the frequency of assessments can be temporarily increased when (1) prodromal symptoms or stress are reported; (2) medication titration and dosing questions are paramount; and (3) before and after major changes in treatment programs.

3.! INTEGRATING FREQUENCY AND SEVERITY IN SYMPTOM RATING: THE HIERARCHICAL CRITERION

Most of the BPRS scales are scored in terms of the frequency and/or severity of the symptom. It is sometimes the case that the frequency and severity do not match. A hierarchical principle should be followed that requires the rater to select the highest scale level that applies to either frequency or severity. Thus, when the anchor point definitions contain an "OR," the patient should be assigned the highest rating that applies. For example, if a patient has hallucinations persistently throughout the day (a rating of "7"), but the hallucinations only interfere with the patient's functioning to a limited extent (a rating of "5"), the rater should score this scale "7".

The BPRS is suited to making frequent assessments of psychopathology covering short periods of time. If, however, an interviewer intends to cover a relatively long period of time (e.g., 6 weeks), then combining ratings for severity and frequency of symptoms must be carefully thought out depending upon the specific goals. If the goal of a project is to define periods of relapse or exacerbation, the rating should reflect the period of peak symptomatology. For example, if over a six week period the patient experienced a week of persistent hallucinations, but was free of hallucinations the remaining time, the patient should be rated a "6" on hallucinations, reflecting the "worst" period of symptomatology. Alternatively, if the goal is to obtain a general level of symptomatology, the rating should reflect a "blended" or average score. For extended rating periods (e.g., 3 months), the interviewer may prefer to make one rating reflecting the worst period of severity/frequency/functioning and another rating reflecting the "average" amount of psychopathology for the entire period.

4.! RATING THE SEVERITY OF PAST DELUSIONS FOR WHICH THE SUBJECT LACKS INSIGHT

Patients may often indicate varying degrees of insight or conviction regarding past symptoms, making their symptoms difficult to rate. Experiences that result from

psychotic episodes can often appear quite real to patients. For example, the belief that others were trying to poison you, or controlled all your thoughts and forced you to walk into traffic, could have created severe anxiety and intense fear. Patients can give vivid accounts of their psychotic experiences that are as real as if the situations actually occurred. It is important in these cases to rate the extent to which these memories of a delusional experience can be separated from current delusions involving the present. Please note that a patient may be able to describe his or her past or current delusions as part of an illness or even refer to them as “delusions.” However, a patient should always be rated as having delusions if he or she has *acted* on the delusional belief during the rating period.

When a patient describes a delusional belief once firmly held, but that is now seen as irrational, then a “1” should be scored for Unusual Thought Content (and also for Grandiosity, Somatic Concern, Guilt, or Suspiciousness if the idea feel into one of these thematic categories). However, if the individual still believes that the past psychotic experience or event was real, despite not currently harboring the concern, it should be rated a “2” or higher depending on the degree of reality distortion associated with the belief.

Consider the following scenarios:

Scenario No. 1: The patient gives an account of delusional and/or hallucinatory experience and realizes in retrospect that he was ill. He indicates that he has a chemical imbalance in his brain, or that he has a mental condition.

- ! Rate “1” on Unusual Thought Content.

Scenario No. 2: The patient gives indications that his past psychotic experiences were due to a chemical imbalance and/or an illness, but entertains some degree of doubt. He claims it is possible that people were trying to kill him, but he is doubtful. The memories of what happened are not bizarre and he indicates that currently he is certain no one is trying to hurt him.

- ! Rate “2” or “3” on Unusual Thought Content depending on degree of reality retained.

Scenario No. 3: The patient describes previous psychotic experiences as if they actually occurred. He can give examples of what occurred, e.g., co-workers put drugs in his coffee, or that machines read his thoughts. However, the patient says those circumstances no longer occur. The patient is not currently concerned about co-workers or machines, but he is convinced that the circumstances on which the delusion are based actually occurred in the past.

- ! Rate “3” or “4” on Unusual Thought Content depending on the degree of reality distortion, and a “1” on Suspiciousness.

Scenario No. 4: The patient holds bizarre beliefs regarding the circumstances that occurred in the past and/or his current behavior in influenced by delusional beliefs. For example, the patient believes that thoughts were at one time beamed into his mind from aliens OR the patient will not watch T.V. for fear that the messages will again be directed to him OR that the mafia is located in shopping malls that he should avoid.

- ! Rate “4” or higher on Unusual Thought Content depending on the degree of preoccupation and impairment associated with the belief. Consider rating suspiciousness.

Scenario No. 5: The patient believes that previous psychotic experiences were real and previous delusional beliefs are currently influencing most aspects of daily life causing preoccupation and impairment.

- ! Rate “6” or “7” on Unusual Thought Content depending on the degree of preoccupation and impairment associated with the belief.

5.1 RATING SYMPTOMS WHEN THE PATIENT DENIES THEM

An all too common phenomenon in clinical practice or research is the denial or minimization of symptoms by patients. Patients deny, hide, dissemble or minimize their symptoms for a variety of reasons, including fear of being committed or restricted to a hospital or having medication increased. Simply recording a patient’s negative response to BPRS symptom items, if denial or distortion is present, will result in invalid and unreliable data. When an interviewer suspects that a patient may be denying symptoms, it is absolutely essential that other sources of information be solicited and utilized in the ratings.

Several situations might suggest that patient is not entirely forthcoming in reporting his/her symptom experiences. Patients may deny hearing voices, yet be observed whispering under their breath as if in response to a voice. The phrasing that a patient uses in response to a direct question about a delusion or hallucination can alert the interviewer to the potential denial of symptoms. For example, if a patient responds to an inquiry as saying “No.” Subtleties in patient responses communicate a great deal and must be followed-up before the interviewer concludes that the symptom is absent.

There are several ways for the interviewer to obtain more reliable information from a patient who may be denying or minimizing symptoms. In all these approaches, interviewing skills, interpersonal rapport, and sensitivity to the patient are of paramount importance. If the patient is experiencing difficulty disclosing information about psychotic symptoms, the interviewer can shift to inquire about less threatening material such as anxiety/depression or neutral topics. The interviewer should then return to sensitive topics after the patient feels more comfortable and concerns about disclosure have been addressed.

The use of empathy is critical in helping a patient express difficult and possibly embarrassing experiences. An interviewer may say, “I understand that recalling what happened may be unpleasant, but I am very interested in exactly what you experienced.” It is advisable to let patients know what you may be sensing clinically; “I have the impression that you are reluctant to tell me more about what happened. Could that be because you are concerned about what I might think or write down about you?” The interviewer should actively engage the patient in discussing any apparent reasons for denying symptoms. The interviewer can discuss openly in an inviting and noncritical fashion any discrepancies noted between the patient’s self-report of symptoms and observations of speech and behavior. For example, “You have said that you are not depressed, yet you seem very sad and you have been moving very slowly.” When denial occurs, the BPRS interview becomes a dynamic interplay between the interviewer’s desire for accurate symptom information and determining the reasons underlying the patient’s reluctance to disclose.

Occasionally, at the time of the interview, the interviewer will have information about the symptoms that the patient is denying. It is permissible to use a mild

confrontation technique in an attempt to encourage a patient to disclose accurate symptom information. For example, a BPRS interviewer may learn from the patient's therapist or relatives of the presence of auditory hallucinations. The interviewer may state, "I understand from talking with your therapist (or relative) that you have been hearing voices. Could you tell me about that?" Letting the patient know in a sensitive and gentle manner that information about his symptoms are already known may aid willingness to disclose. This approach is most effective when a policy of sharing patient information in a treatment team situation is explained to all entering patients. It may be necessary to inform the patient that not all clinical material is shared, but that symptom information needed to manage treatment can not in all cases be confidential.

When you cannot resolve conflicts or contradictions between patient's self-report and the report of others, you must use your clinical judgment regarding the most reliable informants. Be sure to make notes on the BPRS rating sheet regarding any conflicting sources of information and specify how the final decision was made.

6.! USING A STANDARDIZED REFERENCE GROUP IN MAKING RATINGS

The proper reference group for conducting assessments is a group of normal individuals who are not psychiatric patients that are living and working in the community free of symptoms. BPRS interviewers should have in mind a group of individuals who are able to function either at work/school, socially, or as a homemaker, at levels appropriate to the patient's age and socioeconomic status. Research has shown that normal controls score at "2" or below on most psychotic items of the BPRS. BPRS interviewers should not use other patients previously interviewed, especially those with severe symptoms, as the reference standard, since this will systematically bias ratings toward lower scores.

7.! RATING SYMPTOMS THAT OVERLAP TWO OR MORE CATEGORIES OR SCALES ON THE BPRS

Systematized or multiple delusions can be rated on more than one symptom item or scale on the BPRS, depending on the theme of the delusional belief. For example, if a patient has a delusion that certain body parts have been surgically removed against his/her will and replaced with broken mechanical parts, he or she would be rated at the level of "6" or "7" on both Somatic Concern and at the level of "4" to "7" on Unusual Thought Content depending on the frequency and preoccupation with the delusion. Furthermore, if the patient felt guilty because he believed the metal in his body interfered with radio transmissions between air traffic controllers and pilots resulting in several plane crashes, the BPRS item Guilt should also be rated.

The specific ratings for each of the overlapping symptom dimensions may differ depending on the anchor points of the BPRS item(s). Thus, a patient with a clear-cut persecutory delusion involving the neighbors should be rated a "6" on Suspiciousness. Whereas, the same delusion could be rated a "4" on Unusual Thought Content if it is encapsulated and not associated with impairment.

8.! RATING A SYMPTOM THAT HAS NO SPECIFIC ANCHOR POINT CONGRUENT WITH ITS SEVERITY LEVEL

The anchor points for a given BPRS item are critical in achieving good reliability across raters and across research settings. However, there are occasions when a particular

symptom may not fit any of the anchor point definitions. Anchor point definitions could not be written to cover all possible symptoms exhibited by patients. In general, ratings of “2” or “3” represent nonpathological but observable mild symptomatology; “4” or “5” represents clinically significant moderate symptomatology; and “6” or “7” represents clinically significant and severe symptomatology.

The anchor points in this manual are guidelines to aid in the process of defining the character, frequency, and impairment associated with various types of psychiatric symptoms. When faced with a complicated rating, the interviewer may find it useful to first classify the symptom as mild (“2” or “3”), moderate (“4” or “5”), or severe (“6” or “7”), and second to consult the anchor point definitions to pinpoint the rating.

BPRS symptoms that are classified in the severe range usually represent pathological phenomena. However, it is possible for a patient to report or be observed to exhibit examples of mild psychopathology that should be rated at much higher levels. For example, on the item Tension, if hand wringing is observed on 2-3 occasions, the interviewer would rate a “2” or “3.” However, if the patient is observed to be hand wringing constantly, then consider a higher rating such as a “5” or “6” on Tension. Similarly, instances of severe psychopathology that are brief, transient, and non-impairing in nature should be rated in the mild range.

9.1 “BLENDING” RATINGS MADE IN DIFFERENT EVALUATION SITUATIONS

A psychiatric patient can exhibit different levels of the same symptom depending on the setting in which the patient is observed or the time period involved. Consider the patient who is talkative during a rating session with the BPRS interviewer, but is very withdrawn and blunted with other patients. In the interview session the patient may rate a “3” on blunted affect and “2” on emotional withdrawal, but rate “5” on those symptoms when interacting with other patients. The interviewer can consider integrating the two sources of information and make an averaged or “blended” rating.

10. RESOLVING APPARENTLY CONTRADICTORY SYMPTOMS

It is possible to rate two or more symptoms on the BPRS that represent seemingly contradictory dimensions of phenomenology. For example, a patient can exhibit blunted affect and elevated mood in the same interview period. A patient may laugh and joke with the interviewer, but then shift to a blunted, slowed, and emotionally withdrawn state during the same interview. In this case, rating the presence of both elevated mood and negative symptoms may be appropriate reflecting that both mood states were present. Although the simultaneous presence of apparently contradictory symptoms are rare, if such combinations do appear, the rater should consider rating each symptom lower than if just one had appeared. This conservative approach to rating reflects a cautious orientation to the rating process when there is ambiguity regarding the symptomatology being assessed.

CLINICAL APPLICATIONS OF THE BPRS: GRAPHING SYMPTOMS

A graph is printed at the end of this administration manual to help raters plot and monitor symptoms from the BPRS. Because psychotic and other symptoms often fluctuate over time, graphing them enables the clinician to identify exacerbations, periods

of remission, and prodromal periods that precede a relapse. Monitoring and graphing can be the key to early intervention to reduce morbidity, relapses, and rehospitalizations.

Graphing of symptomatology can provide vivid representations of the relationships between specific types of symptoms (e.g., hallucinations) and other variables of interest, such as (1) medication type and dose, (2) changes in psychosocial treatment and rehabilitation programs, (3) the use of “street” drugs or alcohol, (4) life events, and (5) other environmental and familial stressors. The preprinted graph shown at the end of this manual provides space to write specific life events or treatment changes and permits the “eyeballing” of the influence of these variables on symptoms. Repeated measurement and graphing of symptoms over time can be done for individual items (e.g., anxiety or hallucinations), or for clusters of symptoms (e.g., psychotic index). Such clusters can be chosen from factor analyses of earlier versions of the BPRS (Guy, 1976; Overall, Hollister, and Pichot, 1967; Overall and Porterfield, 1963). The blank graph of this manual allows raters to select and write in specific symptoms of the BPRS based on the needs of individual patients.

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SCALE ITEMS AND ANCHOR POINTS

Rate items 1-14 on the basis of patient’s self-report. Note items 7, 12, and 13 are also rated on the basis of observed behavior. Items 15-24 are rated on the basis of observed behavior and speech.

1. **SOMATIC CONCERN:** Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have realistic bases or not. Somatic delusions should be rated in the sever range with or without somatic concern. Note: Be sure to assess the degree of impairment due to somatic concerns only and not other symptoms, e.g., depression. In addition, if the subject rates a “6” or “7” due to somatic delusions, then you must rate Unusual Thought Content at least a “4” or above.

Have you been concerned about your physical health? Have you had any physical illness or seen a medical doctor lately? (What does your doctor say is wrong? How serious is it?)

Has anything changed regarding your appearance?

Has it interfered with your ability to perform your usual activities and/or work?

Did you ever feel that parts of your body had changed or stopped working?

[If patient reports any somatic concerns/delusions, ask the following]:

How often are you concerned about [use patient's description]?

Have you expressed any of these concerns with others?

- | | |
|---|---|
| 2 | Very Mild
Occasional concerns that tend to be kept to self. |
| 3 | Mild
Occasional concerns that tend to be voiced to others (e.g., family, physician). |
| 4 | Moderate
Frequent expressions of concern or exaggerations of existing ills or some preoccupation, but no impairment in functioning. Not delusional. |
| 5 | Moderately Severe
Frequent expressions of concern or exaggeration of existing ills or some preoccupation and moderate impairment of functioning. Not delusional. |
| 6 | Severe
Preoccupation with somatic complaints with much impairment in functioning OR somatic delusions without acting on them or disclosing to others. |
| 7 | Extremely Severe
Preoccupation with somatic complaints with severe impairment in functioning OR somatic delusions that tend to be acted on or disclosed to others. |

2. ANXIETY: Reported apprehension, tension, fear, panic or worry. Rate only the patient's statements, not observed anxiety which is rated under TENSION.

Have you been worried a lot during [mention time frame]? Have you been nervous or apprehensive? (What do you worry about?)

Are you concerned about anything? How about finances or the future?

When you are feeling nervous, do your palms sweat or does your heart beat fast (or shortness of breath, trembling, choking)?

[If patient reports anxiety or autonomic accompaniment, ask the following]:

How much of the time have you been [use patient's description]?

Has it interfered with your ability to perform your usual activities/work?

- 2 Very Mild
Reports some discomfort due to worry OR infrequent worries that occur more than usual for most normal individuals.
- 3 Mild
Worried frequently but can readily turn attention to others things.
- 4 Moderate
Worried most of the time and cannot turn attention to others things easily but no impairment in functioning OR occasional anxiety with autonomic accompaniment but no impairment in functioning.
- 5 Moderately Severe
Frequent, but not daily, periods of anxiety with autonomic accompaniment OR some areas of functioning are disrupted by anxiety or worry.
- 6 Severe
Anxiety with autonomic accompaniment daily but not persisting throughout the day OR many areas of functioning are disrupted by anxiety or constant worry.
- 7 Extremely Severe
Anxiety with autonomic accompaniment persisting throughout the day OR most areas of functioning are disrupted by anxiety or constant worry.

3. DEPRESSION: Include sadness, unhappiness, anhedonia, and preoccupation with depressing topics (can't attend to TV or conversations due to depression), hopelessness, loss of self-esteem (dissatisfied or disgusted with self or feeling of worthlessness). Do not include vegetative symptoms, e.g., motor retardation, early waking, or the amotivation that accompanies the deficit syndrome.

How has your mood been recently? Have you felt depressed (sad, down, unhappy, as if you didn't care)?

Are you able to switch your attention to more pleasant topics when you want to?

Do you find that you have lost interest in or get less pleasure from things you used to enjoy, like family, friends, hobbies, watching T.V., eating?

[If subject reports feelings of depression, ask the following]:

How long do these feelings last?

Has it interfered with your ability to perform your usual activities/work?

- 2 Very Mild
Occasionally feels sad, unhappy or depressed.

- 3 Mild
Frequently feels sad or unhappy but can readily turn attention to other things.
- 4 Moderate
Frequent periods of feeling very sad, unhappy, moderately depressed, but able to function with extra effort.
- 5 Moderately Severe
Frequent, but not daily, periods of deep depression OR some areas of functioning are disrupted by depression.
- 6 Severe
Deeply depressed daily but not persisting throughout the day OR many areas of functioning are disrupted by depression.
- 7 Extremely Severe
Deeply depressed daily OR most areas of functioning are disrupted by depression.

4. SUICIDALTY: Expressed desire, intent or actions to harm or kill self.

Have you felt that life wasn't worth living? Have you thought about harming or killing yourself? Have you felt tired of living or as though you would be better off dead? Have you ever felt like ending it all?

[If patient reports suicidal ideation, ask the following]:

How often have you thought about [use patient's description]?

Did you (Do you) have a specific plan?

- 2 Very Mild
Occasional feelings of being tired of living. No overt suicidal thoughts.
- 3 Mild
Occasional suicidal thoughts without intent or specific plan OR he/she feels they would be better off dead.
- 4 Moderate
Suicidal thoughts frequent without intent or plan.
- 5 Moderately Severe
Many fantasies of suicide by various methods. May seriously consider making an attempt using non-lethal methods or in full view of potential saviors.

- 6 Severe
Clearly wants to kill self. Searches for appropriate means and time, OR potentially serious suicide attempt with patient knowledge of possible rescue.
- 7 Extremely Severe
Specific suicidal plan and intent (e.g., “as soon as _____, I will do it by doing X”), OR suicide attempt characterized by plan patient thought was lethal or attempt in secluded environment.

5. GUILT: Overconcern or remorse for past behavior. Rate only patient’s statements, do not infer guilt feelings from depression, anxiety, or neurotic defenses. Note: If the subject rates a “6” or “7” due to delusions of guilt, then you must rate Unusual Thought Content as least a “4” or above depending on level of preoccupation and impairment.

Is there anything you feel guilty about? Have you been thinking about past problems? Do you tend to blame yourself for things that have happened? Have you done anything you’re still ashamed of?

[If patient reports guilt/remorse/delusions, ask the following]:
*How often have you been thinking about [use patient’s description]?
Have you disclosed your feelings of guilt to others?*

- 2 Very Mild
Concerned about having failed someone or at something but not preoccupied. Can shift thoughts to other matters easily.
- 3 Mild
Concerned about having failed someone or at something with some preoccupation. Tends to voice guilt to others.
- 4 Moderate
Disproportionate preoccupation with guilt, having done wrong, injured others by doing or failing to do something, but can readily turn attention to other things.
- 5 Moderately Severe
Preoccupation with guilt, having failed someone or at something, can turn attention to other things, but only with great effort. Not delusional.
- 6 Severe
Delusional guilt OR unreasonable self-reproach grossly out of proportion to circumstances. Subject is very preoccupied with guilt and is likely to disclose to others or act on delusions.

6. HOSTILITY: Animosity, contempt, belligerence, threats, arguments, tantrums, property destruction fights and any other expression of hostile attitudes or actions. Do not infer hostility from neurotic defenses, anxiety or somatic complaints. Do not include incident of appropriate anger or obvious self-defense.

*How have you been getting along with people (family, co-workers, etc.)?
Have you been irritable or grumpy lately? (How do you show it? Do you keep it to yourself?)
Were you ever so irritable that you would shout at people or start fights or arguments? (Have you found yourself yelling at people you didn't know?)
Have you hit anyone recently?*

- 2 Very Mild
Irritable or grumpy, but not overtly expressed.
- 3 Mild
Argumentative or sarcastic.
- 4 Moderate
Overtly angry on several occasions OR yelled at others excessively.
- 5 Moderate Severe
Has threatened, slammed about or thrown things.
- 6 Severe
Has assaulted others but with no harm likely, e.g., slapped or pushed, OR destroyed property, e.g., knocked over furniture, broken windows.
- 7 Extremely Severe
Has attacked others with definite possibility of harming them or with actual harm, e.g., assault with hammer or weapon.

7. ELEVATED MOOD: A pervasive, sustained and exaggerated feeling of well-being, cheerfulness, euphoria (implying a pathological mood), optimism that is out of proportion to the circumstances. Do not infer elation from increased activity or from grandiose statements alone.

*Have you felt so good or high that other people thought that you were not your normal self?
Have you been feeling cheerful and "on top of the world" without any reason?*

[If patient reports elevated mood/euphoria, ask the following]:
*Did it seem like more than just feeling good?
How long did that last?*

- 2 Very Mild

Seems to be very happy, cheerful without much reason.

- 3 Mild
Some unaccountable feelings of well-being that persist.
- 4 Moderate
Reports excessive or unrealistic feelings of well-being, cheerfulness, confidence or optimism inappropriate to circumstances, some of the time. May frequently joke, smile, be giddy or overly enthusiastic OR few instances of marked elevated mood with euphoria.
- 5 Moderately Severe
Reports excessive or unrealistic feelings of well-being, confidence or optimism inappropriate to circumstances much of the time. May describe feeling “on top of the world,” “like everything is falling into place,” or “better than ever before,” OR several instances of marked elevated mood with euphoria.
- 6 Severe
Reports many instances of marked elevated mood with euphoria OR mood definitely elevated almost constantly throughout interview and inappropriate to content.
- 7 Extremely Severe
Patient reports being elated or appears almost intoxicated, laughing, joking, giggling, constantly euphoric, feeling invulnerable, all inappropriate to immediate circumstances.

8. GRANDIOSITY: Exaggerated self-opinion, self-enhancing conviction of special abilities or powers or identity as someone rich or famous. Rate only patient’s statements about himself, not his demeanor. Note: If the subject rates a “6” or “7” due to grandiose delusions, you must rate Unusual Thought Content at least a “4” or above.

Is there anything special about you? Do you have any special abilities or powers?

Have you thought that you might be somebody rich or famous?

[If patient reports any grandiose ideas/delusions, ask the following]:

How often have you been thinking about [use patient’s description]? Have you told anyone about what you have been thinking? Have you acted on any of these ideas?

- 2 Very Mild
Feels great and denies obvious problems, but not unrealistic.

- 3 Mild
Exaggerated self-opinion beyond abilities and training.
- 4 Moderate
Inappropriate boastfulness, claims to be brilliant, insightful, or gifted beyond realistic proportions, but rarely self-discloses or acts on these inflated self-concepts. Does not claim that grandiose accomplishments have actually occurred.
- 5 Moderately Severe
Same as 4 but often self-discloses and acts on these grandiose ideas. May have doubts about the reality of the grandiose ideas. Not delusional.
- 6 Severe
Delusional—claims to have special powers like ESP, to have millions of dollars, invented new machines, worked at jobs when it is known that he was never employed in these capacities, be Jesus Christ, or the President. Patient may not be very preoccupied.
- 7 Extremely Severe
Delusional—same as 6 but subject seems very preoccupied and tends to disclose or act on grandiose delusions.

9. SUSPICIOUSNESS: Expressed or apparent belief that other persons have acted maliciously or with discriminatory intent. Include persecution by supernatural or other nonhuman agencies (e.g., the devil). Note: Ratings of “3” or above should also be rated under Unusual Thought Content.

Do you ever feel uncomfortable in public? Does it seem as though others are watching you? Are you concerned about anyone’s intentions toward you? Is anyone going out of their way to give you a hard time, or trying to hurt you? Do you feel in any danger?

[If patient reports any persecutory ideas/delusions, ask the following]:
How often have you been concerned that [use patient’s description]? Have you told anyone about these experiences?

- 2 Very Mild
Seems on guard. Reluctant to respond to some “personal” questions. Reports being overly self-conscious in public.
- 3 Mild
Describes incidents in which others have harmed or wanted to harm him/her that sound plausible. Patient feels as if others are watching, laughing, or criticizing him/her in public, but this occurs only occasionally or rarely. Little or no preoccupation.

- 4 Moderate
Says others are talking about him/her maliciously, have negative intentions, or may harm him/her. Beyond the likelihood of plausibility, but not delusional. Incidents of suspected persecution occur occasionally (less than once per week) with some preoccupation.
- 5 Moderately Severe
Same as 4, but incidents occur frequently, such as more than once per week. Patient is moderately preoccupied with ideas of persecution OR patient reports persecutory delusions expressed with much doubt (e.g., partial delusion).
- 6 Severe
Delusional—speaks of Mafia plots, the FBI, or others poisoning his/her food, persecution by supernatural forces.
- 7 Extremely Severe
Same as 6, but the beliefs are bizarre or more preoccupying. Patient tends to disclose or act on persecutory delusions.

10. HALLUCINATIONS: Reports of perceptual experiences in the absence of relevant external stimuli. When rating degree to which functioning is disrupted by hallucinations, include preoccupation with the content and experience of the hallucinations, as well as functioning disrupted by acting out on the hallucinatory content (e.g., engaging in deviant behavior due to command hallucinations). Include thoughts aloud (“gedankenlautwerden”) or pseudohallucinations (e.g., hears a voice inside head) if a voice quality is present.

*Do you ever seem to hear your name being called?
Have you heard any sounds or people talking to you or about you when there has been nobody around?
[If hears voices]: What does the voice/voices say? Did it have a voice quality?
Do you ever have visions or see things that others do not see? What about smell odors that others do not smell?*

[If patient reports hallucinations, ask the following]:
Have these experiences interfered with your ability to perform your usual activities/work? How do you explain them? How often do they occur?

- 2 Very Mild
While resting or going to sleep, sees visions, smells odors, or hears voices, sounds or whispers in the absence of external stimulation, but no impairment in functioning.
- 3 Mild

While in a clear state of consciousness, hears a voice calling the subject's name, experiences non-verbal auditory hallucinations (e.g., sounds or whispers), formless visual hallucinations, or has sensory experiences in the presence of a modality-relevant stimulus (e.g., visual illusions) infrequently (e.g., 1-2 times per week) and with no functional impairment.

- 4 Moderate
Occasional verbal, visual, gustatory, olfactory, or tactile hallucinations with no functional impairment OR non-verbal auditory hallucinations/visual illusions more than infrequently or with impairment.
- 5 Moderately Severe
Experiences daily hallucinations OR some areas of functioning are disrupted by hallucinations.
- 6 Severe
Experiences verbal or visual hallucinations several times a day OR many areas of functioning are disrupted by these hallucinations.
- 7 Extremely Severe
Persistent verbal or visual hallucinations throughout the day OR most areas of functioning are disrupted by these hallucinations.

11. UNUSUAL THOUGHT CONTENT: Unusual, odd, strange or bizarre thought content. Rate the degree of unusualness, not the degree of disorganization of speech. Delusions are patently absurd, clearly false or bizarre ideas that are expressed with partial or full conviction. Consider the patient to have full conviction if he/she has acted as though the delusional belief were true. Ideas of reference/persecution can be differentiated from delusions in that ideas are expressed with much doubt and contain more elements of reality. Include thought insertion, withdrawal and broadcast. Include grandiose, somatic and persecutory delusions even if rated elsewhere. Note: if Somatic Concern, Guilt, Suspiciousness, or Grandiosity are rated "6" or "7" due to delusions, then Unusual Thought Content *must* be rated a "4" or above.

Have you been receiving any special messages from people or from the way things are arranged around you? Have you seen any references to yourself on T.V. or in the newspapers?

Can anyone read your mind?

Do you have a special relationship with God?

Is anything like electricity, X-rays, or radio waves affecting you?

Are thoughts put into your head that are not your own?

Have you felt that you were under the control of another person or force?

[If patient reports any odd ideas/delusions, ask the following]:

How often do you think about [use patient's description]?

Have you told anyone about these experiences? How do you explain the things that have been happening [specify]?

- 2 Very Mild
Ideas of reference (people may stare or may laugh at him/her), ideas of persecution (people may mistreat him/her). Unusual beliefs in psychic powers, spirits, UFO's, or unrealistic beliefs in one's own abilities. Not strongly held. Some doubt.
- 3 Mild
Same as 2, but degree of reality distortion is more severe as indicated by highly unusual ideas or greater conviction. Content may be typical of delusions (even bizarre), but without full conviction. The delusion does not seem to have fully formed, but is considered as one possible explanation for an unusual experience.
- 4 Moderate
Delusion present but no preoccupation or functional impairment. May be an encapsulated delusion or a firmly endorsed absurd belief about past delusional circumstances.
- 5 Moderately Severe
Full delusion(s) present with some preoccupation OR some areas of functioning disrupted by delusional thinking.
- 6 Severe
Full delusion(s) present with much preoccupation OR many areas of functioning are disrupted by delusional thinking.
- 7 Extremely Severe
Full delusion(s) present with almost total preoccupation OR most areas of functioning are disrupted by delusional thinking.

Rate items 12-13 on the basis of patient's self-report and observed behavior.

12. BIZARRE BEHAVIOR: Reports of behaviors which are odd, unusual, or psychotically criminal. Not limited to interview period. Include inappropriate sexual behavior and inappropriate affect.

*Have you done anything that has attracted the attention of others?
Have you done anything that could have gotten you in trouble with the police?
Have you done anything that seemed unusual or disturbing to others?*

- 2 Very Mild
Slightly odd or eccentric public behavior, e.g., occasionally giggles to self, fails to make appropriate eye contact, that does not seem to attract the attention of others OR unusual behavior conducted in private, e.g., innocuous rituals, that would not attract the attention of others.

- 3 Mild
Noticeably peculiar public behavior, e.g., inappropriately loud talking, makes inappropriate eye contact, OR private behavior that occasionally, but not always, attracts the attention of others, e.g., hoards food, conducts unusual rituals, wears gloves indoors.
- 4 Moderate
Clearly bizarre behavior that attracts or would attract (if done privately) the attention or concern of others, but with no corrective intervention necessary. Behavior occurs occasionally, e.g., fixated staring into space for several minutes, talks back to voices once, inappropriate giggling/laughter on 1-2 occasions, talking loudly to self.
- 5 Moderately Severe
Clearly bizarre behavior that attracts or would attract (if done privately) the attention of others or the authorities, e.g., fixated staring in a socially disruptive way, frequent inappropriate giggling/laughter, occasionally responds to voices, or eats non-foods.
- 6 Severe
Bizarre behavior that attracts attention of others and intervention by authorities, e.g., directing traffic, public nudity, staring into space for long periods, carrying on a conversation with hallucinations, frequent inappropriate giggling/laughter.
- 7 Extremely Severe
Serious crimes committed in a bizarre way that attract the attention of others and the control of authorities, e.g., sets fires and stares at flames OR almost constant bizarre behavior, e.g., inappropriate giggling/laughter, responds only to hallucinations and cannot be engaged in interaction.

13. SELF-NEGLECT: Hygiene, appearance, or eating behavior below usual expectations, below socially acceptable standards, or life-threatening.

How has your grooming been lately? How often do you change your clothes? How often do you take showers? Has anyone (parents/staff) complained about your grooming or dress? Do you eat regular meals?

- 2 Very Mild
Hygiene/appearance slightly below usual community standards, e.g., shirt out of pants, buttons unbuttoned, shoelaces untied, but no social or medical consequences.

- 3 Mild

Hygiene/appearance occasionally below usual community standards, e.g., irregular bathing, clothing is stained, hair uncombed, occasionally skips an important meal. No social or medical consequences.

- 4 Moderate
Hygiene/appearance is noticeably below usual community standards, e.g., fails to bathe or change clothes, clothing very soiled, hair unkempt, needs prompting, noticeable by others OR irregular eating and drinking with minimal medical concerns and consequences.
- 5 Moderately Severe
Several areas of hygiene/appearance are below usual community standards OR poor grooming draws criticism by others, and requires regular prompting. Eating or hydration are irregular and poor, causing some medical problems.
- 6 Severe
Many areas of hygiene/appearance are below usual community standards, does not always bathe or change clothes even if prompted. Poor grooming has caused social ostracism at school/residence/work, or required intervention. Eating erratic and poor, may require medical intervention.
- 7 Extremely Severe
Most areas of hygiene/appearance/nutrition are extremely poor and easily noticed as below usual community standards OR hygiene/appearance/nutrition requires urgent and immediate medical intervention.

14. DISORIENTATION: Does not comprehend situations or communications, such as questions asked during the entire BRPS interview. Confusion regarding person, place, or time. Do not rate if incorrect responses are due to delusions.

*May I ask you some standard questions we ask everybody?
How old are you? What is the date? [allow + or - 2 days].
What is this place called? What year were you born? Who is the president?*

- 2 Very Mild
Seems muddled or mildly confused 1-2 times during interview. Oriented to person, place and time.
- 3 Mild
Occasionally muddle or mildly confused 3-4 times during interview. Minor inaccuracies in person, place, or time, e.g., date off by more than + or - 2 days, or gives wrong division of hospital.
- 4 Moderate

Frequently confused during interview. Minor inaccuracies in person, place, or time are noted, as in “3” above. In addition, may have difficulty remembering general information, e.g., name of president.

- 5 Moderately Severe
Markedly confused during interview, or to person, place, or time. Significant inaccuracies are noted, e.g., date off by more than one week, or cannot give correct name of hospital. Has difficulty remembering personal information, e.g., where he/she was born, or recognizing familiar people.
- 6 Severe
Disoriented to person, place, or time, e.g., cannot give correct month and year. Disoriented in 2 out of 3 spheres.
- 7 Extremely Severe
Grossly disoriented to person, place, or time, e.g., cannot give name or age. Disoriented in all three spheres.

Rate items 15-24 on the basis of observed behavior and speech.

15. CONCEPTUAL DISORGANIZATION: Degree to which speech is confused, disconnected, vague or disorganized. Rate tangentiality, circumstantiality, sudden topic shifts, incoherence, derailment, blocking, neologisms, and other speech disorders. Do not rate content of speech.

- 2 Very Mild
Peculiar use of words or rambling but speech is comprehensible.
- 3 Mild
Speech a bit hard to understand due to tangentiality, circumstantiality or sudden topic shifts.
- 4 Moderate
Speech difficult to understand due to tangentiality, circumstantiality, idiosyncratic speech, or topic shifts on many occasions OR 1-2 instances of incoherent phrases.
- 5 Moderately Severe
Speech difficult to understand due to circumstantiality, tangentiality, neologisms, blocking, or topic shifts most of the time OR 3-5 instances of incoherent phrases.
- 6 Severe
Speech is incomprehensible due to severe impairments most of the time. Many BPRS items cannot be rated by self-report alone.

- 7 Extremely Severe
Speech is incomprehensible throughout interview.

6. BLUNTED AFFECT: Restricted range in emotional expressiveness of face, voice and gestures. Marked indifference or flatness even when discussing distressing topics. In the case of euphoric or dysphoric patients, rate Blunted Affect if a flat quality is also clearly present.

Use the following probes at end of interview to assess emotional responsivity:
Have you heard any good jokes lately? Would you like to hear a joke?

- 2 Very Mild
Emotional range is slightly subdued or reserved but displays appropriate facial expressions and tone of voice that are within normal limits.
- 3 Mild
Emotional range overall is diminished, subdued, or reserved, without many spontaneous and appropriate emotional responses. Voice tone is slightly monotonous.
- 4 Moderate
Emotional range is noticeably diminished, patient doesn't show emotion, smile, or react to distressing topics except infrequently. Voice tone is monotonous or there is noticeable decrease in spontaneous movements. Displays of emotion or gestures are usually followed by a return to flattened affect.
- 5 Moderately Severe
Emotional range very diminished, patient doesn't show emotion, smile or react to distressing topics except minimally, few gestures, facial expression does not change very often. Voice tone is monotonous much of the time.
- 6 Severe
Very little emotional range or expression. Mechanical in speech and gestures most of the time. Unchanging facial expression. Voice tone is monotonous most of the time.
- 7 Extremely Severe
Virtually no emotional range or expressiveness, stiff movements. Voice tone is monotonous all of the time.

17. EMOTIONAL WITHDRAWAL: Deficiency in patient's ability to relate emotionally during interview situation. Use your own feeling as to the presence of an "invisible

barrier” between patient and interviewer. Include withdrawal apparently due to psychotic processes.

- 2 Very Mild
Lack of emotional involvement shown by occasional failure to make reciprocal comments, occasionally appearing preoccupied, or smiling in a stilted manner, but spontaneously engages the interviewer most of the time.
- 3 Mild
Lack of emotional involvement shown by noticeable failure to make reciprocal comments, appearing preoccupied, or lacking in warmth, but responds to interviewer when approached.
- 4 Moderate
Emotional contact not present much of the interview because subject does not elaborate responses, fails to make eye contact, doesn't seem to care if interviewer is listening, or may be preoccupied with psychotic material.
- 5 Moderately Severe
Same as “4” but emotional contact not present most of the interview.
- 6 Severe
Actively avoids emotional participation. Frequently unresponsive or responds with yes/no answers (not solely due to persecutory delusions). May leave during interview or just not respond at all.
- 7 Extremely Severe
Consistently avoids emotional participation. Unresponsive or responds with yes/no answers (not solely due to persecutory delusions). May leave during interview or just not respond at all.

18. MOTOR RETARDATION: Reduction in energy level evidenced by slowed movements and speech, reduced body tone, decreased number of spontaneous body movements. Rate on the basis of observed behavior of the patient only. Do not rate on the basis of patient's subjective impression of his own energy level. Rate regardless of medication effects.

- 2 Very Mild
Slightly slowed or reduced movements or speech compared to most people.
- 3 Mild
Noticeably slowed or reduced movements or speech compared to most people.

- 4 Moderate
Large reduction or slowness in movements or speech.
- 5 Moderately Severe
Seldom moves or speaks spontaneously OR very mechanical or stiff movements.
- 6 Severe
Does not move or speak unless prodded or urged.
- 7 Extremely Severe
Frozen, catatonic.

19. TENSION: Observable physical and motor manifestations of tension, “nervousness,” and agitation. Self-reported experiences of tension should be rated under the item on anxiety. Do not rate if restlessness is solely akathisia, but do rate if akathisia is exacerbated by tension.

- 2 Very Mild
More fidgety than most but within normal range. A few transient signs of tension, e.g., picking at fingernails, foot wagging scratching scalp several times, or finger tapping.
- 3 Mild
Same as “2,” but with more frequent or exaggerated signs of tension.
- 4 Moderate
Many and frequent motor tension with one or more signs sometimes occurring simultaneously, e.g., wagging one’s foot while wringing hands together. There are times when no signs of tension are present.
- 5 Moderately Severe
Many of frequent signs of motor tension with one or more signs often occurring simultaneously. There are still rare times when no signs of tension are present.
- 6 Severe
Same as “5,” but signs of tension are continuous.
- 7 Extremely Severe
Multiple motor manifestations of tension are continuously present, e.g., continuous pacing and hand wringing.

20. UNCOOPERATIVENESS: Resistance and lack of willingness to cooperate with the interview. The uncooperativeness might result from suspiciousness. Rate only

uncooperativeness in relation to the interview, not behaviors involving peers and relatives.

- 2 Very Mild
Shows nonverbal signs of reluctance, but does not complain or argue.
- 3 Mild
Gripes or tries to avoid complying, but goes ahead without argument.
- 4 Moderate
Verbally resists but eventually complies after questions are rephrased or repeated.
- 5 Moderately Severe
Same as “4,” but some information necessary for accurate ratings is withheld.
- 6 Severe
Refuses to cooperate with interview, but remains in interview situation.
- 7 Extremely Severe
Same as “6,” with active efforts to escape the interview.

21. EXCITEMENT: Heightened emotional tone, or increased emotional reactivity to interviewer or topics being discussed, as evidenced by increased intensity of facial expressions, voice tone, expressive gestures or increase in speech quantity and speed.

- 2 Very Mild
Subtle and fleeting or questionable increase in emotional intensity. For example, at times seems keyed-up or overly alert.
- 3 Mild
Subtle but persistent increase in emotional intensity. For example, lively use of gestures and variation of voice tone.
- 4 Moderate
Definite but occasional increase in emotional intensity. For example, reacts to interviewer or topics that are discussed with noticeable emotional intensity. Some pressured speech.
- 5 Moderately Severe
Definite and persistent increase in emotional intensity. For example, reacts to many stimuli, whether relevant or not, with considerable emotional intensity. Frequent pressured speech.
- 6 Severe

Marked increase in emotional intensity. For example. Reacts to most stimuli with inappropriate emotional intensity. Has difficulty settling down or staying on task. Often restless, impulsive, or speech is often pressured.

- 7 Extremely Severe
Marked and persistent increase in emotional intensity. Reacts to all stimuli with inappropriate intensity, impulsiveness. Cannot settle down or stay on task. Very restless and impulsive most of the time. Constant pressured speech.

22. **DISTRACTIBILITY:** Degree to which observed sequences of speech and actions are interrupted by stimuli unrelated to the interview. Distractibility is rated when the patient shows a change in the focus of attention as characterized by a pause in speech or a marked shift in gaze. Patient's attention may be drawn to noise in adjoining room, books on a shelf, interviewer's clothing, etc. Do not rate circumstantiality, tangentiality, or flight of ideas. Also, do not rate rumination with delusional material. Rate even if the distracting stimulus cannot be identified.

- 2 Very Mild
Generally can focus on interviewer's questions with only 1 distraction or inappropriate shift of attention of brief duration.
- 3 Mild
Patient shifts focus of attention to matters unrelated to the interview 2-3 times.
- 4 Moderate
Often responsive to irrelevant stimuli in the room, e.g., averts gaze from the interviewer.
- 5 Moderately Severe
Same as above, but now distractibility clearly interferes with the flow of the interview.
- 6 Severe
Extremely difficult to conduct interview or pursue a topic due to preoccupation with irrelevant stimuli.
- 7 Extremely Severe
Impossible to conduct interview due to preoccupation with irrelevant stimuli.

23. **MOTOR HYPERACTIVITY:** Increase in energy level evidenced in more frequent movement and/or rapid speech. Do not rate if restlessness is due to akathisia.

- 2 Very Mild
Some restlessness, difficulty sitting still, lively facial expressions, or somewhat talkative.
- 3 Mild
Occasionally very restless, definite increase in motor activity, lively gestures, 1-3 brief instances of pressured speech.
- 4 Moderate
Very restless, fidgety, excessive facial expressions or nonproductive and repetitious motor movements. Much pressured speech, up to one third of the interview.
- 5 Moderately Severe
Frequently restless, fidgety. Many instances of excessive nonproductive and repetitious motor movements. On the move most of the time. Frequent pressured speech, difficult to interrupt. Rises on 1-2 occasions to pace.
- 6 Severe
Excessive motor activity, restlessness, fidgety, loud tapping, noisy, etc. throughout most of the interview. Speech can only be interrupted with much effort. Rises on 3-4 occasions to pace.
- 7 Extremely Severe
Constant excessive motor activity throughout entire interview, e.g., constant pacing, constant pressured speech with no pauses, interviewee can only be interrupted briefly and only small amounts of the relevant information can be obtained.

24. MANNERISMS AND POSTURING: Unusual and bizarre behavior, stylized movements or acts, or any postures which are clearly uncomfortable or inappropriate. Exclude obvious manifestations of medication side-effects. Do not include nervous mannerisms that are not odd or unusual.

- 2 Very Mild
Eccentric or odd mannerisms or activity that ordinary persons would have difficulty explaining, e.g., grimacing, picking. Observed once for a brief period.
- 3 Mild
Same as “2,” but occurring on two occasions of brief duration.
- 4 Moderate
Mannerisms or posturing, e.g., stylized movements or acts, rocking, nodding, rubbing or grimacing observed on several occasions for brief

periods or infrequently but very odd. For example, uncomfortable posture maintained for 5 seconds more than twice.

- 5 Moderately Severe
Same as “4,” but occurring often, or several examples of very odd mannerisms or posturing that are idiosyncratic to the patient.
- 6 Severe
Frequent stereotyped behavior, assumes and maintains uncomfortable or inappropriate postures, intense rocking, smearing, strange rituals, or fetal posturing. Subject can interact with people and the environment for brief periods despite these behaviors.
- 7 Extremely Severe
Same as “6,” but subject cannot interact with people or the environment due to these behaviors.

DASS

Please read each statement and choose the answer that indicates how much the statement applied to you OVER THE PAST 3 MONTHS. There are no right or wrong answers. Do not spend too much time on any statement. Circle the appropriate number on the left using the following rating scale:

- 0 = Did not apply to me at all
 1 = Applied to me to some degree, or some of the time
 2 = Applied to me a considerable degree, or a good part of the time
 3 = Applied to me very much, or most of the time

- | | | | | |
|---|---|---|---|--|
| 0 | 1 | 2 | 3 | 1. I found myself getting upset by quite trivial things |
| 0 | 1 | 2 | 3 | 2. I just couldn't seem to get going |
| 0 | 1 | 2 | 3 | 3. I had a feeling of faintness |
| 0 | 1 | 2 | 3 | 4. I experienced breathing difficulty (eg, excessively breathing, breathlessness in the absence of physical exertion) |
| 0 | 1 | 2 | 3 | 5. I felt sad and depressed |
| 0 | 1 | 2 | 3 | 6. I found it hard to calm down after something upset me |
| 0 | 1 | 2 | 3 | 7. I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion |
| 0 | 1 | 2 | 3 | 8. I found myself getting impatient when I was delayed in any way (eg, elevators, traffic lights, being kept waiting) |
| 0 | 1 | 2 | 3 | 9. I found myself in situations that made me so anxious I was most relieved when they ended |
| 0 | 1 | 2 | 3 | 10. I tended to over-react to situations |
| 0 | 1 | 2 | 3 | 11. I found myself getting upset rather easily |
| 0 | 1 | 2 | 3 | 12. I felt that I had nothing to look forward to |
| 0 | 1 | 2 | 3 | 13. I couldn't seem to experience any positive feeling |
| 0 | 1 | 2 | 3 | 14. I found that I was very irritable |
| 0 | 1 | 2 | 3 | 15. I was aware of the dryness of my mouth |
| 0 | 1 | 2 | 3 | 16. I felt that I had lost interest in just about everything |
| 0 | 1 | 2 | 3 | 17. I could see nothing in the future to be hopeful about |
| 0 | 1 | 2 | 3 | 18. I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increasing, missing a beat) |
| 0 | 1 | 2 | 3 | 19. I felt scared without any good reason |
| 0 | 1 | 2 | 3 | 20. I felt that life wasn't worthwhile |
| 0 | 1 | 2 | 3 | 21. I felt that I was rather touchy |
| 0 | 1 | 2 | 3 | 22. I felt that I was using a lot of nervous energy |
| 0 | 1 | 2 | 3 | 23. I couldn't seem to get any enjoyment out of anything I did. |
| 0 | 1 | 2 | 3 | 24. I had a feeling of shakiness (e.g., legs going to give) |
| 0 | 1 | 2 | 3 | 25. I felt down-hearted and blue |

CONTINUED ON THE NEXT PAGE

- 0 = Did not apply to me at all
 1 = Applied to me to some degree, or some of the time
 2 = Applied to me a considerable degree, or a good part of the time
 3 = Applied to me very much, or most of the time

- | | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 26. I found it difficult to work up the initiative to do things |
| 0 | 1 | 2 | 3 | 27. I found it hard to wind down |
| 0 | 1 | 2 | 3 | 28. I was intolerant of anything that kept me from getting on with what I was doing |
| 0 | 1 | 2 | 3 | 29. I had difficulty swallowing |
| 0 | 1 | 2 | 3 | 30. I feared that I would be "thrown" by some trivial by unfamiliar task |
| 0 | 1 | 2 | 3 | 31. I felt that I was pretty worthless |
| 0 | 1 | 2 | 3 | 32. I was unable to become enthusiastic about anything |
| 0 | 1 | 2 | 3 | 33. I was worried about situations in which I might panic and make a fool of myself |
| 0 | 1 | 2 | 3 | 34. I was in a state of nervous tension |
| 0 | 1 | 2 | 3 | 35. I felt that I was close to panic |
| 0 | 1 | 2 | 3 | 36. I felt I wasn't worth much as a person |
| 0 | 1 | 2 | 3 | 37. I found it difficult to relax |
| 0 | 1 | 2 | 3 | 38. I felt terrified |
| 0 | 1 | 2 | 3 | 39. I experienced trembling (e.g., in the hands) |
| 0 | 1 | 2 | 3 | 40. I found myself getting agitated |
| 0 | 1 | 2 | 3 | 41. I felt that life was meaningless |
| 0 | 1 | 2 | 3 | 42. I found it difficult to tolerate interruption to what I was doing. |

Singlelis – SCS

Directions: Read each statement carefully and circle one number per question indicating the extent to which you agree or disagree with the statement. Do not circle the words. Answer questions based on the last 3 months or since your last assessment.

1. If my brother or sister fails, I feel responsible

strongly disagree 1 2 3 4 5 6 7 strongly agree

2. I prefer to be direct and forthright when dealing with people I've just met.

strongly disagree 1 2 3 4 5 6 7 strongly agree

3. I have respect for the authority figures with whom I interact.

strongly disagree 1 2 3 4 5 6 7 strongly agree

4. It is important for me to maintain harmony within my group.

strongly disagree 1 2 3 4 5 6 7 strongly agree

5. I value being in good health above everything.

strongly disagree 1 2 3 4 5 6 7 strongly agree

6. Even when I strongly disagree with group members, I avoid an argument

strongly disagree 1 2 3 4 5 6 7 strongly agree

7. I feel comfortable using someone's first name soon after I meet them, even when they are much older than I am.

strongly disagree 1 2 3 4 5 6 7 strongly agree

8. I enjoy being unique and different from others in many respects.

strongly disagree 1 2 3 4 5 6 7 strongly agree

9. I respect people who are modest about themselves.

strongly disagree 1 2 3 4 5 6 7 strongly agree

10. I should take into consideration my parents' advice when making education/career plans.

- strongly disagree 1 2 3 4 5 6 7 strongly agree
11. Being able to take care of myself is a primary concern for me.
- strongly disagree 1 2 3 4 5 6 7 strongly agree
12. My personal identity independent of others is very important to me.
- strongly disagree 1 2 3 4 5 6 7 strongly agree
13. I act the same way no matter who I am with.
- strongly disagree 1 2 3 4 5 6 7 strongly agree
14. It is important to me to respect decisions made by the group.
- strongly disagree 1 2 3 4 5 6 7 strongly agree
15. I often have the feeling that my relationships with others are more important than my own accomplishments.
- strongly disagree 1 2 3 4 5 6 7 strongly agree
16. My happiness depends on the happiness of those around me.
- strongly disagree 1 2 3 4 5 6 7 strongly agree
17. I will stay in a group if they need me, even when I am not happy with the group.
- strongly disagree 1 2 3 4 5 6 7 strongly agree
18. I'd rather say "No" directly, than risk being misunderstood.
- strongly disagree 1 2 3 4 5 6 7 strongly agree
19. I will sacrifice my self-interest for the benefit of the group I am in.
- strongly disagree 1 2 3 4 5 6 7 strongly agree
20. I would offer my seat in a bus to my professor.
- strongly disagree 1 2 3 4 5 6 7 strongly agree
21. I am comfortable with being singled out for praise and reward.
- strongly disagree 1 2 3 4 5 6 7 strongly agree

22. Having a lively imagination is important to me.

strongly disagree 1 2 3 4 5 6 7 strongly agree

23. I am the same person at home that I am at school.

strongly disagree 1 2 3 4 5 6 7 strongly agree

24. Speaking up during a class is not a problem for me.

strongly disagree 1 2 3 4 5 6 7 strongly agree

Religious Coping Activities Scale

Please read the statements listed below and for each statement please indicate to what extent each of the following was involved in your coping with having/having a relative with schizophrenia. Answer questions based on the LAST 3 MONTHS or SINCE YOUR LAST ASSESSMENT. Please use the following scale to record your answers.

1 = not at all
2 = somewhat
3 = quite a bit
4 = a great deal

1. Trusted that God would not let anything terrible happen to me.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

2. Experienced God's love and care.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

3. Realized that God was trying to strengthen me.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

4. In dealing with the problem, I was guided by God.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

5. Realized that I didn't have to suffer since Jesus suffered for me.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

6. Used Christ or other religious figure as an example of how I should live.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

7. Took control over what I could and gave the rest to God.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

8. My faith showed me different ways to handle the problem.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

9. Accepted the situation was not in my hands but in the hands of God.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

10. Found the lesson from God in the event.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

11. God showed me how to deal with the situation.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

12. Used my faith to help me decide how to cope with the situation.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

13. Tried to be less sinful.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

14. Confessed my sins.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

15. Led a more loving life.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

16. Attended religious services or participated in religious rituals.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

17. Participated in religious groups (support groups, prayer groups, Bible studies.)

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

18. Provided help to other members of my religious community.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

19. Felt angry with or distant from God.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

20. Felt angry with or distant from the members of the religious community.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

21. Questioned my religious beliefs and faith.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

22. Received support from the clergy (for example, pastors, priests, rabbis, etc.).

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

23. Received support from other members of the religious community.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

24. Asked for a miracle.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

25. Bargained with God to make things better.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

26. Asked God why it happened.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

27. Focused on the world-to-come rather than the problems of this world.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

28. I let God solve my problems for me.

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

29. Prayed or read the Bible or other religious text to keep my mind off my problems

1 = not at all 2 = somewhat 3 = quite a bit 4 = a great deal

Consumer Satisfaction

Using the following scale, how satisfied were you with today's session?

Very Dissatisfied

Somewhat Satisfied

Very Satisfied

1

2

3

4

5

6

7

What did you think of today's session?

What would you like to focus on in the next session?

Please provide any additional comments if you wish?

APPENDIX B: QUALITATIVE SATISFACTION DATA

THE ROLE OF COLLECTIVISM AND SPIRITUAL/RELIGIOUS COPING ON PATIENT AND FAMILY MEMBER FUNCTIONING IN SCHIZOPHRENIA AND THE FEASIBILITY OF A CULTURALLY INFORMED GROUP THERAPY FOR SCHIZOPHRENIA

Table 5

Patient open-ended responses to: *What did you think of today's session?*

- ! I enjoyed being in a group session
- ! Good
- ! Great
- ! It brought me peace of mind to share what was on my mind
- ! OK
- ! Very good session. However, I need more work in this dynamic or component
- ! I think today's session was great
- ! Educational
- ! Very meaningful, thank you
- ! Educational and deep full of information
- ! It resurfaced the fear I have of not being a positive influence on my family
- ! It was fine
- ! Pretty interesting
- ! Very informative
- ! It was focusing on a loss, and what could be gained from that experience
- ! Good
- ! Wonderful
- ! Education
- ! Very helpful. Good to share
- ! Good info provided by all
- ! Wonderful! As always
- ! It wasn't as lively as other session but still enjoyed it
- ! Good open dialogue
- ! Today's session was very informative. I have learned a lot
- ! Today session was informative
- ! Allowed me to really think more about my biological family
- ! I think I talked too much and commandeered the session
- ! Good
- ! Very good and very glad I am forward in my life. As far as relationships
- ! Educational
- ! Very good - intensive
- ! Very enlightening, insightful

- ! I think it was good. I got to explain my anxiety about making phone calls
- ! Very engaging
- ! The session was nice
- ! It was entirely educational, and well prepared. (Group Leader 1) and (Group Leader 2) - are like lifesavers - psychological
- ! Insightful helpful
- ! Good
- ! Great problem solving and learn a lot about depression/anxiety
- ! Comforting
- ! Not intensive enough, not managed successfully. Otherwise good
- ! Good information discussed
- ! It was very helpful to find people that are going through the same situation as me. People who have experience some of the things that I have experience
- ! Interesting of knowing other patients
- ! It was good to learn more about my disease
- ! Very informative
- ! Excellent I have been waiting for a long time for the staff to have a session on schizophrenia
- ! Realizing what (Patient) did for us
- ! Very helpful
- ! I learned a lot. And the group is speaking out more
- ! Educational
- ! Very extensive - very good, lot of input from everybody
- ! Another great session, a lot of info floated around
- ! It was great
- ! Informative, especially of hormones
- ! I think it was good to split time between how we did last week and the questionnaire
- ! Was very informative in coping with stress
- ! Informative
- ! Excellent. I'm learning more about mental illness. I'm grateful for the University of Miami for conducting, offering such group meeting
- ! Very well directed toward medication effects
- ! Good
- ! Really great
- ! Very good, good problem solving and small step solutions
- ! Educational
- ! Very good, gave me quite an insight
- ! Good information discussed by all
- ! It was a good session. I learned a lot going over the facts about schizophrenia

- ! Tackling hard news
- ! Very comprehensive
- ! Very interesting, all aspects, parent, caretaker, patients perspective
- ! Excellent great discussion
- ! Learning the difference between real or fancied events
- ! Good
- ! I was very good
- ! I think the session was up lifting
- ! Inspiring
- ! Excellent topic for discussion at the right time
- ! Excellent!
- ! Not too stressful. Glad I have time to ease into the group
- ! Open
- ! Today session was very insightful
- ! Very lively and full of answers
- ! Good
- ! Good
- ! Very good
- ! Lots of shared info from everybody. I'm honored to be part of such personal info shared
- ! Another great topic discussed
- ! Wonderful as usual
- ! It was good
- ! I felt bad about not having too much to say but feel the goals will help me in the future
- ! Allowed me to share some things with my family
- ! Relaxing
- ! Interesting. I have learn the importance of communicating well
- ! Interesting
- ! Good
- ! Very insightful/thought provoking
- ! Thanks
- ! Great topic and info shared
- ! Excellent!
- ! I thought that maybe I didn't describe existentialism well enough. I learned some possible solutions to the problems I had
- ! I think that the session was great
- ! It was somewhat closed and people didn't really open up as much as they could have
- ! Very interesting
- ! Informative
- ! Really great!!

- ! It was very good. I really learn something
- ! Educational and relaxing
- ! It brought me a lot: insight, understanding, etc. I can't wait for next session
- ! I love the session
- ! Another great session got better use out of example
- ! Wonderful as usual
- ! It covered a lot of ground on what we were doing
- ! It was good
- ! It was great this was my first time
- ! Found it enjoyable
- ! Today's session was mind opening. It refresh my mind of the importance of great communication
- ! A good session
- ! I feel very good that I am learning better communication skills
- ! I was very good because it open everyone up
- ! Great
- ! Lots of opportunities to learn communication patterns
- ! Very helpful
- ! Good, it helped me get closer to work out my problem of getting a job
- ! Informative
- ! It was very interesting to listen to other people with mental illness
- ! Pretty good to be assertive
- ! I enjoyed the session today. It feels good to know I'm not alone in my illness
- ! Very helpful. Give one an outlook on how to solve problems
- ! Very specific and well directed
- ! Good, informative
- ! Helpful, encouraging
- ! Good
- ! The communication session is really helpful in my general life. Also learn how to communicate with my recovery consumers
- ! Educational. Comforting
- ! Great!
- ! It was difficult for me since I was the only patient there and the focus was on me
- ! Very positive
- ! Interesting
- ! Good
- ! It really gave me time to debrief
- ! Great
- ! Lots of input from others
- ! Informative, some ideas I really like
- ! Very interesting

- ! It was nice having so many people around once you get over the anxiety of getting over the initial introduction
 - ! It was good
 - ! It was fun
 - ! Personal relationships
 - ! Very interesting - everybody involved
 - ! Very helpful. Will help me approach problem solving differently.
 - ! There were a lot of problem solving techniques discussed
 - ! Today's session was helpful
 - ! Very good and it got the group to be very expressive
 - ! Great
 - ! Excellent
 - ! Great to release
 - ! Good session, I learned a lot of ideas about losing weight. I look forward to having a place to go over my problems
 - ! Learn a lot
 - ! I am new to the meeting. Today is my first day participating in group meeting
 - ! Very specific in solving the problem
 - ! Good
 - ! Very good, understanding and comprehension.
 - ! Comforting
 - ! Taught me more about dealing with others, anxiety, depression
 - ! Excellent and informative
 - ! I feel there was a lot to deal with since my mom and I were by ourselves
 - ! Good
 - ! It was informative
 - ! Very informing
-

Table 6
 Family member open-ended responses to: *What did you think of today's session?*

- ! I liked having more people in the group
- ! Good - discussing family dynamics is important
- ! Since this was our first it was a little awkward. I think I will feel more comfortable as time goes by
- ! Very good and informative
- ! I learned I need to treat my mentally ill son with more respect and dignity - as I would any other adult
- ! Very enlightening - made me think
- ! It was interesting because I saw things (family and relationships) from a different perspective
- ! I learn a lot about other people (in the group) peoples and how to act about it
- ! I was very constructive in regards to see how the mental illness is clearly defined that environmental involvement with support will always be needed
- ! Good starting point for family
- ! Excellent - shared being hurt by kids during surgery
- ! It was good to meet other people who have the illness and family members
- ! Great topic! Family plays a very important role in mentally ill people
- ! I'm glad it's a practical oriented group
- ! Good ideas and suggestions
- ! Good
- ! Very uplifting
- ! Members gave good advice: Replacing one addiction for some other pleasurable non-harmful item
- ! Short
- ! Learned several new ideas. Identified with what others were saying
- ! It was interesting; I'm glad to have a new member
- ! Some of the group felt more willing to talk about their problems and even if they could not find a solution. It was good for them and I think that would bring some relief to them
- ! Wide ranging
- ! I liked it. It was very safe and comfortable
- ! More open communication. Good session learned a lot
- ! Great. (Group Leader) very good
- ! It was good and helpful
- ! It was very interesting to hear different perspectives on how to balance family involvement
- ! I think it was helpful in getting (Patient) and I to talk
- ! Good opportunity to share

- ! Very good - I felt more comfortable sharing
- ! It was excellent to see participation of (Patient) and (Patient)
- ! Learned people with Sz could actually participate in a group discussion - gives hope
- ! Very helpful/practical
- ! It is nice to hear from other people solutions to similar problems
- ! Very revealing while difficult. Made me think and reflect
- ! Nice
- ! Great
- ! It was great! Everyone sharing their experiences is very helpful
- ! Very good. It helped me think about the differences in personalities
- ! Good to review symptoms of schizophrenia with family members present
- ! Lots of information discussed
- ! I was actually comfortable with my first session
- ! Very participatory by all attending
- ! Learned some more about SZ
- ! It was very informative
- ! Very interesting. Learn a lot about the sickness and how to treat and respond to people affected with it
- ! More open discussion more revealing about participants
- ! Wished for more feedback on issues presented
- ! Loved listening to others share in group today
- ! Good info
- ! Very informative and helpful
- ! Very helpful
- ! Very good
- ! Learned lots of information from participation
- ! Very interesting and helpful. A larger group provides more perspective
- ! Very informative as always. A lot of helpful information
- ! Good discussion of stress and coping. Open discussion was good
- ! Learned lots - good to speak of other parents
- ! It was inspiring
- ! Good interaction by participants
- ! Everyone participated - it was great!
- ! Very enlightening by the participation specially of the young clients
- ! Good
- ! It was ok
- ! It was good to be back
- ! Helpful with access to resources
- ! Enlightening
- ! Sort of sobering
- ! Great conversation and feedback with therapist and family

- ! Very interesting - learned more on stress and body functions
- ! Wonderful insight
- ! Great session - helped me with insight into (Patient)'s illness
- ! It allowed me to understand better how to relate to (Patient) our son
- ! I loved what (Patient) contributed to our group. It helped by what he said to apply it to our son
- ! Good to know
- ! Helpful to put sick folks together for support
- ! Very helpful; interesting discussion
- ! I like the sharing of ideas and heard to different opinions
- ! Interesting - different perspectives
- ! Very satisfying and good communication
- ! Great!
- ! Great
- ! It was a great group
- ! It was great
- ! Great
- ! Good
- ! Interesting
- ! I think the spirituality discussion helped me better get to know the group better
- ! Good, excellent
- ! Interesting, informative.
- ! Very helpful, interesting to listen to the other members stories
- ! I liked it. I liked the mountain exercise because the idea of stillness around the weather made me realize I could use it in daily life
- ! Very calming and informative
- ! Meditation always helpful
- ! Nice
- ! The session was great! I felt very welcomed. I look forward to coming next week
- ! Very helpful discussions
- ! Very informative and helpful to trigger and interest to learn about spiritual development and applying it to more mental health
- ! The handout was very well organized and I can tell it will be helpful for the future
- ! Probably a little too off track
- ! Great
- ! Good sharing
- ! Very good a lot of ideas were interchanged and a lot of learning
- ! It helped me to understand more about similar issues that schizophrenia individuals deal with
- ! I thought it was helpful and encouraging. Safe, informative, overall, I was glad I participated

- ! Insightful and helped with issues
- ! Interesting stuff on stress. Meditations are okay, I find I don't hear words after a while
- ! I enjoyed listening to other people's opinions and suggestions
- ! Very interesting
- ! Wonderful - made me focus on communication - listening to other person
- ! Good because our son was participating and stayed the whole session
- ! Good interaction - 2 good new members
- ! Identified similar solutions
- ! There was a lot of input on active listening and it was very helpful
- ! All members were very cooperative and we got good answers to questions asked
- ! I think it was very resourceful and educational in understand more the issues that mentally ill individuals deal or cope with, such as communicating
- ! Wonderful introduction to the group, very good facilitator and I already learned a great deal
- ! I thought it was very clarifying and informative. It's great to have a forum to discussion everything. Thank you
- ! Very engaging and good topic
- ! Very interesting
- ! Good group interaction
- ! Very good exercises for communication!
- ! Great, very useful
- ! Excellent. Helped me remember more good things about communication with my son
- ! It went well
- ! Great - learned a great deal
- ! It was a good introduction. The teachers and participants were very pleasant, and the class was helpful
- ! Very good. I learned a lot about other people
- ! I wish (Patient) had been more involved.
- ! Great participation by clients
- ! Our son came tonight - we have been working on this for a long time
- ! Good communication skills
- ! Good
- ! It was very helpful.
- ! Many things were clarified. I think we can use many ideas back home. We'll see!
- ! It was very educational and sharing among participants regarding schizo's symptoms
- ! Good lesson on expressing negative points of view
- ! I enjoyed meeting group members and comments on the topics discussed
- ! I thought it well
- ! Good discussion
- ! Parents sharing about their personal experiences is tremendously helpful

- ! I think that more practice about communicating it makes it better and with greater understanding about issues that have been spoken about. In short, practice makes perfection!
- ! Good skills
- ! Great the fact that my brother was being involved
- ! It was great practicing the communication skills. It gives us a way to practice real life situations
- ! Very helpful
- ! Great, specially our (Patient)'s participation
- ! Very pleased that discussion came around to help (Patient)!!
- ! Interesting, I like problem-solution process
- ! It was very helpful. I appreciate the time spent on my problem
- ! I thought it was very helpful in solving my problem
- ! Very productive. It is nice to hear other people opinions and advice
- ! It was very educational and thoughtful. It helps all of us to think and use common solutions to share with each other
- ! Great oppty to solve long-term problem
- ! Great communication and helpful tips
- ! Love listening to others share their personal experiences. Also, the focus on problem solving was very helpful
- ! Enjoyed the session
- ! A lot of information - more practice with problem solving
- ! Very good, (Patient) was able to express having been helped by the problem solving discussion in his relationships with others at ALF
- ! Helped me think about how and need for having more patience to myself and other - also adjust my expectations with myself and others
- ! Too much time on one member
- ! A+
- ! Small groups are more effective; it's nice to have plenty of time
- ! Today, information of coping solving problems it is wonderful. We all worked together to put a set of setting limits
- ! Good oppty to meet the group
- ! Thorough approach to solving problems
- ! Excellent. I got a lot of the discussions
- ! Very profitable
- ! Problem solving: Breaking the problem down, looking for solutions, and to look at all of the options gives us hope
- ! Very concrete suggestions
- ! Good session. (Group Leader)- thanks for your help and guidance
- ! Great, learned a lot

- ! I loved the "summing up" at the end. Everyone had good ideas = it was good to hear what others think - helped me to clarify my idea
 - ! Very applicable to a lot of problems
 - ! It was full of good information, especially regarding sleep aids
 - ! Was a very good meeting. It was good participation from everybody
 - ! As always it was helpful, but difficult
 - ! It was good. Good involvement for all members
 - ! Very helpful, perhaps help me to eliminate some stress in my mother daughter relationship
-

Table 7

Patient open-ended responses to: *What would you like to focus on in the next session?*

- ! Opening up more
- ! Getting along
- ! Family goals
- ! On the love of my family - but feeling judged
- ! Memory
- ! More interview of the support of the family and the mentally ill person of the family
- ! I would like on the next session is for each person to open up with their ideas to get better
- ! Medication
- ! More on how to have confidence in family in telling them about my conditions
- ! I'm not sure, since we're focusing on family and how we're doing is fine
- ! Blood relatives and close friend relationships
- ! Emotional issues
- ! Family and relationship
- ! Stigma, labels
- ! Self-esteem
- ! Feeling included by my family
- ! Doing and talking about the family is fine
- ! The topics seem to be good as we go along
- ! These discussion on mental illness
- ! I would like to hear discussion of people who suffer different types of mental illness
- ! My family
- ! Family
- ! Please help me move forward in my life
- ! Invasion off privacy. Discrimination. Violation of right
- ! My goals
- ! My progress on reaching out and interacting with others
- ! Whatever the staff introduce
- ! Dating solutions
- ! Kindness in dealing with each other
- ! You guys know what's best
- ! More of the same info
- ! Continue going through the symptoms explanations
- ! Next topic
- ! Continue learning more about the different aspects of schizophrenia.
- ! The biology of the disease sounds interesting
- ! More discussion on mental illness schizophrenia
- ! Interpersonal relationships

- ! Not fighting with mom
- ! Genetic predisposition
- ! Staying focus
- ! Continue building on the same
- ! Scheduled discussion
- ! Any info. additional
- ! Just keep on doing what we've been doing
- ! Learning more
- ! What cause mental illness?
- ! More medication orientation.
- ! Family
- ! Ecology
- ! Maintain tolerant and low key home atmosphere
- ! Just keep doing what we did before about checking in and going over educational material about mental illness
- ! More listening for me
- ! About to deal with stress of life
- ! I would like more discussion on mental illness
- ! How medication works
- ! Spiritual focus
- ! Whatever is next
- ! I would like to focus on that I can no control everything in my life
- ! Continue to build on this info
- ! Continue with today's questionnaire
- ! Life planning on how to be able to handle the anxiety of dealing with daily life such as making a living
- ! To continue the discussion on spirituality existentialism
- ! Family planning and spirituality
- ! Communicating to be left alone
- ! Since it's on communication, maybe how I can communicate what I'm going through with my mother
- ! Continue discussion
- ! Family
- ! Religion
- ! Some of the same last week
- ! Getting deeper into spiritual understanding
- ! I don't know yet
- ! What was proposed seems interesting
- ! Spirituality
- ! The continuation of today's topic
- ! More spiritualism

- ! Secret sign language
- ! Experience negative feeling w/ behavior
- ! Life without medication. Return to work
- ! More of the same with role playing
- ! See how the meeting we talked about works
- ! Expressing my feelings
- ! Whatever topic the staff choose
- ! -Making a positive request-
- ! How not to offend a person when speaking
- ! How to community effective to survive as a mental ill person
- ! Continue
- ! How to get over the fright of saying negative feelings
- ! Don't know
- ! The issues I have then
- ! Continuation of session
- ! How was our holiday
- ! Family
- ! Whatever the topic
- ! Getting my life together to the point that I go back to work and help other people
- ! I will be happy when the other patients come back so there will be less focus on me
- ! Information
- ! Talking
- ! Tv show - jazz music
- ! Problem solving in staying focus/relaxing
- ! Stayed focused
- ! Family, anger
- ! Trying to get (Patient) to take his medicine with me
- ! Just any problems that arose from problem solving
- ! One safe
- ! Don't know
- ! Get better
- ! Continuation of today's session
- ! The solutions to my identity problem - a recap -
- ! Motivation
- ! My own recovery
- ! Relocation
- ! Building on more areas of improvement
- ! Just to see if I'm working on my goals and whether I'm successfully working on my diet and goals
- ! Talk more about mental illness
- ! I would like to focus on more problems

- ! Family
 - ! The next topic
 - ! Transitioning to another level independent
 - ! Issues that keeps me at bay
 - ! Next session will deal with family issues which is fine with me. I also will continue to talk about my goals
 - ! Mental illness
 - ! Problem solving
-

Table 8

Family member open-ended responses to: *What would you like to focus on in the next session?*

- ! More about family interaction
- ! More on family dynamics
- ! How to improve our roles
- ! The rest of this session
- ! It would be enjoyable to continue on this subject
- ! It would be nice to keep focusing on same issues to be able to fully understand how this scope could be understood and manage
- ! Family and how to get along
- ! Coping skills
- ! Family and how we can continue to support our mentally ill person
- ! Problem solving
- ! More on independence of family member
- ! Continue learning how to help (Patient)
- ! More of the same
- ! Homework
- ! More about families
- ! Where to find resources
- ! I would like to be able to feel the ability to talk about relationships with my family, my dad in specific
- ! Our next assignment
- ! How family can provide support
- ! This topic is very interesting
- ! Concrete planning, like budgets
- ! Continue to interact with group
- ! Positive reinforcement for my son
- ! Wellness
- ! How to communicate better with SZ son
- ! The same
- ! Solutions
- ! Dos and don'ts for the family member to make them comfortable
- ! Effects of pot
- ! Medications that the patients take
- ! How to deal with SZ in loved one. Discuss ways to help the person with SZ
- ! Going great so far. I'm learning a great deal
- ! More about reacting to negative and positive symptoms. Also more examples of negative and positive symptoms

- ! Managing this schizophrenia or coping
- ! How to decrease stress
- ! How to be more expressive at reducing schiz. symptoms
- ! The same
- ! Eager to find out how the family (and I) can help
- ! Drug therapy
- ! Learning - no idea
- ! I think it happens spontaneously. It's the love in the room that matters
- ! Spirituality
- ! Same
- ! Dealing with my son in a positive fashion
- ! New resource info
- ! Myself - more listening
- ! How to set "realistic" expectations
- ! Money and budgets
- ! How to better understand other's perspective
- ! More to understand spirituality
- ! Medicine
- ! More of the same
- ! Religion and mental health. More about religious aides - music, art, poetry
- ! What we're doing next
- ! I'm open
- ! Similar topics
- ! Relationships
- ! Mindfulness
- ! Learn from others what works for them
- ! Open
- ! Continue this
- ! Dealing with unhappy memories
- ! I like the spirituality part of it
- ! I have nothing in particular
- ! Continue on the mindfulness, spirituality
- ! More emotional intelligence and reaching out
- ! Communication
- ! I like to discuss about what is the best communicational skill to use with my son
- ! I don't know yet, still experiencing everything
- ! How to deal with someone that is not willing to put someone in the hospital
- ! I'm open
- ! Relaxation techniques
- ! More communication and interchange more of our resources and coping skills
- ! To continue with these skills and getting to know the group better

- ! Anger and letting go
 - ! More communication
 - ! Open
 - ! Everything
 - ! I like practicing communication
 - ! I don't know, but I would like to practice communicating with my son with tools learned in this section/class
 - ! Criticism
 - ! Perhaps the fact that my mother can be involved
 - ! Ways to cope with stressful situations as care givers
 - ! Problem solving
 - ! Communication is always a helpful subject
 - ! About coping skills and resources for individual's treatment for schizo
 - ! See how effective new communication works
 - ! More details about communication
 - ! Continue to practice communication skills
 - ! Problem solving to work toward independence
 - ! Continue to encourage (Patient) to come
 - ! Open-session already planned
 - ! Other people's problems! I also hope to see some success in making a plan and deal with my son
 - ! Somebody else's problem
 - ! More of problems and solutions interaction
 - ! Ongoing issues
 - ! Continue the same
 - ! Continued problem solving skills with (Patient)
 - ! More of us
 - ! Same - schedule is great
 - ! More of the same.
 - ! A continuous of setting limits would be excellent
 - ! Practical solving
 - ! Confronting my son on issues of his illness
 - ! Continue problem solving with family sharing!! Making it real
 - ! Ways to work/help (Patient)
 - ! The chosen topic was very helpful. Problem solving is a daily challenge
 - ! More health-related issues
 - ! Keep working on the same subject. What helpful for everybody
 - ! Hopefully bring my brother
 - ! Communication
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Table 9

Patient open-ended responses to: *Please provide any additional comments if you wish?*

- ! I enjoyed myself. Thanks.
- ! Continued of care on the topic of family/mentally ill w/ schizophrenia or schiz affective disorder. Keep opening us up.
- ! I thank the program for its support.
- ! I would like to continue
- ! Very good session everybody participated
- ! I'm very grateful to be part of group meeting
- ! People go through many experiences. It's not so much what is that experience, but it is, what is learned from the occurrence.
- ! Was interesting and helpful
- ! I would like to continue
- ! Thanks for your concern
- ! (Group Leader 1) and (Group Leader 2) are great facilitators
- ! Very helpful
- ! Keep coming back
- ! I been seeing a doctor since 1983, I been getting SSI and SSA since 1984. I would like to enroll in some evening classes so I can return to work.
- ! Thank you for your time, you're doing a wonderful job.
- ! Thank you for group meeting.
- ! I have met really good people here. A family of sorts in itself.
- ! Keep up the good work.
- ! Abuse. Exploitation. Domestic violence. Disturbing
- ! Thank you for such great meeting
- ! -Good session-
- ! Learning about my condition really helps me to understand
- ! We are doing fine.
- ! Very informing
- ! Thank you.
- ! Facts of illness, don't mislead.
- ! Again, thank you for a very informative group session.
- ! I am interested in the psychological aspects of psychiatry.
- ! Very helpful
- ! Everyone too cute
- ! Great!!! :-)
- ! Impersonation. Identity theft
- ! I hope the world would be a better place to live in
- ! I thank the University of Miami for offering group meeting on mental illness.
- ! Helpful

- ! Thank you!
- ! Thank you University of Miami for the meeting.
- ! It was a great session, and I look toward coming again!!
- ! Good
- ! I don't have anything to say right now.
- ! Grateful to be here in sessions
- ! Thank you for a great meeting.
- ! God Bless you, with precious love
- ! Very good
- ! I am very happy with the sessions. I am feeling the difference.
- ! Thank you for holding meetings on mental illness
- ! One more week of spirituality
- ! Thank you all for your help
- ! The guys that I met was wonderful.
- ! I would like to open up more in the group.
- ! Again, thank you for group meetings.
- ! It's very good to listen.
- ! I can't wait for the next session
- ! Learn to communicating properly
- ! Again interesting people. Communication becoming more effective, thanks
- ! Would like to continue group
- ! To communicate my feelings better
- ! Thank you for meeting.
- ! Very professional session!!!
- ! I enjoy the discussions
- ! Very pleased
- ! Was good
- ! Thankful
- ! I was good to see you guys again
- ! I would like to continue these sessions
- ! Trying to get better with my family.
- ! More spiritual session
- ! Thank you always for the meeting.
- ! (Group Leader) is a very professional moderator, and the group is very responsive to the discussions.
- ! I would like to continue
- ! It was good
- ! I hope everyone is in good health for the next meeting.
- ! Topic helps me think about my situation about housing when it comes up
- ! I would like more discussion on mental illness
- ! The fact of the matter is knowing what works for the situation

Table 10

Family member open-ended responses to: *Please provide any additional comments if you wish?*

- ! Session was very helpful
- ! The two leaders in our group are excellent in summarizing a person's thoughts and drawing thoughts out.
- ! I think it is helping me a lot to understand mental illness.
- ! Great session!
- ! It was a very comfortable atmosphere
- ! Extend the session to 15 more min. Thank you, you guys are great :)
- ! Thank you
- ! Thank you.
- ! Thank you!!
- ! Thanks to all
- ! Instructors or leaders are very empathetic.
- ! Enjoy the session very much
- ! Wonderful group of people
- ! Clients were very participating
- ! Thank you :)
- ! Great group
- ! Needed to stay closer to outline
- ! Good session
- ! Good vibes
- ! Very helpful
- ! Understand limits of insight
- ! Thanks
- ! Thank you!
- ! I am glad we are doing it
- ! Overall very helpful
- ! Wonderful group of people
- ! When you said this was the spiritual part what do you mean by it.
- ! Thank you for providing me with the opportunity to participate in this group.
- ! Thanks
- ! We have a great group
- ! Thank you for providing this group to help people and their families dealing with a mental illness.
- ! The class is very helpful. It is relaxing and the sharing is very helpful.
- ! Thank you. This type of experience is very helpful.
- ! Group is doing very well
- ! Very non-threatening environment

- ! I look forward to learning and growing.
 - ! Thank you for your calmness and allowing for the group to express about their personal experiences
 - ! Thanks
 - ! The 2 facilitators are quite skilled in bringing up important subjects.
 - ! Thank you for your patience in guiding the group today and for your suggestions.
 - ! Thanks
 - ! The group is very structured and helpful.
 - ! It was an excellent session with helpful insights.
 - ! I'd like some more technical advice on some decisions
 - ! Thanks.
 - ! This is like gold for me
 - ! Team work is excellent!
 - ! Thank you
 - ! The leaders of the group are very insightful.
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