Family Intervention for Asian Americans With a Schizophrenic Patient in the Family

Sung-Woo Bae, M.S.W., and Winnie Wai-Ming Kung, Ph.D.

A family intervention model designed to meet the unique sociocultural needs of Asian-American schizophrenia patients and their families is proposed. This five-stage model consists of: preparation, engagement, psychoeducational (i.e., survivor skills) workshop, family sessions, and an ending stage. Guidelines and specific suggestions for implementing each of these stages are offered as a means of dealing effectively with Asian Americans' differential value orientations and cultural characteristics.

Since the 1970s' movement to deinstitutionalize America's mental hospitals, many patients discharged into the community have relied on the care and assistance of their families. Because of the high relapse rate and the chronicity of the disorder, families of schizophrenic patients have reported high levels of burden and psychological distress (Test & Stein, 1980; Winefield & Harvey, 1993). At the same time, studies have indicated that the family environment may have a crucial impact on the course of schizophrenia. Specifically, research on "expressed emotions" (EE) has shown that families' overinvolvement, hostility, and critical comments have significant influence on patient relapse (Brown, Birley, & Wing, 1972; Leff, Wig, & Ghosh, 1987; Vaughan, Snyder, & Jones, 1984). Because the family unit remains the most integral component in the community-based rehabilitation of disabled individuals, interest in intervention with families of schizophrenic patients burgeoned.

The numerous attempts made since the late seventies to involve family members in the treatment process have evolved into an approach referred to as family intervention. General reviews of family intervention research have indicated that the modality can have robust effects in delaying relapse, increasing drug compliance, and reducing hospitalization over time. Some evidence of improved patient functioning and family well-being has also been noted (Dixon, Adams, & Lucksted, 2000; Dixon & Lehman, 1995; Lam, 1991; Mari & Streiner, 1994; Penn & Mueser, 1996). However, most of these studies have focused on the mainstream Caucasian population; only a few (McFarlane et al., 1995; Telles et al., 1995) have included African Americans or Hispanics, and we are aware of no family intervention model developed and tested for its effectiveness with Asian Americans. Based on family intervention research, on the mental health literature relating to Asian Americans, and on the authors' personal and professional experience, this paper will propose a model for working with this population.

FAMILY INTERVENTION MODELS

Before describing a family intervention model adapted to fit the needs and culture of Asian Americans, some of the essential elements of models typically used with the general population will be reviewed. The development of family interventions with schizophrenic patients and their families is unique in that these approaches have been verified in controlled outcome research (Simon, 1997).
These treatments are basically “psychoeducational interventions” designed to improve the family environment through programs that provide families with support, information, structure, and specific coping mechanisms in dealing effectively with their ill relatives (McFarlane, 1997). Based on the identified needs of the families and those of the mentally ill patient, these interventions generally have the common goals of: 1) providing necessary information about the illness to family members; 2) helping family members and patients cope with problems in daily living; 3) educating families and patients about the complex mental health network; and 4) providing expert or peer-mediated social and emotional support to patients and families (Bernheim & Lehman, 1984; O'Shea, Bicknell, & Wheatley, 1991).

Drake and Osher (1987), differentiating these family interventions from traditional insight-oriented and family systems approaches in working with families of schizophrenic patients, noted that they are more supportive, more collaborative, more educational, and less intensive. In general, these interventions include both educational and therapeutic components; they offer didactic materials on the etiology, diagnosis, symptoms, course, and treatment of the mental disorder, and they use therapeutic strategies to enhance families’ problem-solving, communication, and management skills (Solomon, 1996).

Need for a Culturally Sensitive Model

Although no study to date has tested the efficacy of family interventions with Asian Americans, there is some evidence of its appropriateness for this population. For many Asians, family is the basic unit of human life (Tseng, Lin & Yeh, 1995; Sue & Morishima, 1982; Yang, 1995). Asian families have been found to be more involved than Caucasians in the process of caring for their mentally ill relatives; they are more likely to accompany the patient for clinic visits and to participate actively in decisions associated with the patient’s entrance into treatment (Lin, Miller, Poland, Nuccio, & Yamaguchi, 1991). A study of 40 Korean-American schizophrenia patients in the urban Los Angeles area indicated that 26 (65%) lived with their parents, other relatives, or both (Bae & Brekke, under review); further, of the 14 patients who did not live with parents, nine had no parent available (they were deceased, residing in Korea, hospitalized, etc.). Family intervention studies by Xiong et al. (1994) and Zhang, Hequin, Yao, and Ye (1993) in mainland China also reported that most schizophrenic patients tended to live with their families. These findings—suggesting that Asian Americans with schizophrenia may be more likely to be affected by their interactions with family members than are Caucasians, and that Asian families can be a potential source of support to their ill relatives—point to the need for effective family intervention strategies.

Generalizability of Family Intervention Models

That family intervention may well be an appropriate treatment for Asian-American schizophrenia patients does not necessarily mean that direct application of available models is warranted. Most family interventions have been based largely on knowledge gained through studies of Caucasian families, whose cultural values and belief systems may well differ from those of Asian Americans. A good “fit” between services provided by the mental health system and the cultural beliefs and practices of clients and their significant others has been found to be an important factor in reducing attrition (Zane, Sue, Castro, & George, 1982) and in attaining positive treatment outcome (Flaskerud, 1986; Lau & Zane, 2000; Sue, Zane, Hu, Takeuchi, & Fujino, 1991).

A few studies within the family intervention literature have also evidenced differential effectiveness across ethnic groups. For example, one study found that multifamily groups, while superior to single-family interventions with highly symptomatic Caucasian patients, were not effective with less symptomatic African-American patients (W. McFarlane, personal communication, 1997). Telles et al. (1995) provided powerful evidence for the interaction effect between treatment and culture; their replication study of behavioral family management with immigrant Hispanic Americans found that treatment did not yield significant improvement for highly acculturated patients, and even exacerbated symptoms for individuals who were less acculturated. In a similar vein, Xiong et al. (1994) reported that many family intervention approaches utilized in the West had to be adapted for the unique family relationships and social environment of patients in Mainland China. All these findings strongly suggest that family interventions require some modification if they are to address the culturally defined needs of particular ethnic populations.
Family Intervention Model for Asian Americans

In explicating this culturally sensitive family intervention model, several issues require clarification at the outset. First, this model is aimed mainly at patients whose schizophrenic symptoms have been stabilized, and who are residing in the community. Routine medication and outpatient clinical management should be available to patients in addition to family intervention, since most family interventions have been provided as part of a treatment package (Lam, 1991). Second, although Asians share many cultural tenets (e.g., valuing collectivism over individualism; regarding family and kinship ties highly; tending toward conservativism and respect for authority, as taught by Confucius), they are not a single ethnic group (Uba, 1994). In addition to the obvious language differences, the historical, social, and economic experiences and conditions of the various Asian-American groups also differ. Thus, the model put forth here is an attempt to suggest a general approach for Asians, one that could further be refined to fit the needs of particular ethnic groups within the population. (Nonetheless, for practical reasons, the program should be administered to cohesive ethnic groups.) Third, as was the case in Telles et al.’s (1995) study of Hispanics, the different levels of acculturation within and across Asian-American groups are an important factor; this model targets mainly first- or second-generation patients and their families, who tend to maintain their traditional culture and values. Fourth, it should be noted that, even within the same ethnic group, people coming from different socioeconomic and urban/rural backgrounds may have different value orientations. (Although lack of staff and the small numbers of patients falling into these refined categories makes it unlikely that such fine distinctions will be applied in practice.) Finally, since no empirical study has examined family interventions with the Asian-American population, the efficacy of the suggested intervention model awaits validation by empirical research.

The model delineated here covers five periods: agency preparation, family engagement, psychoeducational workshop, the therapeutic stage, and the ending stage. Table 1 presents an overview of the model. The interventions involved at each stage will be discussed in detail below.

Table 1

<table>
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<tr>
<th>STAGE</th>
<th>GOALS</th>
<th>CONTENTS</th>
<th>SERVICE FORMAT</th>
<th>FREQUENCY/LENGTH OF INTERVENTION*</th>
</tr>
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<tr>
<td>Preparation</td>
<td>Preparing providers for effective service delivery</td>
<td>• Ethnicity &amp; language match &lt;br&gt;• Awareness of families' diverse acculturation levels &lt;br&gt;• Cultural sensitivity training for clinicians</td>
<td>Staff recruitment &lt;br&gt;Quality training/supervision</td>
<td>Ongoing basis</td>
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<td>Engagement</td>
<td>Aggressive outreach to prevent early dropout</td>
<td>• Collaboration w/community leaders &lt;br&gt;• Orientation to treatment/negotiation of goals &lt;br&gt;• Providing concrete/immediate help &lt;br&gt;• Initial psychoeducation</td>
<td>Home-visit intervention</td>
<td>3–5 sessions</td>
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<tr>
<td>Psychoeducation Workshop</td>
<td>Broad-based family psychoeducation</td>
<td>• Information about managing illness &lt;br&gt;• Survivor skills</td>
<td>Agency-based multifamily groups—excluding patient</td>
<td>Once every 3 mos.</td>
</tr>
<tr>
<td>Therapeutic Stage</td>
<td>1. Individualized family intervention</td>
<td>• Improving family communication &lt;br&gt;• Enhancing problem-solving skills</td>
<td>Single-family sessions: agency-based including patient &amp; immediate family</td>
<td>Biweekly</td>
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<td></td>
<td>2. Facilitating family social support network</td>
<td>• Sharing of coping skills &amp; mutual support</td>
<td>Multifamily support group: agency-based, excluding patients</td>
<td>Monthly</td>
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<td>Ending</td>
<td>Evaluating treatment process</td>
<td>• Assessment of treatment gains &lt;br&gt;• Invitation to return, when/if needed</td>
<td>Single-family session</td>
<td>1–2 sessions</td>
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*Total intervention period of at least nine months.
vant in work with Asian Americans because of their high dropout rate (Sue & McKinney, 1975), the stigma attached to seeking help outside the family (Shon & Ja, 1982), and a particular set of expectations toward clinicians and treatment (Dhooper & Tran, 1987). Two factors—common ethnicity and common language—seem especially salient in establishing a working alliance.

The literature has consistently reported that Asian Americans tend to perceive ethnically similar mental health professionals as more credible and culturally competent than those of other backgrounds (Coleman, Wampold, & Casali, 1995; Gim, Atkinson, & Kim, 1991). These clients also tend to stay longer in treatment with therapists who share their ethnic origin (Flaskerud & Liu, 1991). For many of these Asian-American patients, English is a second language and, for some, their only language. Bae and Brekke (2000) found that 93% of their sample of Korean-American patients either did not speak English or preferred to be interviewed in Korean. It is not hard to imagine that a language barrier between client and service provider could adversely affect the treatment process. Nor is it likely that the use of interpreters can resolve this barrier or obviate problems such as longer therapy times, loss of subtle nuances in clients’ expressions, erroneous translations, client discomfort, and a change in the therapeutic dynamic (Uba, 1994).

Although the family intervention model proposed in this paper is intended mainly for those who subscribe to traditional Asian-American values, there can be wide disparity in clients’ degree of acculturation. Given that variations in acculturation rate have a differential impact on the treatment process (Atkinson & Gim, 1989), it is necessary to assess each family’s level of acculturation so as to tailor the treatment to the family’s needs. Research has suggested that level of acculturation can be estimated using such criteria as years in the U.S.; age at the time of immigration; country of origin (and its political, economic, and educational climate); degree of adherence to ethnic rituals and customs (Aponte & Barnes, 1995; Ho, 1984).

Ensuring clinicians’ cultural sensitivity and competence is another key factor in effective intervention. Thus, it is important at this stage to provide clinicians with knowledge and techniques useful in delivering culturally sensitive services. This entails understanding essential Asian American characteristics, including the high stigma associated with seeking mental health services, hierarchical but interdependent family structure, preference for indirect communication, and the tendency to expect immediate and concrete help (Berg & Jaya, 1993; Gaw, 1982; Ho, 1987; Shon & Ja, 1982; Sue & Zane, 1987; Wilson, Philip, Kohn, & Curry-El, 1993). Although this will be addressed in greater detail below, it is generally recommended that extensive and ongoing training and supervision be provided to mental health workers before and during the actual intervention to ensure their cultural sensitivity and competency.

Stage 2: Engagement

Engaging and maintaining Asian-American clients in treatment has been a major issue for the past two decades. It has been suggested that high dropout rates and underutilization of mental health services on the part of Asian Americans (Sue & McKinney, 1975; Sue & Sue, 1974; Leong, 1986) can be explained by: cultural beliefs, which stigmatize help-seeking as signifying the family’s inadequacy in caring for its own (Uba, 1994); unfamiliarity with the methods and the goals of “talk therapy” (Dhooper & Tran, 1987); and lack of culturally sensitive services (Atkinson & Gim, 1989).

Given these circumstances, the initial engagement of clients is critical in working with Asian Americans. It is likely that families may decide not to participate in the treatment or to drop out prematurely if their unique cultural concerns are not adequately addressed early on. Therefore, more intensive and aggressive engagement strategies are required at this stage to deal effectively with both underutilization of services and early dropout.

Home-based intervention appears to be a treatment of choice for working with this population of schizophrenic patients and their families. In our own clinical experience, we have found that home visits have several advantages. First, in the comfort of their own home, family members’ initial anxiety and uneasiness about seeking help from “outsiders” can be eased. Secondly, families’ concerns about others seeing them seek help from a mental health agency, and their consequent “loss of face,” can be alleviated. Thirdly, home visits also help to decrease the dropout rate, as they demand less time and effort than is required of families going to clinics or agencies. Finally, visiting clients’ homes gives clinicians a chance to observe the dynamics and interactions of the family in a more natural setting, and to involve more family
members. This, in turn, enables clinicians to gain a fuller understanding of the family, and to develop treatment plans best suited to its needs.

While we strongly endorse the use of home-based treatment for purposes of engagement, the literature is inconsistent in its assessment of this mode. In their review of family intervention studies, Dixon and Lehman (1995) concluded that home visits do not appear to be superior to clinic-based treatment. However, in their study in China, Xiong et al. (1994) reported that home visits appeared to minimize subject loss. Similarly, Connery and Brekke (1999), working with African-American families, deemed home visits to be the central element of their family intervention model. It is worth noting that these two studies were conducted with non-Caucasians. In addition, Leff et al. (1989) strongly recommended that when low participation rates are anticipated, group work with relatives should be initiated with one or more family therapy sessions in the home. Depending on a family’s needs and its level of resistance, the number of home visits may differ. It appears that 3–5 sessions are adequate for building an initial rapport with the family and for addressing its immediate concerns. At this engagement stage, the model stipulates addressing several key issues, as outlined below.

Collaboration with community leaders. Many Asian Americans seek help from “health influencers” in their communities. These are often members of the religious sector or traditional health professionals (Cheung & Snowden, 1990; Lin, Inui, Kleinman, & Womack, 1982; Nishio & Birmes, 1987). Since indigenous leaders know the people in the community well, they are also likely to be able to identify individuals in need of mental health services. Thus, it is important for mental health professionals to establish working relationships with these community figures, as a means of outreach. Not only are collaborations with and referrals from local leaders congruent with Asian American cultural expectations, they have also been shown to enhance utilization of mental health services (Flaskerud, 1986).

Negotiation of goals and orientation to service. An individual’s values concerning mental illness are largely determined by cultural, personal, and societal beliefs (Kirmayer, 1989; Kleinman, 1988; Kleinman, Eisenberg, & Good, 1978). Service providers must recognize that many Asian Americans have perceptions and expectations of Western-style mental health treatment that are rooted in their traditional belief systems and value orientations. The discrepancies between service providers and recipients in expectations of treatment and outcome should be actively discussed and negotiated in the engagement stage. This process can help the professionals to adapt mental health services to the specific needs and experiences of the Asian-American client. As Kleinman et al. (1978) pointed out, this process of negotiation may well be the single most important step in engaging the patient’s trust, preventing major discrepancies in the evaluation of therapeutic outcome, promoting compliance, and reducing patient dissatisfaction.

Since many Asian Americans are unfamiliar with the mental health system, a basic orientation is called for. It is helpful to explain that the role of the mental health worker is somewhat different from that of a physician, and to describe some specific functions that will be carried out by the worker (Ho, 1984). To help acquaint families with the forthcoming treatment, intervention stages and the relevant services that will be offered at each stage can be explained. It may also be helpful to point out that the therapeutic process is a mutual one: that worker, patient, and family members must work together to come up with the best solutions, and that input from the patient and the family is crucial to successful treatment. It is important, as well, at this point to acknowledge that initial anxiety over stigmatization is commonly experienced by Asians who seek mental health services, so as to normalize these feelings.

Concrete help. The concept of “gift giving,” i.e., offering direct benefits as early as possible in the treatment, has been described by Sue and Zane (1987) as being especially important with Asian Americans because of their high dropout rate, skepticism about Western forms of treatment, and need for therapists to demonstrate credibility. They suggested that “some of the gifts [immediate benefits] that the therapist can offer include anxiety reduction, depression relief, cognitive clarity, normalization, reassurance, hope and faith, skills acquisition, a coping perspective, and goal setting” (p. 42). In addition, given the immigrant status of many Asian families, they may have human service needs in areas other than mental health (Takeuchi, Mokuau, & Chun, 1992). Thus, it is important that mental health professionals assume case management functions for these families, connecting them to resources in the community at large. Relevant social service may involve medical
needs, financial assistance, child care, employment services, legal aid, and immigration and naturalization processes. Concrete help (e.g., assisting family members in filling out forms, providing translation services) may also enhance the therapeutic alliance (Vandiver & Keopraseuth, 1998).

**Initial psychoeducation.** Our own clinical experience with Asian Americans suggests that many families have very little formal knowledge about the nature, prognosis, and symptomatology of mental illness. Thus, it is essential for clinicians to provide basic orientation in this area, as well, during the home visits.

**Stage 3: Psychoeducational Workshop**

Psychoeducation, an integral component of most family intervention models, is especially important in this population, since Asian-American families generally lack information and the specific skills required to provide optimal care to their mentally ill relatives. While various formats have been utilized in providing psychoeducation for family members (Leff, Kuipers, Berkowitz, Eberlein-Vries, & Sturgeon, 1982; McFarlane et al., 1991; Tarrier et al., 1988; Smith & Birchwood, 1987), the educational component developed by Anderson, Reiss, and Hogarty (1986) has had an especially important impact on subsequent family intervention research and has been adopted as part of most protocols. This agency-based multifamily group workshop, conducted without patients present, attempts to reduce family members' vulnerability to stress, anxiety, and instability by providing information about the nature of schizophrenia and about effective ways of managing the illness.

Application of Anderson et al.'s (1986) day-long psychoeducational workshop does not appear to require any modification for this stage in the present model. If the engagement phase has been successful in dealing with families’ needs and anxiety, and if trust in the clinician and the agency has been established, families will feel comfortable attending a multifamily survivors' skills workshop at the agency. However, the workshop should not be a one-shot. Based on earlier reports (Berkowitz, Eberlein-Fries, Kuipers, & Leff, 1984), family members may recall only a fraction of what they have been told and retain their own versions of the causes of illness. This may be even more likely among Asian-American families due to their lack of familiarity with Western medical terminology and their strong sense of responsibility, which may lead them to blame themselves for their children’s illness. Therefore, it is recommended that the educational workshop be provided on a regular basis, perhaps as frequently as once every three months, to refresh family members’ memories and reinforce the knowledge acquired.

**Stage 4: Therapeutic Stage**

Psychoeducational workshops, while important in helping families learn to cope, cannot adequately address the therapeutic needs of individual families. This is due partly to the didactic nature of the workshops and partly to the absence of patients. Although one recent study (Schooler et al., 1997) indicated that simply providing education, without further clinical intervention, can be as effective as more intensive treatment, the treatment recommendations developed by the schizophrenia Patient Outcomes Research Team (PORT) endorsed the provision of additional clinical services (Lehman et al., 1998). In our experience, individualized services involving both patients and their family members are an essential follow-up to the survivors’ skills workshop. These interventions should be accomplished by two means—single-family sessions and family support groups.

**Single-family sessions.** Since the major goal at this stage is provision of highly individualized clinical treatment to meet the specific needs of each family, a single-family format is suggested. Although McFarlane et al. (1995) reported some gains in client outcome, as well as cost savings, for multifamily groups, compared to single-family treatment, these findings held true for high-EE Caucasian families and patients, but not for African-American families with low EE. The existing literature does not provide clear indication of whether a single-family or multifamily group is more effective for Asian Americans. Our recommendation of single-family as the treatment of choice is based on reports suggesting that Asian Americans are reluctant to admit emotional or psychological difficulties to people outside the immediate family (Ho, 1984). This reluctance, derived in part from cultural beliefs that public disclosure of family conflicts and of the wish to achieve personal fulfillment is a selfish act (Kim, 1973), has led some to conclude that Asians are not good candidates for group therapy (Paniagua, 1994). Thus, therapeutic interventions that involve deeper revelations of emotional vulnerability and familial conflicts, seem best suited to the single-family model.
There is no compelling evidence in the literature that any one intervention strategy is superior to another at this stage (Dixon & Lehman, 1995), although the psychodynamic group approach has been reported to be less effective (Kottgen, Sonnichsen, Molenhaur, & Jurth, 1984, cited in Lam, 1991). With regard to this latter finding, it has frequently been reported that Asian-American clients prefer directive and structured approaches, rather than treatment that is affective, reflective, and insight-oriented (Berg & Jaya, 1993; Leong, 1986; Sue & Sue, 1990). In addition, the common components found across intervention models (Lam, 1991)—emphasis on a positive approach and collaborative relationship, structure and stability, focus on the “here and now,” use of family concepts, cognitive restructuring, behavioral methods, and improved communication—seem to fit well with the needs of Asian families. In particular, communication and problem-solving approaches, which have been found to be highly applicable to Asian-American families (Berg & Jaya, 1993; Ho, 1987; Leong, 1986), are encouraged.

Agency-based intervention is feasible at this point if outreach efforts at the engagement stage have been successful and concerns over contacts with mental health agencies have been reduced. Although eliminating clinicians’ traveling time would make the program more cost-effective, we suggest that home-based intervention be left as an option for those families with less motivation to participate or greater time constraints. Since time constrains apply even if agency treatment is provided, evening or weekend sessions should be arranged to accommodate clients’ schedules.

Family support groups. A prime goal of family intervention models is to increase families’ social network through interactions with clinicians and other family members (Hatfield, 1987). Given the high stigma attached to mental disorders in the Asian population, it is likely that families of the mentally ill are more vulnerable to problems of social isolation. Since single-family sessions do not provide opportunities to interact with other families, a multifamily support group is proposed as a supplement. For reasons already noted, in serving this population, the focus should be more on education and the sharing of coping skills than on exploration of personal feelings (Ho, 1984).

It is recommended that patients be excluded from the family support group. Due to the inclination of Asians to avoid direct confrontation in interpersonal relationships, and their commitment to attaining harmony in the family at all costs, important issues are often not addressed when patients are present. However, our own clinical experience suggests that when patients are excluded, more candid discussion of ways of coping with the mentally ill relative is possible.

During the group sessions, family members should be helped to share their own experiences and encouraged to interact with each other outside the formal meetings. This will aid these families in learning new coping skills, in providing care for their relatives, and in developing a social support network.

Although the frequency and length of the intervention at this stage may vary depending on the characteristics of service providers and recipients, it is recommended that biweekly sessions for individual families and monthly family support groups be offered. The frequency of family sessions may be reduced as the treatment continues; it is important, however, that the intervention be relatively long-term. In keeping with the findings of Tarrier, Barrowclough, and Vaughn (1989), we recommend that the total intervention period be at least nine months in order to sustain treatment effects. Further, to avoid heightening family’s anxiety, consistency of personnel is important; treatment should continue to be provided by the clinician who initiates contact at the engagement stage (Leff et al., 1989).

Stage 5: Ending Stage

Toward the conclusion of treatment, one or two sessions should be scheduled with individual families and patients to evaluate the extent to which the desired goals have been attained. However, complete termination of treatment is rarely appropriate in working with schizophrenic patients and their families. As Anderson et al. (1986) emphasized, ongoing maintenance contacts and consultations are necessary to assist families in dealing with unexpected crisis situations. It is important to make clear to the families that they have the option to come back for additional mental health services whenever necessary.

It is further recommended that the family support group continue to meet infrequently after the formal intervention ends. After almost a year of getting to know one another, these families can often become something akin to a self-help group, thus requiring little from the agency other than a
venue in which to meet. However, the maintenance of the group can provide families with ongoing peer support for practical and emotional needs. In addition, the sustained connection to the agency makes it easier for families to return for help should the need arises.

CONCLUSION
This paper has proposed a family intervention model for Asian Americans with schizophrenia, designed to accommodate the cultural traditions and help-seeking behavior of this population. Five stages in the treatment process have been identified, based on the family intervention literature, research on the use of mental health services by Asian Americans, and the authors’ own experience in working with this population.

The model raises several issues that need to be further explored. First, the proposed intervention needs to be empirically tested for its effectiveness, and to identify those of its components that require further modification. Second, throughout this presentation, greater emphasis has been placed on addressing common cultural characteristics of Asian Americans (e.g., differential value orientations and unique help-seeking behavior) than on individual characteristics within the culture, which include acculturation rate, socioeconomic status, education level, and urban/rural origin of patients and their families. Investigation of the relationship between cultural and individual characteristics is an important area for future research. Finally, since Asian Americans are not a single, homogeneous group, further refinements of the proposed model are needed to address the particular needs of the different Asian ethnic groups.

References


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