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Culturally Adapted Psychosocial Interventions for Schizophrenia: A Review

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

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

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

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

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

Group Therapy for Schizophrenia

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

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

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