Multi-Family Psycho-Education Group for Assertive Community Treatment Clients and Families of Culturally Diverse Background: A Pilot Study

Wendy Chow · Samuel Law · Lisa Andermann ·
Jian Yang · Molyn Leszcz · Jiahui Wong ·
Joel Sadavoy

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Abstract This study evaluates the incorporation of Multi-Family Psycho-education Group (MFPG) to an Assertive Community Treatment Team developed to serve culturally diverse clients who suffers from severe mental illness. Participants included Chinese and Tamil clients and their family members. Family members' well-being, perceived burden, and acceptance of clients were assessed before and after the intervention. Focus group interviews with clinicians were conducted to qualitatively examine MFPG. Family members' acceptance increased after MFPG. Regular attendance was associated with reduction in perceived family burden. Culturally competent delivery of MFPG enhanced family members' understanding of mental illness and reduced stress levels and negative feelings towards clients.

Keywords Cultural diversity · Assertive community treatment team · Multi-family psycho-education · Severe and persistent mental illness

Introduction

Assertive Community Treatment (ACT) is a well-studied, evidence-based, intensive and comprehensive treatment that provides community psychiatric services for persons who suffer from severe and persistent mental illness, such as schizophrenia (Marshall and Lockwood 2000). Many studies have shown that ACT services led to significant reductions in relapse rates and symptoms, as well as improvement in quality of life (Bond et al. 2004; McGrew et al. 2002). The effectiveness of ACT specifically designed for cultural diverse clients has also been demonstrated (Yang et al. 2005).

Schizophrenia often impacts family relationships negatively. Conversely, it has been shown that family burden adversely affects clinical outcomes of clients (Perlick et al. 1992). Family functioning thus remains a key factor influencing the treatment and recovery process. For example, the Schizophrenia Patient Outcomes Research Team (PORT) found that 83% of clients have families living in close vicinity (Lehman and Steinwachs 1998; Solomon et al. 1998), more than 80% have regular contacts with their family members and 40–65% of clients live with one or more family members. Families can be a vital source of support and can contribute to improved quality of life for clients with schizophrenia.

Indeed, family interventions are now considered to be critical components in the treatment of schizophrenia. They have been shown to improve communication between

W. Chow (✉) · S. Law · L. Andermann
Assertive Community Treatment Team and Mental Health Court
Support Program, Community Mental Health Program,
Department of Psychiatry, Mount Sinai Hospital, Joseph and
Wolf Lebovic Health Complex and the University of Toronto,
260 Spadina Avenue, Suite 204, Toronto, ON M5T 2E4, Canada
e-mail: wchow@mtsina.on.ca

J. Yang
Asian Initiative in Mental Health, Toronto Western Hospital,
399 Bathurst Street, East Wing, 9th Floor, Toronto,
ON M5T 2S8, Canada

M. Leszcz · J. Sadavoy
Department of Psychiatry, Faculty of Medicine, University of
Toronto, Mount Sinai Hospital, Joseph and Wolf Lebovic Health
Complex, 600 University Avenue, Toronto, ON M5G 1X5,
Canada

J. Wong
Primary Care Program Design and Development Unit, Ministry
of Health and Long Term Care, 1075 Bay Street, 9th Floor,
Toronto, ON M5S 2B1, Canada

family members and clients, reduce perceived family burden, enhance linkages with the mental health system, increase the rate of follow-up care and medication adherence, reduce the risk of relapse by 15–25%, improve remission of residual psychotic symptoms, encourage employment and enhance social and family functioning (Bustillo et al. 2001; Dixon et al. 2001; Lam and Dominic 1991; Lehman et al. 1995; McFarlane et al. 1995; Sherman et al. 2005).

The McFarlane Multi-Family Psycho-education Group (MFPG) is the leading approach used in North America for families with persons who suffer from severe and persistent mental illnesses (McFarlane et al. 1995). It is designed to teach families coping and problem solving skills, increase knowledge, and develop a support network. Compared to single-family treatments, MFPG has been shown to be especially effective in extending remission for clients who are at high risk for relapse (McFarlane et al. 1995).

A culturally-modified version of MFPG has recently been demonstrated to be effective in a group of non-English speaking, Vietnamese families living with schizophrenia (Bradley et al. 2006). In this study, the authors found significantly lower relapse rate and greater symptom reduction in clients receiving MFPG intervention, compared to a control group receiving standard case management. Interestingly, the Vietnamese participants reported a much higher level of family burden compared to a group of English-speaking clients and families at the start of intervention. This observation necessitates a closer examination of family functioning in ethnic minority groups to identify specific needs that should be addressed in MFPG intervention.

The cross-cultural literature suggests that Asian families are different from mainstream culture in terms of their perceived causes of mental illnesses, help-seeking behaviors and treatment preferences (Sadavoy et al. 2004), in addition to differences in family structure and family dynamics (Lee 1988). For example, studies have described that delayed help-seeking behavior, particularly in culturally diverse groups such as Asian Americans with schizophrenia, may lead to an increase in family burden, poor treatment adherence, higher relapse rates, and lower utilization of follow-up services (Chung and Lin 1994; Kleinman 1980, 2004).

The pressures and stress of mental illness are high for both clients and family members. In the Asian context, this may be particularly remarkable. For example, most Asian family activities are based around the extended family, numerous family meals and gatherings take place throughout the year. A family member who has mental illness is invariably exposed to these family activities. When faced with a member's suffering and symptoms, family members can often feel apprehensive, frustrated,

helpless, and guilty about the condition of the client. They may also worry that psychiatric medications will bring more harm than benefit for the member, and they may express negative opinions about how the member is doing and adversely affect the person's self esteem, treatment adherence, and attitude towards the illness. Issues of stigma associated with mental illness often arise (Sirey et al. 2001). As well, the family member who suffers from mental illness would highly value how he or she is perceived by the rest of the family, as his or her social existence and support network is often contingent upon the ability to function in family interactions; and this ability is a critical measure of the member's level of functioning and recovery—both a source of value and stress. Overall, the family context is important at multiple levels for many Asian clients (Lin and Lin 1980).

The purpose of this study was to explore the acceptance and effectiveness of a time-limited MFPG program using the MFPG with ACT clients and family members from two ethno-cultural minority groups; Chinese and Tamil. For the first time, we also qualitatively examined the dynamics of MFPG in a culturally diverse ACT context from the clinicians' perspective. We hypothesized that the MFPG structure would be acceptable to families and clients of the ACT team. MFPG would also significantly reduce perceived burden and improve psychological and physical well-being for family members. The descriptive aspect of this study would enhance our current understanding of the needs of culturally diverse clients who suffer from severe mental illness and facilitate the design of culturally sensitive treatments.

Methods

This study was carried out by the Mount Sinai Hospital Assertive Community Treatment Team (MSHACTT; Toronto, Ontario, Canada), a unique program designed specifically for underserved clients from culturally diverse backgrounds. The clinical effectiveness of this Team has also been documented (Yang et al. 2005). The MSHACTT provides culturally competent psychiatric treatment and rehabilitation, especially, but not exclusively, to clients from Asian communities. Forty-eight percent of the MSHACTT clients are Chinese, and 20% are Tamil. The rest (32%) are Vietnamese, Korean, and African-Caribbean.

Participants

As an effort to reduce stigma and improve recruitment, a psycho-social conference was held to introduce the project to clients and families at a community restaurant. The team

researcher, three volunteer research assistants and the MSHACT staff interviewed clients and their families for the study. A large majority of clients and families agreed to participate. Potential participants were given orientation about the study purposes and procedures and signed a consent form. The study was approved by the Mount Sinai Hospital Research Ethics Board.

Two cohorts with a combined size of 14 ACTT clients and 20 family members participated in the study. This includes one cohort of Chinese ethnicity (7 clients and 11 family members) and one cohort of Tamil ethnicity (7 clients and 9 family members). Their demographic characteristics are described in Table 1.

Intervention Procedure

The McFarlane approach to MFG was adopted for its broad evidence support and well-developed step-by-step instruction manual for professionals (McFarlane et al. 1991). Prior to its implementation, the McFarlane team trained the MSHACT Team in a two-day interactive role-play workshop. A preliminary survey was used to determine the time, date and venue of the MFPG meetings. Since most Tamil family members were new immigrants and needed transportation assistance, group facilitators offered to pick them up and drop them off before and after meetings. The Tamil group meetings were held at a supportive housing boarding home where most of the Tamil clients resided. In contrast, the Chinese family members and clients preferred to have meetings at the MSHACT office in Chinatown, Toronto. Meetings occurred on weekends at noon, and lunch was provided by the program in recognition of the symbolic importance of eating together in the Asian culture. Group members often brought dishes to share with others.

A 2-hour MFPG session was held once a month for 12 months. Each session was led by a supervisor supported by two group facilitators who spoke the participants' language. These sessions were slightly modified to meet the specific needs of ethno-cultural clients and family members, addressing issues such as stigma and frustration over the long-term pharmacological management (a session-by-session outline is detailed in Appendix). For example, since

most Asian cultures prefer to use alternative medicine for health maintenance over western medication for symptom control, two sessions were dedicated to listening to concerns, such as medication side effects and the continuous use of medication even when clients appear to be functioning normally again. More time was also spent talking about the Canadian mental health system, such as the use of emergency services, inpatient units and long-term care facilities. In addition, during the first three sessions, group facilitators focused on understanding the cultural normalcy of their cohort. Montage and drawings were also used to help participants express how family life might have changed after the onset of mental illness.

Of the 14 clients and their respective family members, 6 (43%) completed the full 12 sessions, 2 (14%) completed 6–9 sessions, and 6 (43%) completed 2–3 sessions.

Quantitative Measure and Statistical Analyses

The Social Adjustment Schedule (SAS), Family Version (Kreisman and Blumenthal 1985) was used. The SAS is a reference scale designed to assess a variety of domains of life satisfaction and perceived mental illness-related burdens for family members. The SAS was translated into Chinese by a bilingual Chinese researcher who had translated a variety of psychological instruments in published studies. The Tamil version of the SAS was developed by a Tamil professional translator. Trained volunteers conducted structured interviews with family members 1 month before and 3 months after the MFPG intervention. Paired *t*-tests were then conducted to examine pre-and post-treatment differences in 16 domains of the SAS scale.

Qualitative Approach

To supplement the quantitative findings and learn more about the dynamic process of MFPG, group facilitators conducted a focus group following the final session of the MFPG. Five ACT team staff members who had led the MFPG intervention participated. During the hour-long focus group, participants were asked open-ended questions regarding their experience and their observations on the

Table 1 Demographics

		Age(Mean ± SD)	Gender	Language	
				Ethnic language only (%)	Ethnic language + english (%)
Chinese	Client (<i>n</i> = 7)	38.6 ± 6.5	Female 29% (<i>n</i> = 2)	42 (<i>n</i> = 3)	58 (<i>n</i> = 4)
	Family member (<i>n</i> = 11)	64.3 ± 11.6	Female 64% (<i>n</i> = 7)	73 (<i>n</i> = 8)	27 (<i>n</i> = 3)
Tamil	Client (<i>n</i> = 7)	37.6 ± 6.4	Female 14% (<i>n</i> = 1)	58 (<i>n</i> = 4)	42 (<i>n</i> = 3)
	Family member (<i>n</i> = 9)	55.1 ± 17.9	Female 67% (<i>n</i> = 6)	56 (<i>n</i> = 5)	44 (<i>n</i> = 4)

Twelve clients (86%) were diagnosed with schizophrenia while 2 (14%) were diagnosed with schizoaffective disorder

impact of MFPG on patients and family members. Questions were followed by specific probes to clarify the facilitators' responses.

The focus group recordings and minutes were analyzed, and a list of thematic categories was identified.

A questionnaire consisting of 36 specific items relating to the themes discussed in the focus group was developed. Group facilitators' responses were transcribed and the contents were analyzed according to their fit to the 36 items and higher-order themes.

Results

Part I. Quantitative Outcome: Family Members' Perspectives

Firstly, the study has a participation rate of 57% families having attended at least half of the session. This rate is within a reasonable range, as compared to the literature: Sherman et al. (2005), outlined that families' participation in treatment of serious mental illness in conventional outpatient setting is a dismal 2–7%; Dyck et al. (2002) reported that only 50% eligible subjects agreed to participate in MFG after being recruited, and then the drop out rate was a further 20%; and Bradley et al. (2006) reported a combined refusal and drop out rate of about 37% (participation rate of 63%).

The mean score of family members' acceptance of their client relatives was significantly increased (64.20 ± 13.90 vs. 76.30 ± 14.72 , $df = 13$, $P = 0.01$). This acceptance is even more pronounced in those who participated in more than 50% of the sessions ($n = 8$, 61.38 ± 16.54 vs. 80.05 ± 17.02 , $df = 7$, $P = 0.01$). We further did a rank ordered correlation analysis and found that those who attended more sessions had greater reduction in the area of family burden ($r = 0.5$, $P < 0.05$).

Although no significant changes were found in other SAS variables, some positive trends were noted. These changes included the family members' perceived burden of the client (17.92 ± 7.4 vs. 16.14 ± 6.2 , $df = 13$, $P = 0.46$), family members' satisfaction with their own physical health (2.69 ± 1.63 vs. 2.29 ± 1.63 , $df = 13$, $P = 0.40$), mental health (2.42 ± 1.21 vs. 2.00 ± 1.11 , $df = 13$, $P = 0.37$) and health in general (3.17 ± 1.87 vs. 2.71 ± 1.98 , $df = 13$, $P = 0.37$).

Part II. Qualitative Study: Group Facilitators' Perspectives

Several key themes emerged from the content analysis of focus group transcripts. These themes are discussed in detail below:

Reduced Stigma and Shame, Isolation Among Family Members

Prior to the MFPG, family members felt a tremendous stigma and sense of shame regarding their mentally ill relatives. Family members worried that other people would learn about their relatives' mental illnesses, which may lead to a loss in social support due to cultural stigma. Gradually, family members avoided interactions with others in the community and limited their social networks. Mental illness became a taboo subject that they could not talk about or share with anybody, even within the extended family. Since all of the families were first generation immigrants, the language barrier exacerbated their vulnerability to stigma and discrimination. They lived with a high level of distress, but received minimal social support. The families also lacked access to information about their relatives' illnesses, treatment options, and support resources in the community.

The MFPG provided a safe venue where clients and family members could meet and develop trust in each other. They shared their unique experiences and perceptions without any fear of rejection.

Case Illustration A client's mother was very sad, ashamed and disappointed about her son who has mental illness during the first few sessions. She said, "My hope is gone and my son is finished. What else do you expect us to do? How long can I hide the fact that he is not well?" After the MFPG, she had a better understanding of the illness and was able to speak more openly about her problems. She shared about the violence at home and the client was allowed to share his feelings of humiliation, hurt and anger that resulted from family provocation. They were comfortable initiating discussions and seeking help when in difficulty, rather than retreating to isolation which had been the predominant behavioral pattern in the past.

Increase in Understanding of Client's Condition

The family members gained a greater understanding of clients' mental illness through lectures given by our psychiatrist, which helped to reduce disappointment and frustration. Some families had particularly high expectations for clients to strive for academic and professional excellence, which are common goals in the Asian culture. However, chronic functional impairments can lead clients to experience enormous shame, guilt, and fear, and can also result in a tremendous sense of loss and hopelessness on the part of the families. As family members learned that clients' low achievement was associated with mental illness rather than to undesirable personality traits, family members' attitude toward patients changed from blaming and rejection to understanding, empathy and acceptance.

Case Illustration A client's mother and sister were unhappy about his unwillingness to work and his habit of getting up late in the morning. They attributed these to the client's laziness. They said, "He could function more normally but it's just him being lazy." After the intervention, they understood that the client's behavior was due to his negative symptoms and the side effects of medication. They felt less frustrated and gave more concern and support for the client. They would ask, "What are we supposed to do when he refused to get up?" After the MFPG, they lived in better harmony with the client which subsequently resulted in less conflict and improved medication adherence.

Support From Other Family Members Through MFPG; Decrease in Helplessness and Hopelessness

The group usually had 15 min for warm up and snacks. Most of them brought food to share with others. They were able to relax and get to know each other through sharing dishes and tips on how to prepare them. More importantly, family members learned that they were not alone in fighting clients' mental illness. They felt relieved, supported and became willing to contact each other outside of the group sessions. They also learned how to normalize the experience of mental illness as a medical condition rather than a personal failure. Participants felt hopeful in an atmosphere of acceptance, empathy, and understanding. Having a channel to express their concerns within a safe environment reduced their tension and burdens. Some of them also volunteered to be involved with group coordination for the next set of family group meetings.

Improvement in Client-Family Relationships

There are several ways through which MFPG may enhance the relationship between clients and family members:

- i. The newfound knowledge of mental illness may have helped clients and family members to readjust their expectations of each other and becoming more tolerant and accepting of each other.

Case Illustration A client refused to contact her parents for more than 10 years. Her father, who was over 80 years of age, had attempted to contact and connect with her by various means. She would yell at him whenever he visited her. After the family intervention, she became more receptive of his offers and visits. She even gave him \$50 dollars on his birthday, and said, "The money is for you." The father was in tears.

- ii. There is a consensus among group facilitators that MFPG helped increase family members' awareness of

their role in patients' recovery process and relapse prevention. For example, family members realized how negative communication patterns could induce anxiety in clients or even trigger the relapse of mental illness. This motivated family members to learn how to communicate better with clients.

- iii. Group facilitators agreed that training in communication and problem solving skills improved the interactions between family members and clients. Through MFPG, family members and clients learned how to communicate with each other more effectively. Participants also learned to apply negotiation skills to practical problem solving situations.

Case Illustration A client always called his parents and was concerned about whether they were safe. He asked, "Are you OK? I heard that somebody is going to harm or kill you." The parents responded very angrily and said, "I am fed up with your calling and cursing. Please stop calling or else I'll be killed by your craziness." After the family intervention, the parents would respond to his anxious call by saying, "We are fine, nobody is going to hurt us. Just relax and may be we'll meet on the weekend for lunch." The client was reassured and looked forward to meeting with his parents.

Another client had long standing financial problems and smoked at home against his mother's wishes. After intervention, he made an agreement with his mother to reduce the frequency of smoking and to smoke outside of the apartment. He also allowed his mother to assist him in managing his money by creating a joint account. The client managed to withdraw money each week within his means.

Mutual Enhancement of MFPG and ACT

The dual role of the clinician as a group facilitator in MFPG and as a primary team member in ACT places him/her in the ideal position to ensure delivery of both services in a timely manner. ACT enhanced MFPG because clinicians could use their weekly ACT visits to follow up on the assignments from the previous MFPG session, provide assistance and reward positive changes. Evolving issues relevant to the MFPG intervention could also be addressed in a more timely fashion because of ACT. On the other hand, MFPG facilitated ACT practice via improved communication, understanding and trust among clinicians, clients and family members. The knowledge acquired from MFPG sessions also helped family members and clients to work more collaboratively and effectively with ACT clinicians. For example, family members increasingly helped with monitoring and reporting medication adherence and side effects. They also aided the ACT Team by reporting early signs of relapse and assisting in crisis intervention.

Importance of Cultural and Linguistic Matching Between Clients/Family Members and Clinicians

The sharing of common culture and language allows in-depth discussion of values, health beliefs and the use of alternative medicine. Both verbal and non-verbal communications were also enhanced because of similar ethnic backgrounds.

Unfortunately, it is difficult to find a psychiatrist who speaks a minority language and educates families about mental illness without an interpreter. In this study, members from the Chinese MFPG found the educational sessions conducted by a Chinese-speaking psychiatrist particularly helpful and informative. In contrast, we had to use an interpreter for an English speaking psychiatrist in the Tamil MFPG. Some subtle but important points might have been lost in translation; in-depth discussions also appeared difficult.

Several other issues were also raised in the focus group:

Although some family members reported that they found the MFPG sessions helpful, they reverted to their old behaviors and attitudes when in stress. The lack of consistent participation in all MFPG sessions might have also limited the potential benefits of the program. Irregular attendance could be related to clients' illness and/or their chronically strained relationship with family members.

Some family members worried that their community would get to know that they have mentally ill relatives through gossip from other MFPG family members. In this regard, an emphasis on confidentiality and more ethno-specific public education is needed to fight against the stigma attached to mental illness in the minority communities.

Another issue related to the diverse participants' socioeconomic spectrum is the varying levels of education, income and knowledge of mental illnesses among family members. The types of symptoms, course of illness, and level of functioning also differed from one client to another. The challenge for group facilitators was thus to help family members address common issues, such as fighting stigma, developing trust and increasing self-confidence. One way to make MFPG more beneficial to clients and families is perhaps to tailor the format and content of the sessions to meet specific needs of subgroups. For example, the MFPG program may be followed by a series of special talks in small groups addressing common concerns.

Discussion

Our pilot study has shown that MFPG was effective with culturally diverse populations in reducing family burden.

While other studies indicated significant benefits of family psycho-education in improving client outcomes, our study showed favorable family outcome. Family burden adversely affects clinical outcomes of major mental disorders (Perlick et al. 1992). Interventions that reduce such a burden could result in better client outcome, such as lower hospitalization rates (Falloon and Pederson 1985).

Our qualitative study revealed dynamic changes that occurred throughout MFPG. First, MFPG provided real life narratives supporting the benefits of MFPG in reducing family members' perceived burden and improving their overall well-being. It also emphasized the importance of an ethno-cultural specific context for the success of MFPG, which allowed participants to share experience and support each other in their own language during and after sessions. Second, we found decreased hostility and conflicts, and better understanding, among family members and clients. Communication skills training further helped family members handle disagreements in productive ways. Third, increased knowledge about mental illness impacted positively on participants' beliefs about health maintenance, medication and side effects. Family members learned to observe for signs and symptoms of relapse and seek help appropriately and in a timely fashion. Both clients and family members also developed great trust towards staff, which facilitated communication and the treatment process.

A number of barriers made MFPG especially challenging for a culturally diverse population. These included deep-rooted beliefs about health maintenance, stigma of mental illness and a prevailing culture to "save face". The fear of discrimination must be adequately addressed prior to introducing MFPG. MFPG also requires a significant commitment from participants and staff. To accommodate the work schedules of family members, facilitators have to be prepared to work on weekends. The moderate participation rate (57% completion), while is comparable to the literature, may benefit from further effort. In this study, we provided transportation assistance, food, and flexible schedules to optimize attendance. Other strategies to attempt may include: providing a small token monetary appreciation, weekly scheduled reminders, larger proportion of time dedicated to specific interests of the family members (i.e. some departure from the MFPG protocol), and certificate of attendance at end of the program, etc. This study showed the level of family burden is high and responded to MFPG. In turn, having the MFPG program to be more psychologically in tune with the burden suffered by the families, and finding ways to be practically supportive from the beginning may further help with the participation and satisfaction rates.

This pilot study is also unique in that it explores further the ideas of implementing MFPG in an ACT setting—as

put forward earlier by McFarlane et al. (1992), and McFarlane (1997)—that specifically serves ethnic minority populations. There is a dearth of such dual implementation in the literature, for no rational reasons, given how well proven and established both MFPG and ACT are. Potential barriers may still be, even for an ACT team, the extra resources required for MFPG, the relative long duration for its implementation, the time and energy required to mobilize family members, and the (often misguided and inflexibly held) need to preserve clients' confidentiality from family members, etc. One recent study from ACT research in Japan found family involvement critical in its success (Tamaki et al. 2008), and this pilot study's outcome helps to further establish this positive view, and may advocate for ACT protocol to specifically implement MFPG.

Furthermore, this pilot study described one of the first MFPG programs for Chinese and Tamil clients and their family members—ethnic cultures that are well known to have strong family involvement. A randomized controlled trial will be warranted to investigate the true effectiveness of incorporating MFPG to ACT for ethno-specific minority clients. Baseline and follow-up surveys with clients and family members are also needed to identify other facilitators and barriers influencing intervention outcomes.

Outline of 12-Session MFPG Model

- Session 1: Introductions, principles, goals, common emotions among consumers and family members. Learning about the normative stages of emotional reactions to the trauma of mental illness and understanding illness symptoms as a “double-edged sword.” Addressing issues of impact of stigma of mental illness on client and family members. Perspectives and experience of obtaining mental health services when facing language and cultural barriers.
- Session 2: Overview: schizophrenia, learning how to get through “Critical Periods” in mental illness, how a diagnosis is made and characteristic features of psychotic illnesses. What to do in the event of a crisis.
- Session 3: Learning from each other. An opportunity for each person to share his/her family's personal story.
- Session 4: Education session by our ACTT psychiatrists. Basics about the brain: functions of key brain areas; research on functional and structural brain abnormalities in the major mental illnesses; chemical messengers in the brain; genetic research. Eliciting alternative impression of nature of illness, explanatory models, and how modern views and traditional views can inform each other and recognize differences.
- Session 5: Problem solving skills workshop. Learning how to define a problem; brainstorm, and choose possible solutions. Focus on setting limits. Exploring problem solving approaches and rationale for such. Examine the fit of such skills to the explanatory model above. Discuss limitations and expand on skill sets.
- Session 6: Medication review, including side effects and adherence issues, as well as learning how medications work and early warning signs of relapse. Exploring the role of traditional healing, herbal medication, and recognizing some potential benefit and advantages and/or conflicts between multiple treatment modalities.
- Session 7: Empathy workshop: a look at mental illness from the consumer's viewpoint. Understanding the subjective experience of coping with a brain disorder; problems in maintaining self-esteem and positive identity; gaining empathy for the psychological struggle to protect one's integrity in mental illness. Exploring the western notion of empathy and the societal expectations from family and professional workers. Explore the notion of empathic care vs. paternalistic care and more directive approach in Asian societies.
- Session 8: Communication skills workshop: learning effective ways to communicate with each other. Learning how illness interferes with the capacity to communicate: learning how to be clear; how to respond when a topic is loaded; talking to the person behind the symptoms of mental illness.
- Session 9: Self-Care: Learning about family burden and sharing, and handling negative feelings of anger, entrapment, guilt and grief; balance in one's life. Examining the pre-migration role of family vs. post migrational role shifts (if any), and realistic goal setting. From the Mount Sinai ACT Health Concept Survey in 2002, it was shown that more than 50% of the clients and family members considered mental illness to be caused by various stressors. Discussion on how they can reduce stress through daily living skills.
- Session 10: Rehabilitation and recovery; Learning from each other how our clients are recovering from mental illness.
- Session 11: Fighting stigma; Advocacy, learning the mental health system in Canada and how to express their needs. The Asian concept of family is based on extended family. and these core units include uncles, aunts, cousins and their children. Discussions on how to handle and fight with the stigma within themselves and outside the family as well.
- Session 12: Next steps, closing; celebrating the experience by recognizing their growth, support, friendship and their learning, and planning for the next phase of Family Education Group.

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References

- Bond, G. R., Salyers, M. P., Rollins, A. L., Rapp, C. A., & Zippile, A. M. (2004). How evidence-based practices contribute to community integration. *Community Mental Health Journal*, 40, 569–588. doi:10.1007/s10597-004-6130-8.
- Bradley, G. M., Couchman, G. M., Perlesz, A., Nguyen, A. T., Singh, B., & Riess, C. (2006). Multi-family group treatment for English-and Vietnamese-speaking families living with schizophrenia. *Psychiatric Services (Washington, D.C.)*, 57, 521–530. doi:10.1176/appi.ps.57.4.521.
- Bustillo, J. R., Lauriello, J., & Horan, W. P. (2001). The psychosocial treatment of schizophrenia: An update. *The American Journal of Psychiatry*, 158, 163–175. doi:10.1176/appi.ajp.158.2.163.
- Chung, R. C., & Lin, K. (1994). Help-seeking behavior among Southeast Asian refugees. *Journal of Community Psychology*, 22, 109–120. doi:10.1002/1520-6629(199404)22:2<109::AID-JCOP2290220207>3.0.CO;2-V.
- Dixon, L., McFarlane, W. R., Lefley, H., Lucksted, A., Cohen, M., Falloon, I., et al. (2001). Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatric Services (Washington, D.C.)*, 52, 903–910. doi:10.1176/appi.ps.52.7.903.
- Dyck, D. G., Hendryx, M. S., Short, R. A., Voss, W. D., & McFarlane, W. R. (2002). Service use among patients with schizophrenia in psychoeducational multiple-family group treatment. *Psychiatric Services (Washington, D.C.)*, 53, 749–754. doi:10.1176/appi.ps.53.6.749.
- Falloon, I. R., & Pederson, J. (1985). Family management in the prevention of morbidity of schizophrenia: The adjustment of the family unit. *The British Journal of Psychiatry*, 147, 156–163. doi:10.1192/bjp.147.2.156.
- Kleinman, A. (1980). *Clients and healers in the context of culture: An exploration of the borderline between anthropology, medicine, and psychiatry*. London, UK: University of California Press.
- Kleinman, A. (2004). Culture and depression. *The New England Journal of Medicine*, 351, 951–953. doi:10.1056/NEJMp048078.
- Kreisman, D. E., & Blumenthal, R. L. (1985). *Social adjustment scale-family version (SAS-FAM)*. New York: New York State Psychiatric Institute.
- Lam, P., & Dominic, H. (1991). Psychosocial family intervention in schizophrenia: A review of empirical studies. *Psychological Medicine*, 21, 423–441.
- Lee, E. (1988). Introduction to cultural competence. In M. C. McManus (Ed.), *Focal point: A national bulletin on family support and children's mental health: Services to minority populations: Cultural competence continuum* (Vol. 3(1)). Portland: Research and Training Center on Family Support and Children's Mental Health: Portland State University.
- Lehman, A. F., Carpenter, W. T., Goldman, H. H., & Steinwachs, D. M. (1995). Treatment outcomes in schizophrenia: Implications for practice, policy and research. *Schizophrenia Bulletin*, 21, 669–675.
- Lehman, A. F., & Steinwachs, D. M. (1998). Patterns of usual care for schizophrenia: Initial results from the Schizophrenia patient outcomes research team (PORT) client survey. *Schizophrenia Bulletin*, 24, 11–20.
- Lin, T. Y., & Lin, M. C. (1980). Love, denial and rejection: responses of Chinese families to mental illness. In A. Kleinman & T. Y. Lin (Eds.), *Normal and abnormal behavior in Chinese culture* (pp. 387–401). Boston, MA: D. Reidel.
- Marshall, M., & Lockwood, A. (2000). Assertive community treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews (Online : Update Software)*, 2, CD001089.
- McFarlane, W. R. (1997). Fact: Integrating family psychoeducation and assertive community treatment. *Administration and Policy in Mental Health and Mental Health Research*, 25(2), 191–198. doi:10.1023/A:1022291022270.
- McFarlane, W. R., Deakins, S. M., Gingerich, S. L., Dunne, E., Horan, B., & Newmark, M. (1991). *Multiple family psychoeducation groups: A treatment manual*. Biosocial treatment division: New York State Psychiatric Institute.
- McFarlane, W. R., Lukens, E., Link, B., Dushay, R., Deakins, S. A., Newmark, M., et al. (1995). Multiple-family groups and psychoeducation in the treatment of schizophrenia. *Archives of General Psychiatry*, 52, 679–687.
- McFarlane, W. R., Stastny, P., & Deakins, S. (1992). Family-aided assertive community treatment: A comprehensive rehabilitation and intensive case management approach for persons with schizophrenia disorders. *New Directions for Mental Health Services*, 53, 43–54. doi:10.1002/nd.23319925306.
- McGrew, J. H., Wilson, R., & Bond, G. R. (2002). An exploratory study of what clients like least about assertive community treatment. *Psychiatric Services (Washington, D.C.)*, 53, 761–763. doi:10.1176/appi.ps.53.6.761.
- Perlick, D., Stastny, P., Mattis, S., & Teresi, J. (1992). Contribution of family, cognitive and clinical dimensions to long-term outcome in schizophrenia. *Schizophrenia Research*, 6, 257–265. doi:10.1016/0920-9964(92)90009-T.
- Sadavoy, J., Meier, R., & Ong, A. Y. (2004). Barriers to access to mental health services for ethnic seniors: The Toronto study. *Canadian Journal of Psychiatry*, 49, 192–200.
- Sherman, M. D., Faruque, H. D., & Foley, D. D. (2005). Family participation in the treatment of persons with serious mental illness. *Psychiatric Services (Washington, D.C.)*, 56, 1624–1625. doi:10.1176/appi.ps.56.12.1624.
- Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., et al. (2001). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *The American Journal of Psychiatry*, 158, 479–481. doi:10.1176/appi.ajp.158.3.479.
- Solomon, P., Draine, J., Mannion, E., & Meisel, M. (1998). Increased contact with community mental health resources as a potential benefit of family education. *Psychiatric Services (Washington, D.C.)*, 49, 333–339.
- Tamaki, S., Iwao, O., & Junichiro, I. (2008). Family needs and related factors in caring for a family member with mental illness: Adopting assertive community treatment in Japan where family caregivers play a large role in community care. *Psychiatry and Clinical Neurosciences*, 62(5), 584–590. doi:10.1111/j.1440-1819.2008.01852.x.
- Yang, J., Law, S., Chow, W., Andermann, L., Steinberg, R., & Sadavoy, J. (2005). Assertive community treatment for persons with severe and persistent mental illness in ethnic minority groups. *Psychiatric Services (Washington, D.C.)*, 56, 1053–1055. APPENDIX. doi:10.1176/appi.ps.56.9.1053.