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Therapist-Client Similarity on Religiosity and Interdependence as Predictors of Treatment Efficacy and Satisfaction in a Family Focused, Culturally Informed Therapy for Schizophrenia

Ana Martinez de Andino
University of Miami, ana.martinezdeandino@gmail.com

UNIVERSITY OF MIAMI

THERAPIST-CLIENT SIMILARITY ON RELIGIOSITY AND INTERDEPENDENCE AS PREDICTORS OF TREATMENT EFFICACY AND SATISFACTION IN A FAMILY FOCUSED, CULTURALLY INFORMED THERAPY FOR SCHIZOPHRENIA

By

Ana Martinez de Andino

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Ana Martinez de Andino

Approved:

_____	_____
Amy Weisman de Mamani, Ph.D.	Saneya H. Tawfik, Ph.D.
Associate Professor of Psychology	Clinical Assistant Professor of Psychology
_____	_____
Anabel Bejarano, Ph.D.	Guillermo Prado, Ph.D.
Clinical Assistant Professor of Educational and Psychological Studies	Dean of the Graduate School

MARTINEZ DE ANDINO, ANA I. (M.S., Psychology)
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Therapist-Client Similarity on Religiosity and Interdependence as Predictors of Treatment Efficacy and Satisfaction in a Family Focused, Culturally Informed Therapy for Schizophrenia.

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Several studies have examined whether therapist-client match on ethnicity and other demographic variables (e.g., gender, sexual orientation) influences treatment efficacy and satisfaction (e.g., Bhati, 2014; Presnell, Harris, & Scogin, 2012) with psychotherapy. While some suggest that matching on demographic variables may improve attrition rates, most studies do not support the view that matching on ethnicity and related variables enhances treatment efficacy. For example, two recent studies, tested a newly developed, family focused, culturally informed therapy for schizophrenia (CIT-S), and found that while the treatment is effective for reducing patient symptoms (Weisman de Mamani, Weintraub, Gurak, & Maura, 2014) and caregiver burden (Weisman de Mamani & Suro, 2015), no differences were found in treatment efficacy or on consumer satisfaction with treatment at termination when patients and therapists were matched versus mismatched on ethnicity. In this study, we examined the effect of therapist-client similarity on variables that go behind surface level demographic characteristics. Specifically, we proposed to examine therapist-client similarity in two key areas, religiosity/spirituality and interdependence, in a sample of 48 key family members and 36 patients with schizophrenia who were enrolled in CIT-S or a psycho-

education only comparison condition (PSY-ED). We chose to examine these two areas because CIT-S specifically targets these values and practices. Discrepancy values from the 14-item Intrinsic/Extrinsic Revised Scale (I/E) and the 12-item Interdependent Subscale from the Self-Construal Scale (SCS) were calculated by taking the absolute value of the differences between client scores and their therapist scores. Contrary to hypotheses, therapist-client similarity in religious beliefs and values, as well as family collectivistic values, was not predictive of any outcome variable for neither patients nor family members, in either condition. Results suggest that having similar religious or family backgrounds offers no advantage in improving religious and family based treatments for schizophrenia. It may be that therapist personal characteristics, such as flexibility, honesty and openness, may be more important than actual matched values. This is encouraging because results suggest that treatment can be satisfying and efficacious regardless of therapist-client match. In other words, therapists can be competent and successful without holding values that are highly similar to those of the clients that they serve. A content analysis of sessions with the most and least discrepant therapist-client dyads was also conducted to help clarify results. Insights from these analyses are examined in the discussion section.

Key Words: Therapeutic Relationship, Schizophrenia, Religiosity, Spirituality, Interdependence

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CHAPTER ONE: INTRODUCTION

Schizophrenia is a chronic and debilitating mental illness that affects roughly one percent of the world's population (Goldner, Hsu, Waraich, & Somers, 2002; McGrath, Saha, Chant, & Welham, 2008). Symptoms of the illness have been characterized as positive (i.e. hallucinations, delusions) and negative (i.e. amotivation, flat affect). Due to the chronicity of this illness, the majority of patients live and rely on family members for support and most basic needs (Atwood, 1990). In other words, schizophrenia can be considered an illness that affects the whole family, rather than one individual. This has been shown to be particularly difficult and burdensome for caregivers, with higher rates of depression and anxiety and overall lower psychological well-being in this population (Suro & Weisman, 2013; Weisman, Rosales, Kymalainen, & Armesto, 2005; Weisman de Mamani, Weintraub, Gurak, & Maura, 2014). Furthermore, most family treatment studies in schizophrenia focus mainly on patient characteristics and examine caregiver factors primarily only as they pertain to patient well-being. Given the burden that schizophrenia can place on both patients and caregivers, it is important that psychosocial interventions target not only the patient, but the caregiver as well. Thus, it is critical to examine processes that may increase patient *and* caregiver satisfaction with treatment along with treatment efficacy.

Effective treatments for schizophrenia include the use of antipsychotic medication. However, psychopharmacology has been found to be even more efficacious when combined with psychosocial interventions, such as cognitive behavioral therapy, assertive community treatment, and social skills training (e.g., Jauhar et al., 2014; Kopelowicz, Liberman, & Zarate, 2006; Lehman, Dixon, Kernan, DeForge, & Postrado,

1997; Tarrier et al., 1998). Family therapy, in particular, has reliably demonstrated efficacy in the treatment of schizophrenia, with lower rates of relapse and rehospitalization, as well as greater medication adherence (e.g., Falloon, Boyd, & McGill, 1984; Pilling et al., 2002; Weisman de Mamani et al., 2014). The relationship between a therapist and client has been repeatedly found to be a mechanism of change within therapy, such that stronger relationships predict better treatment outcome and psychosocial functioning (Horvath & Symond, 1991; Martin, Garske, & Davis, 2000). Given the insidious nature of schizophrenia, a better understanding of factors that might contribute to treatment success are critical to the field.

In this thesis, I will begin with a literature review on the relationship between the therapeutic alliance and mental health outcomes. Next, I will review literature on associations among therapist-client similarity, the therapeutic relationship, and treatment outcome. Then I will provide a brief review of the literature on family interventions and schizophrenia, as well as the importance of religion/spirituality among psychiatric populations. I will then present religiosity/spirituality and family interdependence as potential factors which might significantly affect the therapeutic relationship and thus treatment outcome in a family-focused therapy. Next, I will propose hypotheses regarding the impact of therapist-client similarity on religious and family values on treatment efficacy and satisfaction. Finally, I will report on the results of analyses used to evaluate these hypotheses and discuss their implications.

Therapeutic Relationship

The relationship between a therapist and client has long been considered a variable of interest for research (Beutler, 1972; Beutler, 1979; Horvath & Symonds,

1991; Martin et al., 2000). The therapeutic relationship is characterized as an affective and collaborative bond between therapist and patient (Kvrgic, Cavelti, Beck, Rüsch, & Vauth, 2012). This relationship has consistently been shown to be an active ingredient and mechanism of change in therapy (Horvath & Symonds, 1991; Martin et al., 2000). The therapeutic relationship can be considered a pathway in which a therapist might encourage the patient to take risks and make behavioral changes during the course of treatment, making it an integral part of improvement (Barber, Morrison, & Gabbard, 2012). A study conducted by Ackerman and Hilsenroth (2003) compared therapist-patient relationships in therapists with different levels of training. Ackerman and Hilsenroth (2003) found that there was no significant difference in the therapeutic relationship across experience (first practicum experience through postdoctoral staff). This study shows that therapist training level does not necessarily affect the development of a strong relationship with the client.

Other studies have found similar results, showing that therapeutic relationship predicts outcome regardless of experience, treatment modality, and theoretical orientation (Ackerman & Hilsenroth, 2003; Bachelor, 2013; Bedics, Atkins, Harned, & Linehan, 2015; Clemence, Hilsenroth, Ackerman, Strassle, & Handler, 2005; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Elvins & Green, 2008; Horvath & Symonds, 1991; Martin et al., 2000). Specifically, stronger therapeutic relationships have been shown to predict better psychosocial functioning, greater satisfaction, and symptom improvement (Clemence et al., 2005; Horvath & Symonds, 1991; Martin et al., 2000). This association has been shown for a variety of disorders, such as borderline personality

disorder, depression, anxiety, eating disorders, and schizophrenia (Bedics et al., 2015; Davis & Lysaker, 2004; Del Re et al., 2012; Farrelly et al., 2013; Martin et al., 2000).

Despite the large amount of research evaluating the link between treatment outcome and the therapeutic relationship, fewer studies have focused on better understanding the mechanisms of change within the therapeutic relationship. Some studies have found that converging perceptions between therapist and patient have been associated with more positive outcome (Bachelor, 2013; Beutler, Arizmendi, Crago, Shanfield, & Hagaman, 1983). This may be a result of a strong, collaborative relationship between the therapist and client over time. A different study found that therapist personal characteristics, such as being flexible, honest, respectful, trustworthy, confident, warm, interested, and open contributed positively to the therapeutic alliance (Ackerman & Hilsenroth, 2003). Therapists in this study received higher alliance scores when patients reported them as more affirming and understanding (Ackerman & Hilsenroth, 2003). In other words, greater acceptance of the patient on the part of the therapist may lay the groundwork for a solid therapeutic relationship. Nonetheless, this area leaves many questions unanswered. It is still unclear how therapists' and patients' values and beliefs might interact and affect the therapeutic relationship and treatment outcome.

Therapeutic Relationship in Schizophrenia

For patients with schizophrenia, a strong therapeutic relationship has been linked with better treatment adherence, lower rates of treatment dropout, better medication adherence, as well as lower rates of hospitalization (Allen, Tarnoff, & Coyne, 1985; Clarkin, Hurt, & Crilly, 1987; Davis & Lysaker, 2004; Farrelly et al., 2013; Frank & Gunderson, 1990; Jaeger, Weißhaupt, Flammer, & Steinert, 2014; Kvrgic et al., 2012;

McCabe, Saidi, & Priebe, 2007; Svensson & Hansson, 1999). A study conducted by Frank and Gunderson (1990) showed that development of good alliance between therapist and patient occurred over the course of six months. After this amount of time, those with stronger relationship ratings were more likely to remain in treatment, comply with medication, and achieved better overall outcomes after two years (Frank & Gunderson, 1990). Frank and Gunderson (1990) hypothesized that stronger therapeutic relationships may be indicative of greater acceptance of the treatment in this population. Later studies have consistently replicated these findings, showing that quality of the therapist-patient relationship predicts course of treatment, global functioning, rates of dropout, and symptom severity (Stark, Lewandowski, & Buchkremer, 1992; Neale & Rosenbeck, 1995; Svensson & Hansson, 1999). A more recent study by McCabe and colleagues (2007) found these results to be true in both inpatient and outpatient settings. McCabe and colleagues (2007) assessed patients' ratings of satisfaction with care and quality of the therapeutic relationship and found this to predict reduced symptom severity, hospitalization, quality of life (QoL) and social functioning across settings. This study also found that lower ratings of satisfaction were associated with greater psychopathology and predictive of later hospitalizations (McCabe et al., 2007). Thus, the therapeutic relationship can both positively and negatively impact outcome for patients with schizophrenia. McCabe and his team (in press) have now replicated the abovementioned results in various treatment settings.

Despite these findings, research appears mixed regarding the association between therapeutic relationship and outcome. Some studies, for example, have failed to find a significant association between therapeutic relationship and treatment efficacy and

outcome (Clarke et al., 2000; Farrelly et al., 2013; Olfson et al., 1999). The most consistent evidence for this association has been for the prediction of greater medication adherence (Farrelly et al., 2013; Olfson et al., 2000; Weiss, Smith, Hull, Piper, & Huppert, 2002). Although more studies than not have found a significant association between therapeutic relationship and outcome, it is important to recognize that this may not always be true. A potential explanation for the lack of significance in these studies could be the patient's level of neurocognition and symptom severity.

A good therapeutic relationship is considered especially critical for patients with schizophrenia, but potentially difficult to form due to both their positive symptoms (e.g. paranoia, delusions) as well as their negative symptoms (e.g. amotivation, flat affect) (Frank & Gunderson, 1990; Kvrgic et al., 2012; Wittorf et al., 2009). In other words, symptom severity may be a barrier to the development of a strong therapeutic relationship. Wittorf and colleagues (2009) found symptom severity and cognitive insight to be predictors of the therapeutic relationship. Specifically, negative symptoms, such as flat affect, emotional withdrawal, alogia, or avolition, were hypothesized to be mistaken as a lack of alliance between the therapist and patient (Wittorf et al., 2009). In this way, therapists may have unique difficulties developing a strong relationship with patients with schizophrenia.

Therapist-Client Match

Research has shown that individuals are typically attracted to others with similar attitudes and likeability (Bhati, 2014; Byrne, 1971; Eagly, 1983; Fabrikant, 1974). As a result, researchers became interested in how similar attitudes and values would affect therapy, the therapeutic relationship, and treatment outcome. Studies began to match

therapists and patients based on language, race/ethnicity, religion, and sexual orientation. However, findings from such studies have shown inconsistent results (Fujino, Okazaki, & Young, 1994; Gottheil, Sterling, Weinstein, & Kurtz, 1994; McCabe, 2002; Presnell, Harris, & Scogin, 2012; Russell, Fujino, Sue, Cheung, & Snowden, 1996; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Yeh, Eastman, & Cheung, 1994a; Yeh, Takeuchi, & Sue, 1994b). A number of studies have found that ethnically matching therapists and clients predicts higher ratings of client functioning and treatment dropout (Russell et al., 1996; Yeh et al., 1994a). One study conducted by Wintersteen and colleagues (2005) found that gender- and racial-matched dyads were more likely to complete treatment, and that mismatched dyads had significantly lower ratings of alliance.

However, studies have also failed to show a significant effect of therapist-client matching on race/ethnicity (Weisman de Mamani et al., 2014). One study compared race/ethnicity match in a sample of participants receiving cognitive behavioral therapy (Presnell et al., 2012). No significant difference in outcome was found for matched versus non-matched groups (Presnell et al., 2012). Other studies, however, have found ethnic matching in Mexican, African and Asian Americans to predict length of treatment, such that clients in matched dyads will stay longer in treatment, reducing premature treatment dropout (Yeh et al., 1994a; Yeh et al., 1994b). Inconsistent findings for race/ethnic match may be partially due to within group ethnic variability. Ethnicity has been conceptualized as a proxy for culture; however, culture within one racial/ethnic group can widely vary (Russell et al., 1996). Interestingly, one study found that attention to cultural content led to greater intimacy and self-disclosure between the therapist and patient (Thompson, Worthington, & Atkinson, 1994). Thus, the crux of therapist-patient

similarity may rest more on cultural sensitivity and knowledge on the part of the therapist rather than on actual ethnic matching.

Family Interventions for Schizophrenia

Patients with schizophrenia often live at home and depend solely upon family members. As a result, family members become caregivers that support the patient both emotionally and financially (Dixon, Adams, & Lucksted, 2000). Caregivers experience a myriad of practical problems due to this burden, such as financial hardship, disruption of the family relationship, as well as psychological distress, such as depression and anxiety (Espina, Ortego, Ochoa de Alda, & González, 2003; Olivares, Sermon, Hemels, & Schreiner, 2013). Research has shown that caregivers of patients with severe mental illness experience increased rates of anxiety, depression, and general emotional distress (GED) compared to the general public (e.g., Lobban et al., 2013). Hence, treatment for the family member should be considered as equally important to the treatment of the patient's schizophrenia. In fact, improving a caregiver's psychological well-being may also lead to an improvement in his/her ability to care for the patient outside the therapeutic environment. Thus, it is critical to include caregivers of patients with schizophrenia in treatment and target improvements in their well-being as important therapy goals in their own right.

Family interventions, such as psycho-education or family-focused therapy, provide a channel through which relatives can receive information, advice, emotional support, and even respite care (Espina et al., 2003; Gutiérrez-Maldonado, Caqueo-Urízar, Ferrer-García, 2009; Lobban et al., 2013; Weisman de Mamani et al., 2014). Of equal importance, family interventions have also been found to profoundly influence the

expressed emotion within the family home (Dixon et al., 2000; Olivares et al., 2013; Tomaras et al., 2000). Expressed emotion (EE) refers to the degree of criticism, hostility, and emotional-overinvolvement in the household (Hooley, 2007). Literature has repeatedly and reliably shown EE to be a strong predictor of relapse in patients with schizophrenia (e.g., Dixon et al., 2000; Hooley, 2007; Olivares et al., 2013; Tomaras et al., 2000; Weisman, 2005). Family interventions have been shown to be equally efficacious to individual psychotherapy in terms of reducing rates of relapse and hospitalization (Dixon et al., 2000; Hogarty et al., 1997; Tomaras et al., 2000). Helping to reduce rates of relapse is beneficial for not only the patient, but also his/her family members, as this helps reduce caregiver burden on a long-term scale (Olivares et al., 2013).

Encouraging families to engage in therapy is therefore of great importance, especially for those affected by schizophrenia. Moreover, specifically incorporating and targeting family dynamics and values in therapy may be of equal benefit. Strong family values and orientation similar to collectivistic cultures has been considered to underlie lower rates of expressed emotion among families (Weisman, 2005). Thus, targeting and strengthening such values may help family members and patients better cope with the illness and its symptoms (Weisman, 2005). The recent study conducted by Weisman de Mamani and colleagues (2014), which tested a newly developed, family focused, culturally informed therapy for schizophrenia (CIT-S), and from which this study will gather its sample, developed a "Family Collectivism" module to achieve such a goal. Furthermore, Weisman de Mamani and colleagues (2014) found that while treatment was effective for reducing patient symptoms and caregiver burden (Weisman de Mamani &

Suro, in press), no differences were found in treatment efficacy or satisfaction at termination when patients and therapists were matched versus mismatched on ethnicity. However, therapist-client similarity on collectivistic values, such as interdependence, may be especially salient for treatment efficacy and outcome when therapy is explicitly focused around this construct.

Religion/Spirituality and Schizophrenia

The majority of the United States population reports an affiliation with an organized religion (77%) or a belief in God or a universal spirit (89%) (Pew Forum on Religion and Public Life, 2015). The importance of religion and spirituality amongst psychiatric populations has been repeatedly shown in the literature as well (Helmeke & Bischof, 2002; Huguelet, Moh, Borras, Gillieron, & Brandt, 2006; Koenig et al., 2014; Koenig et al., 2015; Lim, Sim, Renjan, Sam, & Quah, 2014; Neeleman & Lewis, 1994; Park, 2005; Pearce et al., 2015; Reger & Rogers, 2002; Sullivan, 1993; Tepper, Rogers, Coleman, & Malony, 2001; Weisman de Mamani, Tuchman, & Duarte, 2010; Worthington, Hook, Davis, & McDaniel, 2011). Use of religious practices, such as prayer, positive religious core beliefs and religious coping, have been shown to predict better psychological well-being, less worry, and lower symptoms of anxiety and depression (Brelsford & Friedberg, 2011; Rosmarin, Krumrei, & Andersson, 2009; Weisman, 2005; Weisman de Mamani et al., 2010). Religious involvement has also been associated with greater positive emotions, such as optimism, generosity, self-esteem and gratitude (Koenig et al., 2014; Weisman, 2005).

Clearly, incorporating religion/spirituality into treatment seems the logical next step. A number of studies have examined just that with mixed results. Some studies have

found that religious or spiritual therapies are more efficacious than their secular counterparts (Koenig et al., 2015; Pearce et al., 2015). However, other studies have found religious and spiritual therapies to be equally as efficacious as secular treatments (Lim et al., 2014; Worthington et al., 2011). As the majority of studies have at least found religious and spiritual therapies to be as efficacious as conventional treatment options, it appears that the choice between one or the other falls to the client. Clients more religiously inclined may therefore lean toward therapies that are sensitive and accepting of their faith and spiritual beliefs. Within psychiatric populations, patients with schizophrenia, schizoaffective disorder, and/or bipolar disorder have been found to report religion as more important and salient to their success than other mental disorders, such as depressive disorders (Huguelet et al., 2006; Lim et al., 2014; Reger & Rogers, 2002). Therefore, this issue appears to be particularly relevant for this population.

Many therapists have reported feeling hesitant to broach the subject of religion and spirituality during treatment (Huguelet et al., 2006; Marterella & Brock, 2008). A surprising number of clients have even reported wanting to discuss religious and spiritual beliefs during the course of therapy yet feeling unable to do so with their therapists (Helmeke & Bischof, 2002). However, incorporating religion/spirituality is clearly needed and has been shown to be beneficial for religious clients (e.g., Koenig et al., 2014; Koenig et al., 2015; Rosmarin et al., 2009). Religious and spiritual values can often form the basis for family values and can be an integral part of the family dynamic (Walsh, 2010). Incorporating religion can also facilitate positive change, enhance emotional welfare and provide another social support network for clients (Rosmarin et al., 2009; Rosmarin, Pargament, & Robb, 2010; Sullivan, 1993; Weisman de Mamani et al., 2010).

As a result, religion and spiritual beliefs may be particularly helpful for family members caring for a patient with schizophrenia.

Incorporating religion and spirituality into treatment provides the therapist with yet another handy resource that can accomplish a number of objectives. In fact, therapists with a sensitive, multicultural orientation have been associated with better treatment outcomes, higher ratings of alliance and greater engagement in therapy (Owens et al., 2014). This type of therapeutic approach appears to strike a chord with religious or spiritual patients. Religiously inclined clients appear to place greater value in therapists that are accepting and acknowledge their faith (Hook, Davis, Owen, Worthington, & Utsey, 2013). Thus, when therapist and clients have greater similarity on religious and spiritual values, this may result in better treatment outcome and satisfaction. The studies conducted by Weisman de Mamani and colleagues (2014; 2015) recognized the importance of incorporating religion/spirituality into treatment and as a result included a novel module entitled "Spiritual Coping". Therapist-client similarity on spiritual and religious values may be particularly important when treatment specifically targets and encourages communication of this topic.

The Current Study

The current study aimed to evaluate the role of therapist-client value similarity in a sample of key family members and patients with schizophrenia from a randomized controlled trial evaluating a Culturally Informed Therapy for Schizophrenia (CIT-S) compared to a psycho-education only condition (PSY-ED) (Weisman de Mamani et al., 2014). Value similarity in religiosity and interdependence and their effects on client satisfaction and treatment efficacy at termination was evaluated. Discrepancy analyses

were used to examine similarity in clients' and therapists' scores on self-report measures of religiosity/spirituality and interdependence. The current study investigated whether the similarity of these values at baseline predicts lower ratings of GED, greater satisfaction with treatment, and greater QoL at treatment termination for key family members and patients with schizophrenia, as well as lower psychiatric symptoms at termination for patients. We examined whether value similarity is predictive for patients and family members in both CIT-S and the PSY-ED comparison condition. As CIT-S directly targets religiosity/spirituality as well as interdependent family values, similarity in religious beliefs and interdependent values may be especially important for patients and family members in the CIT-S condition.

Hypothesis

Based on the literature reviewed above, the current study tested the following hypotheses:

It is expected that, for patients with schizophrenia and key family members, greater similarity to the therapist on baseline measures of religiosity/spirituality and interdependence will, at treatment termination, be associated with

1) fewer symptoms of general emotional distress,
2) greater reported quality of life,
3) greater overall treatment satisfaction
4) and fewer psychiatric symptoms (for patients only)(Allen et al., 1985; Clarkin et al., 1987; Davis & Lysaker, 2004; Farrelly et al., 2013; Frank & Gunderson, 1990; Jaeger et al., 2014; Kvrgic et al., 2012; McCabe et al., 2007; Svensson & Hansson, 1999).

Furthermore,

5) it is expected that similarity on these values/practices will be more predictive for patients and key family members in the CIT-S group than those in the PSY-ED group. (Lobban et al., 2013; Pearce et al., 2015; Tomaras et al., 2000; Weisman, 2005; Weisman de Mamani et al., 2010).

Finally, a content analysis of the most similar and dissimilar therapist-patient and therapist-family member pair in the CIT-S group was conducted. Specifically, the three therapy sessions pertaining to religious and family collectivistic values were examined to qualitatively explore whether themes regarding discrepancies in values emerged during therapy for discrepant dyads, or whether themes regarding similarity emerged for the concordant dyads.

CHAPTER TWO: METHODS

Participants

Participants were drawn from a randomized controlled trial designed to test the efficacy of Culturally Informed Therapy for Schizophrenia (CIT-S). CIT-S is a weekly family therapy consisting of 15 sessions for families with a member diagnosed with schizophrenia. The therapy consists of 5 modules: Family Collectivism, Psycho-education, Communication Training, Spiritual Coping, and Problem Solving. A description of the modules is provided below (see Appendix A for handouts). Participants included 36 patients with a diagnosis of schizophrenia or schizoaffective disorder, as confirmed by the Structured Clinical Interview for the DSM-IV, Patient Edition, and 48 key family members of patients The difference in patient and family member samples is due the fact that in 12 cases, family members participated, even though their ill family member (the patient) was not involved or interested in treatment (because this is a family treatment study, to be included, two or more individuals from the same family had to participate in the treatment). To ensure independence of data, when patients had more than one family member participate in the study, only data from the key family member was included. The key family member was defined as the person who spends the most time with the patient. Family members were defined as relatives, step-relatives, spouses, and significant others. They were required to be in long-term relationships of six months duration or greater and to be in regular weekly contact with the patient.

The sample consisted of 25 (28% male, 72% female) key family members from the CIT-S group with a mean age of 58.56 (*SD* = 12.09), and 23 (26.1% male, 73.9% female) key family members from the PSY-ED group with a mean age of 53.04 (*SD* =

8.24). Key family members self-reported their ethnicity as Caucasian (14), African American (6), Hispanic (27), or Other (1). The sample of patients with schizophrenia consisted of 17 (76.5% male, 23.5% female) from the CIT-S group with a mean age of 34.65 (*SD* = 16.77), and 19 (73.7% male, 26.3% female) from the PSY-ED group with a mean age of 37.11 (*SD* = 12.76). Patients self-reported their ethnicity as Caucasian (11), African American (5), Hispanic (19), or Other (1). Finally, the sample also included 9 therapists (33.3% male, 66.7% female) with a mean age of 25.89 (*SD* = 2.62). Therapists self-reported their ethnicity as Caucasian (3), Hispanic (5), and Asian-American (1). See Table 1 and Table 2 for sample characteristics.

Procedure

Participants were recruited for the schizophrenia family treatment through advertisements displayed in newspapers, local hospitals, and cars of Miami's above-ground rail system. Eligibility for this study was determined through an initial phone screen. Participants then completed a baseline assessment interview at the University of Miami Psychological Services Center that lasted about three hours, for which patients and key family members were compensated $25. Assessments were conducted separately and in the individual's language of choice (either Spanish or English). During this assessment, key family member status was determined by selecting the family member or relative who spent the most time with the patient.

Participants completed a comprehensive assessment battery, however only the measures relevant to the current study will be discussed. Assessments were conducted by trained bilingual graduate students. All measures were administered in interview format with the assessor recording the participant's responses, to control for any variability in

reading ability. After baseline assessment, participants were randomly assigned to either fifteen weeks of CIT-S or three sessions of PSY-ED only. Treating clinicians were all doctoral level clinical psychology students. The principal investigator (Amy Weisman de Mamani, Ph.D.) also closely supervised students through weekly meetings to ensure fidelity and adherence to the manual.

Family Collectivism Module

The primary aim of this section of treatment was to enhance the perspective among family members that they were part of a team and all working toward unified goals. Specifically, family members and patients were asked to verbalize their expectations and objectives for treatment. This was meant to foster an opportunity to emphasize commonalities in goals amongst family members and patients. Handouts were also used to guide discussion regarding each individual's role and function within the family unit. As a result, family members and patients were able to consider the ways each individual may impact the family system, as well as brainstorm ideas to improve family functioning in general. The therapists aimed to provide a comfortable therapeutic environment in which each individual could express his or her opinions or complaints in an open and sensitive space. Furthermore, therapists helped the family identify specific behaviors and values that they believed contributed to the overall well-being of the unit.

Spiritual Coping Module

The primary aim of this section was to enhance any spiritual or existential beliefs that might help the patient and family members adaptively cope with the illness. Specifically, patients and family members were encouraged to discuss the role of any current spiritual practices being used, such as meditation, prayer, or volunteerism, as well

as spiritual beliefs and values, such as forgiveness, kindness, and empathy. In addition, handouts were used to foster discussion regarding views on the meaning and purpose of life, beliefs in God or a supreme being, and perceptions of morality. Therapists again aimed to provide a safe environment for all family members to openly share specific practices and values, and intended to guide members toward more adaptive uses of religion. Notably, therapists made no attempt to instill, emphasize, or directly challenge any particular religious orientation or belief. Moreover, if a patient endorsed delusions related to religion or spirituality, the module would include only the discussion of existential beliefs and practices, such as meditation and the perceptions of morality.

Psycho-education Module

This section drew upon an intervention developed by Falloon, Boyd, and McGill (1984), and was adapted to specifically address psychiatric symptoms (Mueser & Glynn, 1999). This approach has demonstrated strong empirical evidence for aiding families of patients with schizophrenia (Falloon et al., 1984). The primary aim of this module was to educate patients and family members on the common symptoms of schizophrenia, as well as the known causes of the illness and potential exacerbating factors. For example, the therapists taught patients and family members how to identify prodromal symptoms that may occur before a relapse. In addition, family members were also given information regarding the role of genetics, environmental factors and neurochemistry on the schizophrenia. During this section, the therapists answered questions, and emphasized the impact of the family system on the patient's psychiatric functioning. The Psycho-education Module lasted three sessions and was used as the comparison condition in the

current study, and alone has previously demonstrated benefits to patients and caregivers (Sota et al., 2008).

Communication Training Module

The last two modules, Communication Training and Problem Solving, were also adapted largely from Falloon and colleagues (1984). The goal of Communication Training was to provide family members and patients with a set of skills to better support one another within the home. Specifically, the therapists taught techniques such as active listening, expressing positive regard, and making requests for behavioral change. The therapists fostered the growth of these skills through discussion, as well as role-play. This module provided patients with the opportunity to discuss appropriate methods of communication regarding their illness. During discussion, the therapists encouraged both patients and family members to communicate in a way that reduced stress for all within the family system.

Problem Solving Module

Finally, the primary aim of this section was to strengthen problem-solving skills. Therapists worked with the family to enhance the ability of patients and family members to manage the challenges associated with schizophrenia. Patients and family members are taught to better identify problems, brainstorm potential solutions without judgment, and then evaluate each option before deciding upon the best solution. The therapists and family then organized an implementation plan for the solution as homework for the upcoming week. This module provided family members and patients with an opportunity to work through any long-standing difficulties, as well as new challenges that may have arisen throughout the course of treatment. The therapists encouraged all to view

challenges of the illness as problems the family could handle as a team. In particular, therapists emphasized the importance of choosing a plan and solution that would be feasible and acceptable to all parties.

Translation of Measures

Measures were translated from English to Spanish using an editorial review board consisting of members from diverse Hispanic backgrounds, such as, Cuba, Mexico, Puerto Rico, Colombia, Nicaragua, and Costa Rica. This approach is considered to be more effective than translation-back translation as it takes into account within-group language variations (Geisinger, 1994). Measures were translated by a native Spanish speaker into Spanish. Each member of the editorial review board then reviewed the translated Spanish version with the original English version. Next, members of the board discussed any discrepancies and worked to come to an agreement about the most easily understood and common wording. To ensure that the Spanish version continued to reflect the English meaning of the original constructs, the members of the board independently compared both versions again. The board met a second time to again discuss any discrepancies and come to a consensus on the translation of all items.

Measures

All assessments are described below and attached in Appendix B.

Demographics: Key family members and therapists completed a demographics questionnaire in which they provided information on age, gender, race/ethnicity, religion, and years of education.

Religion/Spirituality: Key family member, patient, and therapist religiosity and spirituality were measured with the **Intrinsic/Extrinsic-Revised Scales (I/E-R)** (Gorsuch & McPherson, 1989). This scale consists of 14 items which evaluate a person's intrinsic (e.g., "It is important to me to spend time in private thought and prayer") and extrinsic (e.g., "I go to religious services mostly to spend time with my friends") religious orientation using a 5-point Likert scale, with 1 indicating strongly disagree to 5 indicating strongly agree. An overall score was obtained by averaging across items after reverse scoring. Higher scores on the I/E-R indicate greater religiosity/spirituality. The I/E-R has demonstrated adequate to good reliability with a Cronbach's alpha ranging from .57-.83 (Gorsuch & McPherson, 1989). The current study also demonstrated good overall reliability with a Cronbach's alpha of .82, good reliability for key family members with an alpha of .72, as well as good reliability for patients with an alpha of .82.

Interdependence: Key family member, patient, and therapist interdependence was measured with the **Interdependent Subscale** of the **Self-Construal Scale (SCS)** (Singelis, 1994). The subscale consists of 12 items which evaluate the amount of emphasis a person places on connectedness and relations often found in non-Western cultures (e.g., "I will sacrifice my self-interest for the benefit of the group I am in"). The SCS uses a 7-point Likert scale, with 1 indicating strongly disagree and 7 indicating strongly agree. An overall score was obtained by summing the participant's scores for each item. Higher scores are indicative of greater levels of interdependence and family unity. This subscale has demonstrated good internal reliability with a Cronbach's alpha ranging from .73-.74 (Singelis, 1994). The current study demonstrated good overall

reliability with a Cronbach's alpha of .73, good reliability for key family members with an alpha of .73, as well as good reliability for patients with an alpha of .86.

Brief Psychiatric Rating Scale: Patient psychiatric symptom severity was measured using the **Brief Psychiatric Rating Scale (BPRS)** (Lukoff, Nuechterlein, & Ventura, 1986). The BPRS is a semi-structured interview consisting of 24 questions which evaluate psychotic symptoms, such as suspiciousness, hallucinations, and unusual thought content (e.g., "Have you heard any sounds or people talking to you or about you when there has been nobody around?"). The BPRS rates symptoms using a 7-point Likert scale, with 1 indicating not present and 7 indicating extremely severe. An overall score was obtained by summing across all items, with higher scores indicating greater symptom severity. Dr. Weisman de Mamani completed training on the BPRS and a quality assurance program with Dr. Joseph Ventura, the scale's creator. Dr. Weisman de Mamani trained all graduate student interviewers, who then coded six training videotapes. Intraclass correlations between interviewers and Dr. Ventura's ratings ranged from .79 to .98 for total BPRS scores.

Depression, Anxiety, and Stress: Family member and patient levels of GED were measured using the **Depression Anxiety Stress Scale (DASS)** (Lovibond & Lovibond, 1995). The DASS consists of 42 questions answered on a rating scale of 0 (Did not apply to me at all) to 3 (Applied to me very much, or most of the time). The scale is made up of three factors (depression, anxiety and stress) with 14 items per factor. An overall score was obtained by summing across all questions (e.g., "I felt that I was pretty worthless"), with higher scores indicating greater levels of GED. The DASS has excellent internal

consistency, test-retest reliability, convergent validity, and discriminant validity, with a Cronbach's alpha of .96 for family members (Brown, Chorpita, Korotitsch, & Barlow, 1997; Weisman de Mamani, Kymalainen, Rosales, & Armesto, 2007). The current sample also displays excellent overall reliability with a Cronbach's alpha of .97, excellent reliability for key family members with an alpha of .98, as well as excellent reliability for patients with an alpha of .97.

Quality of Life: Family member and patient QoL was measured using the **Quality of Life Inventory (QOLI)** (Frisch, Cornwell, Villanueva, & Retzlaff, 1991). The QOLI is a global measure of life satisfaction consisting of 24 items that conceptualize satisfaction across twelve domains (Health, Self-Esteem, Goals and Values, Money, Work, Play, Learning, Creativity, Helping, Love, Friends, and Spirituality). Each of these domains contains two parts: the importance of that domain for the individual's happiness (e.g., "How important is work to your happiness?"), and the level of satisfaction with that domain in the individual's life (e.g., "How satisfied are you with your work?"). Importance is measured in a 3-point Likert scale, with 0 indicating not important to 2 indicating very important. Satisfaction is measured on a 6-point Likert scale, with 0 indicating very dissatisfied to 5 indicating very satisfied. The QOLI has shown good internal consistency with a Cronbach's alpha of .86 (Frisch et al., 1991). The current study also demonstrated good overall reliability with a Cronbach's alpha of .88, good reliability for key family members with an alpha of .87, as well as good reliability for patients with an alpha of .86.

Client Satisfaction: Family member and patient satisfaction was measured using the one item **Consumer Satisfaction Survey**, which states "Using the following scale, how satisfied were you with the CIT-S treatment program?". This measure uses a 7-point Likert scale (1 "very dissatisfied" to 7 "very satisfied"). The mean satisfaction for family members was 5.86 (*SD* = 1.74), and similarly for patients was 5.81 (*SD* = 1.75).

CHAPTER THREE: RESULTS

Preliminary Analyses

All analyses were conducted using SPSS Statistics software, Version 22. All study variables had a skewness and kurtosis value within the normal range (skewness value of < |3| and kurtosis value < |10| as defined by Kline, 2005), thus no transformations were necessary. There was missing data for key family members (n = 20, 41.7%) and patients (n = 10, 27.8%) on satisfaction with treatment at termination. Since this variable was a one question item, these cases were excluded from analyses. There was no other missing data for key family members. For patients, mean imputation was used for cases with missing data on the interdependent subscale of the SCS (n = 1, 2.8%), on the I/E-R (n = 1, 2.8%), on the DASS (n = 9, 25%), and on the QoL (n = 3, 8.3%). Categorical demographic variables of gender, ethnicity, religion, and level of education were dummy-coded. To identify any potential covariates, the relationship between the demographic variables of gender, ethnicity, language of treatment, level of education, and religion and the dependent variables was examined for both key family members and patients, see Tables 3 and 4. There was a statistically significant relationship between GED, QoL, and level of education for key family members, see Table 3. Therefore, the level of education dummy coded variables will be included as covariates in analyses regarding the GED and QoL dependent variable for key family members. There were no significant covariates for patients (see Table 4), so only baseline levels of the constructs of interest will be controlled for in analyses.

Variables of interest were summed and averaged across items, resulting in an overall score. Higher scores are reflective of greater levels of the construct being

measured (e.g. greater GED, greater satisfaction). After total scores for the variables of interest (interdependence, religiosity/spirituality) were computed for patients, key family members and therapists, discrepancy values were calculated. The absolute value of patient and key family member total scores on these measures was subtracted from the overall score for therapists to constitute discrepancy values for the therapist and the key family member or patient. A smaller discrepancy score is indicative of greater similarity between the therapist and family member or patient.

Primary Analyses

A series of multiple linear regression analyses were run to test our primary hypotheses, controlling for any potential covariates. Treatment groups (CIT-S and PSY-ED), as well as patients and key family members, were analyzed separately. For both CIT-S and PSY-ED three analyses were run, regressing 1) QoL 2) GED and 3) treatment satisfaction on both religious discrepancy and interdependence discrepancy, along with any covariates found to be associated with that dependent variable. For patients, 4) BPRS at termination was also regressed on religious and interdependence discrepancy, controlling for baseline symptom severity. Below is a depiction of this regression equation using QoL as an example:

$$QoL = \alpha + \beta_1(\text{religious discrepancy}) + \beta_2(\text{interdependence discrepancy}) + \beta_n(\text{potential covariates…….e.g., gender})$$

Contrary to hypotheses, in the CIT-S group there was no relationship between therapist-family member ($\beta = -.10, p = .46$) or therapist-patient ($\beta = -.11, p = .57$) match on religious values and GED, controlling for baseline levels of GED for both groups, as

well as level of education for family members only. Moreover, in the CIT-S group there was no relationship between therapist-family member (β = -.17, p = .20) or therapist-patient (β = .02, p = .92) match on religious values and QoL, controlling for baseline levels of QoL for both groups, as well as level of education for family members only. In addition, there was no relationship between therapist-family member (β = -.03, p = .92) or therapist-patient (β = .32, p = .23) match on religious values and consumer satisfaction in the CIT-S group. The relationship between therapist-patient match on religious values and psychiatric symptoms at termination was also non-significant (β = -.24, p = .40) for those in the CIT-S group, controlling for baseline levels of psychiatric symptoms.

A similar pattern was found in the CIT-S group for therapist-family member and therapist-patient match on interdependent values. Specifically, there was no relationship between match on interdependent values and GED (β = -.06, p = .61), QoL (β = -.07, p = .64), or satisfaction (β = .16, p = .57), controlling for baseline levels of GED and QoL and covariates for family members. The same relationship emerged for therapist-patient match on interdependent values and psychiatric symptoms at termination (β = -.10, p = .73), GED (β = .12, p = .53), QoL (β = -.10, p = .52), or satisfaction (β = -.46, p = .09), controlling for baseline levels of psychiatric symptoms, GED, and QoL.

Results of therapist-client match on the variables of interest for the key family members and patients in the PSY-ED group were also non-significant. There was no relationship between therapist-family member match on religious values and GED (β = -.01, p = .93), or QoL (β = .43, p = .09), controlling for baseline levels of GED and QoL, respectively, as well as level of education. Moreover, there was no relationship for match on religious values and consumer satisfaction (β = .29, p = .47) for key family members

in the PSY-ED group. The same pattern occurred for patients in the PSY-ED group regarding therapist-patient match and religious values. Specifically, there was no relationship between match on religious values and psychiatric symptoms at baseline (β = .11, p = .61), GED (β = -.09, p = .61), QoL (β = .22, p = .40), or satisfaction (β = .41, p = .21), for patients, controlling for baseline levels of psychiatric symptoms, GED, and QoL.

The relationship between therapist-client match on interdependent values and GED (patient β = -.09, p = .60; family member β = -.33, p = .41), QoL (patient β = .08, p = .77; family member β = .03, p = .91), and satisfaction (patient β = .20, p = .53; family member β = -.07, p = .56) was non-significant for both patients and family members, as was the relationship between therapist-patient match on interdependent values and psychiatric symptoms at termination (β = -.34, p = .11). Since neither independent variable was significantly related to any of the dependent variables for either patients or key family members, the interaction of these relationships with treatment type was not examined.[1]

Content Analyses

Therapeutic sessions of the most similar and dissimilar therapist-key family member and therapist-patient match on religious and interdependent values were examined. Specifically, the most and least similar therapist-client pairs were selected based on the largest and smallest discrepancy value for interdependent and religious beliefs, based on the I/E-R and SCS. The absolute value of key family member and patient scores on the I/E-R and SCS at baseline were averaged and subtracted from the therapist's average score on each measure to constitute discrepancy values. The I/E-R

scale ranges from 1 to 5, whereas the interdependent subscale of the SCS ranges from 1 to 7. The least discrepant score possible for either variable was 0, whereas the most discrepant score possible was 4 for the I/E-R, and 6 for the interdependent subscale of the SCS. For therapists and patients, the most similar religious pair had a discrepancy value of .08, whereas the least similar pair had a value of 2.22, and the most similar interdependent pair had a discrepancy value of .16, whereas the least similar pair had a value of 2.59. For therapists and family members, the most similar pairs had a discrepancy value of .14 and .08 for religious and interdependent values, respectively. The least similar pairs for therapist and family members had a discrepancy value of 2.15 for religious values, and 1.50 for interdependent values.

Six video-taped therapy sessions that included the least and most discrepant values were then analyzed for the four matched dyads (three for the Family Collectivism module and three for the Spiritual Coping module). Qualitatively, there did not appear to be a significant difference in therapist-client interactions for the most and least similar pairs. In fact, regardless of whether the therapist and client had similar or dissimilar values, common themes emerged which will be elaborated on further in the discussion section.

CHAPTER FOUR: DISCUSSION

The overarching aim of this study was to examine the role of therapist-client similarity on religious and interdependent values in a family focused, culturally informed therapy for schizophrenia (CIT-S). A content analysis of the sessions for the most and least discrepant therapist-client dyads regarding family and religious beliefs was also conducted in order to examine whether common themes emerged for discrepant versus concordant pairs. Since CIT-S specifically targets religiosity/spirituality and collectivistic family values, we expected that therapist-family member and therapist-patient similarity on these values would be associated with fewer symptoms of GED, greater reported QoL, and greater overall treatment satisfaction, as well as fewer psychiatric symptoms at termination for patients. Contrary to our hypotheses, therapist-client similarity on religious and interdependent values was not a significant predictor of psychiatric symptoms, GED, QoL, or satisfaction at treatment termination, controlling for baseline symptoms and covariates. Nonetheless, it is important to note that CIT-S has previously been found to successfully reduce psychiatric symptoms and caregiver burden (Weisman et al, 2014; Weisman & Suro, in press). Thus, overall, the current study's findings demonstrate that similarity between therapist and client on religious and family collectivistic values did not significantly influence treatment efficacy or satisfaction. In other words, CIT-S was an effective treatment for patients and family members regardless of value similarity with the therapist.

Results from this study are consistent with previous research, which has found that therapist-client match on a host of demographic variables (e.g., gender, ethnicity) does not appear to enhance treatment efficacy (e.g., Bhati, 2014; Presnell et al., 2012).

Moreover, Weisman de Mamani and colleagues (2014) examined therapist-client ethnic match in this sample of patients and family members, and also found match to be unrelated to treatment efficacy and satisfaction. Notably, results from the current study extend previous literature and findings to suggest that therapists and clients having similar religious or family backgrounds offer no advantage in improving a religious and family based treatment for schizophrenia. In other words, demographic as well as cultural and background factors do not appear to influence treatment outcomes. This is encouraging as it may indicate that treatments can be satisfying and efficacious for clients regardless of therapist-client match.

With respect to the content analysis, we examined whether different themes emerged amongst discrepant versus concordant therapist-client dyads. We expected that therapists and clients of different backgrounds and values might discuss differences in opinion during sessions, or that therapist might impose or encourage his or her own value system to the client. Similarly, for therapists and clients with concordant values and backgrounds, we expected discussion might involve personal disclosure or examples to facilitate therapy. However, contrary to expectations, common themes emerged across both discrepant and concordant dyads chosen for the content analysis. These themes revolved around acceptance of differing opinions and values, as well as, sensitivity and understanding of the client's background. Rather than the therapists trying to impose their own personal religious or family values, the focus of therapy revolved around the adaptive use of the clients' beliefs in coping with illness. For example, the use of spiritual practices, such as meditation and prayer, were encouraged to reinforce therapeutic skills, such as relaxation and social support, regardless of therapist-client value similarity

regarding religiosity/spirituality. In fact, in no moment, did a therapist discuss similarities or grapple with differences between their values and those of their clients. Instead, the therapist's role was to acknowledge the patient or family member's belief or view point, and use this information to help him/her navigate difficult situations and cope with the stresses and burdens of being a caregiver/patient.

Moreover, when family members or patients had differences of opinion, the therapist continued to reinforce the overarching theme across varying religious and family values. To give an example, we had one Spanish-speaking mother-daughter family with differing opinions. The mother was of Christian faith, and the daughter more non-denominational and existential in her beliefs. In this case, the therapist had religious views similar to the mother (patient), and successfully balanced competing opinions by emphasizing the overarching similarities across the clients' religious perspectives. The therapist continually pointed out how much the family members actually had in common. Specifically, the therapist indicated to the mother and daughter the similarities in their way of thinking, referring to morals and principles they shared regardless of their specific religious doctrine. Despite the fact that the therapist's views were more similar to the mother (patient), she successfully balanced competing opinions by emphasizing the overarching similarities across religious perspectives.

In an earlier study using this data set, Carlson and Weisman de Mamani (2010) analyzed the videotaped therapy sessions from the first 23 families to enter treatment using a variant of the Therapist Competency Adherence Scale, and demonstrated excellent adherence and competence by all therapists in the current study. Results of the current study may be viewed as consistent with the findings Carlson and Weisman de

Mamani, in that the content analysis demonstrated that therapists were adherent to the CIT-S manual by focusing on family member communalities regardless of therapist-client similarity or dissimilarity. In other words, therapists continued to adhere and successfully administer the CIT-S treatment, even when their clients held differing values and beliefs.

Based on the current study's content analysis, results appear to coincide with previous research (e.g., Hook et al., 2013; Thompson et al., 1994), suggesting that the crux of therapist-patient similarity may rest more on cultural sensitivity and acceptance on the part of the therapist rather than on actual ethnic matching. Relatedly, Ackerman and Hilsenroth's work (2003) found that therapists received higher therapeutic alliance scores when clients reported them as higher on a number of personal characteristics, such as flexible, honest, respectful, trustworthy, confident, warm, interested, affirming, understanding, and open. Thus, in line with the importance of such personal characteristics, it may be that a therapist who is open and accepting of other values is more important for the therapeutic relationship and treatment efficacy than actual therapist-client matching on such values.

There were a number of limitations in the present study. First, the current study is limited by its small sample which was also predominantly Hispanic, and our findings may not generalize to the overall population or other minority groups. A small sample limited the power of the analyses, though results appear consistent with the majority of other studies (e.g., Weisman de Mamani et al., 2014). In addition, therapist and key family members were not randomly assigned to matched or mismatched value-similarity. There was also a large percentage of missing data for the variable of client satisfaction at

treatment termination in both key family members and patients. This may have further limited the power of analyses involving this variable, though again results appear consistent with previous research (e.g., Weisman de Mamani et al., 2014). Future studies might benefit from randomly assigning therapists to better examine the nuances within the therapeutic relationship.

In summary, our study findings demonstrate that therapist-client match on religious and interdependent values in key family members and patients with schizophrenia does not affect treatment efficacy or satisfaction at termination. It may be that therapist personal characteristics, such as flexibility, honesty and openness, may be more important than actual matched values. In other words, treatment efficacy and satisfaction may be more influenced when therapists are accepting and open to their client's values, regardless of value or background similarity. Although the CIT-S treatment specifically focuses on family and religious/spiritual values, the current study suggests that similarity in therapist-client values may have less impact on treatment efficacy and satisfaction. Thus, emerging mental health professionals and therapists might focus future training resources on acceptance and openness to differing opinions, as these may be more salient to the development of a strong therapeutic relationship, as well as to treatment outcomes.

Table 1
Demographic Variables by Treatment Condition for Key Family Members and Therapists

	CIT-S (n = 25)	PSY-ED (n = 23)	Therapist (n = 9)
Age	M = 58.56 (SD = 12.09)	M = 53.04 (SD = 8.24)	M = 27.18 (SD = 5.15)
Gender (n, % female)	18, 72%	17, 73.9%	6, 66.7%
Ethnicity (n, %)			
Caucasian	8, 32%	6, 26.1%	3, 33.3%
African American	N/A	6, 26.1%	N/A
Hispanic	16, 64%	11, 47.8%	5, 55.6%
Asian American	N/A	N/A	1, 11.1%
Other	1, 4%	N/A	N/A
Language of Treatment (n, % Spanish)	7, 28%	6, 26.1%	N/A
Religion			
Catholic	10, 40%	7, 30.4%	1, 11.1%
Christian	10, 40%	11, 47.8%	N/A
Jewish	3, 12%	2, 8.7%	1, 11.1%
Eastern	1, 4%	1, 4.3%	N/A
Atheist/Agnostic	1, 4%	1, 4.3%	5, 55.6%
Missing	N/A	1, 4.3%	2, 22.2%
Education (n, %)			
≤ High School	1, 4%	6, 26.1%	N/A
College	18, 72%	14, 60.9%	3, 33.3%
Experience			
Advanced Degree	6, 24%	2, 8.7%	6, 66.7%
Missing	N/A	1, 4.3%	N/A

Note. CIT-S = culturally informed treatment for schizophrenia; PSY-ED = psycho-education; M = mean; SD = standard deviation.

Table 2
Demographic Variables by Treatment Condition for Patients with Schizophrenia

	CIT-S (n = 17)	PSY-ED (n = 23)
Age	M = 34.65 (SD = 16.77)	M = 37.11 (SD = 12.76)
Gender (n, % female)	4, 23.5%	5, 26.3%
Ethnicity (n, %)		
Caucasian	6, 35.3%	5, 26.3%
African American	1, 5.9&	4, 21.1%
Hispanic	9, 52.9%	10, 52.6%
Other	1, 5.9%	N/A
Language of Treatment (n, % Spanish)	1, 5.9%	3, 15.8%
Religion		
Catholic	6, 35.3%	6, 31.6%
Christian	6, 35.3%	7, 36.8%
Jewish	2, 11.8%	2, 10.5%
Eastern	N/A	2, 10.5%
Atheist/Agnostic	3, 17.6%	2, 10.5%
Education (n, %)		
≤ High School	5, 29.4%	11, 57.9%
College Experience	11, 64.7%	8, 42.1%
Advanced Degree	1, 5.9%	N/A

Note. CIT-S = culturally informed treatment for schizophrenia; PSY-ED = psycho-education; M = mean; SD = standard deviation.

Table 3
Relationship Among Demographic Variables and Dependent Variables for Family Members

	Satisfaction	QoL	GED
Age	r = -.08, p = .69	r = -.06, p = .70	r = .02, p = .90
Gender	$t(47)$ = .02, p = .99	$t(47)$ = -.56, p = .58	$t(47)$ = .09, p = .93
Ethnicity	$t(47)$ = -1.04, p = .31	$t(47)$ = 1.07, p = .29	$t(47)$ = -.45, p = .66
Language of Treatment	$t(47)$ = .77, p = .45	$t(47)$ = -.68, p = .50	$t(47)$ = .28, p = .78
Religion			
Catholic	$t(47)$ = -.19, p = .85	$t(47)$ = -.10, p = .92	$t(47)$ = .22, p = .83
Christian	$t(47)$ = -.34, p = .73	$t(47)$ = .35, p = .73	$t(47)$ = .37, p = .71
Jewish	$t(47)$ = .17, p = .87	$t(47)$ = -.98, p = .34	$t(47)$ = .63, p = .53
Eastern	$t(47)$ = .75, p = .46	$t(47)$ = -.63, p = .53	$t(47)$ = -.24, p = .81
Education			
College Experience	β = -.18, p = .66	β = 2.58, p = .02*	β = -.39, p = .01*
Advanced Degree	β = .08, p = .72	β = 2.61, p = .05*	β = -.25, p = .01*

Note. Significant relationships starred (*). QoL = Quality of Life. GED = General Emotional Distress.

Table 4
Relationship Among Demographic Variables and Dependent Variables for Patients

	BPRS	Satisfaction	QoL	GED
Age	r = .05, p = .79	r = -.14, p = .47	r = -.23, p = .19	r = .21, p = .28
Gender	$t(35)$ = -1.00, p = .33	$t(35)$ = -.42, p = .68	$t(35)$ = .16, p = .87	$t(35)$ = .46, p = .65
Ethnicity	$t(35)$ = 1.28, p = .21	$t(35)$ = -.70, p = .49	$t(35)$ = 1.46, p = .15	$t(35)$ = -1.41, p = .17
Language of Treatment	$t(35)$ = .20, p = .84	$t(35)$ = 1.35, p = .19	$t(35)$ = -1.12, p = .27	$t(35)$ = .14, p = .89
Religion				
Catholic	$t(35)$ = -.90, p = .38	$t(35)$ = -.19, p = .85	$t(35)$ = -.10, p = .92	$t(35)$ = .22, p = .83
Christian	$t(35)$ = -.54, p = .59	$t(35)$ = -.34, p = .73	$t(35)$ = .35, p = .73	$t(35)$ = .37, p = .71
Jewish	$t(35)$ = -.18, p = .86	$t(35)$ = .17, p = .87	$t(35)$ = -.98, p = .34	$t(35)$ = .63, p = .53
Eastern	$t(35)$ = -.44, p = .67	$t(35)$ = .75, p = .46	$t(35)$ = -.63, p = .53	$t(35)$ = -.24, p = .81
Education				
College Experience	β = -.20, p = .12	β = .38, p = .15	β = -.08, p = .53	β = -.22, p = .23
Advanced Degree	β = -.01, p = .53	β = .23, p = .39	β = -.14, p = .55	β = -.07, p = .49

Note. BPRS = Brief Psychiatric Rating Scale. QoL = Quality of Life. GED = General Emotional Distress.

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Notes

[1] Although therapist-client match on religious and interdependent values was not a significant predictor of any dependent variable for neither patients nor family members, we also wondered whether participants' baseline levels of these constructs would predict GED, QoL and psychiatric symptoms (for patients only). Thus, on an exploratory basis, we ran a series of multiple linear regression analyses to examine whether higher baseline levels of religiosity and interdependence were predictive of lower GED, greater QoL, and lower psychiatric symptom severity (for patients only). However, no significant relationships were observed.

Handout 1 (Collectivism)

Family Oriented Culturally Informed Therapy for Schizophrenia

ORIENTATION

Role of the Therapist:

- Coordinate, guide, and assist

Goals:

- Reduce tension in family relationships and Improve sense of cooperation and team spirit
- Increase understanding and acceptance of illness
- Increase spiritual and philosophical coping resources
- Improve family's internal communication
- Assist family in developing adaptive problem solving strategies

Format:

- Assessment of each member individually
- Provide education regarding nature of illness, and treatment prescribed, specifically medication
- Spiritual and existential coping techniques
- Communication skills
- Problem solving
- Strategies for specific problems

Expectation of Family Members:

- Quality attendance and participation
- Active role playing
- Completion of all homework assignments
- Cooperation

Family can expect me to provide:

- Quality attendance
- Thoughtful systematic intervention
- Strict confidentiality except with supervisor
- A comfortable working environment
- Journals
- Homework materials
- Telephone consultation

Handout 2 (Collectivism)

1. What does the word family mean to you?

2. What does it mean to you to identify as a member of your particular family?

3. What is the structure of your family (e.g., Is there a hierarchy? Are there alliances or conflicts between certain members? Does one member tend to serve as spokesperson or moderator?)

4. How do you see your role in the family?

5. Are you satisfied with that role?

6. How do you contribute to your family?

7. Do you think you could or should be contributing more or differently?

8. What is the role of other members in your family (discuss each person)?

9. How do they contribute to the family?

10. Do you think they could or should be contributing more or differently?

11. What is your ideal family?

12. How does your actual family compare to your ideal family?

Handout 3 (Education)

Symptoms of Schizophrenia

Common Positive Symptoms (behavioral excesses)

- Hallucinations (e.g., hearing voices, or seeing, smelling, or experiencing sensations that are not actually present)
- Delusions (thoughts that most other people in your subculture would regard as totally implausible)
- Odd thinking and speech (e.g., vague, metaphorical, over-elaborate speech)
- Suspiciousness or paranoid ideation (e.g., beliefs that others are trying to harm you)
- Ideas of reference (e.g., beliefs that others are talking about you)
- Inappropriate affect (e.g., laughing uncontrollably for no reason or upon hearing sad news)

Common Negative Symptoms (behavioral deficits)

- Constricted or flat affect (e.g., restricted smiling or facial expression)
- Poor hygiene (e.g., failing to bathe, wearing disheveled clothing)
- Disinterest in close friends or confidants
- Poverty of thoughts (e.g., difficulty finding words to express oneself)
- Slowness of movement
- Lack of motivation or drive

HOW DO PEOPLE GET SYMPTOMS OF SCHIZOPHRENIA?

- People are born with a genetic predisposition to develop schizophrenia
    - The rate of schizophrenia in first-degree relatives of people with schizophrenia is 8-10%
    - People have a "biological vulnerability" to develop it (i.e., a tendency for the nervous system to become overactive when under stress). Vulnerability changes due to maturation, hormones, etc.
    - The environment may become more stressful (e.g., increases in social or job demands, life events). A stressful environment may interact with a biological vulnerability
    - Drug abuse (PCP, alcohol, marijuana, cocaine) can set off an existing biological vulnerability
    - Coping skills may be inadequate to deal with environmental stress

HOW CAN THE FAMILY HELP?

- Assist in obtaining treatment & rehabilitation services
- Support the use of medication
- Maintain tolerant & low key home atmosphere
- Reduce performance expectations to realistic level
- Encourage participation in treatment and low stress activities

1. Is religion or spirituality important to you?

2. What do these terms mean to you?

3. What is your concept of God or a higher power?

4. What is your main religious or spiritual identity?

5. In which religious tradition were you raised?

6. What effect does religion/spirituality have on you today?

7. What is the role of prayer or meditation in your life?

8. What is the primary content of your prayers or your main thoughts during meditation?

9. What religious/spiritual beliefs and values are important to you?

10. What religious rituals and practices are important to you?

11. Do your religious and spiritual beliefs influence the way you look at problems, such as mental illness, and the way you think about your health?

12. What religious or spiritual issues, if any, have caused problems in your relationships?

13. If resolved, how did you resolve them?

1. What are your guiding existential or philosophic beliefs (e.g., are human beings basically good or bad? What is the purpose or meaning of life?)

2. Are there any supreme beings? What is your concept of a higher power?

3. Were you raised in any spiritual tradition?

4. Which of your values are most important to you?

5. What are your ideas about morality and the concepts of right and wrong?

6. Do you have any rituals or practices that are important to you (e.g., meditation, yoga)?

7. Do your existential philosophical beliefs influence the way you look at problems, such as mental illness, and the way you think about your health?

8. Have any of your existential philosophical beliefs caused problems in your relationships?

9. If resolved, how did you resolve them?

_____

_____

_____

1) **Purify Motivation:**
- Relinquish attachments to substances, feelings, possessions, and vices, that impede in the quest for mental and physical health and happiness
- Recognize truer nature and more healthful goals

2) **Cultivate Emotional Wisdom:**
- Master and reduce toxic and painful affects such as intense anger and fear
- Foster positive attitudes such as forgiveness, gratitude, and generosity
- Cultivate positive emotions such as love, empathy, and compassion

3) **Develop a Peaceful Mind:**
- Prayer
- Yoga
- Contemplation
- Meditation

4) **Cultivate Wisdom and Spiritual Intelligence:**
- Religious/spiritual or existential/philosophical readings
- Attendance at church, temple or other organized groups
- Discussions with priests, rabbis, scholars or other health healers

ACTIVE LISTENING

- LOOK AT THE SPEAKER
- ATTEND TO WHAT IS SAID
- NOD HEAD, SAY “UH-HUH”
- ASK CLARIFYING QUESTIONS
- CHECK OUT WHAT YOU HEARD

EXPRESSING POSITIVE FEELINGS

- LOOK AT THE PERSON
- SAY EXACTLY WHAT THEY DID THAT PLEASED YOU
- TELL THEM HOW IT MADE YOU FEEL

MAKING A POSITIVE REQUEST*

- LOOK AT THE PERSON
- SAY EXACTLY WHAT YOU WOULD LIKE THEM TO DO
- TELL THEM HOW IT WOULD MAKE YOU FEEL

*IN MAKING POSTIVE REQUESTS, USE PHRASES LIKE:

- "I would like you to _____."
- "I would really appreciate it if you would do _____."
- "It's very important to me that you help me with _____."

EXPRESSING NEGATIVE FEELINGS

- LOOK AT THE PERSON: SPEAK FIRMLY
- SAY EXACTLY WHAT THEY DID THAT UPSET YOU
- TELL THEM HOW IT MADE YOU FEEL
- SUGGEST HOW THE PERSON MIGHT PREVENT THIS HAPPENING IN THE FUTURE

SOLVING PROBLEMS

- AGREE ON THE PROBLEM
- SUGGEST SEVERAL POSSIBLE SOLUTIONS
- DISCUSS PROS AND CONS AND AGREE ON THE BEST SOLUTIONS
- PLAN AND CARRY OUT THE BEST SOLUTION
- PRAISE EFFORTS: REVIEW EFFECTIVENESS

PROBLEM SOLVING WORKSHEET

Step 1: Define "What is the problem?" Talk. Listen. Ask questions. Get everybody's opinion.

_____
_____
_____
_____

Step 2: List all possible solutions
"Brainstorm"—Put down all ideas, even bad ones.
Get everybody to come up with at least one possible solution.
DO NO EVALUATE ANY SOLUTION AT THIS POINT

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Step 3: Discuss and list the advantages and disadvantages of each possible solution

Advantages	Disadvantages
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Step 4: Choose the best possible solution OR solutions and list. (May be a combination of possible solutions.)

_____
_____
_____
_____

Step 5: Plan how to carry out the chosen solutions, AND set a date to Implement it.

Date: _____

A. Specifically decide who will do what. List.

_____
_____
_____
_____

B. Decide what resources will be needed, list and obtain them.

_____
_____
_____
_____

C. Anticipate what can go wrong during implementation and decide how to overcome the problems.

_____
_____
_____
_____

D. Rehearse the implementation of the solution.

E. DO IT! (Implement the chosen solution on schedule.)

Step 6: Review the implemented solution and give positive feedback to all participants about their participation.

Step 7: If the implemented solution was unsuccessful, go back to Step 1 and try again. Do no become discouraged.

Appendix B

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?_____

Intrinsic/Extrinsic-Revised (I/E-R) Scale

Answer questions based on the LAST 3 MONTHS or SINCE YOUR LAST ASSESSMENT.

1. I enjoy reading about my religion

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

2. I attend religious services because it helps me make friends

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

3. It doesn't much matter what I believe so long as I am good

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

4. It is important to me to spend time in private thought and prayer

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

5. I have often had a strong sense of God's presence.

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

6. I pray mainly to gain relief and protection

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

7. I try hard to live all my life according to my religious beliefs.

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

8. What religion offers me most is comfort in times of trouble and sorrow.

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

9. Prayer is for peace and happiness.

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

10. Although I am religious, I don't let it affect my daily life. (Note: Answer "5" if you are not religious)

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

11. I go to religious services mostly to spend time with my friends.

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

12. My whole approach to life is based on my religion.

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

13. I go to religious services mainly because I enjoy seeing people I know there.

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

14. Although I believe in my religion, many other things are more important in life. (Note: answer "5" if you are not religious)

1 = I strongly disagree 4 = I tend to agree
2 = I tend to disagree 5 = I strongly agree
3 = I'm not sure

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

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 raring 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, in 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. 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 ad 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 STANDARIZED REFERENCE GROUP IN MAKIG RATINGS

The proper reference group for conducting assessments is a group of normal individuals who are <u>not</u> 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 crashers, 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. "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 heat 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 fast?
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. D

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.

Brief Psychiatric Rating Scale (Version 4.0)

Name/ID #_____ Date_____Rater_____
Hospital/Location_____ Period of assessment_____

NA 1 2 3 4 5 6 7
Not Assessed Not Present Very Mild Mild Moderate Moderately Severe Severe Extremely Severe

Rate items 1-14 on the basis of patient's self-report during interview. Mark "NA" for symptoms not assessed.
Note items 7, 12, and 13 are also rated on observed behavior during the interview. PROVIDE EXAMPLES.

1.	Somatic Concern	NA	1	2	3	4	5	6	7
2.	Anxiety	NA	1	2	3	4	5	6	7
3.	Depression	NA	1	2	3	4	5	6	7
4.	Suicidality	NA	1	2	3	4	5	6	7
5.	Guilt	NA	1	2	3	4	5	6	7
6.	Hostility	NA	1	2	3	4	5	6	7
7.	Elevated Mood	NA	1	2	3	4	5	6	7
8.	Grandiosity	NA	1	2	3	4	5	6	7
9.	Suspiciousness	NA	1	2	3	4	5	6	7
10.	Hallucinations	NA	1	2	3	4	5	6	7
11.	Unusual Thought Content	NA	1	2	3	4	5	6	7
12.	Bizarre Behavior	NA	1	2	3	4	5	6	7
13.	Self-neglect	NA	1	2	3	4	5	6	7
14.	Disorientation	NA	1	2	3	4	5	6	7

Rate items 15-24 on the basis of observed behavior or speech of the patient during the interview.

15.	Conceptual Disorganization	NA	1	2	3	4	5	6	7
16.	Blunted Affect	NA	1	2	3	4	5	6	7
17.	Emotional Withdrawal	NA	1	2	3	4	5	6	7
18.	Motor Retardation	NA	1	2	3	4	5	6	7
19.	Tension	NA	1	2	3	4	5	6	7
20.	Uncooperativeness	NA	1	2	3	4	5	6	7
21.	Excitement	NA	1	2	3	4	5	6	7
22.	Distractibility	NA	1	2	3	4	5	6	7
23.	Motor Hyperactivity	NA	1	2	3	4	5	6	7
24.	Mannerisms and Posturing	NA	1	2	3	4	5	6	7

Sources of information (check all applicable):
_____Patient
_____Parents/Relatives
_____Mental Health Professionals
_____Chart

Explain here if validity of assessment is questioned
_____Symptoms possibly drug-induced
_____Underreported due to lack of rapport
_____Underreported due to negative symptoms
_____Patient uncooperative
_____Difficult to assess due to formal thought disorder

Confidence in assessment:
_____1: Not at all 5: Very confident

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 feel 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.

Quality of Life Inventory

DIRECTIONS: This survey asks how satisfied you are with parts of your life such as your work and your health. It also asks how important these things are to your happiness. Special definitions are used for words like "money," "work," and "play." Keep these definitions in mind as you answer the questions. Answer every question, even if it does not seem to apply to you. It is your feelings and opinions that are important, so there are no right or wrong answers. Just give the answers that best describe you. Answer questions based on the LAST 3 MONTHS or SINCE YOUR LAST ASSESSMENT.

The survey asks you to describe how **important** certain parts of your life (such as work and health) are and how **satisfied** you are with them.

Important means how much this part of your life adds to your overall happiness. You can say how important something is by picking one of three choices: "Not Important" (0), "Important" (1), or "Extremely Important" (2).

Satisfied means how well your needs, goals, and wishes are being met in this area of life. You can say how satisfied you are by picking one of three choices from "Very Dissatisfied" (0) to "Very Satisfied" (5).

For each question, circle the number that best describes you.

HEALTH is being physically fit, not sick, and without pain or disability.

1. How important is HEALTH to your happiness?

0	1	2
not important	important	extremely important

2. How satisfied are you with your HEALTH?

0	1	2	3	4	5
Very	Somewhat	A little	A little	Somewhat	Very
	DISSATISFIED			SATISFIED	

SELF-ESTEEM means liking and respecting yourself in light of your strengths and weaknesses, successes and failures, and ability to handle problems.

3. How important is SELF-ESTEEM to your happiness?

0	1	2
not important	important	extremely important

4. How satisfied are you with your SELF-ESTEEM?

0	1	2	3	4	5
Very	Somewhat	A little	A little	Somewhat	Very
	DISSATISFIED			SATISFIED	

GOALS-AND-VALUES are your beliefs about what matters most in life and how you should live, both now and in the future. This includes your goals in life, what you think is right or wrong, and the purpose or meaning of life as you see it

5. How important are GOALS-AND-VALUES to your happiness?

0	1	2
not important	important	extremely important

6. How satisfied are you with your GOALS-AND-VALUES?

0	1	2	3	4	5
Very	Somewhat	A little	A little	Somewhat	Very
	DISSATISFIED			SATISFIED	

MONEY is made up of three things. It is the money you earn, the things you own (like a car or furniture) and believing that you will have the money and things you need in the future.

7. How important is MONEY to your happiness?

0	1	2
not important	important	extremely important

8. How satisfied are you with your MONEY?

0	1	2	3	4	5
Very	Somewhat	A little	A little	Somewhat	Very
	DISSATISFIED			SATISFIED	

WORK means your career or how you spend most of your time. You may work at a job, at home taking care of your family, or at school as a student. WORK includes your duties on the job, the money you earn (if any), and the people you work with. (If you are unemployed, retired, or can't work, you can still answer these questions).

9. How important is WORK to your happiness?

0	1	2
not important	important	extremely important

10. How satisfied are you with your WORK?

0	1	2	3	4	5
Very	Somewhat	A little	A little	Somewhat	Very
	DISSATISFIED			SATISFIED	

PLAY is what you do in your free time to relax, have fun, or improve yourself. This could include watching movies, visiting friends, or pursuing a hobby like sports or gardening.

11. How important is PLAY to your happiness?

0	1	2
not important	important	extremely important

12. How satisfied are you with your PLAY?

0	1	2	3	4	5
Very	Somewhat	A little	A little	Somewhat	Very
	DISSATISFIED			SATISFIED	

LEARNING means gaining new skills or information about things that interest you. LEARNING can come from reading books or taking classes on subjects like history, car repair, or using a compute.

13. How important is LEARNING to your happiness?

0	1	2
not important	important	extremely important

14. How satisfied are you with your LEARNING?

0	1	2	3	4	5
Very	Somewhat	A little	A little	Somewhat	Very
	DISSATISFIED			SATISFIED	

CREATIVITY is using your imagination to come up with new and clever ways to solve everyday problems or to pursue a hobby like painting, photography, or needlework. This can include decorating your home, playing the guitar, or finding a new way to solve a problem at work.

15. How important is CREATIVITY to your happiness?

0	1	2
not important	important	extremely important

16. How satisfied are you with your CREATIVITY?

0	1	2	3	4	5
Very	Somewhat	A little	A little	Somewhat	Very
	DISSATISFIED			SATISFIED	

HELPING means helping others in need or helping to make your community a better place to live. HELPING can be done on your own or in a group like a church, a neighborhood association, or a political party. HELPING can include doing volunteer work at a school or giving money to a good cause. HELPING means helping people who are not your friends or your relatives.

17. How important is HELPING to your happiness?

0	1	2
not important	important	extremely important

18. How satisfied are you with your HELPING?

0	1	2	3	4	5
Very	Somewhat	A little	A little	Somewhat	Very
	DISSATISFIED			SATISFIED	

LOVE is a very close romantic relationship with another person. LOVE usually includes sexual feelings and feeling loved, cared for, and understood. (If you do not have a LOVE relationship, you can still answer these questions.)

19. How important is LOVE to your happiness?

0	1	2
not important	important	extremely important

20. How satisfied are you with your LOVE?

0	1	2	3	4	5
Very	Somewhat	A little	A little	Somewhat	Very
	DISSATISFIED			SATISFIED	

FRIENDS are people (not relatives) who you know well and care about and that have interests and opinions like yours. FRIENDS have fun together, talk about personal problems, and help each other out. (If you have no FRIENDS, you can still answer these questions).

21. How important are FRIENDS to your happiness?

0	1	2
not important	important	extremely important

22. How satisfied are you with your FRIENDS?

0	1	2	3	4	5
Very	Somewhat	A little	A little	Somewhat	Very
	DISSATISFIED			SATISFIED	

Consumer Satisfaction (overall)

Using the following scale, how satisfied were you with the CIT-S treatment program?

Very Dissatisfied			Somewhat Satisfied			Very Satisfied
1	2	3	4	5	6	7

Please provide comments if you wish: