
Tangible Needs and External Stressors Faced by Chinese American Families with a Member Having Schizophrenia

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This article examines the tangible needs and external stressors experienced by Chinese American families with a member living with schizophrenia, in the context of a six-month pilot study of family psychoeducation. Therapists' notes from 117 family and group sessions were analyzed. The families expressed concerns regarding housing, finance, work, study, and the shortage of bilingual psychosocial services. Interacting with government offices and social services agencies caused anxiety and frustration, partly due to the high stakes involved given their low socioeconomic status, and partly due to the bureaucracy. As immigrants, study participants had needs for language translation, knowledge about resources, and advocacy by case managers. This study also highlights the importance of interventions beyond the micro individual level to the mezzo and macro levels, where changes in organizations and policies are necessary.

KEY WORDS: *caregivers; Chinese Americans; environmental stressors; ethnic sensitivity; schizophrenia*

This study aims to address the knowledge gap in understanding the challenges faced by Chinese American families with a member living with schizophrenia in relation to their tangible needs and external stressors from the environment. I conducted this research in the context of an intervention study of family psychoeducation that I previously developed and pilot-tested as an ethnic-sensitive program for Chinese Americans (Kung, Tseng, Wang, Hsu, & Chen, 2012). Family psychoeducation has been proven effective in reducing caregiver stress and the relapse rate of individuals with schizophrenia (Jewell, Downing, & McFarlane, 2009; Lefley, 2010; McFarlane, Dixon, Lukens, & Lucksted, 2003). The intervention protocols focus on educating the families about the nature of the illness, promoting better communication, and helping family members resolve conflicts (Anderson, Reiss, & Hogarty, 1986; McFarlane, 2002) to reduce “expressed emotions” such as criticism and overinvolvement, which highly predict relapses (Butzlaff & Hooley, 1998; Hooley, 2007; Leff & Vaughn, 1985; Marom, Munitz, Jones, Weizman, & Hermesh, 2005). Few studies had been conducted with Chinese American families, many of whom face unique challenges due to their immigrant status and cultural values (Kung, 2003).

To more thoroughly understand the stresses experienced by these families so as to better meet their needs and to refine the family psychoeducation protocol, a qualitative inquiry was conducted using the clinicians' session notes from the intervention study. Whereas the family psychoeducation model in its original design focused on resolving the psychological and relational issues within the families, this investigation noted that these families' struggles were closely tied to their tangible needs. These needs included basic livelihood such as housing, employment, and finance. They were also faced with stresses that were imposed on them from external systems. These findings highlight the importance for human services practitioners to use the person-in-environment lens in understanding Chinese American families and to intervene at various systems levels to facilitate current relief and lasting changes.

BACKGROUND LITERATURE

Stressors for Chinese American Families

Individuals living with schizophrenia, with its debilitating symptoms and a relapsing course, face enormous challenges. The active symptoms affect their cognition, emotions, behaviors, and quality of life, leading to chronic disability requiring a lot of assistance

(American Psychiatric Association, 2013). For many, their families are their major source of support (Hatfield, 1990). However, the family caregivers are also subjected to immense stress, which affects both their physical health and their mental health (Awad & Voruganti, 2008; Glanville & Dixon, 2005; Hatfield, 1990; Rose, 1996; Tessler & Gamache, 2000). These families need resources in the community to help them cope. In the caregiving literature, caregivers' appraisal of available resources was found to affect their stress level (Zegwaard, Aartsen, Cuijpers, & Grypdonck, 2011), which is in accord with the now classic stress and coping model as postulated by Lazarus and Folkman (1984).

Chinese American families with a member living with schizophrenia experience extra burden due to their immigrant status and cultural values. As immigrants, their knowledge about community resources and social support may be limited, and they have to cope with stresses related to the language barrier and racial discrimination (Sue, Cheng, Saad, & Chu, 2012). In fact, 68% of Chinese Americans are immigrants whose most proficient language is not English (U.S. Census Bureau, 2014). These realities may further compromise their ability to negotiate the systems.

People of Chinese descent are one of the fastest-growing minority groups in the United States, and are now the largest group (24%) within the Asian/Pacific Islander population (U.S. Census Bureau, 2014). Asians being the "model minority" with good health and mental health and socioeconomic stability has been proven a myth (Sue et al., 2012). The extreme cultural stigma ascribed to mental illness can further alienate efforts to seek social support from within the community (WonPat-Borja, Yang, Link, & Phelan, 2012) and dampen efforts to seek external help (Abe-Kim et al., 2007). When coupled with a cultural obligation to care for their family members, caregiver stress is aggravated (Zegwaard, Aartsen, Grypdonck, & Cuijpers, 2013). Because many Chinese immigrants are of lower socioeconomic status (SES) (15.6% live below the poverty line [U.S. Census, 2013]), unmet tangible needs are likely to cause enormous burden when their ability to navigate the complex service systems is limited.

Contribution of This Qualitative Study

Although an increasing number of qualitative studies have explored the stresses experienced by families with a member living with serious mental illness

(SMI) (for example, Corsentino, Molinari, Gum, Roscoe, & Mills, 2008; González-Torres, Oraa, Aristegui, Fernández-Rivas, & Guimon, 2007), few have included Asian Americans. Studies also tended to address families' internal stressors (Zegwaard et al., 2011) while paying little attention to their tangible needs and external stressors. The factors highlighted in this study could be relevant, especially for immigrant families with limited means. This qualitative study addresses this knowledge gap by analyzing family and group therapy session notes collected in an intervention research of family psychoeducation with Chinese Americans.

In qualitative studies on families with SMIs, analyzed data were usually based on one-time interviews of participants who reflected on their experiences (for example, Corsentino et al., 2008). A limitation of these studies is that whereas they may depict participants' most pressing issues at the time of the interviews, participants' ongoing struggles are sometimes taken for granted and omitted, even though these challenges may affect them tremendously. A literature review on stress experienced by families with a member having schizophrenia noted no study based on data collected over time during treatment.

Therapy session notes have been used in qualitative studies to capture the major themes in treatment and issues faced by clients (for example, Chenail, Somers, & Benjamin, 2009; Floersch, 2000). Therapy notes may provide a deeper ongoing understanding of clients' struggles. Clinicians who have been treating these individuals or families over time provide a valuable perspective in understanding their experiences, which complements the client perspective (Swartz, 2006). This report is a novel examination of stress in families with a member living with schizophrenia.

It should be noted that although the use of the term "patients" to describe research participants is outdated, except in clinical outcome studies, for ease of reference it will be adopted for the rest of this discussion because this investigation is based on a clinical intervention study in which participants recruited were diagnosed with schizophrenia and were called patients in the setting in which they were treated.

METHOD

Context of the Family Psychoeducation Study

This ethnic-sensitive family psychoeducation study was a pilot study that I developed specifically for Chinese Americans based on the cultural and contextual

needs of this immigrant population. It involved six months of biweekly individual family treatment in which the patient diagnosed with schizophrenia and his or her caregivers were present, and a biweekly relatives' group for caregivers only. The study took place at one of the biggest mental health agencies serving the Asian population in a northeastern city in the United States. Informed consent from the participants and Fordham University institutional review board approval were obtained. Details of the recruitment process and the protocol are available in the published outcome study (Kung et al., 2012). The inclusion criteria for the patients were that they be Mandarin- or Cantonese-speaking Chinese, age 18 or over, with a schizophrenic form of disorder as diagnosed by the treating psychiatrist, and with one or more relatives willing to participate in the study. Relatives also had to be 18 or older, speak Mandarin or Cantonese, and either live with or contact the patient at least once a month. They could be parents, spouses, or siblings. Twelve families were enrolled in the study. Nine were assigned to the intervention group and three to the comparison group based mainly on their geographic distance from the agency and the caregivers' fluency in Mandarin or Cantonese, given that they were the languages spoken in the relatives' group. Session notes available from the nine families in intervention group alone were examined and reported in this study.

Two trilingual clinicians of Chinese descent were involved in the intervention study. One was the agency's therapist with a master's degree in counseling psychology and four years of full-time clinical experience. I was the other clinician, and the principal investigator, who became involved because it was hard to recruit trilingual therapists (some young patients spoke better English than Chinese). I have an MSW, a PhD in social work, and nine years of full-time clinical experience. I also provided weekly to biweekly supervision to the agency therapist. The former treated four families; the latter treated the remaining five. Both clinicians co-led the relatives' group.

Collection of Qualitative Data and Analyses

Detailed session notes in English, also part of the agency record, were used in this analysis. Family session records documented case development, interventions used, client responses, and tasks assigned. Group session records reported psychoeducation provided, group responses and process, questions

raised, and discussion. Intake summaries and family and group session notes were analyzed for the present report.

Two families had two caregivers participating throughout the study; the remaining seven had one enrolled caregiver. In addition, eight relatives who initially did not enroll in the program were also involved in one to four family sessions, and three additional relatives came to the relatives' group for one to six sessions. Thus data included in this qualitative study were based on nine patients and 19 relatives, with records from 104 family sessions and 13 group sessions.

Session notes were organized and analyzed using the coding techniques and the constant comparison method in grounded theory (Corbin & Strauss, 2008). Qualitative analysis software ATLAS.ti (version 6.0) was used for data organization and retrieval. I coded the data using open, axial, and selective coding line-by-line (Charmaz, 2006). In coding the first three cases, when new codes emerged I went back to the previously coded cases and recoded. At the end, all codes were grouped into broader categories. The other clinician acted as the second coder. Due to time and resource constraints, the second coder overlaid her coding onto documents already coded by me, using the developed code structure while adding new codes as needed. Discussion between the two coders ensued to negotiate differences in coding. Both coders wrote memoranda throughout the coding process to facilitate later discussion and distillation of the codes and categories (Charmaz, 2006). I then went through the documents a third time and applied the final agreed-on streamlined code structure. Next, I reread all the quotations under each code, reflecting on emerging themes using memos written by both coders. Triangulation from various angles was used to ensure accuracy in capturing and interpreting the complex realities (Sands, Bourjolly, & Roer-Strier, 2007). The trustworthiness of the data interpretation was also enhanced because both coders were familiar with all the participants through involvement in the relatives' group, and I also supervised the second coder's clinical work.

FINDINGS

Participant Demographics

The patients' average age was 32 ($SD = 13.64$; range: 18 to 51). Two-thirds were never married, and one-third were married or in a live-in relationship at the time of the study. Most patients resided with their

immediate or extended families (88.9%); only one lived in a residential facility for individuals with mental illness. The caregivers' relationship with the patients varied, including parents (53%), spouses, a sibling, and a live-in boyfriend. The mean age of the caregivers was 56 ($SD = 12.38$; range: 44 to 79), and average schooling was 10 years ($SD = 2.39$). All reported an annual family income of less than \$40,000, with two-thirds earning \$20,000 or less. Although the group came from mostly middle and lower middle class, the very low reported income was likely due to retirement of some caregivers and to less-than-reliable financial disclosure in others. Most relatives were not recent immigrants; the median years of living in the United States was 22 (range: 1.5 to 70). Despite the length of migration, the participants, with the exception of one patient who spoke better English than Chinese, had low acculturation based on their English proficiency and the circle in which they worked or socialized. No family dropped out of the study. The mean number of family sessions conducted was 9.78 (range: 3 to 14). On average, caregivers attended 10 out of the 13 group sessions. Improvement was noted at termination and at six-month follow-up compared with the baseline for the intervention group. Areas of improvement included patients' symptomatology and quality of life, and caregivers' knowledge of the illness, knowledge of treatment and community resources, and social support. These improvements were greater in the intervention group than the comparison group.

Tangible Needs and External Stressors

Major themes emerged regarding families' tangible needs and external stressors. Tangible needs included housing, finance, study, and work, while external stresses resulted from interacting with outside systems. Also captured were patient and caregiver strengths. All are discussed in detail in the following sections with selected quotes cited from the session notes to illustrate the points.

Stress from Housing. One of the most basic tangible human needs and rights is decent housing. However, many families had to live in very crowded environments, which was a source of stress. Seven out of the nine families lived with extended families at some point in the past two years, and four still did during the study. Without adequate physical space, familial stress seemed exacerbated. In one family, due to financial constraint, the patient and her parents had to continue living with the married sister's fam-

ily and her in-laws, even after the sister had died more than a year ago. This further strained the already uncomfortable relationship. The housing issue was finally resolved when the parents were granted senior housing and the patient was placed in a residential facility for individuals with mental illness after a brief stay at a shelter. However, the family continued to experience stress as the senior housing was in a distant community with a high crime rate and no Chinese-speaking neighbors. The patient also felt insecure living by herself at the residential facility due to language and cultural barriers. The family wanted the whole family to live together so that they could take care of each other. However, under the current housing policy no such provision was available for families with an adult child. In another family, the 23-year-old male patient who had delusions and obsessions with sexual themes had to live with his single mother in a studio in the basement with no partition. The impact of the lack of privacy in such an environment was hard to estimate as he struggled with his sexual issues.

Financial Stress. Finance is at the core of many tangible needs. For the majority of the families, money was a major concern. During the family sessions, only two out of eight families did not raise any financial issues throughout: One had relatively stable income, with the patient's spouse being semiretired; the other was a single working mother living with her son with mental illness in a basement studio. It is interesting to note that those most concerned about money were not the poorest. In contrast, some relatively affluent families who owned their small businesses were very distressed about money. A patient's obsessive worries about keeping her restaurant business afloat and money lent to clansmen caused much stress. In fact, this was the trigger for the onset and relapses of her mental illness. Another family having no means to pay for the day treatment program suitable for the patient decided not to enroll her because it was not covered by Medicaid.

The theme of finance actually inundated the treatment process. These families' daily struggles seemed inseparable from money matters and were raised rather frequently during individual family sessions. Concerns were related to social security benefits, including disability assistance, food stamps, and Medicaid. For one family, the patient and her parent's upcoming naturalization interviews in English became a major stressor, because failing it would mean denial of entitlement to more benefits. Entanglement

with extended families about money became the central issue for two patients. They were upset by the incessant financial demands from the in-laws. Conflicts also arose within the family when the patients negotiated pocket money with their parents, often complaining about their frugality. Money was the theme for patients' disturbing behaviors such as stealing money from home, asking relatives for money, spending sprees, and giving money away to strangers. Because finance meant so much to these mostly low-income families, related issues fueled their stresses and reactivity.

Work and Study Stress. Work and study caused much stress to the patients and the caregivers because they relate not only to finances, but also to the individuals' sense of worth. The stress stemmed from the patients being pushed beyond their capacity, or they took on too much, leading to increased symptoms such as anxiety and temper tantrums. Some education-related stress was caused by the parents' high expectations despite the patients' disinterest or low capacity. The parents wanted the patients to attain higher education so that they could secure better jobs and a better future instead of staying in the current day treatment program or working at a sheltered workshop. An 18-year-old patient had had a very early onset of mental illness when he first migrated to the United States at 10 years of age. His compromised intellectual development and language barrier added to his academic difficulty. The school suggested that he enroll in a vocational school, but the parents declined. They wanted him to be in a "normal regular school" because they valued education highly.

Even though both parents are aware that (patient) has made very limited progress academically and often feels stressed with study and homework, they'd rather have him continue his study at the current school. . . . Because of the choice the parents made, client is stressed out.

Another 21-year-old patient was "afraid of school and had no interest in getting her GED or going to college." The mother, however, thought it would be "better for [patient] to go to school to improve her English and then find a long-term job."

One patient's pressure to work and study came from herself. She wished to catch up with her peers' educational attainment when hers was delayed because of her illness.

[Patient] still has a busy schedule, with piano lessons, classes, internship, and going to the gym. She is committed to all activities. . . . It's obvious that her tight schedule is wearing her out.

Another patient's work stress in running a restaurant caused the onset and relapses of her mental illness. The eventual selling of the business in the past year put her and her spouse in a retired mode, thereby reducing much stress for the couple. In some families, the parents' work demand, especially from their own businesses and other child care responsibilities, took a toll on them and they became less patient with their ill children. These stressors were manifested in behaviors of high "expressed emotions," such as nagging and criticism. It seemed that the self- or family-imposed work and study stress is related to the need to keep up with their own expectations or those of their families to be able to earn a stable, decent living in an environment in which they do not feel very secure.

Stress and Constraints in Dealing with External Systems. Tangible stressors not only came from families' concerns because of their own expectations or lack of internal resources, they were also imposed on them as they encountered external systems such as government offices and social services agencies. A family was petrified when it had to deal with the judicial system. The 18-year-old male patient was prosecuted for urinating in public. He had frequent urges to urinate due to the side effects of the psychotropic drugs. Only when the clinician wrote a letter of appeal to the court on behalf of the family explaining the patient's condition was the charge dropped, which brought great relief to the family. Another patient, in her naturalization interview, was further caught in a complicated situation.

Since [patient] mentioned she had a mental illness during the interview (as an explanation for her unemployment during the past five years), she was asked to produce a doctor's note verifying that her mental illness would not cause her to harm herself or others.

This produced immense additional stress for the patient and her family, with the lengthened wait period and the sense that the naturalization process seemed to involve endless hurdles and uncertainties. This was one more hurdle for them after going

through the process of applying for financial assistance and reinstating the cancelled Medicaid. These are indeed very arduous processes, especially when a language barrier is present. The high stakes involved in obtaining the status and the resources intensified the stress.

Constraints of Organizational Policies. Some policies and practices within the social services agency also caused constraints to patient development. A high-functioning patient with a college education obtained in China wanted to improve her English to secure a job instead of staying at the day treatment program. However, she was hesitant:

[Patient] was interested in the English class at the community center, which takes place nine to 12 Monday through Friday. However, she expected not being allowed to attend the classes while enrolled at [day program] given its emphasis on attendance. [Patient] was not ready to leave [day program] as she admitted that it provided some security.

The agency's concern over attendance also scaled back her attempts in the job search. The unsettling experience of a sudden disruption of Medicaid and the feeling of uncertainty probably caused her to opt for stability over venturing out for development. On the whole, the external systems seemed unsympathetic and unfavorable, imposing many threats and constraints to these families. The language barrier clearly exacerbated the stress.

Shortage of Alternative Services. For some patients, alternative or additional services were needed. However, due to various systems' constraints, many patients were deprived of the resources. For example, a day program with group treatment would be appropriate for a patient in addition to individual outpatient treatments.

Given [patient's] bizarre appearance and behavior, group treatment would be a good modality to provide him feedback from others, reduce social isolation, and [help him] acquire interpersonal skills. These could eventually facilitate him to find a partner and have normal sexual fulfillment.

However, there was no suitable group at the agency. The patient, being bilingual, could join groups in other non-Chinese-speaking agencies. According to the policy, the whole case had to be transferred

out. The mother, being monolingual, could not use help elsewhere. The transfer was thus aborted.

A 23-year-old patient required more structure and supervision than the outpatient service could provide. Moreover, the family was exhausted caring for her. Residential care was needed, but there was a dire shortage of placements for those who speak Chinese. As a result, the family considered many alternatives, including renting a place for her to live by herself, moving her to the family's basement, and even marrying her off.

The shortage of services also affected some higher-functioning patients who would benefit from vocational training and better employment opportunities, a desired goal for many patients and their families; however, they were not available. One patient was in a subsidized employment, but the pay was so low that it could not cover even her transportation and lunch expenses. This could hardly bring a sense of fulfillment and independence to the patient and the family.

Patient and Caregiver Strengths

Despite the many challenges related to the tangible needs and external stressors, these families exhibited enormous strengths in coping. The internal resources of the patients and their families acted as buffers to compensate for the shortage of external resources and constraints.

Patient Strengths. The patients' interests and hobbies, as well as their ability to maintain some daily structures and activities, were their strengths. These, in some cases, compensated for the lack of available psychosocial services for monolingual clients. These interests included art and design, literature, playing mahjong, and surfing the Internet. Five out of nine patients had religious faiths and were active in their churches and temples. They also established friendships from their academic and religious affiliations. Some were high-functioning individuals before their illness; for example, they cared for their families, managed a restaurant business, or had high academic attainments. These activities helped to sustain their current functioning and a positive outlook.

Caregiver Strengths. Caregivers exhibited admirable devotion to the care of their relatives and showed a lot of strengths such as resourcefulness, perseverance, and insight. Some families were resourceful in using their own family businesses as training grounds for patients when actual vocational training or placements were unavailable. Such

arrangements provided some structure in the patients' lives as they occasionally helped out in the stores. Extended families also provided help. An uncle, who was the brother of a single mother of a male patient, came to the relatives' group session during which the patients' sexuality and emotional intimacy needs were addressed. This was especially relevant to this patient as his psychotic symptoms had sexual themes. The uncle could help to discuss these issues with the patient, which would be difficult for the mother to do with her young adult son.

A patient's mother, separated from her husband, came to the United States with her son to join her family of origin. When faced with the onset of the son's illness, she went into a deep depression for one and a half years requiring medication and support from her extended family. When she rebounded, she just pulled herself together, moved out with her son, and started taking care of him by herself. She did so admirably—with insight, acceptance, immense patience, and devotion.

The mother states that she has learned a lot from her own illness. She realizes how important it is to take care of herself first before helping her son. Nowadays she has learned to ignore, accept, or go along with [patient's] bizarre behaviors without feeling frustrated, angry, or upset.

The caregivers were generally positive and insightful. During the relatives' group, members showed affirming attitudes toward the patients' behaviors and were supportive of each other. They pointed out the patients' strengths; for example, they commented on how one patient who had a habit of stealing was so smart that she only stole from home. The group members also indicated acceptance toward the patients' problematic behaviors, because "it's the illness, you can't blame the person with the illness." They concluded that "besides medication and treatment, families' love is the most critical factor to helping patients get better." Given the limited external resources available to these families, caregivers' resourcefulness, devotion, and acceptance were really the saving grace.

DISCUSSION

Migration, Vulnerability, and Culture

Although the family psychoeducation protocol focused on the psychological and relational issues within the families, when stresses of these Chinese

American families were closely examined, many were found to be intricately related to their tangible needs such as housing, finance, bureaucracies of external systems, and lack of bilingual services. The numerous needs seemed to spring from their relatively low SES. The stakes involved in obtaining needed resources such as Medicaid and welfare benefits are especially high because they could be the families' last resorts. The families' compromised ability to tap into available resources and to navigate around the systems heightens their sense of insecurity. Thus disruption or denial of these services causes immense anxiety. Such insecurity also leads to their tendency to hold on to as many financial resources and benefits as possible. So, even relatively affluent families tend to refuse to pay out-of-pocket for needed services, which eventually exacerbates their stress. The extreme prudence in spending could be explained in part by these immigrants' pressure to succeed economically in this country, because this was their "American dream" when they migrated (Louie, 2009). Some also have to support their relatives back in China.

Crowded living arrangements with no individual bedrooms for the patients themselves greatly limit the autonomy of the patients and deprive them of the buffer of physical space against the diffuse boundaries among family members (Kung, *in press*). The Chinese culture expects unmarried children to live with their parents (Logan & Bian, 2004), a practice that is in contrast to the housing policies in the United States. In the current system, families are placed in separate households or apartments depending on their categories of need, for example, older adults or individuals with mental illness or other special needs. Many families have expressed the desire for public housing for unmarried adults with SMI to live with their parents. This could ensure physical space for privacy and autonomy while allowing day-to-day support within the families.

Asian cultures have strong work ethics (Harry, 2007). Aspiring to academic attainment is partly cultural and partly a practical attempt to secure better economic opportunities in a foreign land where racial discrimination persists (Gee, Spencer, Chen, Yip, & Takeuchi, 2007). Sometimes a vicious cycle emerges when the patients or the families cannot accept the ill members' limitations, thus causing additional stress to both parties. The high aspirations in securing employment are unfortunately not supported by existing services provisions due to shortages in vocational training and job placements for individuals with

mental illness (Cook, 2006). The situation is far worse among Chinese patients due to the lack of bilingual services.

Dealing with the bureaucracy of government offices and social services agencies intensifies the sense of inadequacy in these immigrant families with special needs. The systems tend to reinforce the sense of helplessness in services users through their policies and regulations, sabotaging the patients' and the caregivers' incentive to venture out for betterment. Moreover, interacting with government officials is anxiety provoking for many Chinese immigrants because of the culture's emphasis on social hierarchy under Confucianism, with officials being the privileged class who could make or break the individuals (Lin, 1977). These immigrants face high-stakes sanctions when they deal with the legal system, social security offices, and the U.S. Citizen and Immigration Services.

Implications for Practice

Because the tangible needs and external stressors of these families are so intertwined with their daily living, they affect familial relationships and psychosocial well-being. It is thus important for practitioners to enable the families to gain access to needed resources to alleviate their stress. Given the patients' compromised cognitive ability because of the mental illness, and the families' difficulty in negotiating with the external systems, the clinicians' mediating role and case management function to connect them to resources is of paramount importance (Test et al., 1997). However, in the recovery movement literature, which has taken center stage in the past decade on debates of rehabilitation for patients with SMI, emphasis is put on facilitating them to regain autonomy in the community by reducing the case managers' roles in "managing" people's lives (Davidson, Rowe, Tondora, O'Connell, & Lawless, 2008). To regain true dignity and independence so that the patients can really "live, work and love in the community" (Ridgway, McDiarmid, Davidson, Bayes, & Ratzlaff, 2002, p. 5), employment opportunities, housing, adequate financial assistance, and psychosocial rehabilitation services are needed. For the vulnerable immigrant Chinese Americans, assistance to access these resources through case managers cannot be overemphasized.

Furthermore, the availability of resources could alter the families' appraisal of stressors, enhance their perceived coping capacity, and thereby reduce the stress they experience (Lazarus & Folkman, 1984;

Zegwaard et al., 2011). Intervening at this level not only alleviates the families' immediate stress, but also increases their confidence in the clinicians' helpfulness and competence, thereby increasing their openness to address other psychosocial issues, which would facilitate patient recovery (Kondrat & Teater, 2012).

As a result of the bureaucracy of many service providers and government agencies and the lack of bilingual services, mental health professionals' advocacy role at the individual level on behalf of the families and at the policy and services provision levels is important. At the individual level, clinicians sometimes have to struggle to discern whether to take the direct advocate's role on behalf of the clients or to facilitate clients to advocate for themselves. The former usually yields quicker results and spares clients of the anxiety in waiting, but the latter could have a more lasting effect as clients feel more empowered when they learn how to advocate for themselves. Practitioners also need to navigate between directly alleviating families' emotional distress by providing practical help, such as rehearsing for the naturalization interview, and indirectly assisting them to find other ways to handle external demands. Many Chinese families do not have a clear idea of the roles of social workers, and sometimes perceive them as teachers (Pearson, 1993). Although clinicians do not want to neglect clients' immediate needs, negotiating with and educating them on the practitioners' appropriate roles is necessary. At the macro level, advocacy to meet pressing needs such as more bilingual vocational training and job placement services, residential care, psychosocial programs, and culturally sensitive housing policies for single adults to live with their families are important.

This investigation was conducted in the context of a family psychoeducation study aimed mainly at clinical interventions at the micro level addressing psychological and relational issues within the family. However, careful examination of the families' stressors indicated the need to also intervene at the mezzo and macro levels. The intense tangible needs and external stressors in this immigrant population with low SES highlight the need to address the clients' issues in relation to the larger environment in which they reside, to bring about relief and change. This coincides with recent studies that found positive results when combining family psychoeducation programs with assertive community treatments, which attended to both family relationships and supporting patient functioning in the community (McFarlane, Lynch, & Melton, 2012).

For the family psychoeducation model for Chinese Americans, based on the findings, some modifications could be made. First, clinicians can spend more time introducing community resources as part of the educational components in addition to information about the causes and the course of schizophrenia. Throughout the treatment process, practitioners should also explore more on the families' tangible needs and external stressors and connect them to resources and advocate with them and on their behalf for needed services. As some of these families are rather resourceful, we can explore their assets within the family—and from relatives and friends—such as informal vocational training opportunities. Throughout the relatives' group, we can encourage members to share their challenging and successful experiences interacting with the external systems so that they can gain practical and emotional support from each other. It was observed in the relatives' group that relatives can really identify with each other's needs and experiences, and the sharing was empowering to both the givers and the receivers. As we zero in on the various challenges faced by these Chinese families, we must not lose sight of their enormous strengths and recognize the patients' competence before they fell ill, and the strengths, devotion, and resourcefulness of the family members.

Implications for Research and Limitations of the Study

Tangible needs and external stressors faced by immigrant Asian or Chinese families with a member having schizophrenia have been overlooked. This study addressed this knowledge gap. Through an intervention study over a period of time, rich data on the clients' needs and stressors were collected from the therapists' repeated encounters and in-depth knowledge of the families' ongoing struggles, which could not be obtained otherwise (Swartz, 2006). The value of session notes in clinical treatments to understand the prevalent themes of client needs and issues is affirmed. Such detailed accounts of the families' needs and the clinicians' possible roles help to embellish the intervention protocol for future studies.

Despite the valuable contributions of this study to practice and research, some limitations exist. Although the session notes provide rich data on the families' stress and the clinicians' roles, they are not a complete documentation of what transpired in the session, unlike video or audio recordings. The clinicians' bias of what to record also affects the accuracy

of the reality depicted (Floersch, 2000). Fortunately, as both therapists in the study know the families' situations through the relatives' group, and I also supervised the other clinician's practice, bias was reduced by multiple perspectives and multiple contexts. Furthermore, as the clinical work was done mainly in Chinese and the session notes were written in English, translation of the contents is a legitimate concern. However, because both clinicians are proficient in both languages and are used to documenting agency records in English, this did not pose a problem.

Although the number of session notes used was sizable (117 in total), the actual number of participants involved was small (9 patients and 19 relatives), which may limit the study's representation. Moreover, due to resource constraints, the second coder did not do the coding separately but overlaid hers on the first coder's. It is likely that the second coder's coding was affected by that of the first coder, although she was encouraged to develop additional codes as appropriate. Fortunately, lavish memorandums written by both coders facilitated the discussion between them before the coding was finalized. Last, although the participants in this study were rather diverse in terms of immigration history, their overall acculturation level was low, and they were all of lower to lower-middle-class SES. Thus the findings are generalizable to this group.

SUMMARY AND CONCLUSION

This inquiry addressed the knowledge gap of the understudied population of Chinese American families with a member living with schizophrenia, and the understudied areas of their tangible needs and external stressors. This group's low SES and low acculturation posed enormous stress to meet their tangible needs pertaining to housing, finance, work, and study, and to interact with the external systems. The rigidity of the bureaucracy, culturally insensitive policies, and lack of bilingual services aggravated their challenges. To attain the recovery movement's ideal of increasing these individuals' autonomy in the community, adequate social services need to be put in place—including *bilingual* psychosocial programs such as day treatment, job training, employment opportunities, and residential services. To assist this clientele to navigate around the systems, the clinicians' active role in case management and advocacy is very important. Moreover, to combat the "culture of chronicity" (Davidson et al., 2008),

service providers and agency policies need to steer away from the tendency to control and micromanage, which impedes patient growth and autonomy. This study also highlights the value of taking the person-in-environment perspective in addressing clients' needs at various levels to attain lasting changes. Despite the challenges, many devoted caregivers manage to support the patients in the community with their meager financial resources and external support, though sometimes at the expense of patient development and caregiver well-being. For research implications this investigation, based on session notes from an intervention study over a period of time, proved to be a viable approach to obtain in-depth knowledge on a clientele in distress. **SWR**

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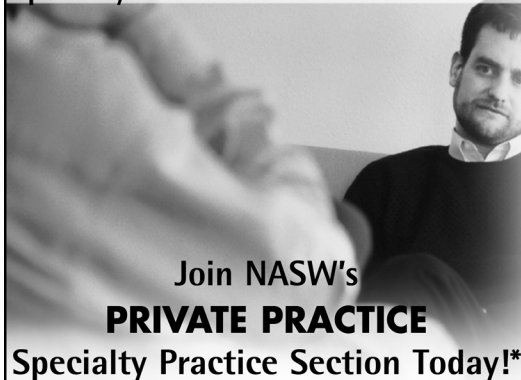
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