

EXPERIENCES OF LATINO FAMILIES PARTICIPATING IN  
PSYCHO-EDUCATION AT FIRST EPISODE  
PSYCHOSIS PROGRAM

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of the Requirements for the Degree  
of Master of Social Work

By  
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CERTIFICATION OF APPROVAL

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## DEDICATION

This thesis is dedicated to my husband, Saul Ortega, and to my children, Tadeo and Diego Ortega. You all have been my biggest motivation to keep going through this process. Saul, you have giving me all the love and support not only for the last three years of this program but since I met you 15 years ago, te amo. Tadeo, tu mami te ama muchisimo, gracias por tenerme paciencia, por esperarme para verme en la noche aunque cuando yo llegara ya estuvieras dormido porque no aguantabas. Perdona a mami por no haberte leído muchas noches, o porque te hice llorar a no poder estar contigo muchas veces. Tadeo tu sacrificio tambien valio la pena ya terminamos y este logro tambien es tuyo. Diego, my baby, you came during this process and you had to endure mommy's hard schedule. Thank you for hanging out with me for the second year of this program, te amo. Gracias a los tres por ser mi fuerza y motivacion, los amo.

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## ABSTRACT

Psychotic disorders can be debilitating for clients, creating a dependency on family for financial and emotional support. Latino clients suffering from psychotic disorders may experience stigma from family members, resulting in family relationship issues, as well as isolation of the diagnosed family member. Psycho-education can be of great support for Latino families as well as an important intervention for the client's treatment. This study utilized qualitative methods to explore the experience of Latino families who have participated in psycho-education services through a first episode psychosis program. The data obtained from participants support reduction of stigma, as well as change in views of psychotic disorders. All participants report positive changes in interfamily relationships, and having more knowledge about client's diagnosis. However, participants reported knowledge but had difficulties naming the symptoms or diagnosis of their loved ones. Psycho-education provided through family therapy was the method most utilized by participants and little to no participation was reported for multi-family groups.

## CHAPTER I

### PROBLEM FORMULATION

In the United States, 18% or 44.6 million people suffer from a mental illness each year; this is the equivalent of 1 in every 5 Americans (National Institute of Mental Health/NIMH, 2016). Moreover, 4.2% or 10.4 million American adults suffer from a serious or chronic mental illness, meaning that mental illness disrupts their daily living including work and interpersonal relationships (NIMH, 2016). Psychotic disorders are considered a chronic mental illness, affecting an individual's ability to process information and the expression of that information (Early Assessment and Support Alliance, 2016). Psychotic mental illness symptoms start presenting between the ages of 15 to 30 (EASA, 2016). Various factors contribute to the onset of psychosis, such as lack of sleep, drug use, and some medical conditions including head injury or neurological illnesses (EASA, 2016). The most commonly known psychotic disorder is schizophrenia (NIMH, 2016). However, some mood disorders, such as, bipolar disorder or depression, can become serious enough to have psychotic features (NIMH, 2016).

Psychotic disorders can be debilitating clients, creating a dependency on family for financial and emotional support (Awad & Voruganti, 2008). Multiple studies support the inclusion of families in the client's treatment, as inclusion can help reduce symptoms related to the mental illness (Weisman de Mamani, Weintraub, Gurak, & Maura, 2014). These same studies have also indicated that family

involvement can improve the quality of life outcome for both the client and family (Weisman de Mamani et al., 2014). The introduction of psycho-educational interventions for families of clients experiencing their first psychotic episode has demonstrated to have a positive outcome in treatment and prognosis for clients (McNab & Burnett, 2007). Additionally, stigma and criticism towards the client decreased when psycho-education was provided to the families (Öksüz, Karaka, Özaltın & Ates, 2017). As families learn about the client's illness, they are more likely to support them, to include them in family activities, and to see the client as separate from the mental illness (Barrio & Yamada, 2010).

Regarding this study, *family* will be defined as per the U.S. Census Bureau as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family (2019). *Latino* will be defined as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race (U.S. Census Bureau, 2019).

*Schizophrenia spectrum* and other *psychotic disorders*, as classified in the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), “are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms” (American Psychiatric Association, 2013, p. 87).

Families of first episode psychosis clients tend to have the most difficulties compared to families of clients who have been suffering from a chronic mental illness

for a long period of time (Kapse & Kiran, 2018). Families struggle with clients' symptoms and behaviors, navigating mental health services, medication, and side effects (Awad & Voruganti, 2008). Psychosis can affect family relationships as different members might have different conclusions on how to best support the client (EASA, 2016). Multifamily psychoeducational groups have been recognized as an excellent intervention for first episode psychosis (Pharoah et al., 2010). This intervention has shown to help clients reduce the hospitalizations and relapse (Pharoah et al., 2010).

The United States Census Bureau (2017) statistics indicates that Latinos make up about 17.8% of the United States population. According to the National Institute of Mental Health (2016), 16.3% of Latinos are living with a mental health condition. While Latinos are affected by mental health challenges as much as the general population, Latinos tend to receive a lower quality of care compared to other populations (National Alliance of Mental Illness, 2018). Latino mental health clients may experience stigma from family members, resulting in family relationship issues, as well as isolation of the diagnosed family member (Hernandez & Barrio, 2015).

Psycho-education can be of great support for Latino families as well as an important intervention for the client's treatment (Barrio & Yamada, 2010). Various sources exist that provide supporting evidence towards group psycho-education as an appropriate mode of service delivery for Latino families. As explained by Barrio and Yamada (2010), multifamily group psycho-education programs with opportunities for socialization and hospitality were successful with this population. The opportunity to

share experiences and points of view were empowering for families in understanding mental illness (Barrio & Yamada, 2010). Further, Latino families that have participated in psycho-educational groups have reported a greater understanding of mental illness and the related symptoms, aiding in fostering a better relationship with the client (Barrio & Yamada, 2010).

Policies have been created in California to support services for clients with severe mental illness. For example, the Early Psychosis and Mood Detection and Intervention Bill (AB 1315) and the Mental Health Services Act: Prevention and Early Intervention (SB 1004) have designated a significant amount of money to support mental health services. Both bills have included case management services, medication support, and psycho-education for families of those affected by mental illness. The Early Psychosis and Mood Detection and Intervention Bill have a specific targeted population, as funds are directed towards the early intervention of psychotic and mood disorders. All money available from AB 1315 is to be utilized in youth ages 14 – 30 years old who are experiencing their first episode of psychosis (Early Assessment and Support Alliance, 2017). Further, the Mental Health Services Act (2018) delineates a purpose of reducing racial disparities in access to mental health services and providing culturally competent and linguistically appropriate interventions.

Although both of these bills indicate the specific purpose of offering services that are culturally competent, and reducing the gap of services being offered to different groups, the struggle to offer these services still stands. As knowledge of

treatment resources is limited and bilingual clinicians are not readily available, monolingual Latinos continue to be challenged to obtain culturally sensible and linguistically appropriate services (Barrio et al., 2008). There are not many psycho-education programs available to Latino families of clients who are suffering from a psychotic illness due to the lack of bilingual and culturally sensitive clinicians. There is a great need for bilingual clinicians to support these programs. In Stanislaus County, a 5% bilingual pay incentive is available for any language. However, this incentive may not be enough to persuade clinicians to apply for available job opportunities. More studies need to be performed researching Spanish bilingual clinicians and its effect on programs for Latino families receiving psycho-education.

### **Statement of Purpose**

The purpose of the present study was to explore a psycho-educational program or similar services available for Latino families in Stanislaus County. This study also explored the experience of those families who have participated in psycho-educational programs and how they have benefited (or not) from services. The goal of this study was to gain knowledge on how the availability of psycho-educational programs in Stanislaus County has impacted Latino families. It is anticipated that there have been positive interfamily relationships and experiences as a result of psycho-education programs, as well as reduction of stigma related to psychotic disorders.

This study utilized qualitative methods to explore the significance of psycho-education programs for Latino families. The questions to be addressed by this study

are: a) What are the experiences of the Latino families who have received psycho-educational programs? b) How have Latino families who received psycho-education changed their interfamily relationships? c) How do Latino families who received psycho-education view psychotic disorders? d) Have psycho-education programs reduced stigma of psychotic disorders within Latino families?

### **Significance of Study**

Psycho-education is a not a novel approach in the treatment of mental illness. However, psycho-education has become a prominent evidence-based intervention for client treatment outcomes (Dixon et al., 2001). Family psycho-education is considered an effective intervention to reduce relapse and hospitalization for schizophrenia (Jewell, Downing and McFarlane, 2009), and also has been found to be effective for clients obtaining and maintaining employment (Magliano et al., 2006). Clients have expressed that the negative symptoms of a psychotic illness have caused isolation, ultimately affecting their family relationships (Hernandez & Barrio, 2015). Multiple studies conducted on the application of psycho-educational interventions have indicated positive effects on client outcomes as well as family relationships (Dixon et al., 2001). Aside from being an effective intervention, psycho-educational groups have also been cost effective (Breitborde, Woods & Srihari, 2009).

The purpose of psycho-education is to reduce stigma and for families to recognize early symptoms of chronic mental illness. The Early Psychosis and Mood Detection and Intervention Bill (AB 1315) and the Mental Health Services Act: Prevention and Early Intervention (SB 1004) explain that by recognizing the

symptoms, families of those affected by mental illness can help their diagnosed relative seek services to prevent debilitating and lifelong struggles that could be avoided by receiving early intervention. This study will emphasize the preferred delivery method used by the programs, based on families' experiences. The psycho-education delivery approach used with Latino families may also be a useful model to be used with other groups and cultures.

Clinical social workers in the mental health field will encounter clients with psychotic disorders who could greatly benefit from family psycho-educational programs. This study will bring to light those programs in Stanislaus County that have been delivering psycho-educational programs to Latino families. This study could benefit Spanish bilingual clinical social workers on service delivery methods, and future programs benefiting Latino clients and families. Psycho-education is an intervention that can be beneficial not only for families, but for the community in general. For social workers, this study can be used to advocate for policy changes and funding to support psycho-educational programs. Policies may be proposed to introduce psycho-education, not only to clients open to mental health services, but to the community. Psycho-educational school-based programs can also be used to help reduce stigma and increase understanding of mental illness.

The National Association of Social Workers *Code of Ethics* (2017) describes ethical principles that promote social justice, service, cultural awareness, and social diversity when practicing within the social work profession. This study promotes social justice by reducing stigma for members of the community who suffer from a

mental illness that includes psychosis. This study further advocates for programs that will empower Latino families and clients by providing knowledge that they can use to seek wellness while maintaining strong family connections. Finally, this study promotes cultural competence and culturally appropriate services by encouraging Spanish bilingual clinicians to facilitate psycho-educational programs for Latino families.

CHAPTER II  
LITERATURE REVIEW

**Psychosis**

Psychosis affects around 100,000 people each year in the United States, which means that 3 in every 100 people will experience some type of psychosis in their lifetime (National Alliance of Mental Illness, 2020). The ages of first occurrence of psychosis are between 15 to 30 years old; men can experience it 5 years prior to women (EASA, 2016). Psychosis affects the brain's capacity to process and express information (EASA, 2016). During a psychotic episode, "a person's thoughts and perceptions are disturbed and the individual may have difficulty understanding what is real and what is not" (National Institute of Mental Illness, 2020, What is Psychosis? para. 3).

Psychotic symptoms can be caused by different reasons, including sleep deprivation (multiple days in a row), certain street drugs, severe stress, certain medications, psychiatric disorders (schizophrenia spectrum, mood, trauma and substance abuse disorders), genetic predisposition, and certain medical conditions (EASA, 2016). Primary psychosis or organic psychosis is comprised of symptoms that are caused by a mental health disorder, such as schizophrenia. Secondary psychosis is inclusive of symptoms that are caused due to a medical condition, medications or drugs (Keshavan & Kaneko, 2013). The five domains related to psychosis are: hallucinations, delusions, disorganized thinking and speech, grossly

disorganized or abnormal behaviors, and negative symptoms (American Psychiatry Association, 2013). These five domains are separated into positive symptoms, negative symptoms and cognitive symptoms (EASA, 2016). The positive symptoms (symptoms that are present or that have been added to client's presentation) are hallucinations and delusions (EASA, 2016). The negative symptoms (when clients is not doing something they were able to do in the past, something taken away) include diminished emotional expression, alogia, avolition, anhedonia, asociality, and lack of concentration (EASA, 2016). The cognitive symptoms include disorganized thought and speech, abnormal movements and motor behaviors (EASA, 2016).

### **Positive Symptoms**

Hallucinations consist of seeing, hearing or feeling things that others will not experience, which can vary in intensity and can include distortion of surroundings (EASA, 2016). The Diagnostic and Statistical Manual of Mental Disorders (2013) define hallucinations as “the perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions and not under voluntary control” (p. 87). Delusions are false beliefs based on false interpretations of reality; these beliefs persist even after evidence of the contrary is presented to clients (EASA, 2016).

Delusions can be the product of a processing dysfunction that includes memory, attention and interpretation (EASA, 2016). Common delusions include, but are not limited to, delusions of reference, a belief that day-to-day occurrences pertain directly to clients (beliefs that the television, radio, street signs, or behaviors are being

directed to client). Delusions of grandiosity are beliefs that clients have a great sense of power, ability or talent that is not true. Persecutory delusions are beliefs that someone is trying to hurt clients, a belief that someone is talking about them or beliefs that someone is trying to poison them. Thought broadcasting are beliefs that others can read clients' mind. Thought insertions are beliefs that thoughts are being inserted by another force. Thought control is the belief that an outside force can control clients' actions and feelings (EASA, 2016).

### **Negative Symptoms**

Negative symptoms are more prominent in schizophrenia and might be less prominent in other disorders (American Psychiatric Association, 2013). Diminished emotional expressions are the lack of expression in clients' facial expressions, eye contact, speech, hand and head movements, and emotional speech (American Psychiatric Association, 2013). Avolition is the diminished participation in self-initiated meaningful activities, work and social activities (American Psychiatric Association, 2013). Alogia is the diminished rate and quality of speech (American Psychiatric Association, 2013). Anhedonia is the decrease of pleasure of activities that in the past client enjoyed (American Psychiatric Association, 2013). Asociality is the lack of participation in social activities (American Psychiatric Association, 2013).

### **Cognitive Symptoms**

Cognitive behaviors as disorganized thought and speech are related to the person's capacity to communicate; this include changes of topics while speaking, or making a conversation hard to comprehend (American Psychiatric Association,

2013). Abnormal movements and motor behaviors could range from child-like behaviors to agitations. Clients could experience catatonic behaviors; inability or uncontrolled movements. Other behaviors could include posturing and mutism (American Psychiatric Association, 2013). Catatonia is a symptom that can also be present in other diagnosis such as bipolar, psychotic, neurodevelopmental disorders as well as other medical conditions (American Psychiatric Association, 2013). Catatonia includes twelve psychomotor disturbances: decline in motor activity, decline in participation during assessment or physical examination (stupor and waxy flexibility), an increase of motor activity, catalepsy, mutism, opposition or no response to directions due to internal stimuli (negativism), posturing, mannerism, stereotypy, agitation, grimacing, echolalia, and echopraxia (American Psychiatric Association, 2013). For a client to have psychosis with catatonic features clients must present with three or more of the above-mentioned symptoms (American Psychiatric Association, 2013).

### **Phases of Psychosis**

Psychosis, when caused by a mental health disorder, usually has three phases (National Alliance on Mental Illness, Minnesota, 2014). The first phase is the prodromal phase; this phase is prior to having a psychotic break (NAMI, Minnesota, 2014). Clients will experience mild symptoms related to psychosis (negative and positive symptoms). Positive symptoms might be present but clients would be aware that those hallucinations or delusions are not real (NAMI, 2014). Client during this stage will have changes in thoughts and behaviors in the way they see their

surroundings (NAMI, 2014). The prodromal stage is difficult to identify, as the phase might last years and never progress to a psychotic episode or psychotic illness (NAMI, 2014). The symptoms of the prodromal stage might include: negative symptoms of psychosis, declining academic performance, decline in hygiene (personal and house cleaning), anxiety, irritability, lack of concentration, changes in sleep patterns, new odd ideas, some paranoia, or a decline in functioning (Yale School of Medicine, 2019).

The second phase is called the acute phase; during this phase the positive symptoms start to appear (Yale School of Medicine, 2019). Clients during this stage had clear positive, negative and cognitive symptoms of psychosis, and would lose touch with reality (NAMI Minnesota, 2014). This stage might also include lack of insight or not recognizing the symptoms being experienced and not seeking the help of treatment (Yale School of Medicine, 2019). Psychiatric hospitalization might be needed, as clients experiencing psychosis might be danger to self or become so agitated that family might not be able to control them (NAMI, 2014). The third phase is the recovery or residual phase; this phase takes time and symptoms might not all go away (NAMI, 2014). Appropriate and early treatment can help clients make a full recovery and return to normal life (Yale School of Medicine, 2019).

### **Medical Conditions**

Secondary psychosis due to a general medical condition happens in about 0.21% in the general population (Griswold, Regno & Berger, 2015). Under the DSM-5 the criteria of a diagnosis of psychotic disorders due to another medical condition

includes: hallucinations or delusions, disturbance is being caused by a pathophysiological symptom of another medical condition evidenced by history, physical and laboratory testing of client, the psychosis not being explained by another mental diagnosis, the episode does not occur through a time of delirium (acute confusion state), or the psychosis causes significant impairment in functioning (2013, p. 115). The groups of medical diagnosis that can cause psychosis are: trauma (traumatic brain injury), autoimmune disorders (systemic lupus erythematosus and N-methyl-D-aspartate receptor encephalitis), cytogenetic disorders (velocardiofacial syndrome and agenesis of corpus callosum), cerebrovascular disorders (stroke and subdural hematomas), space-occupying disorders (cerebral tumors), metabolic disorders (phaeochromocytoma, metachromatic, Wilson's disease), dietary disorders (pellagra, b12 deficiency, and vitamin D deficiency), sepsis/infections disorders (neurosyphilis, toxoplasmosis, and HIV disease), degenerative and demyelinating disorders (dementia, Parkinson's disease, Huntington's disease, multiple sclerosis, Friedreich's ataxia), seizure disorders (Partial complex seizures, temporal lobe epilepsy), endocrine disorders (hyperthyroidism, hypothyroidism and hyperparathyroidism) (Keshavan & Kaneko, 2013). Intoxication to chemicals, such as mercury and arsenic, could also cause psychosis (Keshavan & Kaneko, 2013).

### **Drug-Induced Psychosis**

Licit and illicit drugs can cause symptoms of psychosis, including hallucinations and anhedonia (Ham et al., 2017). The DSM-5 criteria for substance/medication-induced psychotic disorder is as follows: the presence of delusions,

hallucinations or both, evidence by history, physical examination or lab testing that the symptoms started during or soon after consumption of a substance or during the withdrawal of the intoxication of such substance, the drug consumed is capable of causing psychotic symptoms, the symptoms are not better explained by a mental disorder diagnosis, the symptoms have lasted about one month after consumption of the substance, the symptoms does not occur only when in delirium state, and the disturbance causes significant impairment in function (2013, p. 110). The most common recreational drugs that can cause psychosis are amphetamine, methamphetamine, lysergic acid diethylamide (LSD), cocaine, ecstasy, phencyclidine (PCP), and cannabis (Vallersnes et al., 2016). Prescribed medications known to cause psychosis are ketamine (sedative used in surgeries), scopolamine (used to prevent nausea) and benzodiazepines (muscle relaxants that can also be used to prevent seizures) (Vallersnes et al., 2016). Acute psychosis caused by use of recreational substances is hard to distinguish from psychosis caused by organic schizophrenia (Vallersnes et al., 2016). The substance use of amphetamine, methamphetamine, and cannabis has been associated with development of chronic psychosis or schizophrenia (Callagan et al., 2012).

The use of amphetamine and methamphetamine are common substances used in the population who suffer from psychiatric disorders (Bramnes et al, 2012). In 2017, the National Survey of Drug Use and Health (NSDUH) reported that about 1.6 million people admitted to have used methamphetamine in the past year, and 774,000 admitted to have used in the past month (National Institute on Drug Use, 2019). The

average age of first use of methamphetamine in 2016 was 23 years old (National Institute on Drug Use, 2019). Amphetamines could induce or cause symptoms of psychosis that mimic those symptoms of acute schizophrenia spectrum psychosis (Bramnes et al., 2012). Psychosis due to use of amphetamines comes after constant use of the drug (Ham et al., 2017). Positive and cognitive symptoms of psychosis are common (hallucinations, delusions, and disorganized speech) when under the influence of amphetamines (Ham et al., 2017).

Cocaine is a highly addictive substance that can cause symptoms of psychosis including paranoia and hallucinations, in addition to suicidal and homicidal ideation (Roncero et al., 2013). According to the NSDUH, in the United States the population reporting use of cocaine has remained stable since 2014 (National Institute on Drug Abuse, 2016). Approximately 1.5 million people report using cocaine in the last month; the ages of those reporting were between 18 to 25 years old (National Institute on Drug Abuse, 2016). Lysergic acid diethylamide, better known as LSD, is another highly addictive substance that causes psychosis (Ham et al., 2017). LSD is one of the most potent hallucinogens, and was created in 1938 by Albert Hoffman (Ham et al., 2017). LSD has never been utilized for medical purposes, and has only been used illegally (Ham et al. 2013). LSD is a substance that alters perception of time and space at very low doses, compared to other drugs that need larger doses to cause similar effects (Marona-Lewicka, Nichols, & Nichols, 2011). LSD differs from other drugs, such as amphetamine, as it can cause positive and negative symptoms of psychosis (Ham et al. 2013).

Marijuana is the most commonly used drug in the United States; according to the National Institute on Drug Abuse, in 2018, about 11.8 million young adults reported use of marijuana (2020). In 2019, there was an increase of use among 8<sup>th</sup> to 12<sup>th</sup> graders as perceptions of the risks of marijuana continued to decline (National Institute on Drug Abuse, 2020). Marijuana is a common factor in about 50% of psychosis with a diagnosis of schizophrenia and schizophreniform cases (Shrivastava, Johnston, Terpstra, & Bureau, 2009). In the study *The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI): A multicentre case-control study*, the participants who used marijuana were four times more likely to develop psychosis (Di Forti et al., 2019).

### **Psychiatric Diagnosis**

Psychotic disorders include different types of diagnosis including schizotypal personality disorder, delusional disorder, schizophrenia, brief psychotic disorder, schizophreniform disorder, and schizoaffective disorder. Other diagnoses have psychotic features, disorders such as bipolar I and II, post-traumatic stress disorder, and postpartum stress disorder (American Psychiatric Association, 2013).

Schizophrenia is a mental disorder characterized by multiple psychotic symptoms; clients must present at least two symptoms of psychosis (positive, negative, and cognitive); however, one symptom must be delusions, hallucinations, or disorganized speech. The other symptoms can include negative symptoms and cognitive symptoms (grossly disorganized or catatonia). The symptoms are present for a period of one month (can be less if treated successfully). Clients also present a significant decline in

level of functioning since the onset symptoms in one or more areas of relationships, self-care, and work. The symptoms prevail for a six-month period that must include a month of the positive symptoms mentioned above. The time of onset of symptoms can include the prodromal and recovery phase. Clients' symptoms are not caused by a substance use or medical condition. A ruled-out diagnosis of schizoaffective disorder, bipolar or depressive disorder has been completed due to client not presenting symptoms of major depressive disorder or manic episode (American Psychiatric Association, 2013). Schizophreniform disorder presents same symptomology as schizophrenia but it has not lasted a six-month period (American Psychiatric Association, 2013).

Brief psychotic disorder also presents with similar symptomology as schizophrenia minus the negative symptoms. The symptoms are present for a day or more but less than a month; after the episode client goes back to the prior level of functioning. In the United States about 9% of all first psychotic episodes are attributed to a brief psychotic disorder. The onset age is early adolescence to mid-thirties (American Psychiatric Association, 2013).

Schizoaffective disorder includes positive symptoms of psychosis and an uninterrupted period of a major mood episode (major depressive or mania) (American Psychiatric Association, 2013). The symptoms of a major depressive episode involves a period of 2 or more weeks of symptoms that must include depressed mood during most of the day, nearly every day, noticed by client or family members. The symptoms for major depressive episode are present during the duration of the acute

phase and recovery phase of the psychotic episode (American Psychiatric Association, 2013).

Bipolar I disorder is characterized by having one manic episode, before or after a hypomanic episode or major depressive episode (American Psychiatric Association, 2013). The symptoms of a manic episode include: irritability, abnormal amount of energy during most of the day, nearly every day for a period of one week. In addition, clients must also experience three or more of the following symptoms: inflated self-esteem or grandiosity, decrease of sleep (only 3 hours per day), pressured speech or talking more than usual, racing thoughts, easily distracted, increased of goal-oriented activities, and participation in risky behaviors (sexual, buying sprees, business investments). The episode also makes a change in usual functioning for clients; the change in mood is noticeable by others. The symptoms are ruled out to be a cause of substance use or a medical condition. The episode major depressive episode must occur over a period of two weeks, with five of the following symptoms: depressed mood during most of the day, nearly every day, diminished interest in all activities, significant weight loss or weight gain, insomnia or hypersomnia, agitation or retardation of psychomotor, loss of energy, feeling worthless or guilt, lack of concentration, and suicidal ideation. A major depressive episode is common in bipolar I disorder but not required. At least one manic episode is required over a lifetime to meet the criteria for bipolar I disorder (American Psychiatric Association, 2013). Bipolar II disorder includes all of the symptoms related to bipolar I disorder, but clients must present with one hypomanic episode and one major depressive

episode. For bipolar II disorder clients must had never experienced a manic episode. Bipolar disorder I and II with psychotic features include positive symptoms during mood episodes. The psychotic features can be congruent or not congruent with each episode (American Psychiatric Association, 2013).

### **First Episode Psychosis**

First episode psychosis (FEP) is referred to as the first time a person experiences an acute phase of psychosis, either induced from a mental health disorder or due to substance use (Yale School of Medicine, 2019). Every year about 100,000 people in the United States experience psychosis for the first time (National Institute of Mental Health, 2015). According to the Substance Abuse and Mental Health Services Administration (SAMHSA), first episode psychosis clinically refers to the first five years of onset symptoms of psychosis (2019). In the U.S., 13-51% of cases of first episode psychosis also had a substance use co-occurring disorder (SAMHSA, 2019). Due to lack of education and stigma around mental health diagnosis clients and family have a difficult time finding support (SAMHSA, 2019).

Clients experiencing psychosis often don't receive treatment until about a year after of onset symptoms (SAMHSA, 2019). The time between first experiencing symptoms and receiving treatment is known as the "duration of untreated psychosis" or DUP (SAMHSA, 2019, p. 4). The prolonged DUP can predict the outcome of treatment for clients who would develop schizophrenia (Primavera et al., 2012). The progression of schizophrenia can cause serious impairment in the psychosocial and clinical prognosis for client in a short period of time (Primavera et al. 2012). There is

evidence linking DUP and brain structure damage, there are still questions around if the brain can heal after antipsychotic treatment or have permanent damage (Anderson et al., 2014).

Evidence-based treatment for FEP includes coordinated specialty care (CSC) programs that include client in all treatment planning and setting goals (NAMI, 2016). The CSC is a team approach that offers interventions such as psychotherapy (clinician), medication support (psychiatry services), family support and psycho-education, case management, academic and vocational support, and peer support with all team members trained in FEP (SAMHSA, 2019). Cognitive behavioral and family support interventions in CSC programs have been effective in preventing relapse in FEP clients (Alvarez-Jimenez et al., 2011). When reducing the DUP, programs with a CSC approach can help clients have a positive prognosis and social re-integration (Melo et al., 2017).

Psychotherapy for first episode psychosis utilizes cognitive behavior therapy for psychosis (CBTp); this method is designed to reduce stress caused by the psychosis (National Institute of Mental Health, 2020). CBTp method can be utilized in group or individual counseling, includes resilience training, illness management, and utilization of coping skills (National Institute of Mental Health, 2020). Psychiatry and medication services provide client with pharmacotherapy that can also help with symptoms. The medication management is tailored to client to find the correct dose and medication, in addition to education around the benefits and disadvantages of the prescribed medication (National Institute of Mental Health, 2020). Supported

employment and education services support clients' return to academics or work to help them meet goals (National Institute of Mental Health, 2020). Case management supports client in problem-solving by connecting client with community resources that can help them overcome obstacles in different areas of need (National Institute of Mental Health, 2020).

### **Family Psycho-Education**

Family psycho-education and support are very important areas of treatment for FEP, as family are the best support and resource that a client can have (McWilliams et al., 2009). Family psycho-education has been utilized as an intervention in treatment for schizophrenia since the mid-1950s (Carol & O'hanlon, 2013). Family psycho-education is considered a successful evidence-based practice to help reduce relapse, hospitalizations, and obtain positive treatment outcomes (Luckstead et al., 2012). It "is becoming clear that the outcomes associated with family psycho-education benefit not only consumers' clinical profile but also wider quality of life domains" (Luckstead et al., 2012, p. 111). Treatment and stabilization are not the end goals but an important base for client to obtain functionality and better quality of life (Luckstead et al., 2012).

Family psycho-education gives the family members education and understanding about illness, symptoms, emotions during the different phases, and how to support and deal with the possible burden of caring for a family member that suffers from a mental illness (Kapse & Kiran, 2018). Guidelines for family psycho-education include the involvement of family in treatment planning and assessment for

client's treatment (Carol & O'hanlon, 2013). Due to the guidelines, family psycho-education has its barriers during implementation; not all clinicians feel comfortable when utilizing family psycho-education due to it not being compatible with their theoretical training (Luckstead et al., 2012). In addition, families might find it difficult to participate due to fear of stigma or lack of trust in mental health service providers (Luckstead et al., 2012).

Latinos are 17.8% of the U.S. population, and 15% of them have a mental health diagnosis (Mental Health America, 2020). Latinos' lack of utilization of mental health services requires attention and intervention, as not following up with treatment could affect social and economic aspects of clients' lives (Casas et al., 2014). Utilizing family psycho-education should be tailored to client and family needs, including diagnosis, socio-cultural group, approach (group or individual), and setting in order to be effective (Luckstead et al., 2012). Family psycho-education is important in Latino communities, as higher levels of knowledge of psychosis on the caregivers part influences clients to seek treatment (Lopez et al., 2018). "Lack of knowledge about psychosis, a condition oftentimes associated with serious mental illness, may contribute to disparities in mental health service use" (Casas et. al, 2014, p. 1). However, knowledge learned through family psycho-education in minority groups is limited (Lopez et al., 2018). Psycho-education interventions have been improving over the last several years, but there has not been a focus on ethnic and linguistic minorities in the U.S. (Casas et al., 2014).

CHAPTER III  
METHODOLOGY  
**Research Design**

An exploratory design and qualitative methods were utilized to gather data for this study. This study sought to explore the experiences of Latino families who have participated in psycho-education sessions, including family therapy and family groups. A qualitative approach was utilized to interview families of clients who suffer from a psychotic disorder. A descriptive inquiry method allowed this researcher to analyze and describe the experiences of Latino families who participated in psycho-educational services.

There are different challenges that this study found when using a qualitative method to gather information. Latino families participating in programs were not willing to participate in the study due to not feeling comfortable with opening-up to a stranger (the researcher) in regards to family relationships and struggles, especially when it comes to speaking on mental illness and cultural taboos. Another difficulty was that mental health clients did not felt comfortable allowing their families to participate in the study due to clients' current treatment status and family relationship dynamics.

**Sampling Plan**

LIFE Path is a product of agency collaboration among Sierra Vista, Center for Human Services, and Stanislaus Behavioral Health & Recovery Services. LIFE Path

specializes in psychosis related to a psychotic disorder not caused by trauma or substance use. The program offers services for youth 15 to 25 years old who are experiencing a FEP or are at risk of developing a psychotic disorder. LIFE Path provides psycho-education, family therapy, and family group sessions for clients and their families, if they are willing to participate. The participation of the family during treatment is highly encouraged. This study focused on the experiences of 10 Latino family members participating in the first-episode psychosis program – LIFE Path. This study obtained access to Latino families by way of a signed memorandum of understanding (see Appendix A) from Stanislaus Behavioral Health & Recovery Services and Sierra Vista. A list was requested from LIFE Path of Latino families who have participated in the program during the last two years.

Prior to inviting families to participate in this study, the researcher requested that LIFE Path sent letters to all clients, informing them that their relatives were invited to participate in this study. The letter (see Appendix D-English and E-Spanish) included information about the study, as well as a disclaimer that informed clients that all data was kept private in the final product of this research, including the names and information of the families that agreed to participate. This researcher also asked LIFE Path clinicians to distribute a flyer (see Appendix F-English and G-Spanish) to their Latino families. This flyer included general information about the study and details for contacting the researcher. Additionally, the researcher requested permission to recruit potential participants at the multifamily group meetings that LIFE Path holds every other Thursday. As a final strategy, the researcher made phone

calls, from an approved list provided by LIFE Path, and invited family members to participate in the study. A purposive sampling approach was utilized, as the focus of participant recruitment is specific to Latino families who have a member receiving services for a psychotic disorder.

### **Instrumentation**

Family members participating in the LIFE Path psycho-educational program was interviewed as a unit, not individually, and they were asked 18 open-ended questions. Questions asked included family relationships, views on psychotic illness, and if having participated in psycho-education services changed their opinions about psychotic disorders. The interview questions probed how family relationships had improved or deteriorated, as stigma can play a role in a family's ability to provide support to a relative suffering from a mental illness (Hernandez & Barrio, 2015). The questions were designed in basic, easy-to-understand language (see Appendix B). If deemed necessary by the participants, questions were also communicated in Spanish (See appendix C). Face validity was established as a result of several mental health clinicians providing feedback on this instrument. In addition to having Spanish-reading clinicians proof these questions, two monolingual Spanish-speaking persons without professional credentials also reviewed the questions.

### **Data Collection**

The interviews were proposed to take place at LIFE Path or a public venue where families felt comfortable describing their experiences, such as a library, coffee house, or a restaurant. The researcher arranged time and date that best fitted each

family unit. It was estimated that the family group interview was to take about 1.5 to 2 hours to complete. Depending on the number of family members participating in an interview, or if major scheduling conflicts appeared, a second group meeting was necessary. Prior to beginning an interview with families, a consent form (see Appendix H) was reviewed with all members. The informed consent form was available in Spanish if requested by family (see Appendix I). The timeline for data collection was 6 weeks. The researcher was the sole gatherer of the confidential information received during the interview process.

### **Plan for Data Analysis**

A narrative approach was utilized to analyze the responses collected and to address the study's research questions. An audio recording device was utilized due to multiple people being interviewed at once and the nature of the questions. This allowed the researcher to accurately obtain and track participant responses. The audio recording was transcribed into a written document, and each question analyzed separately. Neuman's (2003) approach to analyzing qualitative data was employed. The first step was to sort and classify all answers given by the family members. Open coding was applied after the sorting phase. Open coding included assigning labels to the information gathered and classifying it into categories. Axial coding was subsequently used to combine answers as appropriate and to organize data by patterns or sequence. Selective coding allowed for data to be compared and contrasted. The final step included interpretation and elaboration of data, where the researcher deduced conclusions based on patterns and differences.

### **Protection of Human Subjects**

The researcher provided and reviewed the informed consent created for this research with participants in this study (see Appendix H-English). The consent form included information about research, as well as possible harm and discomfort that participating in this research might of caused. Participants were advised that participation in this study was voluntary and they could withdraw their participation at any moment. The consent form specified the anticipated amount of time that was spent completing the interview. The consent form was translated to Spanish and was reviewed with those family members that participated that did not speak English or that preferred to use Spanish (see Appendix I). All participants were required to sign the consent form prior to participating. Families were made aware that all information gathered was compiled in aggregate form and shared with Stanislaus Behavioral Health and Recovery Services and Sierra Vista.

The researcher protected the information disclosed; participants were notified that their personal information, such as, name, address, legal status, or age was not required to participate in this study. They were also notified that the information obtained from interviews was recorded and, later, transcribed. The participating families were aware that the researcher's faculty sponsor (thesis chair) accessed their information in order complete analysis of data. All information gathered for this study was kept in an office in a filing cabinet with a lock. At completion of this study, all information was deleted.

## CHAPTER IV

### FINDINGS

This chapter will analyze the qualitative data gathered for this study. The proposed sample size for this study was ten participants; due to COVID-19 pandemic safe-distancing guidelines, five participants were interviewed. Three family members had completed the two-year program and two were currently participating in different time frames of the program. The represented family relationships of the participants were three mothers, one father and one sibling; all had authorization to fully participate in LIFE Path program by client. Three family members are related to LIFE Path clients who are minors and two adults. Three interviews were conducted in Spanish utilizing Appendices C and I, two were completed in English utilizing Appendices B and H. Four interviews were recorded as the participants agreed and signed under the consent form, one participant did not feel comfortable with the recording and the interview was just recorded on paper.

A questionnaire of 18 questions was completed through a face-to-face interview with all participants. The interviews were completed in a coffee shop, the LIFE Path office in Modesto or Sierra Vista Turlock location for the convenience of the participants. Group interviews were not needed as only one person of each family participated. The interviews were expected to take an hour to complete; the actual average completion was fifteen minutes. This study utilized qualitative methods to explore the significance of a psycho-education program for Latino families. The

questions to be addressed by this study are: a) What are the experiences of the Latino families who have received psycho-educational programs? b) How do Latino families who received psycho-education view psychotic disorders? c) How have Latino families who received psycho-education changed their interfamily relationships? d) Have psycho-education programs reduced stigma of psychotic disorders within Latino families?

Participants were asked about their overall experience while participating in the LIFE Path program. Two participants shared not expecting the inclusion around the treatment of their loved one and getting services as a support person. One participant that has completed the program shared "...they were always helpful and quick to refer me somewhere...they would talk to me in a way I could understand...overall it was good." All participants shared feeling helped and provided with information they didn't know they needed at the time. A participant who is currently active in the program shared,

It has helped me a lot in understanding what has been going on...before I was thinking that it was conduct problems, thinking what I could do to change the situation... now I know is not what I can do to but what we all going to do for him to get better...at one point I used to feel guilty, as maybe I did this and that's why he is going through it and I know now is not.

This study reviewed the experiences (what they liked and what they could change) in multi-family groups and family therapy, and inclusion of other family members in services. Three participants reported not participating in multi-family

groups due to work conflict, lack of childcare and/or transportation. One participant reported participating in groups but sporadically, this participant shared the experience as “I liked being educated and putting the information to a level of understanding...they told me basically [psychosis] this is how it plays out, signs to see to a level of my understanding.” Only one participant shared attending regularly and reported the experience as being “good”, requesting one possible change as more bilingual staff members available as translation was needed for multi-family group “...I like the program’s staff, the group services and the help they provided us...I would had liked more staff that spoke Spanish, to help with translation.”

Three participants reported receiving family therapy services. They reported receiving support and given information to better understand the diagnosis. Participants also shared what they would like to see some changes within the program and two reported wanting to see other family members participate or more participation from the client.

Table 1.

*Experiences of Family Therapy*

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Participant 1	[family therapy] got me to be closer with my kids, to have more communication... if there was something bothering me to not respond screaming...it helped me when my kids would shut down and not talk... the kids give their opinion now I hear them and we all participate with the conversation.
Participant 3	[during family therapy] they understood... they helped me express what a family goes through... I got the sense that they [clinician] understood... it was not judgmental it was open, it was comforting I guess.

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	“...something that could change was the repetitive questions, How do you feel? Do you hear anything today? Are you seeing things?, the repetitive therapy questions were a problem...but that is one thing that gets on my and [client’s} nerves...”
Participant 4	“...it has helped me understand that mental illness is like any other physical illness, it needs to be treated... there is a process to get better.”  “... [during family therapy] more participation from my son, he doesn’t think he needs it...”

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Participants were asked to report if any other family member participated in services. Two families reported participation of other relatives in services offered by the program. One participant shared they don’t have any other person that could come to get services and their parents don’t live with them. Another participant shared that other family members don’t find the importance to participate “no, is just me, they have their own thing going on, maybe they don’t care.” Another participant shared “at the time it seemed like it was a little too much for them...I was not going to let my child just go, there were not ready...” Two families report having other family members participate or willing to participate, “...my husband and older daughter are not coming yet but they are willing to come.”

Family members were asked what psycho-education was provided to them and how that changed their views on psychotic disorder and support for the client. Participants were asked if they were psycho-educated around treatment options of therapy, medication and the client’s rights. They were also asked if they were psycho-educated around the client’s diagnosis and symptoms. All participants reported

receiving psycho-education about treatment options and the client's right to refuse treatment. Also, five participants report receiving psycho-education about the client's symptoms, however, two participants could give a name for the diagnosis or symptoms described, "...at first I didn't really understand anything...I have been watching some simulation videos on YouTube... is a trip, what he goes through."

Families were asked to share how they have changed their view on their family member's diagnosis and how they are currently helping them. They all reported a better understanding of the client's situation, awareness of the client's changes in behaviors while they were in treatment, "It changed my view on the illness...I thought at first he had like a conduct problem that he didn't care to fix... now I know his brain works differently due to his illness." Another participant shared having a better understanding even though when it all started the symptoms were relate to conduct

...Before I thought it was defiance...I thought it was all teenage things...knowing what he goes through, I can be more patient...when he doesn't want to talk to me now, I give him paper and pen, that developed over time...it took 4 hospitalization for someone to educate me around his symptoms.

Four families report helping clients by making sure the client takes the medication and providing transportation for psychiatric or therapy appointments. One family member reports offering support when the client needs to be heard, participant also shared about having a plan in place when the client is not comfortable,

...He can pull me to the side if he is having these emotions or whatever...if he is starting to feel weird we walk away, he lets me know when is time for us to go to another place...we have a plan.

One participant shared that even though the client lives in another city, she still supports her by checking in, helps the client by recognizing some symptoms and encouragement to ask for help if needed "...I call her to check in, I tell her to use what she learned and to call me if she needs help... I can tell on the phone when she is not doing good..."

Participants were asked about interfamily relationships, what was before starting treatment and what is the status now after participating or completing the program. Four participants shared struggles such as communication problems, not sharing the same ideas about the client's treatment and/or support given during treatment or before treatment.

Table 2.

*Interfamily Relationships Before and After Treatment*

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Participant 1	[Before] yes, specially with members of my family, we have distanced ourselves from them to not hurt us...at the beginning we did have some issues between the kids and my husband...
	[After] ...I can say that it got better, my kids and I have open communication, I understand a little better where they are coming from...With my husband I know I was the one not communicating well with him and that has changed, we are doing good...
Participant 2	No we didn't have issues but after we have become closer due to his diagnosis

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Participant 3	<p>[Before]...I think it came out of being scared, the family member that was there had a family member that had the same diagnosis as my son, but it was at whole different level...they expected the same with my son...it scared them for what could happen to the two younger children...they didn't care he was doing good with counseling and going to school...</p> <p>[After] in a sense yes, they left...they tend to ask how he is doing...they ask my other son if they are ok and feel safe...he tells them to not trip, it not as bad as it was...</p>
Participant 4	<p>[Before and currently] at one point my younger child had a difficult time...she believed I was over protecting him, paying too much attention...and with my husband, we have arguments...we have different opinions...[husband] he understands that he is sick but he doesn't want me to change the way I live to help my child...when [the client] gets into his episodes, I can't function and my husband gets upset...[husband] he believes my actions won't help [the client] him either...we don't have the same ideas...maybe once he starts coming to therapy things will change...</p> <p>[Currently] yes, my daughter is starting to understand and supporting him [the client]...things are getting a little better with her at least...</p>
Participant 5	<p>[Before and during treatment] yes, all of that [arguments, fights]...living together with sibling can cause a problem...</p> <p>[After] things have gotten almost back to normal...but again with everyone in the same house thing can get bad...yes maybe a little better...</p>

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Participants were asked about how they would respond if they would hear negative comments about the diagnosis of their family member. All participants shared that they would try to educate about the illness,

I would tell them to educate themselves...a mental illness is like any physical illness...if someone breaks a foot they might need therapy to fix it, to get

better...if you have a mental illness you also need treatment, therapy to get better.

Two participants admitted that ignoring people would be the first reaction but they would also try to educate them and provide information they know about the diagnosis “I would ignore them...or I would try to explain the best I could to explain what he goes through.”

Overall, the data obtained from participants support reduction of stigma, as well as change in views of psychotic disorders. All participants report positive changes in interfamily relationships, and having more knowledge about the client’s diagnosis. However, participants reported knowledge but had difficulties naming the symptoms or diagnosis of their loved ones. Psycho-education provided through family therapy was the method most utilized by participants and little to no participation was reported for multi-family groups.

## CHAPTER V

### DISCUSSION

This chapter will overview the information analyzed in the previous chapters addressing the objectives of this study: experiences of Latinos participating in a psycho-educational program, current view of psychotic disorders, interfamily relationships and reduction of stigma among the family members interviewed. This chapter will also make recommendations on how the information gather can be applied to social work practice, policy and future research in Latino psycho-education on psychotic disorders.

Overall, the data analyzed demonstrates Latino family members who participated in the LIFE Path program had a positive experience. Families reported being psycho-educated around symptoms and treatment options for clients. All participants reported being notified of the client's right to refuse treatment and release of information about treatment. The experiences reported on family, group therapy and overall experience were positive. The participants shared that information given was easy to understand, they have some knowledge about the symptoms and support (case management, connection to community support) was given when needed or asked for. One participant shared for multi-family groups more bilingual clinicians were needed for translation; this supports the study by Barrio et al. (2008), *Unmet needs for mental health services for Latino older adults: Perspectives from consumers, family members, advocates, and service providers*, which explains that

limited availability of bilingual clinicians continues to be a challenge when providing services for Latinos. Only one family reported participating in multi-family groups, making very limited data to conclude that group sessions are a successful intervention for Latinos.

More participation of other family members was a common answer among participants. Lack of participation from other family members was not reported as a factor in interfamily relationship problems, or reported as a factor in the client not participating in treatment. The inclusion of other family members question was included, to factor in if full family support helped families with stigma reduction and change in views in psychotic disorder. As no other member of the same family participated in this study the data could not support this.

Exploration of interfamily relationships was another objective of this study; all participants shared a positive change. Participants shared that the psycho-education provided by the program helped them understand and support clients more. As the family members understood the struggles of clients, they had a better response when client had a crisis. Two families shared that the clarification of symptoms and the client's behaviors helped them change the view into the client's diagnosis and not thinking that behaviors were due to other behavioral or conduct problems. Some participants shared that attending family therapy helped them with communication skills that they are utilizing now, not just with clients, but with other family members as well. More data is needed to further show that interfamily relationships changed, as

no other member of the same family participated in study to compared answers and further support positive changes.

All participants reported a change in how they viewed clients' diagnosis. Participants report a better understanding of symptoms as well as recognizing when the client is experiencing psychotic symptoms. Some families reported having a different attitude towards the clients' symptoms including reporting having more patience and offering more support. Families report that due to them being able to point out the client's symptoms they can support them through treatment and asking for help when needed. This supports the study by Lopez et al. (2018), *Psychosis literacy among Latinos with first episode psychosis and their caregivers*, that Latino families who have knowledge about the diagnosis and symptoms are most likely to request support.

Participants report supporting clients by making sure the client takes the medication, providing transportation to psychiatrist appointments and therapy sessions as needed. This supports study by Luckstead et al. (2012), *Recent developments in family psycho-education as an evidence based practice*, families support helps the client in better treatment outcome by helping clients take the medication and providing them with transportation to appointments. Another participant shared having a plan in place to support the client if needed in public places, or when cognitive symptoms appear by able providing pen paper for the client to communicate. These data supports that families are changing their views on the diagnosis but also understanding how to better help clients.

Stigma reduction was another objective of this study. The data supports that families who received psycho-education have reduced their stigma around psychotic disorders. Participants reported willingness to provide education to others when given a scenario of overhearing negative comments about clients' diagnosis. However, some participants shared that their first response might be just to ignore bad comments. Further studies need to be completed in the same families, as data obtained could give us more information about the views of other family members to assess if family stigma was reduced.

### **Implications**

This study supports the importance of psycho-education for Latino families specifically to first episode psychosis programs. For clinicians, continuing to support families is important during such difficult times. Family inclusion in treatment and encouragement for all family members to participate could further help client have a better prognosis. The reduction of stigma is an important factor to consider when inviting other family members to participate. For clinicians is important when psycho-educating families to include diagnosis name and all symptoms related even if client is not presenting them at the moment. This would help families and clients feel empowered and in control, specifically when supporting the client in doctor appointments or when seeking help. Families many times are more in sync with the client daily normal activities and are more likely to notice changes in behaviors and symptoms.

For the social work profession this study supports the need of more bilingual social workers willing to work with clients suffering from psychotic disorders. Also, more research needs to be performed in the area of psycho-education for Latino families who are supporting clients going through a first episode psychosis. The research is limited and not inclusive of not just Latinos but minorities in general. This would help provide Latinos with culturally appropriate services. Clinical social workers would benefit from training about supporting and including families when working in early intervention programs. Training could help clinicians support clients maintain those important family relationships, to support better treatment outcomes and prognosis.

Policy providing funding to support research and early prevention programs is needed. The California Mental Health Act is a good starting point, however, the reality is that more is needed to provide adequate mental health services for our communities. Early intervention funding is crucial, to offer community education, more treatment options, and research to better support the whole state regardless of medical insurance. This study is a small contribution to the family psycho-education for psychotic disorders; more programs are needed to further study the topic. The inclusion of first episode psychosis program not just in certain counties, expanding existing programs and possibly extended it to state wide services is needed to fully support clients. Psychotic disorders need lifetime support for mental health services and the reality is that we are not supporting those clients and families. The early stages are crucial for intervention; however, often services are not offered until the

disease has progress so much that the clients' impairment is so great that it impedes them to live a fulfilled happy life.

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## APPENDICES

## APPENDIX A

## MEMORANDUM OF UNDERSTANDING

## PURPOSE:

This document will define the agreement between the researcher, Stanislaus Behavioral Health and Recovery Services and Sierra Vista – located at 1700 McHenry Ave. in Modesto, CA. The purpose of this memorandum of understanding is to serve as a tool that will guide the research to be conducted by Lourdes Santos-Ortega. Mrs. Santos-Ortega is a MSW student at CSU Stanislaus. Her thesis chairperson, Dr. Kilolo Brodie, will monitor this research study. Additionally, the Institutional Review Board at CSU Stanislaus will approve supervision of this proposed study.

## SCOPE OF STUDY:

Psycho-education has become a prominent evidence-based intervention for client treatment outcomes. Clients have expressed that the negative symptoms of a psychotic illness have caused isolation, ultimately affecting their family relationships. Multiple studies conducted on the application of psycho-educational interventions has indicated positive effects on client outcomes as well as family relationships. Psycho-education can be of great support for Latino families as well as an important intervention for the client's treatment. Multifamily group psycho-education programs with opportunities for socialization and hospitality were successful with this population. The opportunity to share experiences and points of view were empowering for families in understanding mental illness. Further, Latino families that have participated in psycho-educational groups have reported a greater understanding of mental illness and the related symptoms, aiding in fostering a better relationship with the client.

This study will explore the experience of those families who have participated in psycho-educational programs and how they have benefited from services. The goal of this study is to gain knowledge on how the availability of psycho-educational programs has impacted Latino families with positive interfamily relationships as well as reduction of stigma around psychotic disorders. The questions directing this study are: a) What are the experiences of the Latino families who have received psycho-educational programs? b) How have Latino families who received psycho-education changed their interfamily relationships? c) How do Latino families who received psycho-education view psychotic disorders? d) Have psycho-education programs reduced stigma of psychotic disorders within Latino families? e) Do families believe that their participation in psycho-education has helped client's treatment outcome?

THE AGENCY (Stanislaus County Behavioral Health & Recovery Services and Sierra Vista) AGREES TO:

- Allow specified CSU Stanislaus Master of Social Work student permission to complete interviews Sierra Vista will be advised of participants by name before data collection commences.
- Send correspondence to potential participants, which advises of the study and provides the researcher's contact information.
- Make staff aware of the forthcoming research (i.e., announce in meetings, a memo)
- Encourage staff to disclose possible study participants who may be interested in participating in the study or be open to being contacted by the researcher regarding the study.

THE RESEARCHER (Lourdes Santos-Ortega) AGREES TO:

- MSW students will adhere to the CSU Stanislaus protocol for research and informed consent
- Inform the participants of their role in this study as well as the purpose of the study.
- Present the participants with an informed consent form and obtain their signature before conducting interview (see Attachment A – Consent Form).
- Conduct this research on a voluntary basis with no expectation of payment from Sierra Vista.
- Safeguard the information received from the research participants and maintain confidential record keeping.
- Submit a copy of the thesis to Sierra Vista upon completion of Master's degree requirements

AGREEMENT TO BE SIGNED AND DATED BY:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Sierra Vista Representative

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Lourdes Santos-Ortega, CSU Stanislaus MSW Student

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Kilolo Brodie, Ph. D., MSW, CSU Stanislaus MSW Thesis Chair

## APPENDIX B

## FAMILY QUESTIONNAIRE

1. Members present in group and relationship to client? (Parents, siblings, grandparents or friends)
2. Is your family member underage or an adult?
3. Does your family member allow you to participate in all aspects of treatment?
4. What do you understand about the diagnosis of your family member? Are you familiar with the symptoms related to the diagnosis?
5. How have you been supporting your family member with their mental health diagnosis and symptoms?
6. How long have you participated in the LIFE Path program?
7. Have all the family members have participated in educational, support groups, or family therapy provided by Life Path? Why or why not?
8. Have you been educated about your family member's diagnosis, symptoms, and possible treatment options (medication, groups or therapy)?
9. Have you been educated in regards of rights of your family member's privacy (e.g., giving you information about treatment such as therapy, medication or counseling and client's right to refuse treatment)?
10. Based on the answers above, if you have been educated and given information about your family member, has that changed how you view your family member's mental illness?
11. If you were to hear bad comments from relatives or non-relatives about the mental health diagnosis that your family member has, how would you respond?
12. Due to your family member's mental diagnosis, has your family faced struggles or problems, such as, family disagreements or arguments about the diagnosis?
13. After participating in educational and/or support groups or family therapy, have those struggles or problems, such as, family disagreements or arguments have gotten better?
14. What have you liked about educational and support groups?
15. What would you like to see different during educational and support groups?
16. What have you liked about family therapy?
17. What would you like to see different during family therapy?
18. Overall, how would you describe your experience when working with Life Path?

## APPENDIX C

## CUESTIONARIO FAMILIAR

1. ¿Personas apoyando al cliente? ¿Cuál es su relación? y (Padres, hermanos, abuelos o amigos)
2. ¿Su familiar es mayor de edad?
3. ¿Su familiar lo deja participar en todos los aspectos del tratamiento?
4. ¿Cuál es su entendimiento acerca del diagnóstico del miembro de su familia?  
¿Conoce los síntomas relacionados con el diagnóstico?
5. ¿Cómo está usted ayudando al miembro de su familia con el diagnóstico y síntomas de salud mental?
6. ¿Cuanto tiempo ha participado en el programa de LIFE Path?
7. ¿Han participado todos los miembros de su familia en grupos de apoyo o educacionales, o en terapia de familia disponible por LIFE Path? ¿Porque o porque no?
8. ¿Ha sido usted educado acerca del diagnóstico, síntomas y opciones posibles de tratamiento de su familiar? (medicamento, grupos o terapia)
9. ¿Ha sido usted educado acerca de los derechos de privacidad de su familiar (¿ejemplo?, darle información acerca del tratamiento como terapia, medicamento o consejería y el derecho del cliente de rechazar tratamiento)?
10. ¿Basado en las respuestas de arriba, si usted ha sido educado y le han dado información acerca del miembro de su familia, ¿esto ha cambiado en como usted ve la enfermedad de salud mental del su familiar?
11. ¿Si usted escuchara a algún miembro de su familia o persona hablar negativamente acerca del diagnóstico de salud mental de su familiar, como usted le respondería?
12. ¿Debido al diagnóstico de salud mental del miembro de su familia, han tenido problemas familiares, como discusiones o malos entendidos?
13. ¿Después de participar en grupos educacionales o terapia familiar han mejorado los malos entendidos y discusiones familiares?
14. ¿Qué es lo que le ha gustado de grupos educacionales o de apoyo?
15. ¿Qué le gustaría ver diferente en grupos educacionales o de apoyo?
16. Que es lo que le ha gustado de la terapia familiar?
17. ¿Qué le gustaría ver diferente durante terapia familiar?
18. En general, ¿cómo describiría su experiencia con el programa de LifePath?

APPENDIX D  
CLIENT LETTER ENGLISH

Date

Lourdes Santos-Ortega  
1700 McHenry Village  
Modesto, CA 95350

To Whom It May Concern:

My name is Lourdes Santos-Ortega. I am a Master of Social Work student at California State University Stanislaus. I am currently working on my thesis focusing on the experience of Latino families that participated in psycho-education through the LIFEPath program. This letter is to inform you that your family will be invited to participate in the study. If interested, your family members would have an interview with me to answer question about their experiences with LIFEPath services. All the information about your family will be kept confidential and will not be shared in the final written format of this study.

Please let me know if you have any questions or concerns in regards to the participation of your family in this study. You can contact me at (209) 255- 2420 or at [lsantos@csustan.edu](mailto:lsantos@csustan.edu).

Sincerely,

Lourdes Santos-Ortega  
Stanislaus State, Master of Social Work student

APPENDIX E  
CLIENT LETTER SPANISH

Fecha

Lourdes Santos-Ortega  
1700 McHenry Village  
Modesto, CA 95315

A quien le interese,

Mi nombre es Lourdes Santos-Ortega, y soy estudiante de Maestría de Trabajo Social de la Universidad Estatal de California, Stanislaus. Actualmente estoy trabajando en mi tesis que se enfoca en las experiencias de familias Latinas que han participado en educación psicológica en el programa de LIFEPath. Esta carta es para informarle que su familia estará invitada a participar en esta investigación. Si estarían interesados, los miembros de su familia participarían en una entrevista conmigo acerca de su experiencia con los servicios de LIFEPath. Toda la información de su familia sera confidencial y no sera mencionada en la forma escrita final de esta investigación.

Por favor déjeme saber acerca de cualquier pregunta o inquietudes que tenga acerca de la participación de su familia en esta investigación. Usted me puede contactar at (209) 255-2420 o a lsantos@csustan.edu.

Atentamente,

Lourdes Santos-Ortega  
Universidad Estatal Stanislaus, estudiante de Maestría de Trabajo Social

APPENDIX F  
FLYER ENGLISH

**PARTICIPANTS  
NEEDED  
FOR  
STUDY**

**WHEN**  
January 1 st to January 30 th

**WHERE**  
**LIFePath**  
1700 McHenry Village, Modesto, CA 95350

**ABOUT THE STUDY •**  
This CSU Stanislaus Master of Social Work thesis study is to learn more about the experiences of the Latino families that have participated in the LIFePath program.

**LATINO FAMILY  
MEMBERS**

**CONTACT**  
**LOURDES**  
**209-255-2420**

APPENDIX G  
FLYER SPANISH

**SE NECESITAN  
PARTICIPANTES  
PARA  
ESTUDIO DE INVE-  
STIGACION**

**CUANDO**

**Del 1ro al 30 de enero**

**DONDE**

**LIFEPath**

**1700 McHenry Village, Modesto, CA 95350**

**ACERCA DEL ESTUDIO:**

**Este estudio de la maestría de trabajo social de la Universidad Estatal de California Stanislaus, es para aprender mas acerca de las experiencias de familias Latinas que han participado en el programa de LIFEPath.**

**LLAMAR A**

**LOURDES**

**209-255-2420**

## APPENDIX H

### INFORMED CONSENT ENGLISH

#### California State University, Stanislaus Informed Consent to Participate in Research

##### Purpose of the Research

The Principal Investigator, Lourdes Santos-Ortega, is a student at California State University, Stanislaus conducting research for master's degree thesis in Master of Social Work program.

This study will seek to learn about the experiences of those Latino families participating in psycho-education services.

##### Procedures

- Latino families will be asked interview with researcher (CSU Stanislaus MSW student) to complete a questionnaire consisting of 13 questions. Total time to complete 1.5 hours to 2 hours. A second meeting could be necessary to complete questionnaire.
- Interview will be audio recorded
- After researcher analyzes data and completes study a copy of the findings will be provided to all participants including agency.

##### Potential Risks or Discomforts

Families may feel emotional discomfort in disclosing family struggles/challenges that are connected to mental illness. Family members will be provided with (a hard copy) resource sheet to assist them with support regarding feelings of uneasiness or concern derived from participation in study – Stanislaus Behavioral Health and Recovery Services crisis line at (209) 558-4600 or triage services at (209) 402-0727 and the national suicide prevention line 1-800-273-8255.

##### Potential Benefits of the Research

Benefits for participating agencies will include receiving knowledge regarding Latino family experiences with psycho-education services. For the participating families, they will have the opportunity to safely share collective feedback on a psycho-educational program.

##### Confidentiality

The data obtained from interviews will be kept in a locked cabinet in the researcher's office. Researcher information gathered will be protected under full disclosure of the law.

The researcher will not retain the research data to use for future research or other purposes.

Costs

There is no cost beyond the time and effort required to complete the procedure(s) listed above.

Compensation

Compensation for participating in this research study will be meal or coffee paid for by researcher.

There is no anticipated commercial profit related to this research.

Participation and Withdrawal

All participants must be 18 years or older. Participation is voluntary, and refusal to participate or stopping participation can occur at any time without penalty or loss of benefits.

Questions

If you have any questions about this research, you may contact me, Lourdes Santos-Ortega, at (209) 255-2420 or my faculty sponsor, Dr. Kilolo Brodie at (209) 667-3126.

If you have any questions regarding your rights and participation as a research subject, please contact the IRB Administrator by phone (209) 667-3493 or email IRBadmin@csustan.edu.

Consent

I have read and understand the information provided above. All of my questions, if any, have been answered to my satisfaction. I consent to take part in this study. I have been given a copy of this form.

In addition to agreeing to participate, I also consent to having the interview audio recorded.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (printed) \_\_\_\_\_

Signature of person obtaining consent \_\_\_\_\_ Date \_\_\_\_\_

Printed name of person obtaining consent \_\_\_\_\_

## APPENDIX I

### CONSENT FORM SPANISH

Universidad del Estado de California, Stanislaus  
Consentimiento para Participar en Investigación

#### Propósito de la Investigación

La Investigadora Principal, Lourdes Santos-Ortega, es estudiante de La Universidad del Estado California, Stanislaus, conduce la investigación para su tesis de Maestría en el programa de Trabajo Social.

El propósito de este estudio es el aprender acerca las experiencias de las familias Latinas participando en los servicios de educación psicológica.

#### Procedimientos

- Se les pedirá a las familias Latinas que se entrevisten con el investigador (estudiante de CSU Stanislaus MSW), para completar un cuestionario consistiendo en 14 preguntas. El tiempo para completar el cuestionario será de aproximadamente de 1.5 hora a 2 horas. Una segunda entrevista puede ser necesaria para completar el cuestionario.
- La entrevista será grabada en audio.
- Después que el investigador analice los datos y complete el estudio, una copia de los resultados se proporcionara a los participantes, incluyendo la agencia.

#### Posibles riesgos o incomodidades

Familias pueden sentir incomodidad emocional al revelar luchas/desafíos conectadas ha enfermedades mentales. Se les proporcionara una hoja de recursos (imprimida) para recibir apoyo con inquietudes que puedan surgir después de participar en este estudio- línea de crisis del condado de Stanislaus (209) 558-4600, información acerca de servicios al (209) 402-0727 y la línea nacional de prevención contra el suicidio 1-800-273-8255.

#### Beneficios Potenciales de la Investigación

Beneficios para las agencias participantes incluyen conocimiento acerca de las experiencias de familias Latinas, participando en servicios de educación psicológica. Las familias participantes tendrán la oportunidad de compartir de forma segura comentarios colectivos sobre programas de educación psicológica.

#### Confidencialidad

Los datos obtenidos en las entrevistas serán mantenidas en un gabinete bajo llave en la oficina del investigador. La información obtenida será protegida bajo las leyes. La investigadora no usara la información para uso futuro, o algún otro propósito.

#### Costo

No habrá algún costo más allá del tiempo y esfuerzo requerido para completar los procedimientos anteriormente mencionados.

Compensación

La compensación por participar en este estudio será una comida o café pagada por el investigador.

No hay ganancias comerciales anticipadas relacionadas con esta investigación.

Participación y Retiro

Todos los participantes tienen que tener 18 años o más. Participación es voluntaria, el reusarse a participar o parar la participación puede ocurrir en cualquier momento, sin penalidad o pérdida de beneficios.

Preguntas

Si tiene alguna pregunta, puede contactarme, Lourdes Santos-Ortega, al (209) 255-2420 o a mi patrocinador, Dr. Kilolo Brodie al (209) 667-3126.

Si tiene preguntas acerca sus derechos y participación, por favor contacte al Administrador IRB al teléfono (209) 667-3493 o por correo electrónico IRBadmin@csustan.edu.

Consentimiento

He leído y entiendo la información anteriormente proporcionada. Todas mis preguntas han sido contestadas a mi satisfacción. Doy mi consentimiento para participar en este estudio. He recibido copia de esta forma.

Firma \_\_\_\_\_ Fecha \_\_\_\_\_

Nombre (imprimido) \_\_\_\_\_

Firma de la persona obteniendo consentimiento \_\_\_\_\_

Fecha \_\_\_\_\_

Nombre imprimido de la persona obteniendo consentimiento \_\_\_\_\_

Además de aceptar participar, también doy mi consentimiento de que la entrevista sea audio grabada.

Firma \_\_\_\_\_ Fecha \_\_\_\_\_

Nombre (imprimido) \_\_\_\_\_