Adolescent Latino Males with Schizophrenia: Mobile Crisis Response

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Although schizophrenia has a biological basis, the presentation of symptoms and the understanding of the disorder vary among cultures. Service providers who understand these cultural variations are in a better position to provide effective crisis intervention. When a person with schizophrenia goes into crisis (often synonymous with the acute psychotic phase), the intersection of culture, diagnosis, developmental stage, and social setting can be overwhelming to the crisis worker. Roberts’s Seven-Stage Crisis Intervention Model provides a useful framework within which to provide culturally competent crisis intervention. This article applies Roberts’s model to a case involving an adolescent Latino male who has a diagnosis of schizophrenia. Included is a review of literature on mobile crisis intervention with youth, cultural competence, and schizophrenia. Specific treatment recommendations are made for understanding cultural variations, developmental influences, and service delivery with this population.

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Rolando

At 8:55 PM the phone rang in the offices of the mobile crisis unit for children and adolescents. “Don’t answer it,” I said to my coworker Kim. “The on-call shift starts in five minutes. If you pick up we might be here for hours. Let the on-call person take it.” Kim reminded me that she was the on-call worker for the night. I agreed to stick around and help out if needed. Kim had done the same for me many times; that was part of the deal working as a team. The call was from Lupe, a mother who was well known to the crisis team staff. Her 16-year-old son, Rolando, had been diagnosed with schizophrenia after his first hospitalization 2 years ago. This would begin the family’s third involvement with mobile crisis services.

Tonight Lupe reported that Rolando and his 13-year-old brother were arguing and pushing each other. Lupe was afraid that the violence might escalate. For the past 2 days, Rolando had been tormented by command hallucinations telling him to kill his brother. Lupe told us that Rolando and Hector got into a fistfight last night and that Rolando stayed home from school...
today. Lupe threatened to call the police if Rolando did not return to school tomorrow. Rolando trashed his room and told Lupe that he hoped she died. Soon after that, Hector threw a pillow at Rolando and told him to shut up. According to the client record, two to three times a year, Rolando would stop taking his medication, become actively psychotic, and attempt to kill his brother. It sounded like tonight was turning into another one of those nights, with one important difference: according to Lupe, Rolando was accusing everyone in the house of trying to kill him. Lupe reported that this was the first time Rolando had been paranoid over a number of days without periods of lucidity. Lupe also reported that she was scared and did not know what else to do.

Introduction

This article focuses on culturally appropriate mobile crisis intervention services for adolescent Latino males with a diagnosis of schizophrenia. The case scenario presented contains a number of elements that identify it as a crisis, including threats to safety, history of violence, failure to successfully employ existing coping skills, and most important, the perception that that situation is a crisis. Less obvious but equally important to recognize are issues of culture and mental illness. After a brief review of the literature on schizophrenia, treatment, and cultural competence, a brief case study is presented to demonstrate how to incorporate culturally competent crisis intervention using Roberts’s Seven-Stage Crisis Intervention Model (Roberts, 2000). Roberts’s model can be applied in hospital and home settings. Solution-focused techniques are integrated with family-centered treatment. Finally, cultural issues relevant to the case study are discussed. Although cases with this mix of culture, diagnosis, and crisis are commonplace in the field, there is a serious dearth of literature that addresses this specific topic. For readers interested in a comprehensive and detailed discussion of mobile crisis units and children and youth, see J. B. Singer (in press).

A basic assumption of crisis theory is that pathology is not necessary for crises to occur. Roberts (2000) defined crisis as “a period of psychological disequilibrium, experienced as a result of a hazardous event or situation that constitutes a significant problem that cannot be remedied by using familiar coping strategies” (p. 7). In this article, the acute psychotic episode is synonymous with a crisis state (although the reverse is not true). There are five ways that Rolando’s acute psychotic state corresponds to the characteristics of a person in crisis (Roberts, 2000):

1. Rolando perceives the precipitating events (Hector’s taunts) as meaningful and threatening.
2. He is unable to deescalate the situation with his usual coping mechanisms (humor or dismissing the exchange).
3. His level of fear, confusion, and paranoia is increasing (he demonstrates impaired reality testing).
4. He reports significant discomfort about the situation (Hector will not leave him alone).
5. He is in a state of disequilibrium (he is agitated, disorganized, and volatile).

The necessity for medication as a primary means of crisis stabilization is a primary differentiating factor between an acute psychotic episode and the traditional definition of a crisis state. Whereas most crises can be resolved through basic communication skills, problem solving, and a strengths-based perspective, crisis resolution for a person with biologically based serious mental illness requires a pharmacological intervention (Herz & Marder, 2002). The first characteristic of a person in crisis—identifying
a precipitating event as meaningful or threatening—is not a precondition of crisis for a person in a psychotic state; indeed, the person in an acute psychotic phase might not have any perception of threat or harm, thus putting himself or herself and others in danger.

The presence of a previously documented serious mental illness both clarifies and complicates crisis intervention. Assessment is clarified because diagnosis follows a standard nosology (i.e., classification of disease) and treatment follows diagnosis (Springer, 2002). For example, knowing that paranoia is consistent with Rolando’s diagnosis of schizophrenia simplifies the assessment of his cognitive abilities. The more familiar clinicians are with diagnostic criteria and standards of care, the more effective they can differentiate between a crisis reaction and a psychiatric disorder. The complication rests in the breadth of knowledge required of the worker. The worker must have a clear understanding of the way the diagnosis manifests itself in youth in general and, when possible, how it manifests itself in a youth in particular. Recognizing how cultural issues influence the crisis helps the worker to identify culturally appropriate solutions. Greene, Lee, Trask, and Reheinscheld (2000) frame crisis not just as a problem to be resolved but as an opportunity for growth. Effective crisis resolution can leave the client in a better place than before the onset of the crisis. Such growth may even be considered the goal of crisis intervention.

Mobile Crisis Intervention

Mobile crisis intervention for youth with schizophrenia is an important component in a comprehensive mental health services program. Whereas adults with schizophrenia are often involved with ACT (assertive community treatment) teams (Herz and Marder, 2002), youth with schizophrenia rely on their families and community for support. Family and community resources are often insufficient to successfully deal with youth experiencing an acute psychotic episode. Mobile crisis outreach for youth brings services to families during times when their coping skills have been exhausted, and it provides immediate assessment, referral, and crisis stabilization. Mobile crisis intervention has been found to reduce hospitalizations for people in crisis (Scott, 2000), and longitudinal studies suggest that early intervention reduces deleterious effects of schizophrenia (Fonagy, Target, Cotrell, Phillips, & Zarrina, 2002).

The crisis intervention worker must think about referrals from the beginning of services. Most children have their first contact with mental health services during a crisis (Burns, Hoagwood, & Mrazek, 1999). While a continuum of care is recommended for all outpatient crisis services for youth, the pervasive life course of schizophrenia makes continuous coordinated care essential for effective symptom maintenance (Herz & Marder, 2002). Herz and Marder suggest that the treatment stages in schizophrenia are as follows:

Prodromal phase: emergence of symptoms
Acute phase: severe positive and negative psychotic symptoms
Stabilization phase: symptom management through medication
Stable phase: use of pharmacotherapy; psychosocial and rehabilitative approaches; and community support programs to minimize and, if possible, eliminate symptoms

The traditional continuum of care model comprises only professional services. A culturally competent model includes informal support networks such as extended family, religious institutions, and neighborhood supports. As yet, there have been no studies that can be considered
Adolescence

Adolescence is often a source of stress for families. Adolescents undergo significant changes in their understanding of the world and how they relate to it (Carter, McGoldrick, & Carter, 1998). Lifestyle changes can be attributed to puberty, development of a sexual identity, changes in cognitive thinking, and attempts to make sense out of unfamiliar emotions and social status (Alestalo, Munnukka, & Pukuri, 2002). Adolescents tend to be more impulsive; they put themselves at a higher risk for harm (to self and others); and they develop their identities through imitating others, including peers (Hillman, 2002; Jobes, Berman, & Martin, 2000). For adolescents with schizophrenia, there is a circular relationship between poor social skills and peer development (Alestalo et al., 2002): challenges associated with developing a peer group can have serious consequences on the development of socially appropriate skills; social skill development is more difficult without a peer group.

Some basic rules for working with adolescents in crisis and traditional counseling are as follows:

1. Let them know you are willing to listen without interrupting their stories.
2. Reflect and restate more than question.
3. Empathize with their situations.
4. Provide them opportunities to take responsibility in the session and in their lives.

5. Be honest when you think that they are telling you what they think you want to hear (Peterson, 1995).

These basic rules work with adolescents of all cultures and can be modified to work with people with schizophrenia.

Culturally Competent Services

Culturally competent service delivery requires clinicians to be aware of their own cultural values, their clients’ worldviews, and culturally appropriate intervention strategies (Sue, Arredondo, & McDavis, 1992). Successful crisis intervention does not require that we as practitioners know everything about another culture; rather, it requires that we be willing to understand everything we can about another culture (Dean, 2001). Although there are studies that examine cultural factors related to service delivery for people with schizophrenia, most studies are limited to similarities and differences between African American and Anglo-Americans (e.g. Sohler, Bromet, Lavelle, Craig, & Mojtabai, 2004; Stone & Conley, 2004; Tolmac, & Hodes, 2004). Cross-cultural studies of medication response and culture have primarily used African American and Caucasian samples (Arnold et al., 2004; Elmsley et al., 2002; Kuno & Rothbard, 2002; Opolka et al., 2003). Relatively few studies compare treatments between three or more ethnic groups (Barrio et al., 2003; Brekke & Barrio, 1997; Elmsley et al., 2002). In an attempt to consolidate some of the knowledge base, Table 1 compares culturally competent intervention practices for Latinos and Anglos within the context of Roberts’s Seven-Stage Crisis Intervention Model.

Research in mental health (U.S. Department of Health and Human Services, 1999) indicates that racial and ethnic differences are important
factors to consider in design of services. Barriers to mental health treatment for Latinos include the following: language barriers; use of informal resources (curanderos and religious leaders); provider sensitivity (Lynch, 2000); and limitations to access to services due to socio-economic, insurance, and other factors (Sue and Sue, 2002). Congress (2000) reported that African American, Latino, and Asian American families may underutilize professional services because of the shame involved with taking a problem outside of the family or culture. Incorporating Latino customs into treatment leads to increased service utilization, length of treatment, and improved client satisfaction (Kopelowicz, 1998).

Despite commonalities within Spanish-speaking cultures, to assume ethnic homogeneity among Latinos dismisses real cultural differences. Authors routinely make generalizations such as the following: “Considerably lower earnings and family income among TABLE 1. Comparison of Latino and Anglo-American approaches to Roberts’s Seven-Stage Crisis Intervention Model

<table>
<thead>
<tr>
<th>Stage</th>
<th>General</th>
<th>Latino</th>
<th>Anglo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>Identify the risk of self-harm, harm from others, harm to others.</td>
<td>Family centered</td>
<td>Individual oriented</td>
</tr>
<tr>
<td>Rapport building</td>
<td>Use basic attentive skills: attending behavior, open- and closed-ended</td>
<td>Use small talk and self-disclosure. Accept</td>
<td>Emphasize professional qualifications; avoid sharing</td>
</tr>
<tr>
<td></td>
<td>questions, paraphrasing, reflection of feelings, and summarization</td>
<td>food or drinks if visiting the home.</td>
<td>personal history.</td>
</tr>
<tr>
<td></td>
<td>(Kanel, 2003)</td>
<td>It is appropriate to tell a little bit</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>about your cultural background. Offer to</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>speak Spanish if possible.</td>
<td></td>
</tr>
<tr>
<td>Identification of the problem</td>
<td>Find the precipitating event.</td>
<td>Family-oriented problems can be the focus</td>
<td>Focus on individual responsibility for problems.</td>
</tr>
<tr>
<td>Dealing with feelings and</td>
<td>Allow for expression of emotions, or encourage people to have their</td>
<td>Look for physical or somatic symptoms. Be</td>
<td>Listen for intellectualization or rationalizations.</td>
</tr>
<tr>
<td>emotions</td>
<td>feelings</td>
<td>cognizant of socially desirable responses</td>
<td></td>
</tr>
<tr>
<td>Generating and exploring</td>
<td>Use solution-focused techniques to identify exceptions and past</td>
<td>Defer to adults first for solutions.</td>
<td>Engage the whole family in identifying solutions to the</td>
</tr>
<tr>
<td>alternatives</td>
<td>successes</td>
<td>Reinforce parental authority.</td>
<td>problem.</td>
</tr>
<tr>
<td>Developing and formulating</td>
<td>Take an active role in providing information on resources as well as</td>
<td>Use specific and concrete plans to</td>
<td>Individualize goals to accommodate individualized</td>
</tr>
<tr>
<td>an action plan</td>
<td>taking suggestions and turning them into measurable goals.</td>
<td>minimize the shame and confusion that</td>
<td>problems.</td>
</tr>
<tr>
<td>Follow-up</td>
<td>Make appointments and ensure transition occurs.</td>
<td>some families might feel. Refer to an</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ethnically matched provider.</td>
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<tr>
<td></td>
<td></td>
<td>Transition and follow-up sessions are of</td>
<td>Refer for follow-up services based on symptomology.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>particular importance with families who</td>
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<td></td>
<td></td>
<td>might distrust professional supports.</td>
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</table>
Hispanics support the argument that one can expect lower schooling attainment from them in the years ahead” (Chapa & Valencia, 1993, p. 177). These generalizations are not necessarily due to cultural ignorance. In fact, they are often attempts to report on governmental data. According to Castex (1994), “the U.S. Government defined and formally created the Hispanic ethnic group on May 4, 1978.” Castex noted that the governmental designation of an ethnic group, although not uncommon, differed from the traditional evolutionary process of group definition among people sharing the same values, language, beliefs, and sometimes geography. Much of the research on Latinos does not specify Mexican American, Puerto Rican, Honduran, or Spanish cultural groups, to name a few. Thus, although the family discussed in the case study is Mexican American, the choice was made to discuss treatment recommendations for “Latinos” in an effort to not misrepresent the literature.

Culturally competent crisis intervention requires accurate translation of ideas as well as words. Sue and Sue (2002) noted that differences in language and culture are often barriers to accessing formal support. Even when professionals are bilingual, mental health concepts are often difficult to translate (Kuipers, Leff, & Lam, 2002). For example, if a Latino mother reported that her son was nervous, one might assess for an anxiety disorder. However, the word nervios in Spanish has a very different meaning from its English translation. Jenkins (1988), in a fascinating ethnopsychiatric review, reported that the word nervios is often used to describe family conflict and daily distress as well as symptoms that meet criteria for schizophrenia. The word loco, or crazy, is reserved for the most severe and dangerous manifestations of an illness and suggests that there is no hope for recovery. The complexity of culture is apparent in the meaning of a single word, cultural variations in a concept, and differences in meanings attributed to behaviors and events.

Identifying the precipitating event in a crisis requires knowledge of culture. According to Congress (2000), legal status, language, and gender roles may precipitate crises. Which events precipitate crises and why may depend on a family’s level of acculturation. Miranda and Metheny (2000) suggested that dysfunction can occur when coping skills are inadequate due to cultural differences. Individual factors (e.g., language preference and family cohesion) and external, or demographic, factors (e.g., immigration experiences and culture of the host country) contribute to acculturative stress (Miranda and Metheny, 2000). The authors also noted that the factors that contribute to acculturative stress can also work to reduce stress.

Holleran and Waller (2003) explored issues of acculturation and discussed the role of traditional beliefs as a protective factor for Latino youth. The authors reported that “a strong, positive ethnic identity—particularly identification with traditional Mexican values and beliefs—may be a protective factor contributing to resilience among Chicano/a adolescents” (Holleran & Waller, 2003, p. 341). Brekke and Barrio (1997) attributed lower levels of symptoms among Latinos and African Americans, when compared to nonminority groups, to higher levels of empathy and social competence. Brekke and Barrio reported that positive sociocultural patterns are present in Latino populations. Bae, Brekke, and Bola (2004) compared data from two similar studies of psychosocial rehabilitation to identify ethnic and treatment outcome variations in schizophrenia. The authors reported no significant differences in gender or ethnicity for a number of measures, including length of illness, vocational functioning, social functioning, satisfaction with life, and self-esteem. Since psychosocial rehabilitation cannot explain
gender or ethnicity differences, it is possible that strong cultural connections contribute to resilience among Latinos with regard to symptomology.

In addition to identifying precipitating events, crisis assessment should address private components of culture, such as values and attitudes, as well as public components of culture, such as behaviors and knowledge (Barrio, 2001). For example, a first-generation 17-year-old Latina, while looking and sounding like a typical American teenager, might have values and attitudes about gender roles or the importance of family that are more similar to the teenager’s parents than to those of her more acculturated peers. If her parents announce that they are getting a divorce, the subjective distress for the 17-year-old Latina might be significantly greater than that for her peers for whom traditional values of family are not as important. Identifying cultural values can help in identifying the “last straw,” as well as possible resilience factors the person can draw from during the resolution of the crisis. When the stressor is not only environmental but biological (such as schizophrenia or bipolar disorder), the role of culture is even more pronounced.

Schizophrenia

Schizophrenia is the psychiatric disorder with the most number of cross-cultural studies (Lin, 1996). It is a devastating illness from which most people never fully recover. Barbato (1998) reported that approximately 29 million people around the world have schizophrenia. Although there is a biological basis for the disorder, cultural factors appear to influence both the presentation and the course of the disorder (Kopelowicz, 1998, 2002; Lopez et al., 2004; Weisman et al., 2000). The treatment of schizophrenia requires that cultural factors be taken into consideration.

Weisman et al. (2000) reported that Latinos tend to present with more somatic complaints, such as stomachaches and tactile hallucinations, and that Anglo-Americans present with more psychotic symptoms, such as delusions and paranoia. The lack of evidence supporting a genetic or biological difference between Latinos and other ethnic groups suggests that a cultural difference accounts for the difference in presentation. Kopelowicz (1998) pointed out that 78% of Mexican Americans chose the Spanish word nervios to describe the symptoms associated with schizophrenia. The word nervios suggests that there is a physical basis for problems. Kopelowicz concluded that the cultural conception of schizophrenia as a biological disorder resulted in somaticized symptoms.

Wiener and Dulcan (2003) reported that initial symptoms of schizophrenia can appear in childhood or adulthood. Childhood onset refers to the presence of symptoms before the age of 12. However, most people with schizophrenia have their first acute psychotic episode between the ages of 15 and 24. Lay, Blanz, Hartmann, and Schmidt (2000) reported poorer outcomes for early-onset schizophrenia than for adult-onset schizophrenia. Outcomes include greater financial dependence, multiple hospitalizations, and impaired vocational and social functioning. The earlier the onset of schizophrenia, the greater the impact on normal social development and educational attainment. A linear progression of increasing delusional syndromes and typical schizophrenic experiences is positively correlated with age (Galados & van Os, 1995). Gender differences are seen only in age of onset, with the disorder appearing in males 5 to 8 years earlier than in females (Galados & van Os, 1995). The true incidence of childhood schizophrenia is unknown (Wiener & Dulcan, 2003).

Misdiagnosis of schizophrenia in children is common. For example, Biederman et al. (2001) reported that 80% of children referred for the
national study of childhood schizophrenia did not meet criteria for the disorder, even though all the children had been referred with the diagnosis and many had psychotic symptoms. The presence of psychotic symptoms alone does not meet criteria for a diagnosis of schizophrenia. Psychotic symptoms can be caused by anxiety, sleep deprivation, drugs, and alcohol (Wiener & Dulcan, 2003), or they can be indicative of other psychiatric disorders (e.g., the manic phase of a bipolar disorder or major depression with psychotic features; Fonagy et al., 2002).

A diagnosis of schizophrenia requires at least two positive or negative symptoms, having a duration of at least 6 months and being coupled with a demonstrable social or occupational dysfunction (APA, 1994). Regardless of culture, in both children and adults, symptoms of schizophrenia are commonly categorized as either positive or negative. Positive symptoms, such as hallucinations or delusions, are manifestations of abnormal behavior or excess normal behavior. Negative symptoms, such as social withdrawal or lack of drive, are deficits in normal behaviors (Barlow & Durand, 1994; Lay et al., 2000). Asarnow (1994) suggested that criteria for adult-onset schizophrenia could be used for diagnosing adolescents. Because the criteria were the same, Wiener and Dulcan (2003) suggested that many treatments used with adults should apply to children, taking into consideration age, developmental stage, and the role of the family.

Treatment

Treatment of childhood-onset or adult-onset schizophrenia requires a multimodal approach, including case management, crisis intervention, skills training, neuroleptic medication, educational support, social support, and family therapy (Fonagy et al., 2002). The primary goal of treatment should be to reduce the frequency and symptom severity of acute episodes (Herz & Marder, 2002). In a review of psychosocial treatments for children and adolescents with schizophrenia, Fonagy and colleagues (2002) found only one randomized controlled trial. Although the results reported a significant reduction in hospital admission rates, the study was criticized for its size and methodology. In the absence of empirical data, guidelines to clinical intervention for youth diagnosed with schizophrenia have been derived from studies with adults or from anecdotal evidence from specialized practitioners.

Three psychosocial treatments for adults with schizophrenia that have demonstrated efficacy are skills training, modified cognitive–behavioral therapy, and personal therapy (Hogarty, 2002). With regard to culture, however, Koplewicz (1998) asserted that it is naive to assume that protocols designed for Anglo-Americans work for Latinos. Koplewicz reported that cultural modifications to social skills training resulted in improved outcomes for Latinos with schizophrenia. He recommended providing well-translated social skills training programs and modifying the goals to match cultural norms. For example, one goal of skills training is independent living. Imposing the cultural bias that living away from the family is better than living with the family fails to consider a core value in Latino culture.

The emphasis on the family is particularly relevant for adolescents. The normative behaviors of adolescents exacerbates the deficits that define schizophrenia—for example, poor social skills, mood, and ego instability. This results in difficulties in peer socialization. For youth with schizophrenia, families provide a socializing and protective function that is often unnecessary among youth without schizophrenia. According to Herz and Marder (2002), families benefit greatly from psychoeducation. Hogarty (2002) reported that educating the family about
the biological basis of schizophrenia reduces anxiety and fear associated with the illness. One result of psychoeducation is that manifestations of the disorder, such as social impairment and disorganized thought, are normalized.

The concept of expressed emotion (EE) has had a major influence on family treatment of schizophrenia (Lopez et al., 2004). Families who are critical, hostile, and overinvolved are labeled as high EE (Herz & Marder, 2002). Families without those qualities are labeled as low EE. Kuipers et al. (2002) stated that EE is a "robust predictor [of the course of schizophrenia] when someone with the illness lives with relatives" (p. 3). Compared to Anglo families, Latino families have consistently rated low EE. However, in Latino families, level of EE is an unreliable predictor of relapse (Koplewicz et al., 2002). Lopez et al. (2004) suggested that family warmth in Latino families is a significant protective factor in relapse. Warmth has been traditionally defined as emotional overinvolvement, which, the authors noted, carries a cultural bias.

Roberts’s Seven-Stage Model

A client in crisis is unable to think, feel, or act in ways that resolve the crisis. Roberts’s (2000) seven-stage model provides an excellent framework within which to provide crisis intervention. Four benefits of using Roberts’s model include the following:

1. It provides a structure within which to organize data, freeing the practitioners to focus on techniques, strategies, and skills they will use.
2. It reminds practitioners of the most important areas to address.
3. It is flexible enough to allow culturally competent intervention.
4. It can be validated and critiqued for efficacy.

Case Study: Rolando

The purpose of the case study is to provide an example of how Roberts’s seven-stage model can be used to organize the multitude of variables discussed here with the purpose of providing culturally competent crisis resolution. Greene et al. (2000) suggest that crisis is an opportunity for growth and that the goal of effective crisis resolution is to leave the client in a better place than before the onset of the crisis.

Solution-focused techniques are recommended and illustrated throughout the following case study, which is based on a client with whom I worked in the late 1990s. For confidentiality reasons and instructional purposes, details have been changed to protect his identity.

Stage 1: Assessing Lethality. There are three parts to the lethality assessment, although they are not sequential and, depending on the situation, not equally weighted: assessment of harm to self, harm to others, or harm by others (including unsafe environments). Accurate assessment of lethality provides the crisis worker with a functional baseline and instills a sense of confidence in the client. Failure to assess for lethality is both a legal liability and a failure to provide a professional service (Bongar, 2002).

Risk factors such as increased likelihood for violence, suicide, and impulsivity suggest that a comprehensive and thorough lethality assessment is particularly important when practitioners work with youth and people with schizophrenia. Suicide is the third-leading cause of death among 15- to 24-year-olds (U.S. Census Bureau, 1996). People with schizophrenia are 40 times more likely than people in the general population to kill themselves (Demetriades et al., 1998). Compared to other ethnic groups, Latino
youth are more likely to attempt suicide (Demetriades et al., 1998) but less likely to complete it (Center for Disease Control [CDC], 1998). Suicide assessment involves determining ideation (thoughts about killing oneself), intent (desire to kill oneself), and plan (when and how to kill oneself, including the means). An additional concern when working with youth is the safety of their family environment. Rudd, Joiner, and Rajab (2001) recommended evaluating the parents’ ability to fulfill essential functions (e.g., provision of resources, maintenance of a safe and nonabusive home) and parenting functions (e.g., limit setting, healthy communication, and positive role modeling). Whether the overall risk for harm increases or decreases is based on the outcome of the parents’ evaluations.

The second part of a lethality assessment is to determine the risk for harm to others. Recent literature suggests that psychosis is related to higher incidence of violence than that found in the general public (Schwartz, Petersen, Reynolds, & Austin, 2003; Schwartz, Petersen, & Skaggs, 2001). Schwartz et al. (2003) recommended that clinicians “pay particular attention to evaluating homicidality in patients who are male, have schizophrenia, who abuse substances, who show acute manic symptoms, and whose global functioning has recently declined” (p. 74). As with the suicide assessment, the crisis worker should assess for ideation, intent, and plan to harm others. Although often ignored by professionals, agencies, and researchers, violence against social workers is a significant problem (Newhill, 2004). According to Turns and Blumenreich (1993), 50% of human service professionals will be assaulted by a client. A recent stabbing death of a 26-year-old social worker by a 17-year-old client has highlighted the need for improved technology and training in harm reduction (National Public Radio, 2004; Sedensky, 2004). Although prediction of violence is far from accurate, a number of authors have developed safety protocols for social workers (e.g., Greenstone & Leviton, 2002; Piercy, 1984).

The final stage of the lethality assessment is to determine if the client is at risk for being harmed by others or is in an environment that could be harmful. With the exception of abusive situations, most youth are protected from harm by an adult. Youth with schizophrenia can be the target of taunting and harassment by peers, possibly leading to beatings or death. This should be assessed to determine if risk for future harm exists.

According to Roberts (2000), most initial contact in a crisis happens over the phone. As a crisis worker, I have found a number of specific benefits to providing crisis intervention over the phone, including the ability to complete assessments or read from a list of questions. Two of the most important benefits of phone counseling are illustrated in Rolando’s case: being able to write notes without distracting the client and having simultaneous phone access to other service providers, including supervisors, psychiatrists, and the police.

The assessment of lethality was urgent in Rolando’s situation. Lupe’s stated reason for contacting the crisis team was that she feared that Rolando would harm his brother. His medical records indicated a history of violence. For maximal safety of everyone involved (crisis workers included), we continued our intervention over the phone. In the following dialogue, Kim uses strengths-based language and open-and closed-ended questions to gather descriptions and specific information; she also uses reflection of feeling to maintain rapport.

**Case worker:** “Lupe, what are you doing to keep yourself safe right now?”

**Lupe (voice trembling):** I took the phone into the bathroom.

**Case worker:** I’m glad you’re safe. Where are Rolando and his brother right now?
Lupe: Yellin’ at each other in the other room.

Case worker: Does Rolando have access to any knives or other weapons?

Lupe: The knives have been locked up since the last time. I don’t think there is anything else in the house.

Case worker: I’m glad to hear that. You take your family’s safety seriously. What started all of this?

Lupe: I don’t know. I think Hector was teasing Rolando. I’m kinda worried; Rolando’s been acting real funny today, como tiene nervios.

Case worker: You’re worried about the way Rolando has been acting. You’re in the bathroom, right? Can you check his bottle? Has he been taking his medication?

Lupe: Ay no! Kim, it looks like he hasn’t taken his meds in at least a week. ¿Que vamos a hacer? [What are we going to do?] I’m afraid to leave the bathroom.

Case worker: No te preocupas. [Don’t worry.] I hear the fear in your voice. You’ve been doing great so far tonight. I see no reason why that will change.’’

The primary concern is to assess for safety. Lupe’s comments suggest that she felt afraid and that her sons were involved in an argument that could quickly escalate. Assessing the parent is an equal part of a lethality assessment when one works with families. It was critical that Lupe’s capacity and ability to protect were assessed (Rudd, Joiner, & Rajab, 2001) and that backup help was considered.

Although there are many cultural issues in this scenario, three are relevant to our discussion of crisis intervention. The first is Lupe’s use of Spanish during times of stress. When Kim responded to Lupe in Spanish, she validated Lupe’s right to speak in a way that is comfortable and that most accurately reflects her feelings. Second, Lupe’s role as the decision maker was respected despite her crisis state. At the time, Kim wrote a note asking, “Should we call the police?” My response was “Ask Lupe if she’s comfortable with the police coming. If so, tell her I’d like to speak with Rolando.” Lupe agreed to police involvement because she believed that the police would provide safety and transportation if needed. Involving Lupe in the decision to call the police affirmed her authority as a parent and provided her the opportunity to make a decision. Third, Lupe referred to Rolando’s behavior as nervios. This was our clue to address behavioral concerns rather than mental concerns. The culturally informed modifications to crisis intervention did not reduce safety, nor did they result in less efficiency. As we will see, they did result in greater rapport and, ultimately, in improved follow-through with postcrisis intervention stabilization services.

Rolando’s current functioning and mental status were assessed. He confirmed that he had stopped taking his meds, had been sleeping poorly, and had no appetite. He denied use of alcohol or other drugs. He reported that he had no thoughts of killing himself and stated that he would only hurt his brother, not kill him. He refused to contract for safety. The following dialogue indicates that the situation was not safe and that it was appropriate for Kim to call the police.

Rolando: Hector won’t stop talking about me. All the time, yo. He and his friends are always saying things about me behind my back. He needs to stop, dogg.

Case worker: How do you know they are talking about you?

Rolando: I know. What, you don’t believe me? [Laughs, then becomes angry] I know what you’re thinking. I know what they’re all...
thinking. I can hear them even when they are not talking.

Case worker: I can understand how you’d be angry if you thought your brother and his friends were talking about you. If you’re willing, I’m going to help you so that he doesn’t talk about you anymore. We’ll get you out of here to a safe place. Are we cool?

Rolando presented with delusions of reference, thought broadcasting, and paranoia—all clear indications of psychosis. According to Herz and Marder (2002), the content of a delusion can provide information about the client’s safety. Clinicians should be most concerned about command hallucinations to kill self or others. It is unclear the extent to which Rolando’s paranoia was based on actual events or delusional thinking; medical records noted that Hector took pleasure in teasing Rolando for being “crazy.” As discussed, the word crazy has a far greater negative connotation in Spanish (loco) than it does in English and might provide a cultural explanation for Rolando’s anger.

Rolando stayed on the phone with us as we traveled to his house. He agreed to be transported by the police to the hospital. The psychiatrist on-call admitted him to the adolescent unit and started him on his meds. Lupe was reassured that her present clinicians could participate in treatment at the hospital. Lupe affirmed that she wanted the present team to be there.

This clinicians’ participation in the hospital treatment addresses a number of cultural competency issues. While the hospital employs a number of Spanish-speaking maintenance workers, there is no bilingual therapist. Rolando speaks English fluently; however, like many bilingual Latinos, he often feels more comfortable expressing emotions in Spanish. There is also a question about how much control Rolando had over his language skills in his acute psychotic phase. Rolando would be forced to communicate in English at the hospital. According to the National Association of Social Workers’ Standards for Cultural Competence in Social Work Practice, “Standard 9: Language Diversity” (2001), there are three considerations for culturally competent practice. Applied to Rolando, they are as follows:

1. The need to reduce frustration and stress as a method of reducing his psychotic symptoms involves reducing the language barrier that might exist, since he is not fully in control of his cognitive faculties.
2. My participation provides continuity of care. One of the barriers to treatment for Latinos is lack of culturally competent service providers. Since the family has passed that barrier, it is important to continue the connection.
3. The mobile crisis unit had a collaborative relationship with the hospital, which enabled me to have privileges to practice even though I was not a hospital employee.

With Rolando in a safe environment, Roberts’s Stage 1 is complete. Safety can be revisited at any point in the assessment, if the need arises.

Stage 2: Establishing Rapport and Communication. The second stage in Roberts’s seven-stage model is establishing rapport and communication. Rapport is a short way of saying that the practitioner and the client have developed “a state of understanding and comfort” between each other (Kanel, 2003, p. 30). Given the variety of cultural issues discussed, it is not unreasonable to expect to continue to develop rapport throughout the intervention. In fact, the crisis team workers first established rapport with Rolando and his family 2 years ago, after
his first hospitalization. Rapport building continues with Rolando and his family during his stay at the hospital. Rolando’s ability to think clearly and to problem-solve was limited during the first few weeks. During the first meeting at the hospital, since Rolando had been stabilized on his meds, the family processed with me some of the elements that facilitated rapport building. The first two comments speak to the value of language and the importance of cultural competence in developing a working relationship (Clark, 2002; Fernandez et al., 2004):

Rolando: “Man, thanks for being here so I can speak Spanish to somebody.”

Lupe: ¿Sabes que? [Do you know what?] I like that you have personalismo [a warm and familiar way of relating to people].

Rolando: The best thing, dogg, is that you don’t mind when I talk about some of the crazy thoughts I have. I know my world ain’t like yours, but you cool with that.

Case worker: I appreciate you saying all of those things. What’s true is that one of your strengths as individuals and a family is that you have a great capacity to trust others.

Rolando’s reference to “my world” is a common way for people with psychotic disorders to identify their experience (Fonagy et al., 2002). It is possible that Rolando was also acknowledging that there was a connection between my urban Jewish social worker world and his rural Latino family world. My willingness to discuss Rolando’s “crazy thoughts” is more important in developing and maintaining rapport than it is in providing relief from his auditory hallucinations or delusions. His focus was improved, and he appeared more relaxed. Because his psychotic symptomology was managed with medication, Rolando was able to address the psychodynamic issues that preceded the crisis.

**Stages 3 and 4: Identifying Major Problems and Dealing with Feelings.** In Stage 3, the crisis worker is interested in finding the precipitating event, or the “last straw.” Hoff (2001) cautioned crisis workers to avoid identifying one family member as the problem. She recommended identifying the entire family as the client (p. 159). In this case, the client is no longer Rolando, and the problem is no longer Rolando’s schizophrenia. It is now a systemic issue with the whole family. This does not mean that Rolando’s contribution to the family crisis should be ignored. Hoff (2001) stated, “Often an individual in crisis may precipitate a family crisis” (p. 137). The discussion of major problems allowed each member of the family to take responsibility for his or her role in the crisis. This approach also acknowledges cultural values about the centrality of the family.

The higher the level of family conflict, the more important it is to deal with feelings while identifying major problems (Stage 4). Reducing family conflict reduces negative expressed emotion, which results in less confusion, anxiety, and fear on the part of Rolando. The identification of the precipitating event can bring up feelings as family members try to blame one another for the crisis. The severity of the illness often requires significant family resources (Marley, 2004). The crisis worker can use strengths-based techniques to normalize feelings and reconceptualize individual blame as group responsibility.

The following dialogue illustrates the use of strengths-based language to help the family accept group responsibility for the problem.
Case worker: Who would like to share their thoughts as to what kicked off this last round of stress?

Lupe: If Rolando would just take his medicine, this wouldn’t keep happening.

Rolando: Mom, you say it like this was my entire fault. What about Hector all in my business?

Hector: What about me? I didn’t do anything.

Case worker: I hear you say it is not your fault. It is normal to blame others, but I find it more helpful if everyone in the family acknowledges their role in the crisis. If one person is powerful enough to cause the family to go into crisis, that same person is probably responsible for the family’s happiness and stability. Once we address how the family attempted to cope with the situation, perhaps we can talk about what the family has been doing to keep things going well these past seven months.

Although it is important to avoid scapegoating, the reality is that Rolando’s diagnosis requires the family to make special accommodations. “A fundamental defect of schizophrenic patients’ brains is their frequent inability to sort, interpret, and respond like normal brains” (Torrey, 1988, p. 28). Stress makes symptoms of schizophrenia worse (Brennan & Walker, 2001). One accommodation is to reduce the level of stress and minimize stimuli in the house. During the session, Rolando’s feelings of safety were facilitated by keeping people from interrupting, encouraging people to talk in turn and to avoid talking over one another. A safe environment is an environment where family members acknowledge each other, take responsibility in front of others, praise each other, and agree to work toward solutions. In this way, a safe environment was established in which Rolando and his family could process their experience of Rolando’s acute psychotic state and begin to discuss their reactions and feelings about it.

Discussing the “last straw” brought up feelings that the family needed to express. Family art therapy is an expressive therapy that is well suited for families with a child who has schizophrenia (Kwiatkowska, 2001). Although expressive therapies are difficult to evaluate using best-practices criteria, the components of art therapy (focused kinesthetic work expressing ideas) address the treatment goals of schizophrenia: developing social skills, reducing family conflict, and increasing client participation in family activities. For a person with schizophrenia, creative or representational drawing can be a normalizing activity. The caseworker asked all family members to draw a picture of the family, how they were feeling at that moment, how they were feeling the night of the crisis, and how they would like to feel. The caseworker set up ground rules for discussing the activity. According to Lupe, this was the first time in months that the family had laughed together; drawing is one of the few activities where criticism is seen as laughable—“Dude, you call that a sun? It looks like mom’s huevos fritos [fried eggs].” While Rolando had a much more difficult time creating a recognizable picture of the family, his drawings of feelings were remarkable. He had an easier time representing abstract concepts than did his brother and mother. Rolando’s pride in his accomplishments was a stepping stone to increased self-confidence.

**Stage 5: Exploring Possible Alternatives.** The family identified one precipitating factor and three main problems that they wanted to work on. The precipitating factor was Rolando yelling at his mom to say that Hector had hidden his medication. When the family processed the precipitating factor, they
were able to see the part that each played in the crisis. The family stated that, as an alternative to blaming, arguing, and escalating emotions, they would like to improve the relationship between family members, reduce conflict between the brothers, and reduce the stimulation in the house. The caseworker recommended a fourth goal in addition to the family’s suggestions. While this is not typical in traditional outpatient therapy, taking an active approach is appropriate in crisis intervention. The goal was to eliminate threats to family members. The caseworker explained that there could be no progress on the other goals until the family believed that they would all be safe. The family agreed to the goals.

An individual session was facilitated with Rolando. The purpose was not to single him out as a problem but rather to provide extra support given that he was transitioning from a most restrictive environment to a least restrictive environment. He discussed his frustration at having no close friends. Rather than have a long discussion about the issue, which can challenge people who have problems processing information, the caseworker helped Rolando draw a sociogram, which is a genogram (McGoldrick, Gerson, & Shellenberger, 1999) that represents a person’s social, rather than familial, world. Through the exercise, Rolando was able to identify friends with whom he could spend more time. Youth with serious mental illness often need concentrated efforts to help them participate in social activities that are crucial for their psychosocial development. Rolando and I also discussed compliance with medication. After a discussion of beliefs, he agreed that his life was more enjoyable when he was on his medications than when he was off them. Leslie et al. (2003) reported racial and ethnic differences in reported use of medication. Latinos reported lower lifetime use of psychotropic medications than did Whites. Although not discussed by the authors, a culturally competent approach to medication compliance was to identify cultural factors that might contribute to reduced use of medication, including beliefs about the efficacy of medication, informed consent, and superstitious and religious beliefs.

**Stage 6: Formulating an Action Plan.** The family had as one of its goals to strengthen relationships. To support that goal, the family was referred to the Family Preservation Program (FPP). Similar to the crisis unit, FPP was mobile and provided services in people’s homes. FPP services were somewhat less intensive (twice a week compared to daily), but they were more long term. FPP provided individual and family therapy to address the ongoing concerns of the family. A bilingual worker was assigned to the case. To ensure continuity of care and reduce the risk of attrition, I agreed to a conjoint transition session with the family and the new FPP worker.

Solution-focused therapy is well suited for Stage 6. One of the classic solution-focused techniques for setting goals is the miracle question (Berg & Miller, 1992).

Suppose that after our meeting today you . . .

go to bed. While you are sleeping a miracle happens and your problem is solved, like magic. The problem is gone. Because you were sleeping, you don’t know that a miracle happened, but when you wake up tomorrow morning, you will be different. How will you know a miracle has happened? What will be the first small sign that tells you that a miracle has happened and that the problem is resolved? (Berg & Miller, 1992, p. 359)

The responses were as follows:

Lupe: I wouldn’t have to yell, “Mijo, get out of bed. You’re going to be late to school.”
Rolando: Hector and I wouldn’t yell at each other.

Case worker: Instead of yelling, what do you imagine doing differently?

Rolando: I don’t know. Say nothing?

Hector: Rolando would be nice to me like he used to be.

It was recommended that the family discuss some of the ways their behaviors contributed to Rolando’s most recent psychotic episode. Because the therapeutic relationship was strong, action was suggested. The clinician determined that the family would benefit from exploring the prodromal symptoms. The final step in the action plan was to have the mom join the local chapter of the National Alliance for the Mentally Ill (NAMI). NAMI provides a social support and educational function, which can reduce stress and increase members’ knowledge of disorders. Fonagy et al. (2002) noted that best-practices in the treatment of schizophrenia is family education about the illness. Education about schizophrenia reduces feelings of shame and guilt and increases tolerance. Families learn that while they do not cause schizophrenia, they can contribute to the level of stress in the house. Networks like NAMI have recently found support in the academic literature (Norcross et al., 2000).

Stage 7: Following Up. The traditional term for the end of services with a client is termination (Hepworth, Rooney, & Larsen, 2002). For the brief but intense nature of crisis intervention, which almost always results in the client moving on to another service, the term transition is a better fit. For youth with schizophrenia, transition to another service is almost a given. When possible, the crisis worker should participate in transition sessions. Particularly for Latino families who have some distrust of professional service providers, acknowledgment of the challenge of moving from one service to another is culturally competent practice.

The final two sessions with Rolando were very important in bringing closure to the crisis. The penultimate session reviewed the progress made by the family. The following dialogue illustrates termination work with the family.

Case worker: What was one of the most important things you learned about yourself and the family as a result of this experience?

Lupe: My house is much more calm if I am calm. I never knew how important I was. I know that sounds silly, but it is true.

Rolando: I’m the most important person in the family! Nah, just kidding, dogg. For real, my brother is a nice guy.

Hector: When Rolando takes his meds and mom goes to her meetings, I don’t get so mad. I don’t know why, but I just don’t.

Case worker: It sounds like all of you have learned a great deal in the last four weeks. I have one more question for you: Let’s say you met a family that was going through the same things as you were going through when you first started crisis services. What advice would you have for them?

Rolando: I would tell them to take their meds. That’s real important.

Lupe: I would tell the mom to do whatever she could to have the family involved with crisis services.

Hector: I’d tell them not to get in this situation in the first place. (Everyone laughs)
The family was successful at meeting their goals and the goals of the program. There were no incidences of violence for the duration of the services. Mom was able to build a new support network. Rolando was stabilized on his meds, and he successfully increased his social circle. Hector demonstrated improved functioning at school as well as at home. When we met with the Family Preservation Program, the goal was to maintain Rolando in the community by engaging the family in communication skills training and cognitive behavioral therapy. The crisis that had been so powerful and vivid 4 weeks prior was a foundation on which the family had built a new way of interacting and being together as a family.

**Implications for Practice**

Although mobile crisis intervention is time limited, it nonetheless has great utility for addressing the needs of youth with a preexisting disorder. Because of the persistent and unpredictable nature of schizophrenia, mobile crisis outreach is a vital component in the continuum of care that is necessary to help people with schizophrenia manage their positive and negative symptoms. Rather than emphasize medication and generic social skills training, this article discussed a number of possible treatments and approaches to working with schizophrenia in a culturally competent way.

Culturally competent crisis intervention requires workers to be aware of their own culture and to be willing to understand another person’s culture. While there is no substitute for being immersed in another culture, resources such as Holleran’s ethnographic research on Latino adolescents (Holleran, 2003; Holleran & Waller, 2003) and Kopelowicz’s research on social skills training and Latinos (Kopelowicz, 1998, 2001) provide clinicians with a starting point for learning about culture in general.

Knowledge of vocabulary words such as *nervios* and *personalismo* allows for more personal understanding of the ways that culture manifests itself in a particular person (see Zuñiga, 1992, for a discussion of *dichos* [sayings] and Latinos).

Although there are many models of crisis intervention (Hillman, 2002; James & Gilliland, 2005; Roberts, 2002), Roberts’s model provides the most flexible model within which to provide culturally competent intervention. A solution-focused approach is appropriate to build on the family’s cultural strengths. While the evidence base for treatments of schizophrenia has increased enormously over the past 10 years (e.g. Hogarty, 2002; Kopelowicz, 1998, 2001), there is little evidence for culturally competent crisis intervention for youth with schizophrenia. This article addressed an important but relatively untapped area for publication: cultural competence and mental illness within the context of crisis intervention.

**References**


