Acceptance and Expressed Emotion in Mexican American Caregivers of Relatives with Schizophrenia

Marina Dorian, Ph.D.*
Jorge I. Ramírez García, Ph.D.*
Steven R. López, Ph.D.†
Brenda Hernández, M.A.*

The relation between Expressed Emotion (EE) and caregiver acceptance was tested with the use of video-recorded interactions between 31 Mexican American family caregivers and their relatives with schizophrenia. Borrowing the concept from Integrative Behavioral Couple Therapy, acceptance was defined as caregiver’s engagement with the ill relative along with low levels of expectations for behavioral change. Three aspects of caregiver acceptance were measured: global acceptance of the patient, unified detachment (i.e., nonblaming but engaged problem discussion), and low aversive responses to patient behavior (e.g., criticisms and demanding change). Relative to high EE caregivers, low EE caregivers were consistently more accepting of their ill relatives across the three measures of acceptance. Unified detachment was negatively associated with emotional overinvolvement and aversive responses were positively related to criticism. Warmth was not related to acceptance. The findings suggest that the study of acceptance in family caregivers is a heuristic avenue for future research due to its potential to shed light on specifically what family members do in caring for their ill relatives with schizophrenia.

*Department of Psychology, University of Illinois, Urbana-Champaign, Urbana, IL.
†Departments of Psychology, Psychiatry and Chicano Studies at the University of California, Los Angeles, CA.

This research was supported by a grant from the Paso del Norte Health Foundation’s Center for Border Health Research and by a National Institute of Mental Health NRSA Training Grant MH14584 (Psychological Research on Schizophrenic Conditions) both awarded to Ramírez García, as well as by an American Psychological Association Minority Fellowship funded by SAMHSA SM56564 awarded to Hernández. A previous version of the paper was presented as a poster at the Association for Behavior and Cognitive Therapies 40th annual convention, Chicago, IL. We would like to thank James M. Wood, Larry D. Meyer, Bernardo Tarín, and Guillermo Ochoa for their assistance in recruiting participants as well as the family caregivers and their loved ones with mental illness for their time. We appreciate the input of Howard Berenbaum on earlier versions of the paper.

Special thanks to the UCLA Camberwell Family Raters: Nick Breitborde, Christina Chang, Perla Placencia, and Susana Solano.

Dr. Dorian is now at the California School of Professional Psychology at Alliant International University, San Diego, CA. Dr. López is now professor of Psychology and Social Work at the University of Southern California.

Correspondence concerning this article should be addressed to Jorge Ramírez García, Department of Psychology, University of Illinois, Urbana-Champaign, Urbana, IL. E-mail: jramirez@uiuc.edu


215
Schizophrenia is a severe and chronic mental illness affecting approximately 1% of the population. The development of the disorder has strong neurobiological underpinnings pertaining both to the structure and function of the brain (Cannon, 2006). Nevertheless, a significant body of research has demonstrated that environmental factors, particularly family factors, are related to the course of the illness. Patients living with families who are high in criticism, hostility, or emotional over-involvement (EOI) are at high risk for relapse. Such family characteristics have been termed Expressed Emotion (EE). High EE is a risk factor that increases the likelihood of psychiatric relapse by a factor of two–three times compared with low EE (Bebbington & Kuipers, 1994). The attention to family factors in EE research is closely linked to the development of family interventions that have been shown to reduce the risk for relapse (Dixon et al., 2001).

EE AND MEXICAN AMERICAN FAMILY CAREGIVERS

In this paper, we tested the link between EE and acceptance in a sample of Mexican American family caregivers of persons with schizophrenia. Research with Mexican American family caregivers suggests that they may be particularly accepting of their relative’s illness (e.g., López et al., 2004). Furthermore, the study of EE among Mexican American caregivers is crucial from both theoretical and public mental health perspectives. Notable differences in EE and caregiving have been found between Mexican Americans and other ethnocultural groups. Mexican Americans tend to have lower rates of high EE than other ethnic and national groups (Jenkins & Karno, 1992). In the United States, and relative to European Americans, Mexican American caregivers have been found to be less critical of their ill relatives (Kopelowicz et al., 2002), as well as more likely to live with and spend more time with them (López et al., 2004; Ramírez García, Wood, Hosch, & Meyer, 2004). These findings suggest that theories and models of caregiving would be incomplete without an examination of the ethnocultural background of caregivers. Public mental health authorities and service providers would also be at a disadvantage if they are not equipped by a solid research base on family caregiving for the mentally ill among diverse ethnocultural groups. This is a crucial issue given the well-documented patterns of low access to high quality mental health services by ethnic minority groups (U.S. Department of Health and Human Services, 2001).

EE AND ACCEPTANCE

Caregiver acceptance has been cited as a characteristic that may be related to EE. Hooley (2004) noted: “...low-EE relatives often make remarks indicating acceptance of the current situation ...” (p. 203, emphasis added). Outside the treatment of schizophrenia, acceptance has emerged as an effective family therapy strategy in situations where attempts to change a partner’s aversive behavior create more suffering than they resolve (e.g., Christensen, Atkins, Yi, Baucom, & George, 2006). Couples researchers have conceptualized acceptance in close relationships as “giving up the struggle to change the unchangeable ... and actively engaging in healthy
behavior despite that which can not be changed” (Cordova & Jacobson, 1997). This notion of acceptance is central in Integrative Behavioral Couple Therapy (IBCT; Jacobson & Christensen, 1998). In the case of caregivers of the mentally ill, pushing for change and responding with criticism and hostility may create more distress for the patient (Butzlaff & Hooley, 1998) and potentially for the caregiver. Acceptance has a chance of causing less distress and leading to more progress in the long run.

In the present study, we used behavioral interactions between caregivers and their mentally ill relatives to measure three acceptance variables hypothesized to be relevant to EE. First, a global rating of caregiver acceptance may be inferred by verbal and nonverbal signs of prosocial engagement and low demand for change. Second, unified detachment in IBCT refers to the ability to remain engaged or unified with the partner while discussing destructive patterns without blaming the partner. Note that detachment does not equal withdrawal, but rather placing enough emotional distance from the problem so that nonblaming discussions can occur. A third behavioral index of acceptance (more specifically of low acceptance) is aversive responses—the expressions of contempt, criticism, blame, and withdrawal from the partner. These behaviors suggest low acceptance because they represent disapproval. The central hypothesis of this paper is that acceptance has explanatory value in understanding EE in family caregivers of persons with schizophrenia.

HYPOTHESES AND STUDY OVERVIEW

We expected that the three acceptance measures would be significantly different between high and low EE caregivers based on the hypothesis that expectations of behavioral change underlie both EE and acceptance. The interrelations of the specific indices of acceptance and EE were also examined. Given that unified detachment involves a certain degree of separation from problems, we hypothesized an inverse association with EOI. Also, we expected a positive relation between aversive responses and criticism. Note that the former is based on stated criticisms to the interviewer and the latter on criticisms directly made to relatives. Finally, we expected a positive association between acceptance variables and warmth because understanding and interest in the person are key aspects of warmth.

METHOD

Participants

Participants were 31 dyads of Mexican American persons with schizophrenia or schizoaffective disorder and their primary caregivers. Patients were informed about the study and if interested, they were asked to provide contact information for their primary family caregiver. At the time of recruitment patients were receiving services at an outpatient mental health center in El Paso, TX, that collaborated with the research team to recruit participants. All participants received monetary compensation for participation in the study ($20 were paid to each member of the dyad for approximately 2 hours of participation in the study).

Patients

Selection criteria for the patients included: (a) diagnosis of schizophrenia or schizoaffective disorder, (b) self-identification as Mexican American, and (c) regular contact with their primary caregiver (defined as once per week or more frequently).
Patients’ diagnoses were confirmed via a clinician administered Structured Clinical Interview for DSM-IV-Patient Edition (SCID-DSM-IV; First, Spitzer, Gibbon, & Williams, 1996). Twenty patients were diagnosed with schizophrenia and 11 with schizoaffective disorder. Mean age was 40 years ($SD = 11.8$; range 20–67) and 68% were male. Patients had an average of 3.5 ($SD = 1.6$) prior hospitalizations, and 32.3% had started or completed high school. Over two thirds (67%, $n = 21$) were born in México (the rest were born in the United States). Over two thirds (71%, $n = 22$) lived at home with the primary caregiver who participated in the study.

Caregivers

A primary caregiver was defined as the relative with the greatest responsibility in caring for the patient and who had personal contact with the patient at least once a week. Two caregivers who reported having a major mental illness were excluded because we judged that their mental illness would create systematic differences in the relationship between the caregiver and the person with schizophrenia compared with caregivers who are not mentally ill (e.g., increase the likelihood of empathy and acceptance). Almost half (48%, $n = 15$) were parents, including 13 mothers and 2 fathers. Other relatives included 9 siblings and 6 spouses. Caregivers’ mean age was 51 years (range 21–79). Over half of the caregivers were born in México (61%, $n = 19$). Caregivers had moderate levels of acculturation ($M = 2.79$, $SD = 0.99$) on an Americanism scale ranging from 1 = low to 4 = high (Marín & Gamba, 1996). Eighteen (58%) were predominant Spanish speakers. Over 80% of the caregivers reported an annual income <$20,000. Education levels ranged from <6th grade to college graduates, with 36% of caregivers having completed somewhere between 9th and 12th grade.

Measures

Patient Clinical Status

Symptom severity was assessed by a clinician who administered the Brief Psychiatric Rating Scale Expanded Version (BPRS; Lukoff, Nuechterlein, & Ventura, 1986). The bilingual clinician received extensive training on the BPRS and administered it regularly at the clinic to patients participating in clinical trials.

Family Task Rated Caregiver Acceptance

Acceptance variables were assessed from video-recorded interactions between the family caregiver and their ill relative. Four standardized family tasks were used to elicit the interactions. Three of the tasks have been used by researchers to produce reliable and valid ratings of family functioning with Latino youth (see Santisteban et al., 2003; Szapocznik, Rio, Hervis, Kurtines, & Faraci, 1991) and with Latino adults with mental illness (Kopelowicz et al., 2006). They consist of planning a dinner menu, telling each other the things family members do that please and displease them, and discussing a recent argument. In order to elicit prosocial processes and positive affect, we added a fourth task: the discussion of special moments or meaningful experiences.

Acceptance variables were based on behavioral conceptualizations of acceptance in relationships (Cordova, 2001; Cordova, Jacobson, & Christensen, 1998). Coders viewed the interactions and made ratings for each of the variables based on a 5-point Likert scale:

www.FamilyProcess.org
**Overall acceptance.** Ratings ranged from $1 = \text{low}$ to $5 = \text{high}$. “Low” reflects little or no acceptance, grudging tolerance, or helpless resignation, and “high” reflects the caregiver’s active engagement, validation, and understanding of the patient with little or no struggle to change the patient’s behavior. For example, a caregiver rated as having high acceptance had the following exchange with his relative, marked by the use of humor and a nonjudgmental attitude when he discussed the patient’s irritable mood.

**Caregiver:** Pues ya la conozco, que (usted) se levanta de un genio de los mil diablos y no vuelve a contentarse hasta después que se bañó, y tomó café, hasta que ya regresa muy contenta que ya se le bajó la riata y pues que quiere que haga yo . . . (laughing)

**Patient:** (also laughing in recognition)

**Caregiver:** ya la conozco, pues me aguanto

**Caregiver:** I know you, I know you get up in a really bad mood and don’t feel better until after you’ve showered, and had coffee. Then you come back very happy, and are no longer angry, what can I do . . . (laughing and joking)

**Patient:** (also laughing in recognition)

**Caregiver:** I know you, so I just put up with it (laughing).

**Uniformed detachment.** Ratings ranged from $1 = \text{little or none}$ to $5 = \text{high}$. The scale reflected the degree to which caregivers discussed problems with their ill relatives displaying high engagement, understanding and/or validating their points of view plus minimal blaming and fault finding. Higher ratings were given to caregivers who were engaged and had more nonblaming discussions. For example, a caregiver expressed the following: “We sometimes disagree about housework and participation . . . we have different needs and I try to see that . . . also we try to be more clear about what needs to get done.” Another caregiver talked about how the main problem between him and his brother is that his brother (patient) demands a lot of his time. The caregiver expressed both understanding of his ill relative “it is hard for you [not spending enough time],” some distance or detachment from the illness “honestly I’ll be kind of harsh and I’ll blow you off,” and sought solutions for the problem “So I think a solution would be for me to administer my time and handle my time a little better, organize myself first . . .”

**Aversive responses.** Ratings ranged from $1 = \text{little or no aversive responses}$ to $5 = \text{many or highly aversive responses}$, and reflect the caregiver’s “nonacceptance” through overall levels of blame, defensiveness, disapproval, demand for change, or critical communication with the patient. Examples of aversive responses include comments that communicated frustration such as “I can’t stand the way he behaves in our family, he is the problem [caregiver talking to the camera and referring to the patient as a third person].” Another caregiver with high aversive responses expressed to her relative that she is aware that he is sick but then went on to express her discontent and expectations of change:

Y yo se que estás malito, pero se que sí puedes ayudarme si tú quieres . . . ¿ Porqué siempre estás sucio el baño? ¡Siempre tengo que andar tras de ti! Yo limpio y ordeno todo, tu nada más procura seguir ese orden, si sacas una camisa acomoda otra vez bien, si sacas un pantalón y está sucio échalo a la ropa sucia, si miras que está sucio el escusado, líniale así, no tengo
I know you are sick, but I know that you could help me if you wanted to. Why is the bathroom always dirty? I always have to be behind you! . . . I clean and organize everything, you just have to try and keep that order, if you take a shirt, organize the drawer again, if you take out some pants and they’re dirty, put them in the dirty clothes, if you see that the toilet is dirty, clean it like this (gestures), there is no reason why I should be dealing with this, and I am always always, always, always and you never, never . . . . this is our everyday argument.

The first and second authors developed a rating manual and trained a team of four raters, including bilingual individuals, to code acceptance variables. The rating team met weekly and discussed ratings to minimize rater drift. Training continued on practice tapes until each rater achieved acceptable levels of reliability (intraclass correlation coefficient [ICC] = .70). The bilingual coders rated both English and Spanish tapes. To assess interrater reliability (IRR), 25% of the videos were randomly selected and rated by two or more raters and reviewed by the primary author. IRR was estimated with ICC with raters as random effects and individuals as the unit of reliability (Shrout & Fleiss, 1979). Acceptable levels of reliability were achieved. The ICCs for English speaking videos were: global acceptance = .77, aversive behaviors = .89, and unified detachment = .69. The ICCs for Spanish-speaking videos were: global acceptance = .64, aversive behaviors = .92, and unified detachment = .97. Acceptance raters were unaware of EE and patient symptomatology (BPRS) scores at the time that they coded for acceptance variables.

Camberwell Family Interview (CFI)-Rated Caregiver EE

The abbreviated CFI was used to assess EE (Vaughn & Leff, 1976). The CFI is a semistructured interview administered to family members (in the absence of the patient) that taps illness and treatment history, symptoms, and family interactions with the patient. It has been translated into many languages and used worldwide to produce reliable ratings of EE. Although EE can vary substantially across ethnic and national groups, its predictive validity with psychiatric relapse as the criterion is robust across ethnocultural groups (see Bebbington & Kuipers, 1994). A Spanish version of the CFI has been successfully used to produce reliable ratings of EE among Mexican Americans that have also predicted psychiatric relapse among patients treated at inpatient (Karno et al., 1987) and outpatient facilities (Kopelowicz et al., 2006).

For this study, trained raters from the University of California in Los Angeles coded the audio recordings of the CFI on its five major dimensions. Two raters were trained by Karen Snyder, who contributed to the first U.S. study of EE (Vaughn, Snyder, Jones, Freeman, & Falloon, 1984), and three were trained by the researchers who were initially trained by Dr. Snyder. Before scoring CFIs, raters obtained acceptable levels of reliability as measured by ICCs between individual trainees and consensus ratings: criticism (.73–.97), hostility (.74–1.0), EOI (.69–.95), and warmth (.73–.94). The consensus ratings and interviews were taken largely from previous research (Karno et al., 1987; Vaughn et al., 1984). To minimize rater drift, raters periodically compared their coding either with another rater or the group of five raters on a subset of interviews. When large differences occurred, a consensus rating was used as the final rating. Given the high intercorrelation between warmth and positive remarks (Chambless, Bryan, Aiken, Steketee, & Hooley, 1999) and that
low warmth, not positive remarks, predicted relapse among Mexican Americans (López et al., 2004), we excluded positive remarks in the present study. EE raters were unaware of family caregiver acceptance and patient symptomatology (BPRS) scores.

**Procedures**

A diagnostician conducted the SCID and BPRS one-on-one with the patient while a researcher separately interviewed the family caregiver and administered the CFI. In most cases, the researcher video-recorded dyad interactions following SCID/BPRS and CFI sessions. Eighteen interactions were conducted in Spanish and 13 in English. Most of the dyads were assessed at the outpatient clinics; others were assessed at University facilities or at caregivers’ homes.

**RESULTS**

**Descriptive Statistics and Intercorrelations**

**Acceptance**

A moderate to high degree of acceptance was observed: overall acceptance ($M = 3.78, SD = 1.1$, range 2–5), aversive response ($M = 2.0, SD = 1.1$, range 1–5), and unified detachment ($M = 3.1, SD = 1.1$, range 1–5). The three acceptance scales were significantly correlated with each other: overall acceptance with unified detachment ($r = .71, p < .01$) and with aversive responses ($r = -.60, p < .01$). Unified detachment was correlated with aversive responses ($r = -.55, p < .01$). Although the intercorrelations are large, we retained the three indices of acceptance to examine whether they are differentially related to EE indices.

**EE**

Using conventional criteria to classify high versus low EE (Vaughn et al., 1984), only (19%, $n = 6$) of the caregivers were high in EE. This rate of high EE is lower than the one-half to three-quarters rate found in other studies (see Butzlaff & Hooley, 1998, for a review). However, the rate of our sample is similar to samples of Mexican American caregivers’ assessed with the CFI in Southern California: 41% (Karno et al., 1987), and 33% (Kopelowicz et al., 2006). Of the six high EE caregivers, one was based on EOI alone, two on hostility alone, and three on criticisms and hostility.

**Mean Differences in Acceptance by EE**

A multivariate analyses of variance (MANOVA) with the three acceptance indices as dependent variables and high versus low EE as the two comparison groups yielded significant mean differences in the three acceptance variables, $F(3, 27) = 3.6, p < .05$, Wiks’ $\lambda = .71$. As hypothesized, low EE caregivers had higher overall acceptance, higher unified detachment, and lower aversive responses than high EE caregivers (see Table 1). All mean differences yielded large effect sizes (i.e., $d > .80$; Cohen, 1988).

**EE Components and Acceptance**

To examine how specific EE dimensions are related to the two major aspects of acceptance, we conducted correlational analyses (see Table 2). We excluded hostility given that the uneven split in our sample of 31 caregivers (only 16% of caregivers displayed hostility) would likely yield unstable correlations (Tabachnick & Fidell,
The goal of the analyses was to examine the unique shared variance between each acceptance and EE variables. Thus, we partialled out aversive responses out of the correlations between unified detachment and EE variables, and we partialled out unified detachment out of the correlations between aversive responses and EE variables.

Unified detachment was highly related to EOI (sr = -.49, p < .01) but it was not significantly related to criticism. The reverse was true for aversive responses—it was highly related to criticism (sr = .56, p < .001) but not significantly related to EOI. Neither of the two specific acceptance variables was significantly related to warmth. Notably, we conducted a second set of analyses with second-order correlations that also partialled out patients’ levels of symptoms (BPRS total scores). The results remained practically identical compared with Table 2 (there were no substantial reductions in the significant partial correlations).

**DISCUSSION**

We found large effect size mean differences in the three behavioral measures of acceptance by high versus low EE. As expected, low EE caregivers exhibited more global acceptance, more unified detachment, and less aversive responses than high EE caregivers. These findings provide initial empirical support for the value of an acceptance paradigm to understanding EE among family caregivers of patients with schizophrenia.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Mean Differences in Acceptance Variables Between Low and High EE Caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance Variables</td>
<td>Low EE (n = 25)</td>
</tr>
<tr>
<td>Global acceptance</td>
<td>3.9</td>
</tr>
<tr>
<td>Unified detachment</td>
<td>3.4</td>
</tr>
<tr>
<td>Aversive response</td>
<td>1.8</td>
</tr>
</tbody>
</table>

EE = expressed emotion.
*p ≤ .05. **p ≤ .01.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>First-Order (Partial) Correlations Between Acceptance Variables and EE Dimensions Partialling Out Acceptance Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance Variables</td>
<td>Criticism</td>
</tr>
<tr>
<td>Unified detachment</td>
<td>−.18</td>
</tr>
<tr>
<td>Aversive responses</td>
<td>.56***</td>
</tr>
</tbody>
</table>

EE = expressed emotion; EOI = emotional overinvolvement.

*aPartialling out aversive responses.

*bPartialling out unified detachment.

*p ≤ .01, **p ≤ .001.
We postulate that the conceptual overlap between acceptance and EE centers on caregivers’ expectations for behavioral change. Caregivers with high expectations for change tend to be highly critical, and/or unlikely to place emotional distance between them and the ill relatives’ problems (e.g., overinvolved), thus resulting in high EE. Similarly, couples therapists and researchers have suggested that spouses who hold high expectations that their partner will change their behavior tend to blame and/or demand change from them (Jacobson & Christensen, 1998). Following the acceptance paradigm (Cordova, 2001), the large mean differences in acceptance variables between high and low EE caregivers can be interpreted as evidence supporting the importance of fostering nonaversive, accepting responses in the emotional reactions of family caregivers toward their ill relative.

A close examination of the relation between specific acceptance and EE variables sheds light on the empirical link between these constructs. Higher levels of unified detachment were related to lower levels of EOI even while partialling out aversive responses (and patient symptomatology). Unified detachment refers to family members joining together in active discussion to solve problems (unification) yet with a certain level of awareness and emotional distance from the problem that is conducive for nonblaming discussion (detachment). Evidence of a nonblaming stance has been observed in previous research of Latino family caregivers who were primarily of Mexican origin (Weisman, Gomes, & López, 2003). Hence, one valuable contribution of unified detachment is that it highlights the combination of some level of externalizing or distance from the problems connected with loved ones while at the same time remaining engaged and active in problem solving processes.

There are empirical bases to hypothesize that unified detachment may be linked with favorable schizophrenia outcomes. Although researchers have found that Mexican Americans are highly engaged with their ill relatives and that prosocial caregiver behaviors such as warmth and support are linked with favorable mental health outcomes (López et al., 2004; Ramírez García, Chang, Young, López, & Jenkins, 2006), recent studies suggest that moderation in the level of emotional engagement is also linked with favorable health outcomes. Breitborde, López, Wickens, Jenkins, and Karno (2007) found that Mexican American patients with schizophrenia living with caregivers with moderate levels of EOI were less likely to relapse than those who were either very high or very low on EOI. Kopelowicz et al. (2006) also found in an independent sample of Mexican American families that adequate boundaries between caregivers and their ill relatives characterized by substantial involvement but without enmeshment predicted a lower risk for relapse.

We also studied aversive or problematic responses. This construct was operationalized using behavioral criteria from couple research that includes demanding change, blaming, and/or criticizing partners. As such, aversive responses are an index of low acceptance given that they represent frustrated expectations of change (Cordova et al., 1998). We found that caregivers’ aversive responses were highly correlated with CFI criticisms. This association produced a large effect size even when patients’ overall symptom levels and/or unified detachment were partialled out. Further research is needed to isolate frustrated expectations of patient behavioral change from other major factors that may underlie caregivers’ levels of criticism.

Neither of the two acceptance variables was significantly related to warmth. Note that acceptance in these two variables was defined as nonblaming discussion (unified detachment) and low levels of demanding change and/or blaming (aversive responses). Warmth is
largely comprised of tone of voice, interest in the person, and empathy and concern for ill relatives. Thus it emphasizes caregivers’ positive affect toward their relatives (hence dubbed positivity by Chambless et al., 1999). One plausible explanation for these nonsignificant correlations is that acceptance variables focus on partners’ or caregivers’ ability to handle conflict situations, while warmth focuses on positive affect per se (e.g., irrespective of how caregivers handle conflict). Acceptance is not necessarily evaluating a situation positively, nor is acceptance the same as warmth, compassion, or love. Linehan (1993) describes acceptance as the full experience of what is in the moment without distortions, judgment, evaluation, or attempts to change. Thus it is possible that caregivers may accept their ill relative’s behaviors with varying levels of positive or neutral affect. However, given that our sample was not large, Type II error is a possibility and these findings await future replications with larger samples.

Caveats, Implications, and Avenues for Research

Given that acceptance is a broad construct with no previous empirical work in the field of family caregiving and EE, we offer two caveats. First, acceptance does not equal giving up on loved ones or a carte-blanche tolerance of their behavior. For example, behaviors that threaten the physical safety of individuals demand resolute and immediate action by caregivers rather than acceptance. Instead, acceptance is more applicable to psychological irritants (Hooley, 2004) that cause distress between caregivers and their ill relatives. Second, acceptance is not the mere absence of criticisms. Acceptance involves a lower need for overt change through awareness and understanding which may in turn lead to solutions to problems, rather than becoming emotionally withdrawn or overinvolved (see Cordova, 2001).

One potential advantage of incorporating acceptance in our understanding of EE is that an established psychosocial treatment modality, IBCT, promotes acceptance (Jacobson & Christensen, 1998) not by attempting to make problem areas go away, but rather by striving to change their emotional impact and meaning. The two most common treatment strategies in IBCT, empathic joining and unified detachment, both aim to reduce blame, the former by reframing emotional reactions, and the latter by encouraging an analytic, nonemotional approach to understanding conflict (Christensen, Wheeler, & Jacobson, 2008). Empathic joining refers to the therapist facilitating the partners’ understanding of emotional pain as that which results from normal, common differences between two people, not emotional pain that each partner causes one another. To promote a nonblaming emotional stance, couples are encouraged to make “soft disclosures” that reveal emotions such as hurt, fear, and shame, rather than “hard disclosures” that oftentimes reflect both harsh emotions such as anger or disgust and finger pointing. The second treatment strategy is referred to as unified detachment, a therapeutic technique closely aligned with the interactional behavior coded in this study. Applying this strategy, therapists teach couples to describe their conflict in an objective, nonemotional way, attending to the triggers that precede the conflict, the interconnectedness of unfolding events, and the potential ways future conflicts can be diffused and even avoided altogether. This calm, intellectual analysis is thought to provide the necessary emotional distance and metacognitive awareness to address ways to promote acceptance and reduce blame. Empathic joining and unified detachment represent two of the main treatment strategies that have been used to promote acceptance in distressed couples that may
also promote acceptance in families caring for relatives with serious mental illness. These treatment methods could serve to reduce stress in the family, and, in turn, reduce the risk for illness relapse.

Empathic joining and unified detachment may not only serve to reduce the likelihood of patient relapse, but they may also serve to lower caregivers’ psychological distress. For example, family caregivers’ acceptance of the current status of their ill relatives may lower the tension often times associated with frustrated expectations. Reducing caregiver distress among Latino caregivers is particularly relevant in light of a recent study that reported that Latino caregivers were twice as likely to be classified at risk for depression compared with samples of adult Latinos (Magaña, Ramírez García, Hernández, & Cortez, 2007). Should further research indicate that caregiver acceptance adds to our understanding of relapse and caregiver distress, then it would be valuable to adapt acceptance based therapeutic techniques, such as those used in IBCT for family interventions. It is worth noting that the original development of behavioral family treatment for schizophrenia drew heavily on methods derived from traditional behavioral couples therapy (for an overview see Jacobson & Margolin, 1979). Inclusion of IBCT treatment strategies would reflect the integration of recent developments in couple treatment, which aim to widen the reach of relationship science and its application.

Cultural values such as familismo (Falicov, 1998; Weisman, Duarte, Koneru, & Wasserman, 2006) offer one possible explanation for the high association between acceptance and EE in our sample of Mexican American caregivers. This purported culturally based value of close and stable relations with family members could contribute to a less critical and more accepting emotional stance. Further research in which cultural constructs are directly measured will determine if indeed cultural values are related to measures of acceptance and EE (see Parra-Cardona, Bulock, Imig, Villarruel, & Gold, 2006, for a qualitative study of Mexican-origin migrant families that directly assessed the central role of the family in their daily lives). As we consider cultural values, however, it is crucial to avoid overlooking the social context that is oftentimes conflated with ethnicity (Falicov, 1998; Lakes, López, & Garro, 2006). In our sample, the roles of immigration, low socioeconomic status, and/or available mental health services and other sources of support should be considered alongside cultural values.

One limitation of the current study is its cross-sectional design. The application of the acceptance paradigm to research on family and mental illness calls for research designs that involve the conceptualization of patients’ behaviors on one hand, caregivers’ expectations of change on the other, and their continuous transaction. Second, our sample was comprised of Mexican American caregivers who are largely poor immigrants living on the U.S.-México border. We caution readers on generalizing the findings to other samples of caregivers including Mexican Americans who live in other contexts and/or other Latinos with different national origins. The findings in this study should be replicated with samples from other sociocultural contexts. Third, the findings should be replicated with larger samples in order to rule out the possibility that Type II error might explain our null findings. Last, an examination of the impact of acceptance on patient and family caregiver outcomes would make a significant contribution. Regarding patients, it is crucial to test whether acceptance contributes additional variance to the robust relation between EE and relapse.

CONCLUSION

The study of EE as it relates to clinical course has largely focused on the actions of families that are associated with negative clinical outcomes. The acceptance paradigm has the potential to add to our growing understanding of families’ prosocial functioning and contribute to a more balanced view of families’ roles in the course of schizophrenia. Furthermore, the inclusion of Mexican Americans in this research base is crucial to improving mental health services for this ethnocultural group (Vega et al., 2007).

REFERENCES


