Family interventions for serious mental illness: translating research to practice

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In his paper, Ian Falloon reviews the research literature and concludes that family psychoeducation is an evidence-based practice that reduces relapse rates and facilitates the recovery of persons who have serious mental illness. A core set of characteristics of effective family psychoeducation programs has been developed, including the provision of emotional support, education, resources during periods of crisis and problem solving skills. However, Falloon and others (1,2) have pointed out that, despite its efficacy, the use of evidence-based family interventions in routine practice is extremely limited. The obvious next step is to determine how to integrate such interventions in existing systems of care.

Much of the literature on barriers to dissemination of evidence-based treatments has focused on the existence of attitudinal, knowledge-based, practical and systemic obstacles to implementation (3). The implicit assumption of this perspective is that decision makers at mental health programs do not recognize the value of evidence-based treatments and must be shown the error of their ways through the provision of training, technical assistance and ongoing supervision of clinical staff. While such dissemination efforts are clearly necessary, evidence and training alone generally do not lead to changes within service delivery systems (4). In our view, the critical missing component in many dissemination efforts is the failure to give voice to administrators, service providers, patients, families, and policy makers who can help identify the steps needed to translate research into clinical practice in particular settings. Giving voice to others means establishing a dialogue with a wide range of stakeholders on how best to implement research-based strategies. Such a dialogue requires attention to parameters of the local setting as much as to the treatment protocol itself. Long-term partnerships between service providers and researchers can lead to trust that then fosters an openness to examine system-wide changes in service settings (5). Documenting and clarifying the steps in developing relationships with key stakeholders that
lead to the implementation of empirically validated treatment would be useful to others embarking on this journey.

An important part of the local setting is the social and cultural context of the families seeking treatment. Indeed, the available evidence suggests that family interventions have been successful in a wide range of cultural contexts around the world. However, little attention has been given to how the given intervention is adapted to the specific cultural context, if at all. Lefley and Johnson (6) address this limitation with their recent compilation of how family interventions have been used across the world. This effort points out the manner in which clinical researchers and practitioners have given voice to their own sociocultural context in adapting existing interventions as well as the sociocultural context of the families with whom they work. Efforts to integrate systematically the social and cultural worlds and to assess the effectiveness of such efforts are vitally needed. In particular, documenting how the intervention was modified for the particular context and whether that modification was related to specific clinical, social or familial outcomes would make a significant contribution (7). Systematic efforts to integrate the sociocultural context can improve the effectiveness of existing treatments for families from diverse sociocultural backgrounds as well as contribute to their acceptance and implementation.

One example of the importance of the sociocultural context is the finding that high family warmth in primarily immigrant, Mexican American families is related to a lower rate of relapse rather than protective factors against relapse. As a result, we learned little about what families do that is associated with a better course for individuals with a mental disorder. Giving voice to culturally diverse patient samples and being open to alternative factors (such as warmth) associated with the course of illness suggest that the predominant research paradigm with its focus on family negativity should be broadened. The implication of these findings for treatment is that attention to enhancing prosocial family functioning could help balance the current treatment emphasis on stress management and stress reduction.

As we consider how to bring effective family interventions to routine clinical practice, it is critical that clinical scientists be open to the perspectives of other stakeholders. The risk of engaging in a dialogue with stakeholders from differing perspectives is that the family interventions that result from these dialogues may differ from those studied under controlled settings. On the other hand, the risk of not doing so is that evidence-based interventions are not used in clinical practice.

References