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THE MARRIAGE AND FAMILY THERAPY PRACTICE RESEARCH NETWORK (MFT-PRN): CREATING A MORE PERFECT UNION BETWEEN PRACTICE AND RESEARCH

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This article describes the Marriage and Family Therapy Practice Research Network (MFT-PRN). The MFT-PRN is designed to build a professional community based on practice-informed research and research-informed practice, increase the diversity of participants in MFT research, and unify researchers and clinicians. Clinics choose measures from a list that best represent their clinic needs. Clients' outcomes are assessed regularly, and therapists receive immediate graphical feedback on how clients are progressing or digressing. Data are pooled to create a large and diverse database, while improving client outcomes. We will discuss advantages of the MFT-PRN for researchers, therapists, clients, and agencies, and provide one model that we hope will inform other collaborative clinical-research models in the field of marriage and family therapy.

The goal of this paper is to introduce the Marriage and Family Therapy Practice Research Network (MFT-PRN) and discuss the benefits this effort can have for both clinicians and researchers. The MFT-PRN has two parts: (a) a web-based assessment portal, and (b) a community of clinicians and researchers who access the portal in a joint effort to improve client care. Clinicians benefit from an easily accessible system that allows them to track client progress thereby improving client care. Researchers benefit from the data such systems can provide to answer clinically relevant questions to enhance our knowledge about the change process in systemic therapy. The MFT-PRN has the potential to bring practitioners and researchers together in their common goal of improving client care.

There have been a number of well-designed studies that show that MFT is a good intervention for a number of mental health disorders and couple and family relationship problems. However, much of the research has been done using smaller samples with limited diversity it terms of training level of therapist, clinical settings, and client demographics. Additionally, research has generally been organized from the point of the researcher, with limited or no influence from clinicians. To truly move our field forward, we need to have clinicians and researchers collaborating—we need to know what is happening in a wider variety of clinical settings to learn what therapists are doing and using that information to inform research. One of the main purposes of the MFT-PRN is to bring practitioners and researchers together to improve client care.

Indeed, a long-standing divide exists between practitioners and researchers, as evidenced by the numerous publications addressing the researcher–practitioner gap (e.g., Crane, Wampler, Sprenkle, Sandberg, & Hovestadt, 2002; Hodgson, Johnson, Ketring, Wampler, & Lamson, 2005;

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Kazdin, 2008; Oka & Whiting, 2013; Pinsof, Goldsmith, & Latta, 2012; Pinsof & Wynne, 2000; Sung Chan & Yuen Tsang, 2008). Explanations for the gap include differing needs and shortcomings of each party (Karam & Sprenkle, 2009), a lack of adequate research training for clinicians (Sprenkle, 2009), research findings not being useful or applicable in actual practice (Pinsof et al., 2012), and practitioner difficulty in understanding research findings (Crane et al., 2002). Yet, despite attention to the so-called gap, there continues to be a disconnect between research/researchers and practice/practitioners.

Maybe an emphasis on the gap inadvertently perpetuates the divide between these groups. The mentality of "bridging the gap" highlights the dissonance and differences between practitioner and researcher, presenting them as opposing parties that need to learn to tolerate one another (Albee, 1970). In reality, both practitioners and researchers are equally important and beneficial to each other and need not be considered as if they live in such dissonant professional worlds. Although there are seemingly separate needs for practitioners and researchers, we believe the similarities are most important. These similarities are summarized well by Kazdin (2008), who stated, "The unifying goals of clinical research and practice are to increase our understanding of therapy and to improve patient care" (pg. 151). Thus, while historically presented as disparate groups—clinicians versus researchers—we propose that it is time for a paradigm shift. A systemic mindset enables us to view each group's roles and contributions as complementary to one another, shifting our perspective away from bridging a gap and toward a more perfect union for the benefit of clients.

Use of Continuous Assessments

As scholars have searched for a way to unify practice and research, they have offered several good ideas, including using assessments that offer therapists direct feedback (Karam & Sprenkle, 2009), focusing on research that addresses the process of therapy (Kazdin, 2008; Pinsof & Wynne, 2000), and conducting research to empirically inform clinicians' work (Johnson, Sandberg, & Miller, 1999). The common thread through each of these solutions is the use of clinical assessments that can inform both clinicians and researchers in their common goal of improving client outcomes.

Clinical benefit of continuous assessment. Research has indicated that therapists are poor judges of client progress and deterioration, with therapists generally being too optimistic in their assessment of client progress (Hatfield, McCullough, Frantz, & Krieger, 2010). Without systematic feedback, therapists often fail to detect client deterioration, which prevents them from assessing new stressors or modifying their treatment approach. A feedback mechanism may ameliorate that process, however, by informing the clinician's treatment planning. Indeed, studies have shown that clients in individual therapy who take regular clinical assessments improve significantly more than clients who do not participant in systematic clinical feedback protocols (Shimokawa, Lambert, & Smart, 2010).

There is also evidence that systematic clinical feedback enhances couple therapy. One study (Anker, Duncan, & Sparks, 2009) randomly assigned 205 couples into either a condition where a systematic feedback system was used or one without a feedback system. Results indicated that couples in the feedback group experienced twice as much improvement, on average. Moreover, they were four times more likely to reach clinically significant levels of change. The positive effects of systematic feedback were still present at a 6-month follow-up, with couples in the feedback group significantly less likely to separate or divorce following treatment. These results were subsequently replicated with similar significantly positive results for those who were in the feedback group (Reese, Toland, Slone, & Norsworthy, 2010). Thus, MFTs collecting ongoing clinical data on their clients have a direct positive effect on client outcomes. Based on this evidence, scholars have argued "that systematic monitoring and feedback of progress across the course of therapy is a potentially important common factor" for couple therapy (Halford et al., 2012). Monitoring progress, receiving feedback, and modifying treatment based on that feedback allows clinicians to engage in evidence-based practice without having to be trained in or adhere to specific empirically supported models. While empirically supported treatments have greatly benefitted our field, and have repeatedly been associated with improved client outcomes, they are not serving the estimated 30–70% of therapists that identify their approach to therapy as eclectic (Jensen, Bergin, &

Greaves, 1990; Norcross & Karpiak, 2012). The client progress monitoring approach allows a therapist to integrate research seamlessly into her clinical work by addressing the idiographic question of whether the treatment she is providing works for each specific individual, couple, or family she is seeing.

Research benefit of continuous assessment. Conducting research that benefits clients requires an examination of what works in therapy (i.e., identifying factors and processes associated with change). Such process research requires collecting assessments that are more proximally related to interventions (instead of simply collecting pre- and posttreatment assessments). Thus, assessments collected multiple times throughout treatment—as is recommended for monitoring client progress (Howard, Moras, Brill, Martinovich, & Lutz, 1996)—provide data that allow researchers to study specific interventions and processes. Doing so allows researchers to offer clinicians pertinent and applicable information about how to conduct therapy (Pinsof & Wynne, 2000). Collecting assessments across treatment is also a crucial part of identifying the specific points during the therapy process at which change is taking place and what that change looks like, such as if clients' symptoms increase before decreasing or when clients cease to make significant changes (Laurenceau, Hayes, & Feldman, 2007).

Such examinations call for systematic evaluations of client progress in a real-world setting. Although scholars studying basic couple and family interactions can download free, large datasets from the internet, such as Fragile Families (www.fragilefamilies.princeton.edu/) or the National Study of Families and Households (www.ssc.wisc.edu/nsfh/), large clinical datasets that assess MFT outcomes and processes are nonexistent.

The most common means of collecting clinical data for research purposes has been to establish a clinic-based data collection system. However, this method has important limitations to MFT research. First, most MFT clinics are too small to collect a large sample of couple or family cases. This limits generalizability and results in sample sizes that are too small to conduct sophisticated multivariate and longitudinal analyses. Second, these clinical samples often reflect a narrow geographical area, thereby often creating homogeneous samples and further limiting generalizability because of the racial and ethnic profiles of the samples. Third, much of the clinical MFT research is conducted in university-based training clinics. Hence, findings reflect those among a very specific group—therapists-in-training with clients willing or only able to see novice therapists. Processes and outcomes among more experienced, licensed, and community-based practitioners are largely unknown.

These limitations to MFT research can be minimized with a system that collects large, heterogeneous clinical data sets in a real-world setting (vs. a university clinic). Such a system can provide the necessary data to conduct high impact MFT process research. The MFT Practice Research Network can meet the needs of both MFT clinicians and researchers. It can provide practicing MFTs with the tools that they need to collect systematic information on their clients' progress, and, simultaneously, provide MFT researchers with large, diverse clinical datasets that they can use to conduct high quality, impactful research.

Practice Research Networks

A Practice Research Network (PRN) is a collaborative effort among researchers, clinical agencies, and private practices to share common assessment measures and protocols to create high quality data sets and provide feedback for clinical and research purposes. PRNs facilitate *evidence-based practice*, as clinicians can use methodologically sound assessments to inform their clinical work. They also promote *practice-based research*, as researchers use data from actual practitioners, instead of highly controlled clinical trials, to advance clinical knowledge (Barkham, 2014).

PRNs began in the medical field among family practitioners (Barkham, 2014), but they now exist in many mental health professions, including Social Work (http://www.socialworkers.org/naswprn/) and Psychology (Castonguay, Pincus, & McAleavey, 2014; Fernández-Alvarez, Gómez, & García, 2014). Since 1993, The American Psychiatric Association has sponsored a PRN, the American Psychiatric Institute for Research and Education (APIRE; Sorsdahl et al., 2013; West et al., 2015). PRNs also exist in other mental health settings (Castonguay, Barkham, Lutz, & McAleavey, 2013), and a network of over 240 university and college counseling centers have partnered to form the Center for Collegiate Mental Health (CCMH) as a way to share common clinical assessment

protocols and collaborate on research efforts (McAleavey, Lockard, Castonguay, Hayes, & Locke, 2014). The exact methods and procedures of each PRN vary according to each network's specific goals, but what they have in common is research conducted with a community of clinicians, in a variety of settings, with research results having a direct impact on clinicians' practice (Barkham, 2014; Castonguay et al., 2013).

Among MFTs, the system most closely resembling a PRN to date has been the Systemic Therapy Inventory of Change (STIC), developed by Pinsof and colleagues, to enable MFTs to gather feedback about their clients' progress (Pinsof et al., 2009). Unlike other clinical feedback systems, which are individually focused, the STIC has validated scales to measure relational functioning. The five scales are individual problems and strengths, family of origin, relationship with a partner, family/household, and child problems and strengths (Pinsof et al., 2015). The STIC includes an Internet-based system to facilitate feedback between therapists and clients.

However, although the STIC facilitates monitoring clinical progress and enabling clinical feedback, it does not provide the network and community a PRN does. The STIC is more similar to the Outcome Questionnaire 45.2 (OQ.45.2)—the most commonly used clinical assessment and feedback system in individual psychotherapy (Lambert et al., 1996)—in that it is a well-designed assessment system that is made available by a group of scholars for therapists to use, usually for a fee. A PRN, however, is a *community* of clinicians and researchers who collaborate to enhance evidence-based practice and practice-based research. A hallmark of PRNs is the sense of *shared ownership* among members of the network (McAleavey et al., 2014). The MFT-PRN represents a collaborative effort among MFT clinicians and researchers to improve MFT practice and the knowledge base of MFT. In the process, it creates a more perfect union of science and practice.

THE MFT-PRN

The MFT-PRN is an Internet-based portal that allows clinics to easily administer assessments regularly. The assessments are scored in real time for therapists to use in their clinical work. Therapists are given graphs of clients' scores across sessions to monitor progress (or deterioration). Use of the MFT-PRN is available at no cost to participating clinics, but clinics need to provide their own Internet-enabled tablet or computer for clients to complete the assessments. Support for the development and continued maintenance of the MFT-PRN is provided by donations to School of Family Life at Brigham Young University.

Each site retains ownership of its data and can use their data for research or other evaluation purposes. Data are stored on a secure server at a Brigham Young University in the United States, and the MFT-PRN allows each site to download their own data as needed. However, each site grants the Principle Investigators of the MFT-PRN rights to use their data for research purposes. To facilitate a sense of shared ownership for participating sites, sites will be able to have access data from other sites. To protect the confidentiality of sites, only data that are pooled across a number of sites will be available. To make sure that research is not duplicated, MFT-PRN members will be asked to provide a short synopsis of their proposed research and secure human subjects approval to use the data. Data will be available to MFT-PRN participants, and on rare occasions to other professionals. With a few minor exceptions, the choice of assessments is flexible, with clinics being able to choose assessments from a list of available assessments that best meet their clinic's needs.

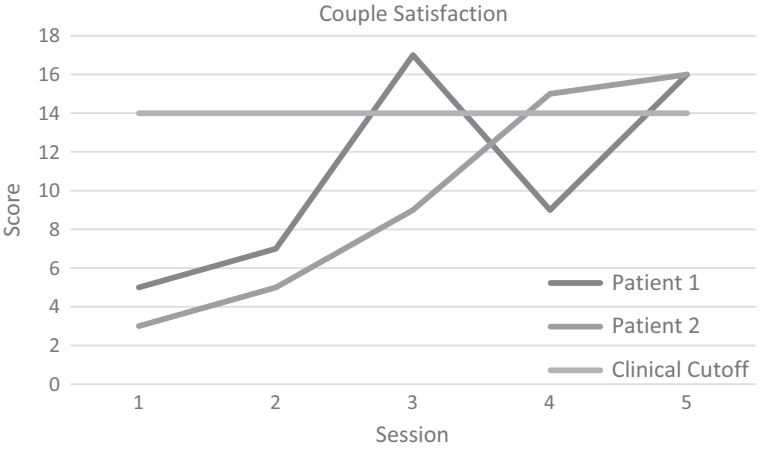
Potential Participants

The MFT-PRN is available to any clinic that has couple or family cases as part of its case load; this decision depends on clinic cases and not the training or license type of the therapists. The goal is to recruit a variety of clinics (training clinics, community mental health agencies, private practices, group practices, etc.) to increase the generalizability of the research. We have also begun including sites from around the world that will participate in the MFT-PRN, thereby facilitating cross-cultural MFT research. The MFT-PRN is set up for individual, couple, and family cases, and assessments are designed for participants ages 12 and up. There are child assessments that parents complete for children younger than 12. The system supports all couple or family relationship configurations (e.g., same-sex couples, grandparent-headed households, single-parent families).

Procedures

The MFT-PRN member clinics will use the assessment system for all their clients in order to enhance research-based practice. The MFT-PRN is approved by the PI's institutional review board, and clients provide consent for their responses to be used for research purposes. Clients are entered into the MFT-PRN using their initials and their therapist's name. This allows data to be de-identified, thereby protecting the privacy of clients' information when used for research purposes.

When clients arrive at the clinic for a session, either a receptionist or therapist finds the client in the Internet-based MFT-PRN by their initials and the therapist's name (the therapist name is used only to check in clients and is not part of any data based used for research). They check a box saying that the client has arrived, and a QR (Quick Response) code is generated for each client within the case. For example, when a couple comes for therapy, the office staff will scan the QR code with the Internet-enabled tablet for each partner, and the appropriate assessments for the clients' session and case type are displayed on the tablet. There is no need for office staff to remember what session it is and what assessments need to be given. This is automatically tracked in the MFT-PRN. Clients complete the assessments in the waiting room and return the tablet. Assessments are scored in real time and displayed in graphical form with clinical cutoffs or population norms, enabling therapists to immediately gather relevant client information quickly, prior to starting the session (see Figure 1). If desired, the therapist can immediately share and discuss the assessment results with the clients or use them as part of their treatment planning. In the case of a family, each family member over the age of 12 will complete assessments. For convenience, it is recommended that clinics have multiple tablets or computer terminals available for clients to use. Data are automatically stored on a secure server for future clinical, administrative, and consented research use.



Session	Patient 1—Total Score
1	5 (Clinically Distressed)
2	7 (Clinically Distressed)
3	17
4	9 (Clinically Distressed)
5	16
Session	**Patient 2—Total Score**
1	3 (Clinically Distressed)
2	5 (Clinically Distressed)
3	9 (Clinically Distressed)
4	15
5	16

Figure 1. Example of graphical results of client scores across five sessions of couple therapy.

A benefit of collecting a larger more diverse dataset is the ability to test therapist and setting effects. To do this, we will have information on the clinic type and the general region the where the clinic is located. Depending on the number of clinics in any area, we may be able to be more specific, but we want to protect the confidentiality of each clinic. In looking at therapist effects, we will get information about the therapist's license type, the type of setting the therapist practices in, years of practice, and race. This basic information keeps therapist and clinic data de-identified.

Measures

To allow for consistency across sites, major assessment packets assessing individuals, couples, and families (according to case configuration) are given at intake, and then at the 4th session, 8th session, 12th session, 16th session, and every multiple of 8 sessions (24, 32, 40, etc.) thereafter. This schedule of major assessments was chosen to allow more assessment times early in therapy when most changes are happening and allowing for the fact that most clients finish therapy prior to the 16th session (Doherty & Simmons, 1996). In addition, a short intersession report is completed before each session after the intake session.

Measures were chosen to cover a wide variety of issues that are routinely seen in systemically oriented treatment settings (see Table 1). Five criteria were used when determining which assessment to use for each construct measured in the PRN. First, any measure had to be psychometrically sound. Each of the available measures has demonstrated adequate reliability and validity. Second, the length of the measure was taken into account. Shorter measures allow clinics to assess multiple constructs without increasing client burden. Third, we focused on measures designed to be used in clinical settings. Measures of a construct that provide clinical cutoffs and indices of meaningful change were chosen when available. Fourth, well-established measures were given preference. Selecting measures that are used frequently facilitates comparisons between research that emerges from the PRN and existing research. Finally, the cost of the measure was taken into account. Unless there was a very compelling reason or the copyright holder provided free-use, only measures freely available in the public domain were included in the PRN. Table 1 provides a summary of the constructs currently available in the MFT-PRN. A list of the specific measures used to assess each construct is available upon request.

Demographics and general information. All clients are asked to fill out a demographic questionnaire at intake. They are asked basic demographic questions, such as age, race, relationship status, income, education. Race questions are patterned after the U.S. Census questions, and relationship status questions allow all types of couple configurations. This section also asks about current medical issues, previous therapy, and presenting problems. Clients will also answer questions about adverse child events (Anda et al., 2006; Foege, 1998) and current adverse events. All adults also complete questions related to emotional and physical abuse as part of the intake assessment. On a limited basis, clinics can add a few additional demographics questions related to specific clinic needs. For example, clinics that serve a large military population have added questions related to rank, deployments, and service time.

As part of the MFT-PRN therapists are able to click on a hyperlink and see how clients answered each question. Thus, they are able to see each client's responses on the demographics questions. Being able to view the demographics questionnaire also helps eliminate the need for duplicate demographics forms. That is, most participating clinics that have opted to use the MFT-PRN demographics questions as the demographic information for the clinic only needs clients to complete one demographics form.

Major assessments. The major assessments are those that are completed at intake, 4th, 8th, 12th, etc. sessions. These are chosen by each respective clinic to allow therapists to get the most relevant information for the clients they see. To meet the needs of a variety of clinics, we have a wide variety of constructs that clinics can choose to assess. (See Table 1.)

Intersession report and the therapeutic alliance. Prior to every session (after the intake), every client takes a revision of the Intersession Report (Johnson, Ketring, & Anderson, 2010), a brief, 13-item measure that asks about client progress in the areas of anxiety, depression, relationship functioning, sleep, and exercise. As part of the intake questionnaire, clients provide their top three presenting problems, beginning with the most pressing problem. The MFT-PRN will take that information and will ask them about their weekly progress on each of these problems. Clients rate

Table 1
Constructs Clinics Can Choose to Assess in Their Client

Constructs	Who can the measure be used for[a]: Adults in couple therapy	Parents in family therapy	Adolescents in family therapy	Adolescents in individual therapy	Adults in individual therapy
Adolescent/Child emotional regulation		✓	✓	✓	
Adolescent/Child functioning		✓	✓	✓	
Adult attachment	✓				
Anxiety	✓	✓	✓	✓	✓
Attachment behaviors	✓				
Communication patterns	✓				
Couple satisfaction	✓				
Cultural sensitivity	✓	✓			✓
Depression	✓	✓	✓	✓	✓
Dissociation	✓				✓
Drug and alcohol problems	✓	✓	✓	✓	✓
Emotional abuse	✓				
Emotional regulation	✓	✓	✓	✓	✓
Family functioning	✓	✓	✓	✓	
Functional health	✓	✓	✓	✓	✓
General mental illness	✓	✓	✓	✓	✓
Gratitude	✓	✓	✓	✓	✓
Health care utilization	✓	✓			✓
Hopelessness	✓	✓	✓	✓	✓
Ineffective arguing	✓				
Management of finances	✓	✓			✓
Parent Attachment		✓			
Parenting Styles		✓			
Peer attachment			✓	✓	
Perceived criticism	✓				
Physical affection	✓				
Readiness to change	✓	✓	✓	✓	✓
Relational power	✓				
Sexual problems	✓				✓
Sexual satisfaction	✓				
Sleep	✓	✓	✓	✓	✓
Stress	✓	✓	✓	✓	✓
Suicide	✓	✓	✓	✓	✓
Violence	✓				

Note. [a]Many of the couple relationship measures may also be used for families with two parents attending therapy to assess the couple relational influences on the family.

their progress on a 7-point scale ranging from "the problem is much worse" to "the problem is solved." Clients also complete the family, couple, or individual therapy alliance scale (Pinsof, Zinbarg, & Knobloch-Fedders, 2008), based on the type of case. These scales measure the bonds, goals, tasks, and within-system alliance. These three assessments take approximately 3–5 min to complete.

Therapist ratings. After three sessions, therapists complete a very brief treatment plan. The treatment plan asks the therapist for a diagnosis (ICD 10 Code) for each client and three treatment goals for the case. Ongoing information from the therapist is gathered after each session. After each session, therapists report using an anchored scale, on client participation, client receptivity to session content, within-session progress, overall progress, their perception of the therapy alliance, and (for sessions when homework was assigned) whether the homework was completed. This quick assessment by the therapists takes 2–3 min.

Termination information. On a weekly basis, the MFT-PRN prompts therapists to ask what cases are still active and what cases have terminated. If the therapist marks a case as terminated, then they will be prompted to complete a brief termination summary. The termination summary will ask therapists to rate the progress on each goal, using an anchored scale, with the exact wording of the goals imported from the treatment plan. Therapists will also report on whose decision it was to terminate therapy and the therapy model or models that most influenced treatment.

Evaluation of Clinics

One of the goals of the MFT-PRN is to facilitate collaboration between researchers and therapists. In addition to the community of clinicians and researchers that will develop through the MFT-PRN, some clinics will have the option to invite researchers to use their MFT-PRN data to provide an evaluation of their clinic. This may help clinics in a myriad of areas, such as training needs, advertising effectiveness, staff evaluations, meeting accreditation or certification requirements, or providing value-based payment information to insurance companies. For the same reasons that clinics do not have a routine assessment process, many clinics do not have the time or staff to conduct a clinic evaluation. In these cases, clinics may contact the staff at the MFT-PRN to request a clinic evaluation that includes a presentation of their clinic's MFT-PRN results to the clinic staff. As part of the evaluation, MFT-PRN staff will also identify areas of clinical effectiveness and solicit information regarding what clinicians are doing to be successful. This information will feed back into the research loop, facilitating practice-informed research, as well be available as a resource to other clinics who want to learn how to better treat a specific problem.

Benefits and Costs of MFT-PRN

Although the MFT-PRN is intended to be a win-win for all parties involved. It is impossible to develop protocols that are without some time investment or cost of implementation. We believe that the benefits outweigh the costs; however, it is important for potential users to have information on both the benefits and costs of the MFT-PRN.

Clients. *Benefits*—The greatest benefit to clients is improved clinical care. Research has shown that monitoring client progress, as done with the MFT-PRN, provides improved treatment outcomes for clients (Anker et al., 2009). Additionally, tracking client progress, or lack of progress can keep therapy focused or refocused on the problems, thus potentially decreasing the number of sessions to attain treatment outcomes. Further, with monitoring, treatment is more likely to remain focused on presenting problems. Finally, using the MFT-PRN is a way for clients to have voice in therapy by providing answers to many questions that therapists may not routinely ask due to time constraints.

Costs—The main cost to clients is the time it takes to complete the assessments. Clients will need to come early or take time out of the session to complete assessments. Additionally, if clients are asked to complete measures that do not appear relevant, it can lead to frustration with the assessment process, the clinic, or their therapist. This time cost to client is also an indirect cost to clinic directors and therapists. That is, if clients are dissatisfied with having to come in early or how long it takes to complete assessments, their therapists and clinic directors also have to manage that frustration (e.g., through clinic procedures, providing information to clients on the benefits of the process, or through supervision and training of therapists).

Researchers. *Benefits*—Much research in MFT is done in training clinics with little cross-clinic collaboration. The benefits of the MFT-PRN to researchers include an increasingly diverse sample (as more sites from around the world are added) and more representative sample. Additionally, the larger number of participants will allow MFT researchers to use statistical analyses that require a larger number of participants. Moreover, with multiple sites collaborating in data collection, the time required to develop large datasets will be significantly reduced. Finally, the large number of participants will allow for longitudinal research questions that look at various patterns of change. Lastly, because the MFT-PRN provides the framework for rapid data collection across multiple sites, it facilitates collaboration among researchers with similar interests by facilitating prospective, research-question-focused studies.

Costs—Many of the standard research costs (such as a data collection system, maintenance, data cleaning, and dataset management) are absorbed by the institution sponsoring the MFT-PRN. The main costs to researchers using the MFT-PRN consist of opportunity costs. For example, it is possible that using the MFT-PRN constrains researchers at participating sites in efforts to expand their own data collection efforts. That is, once a site starts using a core set of measures on a continuous basis, it may become harder to implement unique research projects at that site because any additional questions or procedures a client has to engage in increases client burden. This cost may, in part, be offset by being able to use data that has been collected at other sites. Finally, while not necessarily a cost, the research questions that can be answered using MFT-PRN data are limited to those that can be answered with the MFT-PRN measures.

Clinic directors. *Benefits*—Managing a clinic is a difficult task and many decisions need to be made about clinic policies, procedures, and personnel, usually with limited data. The MFT-PRN will provide data for clinics to track the effectiveness of therapists and provide additional training opportunities to therapists, improve client outcomes, target specific areas where clinic-wide training would be helpful, and document clinic effectiveness to use in grant applications. Although the MFT-PRN was not designed as a tool to evaluate employees, it could potentially be used for personnel decisions. We would hope that any use of the MFT-PRN in such decisions would include data that tracks therapist effectiveness across multiple clients to ultimately develop remediation for underperforming therapists. As discussed, the cost of implementing and maintaining the system is covered by the MFT-PRN sponsoring institution, allowing clinics with limited funds access to a system that they might not have access to otherwise. Finally, the MFT-PRN allows supervisors to easily and quickly track client progress in a way that isn't possible in a typical case review by providing supervisors with data about specific areas they can focus on with supervisees.

Costs—The main cost in dollars is the cost of purchasing and maintaining tablets. With each new policy implemented at a clinic, there is also a time cost associated with the start-up that includes training therapists and reception on procedures. Additionally, if data from the MFT-PRN are used punitively, there may be subsequent increased negative pressure on therapists to perform, which may lead to lower morale. Finally, despite how flexible the system is, it will never be as well-tailored to an individual site as one that they develop in-house.

Therapists. *Benefits*—We venture that all therapists are invested in their clients getting better and welcome additional help in achieving that goal. The MFT-PRN allows therapists to track client progress and modify treatment based on client response to interventions, which has been shown to improve client outcomes (Anker et al., 2009). The MFT-PRN also helps therapists justify their treatment (potentially moving away from a requirement to use CBT or another EST because stakeholders may be less interested in what treatment therapists are using so long as client change is demonstrated). The MFT-PRN will also save therapists time because they don't have to ask all the initial questions about depression or other constructs covered in the measures because they are assessed as part of the MFT-PRN, thereby allowing therapists to quickly move to follow-up questions. The MFT-PRN also gives therapists information across multiple domains that is not possible to assess in a 50-min session. Next, the MFT-PRN can increase ethical practice by providing therapists an easy way to talk to their clients about lack of change, which may lead to modifying the treatment plan or providing an appropriate referral. Finally, it can inform therapists of potential training needs they have.

Costs—It is possible that therapists fear how their clinical effectiveness data will be used by administrators if the data indicate that there is a pattern of clients not making sufficient progress.

Additionally, the MFT-PRN moves therapists who are practicing in a clinic that is using the system into a more data-driven environment, which may be contrary to their philosophical stance of providing clinical care.

Other Systemic PRNs

The development of a PRN is a large, expensive, and time intensive undertaking. While our preference is that interested therapists and clinics participate in the MFT-PRN that we have developed, we recognize that the MFT-PRN may not meet the needs of some clinics and researchers. In those cases, we encourage the development of additional PRNs that will meet the needs of systemic therapists. For example, the field of psychology has multiple PRNs (Castonguay et al., 2013). To those we wish to develop their own PRN, we emphasize the need for a PRN to be founded based on shared ownership between researchers and clinicians. Thus, a good way to start is to get interested stakeholders together at the initial phases of development for a series of discussions to ensure that the PRN benefits both clinicians and a community of researchers. These conversations have continued as we have implemented the MFT-PRN at clinics across the country, and internationally. Clinic administers and therapists have made many helpful suggestions when we have visited their clinics, which have improved the MFT-PRN. A PRN will be successful only to the level of it being mutually beneficial to therapists, clinics, and researchers.

In addition, developers of a PRN need to find a source to fund the project, including the costs of bringing stakeholders together, programming costs, administrative costs, and marketing costs. The MFT-PRN is fortunate to have generous donors from Brigham Young University, who have provided substantial financial support. In a similar way, developers of future systemically oriented PRNs will need to find financial resources.

CONCLUSION

There has been much written about the divide between researchers and clinicians (Sandberg, Johnson, Robila, & Miller, 2002); however, we advocate for a paradigm shift. With the use of the MFT-PRN that facilitates research-informed practice, practice-informed research, and a collaboration among scientists and practitioners, we can move from vernacular that is divisive to building on commonalities and unifying the field as a whole. The MFT-PRN is designed to conduct more rigorous research, to better understand and help clients from diverse settings, and to provide quality information to clinicians to improve client outcomes, all with clinicians as active participants. Collecting data on a larger number of participants with a variety of presenting problems and from a variety of backgrounds and treatment settings will better help us understand how to translate research findings to clinical practice. It will also allow us to better understand therapist's influence on client outcomes. In addition, this research will help us better understand the process of change during the course of systemic therapy and the variables that are important in determining the process of change.

In conclusion, the MFT-PRN is focused on building a community of practitioners and researchers. Currently, researchers generally work independently at their respective clinics, with occasional collaboration across one or two clinics. While these collaborations have resulted in some publications in couple therapy with larger sample sizes (c.f. Johnson et al., 2015), these collaborations are rare and difficult (Wampler & Bartle-Haring, 2015), and are generally conducted at C/MFT training clinics. As a field, we need to expand the collaborations to include licensed practitioners from a variety of clinics, which will improve the quality and diversity of research, along with building connections across researchers interested in similar topics.

REFERENCES

Albee, G. W. (1970). The Uncertain future of clinical psychology. *American Psychologist*, *25*, 1071–1080.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfied, C. L., Perry, B. D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, *256*, 174–186. https://doi.org/10.1007/s00406-005-0624-4

Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology*, *77*(4), 693–704. https://doi.org/10.1037/a0016062

Barkham, M. (2014). Practice-based research networks: Origins, overview, obstacles, and opportunities. *Counselling and Psychotherapy Research*, *14*(3), 167–173. https://doi.org/10.1080/14733145.2014.929414

Castonguay, L. G., Barkham, M., Lutz, W., & McAleavey, A. A. (2013). Practice-oriented research: Approaches and applications. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6 ed., pp. 85–133). Somerset, NJ: John Wiley & Sons.

Castonguay, L. G., Pincus, A. L., & McAleavey, A. A. (2014). Practice research network in a psychology training clinic: Building an infrastructure to foster early attachment to the scientific-practitioner model. *Psychotherapy Research*, *25*(1), 52–66. https://doi.org/10.1080/10503307.2013.856045

Crane, D. R., Wampler, K. S., Sprenkle, D. H., Sandberg, J. G., & Hovestadt, A. J. (2002). The scientist-practitioner model in marriage and family therapy doctoral programs: Current status. *Journal of Marital and Family Therapy*, *28*, 75–83.

Doherty, W. J., & Simmons, D. S. (1996). Clinical practice patterns of marriage and family therapists: A national survey of therapists and their clients. *Journal of Marital and Family Therapy*, *22*, 9–25.

Fernández-Alvarez, H., Gómez, B., & García, F. (2014). Bridging the gap between research and practice in a clinical and training network: Aigle's Program. *Psychotherapy Research*, *25*(1), 84–94. https://doi.org/10.1080/10503307.2013.856047

Foege, W. H. (1998). Adverse childhood experiences: A public health perspective. *American Journal of Preventive Medicine*, *14*, 354–355.

Halford, W. K., Hayes, S., Christensen, A., Lambert, M., Baucom, D. H., & Atkins, D. C. (2012). Toward making progress feedback an effective common factor in couple therapy. *Behavior Therapy*, *43*(1), 49–60. https://doi.org/10.1016/j.beth.2011.03.005

Hatfield, D., McCullough, L., Frantz, S. H. B., & Krieger, K. (2010). Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. *Clinical Psychology & Psychotherapy*, *17*, 25–32. https://doi.org/10.1002/cpp.656

Hodgson, J. L., Johnson, L. N., Ketring, S. A., Wampler, R. S., & Lamson, A. L. (2005). Integrating research and clinical training in marriage and family therapy training programs. *Journal of Marital and Family Therapy*, *31*, 75–88.

Howard, K. I., Moras, K., Brill, P. L., Martinovich, A., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist*, *51*, 1059–1064.

Jensen, J. P., Bergin, A. E., & Greaves, D. W. (1990). The meaning of eclecticism: New survey and analysis of components. *Professional Psychology: Research and Practice*, *21*, 124–130.

Johnson, L. N., Ketring, S. A., & Anderson, S. R. (2010). The Intersession Report: Development of a short questionnaire for couples therapy. *The American Journal of Family Therapy*, *38*(3), 266–276. https://doi.org/10.1080/01926181003780142

Johnson, L. N., Sandberg, J. G., & Miller, R. B. (1999). Research practices of marriage and family therapists. *The American Journal of Family Therapy*, *27*, 239–249.

Johnson, L. N., Tambling, R. B., Mennenga, K. D., Ketring, S. A., Oka, M., Anderson, S. R., et al. (2015). Examining attachment avoidance and attachment anxiety across eight sessions of couple therapy. *Journal of Marital and Family Therapy*, *42*(2), 195–212. https://doi.org/10.1111/jmft.12136

Karam, E. A., & Sprenkle, D. H. (2009). The research-informed clinician: A guide to training the next-generation MFT. *Journal of Marital and Family Therapy*, *36*, 307–319. https://doi.org/10.1111/j.1752-0606.2009.00141.x

Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist*, *63*(3), 146–159. https://doi.org/10.1037/0003-066X.63.3.146

Lambert, M. J., Hansen, H. B., Umpress, V., Lunnen, K. M., Okiishi, J., & Burlingame, G. M. (1996). *Administration and scoring manual for the OQ-45.2 (outcome questionnaire)* (Vol. Stevenson, MD). Salt Lake City, UT: American Professional Credentialing Services LLC.

Laurenceau, J.-P., Hayes, A. M., & Feldman, G. C. (2007). Some methodological and statistical issues in the study of change processes in psychotherapy. *Clinical Psychology Review*, *27*(6), 682–695. https://doi.org/10.1016/j.cpr.2007.01.007

McAleavey, A. A., Lockard, A. J., Castonguay, L. G., Hayes, J. A., & Locke, B. D. (2014). Building a practice research network: Obstacles faced and lessons learned at the Center for Collegiate Mental Health. *Psychotherapy Research*, *25*(1), 134–151. https://doi.org/10.1080/10503307.2014.883652

Norcross, J. C., & Karpiak, C. P. (2012). Clinical psychologists in the 2010s: 50 years of the APA division of clinical psychology. *Clinical Psychology: Science and Practice*, *19*(1), 1–12. https://doi.org/10.1111/j.1468-2850.2012.01269.x

Oka, M., & Whiting, J. (2013). Bridging the clinician/researcher gap with systemic research: The case for process research, dyadic, and sequential analysis. *Journal of Marital and Family Therapy*, *39*(1), 17–27. https://doi.org/10.1111/j.1752-0606.2012.00339.x

Pinsof, W. M., Goldsmith, J. Z., & Latta, T. A. (2012). Information technology and feedback research can bridge the scientist–practitioner gap: A couple therapy example. *Couple and Family Psychology: Research and Practice*, *1*(4), 253–273. https://doi.org/10.1037/a0031023

Pinsof, W. M., & Wynne, L. C. (2000). Toward progress research: Closing the gap between family therapy practice and research. *Journal of Marital and Family Therapy*, *26*, 1–8.

Pinsof, W. M., Zinbarg, R., & Knobloch-Fedders, L. M. (2008). Factorial and construct validity of the revised short form integrative psychotherapy alliance scales for family, couple, and individual therapy. *Family Process*, *47*, 281–301.

Pinsof, W. M., Zinbarg, R. E., Lebow, J. L., Knobloch-Fedders, L. M., Durbin, E., Chambers, A., et al. (2009). Laying the foundation for progress research in family, couple, and individual therapy: The development and psychometric features of the initial systemic therapy inventory of change. *Psychotherapy Research*, *19*(2), 143–156. https://doi.org/10.1080/10503300802669973

Pinsof, W. M., Zinbarg, R. E., Shimokawa, K., Latta, T. A., Goldsmith, J. Z., Knobloch-Fedders, L. M., et al. (2015). Confirming, validating, and norming the factor structure of systemic therapy inventory of change initial and intersession. *Family Process*, *54*(3), 464–484. https://doi.org/10.1111/famp.12159

Reese, R. J., Toland, M. D., Slone, N. C., & Norsworthy, L. A. (2010). Effect of client feedback on couple psychotherapy outcomes. *Psychotherapy*, *47*(4), 616–630. https://doi.org/10.1037/a0021182

Sandberg, J. G., Johnson, L. N., Robila, M., & Miller, R. B. (2002). Clinician identified barriers to clinical research. *Journal of Marital and Family Therapy*, *28*, 61–67.

Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting and Clinical Psychology*, *78*(3), 298–311. https://doi.org/10.1037/a0019247

Sorsdahl, K., Blanco, C., Rae, D. S., Pincus, H., Narrow, W. E., Suliman, S., et al. (2013). Treatment of anxiety disorders by psychiatrists from the American Psychiatric Practice Research Network. *Revista Brasileira De Psiquiatria*, *35*, 136–141. https://doi.org/10.1590/1516-4446-2012-0978

Sprenkle, D. H. (2009). The present and future of MFT doctoral education in research-focused universities. *Journal of Marital and Family Therapy*, *36*, 270–281. https://doi.org/10.1111/j.1752-0606.2009.00159.x

Sung Chan, P., & Yuen Tsang, A. (2008). Bridging the theory–practice gap in social work education: A reflection on an action research in China. *Social Work Education*, *27*(1), 51–69. https://doi.org/10.1080/02615470601141383

Wampler, K. S., & Bartle-Haring, S. (2015). Collecting and pooling assessment and outcome data in couple and family therapy training clinics: Reasons to do it, common problems, and some suggestions for avoiding them. *Journal of Marital and Family Therapy*, *42*(2), 213–216. https://doi.org/10.1111/jmft.12143

West, J. C., Mościcki, E. K., Duffy, F. F., Wilk, J. E., Countis, L., Narrow, W. E., et al. (2015). APIRE Practice Research Network: Accomplishments, challenges, and lessons learned. *Psychotherapy Research*, *25*(1), 152–165. https://doi.org/10.1080/10503307.2013.868948