
Ten Research Questions for Family Therapy

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A growing evidence-base shows that family therapy works, but many gaps in our knowledge remain about the conditions under which family therapy is effective and how it works. In this paper, ten critical research questions about family therapy that need to be addressed are considered. In short these are:

1. Is family therapy as effective in community settings as it is in specialist clinics?
2. For what problems is family therapy cost-effective?
3. Does family therapy work for under-researched problems and populations?
4. Do social-constructionist and narrative approaches to family therapy work?
5. Can family therapy protocols be enhanced for non-responders?
6. Can family therapy be combined with other psychotherapies to effectively treat specific problems?
7. Can family therapy be combined with pharmacotherapy to effectively treat specific problems?
8. What specific factors contribute to the effectiveness of family therapy with particular problems?
9. What common factors contribute to the effectiveness of family therapy?
10. What therapist and client factors contribute to the effectiveness of family therapy?

Keywords: family therapy research, couples therapy research, systemic therapy research, psychotherapy research

Thorough reviews of the large body of research on the effectiveness of marital and family therapy has led to two very important conclusions (Carr, 2006, 2009 a, b, c). First, two thirds, to three quarters of people benefit from marital and family therapy. In contrast, approximately only a quarter, to a third of people recover from psychological problems without treatment. Second, marital and family therapy,

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either alone or as part of a multimodal program involving therapy and medication, is highly effective for a majority of adults and children with common psychological problems. The efficacy of marital and family therapy has been established beyond doubt. It is noteworthy that the overall magnitude of the effects of marital and family therapy in alleviating psychological problems is similar to the overall magnitude of the effect of medical and surgical procedures in treating a wide variety of medical conditions (Caspi, 2004; Shadish & Baldwin, 2003). However, there are many gaps in our scientific knowledge base about the conditions under which family therapy is effective and how it works.

In this article, the 10 critical research questions that I think need to be prioritised within the field of family therapy are outlined. I have selected these ten questions because the answers to them will help family therapists to provide a better service to clients. They will contribute to the current substantial evidence-base which influences policy makers who fund the development of family therapy services. They will also help researchers understand more about the processes involved in effective marital and family therapy. This is important in establishing the scientific basis for systemic practice (Liddle, Santisteban, Levant and Bray, 2002).

1. Is family therapy as effective in community settings as it is in specialist clinics?

Much of the evidence base for the effectiveness of family therapy includes studies conducted in specialist clinics, based in institutes and hospitals affiliated to universities and research centres. In contrast, most family therapists work in nonspecialist community services such as multidisciplinary mental health teams, or single discipline social work services. It would be very useful to know if family therapy works as well in routine services as it does in specialist clinics, since policy makers and service funders are more likely to support the development of family therapy services if there is strong evidence which shows that it works in routine service settings.

Studies of the impact of family therapy on specific problems conducted in specialist clinics are referred to as *efficacy* studies, while those that evaluate the impact of family therapy in routine services are referred to as *effectiveness* studies (Cochrane, 1972). In efficacy studies (or efficacy randomised controlled trials) clients with a specific type of problem (and no comorbid difficulties) are randomly assigned to treatment and control groups. The treatment group receives a pure and potent form of a very specific type of family therapy from specialist therapists in practice centres of excellence. The control group receives either no therapy, a placebo, or treatment-as-usual. Efficacy studies are typically conducted at university affiliated centres, with carefully selected clients who meet stringent inclusion and exclusion criteria. For example, often patients with comorbid brain damage, substance abuse and personality disorders or self-harming behaviour are excluded in efficacy studies of treatments for depression. Therapists are highly trained, intensively supervised, have small case loads, and the fidelity with which they offer treatment is scientifically checked by rating the degree to which recordings of therapy sessions conform to treatment protocols specified in therapy manuals.

Effectiveness studies, in contrast, are conducted in routine health service settings, rather than centres of excellence, with typical therapists carrying normal

case loads, offering treatment to clients who are representative of typical referrals. While therapy manuals and supervision are often employed in effectiveness studies, there is a greater degree of flexibility about their use, than in efficacy studies. Efficacy studies tell us how well therapy works under ideal conditions. Information about the impact of therapy under routine conditions is provided by effectiveness studies. Effectiveness studies tell us how well manualised family therapy protocols work when flexibly implemented by regular therapists with a normal level of supervision, with clients who have a main presenting problem, along with additional complex co-morbid difficulties.

More family therapy effectiveness studies are needed for the full range of problems to which family therapy may be applied. This is because the results of efficacy studies conducted under ideal conditions may not generalise to routine service settings. Effectiveness studies will tell us the degree to which approaches to family therapy that have been shown to be effective in ideal conditions, are also effective when used in routine clinical services. Perhaps in routine service settings they will be shown to work less well because clients have more complex problems and therapists have less supervision and larger caseloads. Alternatively they may be shown to work just as well or better because experienced therapists in routine services may be particularly skilled at fine-tuning treatment to meet clients' unique needs (e.g., Griffin, 2003).

How to Design a Robust Effectiveness Research Study in Family Therapy

It is important that effectiveness studies be designed in a methodologically robust way. Certain basic design features must be present to be able to draw valid conclusions. In any such study a preliminary power analysis should be conducted (with the help of a statistician). A power analysis is statistical method used to determine the number of cases required to adequately test the effectiveness of the family therapy protocol being evaluated (Cohen, 1988). A power analysis will tell you that you may need 30 cases in the treatment group and 30 in the control group, if you want to be able to detect a significant difference of moderate size between groups on particular measure, such as the Family Assessment Device (Epstein, Baldwin, & Bishop, 1983). Cases should be randomly assigned to treatment and control groups. Cases with the core problem of interest (such as childhood depression) but which also have comorbid difficulties, typical of cases attending routine mental health services, may be included.

There are arguments for and against the use of DSM (American Psychiatric Association, 2000) and ICD (World Health Organization, 1992) diagnostic categories for defining psychological difficulties that are the targets for treatment in family therapy trials. However, realistically, for the foreseeable future, it is probable that only research that is framed in these terms will receive funding.

Family therapy protocols evaluated in trials should be manualised at a level of specificity that is appropriate to the therapy approach being used. Examples of therapy manuals include the McMaster Family Therapy manual (Ryan et al., 2005), the Systemic Couples Therapy manual for depression (Jones & Asen, 2002), and the manual for the Maudsley approach to family therapy for adolescents with anorexia nervosa (Lock et al., 2001).

Therapists should be trained in flexibly implementing the therapy protocol being evaluated in a trial and offered ongoing supervision. Fidelity checklists should be used to insure that therapists reliably implement the protocol. Ideally trials should not commence until therapists have demonstrated the capacity to implement the family therapy protocol with a high level of fidelity. Treatment fidelity should be monitored throughout the trial, to insure that therapists are adhering to the therapy protocol being evaluated. Therapist case loads should also be monitored throughout the trial to give an indication as to the type of caseloads that may reasonably be carried by typical therapists providing the type of family therapy being evaluated. Also, the impact of both treatment fidelity and caseloads on outcome may be assessed during data analysis.

Cases and controls should be assessed before and after treatment and at follow-up. Longer term follow-up assessments are preferable since they allow meaningful relapse rates to be investigated, using survival analysis where appropriate. Where feasible, assessments should be carried out by research staff, not therapists, and ideally these staff should be 'blind' to the treatment clients received.

Comprehensive assessment protocols should be used which include measures of specific treatment goals and core problems as well as those aspects of family functioning which the treatment is designed to change. In addition to these assessments, it is valuable to use brief measures to assess the core problem, the therapeutic alliance, and therapy process variables thought to be critical to outcome periodically throughout treatment. These data permit patterns of change over the course of therapy in these variables to be investigated during data analysis.

If it is feasible, it is valuable to video or audio record all therapy sessions from treatment trials so that an archive can be created. This archive may be used as a resource for addressing a wide variety of therapy process research questions, such as clinical features of therapy with cases that improved and those that did not.

A number of different types of analyses should be conducted on trial data (ideally with the help of a statistician). In comparing the outcomes of treatment and control group cases, analyses should be conducted of trial completers, but also of all cases that entered the trial (in intent-to-treat analyses). Differences between treatment and control group dropout rates, recovery rates, and relapse rates should be analysed, using clinically meaningful definitions of recovery, and appropriate non-parametric inferential statistics (Jacobson, Follette, & Revenstorf, 1984). Differences between treatment and control groups, before and after treatment and at follow-up, on continuous variables, assessed with reliable and valid psychometric scales should be analysed with appropriate parametric inferential statistics. Appropriate multivariate statistics should be used to evaluate the effect of client baseline characteristics; therapist characteristics; and therapy process characteristics on outcome.

Results of trials should be reported using CONSORT guidelines (Altman et al., 2001; Moher et al., 2001). The following is a valuable practical guide for family therapists working in routine health service settings on how to implement a robust effectiveness study: *Evidence-Based Outcome Research: A Practical Guide To Conducting Randomized Controlled Trials For Psychosocial Interventions* (Nezu & Nezu, 2007).

2. For what problems is family therapy cost-effective?

Evidence from a handful of studies suggests that family therapy leads to significant cost-offsets and benefits. In a series of studies of a health maintenance organisation with 180,000 subscribers, the Medicaid system of the State of Kansas with nine million subscribers, and a family therapy training clinic, Russell Crane and his team found that family therapy reduced the number of healthcare visits especially for frequent service users and did not significantly increase healthcare costs (Crane, 2008). He also found that with frequent service users, those who participated in family therapy showed significant reductions of 68% for health screening visits, 38% for illness visits, 56% for laboratory/X-ray visits, and 78% for urgent care visits (Crane & Christenson, 2008). Finally he found that the average cost of healthcare for adolescents with conduct problems who received individual therapy was \$16,260, while for those who received clinic-based family therapy, it was \$11,116, and those who received home-based family therapy were least expensive of all, averaging at least 85% less than any type of clinic-based therapy (Crane, Hillin, & Jakubowski, 2005).

Caldwell, Woolley, and Caldwell, (2007) calculated the costs of providing 50,000 distressed couples with behavioural marital therapy or emotionally focused therapy, both of which are relatively brief, empirically supported interventions. They also calculated the public and health-care costs associated with all of these couples divorcing, and the proportion that might not divorce as a result of engaging in couples therapy. They concluded that marital therapy would be cost-effective if funded by government to reduce public costs of divorce, or if funded by insurers to offset the increased divorce-related health-care expenses. In a review of 18 studies of psychotherapy for psychological disorders, Gabbard et al. (1997) found that particularly significant cost-offsets occurred for complex problems, notably in studies of psychoeducational family therapy for schizophrenia (McFarlane, 2004), by reducing the need for inpatient care and improving occupational adjustment.

More research studies which compare service use and occupational adjustment in families treated with family therapy with cases that receive treatment as usual are required to determine if clients who receive family therapy use less medical, social and justice services and have better occupational productivity. Economic data collection and analyses may be routinely built into the design of family therapy effectiveness studies described in the previous section. The critical issue to be addressed is: Does the money saved by providing family therapy cover the cost of therapy and lead to a significant total cost-offset in the short, medium and long-term. Guidance on collecting and analysing cost data are given by Fals-Stewart, Yates and Klostermann (2005).

It would be useful to conduct economic evaluations of marital and family therapy for populations such as frequent emergency service users, and families of patients with conditions such as asthma, diabetes, high blood pressure, cancer, heart disease, as well as families of people with mental health problems that have a chronic relapsing course if left untreated such as anxiety disorders, depression, bipolar disorders and so forth. These studies are important because they will provide policy makers with further economic evidence to justify funding family therapy services.

3. Does family therapy work for under-researched problems and populations?

We have limited evidence on the effectiveness of family therapy with some types of problems. For child and adolescent-focused problems, there is far more evidence for the effectiveness of family therapy in treating externalising behaviour problems and disruptive behaviour disorders (Carr, 2009a), than for treating internalising problems and families in which child abuse and neglect have occurred, so these concerns are an important focus for future family therapy effectiveness research. With adult-focused problems, there has been far more research on the effectiveness of marital and family therapy in the treatment of relationship distress, and mood, anxiety, psychotic, and substance use disorders (Carr, 2009b), than on personality and somatoform disorders, anorexia nervosa, and psychosexual problems. Future research should focus on the effectiveness of marital and family therapy for these problems.

Under-researched populations include families caring for debilitated older adults with neurological or mental health difficulties (Woods & Clare, 2008) and families of children and adults with intellectual or pervasive developmental disabilities (including autism spectrum disorders) and significant adjustment problems (Baum & Lynggaard, 2006; Carr, O'Reilly, Walsh, & McEvoy, 2007). Research on the effectiveness of family therapy for these populations should be prioritised for humanitarian and financial reasons. Family therapy may well be an important intervention for enhancing the quality of life for these populations. Furthermore, family therapy may be a far less expensive way of treating these populations than inpatient or residential care which are currently commonly used.

It is noteworthy that current demographic trends suggest that problems of older adults will become an increasing concern for family therapists in the future. There is also a dearth of research on the effectiveness of family therapy (and other types of psychotherapy) for addressing problems in minority populations including gay and lesbian groups (Perez et al., 1999) and ethnic minorities (Tseng & Streltzer, 2001). Research on the effectiveness of family therapy with these populations is required.

4. Do social-constructionist and narrative approaches to family therapy work?

The bulk of family therapy protocols and systemic interventions that have been evaluated in controlled trials have been developed within the cognitive-behavioural, psychoeducational, and structural-strategic therapeutic traditions (Carr 2009a, b). More trials are required to evaluate the effectiveness of postmodern social-constructionist and narrative approaches to family therapy that are very widely used internationally (Anderson, 2003). The lack of controlled trials in this area is in part due to the fact that the postmodern tradition within which social-constructionist approaches have developed has a greater affinity to qualitative than to quantitative research methods (Chenail, 2005; Larner, 2004). Mark Rivett (2008) has argued persuasively that the whole field of family therapy is undergoing a radical metamorphosis at present, where purist theoretical approaches to family therapy are gradually giving way to pragmatic evidence-based practices. In this vein, Peter Stratton's group at Leeds have developed a treatment manual for a social-constructionist approach to family therapy that will be used in future treatment outcome studies (Allison, Perlesz, & Pote, 2002; Pote, Stratton, Cottrell, & Boston, 2003).

5. Can family therapy protocols be enhanced for non-responders?

Meta-analyses show that two thirds, to three quarters of people benefit from marital and family therapy, and that a quarter to a third of cases do not respond to treatment (Carr, 2009a, b, c). The problem of non-response is not unique to family therapy, and similar rates of non-response occur in other forms of psychotherapy, including cognitive behaviour therapy (Carr, 2009c). There is a need for controlled trials of enhanced family therapy protocols specifically designed to meet the unique needs of non-responders. Compared with individual therapy, family therapy has a wider range of options on which to draw in enhancing treatment protocols to meet the needs of families that do not respond to routine family therapy. This is because the lens through which the presenting problem is viewed, focuses not just on individual constraints and affordances, but on constraints and resources within the wider social system that forms the context for the presenting problem and potential solutions.

Protocols for non-responders may include special procedures for engaging families in treatment and overcoming obstacles to fostering strong collaborative therapeutic alliances with family members and relevant members of the family's social and professional network. They may include specific symptom-focused treatment techniques tailored to the family's unique needs and vulnerabilities, as well as the profiles of family members with the presenting problems. Protocols for non-responders may also incorporate special procedures for enhancing family adherence to homework assignments; addressing ruptures in alliances between therapists and family members; dealing with resistance and transference/countertransference issues; preventing families from dropping out of treatment; and facilitating the development of family relapse prevention plans and gradual disengagement from treatment.

6. Can family therapy be combined with other psychotherapies to effectively treat specific problems?

Very few studies have been conducted in which the effectiveness of family therapy alone, and family therapy combined with another type of psychotherapy have been evaluated.

Although where such studies have been conducted, for example in the field of substance misuse, the benefits of combining family therapy with individual therapy have been strongly supported (Stanton & Shadish, 1997). Where a family therapy protocol can be coherently, concurrently or sequentially combined with another treatment protocol, trials are required to evaluate the relative effectiveness of each therapy alone and both combined. It may be that some therapy protocols, when combined, have additive or synergistic effects. Alternatively, combined therapies may have antagonistic effects.

For anxiety disorders, depression and eating disorders in children, trials are required on the optimal way of combining effective child-focused interventions which have been developed within the cognitive behavioural tradition with family therapy. For adults, ways of combining marital therapy with individual or group therapy protocols for most disorders are required. The profession of family therapy will find considerable support from researchers in the disciplines of clinical psychology, psychiatry and cognitive-behaviour therapy in developing and evaluating multi-

modal treatment programs involving a combination of family therapy and other forms of psychotherapy to address specific presenting problems (Rivett, 2008).

7. Can family therapy be combined with pharmacotherapy to effectively treat specific problems?

There is some evidence that when medication is combined with marital and family therapy, it leads to better outcomes than those shown by cases treated with medication alone. Adults with schizophrenia, bipolar disorder and alcohol misuse treated in this way show enhanced adjustment and lower relapse rates (Carr, 2009b). Children with attention deficit hyperactivity disorder treated with stimulant medication combined with family-based interventions show better adjustment than those treated with medication alone (Carr, 2009a).

This provides an encouraging foundation for further research on multimodal programs, involving marital and family therapy combined with pharmacotherapy for a range of adult and child-focused problems. For adults, there is a dearth of evidence on the effectiveness of such programs for anxiety disorders, somatoform disorders, eating disorders, personality disorders, psychosexual disorders and psychological problems in later life. For children and adolescents, trials of multimodal programs for depression, bipolar disorder, severe obsessive compulsive disorder, and psychosis are urgently required.

There is ample scope for family therapists and psychiatrists to collaborate on joint research projects to address these gaps in our knowledge. A challenge for the profession of family therapy will be to develop coherent overarching frameworks within which to conceptualise the roles of family therapy and pharmacotherapy in the multimodal treatment of such conditions. Such frameworks will need to address the joint role of neurobiological factors and psychosocial factors in problem formation and resolution.

8. What specific factors contribute to the effectiveness of family therapy with particular problems?

The psychological processes by which specific family therapy protocols facilitate change for specific problems, or the identification of 'active ingredients' of family therapy protocols requires far greater attention in future trials. For example, it is probable that the central 'active ingredient' of emotionally focused couples therapy is facilitating partners' expression of, and response to each other's attachment needs (Johnson, 2004). In contrast, it is probable that the central 'active ingredient' in behavioural couples therapy is facilitating fairer exchanges of resources and more systematic problem-solving (Jacobson & Margolin, 1979).

In multidimensional family therapy for adolescent drug abuse (Liddle et al., 2005), functional family therapy for delinquency (Sexton & Alexander, 2003), and multisystemic family therapy for severe adolescent behavioural and psychological problems (Henggeler & Lee, 2003), strengthening the parenting system, enhancing the quality of parent-adolescent relationships, and coordinating the family's relationships with extrafamilial systems such as schools, courts and other involved professionals seem to be the most important shared 'active ingredients' of treatment.

Despite the fact that all of these examples are of relatively well-researched and empirically supported approaches to marital and family therapy, there is still insufficient evidence to make any of the above assertions about the 'active ingredients' of these approaches with certainty. More controlled trials are required in which these processes are correlated with therapeutic outcome.

In popular, but under-researched approaches, such as narrative family therapy (White, 2007), it would be very useful to conduct studies to determine the relative contribution of externalizing conversations, re-authoring conversations, re-membering conversations, unique outcome conversations, scaffolding conversations or definitional ceremonies to positive outcomes for various psychological problems and relationship difficulties. Processes by which therapy is proposed to work, should be routinely assessed in all trials, to determine if it is these factors that are, in fact, promoting therapeutic change. While family therapists who practice narrative therapy may have limited interest in leading research projects on these issues, there is considerable scope for collaborating with university departments that host clinical psychology and family therapy programs, since all of these issues may be addressed within the context of postgraduate theses.

9. What common factors contribute to the effectiveness of family therapy?

A striking feature of evidence for the overall effectiveness of many different forms of psychotherapy, including family therapy, is the remarkable similarity in positive outcome rates of diverse approaches with a range of populations and problems (Carr, 2009c). This observation has led to the hypothesis that a set of common factors (or processes) underpin all effective approaches to psychotherapy, and that these common factors have a far greater impact on treatment outcome than specific therapeutic techniques (Fraser, 2003).

In studies of individual psychotherapy, it has been estimated that factors common to a wide variety of effective psychotherapies are 2 to 9 times more important than specific factors in determining whether or not clients benefit from psychotherapy (Lambert & Barley, 2002; Wampold, 2001). Research on common factors in individual psychotherapy with adults points to the importance of the therapeutic alliance and the number of sessions attended in determining therapy outcome. Results of meta-analyses show that there is a correlation of .22 between the quality of the therapeutic alliance and therapy outcome, making it the most important common factor contributing to therapeutic success (Martin, Graskie, & Davis, 2000). There is also a clear relationship between the number of sessions attended and therapy outcome — the so-called dose-effect relationship. Fifty per cent of adult clients with common problem such as anxiety or depression recover within about 20 sessions, whereas for 75% to recover 40 to 50 sessions are required (Lambert, Hansen, & Finch, 2001).

The contribution of common factors (such as the therapeutic alliance) and specific factors (such as particular techniques specified in treatment manuals) to therapy outcome have rarely been investigated in marital and family therapy (Carr, 2005). Future research on family therapy should routinely build in an exploration of this issue into the design of controlled trials (Sprenkle & Blow, 2004). In family

therapy, factors common to many different approaches deserve investigation. These include the number of family sessions convened, the quality of the therapeutic alliance, goal consensus between family members and the therapist, family members' perceptions of the credibility and rationale for family therapy, and family members' participation in therapy sessions and in tasks between sessions. It would be useful to routinely assess these common factors in controlled trials and correlate them with outcome, to determine their relative importance in determining therapeutic success.

10. What therapist and client factors contribute to the effectiveness of family therapy?

An extensive evidence-base has shown that certain client and therapist characteristics are associated with outcome in individual therapy, but very few studies have been conducted on participant factors and family therapy outcome. Client characteristics associated with a good outcome in individual therapy include personal distress, symptom severity, functional impairment, case complexity, readiness to change, early response to therapy, psychological mindedness, ego-strength, capacity to make and maintain relationships, the availability of social support, and socio-economic status (Clarkin & Levy, 2004).

The following therapist characteristics have been found to be associated with a good outcome in individual therapy: personal adjustment, therapeutic competence, therapist training and supervision, matching therapeutic style to clients' needs, credibility, and problem-solving creativity (Beutler et al. 2004; Lambert & Ogles, 1997; Stein & Lambert, 1995). Research that assesses the correlation between these types of client and therapist characteristics and outcome in marital and family therapy is required.

Closing Comments

Currently, the evidence base for family therapy allows us to claim that in most cases it works for common child and adult-focused mental health problems. This is a critically important development for the discipline and profession of marital and family therapy. However, if the ten questions elaborated in this paper were answered we would be able to say much more. We might be able to say that family therapy is as effective in community settings as it is in specialist clinics, and that it is cost-effective, reducing hospitalisation rates and clients' use of other services. We might be able to say that family therapy is helpful in addressing a far wider range of problems than was previously the case and that it is effective with special populations such as older adults, people with intellectual disability, and diverse groups including ethnic minorities and gay and lesbian people with various difficulties.

The proposed research program would let us know the conditions under which social-constructionist and narrative approaches to family therapy work, the way in which the routine practice of family therapy must be refined to meet the needs of families that have difficulty responding to therapy, and the way in which family therapy can be combined with individual therapy and medication to provide more powerful treatments for various problems.

If the 10 questions outlined above were answered we would be able to say with certainty the specific factors that contribute to the effectiveness of family therapy with particular problems, and the extent to which common factors, and client and therapist factors, contribute to the effectiveness of family therapy. Our current evidence base allows us to say that family therapy works. The type of scientific knowledge that would emerge from the research program proposed in this article would provide more specific guidance on how to enhance our day-to-day therapeutic practice and allow us to provide our clients with a better quality of service.

For this dream to become a reality, three main things are essential. First, as a profession we must all become committed to this type of research agenda. If we are not fully committed, we will not be able to persevere and see it through. Second, where appropriate research funding agencies are not well developed, we have to lobby for research funds and research structures involving universities and health services to be established to support this type of research program, and then apply for research grants from such agencies. This sort of research can't be done as a hobby. It has to be funded.

Finally, as funds become available, we will have to work together in large collaborative teams containing family therapists based in community settings, and academic researchers based in university departments of clinical psychology, psychiatry or other mental health disciplines. On such teams, academic researchers (and their postgraduates and research assistants) will contribute largely to the research design and data collection and analysis, while family therapists will contribute to the development of treatment protocols and conduct marital and family therapy with families who participate in research projects. This idea of developing such practice research networks has been proposed by family therapists in Australia (e.g., Campbell, 2003a, 2003b, 2004) and the United Kingdom (e.g., Stratton, 2007). Professional conferences and family therapy training programmes are the primary meeting places for researchers and therapists, therefore the seeds of such teams will probably be sown in these contexts.

Over the next decade I expect we will see the emergence of many such projects. For example, in the United Kingdom, through a series of practice research networks in Yorkshire, Manchester and London a trial comparing systemic family therapy and treatment as usual for self-harming adolescents and their families has recently begun (Cottrell, 2008). Family therapy will be delivered by qualified family therapists using a modified version of the *Leeds Systemic Family Therapy Manual*. Repetition of self-harm at 18 months, and cost-effectiveness and quality of life at 12 months will be assessed by the research team based in Leeds University, who will also manage the project. This project is funded to the UK Health Technology Assessment program. The project is a model for how we may all use practice research networks to advance family therapy research.

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