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PERSPECTIVE ARTICLE

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The Marriage and Family Therapy Practice Research Network: Current Findings and a Call for Collaboration

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Introduction: Mental health problems continue to rise throughout the world while access to care remains problematic due to low affordability and limited therapist availability. With the mental health crisis only getting worse, clinicians and researchers must work together to improve client outcomes. The Marriage and Family Therapy Practice Research Network (MFT-PRN) was established to improve client care and foster collaborative research in systemic therapy. This project balances research rigor and clinical flexibility, making it accessible and beneficial for practitioners, clients, and researchers.
Areas covered: This paper will address the above issues by discussing how the MFT-PRN brings researchers and clinicians together, through routine outcome monitoring (ROM) and providing assessments that track client progress across sessions, allowing clinicians to create better treatment plans. We will also discuss how the MFT-PRN facilitates researcher collaboration by sharing data collected across diverse settings.
Expert opinion: Professional experience and research findings suggest that using the MFT-PRN enhances therapy outcomes, reduces treatment length, and improves couple and family relationships. The MFT-PRN has facilitated research that leads to improved client care in areas such as therapeutic alliance, teletherapy efficacy, and the impact of adverse childhood experiences on anxiety.
Conclusion: By bringing practitioners and researchers together, the MFT-PRN contributes significantly to advancing marriage and family therapy.

Keywords: Marriage and Family Therapy, Practice Research Network, Routine Outcome Monitoring, research

Introduction

The need for efficacious psychotherapy is great, since in 2019, one in eight people experienced mental illness, and global mental illness rates have only increased due to the COVID-19 pandemic (World Health Organization, 2022). An additional indicator of the current crisis is the cost of mental health care around the world. Currently, global mental health costs are estimated at $381.31 billion and predicted to grow to $537.91 billion by the year 2030 (Duszynski-Goodman, 2024). Between 2019 and 2021, the percentage of United States adults who had received treatment for mental health in the previous year increased from 19.2% to 21.6% (Terlizzi & Schiller, 2022),

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equaling 55.8 million people that received therapy between 2021 and 2022 (Vankar, 2024). In Europe, nearly a quarter of the population reported having at least one mental health illness (Simon et al., 2023; Statista Research Department, 2024). The trend of increasing problems also applies to relationship problems with global trends indicating that divorce rates in South Korea, Norway, and the United Kingdom have tripled since the 1970s (Ortiz-Ospina & Roser, 2020). This trend is not true across all countries, with divorce rates in many countries, including the United States, having declined since then (Wang, 2020). It is unknown whether this decline is due to lower marriage and higher cohabitation rates, or happier, more stable marriages (Ortiz-Ospina & Roser, 2020; Wang, 2020). Further, global statistics indicate that nearly one in three women has been physically and/or sexually abused (United Nations Women, 2023), and between 10–52% of men have experienced intimate partner violence within their marriages (Krug et al., 2002).

With mental health and relationship problems on the rise, many countries also report that mental health care has been harder to access. For example, according to a survey from 2022, 90% of United States adults believe there is a mental health crisis in the United States, yet a third of the respondents experienced barriers to accessing mental health services (Lopes et al., 2022). Accordingly, 80% of the respondents cited cost as the main barrier, and 60% reported stigma as the barrier that kept them from receiving care. Despite the high prevalence of mental illness and the rising demand for services, many people still struggle to find or access care. A study done in Europe found that over 25% of its respondents were not able to access mental health treatment during the COVID-19 pandemic (Statista Research Department, 2024). Another study using data from the 2017–2018 National Health Interview Survey deemed non-affordability as the biggest predictor of inaccessibility (Coombs et al., 2021) and another global study found that stigma, policy, lack of human resources, and poor distribution of services decrease the availability of mental health services (Wainberg et al., 2017).

This brief review demonstrates the increasing prevalence of mental health and relational difficulties. When these increases are viewed in the context of the heightened difficulty of finding good care, it makes a case for therapists to use all available resources to ensure quality care. It also points to the need for increased collaboration to solve the current problems. One way to foster collaboration is by using practice research networks (PRN) and routine outcome monitoring (ROM) to improve client care. A practice research network allows researchers and practitioners to come together to collect larger, more diverse data to better understand change processes. ROM used within a PRN allows therapists to track client progress, create more comprehensive treatment plans, and make corrections to treatment plans throughout the treatment.

Routine Outcome Monitoring (ROM)

ROM is the formalized process of routinely monitoring clients' progress toward outcomes. ROM adds an additional data point and helps clinicians track client data to serve as an addition to the therapist's intuition. While intuition is valuable, additional data is necessary because therapists have been found to be imperfect predictors of client outcomes, indicating that clients are progressing more than they actually are (Johnson et al., 2017). The use of continuous assessments helps clinicians have more accurate knowledge of how their clients are progressing, or not progressing, and aids in identifying barriers to successful treatment. Further, it has been found that continuous assessments help increase the success of couple therapy (Anker et al., 2009; Halford et al., 2012; Johnson et al., 2017).

For research, ROM is instrumental in providing data for researchers on an ongoing basis. Further, the ease of implementing ROM systems expands their use to clinics beyond university-based training and research laboratories that typically have small sample sizes and limited generalizability. Using ROM within a practice research network (PRN) addresses these limitations by providing a large and geographically diverse sample through collecting data from various clinical settings where therapy is practiced.

Many available systems facilitate implementing ROM within a PRN and a review of all these systems is beyond the scope of this paper. Instead, it will focus on one ROM system—The Marriage and Family Therapy Practice Research Network (MFT-PRN; Johnson, et al., 2017). Our article will provide a brief introduction to the MFT-PRN (for more information on the MFT-PRN see Johnson, et al. 2017, or www.mft-prn.net) and provide a summary of findings from MFT-PRN data. We hope that this review will highlight the collaboration that has occurred and the progress made toward improving client care.

The Marriage and Family Therapy Practice Research Network (MFT-PRN)

A practice research network (PRN) includes a group of practices/clinics that work together as practitioners and researchers to improve client outcomes (Johnson et al., 2017). PRNs provide an opportunity for both evidence-based practice and practice-based research to occur. PRNs began in the medical field and are now used in numerous disciplines. Before the MFT-PRN, the closest things that the field of Marriage and Family Therapy had to a PRN were the Systemic Therapy Inventory of Change (STIC; Pinsof et al., 2009), and the Systemic Practice Research Network (SYPRENE; Vitry et al., 2020). STIC is a system that helps track client feedback on clinical outcomes (Pinsof et al., 2009) and SYPRENE is an international research network for systemic therapists doing strategic therapy (Vitry et al., 2020). While STIC monitors clinical feedback, it is not a practice research network that provides shared data nor a network of researchers and practitioners collaborating across clinics, and SYPRENE is narrow in scope as it focuses on strategic therapy only. Accordingly, the MFT-PRN was created to enable researchers and clinicians to work together to improve client care and to have shared access to a large amount of clinical data for the systemic treatment of mental illness and relationship problems (Johnson et al., 2017).

The MFT-PRN is a web-based system that delivers routine assessments to clients in participating clinics that is fully funded by donors to the authors' institution—participating clinics bear no cost (Johnson et al., 2017). The MFT-PRN balances the needs of research (consistency) with the needs of clinics and therapists (flexibility) in developing policies, procedures, and the choice of some assessments. While research focuses on "Does this treatment work for the average client?" practice needs to focus on "Does the treatment work for the clients (individual, couple, or family) I am currently seeing?" The timing of assessments, and short every-session assessments are consistent across sites. While demographics are generally consistent across sites, appropriate cultural adaptations are incorporated. Flexibility is achieved by allowing clinics, therapists, and clients, to have a voice in what assessments are completed and having the MFT-PRN be flexible enough to work within a very wide range of clinic policies.

Procedures and Assessments

Currently, there are two main assessment categories: 1) assessments that all clients take and 2) assessments chosen by the clinic. Assessments that all clients take include demographics, and short assessments taken before every therapy session (ratings of presenting problem progress, a questionnaire of individual or relationship functioning, and a questionnaire on the therapy alliance). Assessments chosen by the clinic are from the MFT-PRN assessment menu. Questionnaires for the menu have been screened for acceptable reliability, validity, sensitivity to change, and clinical utility. All data are encrypted in transit and during storage, and data protection policies and procedures ensure client confidentiality.

Procedurally, before the first therapy session, clients fill out the demographics and clinic-chosen assessments—the demographic questions take approximately 20 minutes to complete and the length of time to complete the clinic-chosen assessments varies. Clinic-chosen assessments are administered every 4th, 8th, 12th, 16th, and multiples of 8 sessions thereafter. Furthermore, three key assessments: progress on presenting problems (Presenting Problem Progress Questionnaire), relationship functioning (Couple Relationship Scale or Family Relationship Scale), or individual functioning (Intersession Report), and therapy alliance (Individual, Couple, or Family Intersession Alliance Measures), are completed before each session—the every session assessment takes 2 minutes to complete. For more information on assessments available within the MFT-PRN, see https://www.mft-prn.net/assessments.

A link to questionnaires can be sent directly to clients via email or text message. The MFT-PRN also generates a QR code to scan and thus administer the questionnaires in person. Assessments are scored in real time and then displayed graphically for easy interpretation, helping clinicians visually track client progress and easily see when client progress deteriorates. Clinicians can also access the completed assessment to view client responses to individual questions. Where available, clinical cut-off scores are shown on the graphs.

Currently, MFT-PRN staff are working on including a screening questionnaire taken before the first session by clients that will determine what questionnaires clients complete. Additionally, therapists will have the ability to add theory-specific questionnaires, such as differentiation, and clinics will be able to add required questionnaires for all clients at their clinic.

To allow more therapists and clients to benefit from the MFT-PRN, the portal and questionnaires are available in English, Spanish, French, Hungarian, Portuguese, Turkish, Korean, Japanese, Chinese (traditional and simplified), and Mongolian. We are currently working on additional translations. (See www.mft-prn.net for an up-to-date list of available languages.) As is evident from the multiple available languages and the current endeavor to offer ad-

ditional languages, the MFT-PRN has gained the attention of the international community. We are interested in welcoming new partners from other countries and we have protocols in place to help facilitate the needed translations.

Table 1. Benefits and Costs of the MFT-PRN for Varying Clinical and Research Roles

	Benefits	Costs
Clients	Better clinical care through improving therapy outcomes for clients (Bickman et al., 2011; Shimokawa et al., 2010), doubling the amount of progress in couple cases (Anker et al., 2009; Reese et al., 2010), decreasing the number of sessions, and giving clients a voice in their therapy experience (Johnson et al., 2017).	Costs may include loss of time to complete assessments, the irrelevance of some of the questions, and frustration with the overall process, which may translate to a lower therapeutic alliance (Johnson et al., 2017).
Therapists	Measure client progress and intentionally modify treatment to enhance outcomes (Anker et al., 2009), provide a rational for specific treatments, save time by gathering a lot of information before each session, and identify weaknesses to improve on and increase ethical practice (Johnson et al., 2017).	Push-back from clients on the time it takes to fill out the assessments, and opportunity cost arising from sending and checking assessments (Johnson et al., 2017).
Researchers	Data to study specific therapeutic processes and outcomes (Howard et al., 1996; Laurenceau et al., 2007; Pinsof & Wynne, 2000). Large and diverse samples for research (Johnson et al., 2017).	Opportunity costs as less focus may be directed at other projects, and research questions are limited to the information that the applied measures collect (el-Guebaly & Atkinson, 2004; Johnson et al., 2017).
Clinical Directors	Helping them track the effectiveness of their therapists and client progress, providing an opportunity to use data to secure funding, and to help identify areas for clinic training (Johnson et al., 2017).	Time and energy of implementing a new procedure, costs of technology to distribute and take the assessments, and potential push-back from clients or therapists on the time constraints of taking and reviewing the assessments (Johnson et al., 2017).

Benefits and Costs

When implementing any new procedures in a clinic, there is an adjustment period. To help in the decision-making process, see Table 1 for a summary of the potential benefits and costs of implementing a ROM project such as the MFT-PRN.

The main benefits of the MFT-PRN are improved client care with clients making changes more quickly. Therapists can also gain a large amount of information about their clients before the first session, and then, with subsequent information, change treatment plans as necessary. Finally, the MFT-PRN has generated, to our knowledge, the largest database on couple and family therapy. Further, with multiple clinics using the MFT-PRN, collaboration on improving client care is increased. In addition to collaboration on client treatment, the MFT-PRN fosters research collaboration.

Researcher Accessibility to Archival Data

A benefit of PRNs to researchers is a large sample of relational and clinical data. Further, a large more diverse database for research benefits clinicians because clients seen by most therapists are different from participants in a randomized controlled trial. Thus, research on clients from treatment as usual settings will be more applicable to the daily practice of most therapists. To build additional research collaborations, clinics participating in the MFT-PRN desiring archival data for research can send a proposal of the requested research questions, project details, key references, a plan of analysis, and a letter of approval from the researcher's Institutional Review Board. This information is then reviewed and approved by the MFT-PRN executive committee, ensuring that duplicate studies are not created and connections between researchers can be encouraged. Finally, to further protect the identity of participants, MFT-PRN data are de-identified for all research.

The MFT-PRN has been helping to improve client care while building a large research database since 2017. Researchers are collaborating on publications that inform practice. As this is an important part of the MFT-PRN's mission, we are going to provide a summary of the completed research to highlight progress as well as encourage other researchers and clinicians to join the collaboration.

Summary of the MFT-PRN Research

To date, thirteen articles using MFT-PRN data have been published, fifty more articles are in progress, and many of these articles are done by researchers outside the authors' institution. This summary does not include a large number of presentations, dissertations, and theses using MFT-PRN data. Our goal is to provide a summary of the key topics and how these findings can improve client care. Key findings hail from the areas of questionnaire development, the therapy alliance, findings related to therapy outcomes, and the use of teletherapy.

Questionnaire Development

Due to some questionnaires being completed during every session, these must be reliable, valid, sensitive to change, and as short as possible. While many quality questionnaires exist, one that met all criteria was not available for some key variables that are important to clinicians and researchers.

Accordingly, a questionnaire to assess couple relationships was developed—the 10-item Couple Relationship Scale (CRS) was created by Anderson and colleagues (2021) to assess aspects of a couple's relationship routinely and quickly. This one-dimensional questionnaire includes items assessing emotional intimacy, commitment, trust, safety, cohesion, acceptance, conflict, physical intimacy, overall happiness, and personal well-being. The questionnaire has strong concurrent and construct validity, good reliability, a reliable change index, and a clinical cut-off. To be most useful, the CRS must be taken consistently, which requires client buy-in. To help increase client buy-in, the authors recommend 1) informing clients of the importance of routinely taking the CRS and other assessments, and 2) discussing the results of the CRS with clients in session, including the rate and direction of change. The authors also recommend that clinicians view the couple's scores before the first session and specifically note if their score is above or below the clinical cutoff, comparing partner scores to see how they each perceive the relationship, and looking at individual scores to identify problem areas and strengths within the relationship.

As with couple relationships, quick, reliable and valid questionnaires are needed to assess family relationships. To assess these, Miller et al. (2022) did some additional research on an existing questionnaire and established a reliable change index and a clinical cut-off score for The Systemic Clinical Outcome and Routine Evaluation version 15 (SCORE-15). The SCORE-15 was created by Stratton and colleagues (2010) to better track familial progress throughout therapy. While the SCORE-15 has three subscales, this research used the SCORE-15 as a one-dimensional scale of family functioning. Using SCORE-15 allows clinicians to track treatment progress, providing the opportunity to better individualize treatment for each family.

Finally, due to the importance of the therapy alliance to client outcomes, it was necessary to develop a short questionnaire to assess the alliance. Thus, the individual, couple, and family Intersession Alliance Measures (IAM) were created to better assess the therapeutic alliance across time (Anderson et al., 2024). Psychometric properties of the three versions were examined and all items loaded on one factor, had good internal consistency, test-retest reliability, concurrent validity, and demonstrated measurement invariance across sex. Further, the couple and family versions had good predictive validity for therapy outcomes. Consistently using the IAM allows clinicians to be more aware of how clients view the alliance between the therapist and client, and between each other, in relational cases. Doing so can help therapists better identify when a rupture has occurred and be intentional about fixing the respective rupture. Further, the length of this questionnaire (4 items) makes it ideal for use across time.

Therapeutic Alliance

The relationship between therapist and client has been associated with client outcomes in therapy (Friedlander et al., 2011), and the results from MFT-PRN research build on previous research to allow additional understanding. Maintaining a therapeutic alliance in relational cases is more complex than in individual cases because the alliance must be created and sustained between the therapist and multiple people simultaneously. Due to this complexity, the therapeutic alliance in couple cases not only influences individual outcomes, but couple outcomes as well.

Articles using MFT-PRN data on the alliance showed how couples' expectations of the therapy predict the therapeutic alliance (Orlowski et al., 2024), and how initial role and outcome expectations are related to the therapeutic alliance and couple relationship satisfaction (Orlowski et al., 2024). Additional results indicate that higher positive expectations in individual partners were predictive of better therapeutic alliances reported before the fourth therapy session (Orlowski et al., 2023; Orlowski et al., 2024), and that better therapeutic alliances reported at the third session were predictive of higher couple satisfaction at session four (Orlowski et al., 2024).

Further findings show that the therapeutic alliance was a moderator between depressive symptoms and couple relationship satisfaction, finding that when the therapeutic alliance was poor, higher depressive and lower couple relationship scores at intake were predictive of more adverse symptoms in both individuals and couples, in comparison to couples who reported fewer symptoms at intake (Wu et al., 2020a). Similarly, Wu et al. (2020b), found the occurrence of four couple groups, namely couples who both reported higher symptoms, female higher, male higher, and both lower. Among these groups, males and females in the "both higher" group indicated higher initial therapeutic alliance levels, while men in "male higher" and "female higher" also reported a higher initial therapy alliance. Finally, results show that if a disagreement existed between couples about whether the presenting problem was individual or relational, there was a greater discrepancy in the couple's initial therapeutic alliance, which lessened over time as the therapy continued (Wu et al., 2020b).

Therapy Outcome

A growing number of studies exist that look at couple process and therapy outcomes. Xu and colleagues (2022) showed that difficulty in aspects of emotion regulation, such as a lack of emotional awareness, difficulty with impulse control, and limited emotion regulation strategies, were predictive of lower couple relationship satisfaction, and nonacceptance of negative emotions increased couple relationship satisfaction. Since nearly all couples experience emotion dysregulation, which was found to influence couple relationship satisfaction, clinicians must monitor emotion regulation among the couples they are seeing.

Additional research showed that client-rated participation and goal-progress predicted the clients' personal functioning while therapist-rated session variables did not (Wu et al., 2023). As therapist perceptions of therapy sessions did not consistently predict client outcomes, clinicians must monitor client progress through consistent client feedback. Therapists can then use the feedback to guide and amend their treatment plan to better client care and outcomes. The authors suggested that for clinicians-in-training, comparing therapist perception and client feedback could be particularly useful in helping new therapists develop better clinical judgment and treatment plans (Wu et al., 2021).

Finally, research has shown that adverse childhood experiences (ACEs) impacted the rate of improvement for anxiety symptoms across therapy sessions (Banford Witting et al., 2024). The authors found that the number of ACEs reported did not significantly impact the rate of reduction in anxiety symptoms, but that people with more ACEs reported greater amounts of anxiety at the onset of therapy. If clinicians notice that clients present to therapy with high levels of anxiety, they should assess the number of ACEs the client has experienced. Similarly, clinicians should monitor client anxiety if they report higher levels of ACEs. Encouragingly, therapy was found to be equally advantageous for clients with both many or few ACEs.

Teletherapy

In response to the COVID-19 pandemic, teletherapy has become a more popular option for service delivery. Therefore, research is needed to best understand how to use this service delivery option. MFT-PRN research has explored how teletherapy impacted therapeutic outcomes. First, teletherapy services are just as effective as in-person therapy in enhancing client outcomes (Bradford et al., 2023). However, the therapeutic alliance did not develop as quickly through teletherapy, with in-person alliances developing twice as fast. Further, research found that couples who received therapy via telehealth reported higher couple satisfaction at intake than couples attending therapy in person, although their rate of improvement was slower (Bradford et al., 2024). The therapeutic alliance was then added as a mediator, revealing that couples in teletherapy reported higher therapeutic alliance scores than their in-person counterparts, although the rate of improvement in the alliance was slower in men who were receiving teletherapy.

This has several clinical implications. First, if clients are not able to come in person, therapists can offer teletherapy that is as effective as in-person therapy. However, clinicians should spend extra time establishing a strong therapeutic alliance since the alliance mediates therapy modality and couple satisfaction and takes twice as long to develop via teletherapy (Bradford et al., 2023; Bradford et al., 2024). Second, due to the added time and complexity of developing the alliance, and its impact on other therapy outcomes during teletherapy, treatment may take longer and require more intentionality and focus.

Conclusion

The Marriage and Family Therapy Practice Research Network (MFT-PRN) is a way systemic researchers and clinicians can collaborate to improve client outcomes. Benefits of the MFT-PRN include access to routine assessments, large and diverse sample sizes, monitored outcomes, contribution to the increase of evidence-based practice and practice-based research, and intentional and ethical practice. To date, collaboration has been successful in improving client outcomes with many clinics using the MFT-PRN. Research collaborations have also demonstrated results that can further improve client outcomes. Results include information about the therapeutic alliance, therapy process and outcomes, couple relationship satisfaction, teletherapy, and advances in measurement.

To date, we have collected data on over 14,000 clients. We are also in the process of making additional refinements to the MFT-PRN, such as the previously mentioned screening questionnaire, and transitioning to a more user-friendly interface. We are also working to add additional partners. While recruiting current collaborators, we have had the wonderful opportunity to meet and learn from therapists and clinic directors from around the world. It has been amazing to see what people are doing to help couples and families. Adding more partners will only increase the value of what can be learned via the MFT-PRN. We hope that continuing data collection and exploring the collected data will help further the field of Marriage and Family Therapy and bring clinicians and researchers together to better treat mental health problems and relationships.

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Lee N. JOHNSON: conceptualization, funding acquisition, project administration, supervision, writing original draft, writing review and editing.
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