

Family Therapy Practitioners Researching the Reactions of Practitioners to an Outcome Measure

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Family therapy is under increasing pressure to use 'objective' measures of effectiveness, but there are strong voices in the field objecting to such research. The primary objective of this project was to investigate the acceptability and perceived potential usefulness of a short self-report questionnaire. A secondary objective was to explore the viability of conducting such research by a group of practitioners who would collaborate primarily through emails. Nine experienced family therapists were interviewed as they worked through the 16 items of a pilot version of the SCORE questionnaire. The recorded interviews were analysed using Template Analysis. The SCORE was found to be generally acceptable for use with clients but the exercise generated information on a variety of concerns about the content of the measure. Beyond its potential as an outcome measure there was considerable interest in how it could be used therapeutically. The operation of the Practitioner Research Network proved functional but indicated some of the difficulties that such networks might encounter.

Key words: outcome measures, systemic practice, qualitative research

The Need for a Self-Report Measure of the Effects of Systemic Family Therapy

Systemic family therapy is increasingly being called upon to justify its activities by reference to evidence of effectiveness (Stratton, 2005). Sometimes there are simple measures that indicate that useful change has occurred. For example, did the person diagnosed as anorexic gain weight? Has the child been taken off the 'at risk' register? Then there are less direct measures — did the person being treated for depression reduce their scores on the Beck Depression Inventory?

Family therapists often have problems with such indicators. First, because most of us are not working in specialist clinics, a set of measures designed for a single

condition would only apply to a small proportion of our cases. Second, the available measures are not consistent with the theoretical approach of family therapists. We would argue that this is not primarily a matter of a constructionist therapeutic position being unable to make use of realist data, but that our objectives go beyond what existing indicators can measure. A diagnosis attempts to narrow the definition of what needs to be 'cured' in a way that is antithetical to the aspirations of systemic family therapists. If a family comes with one of its members trailing a diagnosis of anorexia, depression or attention deficit hyperactivity disorder we will have wider objectives than to reduce symptomatology of the labelled condition. Family therapists are likely to be interested in the relationships both to the label and within the family. The purpose of family therapy is more likely to be to broaden out understanding and increase the curiosity of the family rather than to narrow the thinking down into a single explanation.

So what is available for a family therapist to report on their effectiveness? There are measures of family functioning such as the Family Environment Scale (Moos & Moos, 1981). Typically, such measures were constructed in the United States in the 1970s or earlier, and offer typologies of families that were current at that time. A review of existing measures and their limitations is provided by Janes (2006). There are general indicators of therapeutic change such as the Clinical Outcomes and Routine Evaluation



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(CORE; Barkham, et al. 1998; Evans et al., 2000) and the Outcome Rating Scale (Miller & Duncan, 2000 available at www.talkingcure.com). These measures are formulated in terms of change within the individual, although they may include questions about how the individual is coping in their relationships.

One can ask the family whether the therapy has been helpful. Such questioning, while valuable, does not generate data in a generalisable form. Also it is usually asked by the therapist, so is subject to social desirability effects.

Each of these approaches is inadequate for providing evidence of the effectiveness of a relational therapy that will both tap into the strengths of current family therapy, and be convincing to external scrutiny. A group of practitioners (the SCORE group), supported by the UK Association for Family Therapy, therefore set out to create a measure that can be made freely available, designed for use in generic family therapy and that enables family members to report on the operation of their close relationships.¹

Is a Credible Self-Report Measure Possible?

One of the SCORE group's objectives was that networks of practitioners would be able to collaborate to generate significant research data without any individual having to meet demands that would interfere with their clinical work. The working group took the CORE as a model for a general purpose self-report measure that practitioners could easily use, and then report data back. However we felt that the CORE was too focused on diagnostic categories and individual pathology to be informative about the concerns of family therapists. We therefore did not attempt to adapt CORE, but to create a new set of questions specific to our objectives. It became called 'systemic CORE' or SCORE. Like CORE, we aim for a set of questions that can be answered by or about clients, and which will address issues that would be seen by family therapists as central to their concerns whatever the family constitution or reason for referral.

The SCORE project is, at the time of writing (May 2006) well on schedule. A comprehensive review of existing measures (Janes, 2006) along with feedback from practitioners was used to create a preliminary version of 16 items. This version has completed successful pilot work with therapists and the general public, which has produced encouraging results, and is proceeding to full psychometric refinement of the measure through the acquisition of substantial clinical data. This article presents a study from the initial phase, which

was designed to investigate what kind of measure would be meaningful and acceptable to practitioners.

Preliminary work included inviting comments from practitioners through the AFT discussion list and website, and during presentations at conferences. Some therapists offered suggestions of formats and items; others pointed to concerns about the whole enterprise of creating a quantitative measure of change during family therapy. We therefore set up a qualitative study to examine in detail the reactions of highly experienced family therapists to the pilot version.

The Role of Researching the Reactions of Experienced Therapists

The field of systemic and family therapy has attracted concern (Cottrell, 2003; Rivett & Street, 2003, p. 132) for the relatively limited extent to which it has clearly demonstrated beneficial therapeutic outcomes. Eisler (2003) described a 'perception of reluctance or only a grudging acceptance of the value of research' in the field. Yet we considered that many family therapists are hoping to negotiate the challenge of integrating therapeutic practice which is theoretically post-modern and adopts an approach of continued curiosity and multiple perspectives, while also looking to meet the demands of research and evidence based practice. Our task was to test the validity of this contention. Establishing this balance is important because the purchasers of family therapy, therapists and families are asking the very reasonable question 'Is therapy going to help?'. Family therapy must be able to respond to this demand and needs the cooperation of the therapists in producing relevant and meaningful data.

Janes (2006), in a systematic review of self-report measures considered that these needed to be user friendly for routine use in clinical practice; thus ease of use and immediate value to therapists in their day-to-day clinical work were crucial in overcoming potential barriers to the use of a measure. The research reported here sought to gather information on the clinical relevance and usefulness of SCORE from experienced therapists working with different problems in various contexts. It was hoped that findings would provide information to the developers of the questionnaire as to whether it could fulfil its aim of being a simple, acceptable and universal measure of outcome. In addition, the research would give valuable information about how therapists would make use of the measure as a clinical tool. Therapists' views on the usefulness of the information from SCORE would be valuable feedback to the development team, but also importantly it would include therapists in shaping the direction of (and therefore the usefulness of) the

measure. In addition, the research would give valuable information about how therapists would make use of the measure as a clinical as well as a research tool.

Our research focused on three particular areas of interest: (1) Whether or not the therapists' practice preferences would affect whether they would use the measure; (2) Whether the therapists felt that SCORE would give them useful information about the families who come for therapy; (3) Whether therapists are concerned about the ability of SCORE to cope with the variety of families they see, and in particular its sensitivity to issues of culture and difference.

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Research Objectives

Our primary objective in carrying out this research was to answer the research question: 'Do family therapists think that the SCORE questionnaire has the potential to give them useful information about families coming to therapy? If so in what ways?'

We were particularly interested in family therapists' views of the SCORE Questionnaire for a number of reasons. One was that little is known about therapists' views on outcome research. We were interested to learn more so that the designers of the questionnaire could accommodate the learning and increase SCORE's usefulness to therapists and the families that consult them. Another was that tools such as SCORE can have different functions and purposes for managers, providers of service and purchasers of service. This was our opportunity to give the therapists views priority over often more influential voices.

Many family therapists are concerned about the epistemological and methodological difficulties involved in researching the complex world of systemic psychotherapy (Gurman, & Kniskern, 1979; Gurman et al., 1986; Cecchin et al., 1994; Eisler, 2005). But we also recognise that they are concerned to understand the process of therapy and clients' experiences of

therapy (Rivett & Street, 2003; Vetere & Lask, 2003; Campbell, 2001; Gorell Barnes, 1998). Our interest in the therapists' views was motivated by a wish to get a clearer idea about what clinicians want from research so that this can inform the further direction of research and perhaps facilitate the adoption, and creative application, of research into every day clinical practice, as discussed by Andersen (1997).

We were also interested in whether such a collaborative qualitative piece of research was viable given the time-limited nature of the project, the limited resources and the geographical distance between the researchers. It was a particular test of our modern day communication systems.

Context, Procedures and Methods

The research was carried out within the context of a postqualification training conducted by the first author (Peter Stratton) to upgrade a Diploma in Family Therapy to MSc level. The three participants on the course (Marie McGovern, Annette Wetherell and Carol Farrington) were the researchers who carried out the fieldwork. The research was planned as a collaborative project with all four researchers sharing ideas and progress particularly by use of emails.

Methodology

The study was designed to gain 'clinically meaningful' research information (Hetherington et al., 2001) in a collaborative study. The collaboration and an intention to create the greatest potential utility of the results directly informed the design of the study and the choice of method of data analysis. The philosophical position thus created was one of 'contextual constructionism' whereby the researchers were guided by the multiple contexts of the research including the societal, professional, personal and academic, whilst understanding that the data would yield multiple meanings and understandings and that analysis is always 'partial and subjective' (Madill et al., 2000). Family therapists were to be recorded as they provided a commentary on their thinking about each item in the SCORE, using a technique described by Diriwächter et al. (2005).

The use of template analysis (King 1998) was considered to meet the aims of the research in that it allowed the researchers to focus on the range of specific areas as a priori themes whilst retaining a broad openness to the potentially varied positions of the participants in regard to each item of SCORE. The method (fully described at http://www.hud.ac.uk/hhs/research/template_analysis/) is a qualitative

analysis technique in which the researcher develops a template of the themes likely to occur in the data. The template is then used to analyse the text and is refined through multiple reading and considerations of the data until a point is reached where the template forms a detailed and hierarchically ordered summary of the data set. This allows the researcher's discussion and interpretation of the data to be understood and demonstrated to the reader with close reference to the words of the participants. In addition, the transparency of the analysis process appealed as the researchers were researching fellow therapists' views and there was a high risk of prejudgments and assumptions about the meanings contained in the participant's responses. Madill et al. (2000), in reviewing epistemologies of qualitative research make a general claim that in qualitative research 'results can be justified to the extent that they are grounded in the data'. The present research needed a high degree of reflexivity in acquiring and processing the data and we wanted a technique that made the reflexivity apparent. The visibility of the processes of template analysis confirmed it as the method of choice.

The SCORE Self-Report Measure

The SCORE is undergoing continuous development. The version used in this research contained a 16-item Likert scale on which the interviewee rated the fit for their family of each description. Examples of the questions and the scale are given in Figure 1.

The 16 items were derived by the SCORE team by reviewing existing measures, research on well-functioning families, and clinical reports. They are not presented as the most important characteristics of an ideal family, but as a choice of self-descriptions which are clinically meaningful and which could be expected to change during successful family therapy.

The SCORE as used clinically invites the family member to specify who they will count as 'family' for this purpose. Usually they elect to refer to members of their household, sometimes they opt for significant relationships that do not include family members. The form continues after the questionnaire with qualitative material, ratings of the family's problems and, once therapy has started, a judgement about the appropriateness of family therapy. These sections were omitted for the current research which focussed entirely on the 16 questions.

Information about the currently usable version of SCORE will be posted on the AFT website (www.aft.org.uk) as it becomes available.

	1. That fits our family very well	2. That fits us well	3. Fits us a bit	4. Doesn't really fit us	5. Doesn't fit us very well	6. That's not us at all
Our family shares enjoyable times together						
We find it hard to cope with everyday problems						
In our family it is best not to show how you feel						
We blame each other when things go wrong						
People in the family are nasty to each other						
We feel hopeful about the future						

FIGURE 1

The format of the SCORE 16 Pilot Version with sample items.

Procedures

We drew up an interview schedule and four specific questions (listed below) were devised to be asked against each of the 16 questions in the SCORE questionnaire. This preparation was done through face-to-face meetings and e-mail collaboration. These questions were piloted on two colleagues (non-family therapists). At this stage some concerns were raised about the questions selected, their wording and the repetitive nature of the interview. However, it was decided to keep to the original design in order to meet the varying demands of the research project. This refers particularly to the need to keep the work focused and collaborative throughout the design and interviewing process. There was also a wish for each of the researchers to pursue their specific interest in one of the three areas listed above. The data therefore needed to capture these aspects in sufficient detail to enable each researcher to analyse the material and write up dissertations separately.

After all of the ethics approvals had been received the three researchers interviewed nine experienced (at least three years post-qualification) family therapists. Each researcher interviewed three therapists, made contemporaneous notes and transcribed the interviews. The nine data sets were then pooled and each researcher conducted an independent template analysis while sharing information about their experiences in the interviewing. The therapists were selected on criteria of experience, willingness to participate, and having very limited contact with the Leeds Family Therapy & Research Centre. This last was to ensure that their orientations varied from those of the researchers who had all trained at LFTRC. Five of the therapists were male and four were female. There was

variety in the interviewee's first profession: six were social workers, one was a nurse, and two were psychologists. The participants are all based in the north of England, because the sampling was done through the personal contacts of the researchers.

The family therapists were met by the researchers and given a copy of the SCORE questionnaire. The interviewees were invited to think of two families. They were asked to choose one family in difficulty at the beginning of therapy and one family where the work was well underway. The interviewees were then asked to have in mind one family member and think of their likely response to each question on the SCORE questionnaire. The therapist was then invited to complete the task again for the second family. This exercise was undertaken in order to familiarise the interviewee with the SCORE questionnaire and no clinical information was discussed. After that exercise was completed the interviewer then went through each of the questions asking the four questions below. The interview from this point was recorded on audio-tape. Regarding each of the 16 SCORE questions we asked the therapists:

1. What kinds of thoughts came to mind as you answered this question?
2. Do you think the question is likely to give you information about the family that will be useful to you as a family therapist?
3. Does this question reflect whether positive change on the score of this item would indicate successful therapy?
4. Does this question reflect whether positive change on the score of this item would indicate a shift towards improved family functioning?

These questions were all asked 16 times, once for each SCORE item, and produced some diverse and interesting responses.

Outcomes

What Did the Family Therapists Think of the SCORE Measure?

The therapists' responses to the SCORE questionnaire ranged from very broad position statements in relation to their hopes to use an outcome measure, to very detailed responses to specific words and then to meanings that could be communicated through the use of the measure. Therapist's theoretical orientation was not in itself an indicator of their perspectives on the measure. While one therapist reflected that, 'There are some questions that I feel might be at odds with the

kind of approach that I would attempt to take', other therapists considered that whatever responses were given by family members these would provide useful information that could be worked with in therapy. There were some areas of consensus: all 9 therapists viewed item 16 relating to 'hope' as useful:

I think this is an important question and I think a lot of families come feeling hopeless, don't they really, and actually, if you can get them feeling more hopeful after the first session that's quite a good indicator.

Other items prompted greater differences; for example, question 8: 'In our family it is best not to show how you feel'. Comments varied from wondering if there was an embedded assumption in the question and observing that for some families it was good to show feelings whereas in other families the reverse was the case, to:

It would give me information because then I would get curious about that belief, why it is either way, good or bad or not so good.

The first item, 'Deep down we love each other', elicited a variety of mainly positive responses:

It's helped me think really about the complexities of families where abuse happens, because its not straightforward or easy, and it reminded me not to jump to conclusions, for instance that a child would necessarily hate the perpetrator, and just to think about the complexity of the relationship, the both — and so to speak, rather than just one way of perceiving things.

Detail of the therapist responses was contained in the templates that each of the researchers generated. One of the templates is provided in Figure 2 as an example of the detailed analysis provided by this method.

It can be seen from this template that the therapists rapidly became engaged in talking about how the items of the SCORE might be useful. There were strong themes that were about capacities of the SCORE items to indicate different kinds of therapeutic change. Even the final major theme of 'things that got in the way' was primarily about ways that the measure could be more effective. The other major theme was 'usefulness of the information' which the sub-themes show to be primarily about the potential value of SCORE to the therapist and family working together.

The research was also able to identify some of the difficulties therapists had with use of an outcome measure. This was primarily about the problems of using a quantitative tool to evaluate complex relationships in complex social and cultural contexts. The final template, shown in Figure 2, illustrates some aspects of this complexity, such as the need to acknowledge both hope and distress, the scope for commenting on both

Indicators of Change

- 1 Diminishing problems over time
 - a. Diminishing problem narratives
 - b. Diminishing problem behaviour
 - c. Evidence of change through scoring
- 2 Increase in families and therapists hopefulness
 - a. Reference to love
 - b. Reference to care
- 3 Qualifications
 - a. See 'what gets in the way'

Relevant and Fit of the Questions

- 1 Acknowledging hope
 - a. Particular fit: Questions 3 (4 responses) 16 (6 responses)
 - b. Potential for change, to build on
 - c. That there are still some good aspects
 - d. Hopefulness as a good measure of change over time
- 2 Acknowledging distress
 - a. Need to acknowledge distress
 - b. Levels of distress are a good measure over time
- 3 Trigger for conversations
 - a. Particular fit: Questions 2 (3 responses) 14 (3 responses)
 - b. Different questions trigger different conversations for different families
- 4 Lack of fit
 - a. To particular cases held in mind
 - b. Language See 'what gets in the way'

Usefulness of the Information

- 1 Themes therapists are interested to explore
 - a. Styles of communication
 - b. How bad things are
 - c. How good things are
 - d. Belief systems/perceptions
 - e. Power/gender
 - f. Levels of risk
- 2 Indications about the work the family want to do
 - a. Clarifying what family members want to be different
 - b. Questions 1 and 4 useful
- 3 Comparing responses for difference
 - a. Between family members
 - b. Over time
- 4 Taking it back to discuss with the family
 - a. Attitudes to change
 - b. Clarifying
 - c. Acknowledging complexity
 - d. Exploring beliefs
 - e. Encouraging thinking within family

Things That Got in the Way

- 1 Culture
 - a. Gender
 - b. Western society
 - c. Class
- 2 Language
 - a. 'I' vs. 'We'
 - b. Negative words :
 - i. Types of words
 - ii. Reinforcing negative thinking
 - iii. Invites families to make assumptions about therapy
 - iv. Words having different meanings
- 3 Complexity of family relationships
 - a. Life cycle
 - b. Differences with different families' presentations and within families
 - c. Positive change being different from the mainstream assumption
 - c. Fixed relationships

FIGURE 2
Example of a final template.

problem narratives and behaviour, and the potential for gaining some understanding of the family's experience beyond the problem that has brought them to therapy. The template also illustrates the therapist's views of a range of potential limitations to the questions, shown in Figure 2 under 'Things that got in the way', with sub-headings: 'Culture', 'Language', and 'Complexity of family relationships'. The coded templates allowed the researchers to return to the therapist's responses to explore these themes further. For example, in relation to Question 3, 'Each of us gets listened to in our family', one therapist commented:

Families might be organised in a way that the cultural expectations are that the more senior members of the family are more listened to,

There was evidence to suggest that all nine therapists would be interested in using the measure for evaluating outcomes. The analysis showed that the therapists were also interested in the possibility that SCORE could be used to facilitate their therapeutic work with clients, by providing a springboard for discussion or highlighting areas of interest to the therapist. This can be seen in the final template's (Figure 2) headings such as: 'Taking it back to the family', 'Triggers for conversation' and 'Indications about the work that the family want to do'. The therapists repeatedly stressed a need to refer to the family's wider context to understand their responses to the questions. An example of this was given in relation to the questionnaire item, 'We find it hard to cope with everyday problems', where a wider conversation might include factors such as financial limitations as well as the meanings related to beliefs about coping.

Lastly, the analysis showed that the therapists felt that SCORE would indicate where positive changes had occurred through therapy despite the limitations described above. An example of this relates to the item 'Deep down we love each other', where a therapist commented that, 'Most families would struggle not to answer in a positive way with that', but also said that a (positive) change would be indicative of improvement:

Yes I think so ... this word 'love' I struggle with, ... it depends on the meaning of that for the family but I would have thought that this would be a positive factor

***What Was the Experience of the Researchers?
Some Reflections Upon the Process of Being Involved
in This Research.***

We conceptualised the research as an exploration of the practicability of operating a practitioner network under conditions of limited time and access to face-to-face meetings. It therefore seems appropriate to provide a brief qualitative account of the experience of each of us.

Annette:

I guess I experienced the process of trying to merge the two worlds of therapy and research. One example of this was during the interview process. My instinct as a therapist was to broaden out and expand on the responses of the participants to understand further and clarify; however, I needed to remain within the structure of the questions we agreed. I would, however, allow myself some opportunities to expand on themes that appeared interesting but not to such a great extent that the focus and purpose of the interview was lost. This flexibility added to my experience and to the richness of the data.

My experience was enhanced by the fact that the template analysis allowed for the concept of multiple meanings and gave space for the appreciation of the complexity of responses. This enabled me to consider that the conversations that had taken place were not so far removed from the findings.

I enjoyed the variety of opinion expressed by the participants with regard to the questions, and their different responses. This further confirmed my belief that communication is complex and influenced by context and culture etc. I did not, however, enjoy the repetition of asking the same question 16 times.

Marie:

My experience of participating in the research was one of increasing engagement with the process and interest in the potential outcomes. I felt that this had parallels with the responses from the participants' steady engagement with SCORE despite recognition of limitations. The process of asking questions and analysing answers according to an epistemological stance that is quite distant from my own theoretical therapeutic stance was a significant challenge. The process of making decisions about specific meanings and returning to the data, via the templates, to look for evidence to support the decisions allowed me to experience the production of 'evidence'. I feel that the closeness of this research to the therapeutic work of the family therapists gave the findings a greater value than I had anticipated.

Carol:

The project was a huge learning curve for me and one that enhanced my thinking and challenged at the same time. Where does a postmodern co-constructionist therapy and analysing data where ideas of truth and fact fit? However, I found that the process of meeting with and hearing different descriptions from both the family therapists we interviewed and my fellow researchers did fit with postmodernism and that the challenge was presenting the research in a way that expressed those

ideas. Template analysis was useful to me in holding and expressing the ideas of multiple descriptions and opinions. The repetitive nature of the questions, whilst somewhat tedious (my description), did produce some interesting comments. One of the therapists interviewed later told me that she thought there must be something more to the questions because I kept asking the same question. She thought she must be missing something.

Peter:

My first take on the experience of this project is about the strong and increasing enthusiasm as the research progressed. Their achievements went well beyond what was required for the course and I believe they had fun some of the time.

I have a brief to foster Practitioner Research Networks (PRNs) of family therapists in the UK and in Europe, as well as for psychotherapists generally in the UK Council for Psychotherapy. My experience, as in this case, has been of much hesitation by therapists that stems from an idea that research is too difficult, too alien and too unrewarding for them. And then if they do take part in research, they discover competencies and enthusiasms that they did not know they had. Partly because there is tremendous common ground of skills and objectives that are transferable, in both directions, between research and systemic therapy. My hope is that other practitioners, reading this report, will conclude that research is manageable, useful, and potentially enjoyable, and get together to seek out someone who will have a co-ordinating role in a networked project.

Experiences of the Participants

We are in the process of gathering retrospective feedback from the nine therapists about their participation in the research. Some of the thoughts and themes of participants are described here. One of the participants found that the experience clarified the importance of articulating what it is they are trying to achieve in therapy particularly within the context of the demands for evidence based practice and in the climate of postmodernism and social constructionism. It invited them to think more about how they might inhabit a both/and position with regard to research.

The experience also invited thinking about how it was important to do something with regards to research even if it was not perfect, one participant reflected that it is better to do something than to do nothing.

One of the participants was also excited about the possibility of raising the profile of the child's/young

person's voice with regard to change or the lack of it rather than just being informed by the adult lens.

Concluding Discussion

The Implications of the Research Findings

The degree of engagement in the explorations of the SCORE by the nine therapist interviewees and the three therapist researchers suggests that concerns about the acceptability of such measures might be overstated. We suspect that it is the experience of working through the questionnaire, even as a simulation of a member of a family in therapy, that dispels some of the more abstract concerns about such an enterprise.

The findings indicate that the uses of SCORE as a potential therapeutic tool have perhaps been underestimated and should be considered further, particularly as therapists need to feel that there is some benefit to be derived from participating in research (Higgitt & Fonagy, 2002). The therapists who participated in the research were aware of the limitations of the outcome measure in capturing the complexities of the experience of families and their individual members yet there was also a consensus that the questionnaire could demonstrate positive outcomes in family therapy. Family therapists who plan to use SCORE in the course of their work are likely to be able to give due weight to the contextual limitations of the data. This research indicates that the recognition of these limitations does not outweigh the need to routinely demonstrate outcomes. Eisler (2003) argues for a position in which family therapy works against creating a clinician / researcher gap where an unhelpful dichotomy is constructed. The developers of SCORE have deliberately and specifically worked to bridge this gap and this research suggests that SCORE is likely to stimulate interest and involvement in research which fulfils these hopes.

Lessons about Practitioner Research Networks

Although the geographical separation of the researchers (within a 120-mile diameter) is small, the project provided a test of networked practitioner research supported by information technology. Overall, the collaboration clearly worked in that the research reported here was successfully completed, and in a way that enabled each of the researchers to pursue their specific interest within the pooled data. The combination of e-mail and telephone turned out not to be entirely adequate for this work and the group contrived to meet at the university several times during the course of the study. The meetings, their context as the home ground

of the first author, and a tendency for 'hub and spoke' communication even though all e-mails went to all four researchers, tended to put Peter Stratton in an 'expert position', despite our best efforts. It seems likely that the coordinator of a PRN would have difficulty in avoiding this role, but it is difficult to envisage such research being carried through without one person providing this kind of support.


While the idea of web-based collaboration is attractive, at least some enthusiasts for PRNs believe that they need to be sufficiently locally based to allow for face-to-face meetings. It does seem to be in these that the enjoyment and creativity can flourish.

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Editors and their Sheds: At the Coalface

“From students’ writings, we learn which theories assist them in understanding and managing their cases and which do not. The much touted ‘radical constructivism’, for instance, has been quietly discarded by our students.”

(Rosemarie Welter-Enderlin (317), in ‘The State of the Art of Training in Systemic Family Therapy in Switzerland’, *Family Process*, 44: 303–320)

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