The research-informed clinician: a guide to training the next-generation MFT

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The gap between clinical research and practice is a major challenge facing marriage and family therapy (MFT) training programs. Until now, the answer to bridge this gap has primarily been the Boulder Scientist-Practitioner Model. Although realistic for doctoral students, it may not be a good fit for MFT master's students who have primarily clinical career ambitions-which we believe is a legitimate and positive career choice. The following article articulates a "research informed" perspective as opposed to the scientist-practitioner framework as a research-training model for clinically oriented MFT master's programs. After articulating the similarities and differences between these two approaches, the authors outline 10 practical ideas to integrate research into programs that desire to remain clinical in focus, but also research informed.

At least once every decade going back to the 1970s, a widely cited article or chapter (Breunlin, Schwartz, Krause, & Selby, 1983; Crane, Wampler, Sprenkle, Sandberg, & Hovestadt, 2002; Liddle, 1991; Olson, 1976; Sprenkle & Moon, 1996) has appeared in the family therapy literature decrying the clinician research gap and calling
articles continue to be written suggests that progress is,
directly or indirectly, the solution most often offered is fo
the Boulder Scientist-Practitioner Model (Benjamin & Bak
developed within psychology in the post-World War II era
research and practice. It called for strong training in rese
created the expectation that students would become app

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Deny

The purpose of this article is to offer a more modest but realistic alternative for most marriage and family therapy (MFT) master's students, who constitute nearly three-quarters (Northey, 2002) of all MFT trainees. Although the Boulder ideal may be realistic for doctoral students, and those master's students who go on to pursue research careers, we believe it is not a good match for those MFT master's students who have primarily clinical career ambitions. The following article articulates a "research informed" perspective as opposed to the scientistpractitioner framework as a research-training model for clinically oriented MFT master's programs. We will discuss why the Boulder model may not be a good fit for this group of students and their programs. Then, we will highlight the similarities and differences of the two approaches. The heart of the article will be 10 ways to infuse research into programs that desire to remain clinical in focus, but also research informed. Our approach stresses the importance of a broad understanding of research in the curriculum and offers practical strategies for MFT educators to model research-informed behaviors to their therapists-in-training.

THE BOULDER SCIENTIST-PRACTITIONER MODEL IN MFT: A QUESTIONABLE FIT FOR PROFESSIONALLY ORIENTED MASTER'S PROGRAMS?

We think it is admirable that some MFT educators want to incorporate the traditional Boulder Scientist-Practitioner Model into training programs (Crane et al., 2002; Hodgson, Johnson, Ketring, Wampler, & Lamson, 2005). Furthermore, we acknowledge that it works well in some settings (Hodgson et al., 2005), although even these proponents note that it is "not the perfect solution" (p. 75) for MFT programs. We believe the Boulder Scientist-Practitioner Model was born (Raimy, 1950) in a context far different than the typical MFT training program. Clinical psychology was then and remains primarily a doctoral-level discipline. Doctoral programs in clinical psychology, especially those adhering to the scientist-practitioner perspective, devote more time early on in the curriculum to research training rather than clinical skill development. It is interesting that a major impetus for the Boulder Model was actually to infuse more clinical training into what were considered research-heavy programs - the opposite of the concern about many MFT

psychology doctoral programs, the only true prolonged

being a clinician comes during the required internship y

research training, to the exclusion of clinical training, is

oriented MFT doctoral programs. In those psychology p

the model, many of these students seek career paths in

fundamentally different environments from the clinical

graduates aspire to work.

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Marriage and family therapy is a master's-level-dominated discipline with only 22 Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) approved PhD programs versus 66 master's programs as of spring 2008 (AAMFT, 2008). Furthermore, MFT training programs traditionally have distinguished themselves from other mental health degrees by the high standards placed upon direct clinical exposure and face-to-face client contact hours. The MFT master's degree is typically a professional degree in some of the same ways the MD is a professional degree. However, just as MDs need to be research informed even though they typically do not do original research, the same is true for professionally oriented MFT students.

In developing such rigorous dedication to clinical training, most MFT master's programs do not have the time, the resources, or in some instances the inclination to emphasize rigorous research training - although there are some notable exceptions. We are aware of one master's program, Virginia Tech-Falls Church, where students regularly participate in randomized clinical trials (RCTs) research led by the faculty. We applaud and encourage these efforts, but the target audience for this article is the more professionally oriented programs. Most prospective students applying for these programs do not have a background or an appreciation for research (Crane et al., 2002); and most faculty in the professionally oriented programs are unlikely to train students to do original research, let alone do funded clinical trials. Of course, MFT master's students are a very heterogeneous group, and many either have a strong research interest or their programs cultivate one; but it would be blind to deny that many whose aspirations are strongly clinical have little proclivity for research. Therefore, it is clearly an educational challenge to expand student minds to a research-informed perspective, especially since as of spring 2008 only six COAMFTE programs (Auburn, Brigham Young, Colorado State, PurdueCalumet, Utah State, and Virginia Tech-Falls Church) require a master's thesis of all students. Furthermore, few programs offer any formal research training beyond the one research course mandated in the COAMFTE Standard Curriculum (COAMFTE, 2002).

While it might be theoretically possible to address these
programs less clinically intense, or trying to attract differ
oriented faculty, we take the position that it is a legitimat
profession to have a primarily clinically oriented master's
Again, the example of the MD degree is instructive. Most
aspire to be researchers, and few argue that all physician
original research on top of the rigors of learning to be go
enough challenge in itself. That some MDs do go on to b

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not detract from the value of strong MD-only programs. Similarly, we think it is a positive choice for many of our programs to focus on producing excellent practitioners, as that is also a significant challenge in itself. It is also a legitimate choice for these programs to choose a researchinformed model for their students and not try to produce scientist-practitioners. If a few master's programs are able to produce both strong clinicians and original researchers, that is certainly admirable; but it should not detract from the value of strong practitioner programs. Strong clinical programs should emphatically not be considered "second class," especially if they produce research-informed graduates.

THE SCIENTIST-PRACTITIONER MODEL VERSUS THE RESEARCHINFORMED PERSPECTIVE: SIMILARITIES AND DIFFERENCES

The research-informed perspective is not a radical departure from the scientist-practitioner model in that the two perspectives share several common goals. Both are concerned about integrating research and practice and want to avoid the "either/or" split that seems too often to put clinicians and researchers into two camps that do not talk with each other. Indeed, both want to find ways to bridge what is often called the "researcher/clinician gap" (Sprenkle, 2002). Both want to change the culture of family therapy (Crane et al., 2002; Liddle, 1991) from one that primarily values charisma and intuitive appeal to one that honors evidence. Both believe that the future of family therapy (including practical issues like employability and reimbursement) depends on demonstrating effectiveness and accountability. Both also believe that training faculty has a major role in bringing about these changes. Furthermore, as noted above, even though we are advocating the research-informed perspective, we are pleased when the scientist-practitioner model succeeds. Finally, we are confident that, conversely, all scientist-practitioner model advocates would support professionally oriented master's students becoming research informed.

There are, however, significant differences in matters of emphasis in the two models. The major difference is that the scientist-practitioner model emphasizes learning to do original research and is concerned with equipping students to ge
researchinformed perspective focuses more on integrati
practice. (Please note that scientist-practitioner advocate
integration, so we again want to stress that these are no
matters of emphasis.) Second, as noted previously, altho
settings, the context of the scientist-practitioner model is
is more likely to be utilized in an academic or applied res
perspective is a professional master's orientation and is

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with a strong clinical orientation. The scientist-practitioner model tends to emphasize rigorous quantitative and qualitative trainings, and there is a stronger emphasis on learning research methodology and statistics associated with cutting-edge methods. The research-informed perspective emphasizes a broad range of less formal research orientations. The scientist-practitioner model places a strong emphasis on RCTs outcome research, although it may also give attention to progress (Pinsof & Wynne, 2000) or client-focused research, which is a hallmark of the researchinformed approach.

Master's programs with a clinical emphasis need a systematic way to weave research findings and empirical support into curricula, while still maintaining the rich, applied theoretical base and systemic therapy training that are hallmarks of MFT education. With few role models within our own discipline (Crane et al., 2002), it is up to current and future MFT faculty to lead the way in disseminating this new ideology. Good research-informed habits should be developed early on in the training process and must be modeled actively by MFT educators. The following 10 principles are offered as guidelines to be infused throughout all didactic, supervisory, and clinical training components of MFT master's programs.

Share How Research Has Contributed to the Evolution of Faculty Members' Own Clinical Work and Professional Development

Marriage and family therapy faculty members will need to share how research informs their clinical work in order for students to have realistic working models for this "researchpractice link." Faculty, even when they are not themselves research active, should model a spirit of inquiry and life long therapist development. Given that even state-of-the-art knowledge is quickly outdated, faculty should inform students with engaging personal accounts on how keeping up with research developments can foster professional growth.

Faculty should share how they have used evidence over the years (whether from reading influential publications, using validated assessment instruments, learning empirically supported treatments [ESTs], or doing actual research) to update their clinical thinking. In doing so, they can explain to students how research has
treatment. For example, one faculty member was an ear
experiential techniques as central interventions to help c
enamored by the compelling, yet empirically unsupporte
Virginia Satir. With the advent of Emotion-Focused Thera
evidence to support his experiential clinical beliefs. Then
from a related body of literature, the attachment framew
cycles of couple interaction and update the EFT clinical m

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sharing his research-informed clinical journey, students appreciated the positive impact of research on his career development.

We are aware that some MFT faculty do not value research and that the culture of the MFT profession has itself not always valued research (Liddle, 1991). Furthermore, some MFT faculty may not think of research as important to their professional development. Sprenkle (2002) has written about the negative consequences of these attitudes and how it breeds a false dichotomy between practice and research in the same way there is a false dichotomy between art and science. While changing the culture of family therapy is beyond the scope of this article, we acknowledge that this first of our 10 points, as well as the suggestions that follow, cannot be implemented where such attitudes prevail. As a first step in raising awareness, we hope that such faculty might consider the ways in which research has disconfirmed some widely held clinical beliefs (see Point 4 below). We also believe that this antiresearch bias may be somewhat a generational phenomenon and that more recently trained MFT faculty are more likely to see the benefit of research for their development. However, we also acknowledge there is no empirical evidence to support this assertion.

Demonstrate How Supplemental, Nonclinical Research Findings Relevant to the Study of Marriage and the Family Can Be Used to Psychoeducate Clients in Session

Psychoeducation, if presented clearly and credibly, may be a powerful intervention for therapists-in-training to add to their growing skill set. Psychoeducation does not originate from clinical wisdom or pop psychology; rather, it is derived from research. The research-informed clinician must be aware of current research in family studies to be able to provide this information to clients.

While it is crucial to be a good consumer of research that is directly applicable to the practice of MFT, students should also be guided to explore nonclinical research that is relevant to working with couples and families. Instructors may aid students in this process by leading discussions in class designed to take findings from the classroom into the therapy room.

By studying supplemental, nonclinical research relevant
groundbreaking studies on marriages, therapists can dis
about their current relationships. For example, an expres
might enter therapy hopeless based on the faulty assum
failing marriage. Based on Gottman's longitudinal findin
clinician helps his or her clients learn that what separate

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couples is not whether they fight, but how they fight. Helping the couple to modify their conflict style may be a more realistic goal (Gottman, 1999).

As another example, no longer is the decision to divorce necessarily considered a failure or long-term deleterious outcome. E. Mavis Hetherington's (2002) longitudinal research, challenging previously held beliefs that all divorce will negatively impact children in the family system, found that problems of children in high-conflict marriages often decrease after a divorce. Ahrons's (2007) longitudinal research also showed that parental tension and child triangulation were more potent predictors of problems for offspring after 20 years than marital status. Therapists can incorporate these findings to engender hope for confiictual couples struggling with the decision to stay in a loveless relationship for the sake of their kids or for divorcing families attempting to co-parent in the best interest of their children.

Whether talking about the empirically derived factors that predict relationship success and failure, the impact of divorce on children, or other empirically derived information about couple and family processes, research comes alive when therapists integrate relevant findings into sessions. Citing current nonclinical research in family studies and human development both educates clients and serves to normalize their behavior.

Teach How to Locate, Comprehend, and Critically Evaluate Relevant Research Findings

It is essential to learn how to locate and interpret current empirical sources in order to be a research-informed clinician. Without developing these reading skills, how can an MFT stay current with the latest trends impacting clinical practice? Certainly, locating this material is a lot easier than it used to be with electronic searches and the advent of full text articles. Faculty can fairly easily guide students in how to access this material by incorporating literature search tutorials into their curriculums. Instead of assuming that students already know how to find such materials, guided walk-throughs of search engines like PsycINFO, Medline, or Google Scholar can help ease tensions of anxious students. Without providing guidance in this elementary step, students may become frustrated just trying to locate relevant sources, much less understand them.

Student members of American Association for Marriage
therapists-in-training, are supplied with online copies of
Therapy, an exemplar for integrating research and practi
materials is often another matter. Often research articles
novice clinicians can understand. As a result, the majority
scholarly journals (Johnson, Sandberg, & Miller, 1999).

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For this reason, we recommend that faculty do two things: (a) expose master's students to more easily digestible sources like Familytherapyresources.net (which comes complimentary with an existing AAMFT membership), The Psychotherapy Networker (which contains a consumer-friendly column, "Research Into Practice" by Jay Lebow), Family Therapy Magazine (which contains "Research Digests" and research-informed "Clinical Updates"), Psychology Today, and the New York Times (whose Science Section frequently contains research summaries relevant to clinicians); (b) actively mentor students through mechanisms like a journal club whereby faculty, alone or in teams, lead discussions of selected articles from leading journals like Journal of Marital and Family Therapy, Family Process, the Journal of Family Psychology, Family Relations, and the Journal of Consulting and Clinical Psychology. Research-naïve students find it much less intimidating to wade through methodology, results, and discussion sections if there are supportive mentors nearby.

Faculty can reinforce how these finding from the research articles can be applied in the clinical setting. Clinical supervision groups (as well as classes) might use the structure of Williams, Patterson, and Miller (2006), who have recently proposed a six-step model for using research to inform clinical work. The model begins with defining a clinical issue and then conducting the literature search. After selecting appropriate articles to read, the research-informed clinician must next evaluate the research quality and then synthesize the pertinent findings. The final step, according to the model, forces the clinician to decide how he or she will apply this newly acquired knowledge to a problem in his or her caseload.

Supervisors can facilitate this process. If a supervisee is having difficulty with a certain type of case or presenting problem, the supervisor may ask the therapist-in-training to conduct a relevant literature search to provide information about the etiology and appropriate treatment options. Consider a familiar example where a supervisee is frustrated with this repeated pattern between a couple: The husband continues to disengage at the slightest sign of argument, fueling the wife's desperation and demands for his attention. After consulting the research, the supervisee learns that generally it is the woman who raises and pursues the issues and the man who attempts to avoid t
This body of research also suggests that in unhappy mar
and women do not (Christensen & Heavey, 1990). The su
interventions and techniques to address this specific neg
this knowledge, the supervisee can consult with his or he
appropriate treatment plan. If this process is conducted
members may learn from their peers and expand their re
anticipation of encountering the same scenario later in t

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Regarding assessing some of the highlights of research quality, Jay Lebow (2006) offers the following straightforward questions that faculty may use in helping their students evaluate research: Who did the research? Where has the study been published? Has the conclusion been replicated in numerous studies? How well was the research conducted in terms of methodology? Is the study applicable to most people? How clinically significant are the findings? These questions force research-informed clinicians to actively engage their critical-thinking skills.

Demonstrate the Power of Research to Confirm/ Disconfirm Commonly Held Clinical Beliefs

A powerful way to drive home the importance of research is to show how it has helped to disconfirm previously held myths about clinical work. In rejecting these previously unsubstantiated beliefs, students can appreciate how research has increased this profession's stature. By demonstrating the benefits of relational therapies, research has carved out a place for MFT in domains dominated previously by individual approaches. For example, research has shown that couple treatments of family violence and substance abuse are in some circumstances preferable to standard methods.

Within the field of intimate partner violence (IPV), there is a popular belief about never treating couples conjointly. Batterers and victims are typically treated individually or in gendersegregated groups. Research conducted by MFT PhDs (Stith, Rosen, & McCollum, 2003), however, demonstrates that carefully conceptualized couples treatment that is supportive in nature appears to be at least as effective as traditional treatment for IPV. Couples therapy can provide a controlled, regulated structure for partners to discuss highly confiictual and emotionally charged topics. As relationship distress is a powerful predictor of partner aggression (O'Leary, Heyman, & Neidig, 1999), improvements in a couple's functioning combined with the acquisition of conflict resolution skills may reduce the reoccurrence of IPV.

Regarding substance abuse, traditions have held that partners be segregated, that treatment be confrontational, and that former addicts are the best
Therapy (BCT), a partner-involved nonconfrontational tre
teaches skills to promote partner support for abstinence
common relationship problems, has been proven to be b
stabilizing abstinence and improving marital relationship
research has demonstrated the effects of BCT on reducir
IPV among substance-abusing men and their female par
levels of violence (O'Farrell, Murphy, Stephan, Fals-Stewa

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have also shown that a history of previous substance abuse has no bearing on a therapist's results.

Advocate for the Inclusion of Multiple Types of Research Evidence

We advise educators to take a pluralistic approach to psychotherapy research (Sprenkle & Moon, 1996) and help students appreciate how a broad range of research methods can be systemically selected to suit specific research questions. While some questions clearly call for rigorous experimental methods, other legitimate research questions can only be addressed through qualitative inquiry (e.g., What do clients and therapists believe are pivotal moments in couples therapy? What distinguishes successful reframing interventions from those that were not successful?).

Often this type of research is initially more digestible and interesting to the MFT-in-training because of its applied nature and descriptive focus. Using Bradley and Furrow's (2004) task analysis work as another example, students may learn how an empirically validated model like EFT was improved through disciplined observation from actual therapy sessions. These authors used taped examples of effective and noneffective blâmer softening incidents to refine how a therapist can perform more competent softening interventions.

Clarify the Distinction Between "Efficacy" and "Effectiveness" Research and Explore Current Controversies Surrounding Empirically Supported Treatments

Understanding the distinction between efficacy and effectiveness is important to developing informed opinions about the controversies surrounding ESTs. Some of these controversies, like whether there should be an approved list of reimbursable treatments, have great practical as well as academic interest for master's students. Efficacy research is typically synonymous with internal validity and highly controlled RCT research, whereas effectiveness research is more associated with transportable mental health services research. Effectiveness studies are designed to test ecological validity. In other words, these studies help treatment developers to understand whether their intervention wil
settings. Faculty must help students understand that jus
be proven to be efficacious in an RCT, it does not guaran
effective in practical applications with typical clinicians in
things, RCTs use samples that are more homogeneous t
most clinics. Clinicians are often less willing to adhere to
adherence to treatment models than those used in resea
adherence is highly correlated with outcome (Wampold,

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A good starting point is to teach how a treatment comes to be classified as an EST as well as the various stages and components of the RCT (Chambless & Hollon, 1998). Then students can be made aware of the controversies surrounding ESTs, like whether they have given sufficient attention to differences among therapists (Blow, Sprenkle, & Davis, 2007). Recent publications, like Evidence- Based Practices in Mental Health: Debate and Dialogue on the Fundamental Questions (Norcross, Beutler, & Levant, 2005), can be incorporated into existing MFT curriculums to stimulate class discussion around these issues.

These discussions enhance critical-thinking skills and afford the opportunity to understand both the benefits of RCTs (which are clearly necessary for the profession to be credible to external audiences), as well as concerns about them. It is reassuring for students to know that ESTs are not simply good or bad and that even leading scholars disagree on these highly contested issues.

Outline the Historical/Theoretical MFT Roots in Current Evidence-Based Practices

We believe that faculty should stress that many current couple and family ESTs have roots planted firmly in the soil of traditional MFT models. To ignore this relationship diminishes our history and the links from the past to the present. Faculty can emphasize these connections and make the world of ESTs a less foreign and unwelcoming place. For example, when teaching about structural and strategic therapies, faculty can point out the connections between these classic models and the ESTs that address at-risk youths and their families, like Functional Family Therapy (Alexander, Pugh, & Parsons, 1998), Brief Strategic Family Therapy (Szapocznik & Williams, 2000), Multidimensional Family Therapy (Liddle, 1999), and Multisystemic Therapy (Cunningham & Henggeler, 1999; Henggeler, 1998). Most ESTs are themselves integrative and include components of traditional models. As another example, EFT, in addition to containing elements of structural and strategic therapy, integrates Satir experiential, clientcentered, and other systemic components (Johnson, 1996).

introduce "Progress Research" and, If Feasible, Incorporate Instruments Into Training That Give Therapists Direct Feedback

Progress research (Pinsof & Wynne, 2000), or research th
feedback while therapy is progressing, can be valuable t
because it gives clinicians firsthand insight into the chan
Sometimes called client-focused research (Howard, Mora
Lambert, Hansen, & Finch, 2001), this approach employs
and clinical tools. Instead of attempting to extrapolate fr

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outcome studies, this potentially user-friendly research focuses on whether or not a particular treatment is working for a particular client throughout the course of whatever method the therapist is using. This emerging technology, based on the dosage and phase models of psychotherapy (Howard, Kopta, Krause, & Orlinsky, 1986), has the capacity to (a) monitor treatment progress over the course of therapy, (b) provide feedback to clinicians, clients, and supervisors, and (c) predict client response based on an initial profile.

In typical outcome research, problems in treatment and therapeutic impasses cannot be detected in real time. By continually monitoring change using progress research tools, the research-informed clinician has the information to modify therapeutic approach and intensity, foster or repair the therapeutic alliance, and respond to inconsistencies in the treatment process.

While several established assessment instruments have been developed to measure change in individual psychotherapy, including the OQ-45, COMPASS, and ORS (Howard, Brill, Lueger, O'Mahoney, & Grissom, 1995; Lambert & Finch, 1999; Miller, Duncan, Brown, Sparks, & Claud, 2003), until recently MFT has lacked empirical tools to monitor how people change during therapy. A newly developed system for tracking client change and providing feedback to therapists during individual, couple, or family treatment is called the Systemic Therapy Inventory of Change (STIC; Pinsof et al., 2009). Both the STIC and its accompanying feedback technology will soon be offered at a nominal cost by the Family Institute at Northwestern University to all MFT and clinical psychology programs interested in tracking client change.

Educators should stress the value of getting feedback on trainees' work, regardless of what modality or model of therapy they practice. Students are already accustomed to getting feedback directly from their supervisors. Lambert et al. (2001) determined when client-focused feedback was provided to therapists, alerting them of potential treatment failure with at-risk clients, outcomes approved. Based on future trends and the influence of the managed care movement (Wampold, 2001), it appears that agencies that employ master's students will increasingly rely on some kind of feedback
students for this eventuality - especially as there is evide
improves their therapy.

Until computer feedback technology is available at the re
look for simpler and less expensive alternatives. As an ex
talkingcure.com, Scott Miller and Barry Duncan, have de
measures of process and outcome that can be used to tr

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By incorporating this feedback into supervision, faculty can model how research, in addition to theory, can guide clinical decision making. Just as supervisors utilize video or audio clips, they can also use client-focused technology like the STIC (Pinsof et al., 2009) as the focal point for supervisory sessions. STIC, for example, generates useful web-based feedback - including charts and graphs of initial client concerns and ongoing progress such as how the therapeutic alliance is changing.

Emphasize the Role of Common Factors, as Well as Model Specific Mechanisms of Change

Master's students, especially those taught a variety of models, often feel overwhelmed by competing claims. They also often feel low therapist self-esteem as they try to implement complex interventions. The common factors movement within MFT (Blow et al., 2007; Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004; Sprenkle, Blow, & Dickey, 1999) helps students to gain confidence that some of the things they typically already feel good about (like their ability to establish strong alliances with clients) are potent evidence-based contributors to change.

The moderate common factors approach (Sprenkle & Blow, 2004) stresses that although models are important to give coherence and direction to therapy, why they work has less to do with the uniqueness of the models and more with their ability to activate common mechanisms of change that are found in all effective relational psychotherapies (see Shadish & Baldwin, 2003; Shadish, Ragsdale, Glaser, & Montgomery, 1995, for a review of the empirical evidence). See also Davis and Piercy (2007a, 2007b) for a study in which the authors describe common change mechanisms in three MFT models that use very different language to describe what they do. While there is strong evidence for the effectiveness of certain approaches, there is not yet strong evidence for the relative effectiveness of the various models vis-à-vis each other. Knowing this information helps master's students realize they need not make a premature commitment to the superiority of any one model, even though there may be value in choosing a model that is a good fit for their own worldview (Simon, 2006). Believing in a model is itself a common factor asso
(Wampold, 2001).

Students can also be taught about the longer history of c
psychotherapy. Wampold (2001) offers an impressive me
argues that the medical model of psychotherapy, where
drugs in drug trials, is misleading since (among other thi
the treatment is typically more potent than the treatmen

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model as an alternative to the medical model, and students often find the former more simpatico with family therapy's emphasis on context.

Of course, the common factors movement is itself controversial. Sexton, Ridley, and Kleiner (2004) believe that common factors are too general and that therapists should turn to mature models of change for specific guidance. Faculty should encourage critical thinking around this issue, and actively help students to weigh the pros and cons of the common factors debate in interactive class discussions.

Refine Core Research Course Content to Promote Research and Practice Integration

Although COAMFTE (2002) requires accredited schools to have at least one MFT research class in the curriculum, there is great variability in the content of this course from institution to institution. Based on the guidelines set forth in this article, we offer an outline of what an MFT research-informed course might look like. For a complete syllabus, interested MFT faculty members may send requests to the first author.

Week 1: Overview/ What does it mean to be a research-informed clinician?

Week 2: How to locate, comprehend, and critically evaluate relevant research findings.

Week 3: Multiple types of research evidence.

* Components of EST/RCTs

* Outcome Versus Progress Research

* Quantitative Versus Qualitative Methods

Weeks 4-6: Family-Based Child and Adolescent ESTs.

* Multisystemic Therapy (MST)

* Functional Family Therapy (FFT)

* Brief Strategic Family Therapy (BSFT)

* Multidimensional Family Therapy (MDFT)

Weeks 7-10: Couple ESTs.

* Emotion-Focused Therapy (EFT)

* Integrative Behavioral Couples Therapy (IBCT)

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* Premarital Relationship Enhancement Program (PREP)

* Including partners in the treatment of alcohol and substance abuse

* Conjoint treatment of intimate partner violence

Week 11: Common Factors Research.

Week 12: Common Factors Versus Specific Ingrethents/ Medical Versus Contextual Model Debate.

Week 13: Using Nonclinical Research/ Psychoeducation.

* Gottman - predictors of relationship success

* Effects of Divorce on Children

Week 14: Using Research to Get Feedback on Your Work.

* Client-Focused Research

* Clinical Feedback Instruments

Week 15: Personal Integration of Research Into Practice Project.

As part of this course, we suggest encouraging students to develop a unique statement reflective of their personal journey in the integration of art and science. Similar to a "theory of change" article, which many MFT master's curriculums already require, programs can institute a "theory of research into clinical practice" assignment. The written portion of this project can be divided into three parts: (a) personal reflection on what it means to be a research-informed clinician, (b) critical analysis explaining how empirical findings from MFT and related disciplines are integrated into the student's primary theoretical orientation or integrated model, and (c) articulation and case examples of how research-informed practices have been utilized effectively in the student's own therap
this project may also take the form of a video presentatic
they have incorporated their unique research-informed p
their actual sessions. Examples might include (but shoul
using progress research instrument feedback in session,
clients, highlighting research findings to dispel myths or
attempting an empirically validated intervention, or usin

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of common factors (i.e., the therapeutic alliance). This assignment could be completed at the end of an MFT research course or as a graduation requirement.

CHALLENGES TO OVERCOME

Although the disadvantages of adopting such a research-informed approach seem minimal in comparison to the benefits, there are several challenges to overcome. First, faculty must be willing to commit to changing the MFT culture that many believe does not support research (Crane et al., 2002). Second, researchers must work harder to make their findings as accessible as possible by clearly and articulately spelling out the clinical implications of their work. A recent publication, Jay Lebow's Research for the Psychotherapist (2006), is an excellent example of how to distill psychotherapy research into concise, easily digestible segments for either the beginning therapist-in-training or the seasoned, veteran practitioner. Third, while we believe this article could be an early template and important first step in the process, the COAMFTE will probably need to support this perspective and develop more rigorous standards for research-informed training in master's programs. Furthermore, if this ideology is to be taken seriously, it also needs additional support from AAMFT, perhaps in the same way that the American Psychological Association appointed a Presidential Task Force on Evidence-Based Practice in 2005.

CONCLUSION

The goal of this article has been to present a realistic alternative to the scientist-practitioner model - the research-informed perspective. While we have highlighted differences, we have also stressed that the two approaches share common goals and that we support the scientistpractitioner model when it is feasible.

Our practical alternative rests in the belief it may be counterproductive to assume the scientist-practitioner model will work in all or even a majority of clinical master's programs. This is not joining these students where they are. Or, to use an analogy from the readiness to change literature (Prochaska & DiClemente, 1984), it is lik
are in the precontemplation or contemplation stage.

If our students are to value research, we must begin whe
consciousness about research. We hope that the 10 step
help faculty bring clinically oriented master's students to
researchinformed clinical practice. We believe this is an i
2-3 years of formative imprinting that occurs in a master
adequate exposure to a research-informed perspective i

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in professionally oriented programs will not likely pick up these skills in the workplace or private practice setting. A missed opportunity may become a lost opportunity both for the student and the profession of MFT.

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