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Trends and Problems in Marital and Family Therapy Research: Possible Use of Action Research

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Abstract: Although research in marital and family therapy (MFT) is becoming increasingly important, it continues to encounter several major problems. Studies have shown that research has very little influence on the practice of the majority of MFT practitioners. Practitioners see research as unrelated to their concerns. The practice of the majority of MFT practitioners is very individualized, as are the clinical problems and circumstances. Some have therefore started to emphasize the transferability of results instead of generalizability, and studying the practitioner's own practice instead of general concepts. Action research in the field of psychotherapy, as well as in the field of MFT, has been mainly overlooked as a potential method for solving these problems in MFT research. The paper addresses one of many possible ways to use the repeating cycles of the four basic steps in action research (observing and gathering information, reflecting, planning, and acting). The use of these four steps in action research enables therapists to study and improve their own practice in a more systematic, structured, and valid manner. This kind of research connects research and therapy. It is very individualized and oriented towards actions that create therapeutic changes.

Key words: action research, marriage counselling, family therapy, experimentation

Trendi in problemi v raziskovanju zakonske in družinske terapije: Možna uporaba akcijskega raziskovanja

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Povzetek: Čeprav raziskovanje v zakonski in družinski terapiji (ZDT) postaja vedno pomembnejše, se srečuje z nekaterimi večjimi problemi. Raziskave so pokazale, da ima raziskovanje zelo majhen vpliv na prakso večine zakonskih in družinskih terapevtov. Ti vidijo raziskovanje kot nepovezano z njihovim zanimanjem. Praksa večine zakonskih in družinskih terapevtov je zelo individualizirana, kot so tudi klinični problemi in okoliščine. Zato so nekateri začeli poudarjati transferabilnost rezultatov namesto generalizabilnosti in raziskovanje terapevtove lastne prakse namesto splošnih konceptov. Akcijsko raziskovanje na področju psihoterapije, kot tudi na področju ZDT, je bilo večinoma spregledano kot potencialna metoda za razreševanje teh problemov. Uporaba ponavljajočih se ciklusov štirih osnovnih korakov v akcijskem raziskovanju (opazovanje in zbiranje informacij, refleksija, načrtovanje in izvedba)

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je možna na različne načine, ta članek pa opisuje enega izmed njih. Uporaba teh štirih korakov akcijskega raziskovanja omogoča terapevtu, da raziskuje in izboljša svojo lastno prakso na bolj sistematičen, strukturiran in veljaven način. Ta vrsta raziskovanja povezuje raziskovanje in terapijo. Je zelo individualizirana in usmerjena k akcijam, ki omogočajo terapevtsko spremembo.

Key words: akcijsko raziskovanje, zakonska terapija, družinska terapija, raziskovanje

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Eysenck (1952) reviewed 24 studies and concluded that psychotherapy is no more effective with neurotics than is spontaneous remission. This represented the first great challenge for research in psychotherapy. Although Eysenck's findings were broadly criticized, they also provided a great incentive to seek proof of the effectiveness of psychotherapeutic services. Today it has been empirically confirmed that psychotherapy generally produces beneficial effects (Kopta, Lueger, Saunders, & Howard, 1999).

In the past few years, effectiveness research—which deals with the extent to which clients change over the course of therapy and generally uses randomized clinical (i.e., controlled) trials in which treatment subjects are randomly assigned to experimental and control groups under carefully monitored conditions—has also become an economic, professional, and ethical necessity in marital and family therapy (MFT). Increasingly, insurance companies and government agencies have begun to expect documentation on the appropriateness of the care that MFT provides, and to insist that MFT conform to the standards of "evidence-based practice" (Greeno, 2001; Pinsof, 1997).

Similar to effectiveness research is efficacy research. Effectiveness research refers to therapy outcomes in routine, everyday practice, whereas efficacy research refers to therapy outcomes in a research setting, in which therapists are usually well supervised, practice is applied with greater precision, clients are carefully selected, and the therapist and researchers can be particularly enthusiastic.

Increasing evidence supports the efficacy of family-based psychotherapies for a variety of psychological disorders (Diamond, Serrano, Dickey, & Sonis, 1996; Pinsof & Wynne, 1995; Sprenkle, 2002). There is compelling evidence that MFT is making significant progress toward becoming an evidenced-based discipline (Sprenkle, 2003). In certain areas (e.g., drug abuse, conduct disorder and delinquency, alcoholism, and family management of schizophrenia) the most high-quality, accretive, programmatic research has taken place, and family therapy research has clearly established the effectiveness of family therapy (for a review cf. Sprenkle, 2002).

There are also other important kinds of research on MFT in addition to effectiveness and efficacy research. Although effectiveness and efficacy research has been and still is quite necessary, successful and fruitful, according to some research-

ers (e.g., Elliot, Slatick, & Urman, 2001; Johnson, 2003) certain major problems encountered today in research in MFT (and in therapy in general) are mainly the consequence of the predominance of this type of research over other types.

Problems in research on MFT

Gap between research and practice

As in psychotherapy in general (e.g., Fonagy et al., 2002; Heppner, Kivlighan, & Wampold, 1999; Kopta et al., 1999; Strupp, 2001) the gap between psychotherapy research and clinical practice has also been wide, and especially so in MFT (e.g., Sprenkle, 2003). Studies have shown that research has almost no influence on the practice of the majority of marital and family therapists (e.g., Pinsof & Wynne, 2000). In spite of several decades of appeals to bridge the researcher-clinician gap (Breunlin & Schwartz, 1983; Johnson, 2000, 2003; Liddle, 1991; Olson, 1976; Pinsof & Wynne, 2000; Sprenkle, 2003), the problem is still significant. This is somewhat ironic given that the early family therapy pioneers considered themselves to be "family researchers" (Wynne, 1983). Family therapy had its roots in research (Sprenkle & Moon, 1996). Now, however, therapists see research as unrelated to their concerns, irrelevant, or incomprehensible (e.g., Cohen, Sargent, & Sechrest, 1986; Sandberg, Johnson, Robila, & Miller, 2002). Some see a system perspective as incompatible with traditional research designs (Lebow, 1988).

This gap leads to questions about reasons for this situation—what it is in current research that makes therapists not see it as useful (e.g., Pinsof & Wynne, 2000). The practitioners in the Sandberg, Johnson, Robila, & Miller (2002) study noted that research would be more applicable to clinical practice if it could reflect what is really happening in the field. Even those studies that do relate directly to the day-to-day practice of therapy appears to be written in a "dry and boring" or overly complex way. Numerous additional responses called for more research updates that are easy to read and directly related to clinical practice (Sandberg, Johnson, Robila, & Miller, 2002). Many authors (e.g., Johnson, 2003; Pinsof & Wynne, 2000; Sprenkle, 2003) emphasize that studies have shown that practicing therapists do seek and want research that focuses on the therapist's and/or client's behavior, leading to important moments of change during therapy—in other words, what in the process of therapy brings change. Therapists want information regarding the "next move" during treatment. Although they ask some of the same questions that traditional (outcome) researchers have asked (e.g., "Does this therapy model work?"), they are also interested in more practical concerns, such as: "How are my clients responding?", "Who should be present at the next session?", "How can I best help this substance abusing adolescent?", or "Is this couple ready to terminate?" (e.g., Sprenkle & Moon, 1996). More evidence is needed to further understand how change occurs within relation-

ships (Hodgson, Johnson, Ketring, Wampler, & Lamson, 2005).

Perhaps practicing therapists see little value in research because it was too often performed for scholarly interest rather than for clinical application (Kopta et al., 1999). One of the most important contemporary trends in psychotherapy research is that it is trying to come as close as is possible to practice (e.g., Johnson, 2000; Kopta et al., 1999; Strupp, 2001). It is about helping therapists, not proving the successfulness of one school or model against other schools. In effectiveness research it is difficult to find what it is in therapy that has worked and how it has worked. If one says that something has worked but cannot specify what has worked, this directly opposes the criterion of replicability in scientific research. If one says that psychoanalytic therapy was more helpful than client-centered therapy, it is of minimal value if the researcher cannot specify what actually happened in the therapies.

In response to these demands and in opposition to the form of research that has prevailed so far—that is, effectiveness and efficacy research—researchers started to use research methods that focus on change process or process research (e.g., Johnson, 2003). This kind of research is helpful for deciding what to do with certain clients at certain moments in therapy (Persons & Silberschatz, 1998; Pinsof & Wynne, 2000). It investigates what occurs within a therapy session and strives to identify the active ingredients within the "black box" of therapy that lead to change. It explains *how* and *why* change occurs in therapy. The rationale of process research is that by increasing the understanding of human change processes, greater control can be obtained in the effective design and delivery of therapeutic interventions (Diamond & Diamond, 2001; Elliott, Slatick, & Urman, 2001; Greenberg & Pinsof, 1986; Johnson, 2003; Kopta et al., 1999).

Studying therapy used in practice

The next problem is that the most frequently practiced and most rapidly growing type of treatment in general and in the field of MFT, eclectic therapy, is still poorly defined and inadequately researched. Nonetheless, this movement in clinical practice may be the phenomenon that best defines psychotherapy's maturation process (Kopta et al., 1999). The strict therapeutic protocols that are necessary for comparing global therapeutic models and are most frequently used in randomized clinical trials are not representative for the eclectic (the use of various therapeutic intervention models) or integrative (techniques or theoretical tenets from diverse treatment approaches try to be linked by an overarching organizational or conceptual framework) practice of therapy, which is together with systemic (Johnson, 2003) the most common for the majority of marital and family therapists (Lebow, 2003; Pinsof & Wynne, 2000). Rather than adhering to one model, marital and family therapist usually use multiple models or treatment approaches in an effort to help their clients (Pinsof & Wayne, 2000). Although poorly researched, eclectic marital therapies have clear empirical support in meta-analytic research (Shadish & Baldwin, 2003). When tailoring couple therapy to individual differences, a moderate level of eclecticism affords the best

outcome. It is also hypothesized (Snyder, Schneider, & Castellani, 2003) that at some intermediate range of eclecticism, treatment outcome is optimized by the therapist's ability to draw on diverse interventions targeting unique attributes of clients' individual or relationship functioning that lie outside the domain of any one system or school of therapy. A higher level of integration provides some protection against the weakening effects of high levels of eclecticism.

Therapy manuals

There is also a problem with the use of therapy manuals in outcome research, which is an APA requirement for the recognition of "empirically supported treatments" or ESTs (e.g., Chambless et al., 1998; Duncan, 2002; Kopta et al., 1999). This is especially problematic in therapies that do not use one-dimensional interventions narrowly focused on one symptom and that are not truly formulaic. For these kinds of therapies, manuals are not therapy. The nuances and creativity of an actual encounter flow from the moment-to-moment interaction of the participants, not from Step A to Step B. Experienced therapists know that psychotherapy requires the unique tailoring of any approach to a particular client and circumstance (Duncan, 2002). Simply put, psychotherapists do not do therapy by the book (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Henry, Strupp, Butler, Schacht, & Binder, 1993). Manuals also cannot take into account individual differences between therapists and clients. It is not possible to spell out factors of the quality of a relation in a manual (Strupp, 2001).

However, I agree in part with Johnson (2003), who does not believe that manuals are useless, especially if they are written in a style that simply offers a prototype and a guide to the focus and structure of therapy. Manuals can also improve the training and practice of practitioners. However, it is important that therapists study their clients themselves, and add to and reshape the interventions that are described in the manual.

Symptomatic reduction as a relevant positive outcome

There is also a problem in the use of symptomatic reduction of DSM-IV diagnosis as the only relevant positive outcome of psychotherapy. Not all therapies rely on symptom change as the dependent variable. Such a dependent variable is more characteristic of cognitive behavioral therapies. Psychoanalytic treatments aim more than anything at relationship change (e.g., Hinshelwood, 2002).

Furthermore, it is known that symptoms are erratic, that if one disappears it may give way to another, that some symptoms are useful because they are part of defenses and their careless destruction might be dangerous, etc. (Fonagy et al., 2002). This is even more problematic if one takes into account the client's family; family therapy showed that symptoms that vanish from one part of the family system may arise in a refashioned form in another part (e.g., Erzar, 2002; Gostečnik, 2002, 2004;

Kompan-Erzar, 2001, 2003). One also has to take into account the rather frequent cases in which treatment comes to an end without any noticeable improvement, but in which one is justified in thinking that the situation would have been far worse without such treatment (e.g., cases of patients that may have thus avoided inpatient psychiatric care) (Fonagy et al., 2002).

Individualized practice of every MFT practitioner and the use of transferability instead of generalizability

The next problem is that every (MFT) therapist and his practice is something very individualized, especially in some sorts of therapy that are less structured and provide more space for aspects of the therapist (for example Gostečnik, 2002, 2004; Kompan-Erzar, 2003). In some studies, the variance attributable to therapist differences has been greater than the variance attributed to treatment differences (e.g., Crits-Christoph et al., 1991, Crits-Christoph & Mintz, 1991). Wampold (1997) has described this situation:

> We suspect that a great deal of the variance in success of (basketball) teams is due to the players' ability, institutional support, and motivation and very little is due to whether the teams play man-to-man defense or zone defense. If the goal is to identify the most important factors related to winning records so coaches could build the best teams possible, it would make little sense to arrange studies that examine the type of defense used by homogenizing players' abilities, institutional support, and so forth. Why then are we trying to homogenize therapy and therapists, when we know that these very variables contribute to much variance in outcomes, so that we can examine differences between treatments, when treatment differences historically have accounted for so little variance? (p. 34)

Thus, instead of studying certain general conceptual frameworks that should work for everybody, it is desirable for MFT therapists to study their own practice and try to determine what is most effective for them. With this in mind, one could also better understand findings that indicate, for example, that in reality psychoanalytic clinical practice is not logically deducible from psychoanalytic clinical theory, but instead largely on the basis of trial and error (Fonagy et al., 2002). In addition, every family, every marriage, every client, every relation, and every therapy is specific. The problem is also similar in other types of psychotherapies. Beutler (1991) calculates that about 1.5 million interactions between potentially important patients, therapists, and therapy variables would have to be studied in order to evaluate all relevant differences among treatment types. Pine (1998) suggests that it is no longer useful to look for a single model of therapeutic action in psychoanalysis, and that the mechanisms should be individualized according to patient and therapist. Pinsof & Wynne (2000)

emphasize the idiographic (i.e., particular to the case in question) nature of MFT.

Thus there is a problem with generalizing the results of certain type of studies, especially randomized clinical trials. This is why some emphasize transferability instead of generalizability (Barnes et al., 2005; Kendall & Southam-Gerow, 1995; Lincoln & Guba, 1985; Zyzanski, McWhinney, Blake, Crabtree, & Miller, 1992). Transferability refers to how much some results (e.g., what was successful in one therapy) can be transferred to another practical situation. The emphasis is not on common properties of participants (e.g., that all participants have depression), but on describing and specifying the circumstances and situations of a therapeutic case or moment. The reader can then transfer the results of research into his own therapeutic practice and consider differences between situations. Research is moving in the direction of appreciating microscopic research on the therapeutic process, especially in the context of well-informed case studies (Strupp, 2001).

Synopsis

Randomized clinical trials have their own important place in psychotherapy research. They can provide valuable information about psychotherapeutic efficacy (e.g., whether a type of psychotherapy can possibly work under certain conditions). Randomized clinical trials are important to the field because they are widely recognized by the scientific community and funding agencies as providing valid proof of effectiveness. Although there are limitations to randomized clinical trial research, some of which are noted above, they remain the "gold standard" for recognition by the scientific community and by external audiences (Sprenkle, 2003). Practitioners also have an ethical responsibility to their clients and to themselves to demonstrate that what they do is efficacious. I agree with Sprenkle (2003) and Goldfried & Wolfe (1996), however, that this kind of research methodology may have obscured other important research methods that have not received much attention.

Researchers have tried to solve some of the problems described above through process research.

Process research

Important process research methodologies include significant event text strategies—for example, task analysis, which focuses on identifying the steps or stages involved in the resolution of certain phenomena that are of therapeutic interest, and the therapist interventions that facilitate those stages (Pinsof, 1997; Rice & Greenberg, 1984)—conversational analysis (which studies how speakers perceive each others' utterances, based on how they respond to each other), and perhaps grounded theory methodology, which focuses on the generation of theory mainly through an inductive examination of participants' descriptions of their experiences (cf. Glaser & Strauss,

1967; Strauss & Corbin, 1990).

However, the most frequently used process research methodology has studied the therapeutic process through coding systems, in which frequency counts of variables across sessions were correlated with other processes or outcomes (Diamond & Diamond, 2002). Studies using a coding system generally focused on more specific clinical phenomena or variables such as client and therapist characteristics, the therapeutic bond, therapeutic interventions, and patient psychological functioning (Diamond & Diamond, 2001; Elliott, Slatick, & Urman, 2001; Greenberg & Pinsof, 1986). Such studies usually quantitatively measure in-session processes on indices of quantity (e.g., number of interpretations in a session) or intensity (e.g., degree to which the therapist was empathic). This kind of process research has also yielded disappointingly general or contradictory results (Orlinsky, Grawe, & Parks, 1994; Shapiro, Harper, Startup, Reynolds, Bird, & Soukas, 1994; Stiles, 1996; all cited in Elliott, Slatick, & Urman, 2001). Researchers have failed to demonstrate any kind of consistent relationship between in-therapy therapist behavior and patient behavior, or between both of these and patient outcome, except for finding a certain degree of a positive relationship between the therapeutic alliance (an interactive variable measured through patient self-reports) and outcome (Pinsof, 1997; Pinsof & Wynne, 2000). There is also much criticism (e.g., Diamond & Diamond, 2001; Elliott, Slatick, & Urman, 2001; Stiles, 1996; Stiles & Shapiro, 1994) of the quantitative process-outcome paradigm on various grounds, mostly having to do with the simplistic assumptions it makes about the nature of the therapy process (e.g., if something is good, then more of it must always be better). For example, knowing that 10 interpretations per session is more strongly correlated with outcome than 20 interpretations does not really help the therapist know when to use interpretations. Such research designs with coding systems are also blunt instruments for understanding anything as complex and nuanced as the process of change in psychotherapy (Elliott, Slatick, & Urman, 2001), although they may have come important value.

No process research methodology, and especially methodologies using coding systems, yields satisfying results. Many process researchers have responded by calling for more open, discovery-oriented methods for understanding therapeutic change and shifting focus from hypothesis testing or predictive methodologies to a discovery-oriented research paradigm (Diamond & Diamond, 2001; Elliott, Slatick, & Urman, 2001; Greenberg & Pinsof, 1986; Rice & Greenberg, 1984; Sprenkle & Moon, 1996).

Possibility of action research

There is one other interesting research methodology that in our opinion has been mainly overlooked in the field of psychotherapy research and in the field of MFT. Because of constantly adapting therapeutic interventions and stances to the individual characteristics of the course of treatment (for example Rožič, 2004) and

the problems of research in MFT, described above, at Ljubljana's Franciscan Family Institute we have started to develop the use of action research methodology for studying marital and family systems and therapy (see for example Cvetek, 2004). In the time of writing this article one description of the use of action research specifically in the field of marital and family therapy has been published (Mendenhall in Doherty, 2005), that has some differences from our approach. It emphasizes different elements of action research (for example inclusion of local community in research) that will be described in the continuation.

There are many reasons why we think action research methodology is very useful for studying MFT. The objective of action research as a research strategy is to reach an interaction between practice and theoretical research. It aims to solve current practical problems while expanding scientific knowledge. Unlike other research methods, in which the researcher seeks to study phenomena without changing them, the action researcher is concerned with creating change in the phenomena studied and simultaneously studying the process (Baburoglu & Ravn, 1992). This kind of research methodology is very close to therapeutic practice; it is very individualized and contextually oriented, it is characterized as being problem focused, involving change and aiming at improvement, and it may be an important bridge between research and therapy. It is performed by therapist-practitioners themselves. In fact, it is very similar to therapeutic work, in which in general there are two phases of work—therapy and analysis of therapy and supervision—only that it is more methodologically rigorous, systematic, structured, and valid.

"Action research is simply a form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own practices, their understanding of these practices, and the situations in which the practices are carried out" (Carr & Kemmis, 1986, p. 162). In action research researcher studies the family system through action. Kurt Lewin, the founder of action research, said that it is only possible to understand a social system by trying to change it (Carr & Kemmis, 1986). This is what therapists try to do. Elliott (1991) notes that a desire for innovation and implementing change is a prerequisite for action research.

This kind of research is especially suitable for studying MFT, because a social *system* is being worked on. The methodology of action research is very well known in the field of teaching. It is used by teachers that want to achieve certain changes in class (to improve social relations among students, to improve the participation of students in teaching, etc.). The use of action research is also often used in the field of nursing and some others.

According to Hyrkas (1997), "the most characteristic feature of action research is considered to be the spiral-like progress with alternating phases and cycles that evolve over a period of time" (p. 802). Action research involves a spiral of steps, which consists of: (1) observing and gathering information, (2) reflecting, (3) planning, and (4) acting (Figure 1).

Action research could be considered further as a way of organizing research

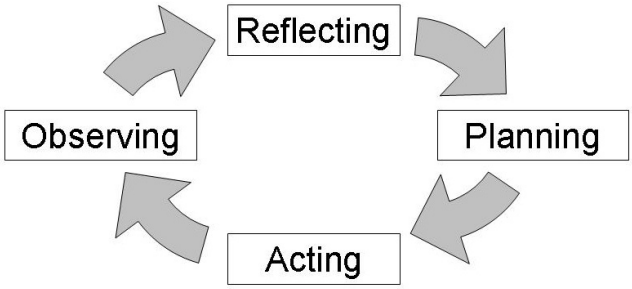

Figure 1. Steps in action research.

and practical actions rather than as a method in its technical meaning. Many methods and techniques can be applied in research organized in this four-step action research model. Studying different possibilities of the four steps in action research for use in MFT research is still in progress and will probably remain so because organizing this kind of research allows a great deal of free space for useful innovations. For example, these four steps can be applied so that there is one cycle for one therapy session (in the therapy sessions, planned actions are carried out, information is gathered in the session or after it, and then reflection and planning is possible and new plans can be carried out in the next session), they can be used less frequently (e.g., when therapy gets stuck), or perhaps even all four steps can be used in the session.

Currently the most promising form of action research that has proved the most useful at our institute is the use of one cycle for one therapy session (described above):

1. Observing and gathering information.

In this step the therapist describes and defines (usually after the therapy session) what has happened, what the current situation is (what the problem is), and what the context is. The therapist can describe what is known about client system so far, what actions have already been carried out and what outcomes were achieved, and how and why these differed (if so) from what was expected. In order to improve the validity of the descriptions, it is desirable to involve the results of questionnaires, scales, observations, and information to provide evidence for the conclusions.

2. Reflecting.

The situation and problem are interpreted, analyzed, and explained. It is determined what theory would say about the problem and the therapists may form their own theories about the specifics of the case. The worth, effectiveness, appropriateness, and outcomes of activities already carried out are evaluated and the therapists define what has been learned about the therapy, relations, themselves, and so on from

previous actions.

Here it is worth mentioning that the explanations and theories about a case need not be absolutely grounded in solid proof, although one tries to come close to this in order for the study to have the best possible research contributions and value. However, it is not necessary (and in clinical practice it would probably be too difficult) to find proof for explanations and theories, especially because one can view them as some kind of hypothesis that can and will be tested in the following cycles. Intuition can also be used in the process of explaining and theorizing. In our experiences we have also found that reflecting itself could change the researcher-therapist's stances and relations to the clients, that is very important in some form of marital and family therapy (for example Rožič, 2004). Sometimes the reflection could be considered as a kind of intervention, especially if supervision is included in the reflection, which makes planned activities possible to perform.

3. Planning.

At this stage, on the basis of the information gathered and reflection, the therapist defines the outcomes he hopes to achieve in the next therapy session and why he believes they are worth pursuing (the contributions he expects those outcomes to make to the long-term goals, or solutions, and why he expects them). The therapist describes the actions he is planning to take to achieve these outcomes, how these actions can be carried out, and why he thinks these actions will achieve desirable outcomes in the particular situation. One can define theoretical constructs or ideas that provide a foundation for the planned actions and solutions.

4. Acting.

In this stage, planned activities (usually in the therapy session) are carried out. This is a description of one cycle of action research. The value of action research especially lies in repeating cycles of these four steps. In the subsequent cycles it is possible to also check accomplishments of this cycle and properly adopt subsequent actions. The use of assessment instruments (such as questionnaires and tests) with high validity and reliability to further corroborate findings is also recommended.

Such action research is characterized by strong involvement of research (findings) and theory in action (research findings provide feedback) and linking research with planning and action in iterative cycles.

As mentioned, the only published description of the use of action research specifically in marital and family therapy is in Mendenhall and Doherty (2005), and even there the emphasis is on studying (local) communities (in a broader sense than families). There have been some calls for increased visibility and implementation of action research from organization like Collaborative Family Healthcare Association, Society for Teachers in Family Medicine, the Families and Democracy Project/Center for Citizen Health Care. But these (including Mendenhall and Doherty, 2005) in con-

trast with us emphasize some features like "collaborative stance between researchers and participants" and "a local community focus" as essential features of action research. Sometimes these kinds of research are also called Community-based Participatory Research. At our Institute we think that diffferent ways of using principles of action research are very welcomed and desired. They enrich the field of research. But in our way of using the principles of action research, the essential feature of action research is the use of the spiral of four steps (Figure 1), not the necessary inclusion of local community in action research or inclusion of research participants in all phases of action research. There are some authors (for example Hyrkas, 1997) that support our understanding. We think it is problematic to consider local communities as families, because they have differrent characteristics and require different approaches. We think the field of marital and family therapy research would suffer a great loss with limiting the action research to studying (local) communities. Although also discussible, we think that in some studies the role of therapist as researcher (as opposed to therapist *and* clients—participants—as researchers) in action research is preferable, especially in some difficult cases. Certainly in the cases where the inclusion of clients is possible and useful for clients (for example in the planning step), it should be done. Because of the differences in the understanding of some features of action research, we could present our kind of research with the working name: therapist's action research.

This kind of action research may represent some solutions to problems faced by MFT research today and described in this article. In their conclusions to their study on barriers to researcher-clinician cooperation, Sandberg, Johnson, Robila, and Miller (2002) stated that: "in-depth case studies of mutually beneficial, collaborative relationships where clinically relevant and applicable research is the major outcome would be of great value" (p. 67). This kind of action research has probably even more advantages than case studies because of the use of the clear four steps. Based on transferability, it is useful for other practitioners because it is focused on the "next move" during treatment and on actions that bring important changes during therapy. This is what practicing marital and family therapists want and expect. It is also very individualized and personal, very adapted to individual problems, the client system, circumstances, and the therapist, and so on.

This kind of research is also related to what Howard, Moras, Brill, Martinovich, and Lutz (1996) called "client-focused research" and what Pinsof and Wynne (2000) called "progress research". Pinsof and Wynne (2000) stressed the importance of feedback in the course of treatment to make decisions about the therapist's next move and the importance of means for obtaining information about client change systems during therapy. They also emphasize that both efficacy and effectiveness research suffer from a uniformity myth, and that the best therapy is "disciplined improvisation". Sprenkle (2002) came to the conclusion that all of these would require more attention to proximal outcomes, rather than just final outcomes at the end of therapy, and that this is an area that will require a great deal of effort in the future.

Despite of some of its limitations, action research can be a helpful tool in these efforts.

Problems of action research

Action research is often seen as inappropriate for producing findings with high external validity, i.e. findings that are valid outside the context of the action research (Berkowitz & Donnerstein, 1982; Cook & Campbell, 1976). It has a low control of variables in the study. Fundamentally positivist views reject action research because the methods and findings of any one study are not replicable in another situation, and action research therefore lacks generalizability. Francis (1991; cit. in Kock, McQueen, & Scott, 2000) also emphasizes the problem of personal over-involvement, which may hinder good research by introducing personal biases in the conclusions.

The higher reliability and validity of the instruments for data collection and analysis used in action research can be helpful. Because of successive iterations in the action research cycle, disconfirmatory evidence in further iterations may help correct distortions in the findings of previous iterations. As stated previously, there is also a problem with the generalization of findings in MFT research, and one suggestion is the use of transferability instead of generalizability. Although the findings may be individual, unique, and specific, they can be useful in other practical situations. In order for the reader to successfully transfer the findings of action research study to his own case, important specifics of action research study must be described.

Waterman (1998) and Badger (2000) proposed three categories of validity that should be considered in action research: dialectical, critical, and reflexive validity. Dialectical validity refers to the constant analysis and report of movement between theory, research, and practice in examining the tensions, contradictions, and complexities of a situation. Critical validity involves analyzing the process of change, but the measure of validity is not the degree of change effected, but rather the analysis of intentions and their ethical implications and consequences. Reflexive validity is the researcher's recognition and exploration of biases, demonstrating validity by considering the process of interpretation.

One issue in this kind of research in MFT that has turned out to be problematic at the realization level is that sometimes it is hard to carry out planned activities. They may no longer be appropriate for a current situation. Families and marriages are systems that change, and between two therapeutic sessions many things can happen. Therapists-researchers must evaluate the current state and assess whether the planned actions are still appropriate. If not, they should not insist on the planned actions and should adopt or even abandon them. The latter case is likely very instructive for understanding the therapeutic situation and valuable for forming more effective planning of actions and their realization. Some could argue that it is senseless to plan future therapeutic actions because therapists should consider the current therapeutic situation that clients bring to the therapy session and act according to this and not

according to their planned actions. I agree with that—a therapist should consider therapeutic situation, but the therapist should also know, at least in general, in which direction solutions for clients exist. This issue also opens the question of how possible and useful more concrete or global, or more short-term or long-term, planning is in different therapeutic approaches. This should be answered in future studies of action research.

Conclusions

We can say there is not only one, single good simple method in MFT research. There are some good methods (some of them mentioned in the article) that have their own strengths and weaknesses. Action research also has its own limitations and variations. However, the use of a wider range of methods can yield further payoffs for therapy researchers (Elliot, Slatick, & Urman, 2001; Sprenkle & Moon, 1996). Action research encourages research from a wide variety of perspectives. Different questions require different methods. Furthermore, methodological pluralism allows the application of multiple research methods to the same research question or data. Different approaches can corroborate, enrich, or qualify each other, making possible a much richer overall understanding of therapy.

Johnson (2003), in describing new directions in couple therapy, said:

> Perhaps we also need to change our mindset regarding research. […] Surely, the passion of clinicians to understand problems and shape more powerful interventions can be at least as generative as large research grants and complex statistical analysis. […] Perhaps […] more emphasis [needs to be] given to the wisdom of clinicians rather than the rigors and requirements of complex statistical methods that were originally formulated to study samples of seeds, samples of thousands. We do not need to use the model of abstract science as the only guide. […] We do not need to indulge in "physics envy". We can put the needs of the practitioner first and still be scientists. […] The field of couples therapy appears to be in the process of integrating description, prediction, and explanation. Theory, practice, and systematic investigation are beginning to create a coherent whole. (pp. 377–379)

Action research appears to be one step further in this direction.

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