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Introducing SYPRENE: An International Practice Research Network for Strategic and Systemic Therapists and Researchers

GRÉGOIRE VITRY*,†,‡
NATHALIE DURIEZ§
SOPHIE LARTILLEUX-SUBERVILLE¶
RYTIS PAKROSNIS**
ALEXANDRINA BEAU††
TERESA GARCIA-RIVERA‡‡,1
OLIVIER BROSSEAU*
PEDRO VARGAS AVALOS§§
ERIC BARDOT¶¶
WENDEL A. RAY***

SYPRENE, a new international Systemic Practice Research Network (PRN), has been established to fill the gap in practice-based research on the effectiveness and efficiency of strategic therapies. This article presents the rationale for the creation of SYPRENE and describes data collection methods, and the encoding system implemented within this PRN. More developments are expected in the recruitment of practitioners, the types of data collected, findings, and the implementation of SYPRENE in supervision, trainings, and professional schools.

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STRATEGIC THERAPY

Strategic therapy is an application of systems theory and is founded on the fundamental idea of "approaching human relationships with an interactional view" (Watzlawick & Weakland, 1980). Jay Haley (1963), influenced by his studies with Milton Erickson,

*LACT, Paris, France.
† University Paris Descartes, CERMES3, Paris, France.
‡University Paris 8, Laboratoire de Psychopathologie et Neuropsychologie, Saint-Denis, France.
§University Paris 8, Saint-Denis, France.
¶Mental Research Institute, Palo Alto, CA.
**Vytautas Magnus University, Kaunas, Lithuania.
††UTHEF, Psychotherapist Center of the Hospital of Nancy, Nancy, France.
‡‡CIRCÉ, Paris, France.
§§Residencia de Terapia Familiar - UNAM - Facultad de Estudios Superiores Zaragoza, Mexico City, Mexico.
¶¶Institut MIMETHYS, Nantes, France.
***University of Louisiana-Monroe, Monroe, LA.
Correspondence concerning this article should be addressed to Grégoire Vitry, LACT 132, Rue Montmartre 75002 Paris, France. E-mail: gvitry@lact.fr.
[1]Deceased.

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popularized the term *strategic therapy* and defined it: "Therapy can be called strategic if the clinician initiates what happens during therapy and designs a particular approach for each problem" (Haley, 1973, p. 1). In the 1980s, strategic therapy flourished in three unique and creative groups: (1) the Mental Research Institute (MRI) in Palo Alto, California, with later collaborations with Centro di Terapia Strategica in Arezzo, Italy; (2) the Family Therapy Institute in Washington, D.C.; and (3) the team of Mara Selvini Palazzoli and her colleagues in Milan, Italy. The essence of these strategic therapies is an interactional-systemic perspective that favors short-term problem-solving approaches. Therapists using this approach treat patients[1] suffering from a wide range of mental disorders, usually within 10 sessions (Weakland & Fisch, 1992, 2010; Weakland, Fisch, Watzlawick, & Bodin, 1974). There are now many propagations and hybrids that address positive feedback loops, successful and unsuccessful attempted solutions, paradoxes and counter paradoxes, hierarchies, and first-order versus second-order changes by using strategic therapy methods such as reframing and utilization and behavioral directives such as symptom prescription, ordeals, and acting "as if" (Hoyt, 2019).

In strategic therapy, the practitioner identifies who is involved in a problematic situation in order to target for the intervention the most mobilizable patient, dyad, or group. The central evaluation focuses on the concept of problem-solving (Weakland et al., 1974). The practitioner questions the patient(s) to determine a clear and current contextual and behavioral description of the problem. The expression of the problem is specific to each patient. This description answers the following questions: (1) What is actually the problem? (2) Who is involved (e.g., just the patient him/herself, or with others or with the world)? (3) When does it occur? (4) Where does it occur? (5) How does it work/function?

A strategic therapist uses *prescriptions* to help the patient set up actions that keep him or her away from the old, unsuccessful attempted solution. There are also indirect suggestions (such as metaphors and hypnotic suggestions) that the therapist can give (Vitry, de Scorraille, & Garcia-Rivera, 2019). When the problem is described in such a way that both therapist and patient agree upon an objective to be achieved, then the therapist and client can implement the appropriate strategy for change and, by the end of the 10th session, each party will be able to evaluate from their respective point of view if the problem has been solved, improved, or not solved.

EFFECTS OF STRATEGIC THERAPIES

In order to assess the outcome or success of psychotherapy, Cochrane (1972) distinguished three concepts: *effectiveness*, *efficacy*, and *efficiency*. Effectiveness characterizes the measure of a treatment performance under natural clinical conditions. Efficacy deals with the measure of a treatment performance under ideal laboratory conditions such as randomized controlled trials (RCTs) used by evidence-based medicine. Efficiency is the ratio between resources and effectiveness.

Empirical studies have shown brief strategic therapy (BST) to be clinically effective in treating several psychological disorders. Nardone and Watzlawick (2005) reported strategic therapy techniques that resolved anxiety disorders, depression, obsessive–compulsive behaviors, paranoia and obsessive doubts, vomiting, and bulimia. Nardone, Verbitz, and Milanese (2005) developed a BST protocol for the treatment of Binge-eating disorder. Pietrabissa et al. (2016) showed a BST protocol to be effective in OCD treatment. From these empirical studies, Wittezaele and Nardone (2016) built an interactional processes-based classification of mental disorders. Nardone and Portelli (2005) at the Centro di

[1]We use the term *patient* (rather than *client*) to be consistent with the research literature, but either term is often used in clinical practice (see Hoyt, 2017, pp. 1–2 and pp. 217–218).

Terapia Strategica of Arezzo (Italy) reported 87% of 3,640 cases were resolved in an average of seven sessions, with 1- to 5-year follow-ups.

Horigian et al. (2015) also reported that brief strategic family therapy (BSFT) was efficacious in the prevention and treatment of adolescent drug use and associated behavior problems. The BSFT model combines structural and strategic therapy techniques to address systemic/relational interactions associated with adolescent problem behaviors (Horigian, Anderson, & Szapocznik, 2016). Jackson, Pietrabissa, Rossi, Manzoni, and Castelnuovo (2018) found that brief strategic therapy (BST) was statistically and clinically superior to cognitive behavioral therapy (CBT) in improving binge-eating frequency, weight, and global functioning.

Various authors (e.g., Tasca, Grenon, Fortin-Langelier, & Chyurlia, 2014), however, have noted that this research has only limited generalizability to "real-world" practice and practitioners. As Lebow (2018) wrote: "Research that provides the evidence base for psychotherapy is typically conducted in the highly controlled conditions of randomized clinical trials [. . .]. However, therapy, and most especially couple and family therapy, is typically conducted under conditions far afield from those in the typical randomized controlled study." He goes on (p. 273) to conclude: "We also need to know more about how couple and family therapies work in the real-world settings and how to improve treatment dissemination. Effectiveness research projects like this one (Baucom et al., 2018) are essential to our learning more about couple and family therapy and to advancing the family centered public health agendas that is part of the ethos of couple and family therapy."

THE USE OF PRACTICE RESEARCH NETWORKS FOR EFFECTIVENESS STUDIES

Methods for evaluating psychotherapies have evolved over time (Goldfried & Wolfe, 1996). In addition, concerns about the scientist–practitioner gap have been well documented (e.g., Tasca et al., 2015; Teachman et al., 2012). Pinsof and Wynne (1995) point out that the results of efficacy studies do not allow identification of or recommendations for therapeutic practice under normal everyday conditions. Some also find the criteria used in pharmacological studies to be impractical, even meaningless when transposed to a human being and/or unacceptable on ethical grounds (Hendrick, 2009). RCTs often overlook an essential dimension of treatment: the particular patient/therapist relationship.

Randomized controlled trials "are limited in the degree to which patients, treatments, treatment settings, and providers may be representative of those in community settings, where most patients receive care" (West, Zarin, Peterson, & Pincus, 1998, p. 620). Goldfried and Wolfe (1998) state that no amount of concern for methodological rigor—internal validity—can substitute for a research paradigm that will allow generalization to clinical reality—external validity. Practice-based research addresses these limitations and broadens the scope of research (West et al., 1998), and practice-based evidence complements evidence-based practice (Thurin, Thurin, & Midgley, 2012). Criticisms of experimental methods (e.g., low external validity) led researchers to move toward studies of therapies in naturalistic settings using the case study method. However, case study does not allow for statistical generalization of the results. It is to overcome this problem that Practice Research Networks (PRN) have been developed. By multiplying the number of cases coming from naturalistic clinical practice, researchers hope to obtain both specific information and greater generalizability.

A PRN can be defined as a group of practicing clinicians who work together to collect data and conduct a variety of researches (Thurin et al., 2012) or as a "network of clinicians that collaborate to conduct research to inform their day-to-day practice" (Barkham & Mellor-Clark, 2003, p. 322). The PRN is based on an infrastructure which yields potentially large databases to be used as practice-based evidence (Thurin et al., 2012) and is often

linked to an academic center (Barkham & Mellor-Clark, 2003). A PRN is characterized by an intense cooperation between clinicians and researchers, through an organization that endeavors to answer, through research, practice-based questions (Thurin, Thurin, Cohen, & Falissard, 2014). As Johnson, Miller, Bradford, and Anderson (2017, p. 561) wrote:

> "Clinicians benefit from an easily accessible system that allows them to track client progress thereby improving client care. Researchers benefit from the data such systems can provide to answer clinically relevant questions to enhance our knowledge about the change process in systemic therapy."

Practice Research Networks in the field of mental health were introduced in the mid-90s but, for the time being, are still not widely used worldwide (see Table 1 for a list of mental health PRNs). Campbell (2003) explains some of the significant difficulties in establishing research programs (e.g., research has no central role in services, has high costs, and requires large efforts for the generation of even small amounts of data) and writes (p. 52): "A very interesting way of overcoming these obstacles is to develop PRN." As he notes, a PRN can, through the creation of an economy of scale, allow for the generation of very large data sets. There are not many PRNs in the world of psychotherapy; and of those that do exist, most are general and are mainly about collecting data but are not used extensively for training or improving one's clinical practice. Moreover, with the exception of the MFT-PRN at Brigham Young University (Johnson et al., 2017), there have been no PRNs for systemic/strategic therapies. Unlike the MFT-PRN at BYU, which allows for the use of a large number of questionnaires depending on the type of diagnosis, SYPRENE aims to use a minimum and mandatory number of questionnaires to reduce costs, simplify assessment and training, and aid comparisons between different cases and techniques.

THE CREATION AND IMPLEMENTATION OF SYPRENE

The Systemic Practice Research Network (SYPRENE), created by LACT[2] Research, is a PRN of professionals involved in systemic therapeutic intervention and research which, we hope, will help to fill the gap of research studies on the effectiveness and efficiency of the strategic model. The research network was set up as a result of cooperation between several international institutes[3] and numerous therapists, with the goal of developing a new therapy assessment platform that would facilitate creating a database and allow communication between and among practitioners and researchers. The main center of SYPRENE is in Paris, at LACT, where data are stored and statistics are generated. Each participant can see their own data; aggregate statistics are computed by a professional researcher at LACT. It endeavors to strengthen cooperation with the multidisciplinary world of science and offers a self-improvement process to therapists. It fosters research thanks to a unique online data collection tool which allows naturalistic studies to assess the differential effectiveness of therapeutic processes by type of problem treated. These results, we believe, will allow therapists to share and improve their practices. SYPRENE is intended to serve all practitioners—isolated individuals as well as those grouped in treatment and research centers. In an era of globalized interconnection and contextual model (Wampold & Imel, 2015), SYPRENE welcomes the prospect of international collaborative research. Using a naturalistic "real-world" research perspective (Seligman, 1995),

[2]LACT is an acronym signifying "Liberating actions for transformation." LACT is a freestanding research, training and psychotherapy institute based in Paris. It is supported by tax credits from the French government. SYPRENE was originally called "LACT Research"; we changed the name to SYPRENE in 2018.

[3]LACT, University Paris 8, CIRCÉ, Centro di Terapia Strategica—CTS, Mental Research Institute, MIMETHYS Institute, National Autonomous University of Mexico—UNAM.

TABLE 1
Mental-Health PRNs

Name	Country	Date of creation
American Psychiatric Institute for Research and Education's Practice Research Network—APIRE/PRN (West et al., 2015)	USA	1993
Art Therapists' PRN (Huet, Springham, & Evans, 2014)	UK	2008
Center for Collegiate Mental Health—CCMH (McAleavey, Lockard, Castonguay, Hayes, & Locke, 2015)	USA	2009
Child and Adolescent Services Research Center—CASRC	USA	2006
Children And Young People Practice Research Network ("CYP PRN," n.d.)	UK	
HGI Practice Research Network (Andrews, Wislocki, Short, Chow, & Minami, 2013)	UK	2007
International Project on the Effectiveness of Psychotherapy and Psychotherapy Training—IPEPPT (Elliott & Zucconi, 2008)	Italy	2004
Marriage and Family PRN—Bringam Young University, USA (Johnson et al., 2017)	USA	2017
Nijmegen Family Practice Academic Network	The Netherlands	n.a.
Northern Improving Access to Psychological Therapies Practice Research Network—IAPTPRN ("Northern IAPT Practice Research Network," n.d.)	UK	2014
Pennsylvania Practice Research Network—PPRN (Borkovec, Echemendia, Ragusea, & Ruiz, 2001)	USA	1994
Pragmatic Case Studies in Psychotherapy—PCSP (Rutgers Graduate School of Applied and Professional Psychology and the Rutgers University Libraries, n.d.)	USA	n.a.
Réseau de Recherches Fondées sur les Pratiques Psychothérapiques—RRFPP (Thurin & Thurin, 2010)	France	2008
Réseau de Recherche sur la Pratique Psychothérapique—PPRNet (University of Ottawa, n.d.)	Canada	
Société pour la recherche en psychothérapie—SPR	France	1995
Systemic Practice Research Network—SYPRENE	France	2018
UKCP's—Practitioner Research Network	UK	n.a.
Washington DC Area Psychotherapy Practice Research Network—DC-PRN	USA	n.a.
Wessex Primary Care Research (Van Weel, Smith, & Beasley, 2000)	UK	1994
Wisconsin Research Network (Van Weel et al., 2000)	USA	1988

n.a. = not available.

we intend that data collection be done in the least restrictive possible way for practitioners and thus can be easily and usefully integrated into their practice.

The Birth of the Database and the Recruitment of Practitioners

The database was initially designed in 2014 at LACT to study multiple clinical interventions. The first version of the database led to the creation of LACT Research in 2015 and the establishment of a scientific committee. Practitioners trained in strategic therapy approaches with at least one year of experience were contacted. Interested invitees made an appointment to be trained in coding sessions (1 hour per participant) and then were able to join the monthly meetings to exchange feedback on the experience of coding. Ninety practitioners were initially invited and received the required one hour of coding training, but 36 of them either did not register any patients or only coded one patient; an additional 33 dropped out after they realized that they would need to incorporate coding into their practice on a regular basis; 21 practitioners subsequently continued with the PRN.

Progressive Expansion of the Database and Dynamization of the Network

SYPRENE allows a practitioner: (1) to take a step back from one's own practice to better monitor and prepare interventions; (2) to better identify their own resources and difficulties; (3) to participate in a research program; (4) to carry out self analysis of his or her own practice (average number of appointments, rate of dropout/no shows, types of problems clients seek help for, average duration of treatment, effectiveness related to problem type); (5) to keep track of the sessions to simplify the management and recording of appointments; and (6) to measure the effectiveness and efficiency of interventions. SYPRENE allows therapists to document their work, session by session, and to be better prepared when supervised. The data collection is also integrated into the training of practitioners from LACT and University Paris 8 International School's strategic systems approach. SYPRENE allows a practitioner to be part of a network which holds a web meeting once a month in French and in once a month in English/Spanish and to be listed on the network website.

Experience has shown that the enthusiasm of practitioners trained in encoding is not in itself a guarantee of their ongoing active contribution to the encoding process. As noted above, many who had received the initial coding training did not continue. Informal interviews with those who did continue suggest that the motivating benefit of being part of an emerging community of practitioners with promises of meetings and exchanges often took precedence over the constraint of the extra time needed to include data collection in one's already often crowded agenda.

With this in mind, the LACT Research Scientific Committee took several decisions: (1) to maintain within the network a practitioner who, without contributing to the database, actively participated in web meetings; (2) to direct the monthly meetings of practitioners, initially dedicated to the exchange of encoding practices, toward exchanges of professional practices (with or without case studies); (3) to highlight the network's news, ambitions and progress at each of the four annual sessions of the international webinar, created in 2017 in partnership with LACT and MRI, to stimulate meetings and exchanges on current practices in the world of brief therapies; (4) to establish a list of descriptive data that the practitioner must enter (these mandatory data are described below in the Methodology section); (5) to simplify the computerized input format of these mandatory data and create a paper form to facilitate the entry of a session by the practitioner (or clerical assistant) and its possible entry into the database; (6) to integrate useful data to complete the entry of different practices of the systemic and strategic approach; and (7) to choose a questionnaire (the General Health Questionnaire, Goldberg, 1972; Goldberg & Williams, 1991).[4]

METHODS AND INSTRUMENTS

Data Collection and Encoding System

The main methods of SYPRENE data collection are the following: (1) Questionnaires that are completed and returned by patients and (2) Specific interview questions to evaluate the results of therapies. In collecting data, both the patient's and the therapist's points of view are taken into account.

Those practitioners who wish to contribute data to SYPRENE are expected to (1) inform their patients about the SYPRENE program and ask for the patients' consent to

[4]The choice of the GHQ12 was made on the following criteria: (1) it provides a general health score that the patient completes; (2) it can be used for different situations and problems; (3) it is quick and easy to complete by the patient (2 minutes) and avoids disturbing the intervention too much (it is administered at the opening and closing of the session); (4) it allows a good measure of the evolution of the patient's general health between the beginning of the first session and the end of the last session.

participate and (2) to encode the intervention(s) after every session with the patient and provide all the required data that contribute to the production of statistics.

Data encoding system

The coding system is designed to (1) allow therapists to rapidly encode after each session (2–3 minutes); (2) set up scientific studies; (3) secure the information and give access for all secured data to the therapist for personal study or statistical research; and (4) allow the therapist to synchronize his or her agenda and manage appointments, including the possibility to send a confirmation of the appointment via email or text messaging. Ease of use helps make participation in SYPRENE attractive to practitioners (Audin et al., 2001; Borkovec et al., 2001; Castonguay et al., 2010). Both the patient's and the practitioner's assessment of the therapy are stored in the system.

The encoding program is accessible free of charge to any professional therapist with at least 1 year of practice. Consistent with the naturalistic approach of the study, all patients are included rather than there being any predetermined selection criteria.

The encoding system is a secure-internet-based tool. Data security is based on the following: (1) access reserved by login and password; (2) no access creation is possible without validation by the administrator; (3) the site is in HTTPS; (4) the data handled by both parties are hermetically sealed; (5) the uploaded documents are placed in a protected area with no direct access to this data; (6) all statistics and dashboards are anonymous. The confidentiality of information is based on the written consent of the patient at the start of the therapy (including the possibility of recording sessions and the right of retraction) and the ability to use the program with encrypted patient names.

The basic unit of coding is a session. The data encoding system is structured to record information for each session. In order to collect data and evaluate them, we use the following tools:

The *MyLACT Form* is a document that the therapist completes with some required personal details regarding demographics and practice experience. It is the first step each therapist takes to be part of the SYPRENE Network.

The *Patient Identification and Consent Form* is a document that the research network therapist gives to the patient to collect his or her personal data and to ask for informed consent for the use of data from the sessions that he or she will do with the therapist. The patient provides demographic details, referral source information, and signed consent for participation.

The data encoding system requires that the practitioner include for each appointment:

(1). *Essential minimum information*: (1) Appointment information; (2) diagnosis; (3) severity of potential risk; and (4) the first and last session General Health Questionnaire (GHQ-12) scores. The GHQ-12 is a self-administered patient questionnaire made up of 12 questions, each scored on a 5-point scale (0–4) to quantify the level of subjective psychological suffering. The questions cover the themes of concentration, sleep, decision-making, stress, usefulness in life, difficulties to overcome, normal daily activities, problem management, self-esteem, and happiness. The maximum score of 48 means that the patient considers that everything in his life has deteriorated in recent weeks. The minimum score of 0 means that the patient considers that in recent weeks everything is better than before (Goldberg, 1972; Goldberg & Williams, 1991). Rating is also gathered regarding whether the problem was solved [from the practitioner's point of view] with items rated on a 10-point Likert scale (from "Problem unsolved" to "Problem solved").

(2). Additional/optional information: (1) patient's attempted solutions and logics (contradiction, paradox, belief—see Wittezaele & Nardone, 2016); (2) symptoms; (3)

therapeutic prescriptions/interventions; and (4) whether the problem was solved [from the patient's point of view] with items rated during the sessions on a 10-point Likert scale (from "Problem unsolved" to "Problem solved").

The progression of therapy: How do we turn it into data?

SYPRENE therapists see patients in single-, dyadic-, or multiperson appointments, with 1:1 most common. When SYPRENE therapists work with multiple persons, they ask each member of the couple, family, or group to complete the Consent Form and the GHQ-12.

For each appointment, from the second appointment to the one before last, the research network practitioner fills in at the end of each session his or her ratings and new information about the patient in the data encoding system. At the last appointment, the practitioner gives each patient (individual, both members of the dyad, or all members of the group) the GHQ-12. He or she also rates the patient's progress. Each participant receives many hours of training and supervision using SYPRENE, including learning from one another through discussions with other practitioners.

Pilot Effects with the Network

Therapists

We now have data from 21 therapists. For each therapist, all patients who gave consent are included in the database. The nationalities of the SYPRENE practitioners are as follows: French (52%, $n = 11$), Italian (29%, $n = 6$), Mexican (9%, $n = 2$), Spanish (5%, $n = 1$), and Canadian (5%, $n = 1$). Fifty-two percent are women ($n = 11$), and 48% are men ($n = 10$). The average age is 47 years. They have an average of 12 years of experience. Of the 21 practitioners, nine are psychologists (44%), six are therapists/counselors (27%), and 6 (27%) are psychotherapists. All practitioners identify themselves as "strategic therapists." Three also specify "Ericksonian hypnotherapy" as a secondary specialization. Their areas of clinical expertise include (note: some practitioners have more than one specialty): (1) couple conflicts and family relational problems (76%); (2) anxiety, depression and bipolar disorders, trauma, and PTSD (67%); (3) eating disorders (67%); (4) OCD, obsessions and compulsions (62%); (5) work problems—harassment, burnout, conflicts, and adapting to changes—(62%); (6) addictions—drugs, internet, sex, and money—(57%); (7) sexual problems (48%); and (8) problems in school relations—harassment, conflicts, stress, teachers, and peers (43%).

Patients

There have been 820 patients thus far for whom therapy was completed and for whom assessment data were collected; 65% ($n = 533$) were female; and 35% ($n = 287$) were male. The information regarding marital status (reported by 56% of patients; information on the age and marital status of patients was only required from 2017 onwards) was as follows: 45% living alone (single, separated, widowed) and 55% living as a couple (married or in a relationship). The average age (indicated by 55% of patients) was 39 years; 6% were under 25 years old, 52% were between 25 and 44 years old, 34% were between 45 and 64 years [$\approx$ average human life expectancy at birth, 2011 estimate] old, and 3% were over 65 years [$\approx$ average human life expectancy at birth, 2011 estimate] old. As for their occupation, 67% were employed and 33%—inactive (e.g., without profession, job seeking, or retired).

Benefits of SYPRENE for Practitioners and Patients

Encoding leads practitioners to formalize regular feedback regarding their interventions. They report what they have implemented during each session; evaluate the

evolution of the patients' symptoms, thus noting the effects of the intervention strategy; and evaluate what remains to be covered to achieve the therapeutic objective, which helps them to adjust if necessary (by themselves or through supervision) elements of the interventions.

These benefits were confirmed by feedback from practitioners. The respondents attributed the main benefits of using the database to taking a step back from their practice, learning to identify their own resources and difficulties, and structuring interventions. The main benefits of the monthly web meetings were meeting with other practitioners, discovering new practices, and sharing difficulties.

Data about possible benefits of participating in SYPRENE were not collected from patients. We will investigate in a further study whether patients are pleased by the attention they receive, as well as whether they believe that their treatment and outcome benefited from the research.

Discussion: Limitations, Challenges, and Opportunities

SYPRENE was initiated in order to unite efforts of many practitioners and create an easily accessible data collection tool, to evaluate the effectiveness and efficiency of strategic (and subsequently, other systemic) therapy practices, and to encourage practitioners' monitoring of and reflection on their clinical work. As Johnson et al. (2017, p. 563, italics in original) described:

> A Practice Research Network (PRN) is a collaborative effort among researchers, clinical agencies, and private practices to share common assessment measures and protocols to create high quality data sets and provide feedback for clinical and research purposes. PRNs facilitate *evidence-based practice*, as clinicians can use methodologically sound assessments to inform their clinical work. They also promote *practice-based research*, as researchers use data from actual practitioners, instead of highly controlled clinical trials, to advance clinical knowledge (Barkham, 2014).

Despite an encouraging start, we are at the beginning of the SYPRENE process and a big task lays ahead. Thus far, we have a limited number of patients who have completed the GHQ-12 at both the first and last session. We need to have more completed therapies evaluated with the GHQ-12 to have more reliable data. It will also be interesting to have practitioners working in hospital settings (not just outpatient offices) integrated into SYPRENE.

SYPRENE's future success is based in part on a network that is now established and growing and on data collection practices that do not disrupt consultation in natural settings. While more data are generally desirable, the more naturalistic aspect of the therapy consultation can be weakened and more risks are taken of losing practitioners who become tired of the amount of work required. As the adage says, the great is the enemy of the good.

We have found it difficult to recruit practitioners who remain committed for the long term. In particular, many therapists are overscheduled and are more interested in conducting clinical activities than in taking time to gather data for deliberate practice (Boswell, Kraus, Miller, & Lambert, 2013). Particular attention should be paid to retaining motivated therapists as well as to the ergonomics of the program to make it as fast and easy to use as possible. It may be easier to have therapists incorporate PRN (or other feedback) as an intrinsic part of their training rather than attempting to have experienced clinicians change their practice habits. The number of cases needs to be expanded; the larger the number of diagnoses and the bigger the number of patients per diagnosis, the more we will be able to use the base to yield a finer quantitative and qualitative analysis. SYPRENE is ultimately intended to unite practitioners from various systemic therapy

approaches, but as a starting point, practitioners from strategic therapies only were contacted and invited, because the developers of SYPRENE come from the strategic approach. The base may grow in the future with data from other systemic therapies (e.g., systemic family therapy, structural family therapy, solution-focused, narrative) and also particular techniques used during the intervention (e.g., reframing, restructuring, acting "as if") can be included.

This article presents a report of the SYPRENE project thus far. Many participants, both therapists and patients, have been enthusiastic, and the database is growing. Some practitioners, however, have left. Coding and analysis is continuously being improved, with an eye toward balancing the addition of instruments with the avoidance of a burdensome workload. The more the database develops, the more it will be possible to analyze and apply results for different problems and clinical methods. LACT could also provide the software to organizations (hospitals and companies), who use systemic and strategic approaches, and could provide universities with data. For more information, please visit: https://www.login-lact.org/en/

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