25 Years of systemic therapies research: Progress and promise

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METHOD PAPER

25 Years of systemic therapies research: Progress and promise

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Abstract
Objective: In this article we describe and assess the state of the science on systemic psychotherapies. In the quarter century since the first issue of *Psychotherapy Research* was published, considerable progress has been made. There is an increasingly solid evidence base for systemic treatments, which includes a wide range of approaches to working conjointly with couples and families. Moreover, there are exciting new developments that hold promise for explicating the dynamic processes of therapeutic change in couple and family systems. **Method:** We begin by explaining how we view "systemic therapies" as different from individual approaches and then summarize what we have learned in the past 25 years about this set of treatments, how we have learned it, and what we have yet to learn. **Results and Conclusions:** We consider current trends in research on outcomes and change process mechanisms, and end with speculations about what lies ahead in the interrelated domains of systemic research and practice.

Keywords: couple and family therapy; systemic therapy; mechanisms of change; family treatment

On this 25th anniversary of the launching of *Psychotherapy Research,* we assess what we have learned about systemic therapies since 1990, how we have learned it, and what we have yet to learn. In this article, we consider recent research on therapeutic outcomes and change process mechanisms, and the significance of the current state of the science for what lies ahead in the interrelated domains of systemic research and practice.

The moniker *systemic therapy* includes a diverse set of therapeutic interventions that on the surface may appear to be different species, and in fact, under some methods of categorization, might well be. Consider that among even just a few of the systemic therapies (e.g., emotion focused couple therapy (EFT), narrative family therapy, multisystemic family therapy, attachment-based family therapy (ABFT), structural-strategic family therapy, psychoeducational family therapy), the foci (emotion, behavior, cognition), the philosophical roots (objectivist, constructivist), and the intervention styles (client-centered, therapist-centric; directive, collaborative; depth-oriented, didactic) diverge substantially.

What then, in 2015, do these therapies have in common, and what defines them as different from other therapies? Briefly, the distinguishing features are the same features that originally defined systemic therapies as distinct: A primary concern with shifting the *inter*personal and *inter*actional (vs. *intra*personal) dynamics that shape and maintain psychological problems, and case formulations that locate and treat problematic feelings and behaviors in the context of dyadic, family, or wider systems. Systemic therapists eschew linear formulations (i.e., *A* causes *B*), preferring to work from a "meta-perspective" that focuses on circular causal explanations of the ways in which problems both sustain and are sustained by patterns of interacting with important others in their

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lives. As explained by Watzlawick, Beavin, and Jackson (1967), "If a person exhibiting disturbed behavior (psychopathology) is studied in isolation, then the inquiry must be concerned with the *nature* of the condition and, in a wider sense, with the *nature* of the human mind. If the limits of the inquiry are extended to include the effect of this behavior on others, their reactions to it, and the context in which all of this takes place, the focus shifts from the artificially isolated monad to the *relationship* between parts of the system" (p. 21). Rohrbaugh (2014, p. 2) nicely summarized the essential features of a systemic paradigm: *Circularity, context, and pattern interruption* and suggested that these features imply that systemic theories are more concerned with how problems are maintained interpersonally, i.e., circular causality, rather than how and why they originated. A full discussion of the history and distinguishing features of systemic therapies is beyond the scope of this article, but is well explained elsewhere (cf., Friedlander & Diamond, 2011; Gurman, 2008; Rohrbaugh, 2014; Sexton, Weeks, & Robbins, 2003).

Just as individual therapies have evolved from "pure" or singular approaches to more integrative ones, so have systemic therapies. Further, while early systemic theories and couple and family therapies (CFTs)—and the research that attended them—focused on observable patterns of interaction, they have evolved to include attention to cognition (e.g., attributions and the ways in which individuals and families make meaning of events), emotion, and culture. This shift has been especially salient in the past 25 years, as progress in basic psychological science, e.g., research on emotion, adult attachment, parenting, family communication in relation to psychosis, and marital interaction (e.g., Gottman, 1999) has become incorporated into systemic theory, research, and practice. Although there is some disagreement about whether such variables are truly compatible with a systemic perspective (Rohrbaugh, 2014), many contemporary CFTs show these kinds of influences from other approaches.

Another major change has been the accelerated development of several broad-based, manualized family intervention programs, which have been widely disseminated, internationally as well as nationally. Yet a third notable development is the increasing integration, both theoretical and technical, CFTs that originated as separate "schools," each with its own proponents and adherents (Lebow, 2013). For example, traditional behavioral couple therapy (BCT; Jacobson & Margolin, 1979), which paid less attention to recurring patterns of interpersonal behavior, was further developed as integrative behavioral couple therapy (IBCT; Christensen, Jacobson, & Babcock, 1995; Jacobson & Christensen, 1996), which has a more systemic focus (and also incorporates acceptance-based ideas).

It is thus particularly challenging to draw clear boundaries between "systemic" and "nonsystemic" approaches. Systemic therapy is typically, but not always, a conjoint approach for working with couples and families, largely because a relational perspective on symptoms and problems leads logically to an interest in working with all actors simultaneously. On the other hand, systemic practice can also involve thinking systemically in formulating cases but working—occasionally or even exclusively—with individuals in order to accomplish systemic change, or working with wider systems, including multiple family groups. Further, systemic practice includes psychoeducational approaches in which families are seen together for the purpose of supporting one member's recovery from severe and persistent disorders, e.g., schizophrenia and bipolar disorder. These approaches are systemic, even though they do not postulate that the origin of the mental illness is in dysfunctional family interactions, in that they include assessment of and (if needed) modification of recurring patterns of interpersonal behavior that present challenges to recovery and increase the likelihood of relapse.

For this reason, and because this is the only article in the *Special Issue* to focus on systemic or couple/family therapy, we included in this review not only approaches that are most readily identified as systemic, but also couple and family treatments that target specific individual problems (e.g., schizophrenia) by including the family system in the patient's assessment and treatment. However, given space limitations, we focus our discussion most closely on CFTs that have an explicitly systemic focus, i.e., those that explicitly target interpersonal change in a conjoint treatment format. We begin with major sections on treatment outcomes and change processes, followed by a discussion of advances in methods and measures, and conclude with some speculations about the future of systemic therapy research.

Do Systemic Therapies Work?

The Simple Answer

Over the last two decades, psychotherapy research and practice in general have been preoccupied with questions about the evidence base for specific treatment approaches, i.e., does it work? With regard to systemic CFTs, it is clear that the simple answer to this global question is a resounding "yes." Many reviews and meta-analyses of CFT since 1990 have established that, compared to no-treatment or wait-list controls, these treatments are efficacious for a variety of problems, and indeed more efficacious

than individual treatments for some client concerns (Alexander, Holtzworth-Munroe, & Jameson, 1994; Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Carr, 2014a, 2014b; Friedlander & Diamond, 2011; Friedlander & Tuason, 2000; Sexton, Alexander, & Mease, 2004; Sexton, Datchi, Evans, LaFollette, & Wright, 2013; Shadish & Baldwin, 2005; Shadish, Ragsdale, Glaser, & Montgomery, 1995).

There are of course, different standards for assessing the evidence base of a therapy approach and within these standards, different labels to identify the level of research support. With regard to the most widely used, if controversial, standards (Chambless & Hollon, 1998), CFT fares well. Numerous CFTs are listed on the Division 12 (Clinical Psychology) and/or Division 53 (Clinical Child and Adolescent Psychology) websites of evidence-based treatments as having "strong" research support (previously called "well-established" treatments) or "modest" research support, (previously called "probably efficacious"), with fewer labeled as "controversial," i.e., those with mixed results or for which the claims about how it works are at odds with the research evidence. Table 1 displays this information. Interested readers will find descriptions of the treatments and research citations at the following sites: http://www.div12.org/PsychologicalTreatments/treatments.html and http://effectivechildtherapy.com/content/ebp-options-specific-disorders. Also many couple and family treatments are included in SAMSHA's National Registry of Evidence-Based Programs and Practices (http://nrepp.samhsa.gov/AboutNREPP.aspx). This online database indexes evidence-based treatments and rates the quality and breath of their research support.

The More Complete, Complex, Answer

As recently noted by Sexton et al. (2013) in *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change,* the more complex, accurate answer to the question is "yes, but …" That is, the bulk of the CFT outcome research has focused on a rather narrow range of systemic interventions and a specific set of problems. For example, Multisystemic Therapy, Functional Family Therapy, and Multidimensional Family Therapy were designed for and applied to co-occurring sets of youth externalizing behaviors, i.e., antisocial behavior at school and home and problematic substance use and abuse. These are mature, widely disseminated, comprehensive interventions that target multiple, intersecting social systems (family, peers, school). Effect sizes are generally moderate to high (with some mixed results that depend on moderating client characteristics). The quality of this research evidence is also high, although it drops off a bit in clinical effectiveness studies in the community (Sexton et al., 2013). Similarly, there is strong evidence for the efficacy of family psychoeducational treatments for schizophrenia and bipolar disorder (Lefley, 2009).

Other family therapy approaches, however (e.g., solution-focused therapy, constructivist therapy, Bowen therapy, narrative therapy), are virtually untested or have comparably weaker evidence of efficacy. Interestingly, this same assessment of the state

Table I. Empirical support, systemic therapies.

"Strong" research support/"Well-established" treatments[a]	Behavioral Couples Therapy for Alcohol Use Disorders
	BFST for Disruptive Behavior Problems and Substance Abuse
	Emotion-focused Therapy for Couples
	Family-Based Treatment for Anorexia Nervosa (Maudsley Hospital model)
	Family Focused Therapy for Bioplar Disorder (depression only)
	Family-focused Treatment for Adolescents with Bipolar Disorder
	Family Psychoeducation for Schizophrenia
	Functional Family Therapy for Disruptive Behavior Problems and Substance Abuse
	Multidimensional Family Therapy for Substance Abuse in Adolescents
	Multisystemic Therapy for Disruptive Behavior Problems and Substance Abuse
"Modest" research support/"Probably efficacious" treatments	Behavioral Couples Therapy for Depression
	Behavioral Family Therapy for Substance Abuse
	BFST
	Family Psychoeducation and Skill Building for (youth) Bipolar Disorder
	Family-based Treatment for Bulimia Nervosa (Maudsley Hospital model)
	Family Focused Group Therapy for OCD
"Possibly efficacious" treatments	Family Therapy for PTSD Transitional
	Family Therapy for Substance Abuse
	Strengths Oriented Family Therapy

[a]Sources: Division 12 & Division 53 website lists of evidence-based treatments. The Division 12 list uses the categories "strong," "modest," and "controversial research" support; the Division 53 corresponding categories are "well-established," "probably efficacious," and "possibly efficacious".

of the science has echoed in the literature throughout the past 25 years (Friedlander, Heatherington, & Escudero, in press; Heatherington, Friedlander, & Greenberg, 2005). If anything, the divide between well researched and under-researched interventions has widened over time as more and more research builds for a select group of models.

A somewhat similar situation exists in the couple therapy arena. First, overall, there is less efficacy research on couple therapy; Sexton et al.'s (2013) review of the 13 meta-analyses and 249 studies from 2003 to 2010 found that only 18% of the research focused on couple (vs. family) therapy, and that most of the research on manualized couple therapies was conducted in university rather than community settings. Second, most of the research, and the strongest research, focuses on two approaches, Behavioral Couple Therapy and Integrative Behavioral Couples Therapy. Both are successful in improving couple satisfaction and general mental health, with more mixed results for symptom reduction, depending on the disorder; for example, results tend to be better for substance use problems in one spouse than for depression. EFT for couples (Greenberg & Johnson, 1988) also has strong empirical support (Lebow, Chambers, Christensen, & Johnson, 2012). Fewer studies (only 12) examined outcomes of general couple therapy, with 2/3 of these studies reporting significant positive outcomes (Sexton et al., 2013). A few other models have been tested in single randomized controlled trials (RCTs), including insight-oriented couple therapy (Snyder & Wills, 1989) and integrated systemic therapy (Goldman & Greenberg, 1992), which showed similar successful results to existing treatments but better maintenance over time. The latter result is potentially important given the well-established finding that couple therapy results in clinically significant reductions in relationship distress, but that the effect dissipates over time (Shadish & Baldwin, 2005; Snyder & Halford, 2012).

The Answer is Still Incomplete

Beyond the fact that some treatments are well-studied and others are not, our answer to the more complex question of whether systemic therapies work is still incomplete for several additional reasons.

Some important presenting problems are less well-studied. The criterion for determining whether treatments are "empirically supported" has been symptom reduction for individual *DSM* disorders (American Psychiatric Association, 2013). Although systemic therapies can and do address dysfunctional interpersonal patterns that sustain individual diagnoses (e.g., couple therapy for depression), they also focus on relational conflict. Unfortunately, the degree to which these approaches are "empirically supported "in terms of addressing relational problems is undocumented. Despite valiant efforts, attempts over the past 25 years to include relational diagnoses as bona fide disorders in the *DSM* have not been successful (Kaslow & Patterson, 2006). Treatments for some of the common presenting problems in clinical practice (e.g., parent-adolescent conflict) remain excluded from lists of empirically supported treatments unless they are also identified with a *DSM* diagnosis, e.g., adolescent substance abuse, conduct disorder. For this reason, the standard RCT-diagnosis-based framework for efficacy studies does not always fit, particularly for couples and families seeking help for relational conflict rather than for a problem situated within one person (Friedlander, Lee, Shaffer, & Cabrera, 2014). Moreover, the common practice of using a generic systemic approach with multi-problem families with complex, co-morbid diagnoses (paternal alcoholism, maternal depression, *and* youth substance abuse) is difficult to study within the framework of RCT methodology, which is based on individual diagnoses and the manualized intervention protocols that attend them (Escudero, 2012).

To address this conundrum, Sexton et al. (2011) proposed an alternate set of standards for CFT outcome research, "Guidelines for Evidence-Based Treatments in Couple and Family Therapy." In this scheme, both full treatments and specific interventions (e.g., reframing) are considered. The guidelines take into account not only the quality of the research evidence, but also the clinical relevance/significance of the demonstrated outcomes (individual functioning, couple/family relationship functioning, and cost-benefit feasibility of implementation in community settings), whether the research has demonstrated change mechanisms consistent with theoretical predictions, and evidence of effectiveness across different research sites and with clients from different cultural backgrounds.

Based on these considerations, Sexton et al. (2011) derived a broader set of outcome-relevant labels: (1) "Iatrogenic or harmful interventions/treatments," (2) "Pre-evidence informed" interventions or treatments/common practices/non-specific theoretical approaches, (3) Level I: "Evidence-informed" interventions/treatment, (4) Level II: "Promising" interventions/treatments, and (5) Level III: "Evidence-based" treatments. The evidence-based treatments are then further evaluated by (1) the strength of the research evidence, (2) the strength of the evidence for proposed change mechanisms, and (3) "contextual efficacy," i.e., the ecological validity (settings, clients, etc.,) of the research evidence. Examples of Level I

approaches are Snyder's (2006) Affective Reconstructive Marital Therapy and Structural Family Therapy (Minuchin & Fishman, 1981). ABFT (Diamond, Siqueland, & Diamond, 2003) and the specific intervention of reframing are cited as examples of Level II approaches, and Behavioral Marital Therapy (Jacobson & Margolin, 1979) and Family Psychoeducation for Schizophrenia (Goldstein & Miklowitz, 1995) as Level III treatments. (*Note:* Since this 2011 article, some of these treatments have been further developed and might be classified differently now.) Sexton et al. did not attempt to create a comprehensive classification of evidence-based treatments for particular CFT problems, or an "either/or" (empirically supported/not empirically supported) list, arguing instead for the use of a continuum of evidence, with careful attention to the quality of the evidence in terms of external as well as internal validity.

Also notable in this effort is the inclusion of evidence-based "interventions" in addition to full treatment programs. This inclusion reflects increasing attention in the (individual as well as CFT) psychotherapy literature on trying to articulate and assess the evidence for transtheoretical, empirically supported principles of change (Beutler & Castonguay, 2005; Rosen & Davison, 2003). For example, Chorpita and colleagues (Chorpita & Daleiden, 2009; Weisz & Chorpita, 2012) argued for training clinicians in interventions that are common *across* evidence-based treatment protocols. These authors contended that among the advantages of such a modular approach is parsimony (i.e., one can learn 20 core practice elements rather than rely on multiple manuals) and flexibility (i.e., one can choose to eliminate or add a particular element in accordance with the target problem) (Chorpita, Daleiden, & Weisz, 2005).

Indeed, the empirical support for modular treatments is increasing (Chorpita et al., 2013). In couple therapy, it has been noted that effective treatments differ but share certain core elements, leading to predictions that "the next decade likely will find a much more evidence-based approach to articulating and testing such principles" (Lebow et al., 2012, p. 160). For example, in family therapy, one principle of change might be *helping clients achieve a new, more constructive perspective on their interpersonal conflicts*, with different approaches using various strategies (reframing, narrative strategies, creating space for partners to really listen and understand the other's primary, underlying emotion). Empirically supported principles of change also might include, but are not limited to, relationship factors (Norcross, 2011).

Recently, Lebow (2013) provided a thoughtful integrative perspective, arguing that the era of separate and competing "schools" of family therapy is over. He and his colleagues (Breunlin, Pinsof, & Russell, 2011; Russell & Lebow, 2011) attempted to cast a systemic net over the entire field of psychotherapy, integrating different modalities (biological, individual, couple, and family) as well as different theoretical approaches (CBT, EFT, IBCT, etc.,) within a comprehensive problem-centered meta-framework. This shift has obvious implications, and provides fertile ground for future outcome research. Moreover, the shift ties outcomes and change process research closely together in more clinically meaningful ways.

Current practice and effectiveness data are lacking. A second reason why our answers are still incomplete is that we do not fully know how CFT is currently practiced in community settings and what characterizes outcomes in these settings. What treatments, or combinations of treatments, are being used? Northey's (2002) survey found that 31% of American Association for Marriage and Family Therapy members claimed behavioral or cognitive-behavioral marital therapy as their primary orientation, but the others' orientations are unspecified. Further, when carefully specified or manualized treatments are being used in the community, with what fidelity is the treatment being applied? Research suggests that even in carefully controlled clinical trials for well specified treatments, e.g., Brief Strategic Family Therapy (BSFT), obtaining fidelity can be an elusive goal (Robbins et al., 2011). Moreover, fidelity may be especially elusive in difficult cases, where therapist responsiveness calls for deviation from the "map." For instance, in a multi-site trial of BSFT the lowest fidelity was found in cases involving especially high substance use and youth externalizing behavior, including multiple arrests (Lebensohn-Chialvoa, Haslerb, Rohrbaugh, & Shoham, 2010).

Further, there is a dearth of training opportunities in couple and family therapy, as well as a number of constraints on CFT practice in community settings (Lebow, 2013). Given these facts and that most of the CFT approaches with well-established efficacy focus on a specific set of problems, it is likely that (as in individual therapy) many couple and family therapists are using some type of treatment—or combinations of treatments—that have not been fully tested.

There are two obvious immediate research needs. The first is for more well-designed studies of treatment effectiveness of CFT in community settings, and across additional treatment approaches. Even beyond those understudied approaches previously reviewed, there are newer extended systemic formats in need of testing. These formats are especially popular in Europe and include network and community-based

interventions, multifamily group therapy, family day treatment (Asen, 2007, Asen & Scholz, 2010), and extended residential treatment (10–12 wks.) for whole families with treatment resistant adults (Asen, Dawson, & McHugh, 2001). In general, these extended systemic treatments represent innovative approaches that combine therapy modalities, e.g., individual family, groups of families, groups of parents, and groups of children, with an extraordinary sensitivity to cultural and community diversity. Promising programs of multifamily group intervention have been used in the treatment of drug addiction (Schaefer, 2008), child abuse (Asen, George, Piper, & Stevens, 1989), eating disorders (Dare & Eisler, 2000; Scholz & Asen, 2001) and adolescents with wide range of difficulties (Wattie, 1994).

The second immediate need is for a better understanding of the constraints on CFT practice outside of research settings. How compatible are the guidelines for carrying out a particular treatment in an everyday practice setting (scheduling practices, number of sessions allowed by the clinic or payers, expectations of the typical clients in the setting, readiness of therapists to adopt the treatment)? How accessible, in terms of the cost and time involved in training and implementation, are the manualized, marketed treatment programs (e.g., as MST and BSFT) to clinicians in community settings? What percentage of practitioners actually use these manualized approaches, and what are their experiences or challenges in using them, including impediments to practicing them with high fidelity?

An ongoing project headed by Goldfried (2011) to solicit feedback from practitioners about their experience using empirically-supported CBT treatments in community settings is a good model for discovering the effectiveness of systemic therapies. Indeed in general, the quest for better outcomes and more meaningful dissemination of couple and family therapy requires bridging the rather wide gap (Dattilio, Piercy, & Davis, 2014) between research and practice in systemic therapy. The development of sustainable practice-research collaborations and networks (Borkovec, 2004; Castonguay et al., 2010) is a wide open and potentially fruitful project.

Knowledge of moderators is sparse. To be most clinically useful, CFT effectiveness researchers need to pay more attention to moderators, including client, therapist, and systems factors. Testing moderators of effectiveness is the next most important research step for the "mature" treatments, i.e., those that are already well supported by the available evidence and are being widely disseminated. A good example is a recent study (Robinson, in press) which found that above and beyond SES factors, the quality

of the neighborhood interacted with extent of parental monitoring in multisystemic family therapy, such that parental monitoring predicted decreases in youth externalizing behavior only in relatively "better" neighborhoods. This finding echoes the results from basic research regarding family strengths in extremely poor neighborhoods. For example, neighborhoods below a certain level of poverty significantly diminished and virtually nullified the effects of family strengths on adolescent functioning/delinquency (Gorman-Smith, Tolan, & Henry, 2000). These findings underscore the importance of considering wider social systems in the development of systemic theories and the testing of family interventions. Knowing more about the limits of CFT treatment packages—or at least knowing more about how their outcomes and processes should be qualified for differing contexts—will enhance both their clinical applications and our understanding of how they work.

As globalization increases, an especially important moderator for the next quarter century of research is client culture and the fit (or lack thereof) with the assumptions and tasks of the treatment approach being used. There is plenty of theory and opinion on this topic but a dearth of programmatic research. It may be more useful and practical for researchers to ask more focused research questions involving populations and needs in their own domains (e.g., "Is group psychoeducational family therapy for schizophrenia equally effective for Latino/a families in community mental health settings in Los Angeles as it is for Anglo families? And if not, how can it be adapted?") rather than very broad questions ("Does culture matter?" "Does matching of therapist and client culture matter?").

Another highly salient demographic trend has to do with family structure. In Europe as in many developed countries, more people are remaining single and many are marrying later, and the population is aging. Gay unions, gay marriage, and more liberal adoption laws in some places mean an increase in diverse family forms and arrangements with extended family "kin" (birth parents, coparents) of different kinds. What, if any, are the ways in which these variables influence the nature and outcome of CFT?

Further, even among the most well-studied therapies, we do not yet fully know what accounts for change, particularly precisely *how* changing interpersonal dynamics can reduce individual distress. The question of *how* therapy works is of more than purely theoretical or academic interest. Effectiveness and mechanism of change questions are interrelated, since a full understanding of the change mechanisms that mediate good outcomes provides leads for selecting important moderators of treatment outcomes. For

example, in couple therapy, a significant minority of clients, approximately 25–35%, do not improve (Snyder & Halford, 2012). This is a stubbornly stable finding, although newer developments in couple therapy, e.g., IBCT, show moderately better outcomes (Christensen, Atkins, Baucom, & Yi, 2010; Snyder & Halford, 2012). But what are the characteristics of the non-responding couples? Do these characteristics interact with the specific tasks and stages of systemic treatment or with the way in which it is implemented, that explains their lack of response? This knowledge has the potential to move our work forward substantially in the next 25 years.

We turn now to a discussion of change mechanisms: What we know, how we know it, and what we have yet to discover.

How Do Systemic Therapies Work?

What We Know So Far

Within the past 25 years, change process research in CFT has focused increasingly on common factors (Sprenkle, Davis, & Lebow, 2009), particularly the working alliance, as well as on specific factors within empirically supported systemic therapies. The research on specific factors has included study of in-session micro-changes (e.g., Bradley & Furrow, 2004), change over the course of therapy (e.g., Shpigel, Diamond, & Diamond, 2012), and therapist adherence to and competence delivering theory-specific interventions (e.g., Diamond, Diamond, & Hogue, 2007; Hogue, Dauber, Samuolis, & Liddle, 2006; Huey, Henggeler, Brondino, & Pickrel, 2000; Robbins et al., 2011), among others.

As a complete review of CFT change process research is beyond the scope of this article, we will focus in depth on change process research in three arenas. These areas were chosen for their trans-theoretical applicability and because they illustrate how change process research has direct relevance to clinical practice. We begin by summarizing what is known about *in-session processes that maximize engagement* in CFT, followed by a review of research on *how the therapeutic relationship, particularly the working alliance, can be a catalyst for systemic change*. Finally, we discuss how *two powerful systemic interventions, reframing and enactment, can effect interpersonal change in couples and families*, both within theory-specific models and within more general systemic approaches.

Engagement in treatment. Engagement has been studied in three ways: Encouraging family members to participate in conjoint treatment, keeping families in therapy, and facilitating clients' active participation in the session. In general, results suggest that successful engagement in treatment requires a planful strategy that pays attention to shifting systemic forces within the family.

Research on engaging and retaining family members has primarily been conducted within BSFT. The earliest studies tested the effectiveness of a specially designed engagement intervention for Hispanic families with adolescent drug users (e.g., Santisteban et al., 1996). A recent, multi-site controlled trial of BSFT with diverse families showed that adherence to the treatment manual facilitated engagement and retention (Robbins et al., 2011). A small sample, comparative analysis of first sessions from this controlled trial (Sheehan & Friedlander, in press) indicated that keeping families in treatment was more likely when the therapist created rapport, paid attention to resistance, and facilitated parent involvement, safety, and discussions about family members' shared contributions to the problem.

Studies on within-session engagement, or active involvement in the therapy process, have focused primarily, but not entirely, on adolescents, where the key seems to be "rolling with resistance," identifying personally meaningful goals for the adolescent, and becoming an ally (Diamond, Liddle, Hogue, & Dakof, 1999; Higham, Friedlander, Escudero, & Diamond, 2012). With adults as well as adolescents, therapists who are successful at engagement tend to be supportive (Foster et al., 2009), transparent (James, Cushway, & Fadden, 2006), and light-hearted (Escudero, Boogmans, Loots, & Friedlander, 2012; Heatherington, Escudero, & Friedlander in press). Consistent with a problem-centered approach (Pinsof, 1995), case studies suggest that effective therapists work first with the problem in which family members are most invested so that, later on, they can leverage therapeutic work with another problem or with a different subsystem in the family (e.g., Escudero et al., 2012; Friedlander et al., 2014; Heatherington et al., in press; Raymond, Friedlander, Heatherington, Ellis, & Sargent, 1993).

Therapeutic relationships. Various investigations of clients' perceptions of successful CFT, most of which are qualitative, point to qualities of the therapeutic relationship, including empathy (Hammond & Nichols, 2008), which was not considered a particularly important element of systemic therapies in the early days of their development (see Chenail et al., 2012, for a comprehensive review of this literature). Several investigations (Christensen, Russell, Miller, & Peterson, 1998; James et al., 2006; Sells, Smith, & Moon, 1996), for example, concluded that clients have favorable views of CFT therapists who demonstrate warmth, who are informal and authentic, and

who help them feel safe and develop clear treatment goals. It seems that clients tend to appreciate therapists who are "caring and understanding" as well as "able to generate relevant suggestions" (Kuehl, Newfield, & Joanning, 1990, p. 318).

These therapeutic qualities reflect the basic components of the working alliance (an emotional bond and negotiation of goals and tasks) that are central to individual psychotherapy (Bordin, 1979). A recent meta-analysis showed that the strength of the alliance—as rated by observers or as reported by clients—is as robust a predictor of outcomes in CFT as it is in individual therapy (Friedlander, Escudero, Heatherington, & Diamond, 2011). Indeed, even in disparate approaches to CFT, alliance is a key common factor (Davis & Piercy, 2007).

There are, however, some unique aspects of alliance in systemic therapies that have been carefully operationalized and studied intensively in the last 25 years. Two of these unique features are (1) the presence of "split" or "unbalanced" alliances among family members, and (2) within-system alliances (Pinsof, 1994), or the degree to which family members collaborate productively on the goals and tasks of conjoint therapy.

Split and ruptured alliances. Family members' disparate feelings about the therapist or about participating in therapy are common occurrences in CFT (e.g., Goldsmith, 2012; Heatherington & Friedlander, 1990; Knobloch-Fedders, Pinsof, & Mann, 2007; Robbins et al., 2006; Symonds & Horvath, 2004). Although these "split" or "unbalanced" alliances do not invariably lead to dropout (e.g., Flicker, Turner, Waldron, Brody, & Ozechowski, 2008; Muñiz de la Peña, Friedlander, & Escudero, 2009), severely split alliances tend characterize poor outcome cases more so than good outcome cases (e.g., Beck, Friedlander, & Escudero, 2006; Friedlander, Lambert, Escudero, & Cragun, 2008). On the other hand, the association between discrepant alliances and dropout depends on how the split is operationalized and how termination is defined (Bartle-Haring, Glebova, et al., 2012). It does seem that in couple therapy with heterosexual partners, the male partner's alliance with the therapist tends to be relatively more influential than the female partner's alliance (e.g., Bartle-Haring, Glebova, et al., 2012; Symonds & Horvath, 2004), but this pattern may differ depending on the therapist's gender and on which partner initiated the request for help.

Compared with the increased attention to alliance ruptures in individual psychotherapy, relatively little attention has been paid to the rupture repair process in systemic therapies. Operationalizing ruptures as clients' negative alliance-related behavior, either as challenges (e.g., questioning the therapist's competence) or as passive withdrawal (e.g., refusing to reply or avoiding eye contact), evidence suggests that parents as well as adolescents experience ruptures (Escudero et al., 2012; Friedlander et al., 2014; Heatherington et al., in press; Shelef, Diamond, Diamond, & Liddle, 2005). Since ruptures can lead to dropout, it is important to know how to repair them successfully (Goldsmith, 2012). Evidence suggests that by enhancing emotional connections, therapists can successfully repair even severe alliance ruptures (Escudero et al., 2012; Heatherington et al., in press). Moreover, it has been shown that in cases where ruptures are repaired (i.e., returned to their pre-rupture level) within one or two sessions, the outcomes tend to be better than in cases with no ruptures (Goldsmith, 2012).

Within-system alliances. Unbalanced alliances are often accompanied by poor within-system alliances (Pinsof, 1994), or that aspect of family members' relationships to each other that pertains to their ability to collaborate and function as allies in regard to their goals for the their therapy and their agreement about the appropriateness of the tasks in which they expect to engage in their therapy. Not surprisingly, when clients differ in their feelings about the therapist or about participating in treatment, the result is poor family collaboration (e.g., Escudero et al., 2012; Friedlander, Heatherington, Johnson, & Skowron, 1994; Friedlander, Lambert, & de la Peña, 2008), and a weak within-system alliance seems to be more problematic in couple therapy than either partner's alliance with the therapist considered alone (Anderson & Johnson, 2010; Pinsof, Zinbarg, & Knobloch-Fedders, 2008). Research suggests that families may experience a poor within-system alliance due to (i) differing views on the problems or potential solutions, (ii) differing views on the value of therapy for addressing problems and finding solutions, or (iii) family members not feeling connected in coping with their concerns, even when they agree with one another about the nature of these concerns (Lambert, Skinner, & Friedlander, 2012).

Also not surprisingly, a poor within-system alliance is readily observable in session (e.g., Lambert et al., 2012). Studies suggest that the within-system alliance is predictive of parents' reports of early improvement after the third session (Friedlander, Lambert, & de la Peña, 2008) and tends to strengthen over time (Escudero, Friedlander, Varela, & Abascal, 2008; Montesano, Feixas, Muñoz, & Compañ, 2014). There is some evidence that in heterosexual couple therapy, ae female partner's personal distress may *decrease* as the male partner's perception of the within-couple alliance increases, but her distress may *increase*

as his personal alliance with the therapist increases, underscoring the need to consider split alliances in the context of the within-system alliance, (Anderson & Johnson, 2010).

Systemic interventions and the process of change. The conjoint nature of CFT allows interventions that promote interpersonal change and learning, both directly and indirectly. In *reframing,* clients are encouraged to consider alternate constructions of their problems, via direct encounters with the therapist and/or each other, or indirectly, by witnessing changes between others. In *enactments,* therapists assess family interactions *in vivo*, and intervene to promote therapeutic change. Below, again as illustrations of some key change process research findings, we discuss each of these in turn.

Reframing. Typically, families present for therapy complaining about a specific family member (i.e., the identified patient), and typically, these complaints are formulated in intrapersonal terms (e.g., "my son is disrespectful" or "my husband is selfish"). One of the hallmarks of systems therapy is reframing the presenting problem in relational or interactional terms, rather than intrapersonal terms. Reframing can be accomplished with a range of interventions, including circular questioning (e.g., "Which person in the family most provokes your son's disrespect?"), initiating in vivo enactments of interactional patterns, and focusing on the function of the symptom or the impact of the problematic behavior on family relationships (Nichols & Tafuri, 2013). Reframing is designed to reduce blame and provide the rationale and motivation to identify and transform interactional patterns that cause or maintain distress.

A robust body of research focuses on reframing problems (and/or solutions) in interpersonal terms in family therapy and addresses associations between reframing and problem construction, as well as the immediate impact of reframes during the session. In regard to the therapeutic effects of reframing and problem constructions, parents participating in ABFT for depressed adolescents tend to define their problems in interpersonal terms after the therapist has made a relational reframe intervention (Moran, Diamond, & Diamond, 2005), such as. A statement or question that is designed to shift the focus of the conversation from the adolescent's depression to the rupture in the adolescent-parent relationship, e.g., "When your daughter is feeling depressed about not succeeding in school, does she come to you for support?" In constructivist family therapy, parents' problem constructions may shied from intrapersonal to interpersonal when each family member is

encouraged to express his or her individual perspective; the affective responses of family members may shift when the "new story" emerges and hope or the possibility of change is acknowledged. In terms of the immediate impact of reframing, delinquent adolescents in Functional Family Therapy may respond less negatively to a reframe intervention than to other types of interventions (Robbins, Alexander, Newell, & Turner, 1996). And in ABFT, when a therapist makes relational reframe interventions, attends to core relational themes, and highlights vulnerable emotions (e.g., pain, loss) associated with relational ruptures, parents tend to be less negative, particularly when the parent-therapist alliance is strong (Moran & Diamond, 2008).

Enactment. Perhaps the most unique feature of systemic therapies is the use of enactments, which are in-session family interactions, usually initiated by the therapist, e.g., "can you and your partner talk with your daughters about your rules regarding their use of the Internet?" Enactments allow the therapist to assess a couple's or family's relational patterns, and provide opportunities to restructure these patterns to facilitate change (Davis & Butler, 2004; Woolley, Wampler, & Davis, 2012). Indeed, enactments are a staple across a wide range of CFTs, including Structural Family Therapy, EFT and BCT.

Over the past 25 years, a number of process studies have attempted to map out therapist interventions and client performances associated with successful or productive enactments. Results indicate, for example, in helping family members remain engaged with one another in the session, therapists who focus family members on their thoughts and feelings about the impasse, on the potential benefits of engagement, and on their attributions for one another's behavior may be able to facilitate the family's movement from disengagement to sustained engagement (Friedlander et al., 1994). Additionally, during adolescent-parent enactments in MFT, adolescents may be more disclosing and their parents more open and responsive when therapists shift the focus of the conversation from the adolescent's problem behavior to feelings of pain, loss and regret associated with the relational rupture (Diamond & Liddle, 1996).

More recently, enactment has been examined in the context of CFT models that focus primarily on attachment and emotional processing, particularly EFT (Greenberg & Johnson, 1988) and ABFT (Diamond, Diamond, & Levy, 2014). These therapies use enactments to resolve ruptures in family members' attachment relationships and to create safer and stronger emotional connections. Consequently, research on these models has explored the

link between in-session enactments between family members, changes in attachment and emotions, and, in turn, changes in psychological relationship satisfaction, attachment, forgiveness and psychological symptoms. For example, studies examining the resolution process in EFT among couples treated for attachment injuries (e.g., infidelity, abandonment) suggest that couples who successfully resolve their attachment ruptures may become more affiliative with one another, that is, more disclosing, expressing needs, affirming and understanding. In addition, resolvers may exhibit deeper levels of experiencing (i.e., coming into contact with new feelings and new meanings related to such feelings) and less blaming, withdrawal and defensiveness behaviors (Makinen & Johnson, 2006; Zuccarini, Johnson, Dalgleish, & Makinen, 2013). Resolution is characterized by a softening process, during which the injured individual processes primary vulnerable emotions related to the injury, expresses needs for care and support, and the offending other responds in kind (e.g., expresses commitment to the relationship, shame and sadness). Specific strategies used by therapists to facilitate the softening process include reflection of primary emotion, evocative responding and heightening (Zuccarini et al., 2013).

In other studies (Woldarsky Meneses & Greenberg, 2011, 2014) the process of forgiveness has been examined in the context of EFT. Results suggest that he forgiveness process may require the injurer to contain and tolerate the partner's anger; accept responsibility for the injury, exhibit shame/regret/remorse/empathy; and express a heartfelt apology. With regard to the injured partner, forgiveness may involve a shift in the view of the other (Woldarsky Meneses & Green-berg, 2011). With regard to the link between interpersonal forgiveness and outcome, expression of shame, followed by acceptance and then forgiveness may be key to increasing relationship satisfaction in couples (Woldarsky Meneses & Greenberg, 2014).

These few examples illustrate the fruits of the past quarter century of research on the process of change in systemic therapy. These and other findings were made possible by parallel advances in the methodology of studying CFT, to which we now turn.

How We Know What We Know

In recent decades new self-report measures, observer rating systems, and statistical models have been developed to study therapeutic change across time. This is a major step forward, in that it facilitated a growing number of small sample and evidence-based case studies that demonstrated links between specific in-session processes and client outcomes (e.g.,

Escudero et al., 2012; Friedlander et al., 2014; Gill, Hyde, Shaw, Dishion, & Wilson, 2008; Montesano et al., 2014). Moreover, a few investigations highlight the value of systematically providing therapists with feedback from family members about how they view the treatment progressing (e.g., Anker, Duncan, & Sparks, 2009; Reese, Toland, Slone, & Norsworthy, 2010). In this section, we briefly review a selection of the measures, designs and analyses that have been used to capture systemic dynamics.

Measures. A key task for family therapy researchers is to adapt or devise new measures of important constructs to fit the systemic context. Considerable attention has been paid, for example, to the *therapeutic alliance* in systemic therapy An early set of self-report measures, the Couple Therapy Alliance Scale and the Family Therapy Alliance Scale) (Pinsof & Catherall, 1986) have more recently been factor analyzed, shortened and built into a comprehensive measure of family progress, as described below (Pinsof et al., 2009). Further, two observational measures of the alliance in CFT have appeared in the literature. The first, the VTAS-R (Diamond et al., 1999) is a revision of the individual therapy-focused Vanderbilt Therapeutic Alliance Scale. It contains 26 items concerning client behaviors in relation to the therapist, rated by trained judges. A factor analysis of ratings made from videotapes identified six VTAS-R items that reliably estimate "a positive working alliance" for parents and adolescents across three therapy approaches (Robbins, Turner, Alexander, & Perez, 2003): The client's acknowledgment of the problem, straightforward relating, open exchange with the therapist, apparent identification with the therapist's approach, experience of the therapist as understanding and supportive, and collaboration to solve the adolescent's or family's problems. The second observational measure, developed empirically from a review of the CFT literature, clinical experience, and an intensive analysis of taped family sessions in which clients' private perceptions of the alliance were known, is the System for Observing Family Therapy Alliances (SOFTA-o; Friedlander, Escudero, & Heatherington, 2006; Friedlander et al., 2006). Using the SOFTA-o, trained judges can reliably rate clients' behaviors on four dimensions: Engagement in the Therapeutic Process, Emotional Connection to the Therapist, Safety within the Therapeutic System, and Shared Sense of Purpose within the Family (similar to Pinsof, 1994) within-system alliance. The latter two dimensions reflect unique aspects of conjoint CFT. An e-version (Escudero, Friedlander, & Heatherington, 2011) allows coding of digitally video-recorded therapy sessions, and qualitative comments that are time-stamped, making it useful for

training, supervision and practice (Carpenter, Escudero, & Rivett, 2008; Escudero & Friedlander, in press) as well as research.

Another set of systemic constructs, *interpersonal control, complementarity, and symmetry in communication* (Bateson, 1935) was operationalized by adapting a system for coding dyadic relational discourse (Rogers & Farace, 1975) to multi-person groups. This measure, the Family Relational Communication Control Coding System (FRCCCS; Friedlander & Heatherington, 1989), has been used in several studies of conjoint family therapy (e.g., Beyebach & Carranza, 1997; Friedlander & Heatherington, 1989; Raymond et al., 1993). Most recently, the FRCCCS was used in conjunction with the SOFTA to identify patterns of interaction that characterized better versus worse alliances, as reported by observers (Muñiz de la Peña, Friedlander, Escudero, & Heatherington, 2012). Results suggested that competitive symmetry, reflecting a struggle for control, between therapist and adolescent may be more frequent in problematic alliance cases and may decrease in cases where the alliance improves over time.

Finally, the measurement of *progress and outcomes as well as processes* in CFT has seen advances. In systemic therapies, assessing outcomes requires attention to changes in both individual problems and relational problems. Tracking how people change in psychotherapy, along with the "feeding back" to clinicians of data on how clients are doing during the course of therapy—i.e., client focused "progress" or "feedback" research (Howard, Moras, Brill, Martinovich, & Lutz, 1996; Kazdin, 2007), has emerged in the past two decades as an important component of individual therapy, with empirical evidence demonstrating that tracking and regularly feeding back to clinicians client change data improves outcomes (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Lambert & Shimokawa, 2011; Shimokawa, Lambert, & Smart, 2010). Some adaptations of feedback systems for individual therapy have been adapted for family therapy (e.g., Partners for Change Outcome Research System; Miller & Duncan, 2004; Clinical Outcomes in Routine Evaluation; Stratton, Bland, Janes, & Lask, 2010), and one progress feedback system has been designed specifically for multi-systemic and multi-dimensional feedback, the Systemic Therapy Inventory of Change (STIC; Pinsof et al., 2008, 2009; Pinsof, Goldsmith, & Latta, 2012). The STIC consists of (i) an initial demographic questionnaire and an integrated set of client-report questionnaires to assess multiple client systems (e.g., individual, family-of-origin couple, family and child) that clients complete before the first session to identify clinical problems and set pre-treatment levels for tracking change; (ii) briefer versions of the six system scales

that clients complete after every session; and (iii) three brief alliance scales, to track in the alliance in individual, couple and family therapy over time (Pinsof et al., 2008). A software system and website (Psychotherapychange.org) collects STIC data, analyzes them and feeds them instantly back to therapists (and supervisors if desired), informing the therapist about any statistically significant changes in client functioning or alliance since the last session. This (Pinsof et al., 2008, 2009, 2012) set of scales, which has consistently demonstrated reliability and validity, permits investigation of how much couple therapy impacts adult, family and child functioning or how much individual therapy affects couple, family and child functioning, and can be used to test moderators and mediators of change. User friendly and Internet based feedback systems like the STIC, used collaboratively with clients as an integral part of treatment, begin to close the practice-research gap by giving therapists useful data to inform and influence the therapeutic process as it unfolds.

Designs and analyses. In recent years, group designs of systemic CFT therapies have become considerably more complex. The current process literature contains multi-level models that test for therapist effects (Anker, Sparks, Duncan, Owen, & Stapnes, 2011) and actor-partner interdependence (Anker, Owen, Duncan, & Sparks, 2010; Friedlander, Kivlighan, & Shaffer, 2012), and reciprocity has been studied in small samples using sequential analysis (Friedlander, Lambert, Escudero, et al., 2008; Moran & Diamond, 2008; Muñiz de la Peña et al., 2012; Raymond et al., 1993).

Evidence-based case studies, as defined by Carlson, Ross, and Stark (2012), include transcribed in-session data and quantifiable assessments of clinically meaningful changes across time (e.g., Escudero et al., 2012; Friedlander et al., 2014; Gill, Hyde, Shaw, Dishion, & Wilson, 2008; Heatherington et al., in press; Montesano et al., 2014). Some small sample studies report data on every session (e.g., Friedlander, Lambert, Escudero, et al., 2008) or on sessions selected for intensive analysis based on alliance (Moran & Diamond 2008; Higham et al., 2012; Lambert et al., 2012; Muñiz de la Peña et al., 2012) or session impact scores (Friedlander, Bernardi, & Lee, 2010).

The literature also contains qualitative analyses of a single, representative session (Sutherland & Strong, 2011), of a few sessions (Beck et al., 2006; Lambert et al., 2012; Moran et al., 2005), and of in-session moments that clients identified as especially good or poor (e.g., Bowman & Fine, 2000; Helmeke & Sprenkle, 2000; Strickland-Clark, Campbell, & Dallos, 2000). Qualitative studies have used methods based on grounded theory, conversation analysis

(Diorinou & Tseliou, 2014; Sutherland & Strong, 2011), ethnography (Kuehl et al., 1990), and constant comparison (Friedlander, Heatherington, & Marrs, 2000; Higham et al., 2012; Lambert et al., 2012).

To date, there have also been quite a few task analyses of change events (Bradley & Furrow, 2004; Coulehan, Friedlander, & Heatherington, 1998; Friedlander et al., 1994; Furrow, Edwards, Choi, & Bradley, 2012; Higham et al., 2012; Makinen & Johnson, 2006; Nichols & Fellenberg, 2000; Woldarsky Menses & Greenberg, 2014; Woolley, Wampler, & Davis, 2012). Discovery-oriented task analyses are particularly informative in that they illuminate step-by-step changes, in session, that lead to successful resolutions of specific issues. When followed up by larger scale studies (e.g., Woldarsky Menses & Greenberg, 2014), the specific change strategies can be analyzed in relation to post-therapy client outcomes. The findings of these kinds of studies are particularly relevant to clinical practice as well as for testing micro-theories of change processes.

Summary: Looking Ahead

This 25-year retrospective reveals considerable progress in systemic/CFT therapies, not only in the development of treatments, but also in the evidence base for their effectiveness and in methodologies for studying them. Needs and directions for future research have been addressed throughout this article with regard to specific topics, and point to some general future trends. To close, and as a charge to the next generation of systemic therapy researchers, we list some recommendations for what the next 25 years should bring:

(1) Demonstrations of therapy efficacy and effectiveness of CFTs across a broader range of individual *and* relational problems. Ideally, these demonstrations would also include increased attention to cost-benefit considerations, i.e., demonstrations that the costs of training and implementation of systemic treatments are offset by its benefits, such as preventing family violence, school dropout, and substance addiction.

(2) More fine-grained, nuanced research on change processes and moderators and mediators of treatment effectiveness. While we know that systemic therapies work, it is the answers to *how, for whom, and under what circumstances* that will deliver the most clinically important information to practitioners.

(3) More conceptual and empirical work on empirically supported principles of change in couple and family therapy.

(4) Broader study of the use of regular, systematic feedback over the course of therapy to therapists (and other stakeholders) about clients' functioning, to inform assessment, plan treatment and monitor progress for both clinical (mid-course corrections) and research (understanding how clients change) purposes. Researchers should assess the promise of this technology for diminishing the divide between researchers and clinicians by making data immediately useful, actionable, and relevant to practice.

(5) More collaboration between people engaged primarily in clinical practice, those engaged primarily in clinical research, and those engaged primarily in basic research on systemic processes in couples and families. The development of practice-research networks for CFT is recommended.

(6) The use of information technology, not only to deliver progress feedback, but also as an adjunct to treatment itself. The development, use, and study of "apps" in couple and family therapy is a wide-open arena for research.

(7) Consideration of the ways in which systemic thinking can be integrated into general psychotherapeutic thinking and practice. There is a considerable body of evidence that attention (both theoretically and practically) to interpersonal and contextual variables is not something that should just pertain to family and couple therapy. The field of psychotherapy needs to transcend the arbitrary family, couple and individual therapy distinctions and move toward a more inclusive, comprehensive and integrative perspective that links the systemic and individual (and perhaps biological) into an optimally successful psychotherapy.

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