How is Systemic and Constructionist Therapy Change Process Narrated in Retrospective Accounts of Therapy? A Systematic Meta-synthesis Review

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Abstract

Despite the considerable potential of qualitative approaches for studying the systemic and constructionist therapy process due to shared theoretical and epistemological premises, to date there is lack of a comprehensive qualitative synthesis of how change process is experienced and conceptualized by clients and therapists. To address this evidence gap, we performed a systematic meta-synthesis review of 30 studies reporting clients' and therapists' retrospective narratives of change process across systemic and constructionist models and across a range of client configurations, including individuals, couples, families and groups. The studies were identified following a systematic search in PsycINFO and MEDLINE resulting in 2977 articles, which were screened against eligibility criteria. Thematic analysis led to the identification of four main themes; 1) navigating through differences, 2) towards non-pathologizing construction of problems, 3) navigating through power imbalances, 4) towards new and trusting ways of relating. Findings illustrate the multi-faceted aspects of systemic and constructionist change process, the importance for their reflexive appraisal and the need for further research contributing to the understanding of the challenges inherent in the systemic and constructionist therapeutic context.

Keywords: Change process; constructionist therapy; psychotherapy process; systematic meta-synthesis review; qualitative research; systemic therapy

In this paper we present a meta-synthesis of qualitative studies focusing on systemic and constructionist psychotherapy change process, which have sampled client and therapist post-hoc narratives of therapy process. Our aim is to depict how change process is experienced and conceptualized by therapists and clients.

With the term "systemic and constructionist approaches" we refer to a variety of models and approaches from the field of couple and family therapy (for an overview see Sexton, & Lebow, 2015), which, despite their differences, share common premises (see also, Tseliou, Burck, Forbat, Strong, & O'Reilly, in press). Such approaches depart from merely treating individual psychopathology, in that they endorse a holistic, contextual perspective, focusing on discursive, meaning-making, interaction between therapists and clients for the understanding and the treatment of mental distress (Heatherington, Friedlander, Diamond, Escudero, & Pinsof, 2015). By leaning on systems or discursive theories, such approaches endorse a preference for a recursive instead of linear perspective concerning therapy process and change (Heatherington et al., 2015) and for considering language as constitutive of phenomena and not as merely mirroring the world (Austin, 1963). Accordingly, they conceptualize change process as a joint, discursive, interactional accomplishment, where clients and therapists engage in a dynamic process of mutual influence through continuously negotiating meaning while interpreting each other's contributions in the therapeutic dialogue. Such approaches conceptualize change process as facilitated by therapist's multi-partiality and collaborativeness and as entailing shifts towards new ways of understanding, communicating and relating, celebrating the acceptance of difference and favouring non-pathologizing constructions of problems which emphasize positives and strengths (Anderson, 2012; Strong & Smoliak, 2018 cited

in Tseliou et al., in press).

Psychotherapy process -as opposed to outcomes (see Gelo, Pritz, & Rieken, 2015 for an overview)- constitutes a key focus in psychotherapy research for the past few decades. Innovative proposals aiming to overcome such dichotomy have suggested to approach change as the study of small outcomes within process (Pinsof, & Wynne, 2000). Consequently, Change Process Research (CPR) investigates both such outcomes but also in-therapy processes which bring about such outcomes (Elliott, 2010), aiming, e.g., to unpack how the therapeutic relationship or the therapeutic interventions work over the course of the therapeutic dialogue. CPR of couple and family therapy has contributed pertinent insight into common factors facilitating therapeutic change, like alliance (Friedlander, Escudero, Heatherington, & Diamond, 2011; Sprenkle, 2012; Sprenkle, Davis, & Lebow, 2009; Sprenkle, 2012). Reviews of mostly quantitative CPR of systemic therapy (Friedlander, Wildman, Heatherington, & Skowron, 1994; Friedlander, Heatherington, & Escudero, 2013; Heatherington, Friedlander, & Greenberg, 2005; Heatherington et al., 2015), however, documented the paucity of CPR as compared to efficacy research and underscored the need for methodological advances which can better attend to the challenges posed by systemic and constructionist approaches.

A significant methodological challenge for CPR is the preference of systemic and constructionist therapeutic approaches for complexity and interdependence (Tseliou & Borcsa, 2018). Positivist research methodologies seem to bear limitations when the aim is to unpack the detail of complex processes as unravelled in multi-actor, interdependent contributions to therapeutic dialogue (e.g., Friedlander et al., 2013). As far back as the 1950's, early contributors in the field like Bateson employed approaches which resemble

hermeneutic, qualitative research methodologies (Tseliou, & Borcsa, 2018). The latter share the systemic and constructionist preferences for approaching phenomena with a perspective favouring holism, inter-complexity and the performative aspect of language use (O'Reilly, & Lester, 2017; Tseliou & Borcsa, 2018). Given also the potential of qualitative research methodologies for advancing knowledge of psychological phenomena by allowing for thick descriptions and theoretical advancements from participants' own perspective (Willig, 2019), they can contribute a holistic, in-depth approach to the study of change process from therapists' and clients' point of view.

A limited number of reviews have focused exclusively on qualitative research of systemic and constructionist therapies (e.g., Chenail et al., 2012; Franklin, Zhang, Froerer*, &* Johnson, 2017*;* Grácio, Gonçalves-Pereira, & Leff, 2016; Ong, Barnes, & Buus, 2019a; 2019b; Tseliou, 2013). These reviews have depicted the potential of qualitative research to highlight nuances of the therapeutic process which otherwise remain obscure, thus enhancing opportunities for practitioner reflexivity on the details of therapeutic practice, while contributing to researcher-practitioner dialogue (Burck & Simon, 2017; Strong, 2016). However, with the exception of Chenail et al. (2012), who present a qualitative meta-synthesis of clients' experience of couple and family therapy and Ong et al. (2019b) who present a narrative review of conversation analysis studies of family therapy findings, they have mostly focused on methodological issues of the reviewed studies. Chenail et al. (2012) have reported only client's experience of conjoint couple and family therapy, whereas Ong et al. (2019b) have focused on in-session dialogue.

Thus, to-date, the field lacks a comprehensive overview of how therapists' and

clients' narratives distill their experience and conceptualization of systemic and constructionist change process, in respect of what they perceive as facilitating change or what they may consider as hindering change.

To address this gap, we conducted a meta-synthesis of qualitative studies focusing on retrospective accounts of how clients and therapists conceptualize and experience systemic and constructionist therapy change process. Sixty-five studies were identified which reported how clients and therapists conceptualize, experience and discursively perform systemic and constructionist change process. In this paper we synthesize a sub-sample of 30 papers which report retrospective accounts of change process. The remaining 35 papers, reported elsewhere (Tseliou et al., in press), explore the discursive performance of change process within-session dialogue. Given systematic reviews' publication standards, below we inevitably reiterate the description of methods.

Method

Design

Drawing on constructionist epistemology (Tseliou et al., in press), we conducted a systematic review using meta-synthesis methodology to synthesize heterogeneous qualitative data. Meta-synthesis is a standard, systematic approach for synthesizing qualitative research studies' findings (Chenail et al., 2012; Sandelowski & Barroso, 2007; Willig & Wirth, 2018). We followed standard protocols for searching, screening, data extraction and synthesis (Higgins & Green, 2011; Moher et al., 2015; Shamseer et al., 2015). Our review included a scoping element (Levac, Colquhoun, & O'Brien, 2010; The Joanna Briggs Institute Reviewers' Manual 2015) to map the field of qualitative research

of systemic and constructionist therapy process. The systematic review protocol was registered in the PROSPERO database (CRD42018097369).

Search Strategy

We performed a pilot search in the PsycINFO and MEDLINE data-bases (EBSCOhost) in June 2018. We then ran a final, extended search in July 2018, without posing any limitations in date of publication (for search terms, see Table S1[1], SuppInfo, supplemental material).

Our search yielded 3343 results (2660 PsycINFO, 683 MEDLINE) of which 65 articles were eligible. This paper reports the sub-group analysis of 30 papers examining retrospective accounts (see Figure 1 for PRISMA flow diagram) whereas in our other article (Tseliou et al., in press) we synthesize the remaining 35 reporting in-session dialogue.

Insert Figure 1 here.

Inclusion and Exclusion Criteria

We defined our inclusion and exclusion criteria (see Table S2, SuppInfo, supplemental material) according to SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) (Cooke, Smith, & Booth, 2012). The review focused on primary qualitative research studies of systemic and constructionist therapy process published in peer-reviewed journals only in English (main language of the review group).

[1]We follow the same table and figure format like in our other article (Tseliou et al., in press).

Defining inclusion and exclusion criteria concerning change process was a challenging task given the lack of a clear definition of process in the field, and the extensive discussion regarding the process and outcome divide (Franklin et al., 2017; Pinsof & Wyne, 2000). Due to our scoping aim, we decided to be as inclusive as possible and defined change process as referring to processes which bring about change, taking place as therapy unfolds and to changes reported by clients and therapists, following change process conceptualizations (e.g., Elliott, 2010; Franklin, et al., 2017), thus including studies reporting clients' and therapists' narratives concerning both. Because we were interested in reports depicting change processes for models espousing systemic, constructionist or dialogic and not linear theories for treatment, we included first-order cybernetic models, like structural family therapy and post-modern developments, like narrative or dialogic approaches. Such models/approaches conceptualize change processes as mutually negotiated, interpretative, meaning-making processes, jointly accomplished by therapists and clients, constituting our focus here (Tseliou et al., in press). Accordingly, we excluded family therapy models leaning on behavioural or psychodynamic approaches and integrated or mixed-model manualized treatments if they included such approaches, as well as consultation and role-plays. We posed no restriction on session format, type of client population, therapy setting and reported problem. We included papers citing use of a systematic qualitative research method from the inductive, hermeneutic tradition in qualitative research (Willig, 2019). Our choice to focus on a variety of such qualitative research methods, relates to our aim for articulating change processes by following a bottom-up perspective depicting therapists' and clients' own accounts of change processes. We included two studies (papers 33 and 53 in Table S3,

SuppInfo), where although the term "grounded theory" was not explicitly used, authors reported the use of the "constant comparison method" citing Strauss and Corbin. We excluded mixed method studies due to our sole focus on inductive, hermeneutic qualitative studies and excluded non-research, clinical or quantitative case studies. Given our interest in original research studies, we excluded systematic reviews and meta-analyses.

Finally, we included only studies analysing qualitative data, collected by observation (including audio and videotaped sessions) and by self-report (interviews or focus groups) due to our interest in capturing change process as both the unfolding of the actual in-session therapeutic dialogue but also as the narrative of the experience of the therapeutic encounter. Here, however, we synthesize only the second group (retrospective narratives) (criterion 8, Table S2, SuppInfo, supplemental).

Procedure of Screening

Following the removal of duplicates, 2977 titles and abstracts were screened against inclusion and exclusion criteria by all team members, excluding, for example, articles reporting clinical case studies and articles not reporting empirical data. Team members indicated their decision and rationale for exclusion. Reviewers' screening was cross-checked and authenticated by other team members and verified by the lead author for consistency. We resolved cases of disagreement via discussion and comparison against the criteria. Our preference for consensus rating reflects our constructionist epistemological preferences (see also, Franklin et al. 2017). This process resulted in 309 articles judged eligible for full-text screening. Utilising the same process, 65 articles were

judged as eligible for inclusion (for a full list see SuppInfo, supplemental material) (Tseliou et al., in press). Here we synthesize 30 papers out of 65, focusing on retrospective accounts of change process (see SuppInfo for Tables S3, S4 and the list of synthesized references).

Data Extraction

All team members piloted the tables constructed by the lead author who then revised them following group discussion. Tables S3 and S4 (SuppInfo, supplemental) present synthesized studies' characteristics including quality appraisal, and information on whether papers sampled in-session discourse or post-hoc narrative as their data. Table S6 (SuppInfo, supplemental) was designed for the extraction of findings of studies synthesized here. For data extraction we followed both an inductive and a deductive process. For example, in Table S3, team members could choose from pre-constructed codes like "individual, couple, family, network, group" to code session format. On the contrary, in Table S6, we extracted studies' findings verbatim from the articles (for an overview of codes and abbreviations of tables S3 and S4, see table S5, SuppInfo, supplemental). All team members were involved in data extraction, with the lead author extracting data for 50% of the articles. The lead author cross-checked data extraction and two team members cross-checked the lead author's data extraction (authors 2 and 4). Disagreements were resolved via discussion and the lead author refined the final tables.

Devising a strategy for data extraction of the studies' findings was a challenge for several reasons (Chenail, et al., 2012; Timulak, 2009). First, the findings of the included studies varied, based on each study's analytic methods. Second, the articles included

lengthy reports of findings. Third, in many cases, excerpts of data were scattered within analytic claims. We proceeded with a variety of practices depending on the particularities of each paper, including: a. to extract analysis verbatim b. to extract as much detail as possible c. in cases where excerpts were imbedded with analytic claims to extract all text. For the rest of the cases we chose to extract only analytic claims or simply categories or themes if there was no further analysis included (for data extraction of detailed, sequential, micro-analysis, in Conversation Analysis (CA) and Discourse Analysis (DA) studies, reported in our other paper, see Tseliou et al., in press).

Quality Appraisal

As reported (Tseliou et al., in press), we appraised studies' quality using CASP (Critical Appraisal Skills Programme, 2017) to indicate studies' rigour to the reader, rather than as a mechanism to exclude research from our review (Willig & Wirth, 2018). Quality appraisal in systematic reviews of qualitative research studies is a debated issue, due to the existing variability regarding the epistemological preferences of different qualitative research methods (Willig, 2013). For example, reflexivity may apply to constructivist grounded theory or Interpretative Phenomenology, but CA and DA methodologies may require attendance to idiosyncratic criteria like sequential analysis grounded on next-turn proof or deviant case analysis (Ong et al., 2019; Tseliou, 2013).

Given that CASP is not a psychometrically tested tool but only provides a list of broadly defined evaluative criteria, we included two additional criteria, the inclusion of evidence (i.e. extracts) and the type of analysis (i.e. sequential or not when applicable) (see Table S4, SuppInfo; see also, Tseliou et al., in press). One team member (author 2)

and the lead author screened all papers independently and cross-checked each other's screening. Disagreements were resolved via discussion, aiming to reach an agreed understanding through dialogue, rather than to undertake a confirmatory approach. The column "quality appraisal" (Table S3, SuppInfo, supplemental) reflects final decisions concerning the CASP screening and the screening against method specific criteria. Table 7.2 (SuppInfo, supplemental) presents an overview of quality appraisal of the studies synthesized here.

Method of Analysis

We employed a descriptive-interpretative analysis (Timulak, 2009), broadly following thematic analysis principles (Braun, & Clarke, 2006) and treated authors' discourse reporting their findings, as our data. We acknowledge the tensions involved in synthesizing findings from qualitative studies, employing different methods to analyse different types of data (Timulak, 2009). Therefore, we conducted two sub-group analysis of the total sample of 65 studies. Of the 30 studies synthesized here, two (articles 20 and 35 in Table S3, SuppInfo) reported some in-session data but mostly retrospective accounts and this is why they are included in this sub-sample. We refrained from re-analysing extracts included in the synthesized studies aligned with arguments concerning the difficulty of doing so without access to their discursive context (Willig & Wirth, 2018). Our analytic process included two stages. In the first stage, we engaged in a process of open coding by assigning codes, including in vivo ones (verbatim phrasing), to the extracted text of studies' findings in as much detail as possible. We then grouped codes in sub-themes under broader, main themes by contrasting and comparing them

within and across papers and by trying to keep as much variability as possible. Analysis at this stage depicted 5 main themes with 33 sub-themes, illustrating reported changes and therapeutic interventions alongside therapists' ways of relating, facilitating but also hindering change processes. Author 2 cross-checked analysis performed by the lead author and verified by all group members (Tseliou et al., in press). Stage two included a comparison across the 5 main themes and 33 sub-themes, aiming to illustrate different aspects of change processes and facilitators and hindrances *per each aspect*, resulting to a revised schema of main themes and sub-themes. We then proceeded with screening the synthesized papers once more for further evidence of our schema and for disconfirming cases. We also engaged into extracting data excerpts to illustrate our sub-themes. Our revised schema of 4 themes and 12 sub-themes is reported here (for details, see Table 8, SuppInfo; see also Tseliou et al., in press for a similar process). All group members verified analysis of this stage, performed by the lead author.

Findings

Synthesis of Studies' Characteristics and Quality

For an overview of the 30 studies' characteristics see tables S7.1 and S7.2 (reported in SuppInfo, supplemental due to space limitations).

Studies were published between 1994 and 2018. Eight out of 30 were non USA - non European studies (1: South-Africa, 1: Australia, 1: Japan and 5: Canada) and 22/30 were USA-European (11 USA and 11 European). Studies' focus varied, including the investigation of how a model is implemented (8/30) or a broadly defined investigation of overall process (11/30). Fourteen out of 30 sampled only adults, 2/30 only children, 10/30 adults conjointly with children, adolescents or both and 4/30 did not specify patient

population. Therapist population was not specified in 9/30 cases, whereas 12/30 cases reported a therapeutic team. Eighteen out of 30 explored clients' views or experiences of process, 3/30 therapist's and 9/30 both clients' and therapists' views. Ten out of 30 sampled sessions with an exclusive couple and 14/30 with an exclusive family configuration, whereas in one case the configuration was network. Five out of 30 cases sampled a mixture of session format, including individual sessions in 4/5 cases. Of the 30 studies, 18 reported constructionist models, verbatim citing "reflecting team" (5/30), "solution focused brief therapy" (3/30), "constructionist" and "dialogic systemic couple therapy" (2/30), "collaborative, narrative and reflecting team" (2/30, coded as variety of constructionist), "narrative" (2/30), "postmodern" (1/30), "Post-Milan" (1/30) and "open dialogue" (1/30), 5/30 reported systemic family therapy (verbatim citing "SFT"), mostly not specified (3/5), 5/30 reported eclectic/integrated approaches (verbatim citing "eclectic", "integrated" or models like "Milan" and "Narrative") and 2/30 reported a variety of systemic and constructionist models (verbatim citing various models like "strategic", "solution focused", etc.) (see Tables S3, S5 and S7.1, SuppInfo for details).

Most studies deployed Grounded Theory methodology (17/30). Nineteen out of 30 did not explicitly state their epistemological approach. Fourteen used semi-structured interviews and 8 deployed Interpersonal Process Recall (IPR) procedures. Eighteen out of 30 did not specify transcription type and most (23/30) included evidence of analysis, i.e. excerpts of data. Concerning quality, 3 studies (articles 1, 45, 54 in Table S3, SuppInfo) were assessed as fulfilling all CASP criteria, 18/30 as lacking reporting of adequate attendance to ethical procedures, 8/30 as bearing flaws in research design and 12/30 as inadequately addressing the researcher-participant relationship.

Qualitative Meta-Synthesis of Studies' Findings

Analysis designated 204 initial codes, synthesized to 4 main themes and 12 sub-themes. For an overview of main themes, sub-themes and references, see Figure 2.

Insert Figure 2 here.

Below we present the main themes, each one including three sub-themes, depicting client's and therapists' *experience and conceptualization of change process*. All themes illustrate the reported change processes highlighting the dynamic process of clients' and therapists' navigation through hindrances and facilitators concerning therapeutic interventions and the ways of therapists' relating with clients. Theme 1, "Navigating through differences", synthesized from 21 papers, highlights shifts towards new ways of communicating via clients' and therapists' negotiation of different perspectives concerning the reported difficulties, with the therapist connecting from a position of fairness and impartiality. Theme 2, "Towards non-pathologizing construction of problems", synthesized from 18 papers, illustrates the development of new ways of understanding the reported difficulties via therapists' emphasizing positives and strengths and normalizing, at times experienced by clients as a hindrance. Theme 3, "Navigating through power imbalances" highlights the process towards empowerment and agency through a dynamic movement between therapists' expertise and collaboration, directivity and non-directivity. Finally, Theme 4, "Towards new and trusting ways of relating" illustrates shifting towards new ways of relating by means of experiencing safety, trust and care in the therapeutic relationship. Due to space restraints, instead of using in-text citations we report the studies' reference numbers as appearing in Table S3 (SuppInfo,

supplemental). We also include verbatim data extracts in the format they are reported by synthesized studies, to illustrate our analytic claims.

Theme 1. Navigating through differences.

Theme 1 depicts how clients' and therapists *navigate through differences in epistemologies* about the reported difficulties, and how *fairness and impartiality* seem to facilitate *shifts towards new ways of communicating*.

Navigating through different epistemologies. Fourteen studies illustrate the dynamic process of therapists' and clients' negotiation of different perspectives concerning the reported difficulties within the challenging, multi-actor setting of systemic and constructionist therapies. Specifically, clients and therapists espouse *different epistemologies* regarding the reported difficulties (5, 21, 54), by ascribing to different theories of change, with clients rarely expressing systemic views (54). Overall, therapists are reported as struggling to combine their systemic perspective with family members' linear views concerning the reported difficulties and unbalanced allocation of responsibility (5). Such struggle is reported as coupled with their difficulty to maintain neutrality (5, 21) and with clients' difficulty to understand the necessity for a relational orientation of therapy, like in the case of depression treatment (48).

Extract 1a (48, p. 53)

"One somehow becomes labeled…if one has to go to couple therapy you feel like the relationship…it's the name couple therapy…it means that the relationship is the problem…I don't think that's kind of the issue here since I think that the problem here has more to do with my work" (H14).

At times, such process seems to result in a lack of coordination of meaning, particularly in cases of cultural difference (20, 26). Also, family members report *feeling disconnected and unsafe* (26) or confused (48). Therapists, on the other hand, report an *impasse*, referring to their feelings of anger (26), helplessness and frustration due to the excessive degree of blaming between family members. Such blaming is challenging for "therapist idealism" (5, p. 314), at times resulting in the therapist feeling stuck (14, 26).

Overall, however, clients acknowledge the *merit of engaging with difference*. Therapists' noticing of differences or pointing out issues in a different way and allowing for different perspectives to emerge (1, 33), as well as being exposed to different ways of conceptualizing problems in the context of a reflecting team setting (34, 51), are reported as helpful and beneficial towards allowing for the expression of different views (26, 51, 54).

Extract 2 (51, pp. 256-257)

***Wife*#2:** Some people might not like an audience [the reflecting team]. It didn't bother me. From my viewpoint, more opinions could only help. They might think of something one regular counselor doesn't see. It might bring up a point to make everything crystal clear.

On the other hand, therapeutic team settings like reflecting teams, are also reported as a hindrance due to clients' *unfamiliarity with the setting*, constructing an unusual experience (1). Clients report difficulties with the recording of sessions, the team configuration and what they narrate as artificial in atmosphere (39), given their lack of familiarity with therapists' techniques (26). Such atmosphere is reported as fostering fear of judgement and evaluation (14, 45), feeling exposed (34) and not knowing how to

participate (14), lack of sense of safety and feelings of disconnectedness (26), bewilderment (30) or uneasiness (45), coupled with anxiety for the unknown, alien setting (26, 34).

Extract 3 (1, pp. 241-242)

Like they talk to one another, they don't look at us...a bit strange. (Tina).

Interviewer: ...And did you understand what they were talking about?

Tina: I don't know why they do that, to be honest.

Interviewer: ...Can you tell me about your feelings when they're doing that?

Tina: *slight pause* Confused.

Fairness and impartiality. Twelve studies highlight how therapist *fairness and impartiality* facilitated family members' movement towards shared accountability for the reported difficulties. Both therapists and clients considered as critical the role that therapists' interventions may play in *balancing tensions* arising out of family members' different perspectives concerning accountability for the reported difficulties (53, 63, 65). The therapist acting as a mediator or facilitator (53) when intervening to stop negative interaction cycles enacted by family members (63), while inviting and accepting difference at the same time (65), were constructed as facilitative of change process. In couple work, for example, therapeutic interventions included engaging couple partners in positive and rewarding interaction while going through difficult relational issues (63). Clients further, underscored the importance of *therapist impartiality*, i.e. the therapist welcoming a multiplicity of perspectives while not taking sides, *being fair and multi-*

partial (6, 8, 34, 39, 45, 48, 52, 53, 54), thus facilitating family members' reflection on their role in the reported difficulties (34, 65). Such processes seemed coupled with the importance of the therapist making family members feel as being treated equally (6, 45). In particular, clients highlighted the unhelpful aspect of therapist unequal treatment of couple partners (6) and the hindering effect on change process of team members presenting a partial, unbalanced view leading to feelings of vulnerability (14).

Extract 4 (52, p. 332)

Wife #2: He's a good mediator because he hears both sides. Like your friends are partial to one side or the other. J is objective and does not take sides. I like this.

Shifting towards new ways of communicating. Seven studies illustrate how navigating through differences both among family members but also between therapists and family members was reported as facilitating shifts towards *new ways of communicating*. Family members reported altered (34) and improved communication related to different ways of understanding, indicating emotional connectedness (8). They also reported more sincere communication including the open expression of vulnerability narrated as leading to higher hope for change (15). Family members' potential to communicate differently seemed enacted within an open and relaxed atmosphere in therapeutic sessions, where they reported feeling safe to engage into conversations with each other, as opposed to doing so in the unsafe environment of home (45, 48). Consequently, family members reported changes in the family climate with family members being more "thoughtful and considerate, showing more patience and respect for each other" (53, p.153), as well as better communication, like in the case of not being

afraid to talk openly (53), or in the case of communication facilitating boundaries' setting by parents (52).

Extract 5 (8, p. 181)

"I'm finally able to talk to my partner and listen without becoming angry."

Theme 2. Towards non-pathologizing construction of problems.

This main theme depicts change processes entailing shifts towards *non-pathologizing construction of problems* leading to the *development of new ways of understanding* by means of a *balanced emphasizing of positives and strengths*.

Normalizing difficulties and (over)emphasizing positives. This sub-theme, synthesized from eleven studies, illustrates the process of *highlighting positives and normalizing difficulties*, at times reported by clients as also hindering change processes and leaving them feeling as not been understood. Therapists and clients report therapists' efforts to refrain from locating problems within individuals or identifying individuals as the problem (39), while trying to forward a non-pathologizing view (56) by means of emphasizing positives (1, 16, 33, 39), reframing, finding exceptions and providing a different perspective (63). Non-pathologizing constructions of problems were further enhanced by means of normalizing reported difficulties (63). Therapists and clients report how normalizing clients' problems and ongoing challenges (8, 16) by constructing them as normal, realistic (16) and understandable (8) facilitated change process.

Extract 6 (56, p. 243)

''When I felt I'd failed in something, then they saw it from another angle . . . and turned it into something positive . . .

and when you're constantly lifted like this, then you do a better job'' (F2).

On the other hand, *overemphasizing positives* (9, 14, 15) was also reported as hindering change process, leaving family members feeling that the therapist does not directly address the problem and does not really understand their difficulties (14, 52).

Extract 7 (14, pp. 30-31)

I didn't feel like I was doing as much as she [the RT member] was giving me credit for. So in a sense there I [had] a bit of that vulnerability, because I saw her seeing me as higher up than I see myself. She saw me as doing more than I see myself doing, and that kind of made me feel like maybe I'm not doing enough.

Instilling hope and (over)emphasizing strengths. Fourteen studies illustrate how non-pathologizing was further facilitated by *emphasizing strengths and instilling hope*. Clients and therapists refer to the therapist amplifying clients' strengths and resources (1, 15, 16, 33, 39) and emphasize the importance of therapists' interventions *facilitating empowerment and instilling hope* (8, 15, 16, 33, 39, 63). They further report the therapist identifying relational strengths, like good communication, commitment and respect (16) and highlight how therapists' focusing on strengths, instills hope (8, 63). Clients and therapists narrate how therapists further expressed statements of hope and support (15, 16, 63) and celebrated steps (63) while providing reinforcement for positive growth (15, 16), which then looped back to clients' hopefulness that things will improve (16). Therapists also highlighted the importance of themselves holding hope and believing in clients' potential for healing and change (35) by drawing on their own hope and spirituality while trying to create a context for hope (63).

Extract 8 (33, p. 63)

(therapist quote) I believed she could do it. .. found strengths and resources she had through questions

On the other hand, clients underlined the importance of the *therapist also being challenging* and, when needed, confronting family members (53, 54). *Overemphasizing strengths* (9, 14, 15), or therapist or family members' excessive hope and high expectations (9) without addressing the problem directly (48, 52) were reported as enhancing clients' vulnerability (15), at times hindering change process.

Extract 9 (54, p. 276)

Connie: I felt I accomplished a little, but I did wonder if he understood the problems and difficulties I'm facing. When he said how I should be proud of what I had achieved, I felt good. But, I didn't come to therapy to talk about how things were going well. Why would I come if everything was so great?

Developing new understandings. Seven studies highlighted how non-pathologizing constructions of problems seemed to facilitate shifts towards *new ways of understanding*. Clients reported *engaging with new perspectives* (19) and insight, coupled with increased understanding and awareness (8) both triggering changes in affect (8, 19) and behaviour (19), like feeling more capable, confident and hopeful (34, 53, 54). Therapists reported how the process of clients' undertaking new perspectives was interrelated with the process of client's discovering new or different connections between aspects of their lives and among each other, thus conceptualizing experiences under a different light (19). Enabling new understandings included viewing the reported difficulties in an altered way (51, 53), with clients and therapists reporting how this was

connected with clients' being exposed to the different views concerning the problems which were openly expressed (52), like in the case of a reflecting team session (51).

Extract 10 (8, p. 183)

"The therapist helped to change things by pointing out the other person's feelings which you might not have realized. It just gave me insight into how selfish I was. I'm more aware of her feelings instead of just my own."

Theme 3. Navigating through power imbalances.

This main theme illustrates how the dynamic process of therapists' *oscillating between expertise and collaboration and directivity and lack of directivity* is coupled with processes of *shifting from powerlessness to agency*.

Oscillating between expertise and collaboration. Fourteen studies illustrated how therapists and clients highlighted a delicate balance between therapists' expertise and collaborative practices. On the one hand, therapists and clients highlighted the need for *collaboration* and for the therapist *sharing expertise*, i.e. the need for both the therapist and clients respecting each other's knowledge and expertise and jointly deciding about the goals of therapy (30, 45, 53, 56). Therapists were reported as being flexible and as engaging into practices in which they asked for permission of family members or shared decisions regarding the sessions' content, while respecting clients' needs (45), trying to bring clients' expertise into the process (54). Therapists were, thus reported as using their power in a different way, more from a position of a collaborator (35, 45), treating clients as experts (39), while being flexible, transparent and reflexive (21, 48, 56), engaging into participatory practices argued as "blurring their differences" with clients (56, p. 240).

Extract 11a (54, p. 277)

Gail: I thought she was gonna tell us what to do and that she was gonna do all the talking. But she listened. She let us talk. And she didn't cut us off. She let us go at our own pace. With family therapy you kind of control it in a way. They don't control it. So it's not so bad as I thought it would be.

Extract 11b (56, p. 240)

''If you don't have (mutual participation), it's easy for the therapist to see themselves as an expert, which can make family involvement more difficult'' (T.C.). ''Instead . . . I do try to treat them as experts and elicit their expertise.''

On the other hand, there were cases where collaboration did not work and therapy got stuck (48). The *power imbalance* between therapist and clients, such as therapist's dominance in dialogue, unequal treatment of family members (6) and allowing unequal participation of family members (9) or therapist's disrespect for clients' needs (45) was reported as possibly leading to clients' feelings of disempowerment, lack of control and safety (26), including difficulties in speaking or problems in collaboration (48). Children particularly could feel excluded or confused about rules (31). Furthermore, clients expected the therapist to be more expert (30) and argued for the necessity for therapist exercising "professional authority" (56) and giving advice (52).

Extract 12 (52, p. 334)

Husband #5:

I've talked with a lot of counselors, and they always come up with this thing in a soft voice and it's like, "Well, what's been going on with your life?' and "How do you feel?" It's bullshit. I

want someone to come straight to the point and give me their impressions of what to do. I don't want to be talked down to like I am a kid. I'm a professional, so talk to me like one.

Balancing directivity with lack of directivity. Seventeen studies highlight the dynamic process concerning therapists' movement from directivity to non-directivity. For clients and therapists, therapists' interventions should accomplish a *balancing of directivity with lack of directivity* (20, 21, 22, 35, 48, 52, 53, 54, 56). In particular, they highlight how therapists balanced being directive, e.g. by making use of practical suggestions (22) and offering concrete help, advice and guidance (48, 53, 54, 35), with not being directive (20), while refraining from offering advice and guidance and offering suggestions instead of directives (54). Therapist's non-directivity was narrated as therapists' refraining from imposing their own view or exercising pressure on clients to adopt a particular view and, instead, allowing clients to find their own way and determine the focus of therapy (6).

Extract 13 (part of original extract) (6, p. 300)

Nina: To me it's like we went to [our therapist], and we said to her "we want to dig a big hole. But we're in the dark and we don't know how. But we want to." And she said "Okay I'll hold the light for you." And we did the digging ourselves.

On the other hand, clients and therapists acknowledged the importance of the therapist being *active and directive* (48), e.g., in structuring the session, by having a focus (33) and a plan (17), setting a timeframe (63) and taking responsibility for what is discussed (6), while constantly monitoring the overall process (56). Therapists' organizing and structuring the session was also reported as helpful (48, 56), including

paying attention to the rhythm and pacing of the process (8) by allowing time (21, 34, 56). Accordingly, not allowing for enough time within the session or in treatment overall (6), engaging into premature questioning or too slow pacing (39, 54) were reported as problems.

Finally, clients feeling that *therapy lacks direction*, e.g. when the therapist failed to provide a concrete or clear treatment plan (52, 53), while simultaneously refraining from providing directions (14) was reported as hindering change process.

Extract 14 (52, p. 334)

***Husband** #8:* I'm not clear what we are trying to accomplish and I'm frustrated.

From powerlessness to agency. Twelve studies illustrated the process of shifting towards empowerment and agency. Therapists and clients identified *shifts from powerlessness to acquiring personal agency and competence* (5, 35, 39), confidence and satisfaction (53). They further reported a gradual sense of *empowerment and increased self-efficacy* (16, 30, 35) including enhancement of feelings of self-worth (30) and seeing self under a new light (6, 19). Additional shifts reported, include a *shift from hopelessness to hope* (15, 16, 35, 63) and a shift towards increased hope and courage (17, 35, 55). Change processes were reported as including processes making clients aware of their own abilities (35). Therapists' non-directivity and externalizing conversations, in particular, were reported in one study (39) as contributing to the celebration of clients' strengths and to their acknowledging how their behaviour could contribute to problems and solutions.

Extract 15 (16, p. 102)

''That made me feel a lot of hope for where we're at, and where we're going. Just knowing we are empowered in a sense to recognize what's wrong and how to move past it.''

Theme 4. Towards new and trusting ways of relating.

This main theme illustrates clients and therapists connecting within *safe, trusting and caring relationships* facilitating *shifts towards new ways of relating*.

Safety and trust. Sixteen studies depicted clients' and therapists' narrative concerning safety and trust in the therapeutic relationship. Clients emphasized the importance of a *trusting and secure relationship* (6, 8, 45, 54) as a precondition of change (8), as well as of a supportive atmosphere (53), allowing them to freely express themselves without fear for criticism, enabled to "explore new ways of thinking and being" (19, p. 68). Therapists and clients further report the importance of the therapist *promoting safety and allowing for exposure and risk* (15, 17, 53, 65). Clients, for example, highlighted the importance of the therapist allowing the expression of negative feelings (17) and managing to navigate communication barriers (15) so that family members feel safe enough to talk (52) and to take risks (53). Lack of safety, on the other hand, was reported as making family members feeling not heard or undermined, in particular within the reflecting team setting (26). Furthermore, clients highlighted the significance of the therapist allowing for vulnerability (45), that is, for a space to be open and feel vulnerable as a precondition for change process.

Extract 16 (52, p. 331)

Wife#10: We don't talk at home. I don't feel scared to say stuff here. It's more neutral here, and I can say a lot more here than at home.

Both clients and therapists emphasized the importance of the *therapist being trustworthy* (15, 34, 48, 53, 54, 65), that is intelligent, competent and professionally

skilled, feeling secure in his or her own positioning (65), and being transparent (34), while trusting family members by believing them (56) and gaining their trust (54). They further underlined the importance of the *therapist being non-judgemental* (6, 35, 39, 52, 53, 54), that is being respectful, non-blaming and validating (39, 52, 53, 54, 56), making family members feeling honoured, understood (54) and taken seriously (56).

Extract 17 (54, p. 274)

Maria: I look for a person who's right there with me. Nonjudgmentalism, where it wouldn't matter what I talked about. If all of a sudden I decided to say, "I once had an affair with another woman," there's not this like, you know, this look on their face.

Strong alliance and care. Thirteen studies illustrate clients' and therapists' emphasis on alliance and caring aspects of the therapeutic relationship. Specifically, clients and therapists emphasize the importance of building and maintaining a *strong therapeutic relationship with mutual care and connection, fostering alliance* (21, 45, 63, 65), which they consider as facilitating the challenging of significant beliefs, particularly when extreme views were expressed (65). Aspects of building a strong alliance include the therapist acknowledging and respectfully challenging the family members' different viewpoints (65). Both clients and therapists underscored the importance of the therapist simultaneously showing sensitivity and respect (65) making clients feeling listened to, respected and valued (35). Also, both outlined the importance of the therapist connecting in a friendly and humane way (53, 56), that is by being a relaxed, sensible, ordinary person who is willing to help (52), *caring and sensitive* (6, 45), as well as genuinely interested (6, 48, 52, 56), patient (53) and supportive (54, 65). Finally, both clients and

therapists further highlighted the importance that the *therapist is fully engaged*, that is the therapist "being there" and fully accessible (35, 48), listening (19, 39, 53, 54) but also sharing personal experience (53).

Extract 18a (48, p. 51)

"What we got from it was…a genuine interest in the people" (H23)

Extract 18b (35, p. 9)

'The therapist is available whenever needed'.

Shifting towards new ways of relating. Eight studies illustrated shifts towards new ways of relating. Therapists and clients identify shifts *from less balanced to more equal participation between family members* (6), or *towards new ways of interacting and relating* (6, 17, 39, 52, 53, 63). Family members were reported as feeling connected and relating with each other by being more accountable for ones' own behaviours (53), moving towards increased family cohesion (17) and jointly working towards common goals (45). They are also reported as being more open with each other (53) and coordinating more with other family members' thoughts and feelings (34), with family relationships in better harmony despite conflicts (53) and couple partners "getting into each other's shoes and observing their interaction from a distance (63, p. 218).

Extract 19 (39, p. 487)

Client 6: In the past week we have got along a lot better. There hasn't been so much bickering with each other. My son has not been so demanding and has been more talkative towards me. It has been easier and I see both of us trying really hard. That has been a change.

Discussion

Our synthesis of 30 studies reporting retrospective therapists' and clients' narratives of systemic and constructionist therapy change process illustrated their experience and conceptualization of change processes, including facilitating but also hindering aspects. Our choice to review qualitative studies, sampling a combination of systemic and constructionist models and both clients' and therapists' voices, provides a broad scope of change process aspects from a binocular view, adding further evidence to previous reviews of qualitative (Chenail et al., 2012) and quantitative studies (Friedlander et al., 2011; Heatherington et al., 2015).

Specifically, our synthesis highlights how clients value being exposed to different perspectives concerning the reported difficulties in the multi-actor, polyphonic setting of systemic and constructionist therapies and how this contributes to their engaging with new ways of communicating with each other. However, clients especially underline the importance of the therapist balancing the tensions between the different and at times conflicting views of family members from a position of fairness and impartiality, thus alerting us to the challenges inherent in performing impartiality within such settings (Chenail et al., 2012; Ong et al., 2019b). Therapists, for example, report frustration when faced with family members' linear views and blaming (26). Similarly, although reflecting team settings are reported as an overall positive experience (15), clients also report feelings of vulnerability, uneasiness and bewilderment with the process (14, 30, 45, see also, Ong et al., 2019b), when this unfamiliar setting remains unexplained and non-transparent. Our synthesis sensitizes post-modern and systemic therapists to elicit clients' voices concerning post-modern practices like reflecting teams. Our synthesis reminds therapists of ways to counter clients' unusual experience with reflecting teams, like

openly sharing what reflecting teams are for or building rapport prior to introducing clients to such formats (15).

Our synthesis illustrates shifts to new ways of understanding the reported difficulties by means of non-pathologizing constructions, emphasizing positives, normalizing and highlighting strengths, including relational strengths (16). On the other hand, too much emphasis on resources and clients' resilience is also reported as leaving them feeling that their difficulties are not acknowledged (14, 52), asking therapists to become more challenging (53, 54). Similarly, clients value therapists' invitations to share expertise and engage in participatory and collaborative practices within change processes. On the other hand, they tend to favor a balance between the therapist being directive and collaborative, asking for guidance and structure (48). This poses a challenge for constructionist, collaborative practices and, in that sense, our synthesis enhances therapist awareness and critical reflection, concerning aspects like the post-modern quest for downplaying therapist expertise (see also, Tseliou et al., in press).

Our synthesis further highlights how clients gradually experience new and trusting ways of relating by means of engaging in a secure and trusting therapeutic relationship. Clients and therapists underscore the importance of a strong therapeutic alliance (see also, Friendlander et al., 2011) and of certain ways of therapists' relating, like being humane, caring and available (35, 48, 53), but also competent and trustworthy (e.g., 15, 34), as shown elsewhere (Chenail et al., 2012).

Overall, aligned with the review by Chenail, et al., (2012), our synthesis adds further qualitative evidence to the argument that couple and family therapy work because of common factors leading to change across models and approaches (Sprenkle, 2012;

Sprenkle et al., 2019; Wampler, 2015). Also, our synthesis adds further evidence to common factors identified specifically for couple and family therapy (Sprenkle et al., 2009), like the importance of introducing a relational view to problems and interrupting problematic patterns (Sprenkle, 2012). In that sense, our meta-synthesis may reiterate points practitioners feel are well known, like the significance of the therapeutic alliance. On the other hand, our synthesis also illuminates challenges idiosyncratic to systemic and constructionist therapeutic practice, like celebrating different perspectives, emphasizing resources and strengths, downplaying power and accomplishing fairness and multi-partiality.

By synthesizing qualitative research depicting the nuances of such challenges, this review captures clients' and therapist's idiographic experience enhancing therapists' awareness in ways which can then have an impact on practice (Heatherington et al., 2005; Pinsof & Wynne, 2000; Sprenkle, 2012). In tune with Heatherington et al. (2015, p. 359), however, we think that we still lack "fine-grained" research better illuminating systemic and constructionist change processes in respect of idiosyncratic and common factor aspects. One promising direction may be research unpacking how such aspects get performed in the here and now of "live", in session dialogue, a project we partly undertake in our other article (Tseliou et al., in press).

A reflexive appraisal

Our choice to follow a non-standard route for a systematic meta-synthesis review by selecting a broad scope in respect of focus and research question posed a number of challenges and limitations. Sampling studies reporting various therapeutic models and

approaches as well as session formats, possibly designating different perspectives as concerns change process (Ong et al., 2019a), may have hindered a more detailed and in-depth account of how change process is conceptualized and experienced in specific settings or from specific demographic populations. Certain studies concerned specific contexts, like intellectual disabilities (1) or specific cultural contexts (45). Furthermore, our grouping of systemic and constructionist models or of various session formats can be questioned on the basis of the extensive discussion in the field concerning their differences (Tseliou et al., in press). Similarly, our inclusive approach concerning the conceptualization of change process, coupled with the lack of a clear definition of process in the field may question the comprehensiveness of our overview and the clarity of our inclusion/exclusion criteria. Our choice to refrain from excluding studies based on quality appraisal, resulted in including studies which, e.g., did not report therapist population (e.g., 6, 17, 19) or leaned on the same data set (14, 15, 16), thus questioning the comprehensiveness of our data set. In that sense, our findings should be approached with caution. Concerning synthesized methods, approaches like CA and DA are underrepresented in the sub-sample synthesis reported here, because they tend to focus on "in-session" dialogue as naturally occurring speech and are included in our other article (Tseliou et al., in press). Furthermore, we have identified no studies prior to 1992. This may reflect the paucity of studies reporting the use of a systematic qualitative research method prior to this time. Reflecting many other reviews, we also recognize a limitation in our selection of papers solely written in English, and the consequent reporting bias. Finally, we acknowledge that utilizing thematic analysis to synthesize studies' findings may have limited the potential for conceptually bridging the diverse sample of studies.

Future research could investigate change process experience by focusing on specific systemic or constructionist models, on specific change process aspects identified in our review or on differences among different settings and populations, also comparing with other psychotherapeutic approaches, like cognitive-behavioural or psychodynamic.

Drawing on a constructionist epistemological perspective, we acknowledge the situated nature of our claims. Our leaning on triangulation processes and consensual rating for validating analysis reflects our preference for systematicity, transparency and polyphonic processes rather a quest for objectivity. We acknowledge that power asymmetries may pose a challenge to celebrating polyphony. Our team consists of peers, from different institutions, where we adopted a transparent and jointly agreed process between team members in order to counter such challenge.

Conclusion

Our synthesis has unpacked aspects of how systemic and constructionist change process is experienced and conceptualized by clients and therapists. Despite its limitations, it has highlighted the importance of attending to clients' and therapists' voices concerning what facilitates and importantly what hinders change process. We need future research to further unpack the idiosyncratic aspects of systemic and constructionist therapies, like the performance of collaborative and empowering practices or their preference for a relational perspective. Furthermore, we need a deepened understanding concerning the dynamics of multi-actor therapeutic dialogue and the challenges it may raise for members' equal participation and therapist impartiality. Our hope is that this review will

inspire such research and will inform systemic and constructionist therapeutic practice by contributing to its reflexive appraisal.

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Figure 1. Stages and results of search strategy and screening

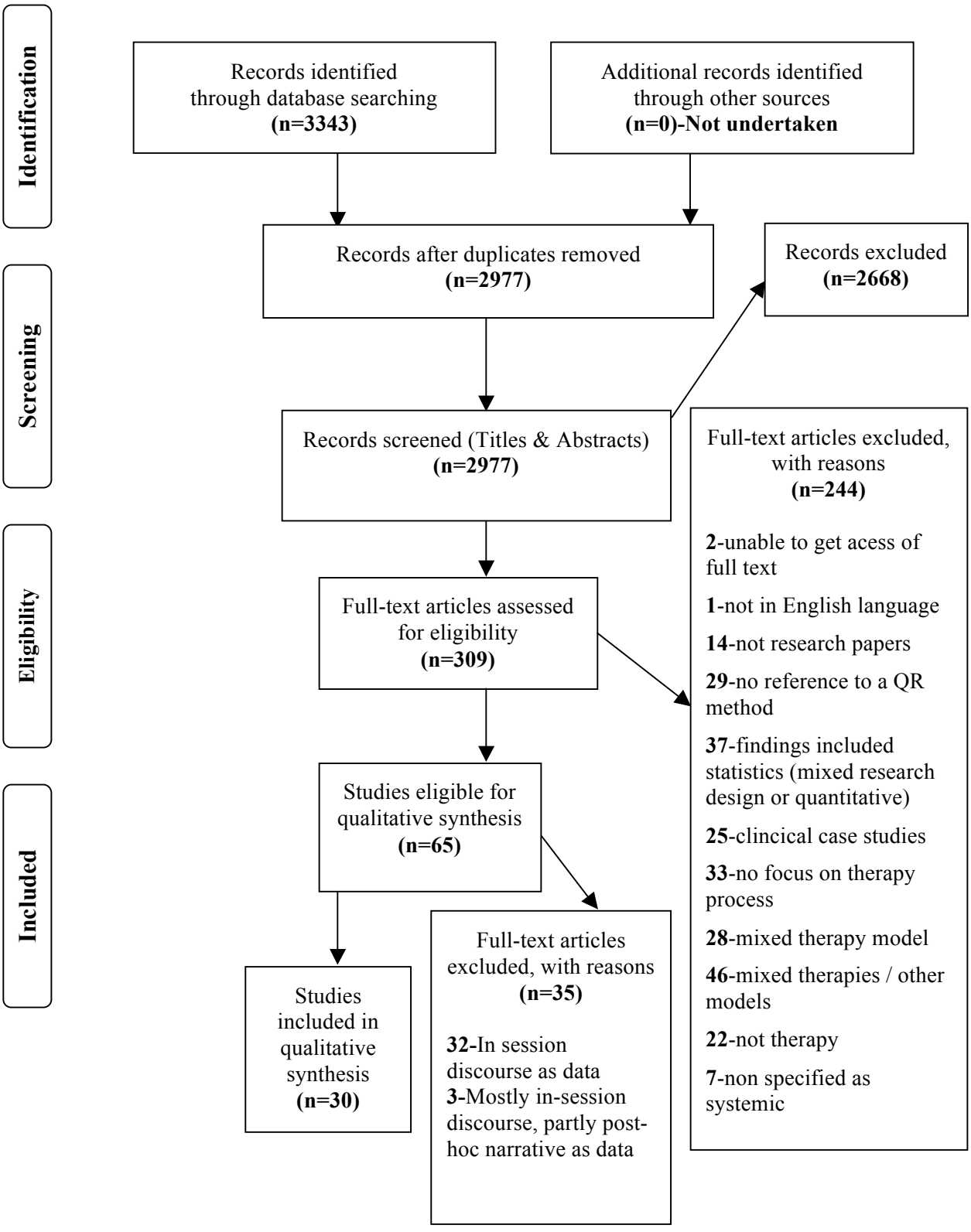

Figure 1. PRISMA flow chart. Adapted from Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

Figure 2. Main themes and sub-themes

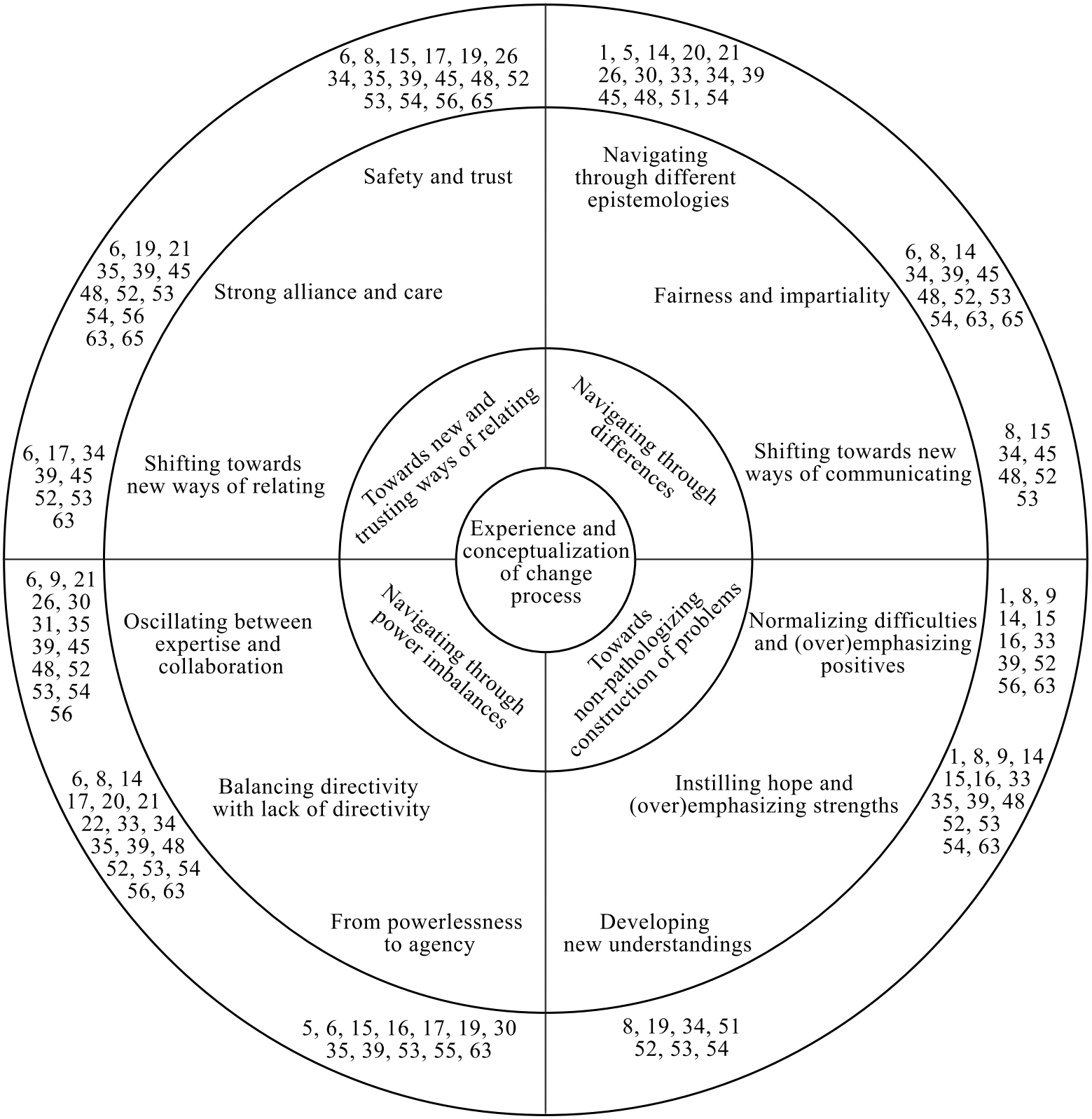

Figure 2. Synthesis of studies' findings.
Numbers in the outer circle indicate the references where sub-themes were identified and correspond to the ones reported in Tables S3 and S4 (SuppInfo, supplemental material) and in the reference list (SuppInfo, supplemental).

Legend for supplemental material

File name	Description
Suppinfo1_Tables S1-8_List of references (pdf document)	Table S1. Search terms of final search. Table S2. Inclusion / exclusion criteria. Table S3. Study characteristics I. Table S4. Study characteristics II: Process focus, phenomenon studied, evidence in analysis and type of process discourse. Table S5. Overview of codes and abbreviations appearing in data extraction tables. Table S6. Studies' findings: Post-hoc narrative of change process conceptualization and experience (sample). Table S7.1. Synthesis of (post-hoc narrative) studies' characteristics. Table S7.2. Synthesis of (post-hoc narrative) studies' methodological characteristics and quality. Table S8. Stages and steps in analytic process List of synthesized references (including all 65 eligible studies)

Table S1

Search terms of final search

"(systemic therapy or systems oriented or family therapy or systemic family therapy or systemic couple therapy or couple therapy or Structural therapy or Strategic therapy or Milan therapy or Post-Milan therapy or Dialogic therapy or Open-dialogue approach or Narrative approach or Collaborative therapy or Reflecting teams or Social Constructionist therapy or Constructivist therapy) AND (therap* sessions or therap* dialogue or therap* setting or therap* relationship or alliance or therap* self or intervention or therap* technique or client experience or therap* experience or therap* family members interaction or sequences or significant events or interpersonal process recall or within session or retrospective experience or between session) AND (Qualitative or Case study or Qualitative approach or Grounded theory or Interpretative Phenomenological approach or Discourse Analysis or Conversation Analysis or Thematic analysis or Narrative analysis or Narrative Inquiry or Ethnography or Action research or Framework analysis or Recursive frame analysis or Hermeneutic case studies) OR (systemic therapy or systems oriented or family therapy or systemic family therapy or systemic couple therapy or couple therapy or Structural therapy or Strategic therapy or Milan therapy or Post-Milan therapy or Dialogic therapy or Open-dialogue approach or Narrative approach or Collaborative therapy or Reflecting teams or Social Constructionist therapy or Constructivist therapy) AND (process research or change or change and process research or change process research) AND (therap* sessions or therap* dialogue or therap* setting or therap* relationship or alliance or therap* self or intervention or

therap* technique or client experience or therap* experience or therap* family members interaction or sequences or significant events or interpersonal process recall or within session or retrospective experience or between session) AND (Qualitative or Case study or Qualitative approach or Grounded theory or Interpretative Phenomenological approach or Discourse Analysis or Conversation Analysis or Thematic analysis or Narrative analysis or Narrative Inquiry or Ethnography or Action research or Framework analysis or Recursive frame analysis or Hermeneutic case studies) Peer Reviewed; Publication Type: Peer Reviewed Journal; English; Language: English; Exclude Dissertations AND Also search within the full text of the articles.

Table S2[1]

Inclusion / exclusion criteria

Inclusion criteria	Exclusion criteria	Rationale
1. Articles published in peer reviewed Journals	Books, grey literature	Accessibility
2. English language	Non-English language	Accessibility to article's text
3. Publications of any date	Publications of a specific date only	Breadth of scope
4. Articles reporting original / empirical research studies	Systematic reviews / meta-analyses	Original research
	Commentaries / theoretical papers / book reviews	
5. Study designs and research method:		
Explicit reference to: Grounded theory, Interpretative Phenomenological Approach,	Articles without referencing a specific, systematic qualitative method	Interest on systematic qualitative research methods /

[1] * asterisk denotes inclusion/exclusion criterion applied for performing sub-analysis presented in this paper

Discourse Analysis (including dialogic analysis), Conversation Analysis, Thematic analysis, Narrative analysis / Inquiry, Ethnography, Action research, Framework analysis, Recursive frame analysis, (Hermeneutic) Case studies

Mixed methodology designs including findings from statistical analysis

Clinical case studies and quantitative research case studies

methodologies from the interpretative / hermeneutic qualitative research tradition

Qualitative data collected by means of: observation (including audio/videotaped sessions) and self-report (interviews / focus groups)

Quantitative data

6. Phenomenon of interest:

Systemic and constructionist couple and family therapy process:

Explicit reference to systemic couple / family therapy or to a systemic or constructionist couple and family therapy model (including literature review): Structural,

Family based interventions with mixed / integrated models including other approaches (e.g., CBT)

Aim to capture process in systemic, constructionist terms

Strategic, MRI, Milan, Post-Milan, Reflecting Teams approach, Open dialogue approach, Dialogic approaches (i.e., post-reflecting team developments), Narrative approaches, Solution-focused approaches, Collaborative approaches, Social Constructionist / Post-modern approaches	Studies with mixed sample of therapies (including other therapies like individual, CBT, etc.)	
Process: 'how therapy unfolds / evolves / takes place' and 'how it works' (process as change). In session, actual therapeutic dialogue and narration of experience concerning problem definition, therapy interventions, use of therapy techniques and therapeutic relationship	Focus other than process like training process, evaluation of specific therapy organization settings, etc.	Aim to capture process as both change process and process as therapy unfolding
7. Population / sample:		
Individuals, couples, families and children, adolescents, adults as 'identified patients'	Studies with a specific type of population only	To include post-modern developments of

		systemic couple and family therapy
Single therapists or therapeutic teams, leading therapists or any therapist including trainees	Consultation, role-play, settings	Peculiarities in the setting
8*. Type of data:		
Post-hoc narrative of therapy process (interviews, focus groups, written accounts, IPR interviews)	In-session discourse (observation, audio/video taped sessions)	To capture change process in retrospective accounts of therapy

Table S3

Study characteristics I[2]

Reference (Author / year of publication)	Aim / research question(s)	Method		Sample characteristics			Data / Data collection method	Epistemology	Ethics	Therapy model / approach	Quality appraisal
		Methodology	Method of analysis	Patient population / referral problem	Session format	Therapist population					
1[3]. Anslow (2013)	Exploration of experiences of adults with learning disabilities from RT type of SFT (238[4])	IPA (abstract)	IPA (239)	Adult / learning disabilities (238)	Family (238)	Therapeutic team (238)	5 Semi-structured interviews / DVD assisted recall (238)	Indirectly stated: Phenomenological / Interpretative (239)	IRB approval and informed consent (238-239)	RT (238)	CASP: OK
5. Bowen et al. (2005)	Advance understanding of blaming in family therapy process (311)	GT (312)	GT (313)	Child and adult/ children with variety of referral problems (312)	Family (312)	Therapeutic team (312)	5 semi structured IPR, transcribed audio-taped interviews (311)	Unstated	Unstated	Eclectic/Integrated: Milan (incorporating narrative/ collaborative) (312)	CASP: #3, #5, #6, #7, #9, #10
6. Bowman & Fine	Clients' views of what was	GT (298)	GT (298) and Taylor	Adult (297)	Couple (297)	Unspecified	5 semi-structured,	Social constructio	Unstated	Variety of constructio	CASP: #6, #7,

(2000)	helpful/unhelpful in couple therapy (295, 297)		and Bogdan (1984) approach (p. 298).	/Unspecified			transcribed audio-taped interviews with both couple partners (298)	nist (298)		nist: Social constructionist, narrative, feminist, solution-focused (298)	#8
8. Christensen et al. (1998)	Development of explanation of change processes in couple therapy (178)	GT (178)	GT / constant comparison method (180)	Adult / relationship distress (178)	Couple (178)	Single (179) .	24 semi-structured, audio-taped, transcribed interviews (179-180)	Unstated	Unstated	Eclectic/ Integrative: Variety of SFT models (179)	CASP: #7
9. Chwal et al. (2014)	Understanding of drop out at a specific center (44)	GT (44)	GT (44)	Adult / Unspecified (44)	Family (44)	Single (43)	10 Semi-structured audio-taped, transcribed interviews (45) of 6 cases	Unstated	Informed consent (45)	SCT / constructionist (43)	CASP: #3, #4, #6, #7, #8, #9
14. Egeli et al. (2014a)	Exploration of experience of vulnerability in couple therapy with reflecting team format (20)	Qualitative CS (24)	TA (26)	Adult / relationship problems (25)	Couple (25)	Therapeutic team (25)	IPR, audio-taped, transcribed interviews with 3 couples conjoint and separate (25-26)	Constructivist (24)	IRB approval (24)	RT (25)	CASP: #6
15. Egeli et al. (2014b)	Exploration of experience of hope and vulnerability in couple therapy with reflecting team format (199)	CS (201)	Indirectly stated: Inductive, hermeneutic TA (204)	Adult / relationship problems (203)	Couple (203)	Therapeutic team (203)	IPR, audio-taped, transcribed interviews with 3 couples (203)	Constructivist (205)	Informed consent (202)	RT (203)	CASP: #6, #7

16. Egeli et al. (2014c)	Exploration of experience of hope in couple therapy with reflecting team format (93-94)	CS (96)	TA (97)	Adult / relationship problems (96)	Couple (96)	Therapeutic team (96)	IPR, audio-taped, transcribed interviews with 3 couples (97)	Unstated	Informed consent (97)	RT (96)	CASP: #6, #7
17. Fraenkel et al. (1998)	Exploration of family members' experience of treatment for sexual abuse (abstract)	Ethnography (41)	GT (47)	Child and adult / intra-familial child sexual abuse (46, 47)	Mixed: Family, group, individual (44)	Unspecified	Written descriptions in two-item scale, (Therapy Experiences Scale) (46)	Unstated	Unstated	Eclectic/Integrated: Constructionist, feminism and SFT (44)	CASP: #5, #7, #8
19. Gehart-Brooks & Lyle (1999)	Investigation of client and therapist perspectives of change in collaborative language systems therapy (59)	Ethnography (60)	Indirectly stated: TA ("Kvale's approach" (61)	Unspecified	Mixed: Individual, couple, family (61)	Unspecified	3, audio-taped, transcribed interviews with 4 therapists and 5 families (11 clients in total) over 4 months (61)	Indirectly stated: Constructionist (62)	Unclear	Collaborative (59)	CASP: #3, #4, #7
20. Guregård & Seikkula (2014)	Investigation of therapy process in respect of barriers concerning culture and power difference between therapist and refugee families and their overcoming	Unspecified	Dialogue sequence analysis (45)	Unspecified	Network (43-44)	Therapeutic team (44)	15 videotaped, transcribed early sessions of 6 families, videotaped transcribed therapists' reflections (with IPR), audio-taped transcribed interviews with 5 of the 6	Unstated	IRB approval and informed consent (46)	OD (43)	CASP: #6, #8, #9

	(41-42)						families, written comments by therapists (44)				
21. Heiden-Rootes et al. (2015)	Exploration of therapists' identification and response to challenging clinical situations (264)	Modified GT (264)	GT (264)	Unspecified	Mixed: Couple, family (265)	Unspecified	11 semi-structured, audio-taped interviews with therapists (264)	Unstated	Unstated	Systemic (SFT)-not specified (263-264)	CASP: #4, #5, #7
22. Helmeke & Sprenkle (2000)	Exploration of couple partners' experience of significant / pivotal moments in therapy (471)	GT (471)	GT (472)	Adult / marital issues, (473)	Couple (471)	Single (472)	23 videotaped, transcribed sessions of 3 couples, post session questionnaire, 2 post-therapy research interviews with IPR procedure (472)	Unstated	Informed consent (471-472)	Eclectic/Integrated SFT (474)	CASP: #7, #8
26. Lever & Gmeiner (2000)	Exploration of therapist, family members' and reflecting team members' experience of initial sessions in cases of drop out (42)	CS (42)	"Cross-case analysis" (p. 43) / Tesch TA method (44)	Adult (43)	Family (43)	Therapeutic team (43)	Field notes and semi-structured phenomenological, audio-taped, transcribed interviews with families, therapy sets and reflecting teams of 2 cases with 2	Social constructionist (42)	Unstated	RT (43) / Narrative (63)	CASP: #6, #7, #8

							sessions (43)				
30. Lloyd & Dallos (2008)	Exploration of service users' experiences of initial SFBT sessions (10)	Ethnography (11)	IPA (11)	Child and adult / child ID (12)	Family (12)	Single (11)	7 semi-structured, transcribed interviews and audiotapes of sessions with structural recall (11)	Unstated	IRB approval and informed consent (10)	SFBT (Abstract)	CASP: #8
31. Lobatto (2002)	Investigation of influence of parents' presence on how children talk in sessions (333)	GT (334)	GT (334)	Child / with variety of referral problems (333)	Family (333)	Unspecified	6 audio-recorded, transcribed interviews ("semi-structured" questionnaire) (333)	Social constructionist (334)	Informed consent (333)	SFT-Not specified (330)	CASP: #3, #5, #7, #8, #10
33. Metcalf & Thomas (1995)	Investigation of therapist and client perception of therapy process and change (50)	Unspecified	Indirectly stated: GT (52)	Adult / variety of referral problems (55-56)	Couple (51)	Single (51)	Interviews (separate) with couples and with their therapists of 6 cases (52)	Unstated	Unstated	SFBT (51)	CASP: #3, #6, #7, #8, #10
34. Mitchell et al. (2014)	Exploration of family members' experience of two different reflecting team formats (240)	GT (243)	GT (243)	Child, adolescent and adult / variety of referral problems (241)	Family (241)	Therapeutic team (241)	15 audio-taped, transcribed, semi-structured interviews (243)	Unstated	IRB approval (243)	Post-Milan systemic (240)	CASP: #3, #8
35. Morino (2018)	Exploration of change process from therapists' and families' perspective in cases of conduct	GT (4)	GT (4)	Child and adult / conduct disorder (3)	Family (3)	Therapeutic team (3)	Middle audio-taped sessions of 2 cases, 4 interviews with family members,	Unstated	IRB approval and informed consent (21)	Eclectic/Integrated: Narrative, solution – focused, Milan,	CASP: #3, #4, #8

	disorder receiving home based treatment (2-3)						transcripts of focus group with therapists (3)			Structural (3)	
39. O'Connor, Meakes, Pickering, & Schuman (1997)	Exploration of clients' experience of narrative therapy (482)	Ethnography (482)	QCA / GT (484)	Child and adult / problems with children (483)	Family (483)	Therapeutic team (484)	8 audio-taped, transcribed, "semi-standardized" interviews (483)	Unstated	Informed consent (483)	Narrative (482)	CASP: #6, #7, #8
45. Pandya & Herlihy (2009)	Exploration of South Asian families' perception of FT alliances (396)	Unspecified	TA (390)	Adult / Unspecified (388-389)	Family (388)	Unspecified	9 Semi-structured, recorded, transcribed interviews (388, 389)	Unstated	IRB approval and informed consent (88, 389)	SFT-Not specified (388)	CASP: OK
48. Rautiaine, & Seikkula (2009)	Exploration of therapists' and clients' experience of couple therapy process (44)	GT (47)	Modified GT (47)	Adult / depression (43)	Couple (43)	Co-therapy (43)	25 videotaped, transcribed interviews with couples and their therapists (46-47)	Unstated	IRB approval and informed consent (45)	SCT/ dialogic (43)	CASP: #8
51. Sells et al. (1994)	Exploration of couple and therapist perceptions of RT practice (249)	Ethnography (248)	DoMA (249)	Adult / marital difficulties (251)	Couple (251)	Therapeutic team (251)	7 audio-recorded, transcribed, interviews with couples and therapists, therapists' reflexive, field notes (252)	Indirectly stated: Constructionist (253, 255)	Unclear	RT (251)	CASP: #4, #7
52. Sells et al. (1996)	Exploration of client and therapist perceptions of	Ethnography (322)	DoMA (325)	Unspecified	Mixed: Individual, couple, family	Unspecified / team implied	Audio-recorded, transcribed therapists'	Indirectly stated: Constructionist (322)	Unclear	Variety of systemic and constructio	CASP: #4, #7

	effectiveness of FT process and of value of ethnography (322)				(324)	(323)	field notes of ethnographic interviews conducted by themselves (with their own clients), 14 audio-taped, transcribed, interviews with same therapists but different clients (324)			nist: Structural, strategic, solution-focused, experientia l (324)	
53. Sheridan et al. (2010)	Investigation of parents of adolescents experience from participating in FT (145)	Multiple CS (146)	Indirectly stated: GT (148)	Adult and adolescent/ adolescent mental health (147)	Family (146)	Single (147)	15 audio-taped, face to face semi-structured, and follow-up, phone interviews with parents of 11 cases (147)	Constructi vist (abstract)	IRB approval and informed consent (147)	SFBT (146)	CASP: #6
54. Singer (2005)	Exploration of clients' experience of therapy (269)	Phenomen ology (272)	Phenomenol ogical analysis (273)	Child, adolescent, adult / variety of referral problems (271)	Mixed: Individua l, couple, family (271)	Therapeu tic team (271)	Clients' case notes (p. 271) and 9 open-ended, recorded, transcribed interviews with clients (273)	Constructi vist (270)	IRB approval and informed consent (271)	Post-modern (271)	CASP: OK
55. Strickland-clarke, et al.	Exploration of "children's experience of	Comprehe nsive Process	GT (328)	Child / children variety of	Family (326)	Unspecif ied	Semi-structured (p. 328)	Unstated	IRB approval (326)	SFT: Indirectly stated	CASP: #6, #8

(2000)	being in family therapy" (326)	Analysis (326) / Phenomenology (327)		referral problems (326)			interviews with 5 children and their therapists with use of video replay (327-328)			(337)	
56. Sundet (2011)	Investigation of experience of helpful therapy by families and their therapists in post-modern practice (237)	GT (238)	Modified GT (239)	Child, adolescent and adult / Child and adolescent mental health (237)	Family (237)	Unspecified	Audio-taped, transcribed interviews with 4 therapists and 10 families (30 people in total) (237, 239)	Unstated	Informed consent (237)	Variety of constructionist: Collaborative, Narrative, RT (236)	CASP: #7
63. Ward & Wampler (2010)	Exploration of therapist conceptualization of hope and of its use to enable change in in therapy (abstract)	GT (214)	GT (215)	Adult (abstract) / Unspecified	Couple (abstract)	Unspecified	15 semi-structured, recorded, transcribed interviews with therapists (214)	Unstated	Informed consent (215)	Variety of systemic and constructionist: eclectic integrated, structural, intergenerational, emotion-focused, feminist, narrative (215)	CASP: #7
65. Yon et al. (2018)	Exploration of how therapists question a	Unspecified	TA (186)	Adult and adolescent / child	Family (185)	Co-therapy (185)	2 semi-structured, IPR interviews	Unstated	IRB approval and	SFT-Culturally engaged	CASP: #3, #4, #5

family's core cultural belief system whilst building and maintaining a strong therapeutic alliance (abstract)	protection issues, alleged honour crime, fear of forced marriage (184)	(1 with therapist and 1 with family members of 1 case) (186)	informed consent (185)	(185)

Table S4

Study characteristics II: Process focus, phenomenon studied, evidence in analysis and type of process discourse

Reference (Author / year of publication)	Focus of study in terms of process	Phenomenon studied	Type of process discourse	Transcription type	Type of analysis / Evidence
1. Anslow (2013)	Model	LD client experience of RT	Post-hoc session narrative	Verbatim	NA / Included
5. Bowen et al. (2005)	Problem talk (blaming)	Therapist conceptualizations of blame sequences	Post-hoc session narrative	Verbatim	NA / Not included (quotes)
6. Bowman & Fine (2000)	Overall process	Client perceptions of therapy process (helpful / unhelpful)	Post-hoc session narrative	Unspecified	NA / Not included (quotes)
8. Christensen et al. (1998)	Overall process	Partners experience of process of change	Post-hoc session narrative	Unspecified	NA / Not included (quotes)
9. Chwal et al. (2014)	Overall process	Client experience of drop-out	Post-hoc session narrative	Unspecified	NA / Not included (quotes)
14. Egeli et al. (2014a)	Therapy concept	Couple partners' experience of vulnerability	Post-hoc session narrative	Unspecified	NA / Included
15. Egeli et al. (2014b)	Therapy concept	Couple partners' experience of hope and vulnerability	Post-hoc session narrative	Unspecified	NA / Included
16. Egeli et al. (2014c)	Therapy concept	Couple partners' experience of hope	Post-hoc session narrative	Unspecified	NA / Included
17. Fraenkel et al. (1998)	Overall process	Family members' experience of recovery from sexual abuse	Post-hoc session narrative	Unspecified	NA / Not included (quotes)
19. Gehart-Brooks & Lyle (1999)	Model	Client and therapist perspectives of change in collaborative therapy	Post-hoc session narrative	Verbatim	NA / Included
20. Guregård & Seikkula (2014)	Therapeutic dialogue	Change in dialogue with culture / power difference	Both (mostly post-hoc)	Verbatim	Sequential / Included (5 and quotes)
21. Heiden-Rootes et al. (2015)	Overall process	Therapist response to challenging clinical situations	Post-hoc session narrative	Unspecified	NA / Included
22. Helmeke & Sprenkle (2000)	Therapy concept	Couple partners' experience of pivotal moments in therapy	Both (mostly post-hoc)	Unspecified	NA / Included
26. Lever & Gmeiner	Therapeutic	Client and therapist experience of therapy	Post-hoc session	Verbatim	NA / Included

(2000)	relationship	in relation to drop-out	narrative		
30. Lloyd & Dallos (2008)	Model	Client experience of initial SBFT sessions	Post-hoc session narrative	Verbatim	NA / Included
31. Lobatto (2002)	Overall process	Children talk in therapy	Post-hoc session narrative	Verbatim	NA / Not included (quotes)
33. Metcalf & Thomas (1995)	Overall process	Therapist and client perception of therapy process	Post-hoc session narrative	Unspecified	NA / Included
34. Mitchell et al. (2014)	Technique	Families' experience of reflecting team formats	Post-hoc session narrative	Verbatim	NA / Included
35. Morino (2018)	Overall process	Client and therapist perceptions of change in home-based treatment	Both (mostly post-hoc)	Unspecified	NA / Included
39. O'Connor, Meakes, Pickering, & Schuman (1997)	Model	Clients' experience of NT	Post-hoc session narrative	Verbatim	NA / Included
45. Pandya & Herlihy (2009)	Therapeutic relationship	Families' perception of alliance	Post-hoc session narrative	Unspecified	NA / Included
48. Rautiaine, & Seikkula (2009)	Overall process	Therapist and client experience of process (helpful / unhelpful)	Post-hoc session narrative	Verbatim	NA / Included
51. Sells et al. (1994)	Model	Client perceptions of RT process	Post-hoc session narrative	Unspecified	NA / Included
52. Sells et al. (1996)	Model	Client and therapist perceptions of RT process effectiveness	Post-hoc session narrative	Verbatim	NA / Included
53. Sheridan et al. (2010)	Model	Client experience of RT process	Post-hoc session narrative	Unspecified	NA / Included
54. Singer (2005)	Overall process	Client experience of therapy	Post-hoc session narrative	Verbatim	NA / Included
55. Strickland-Clarke, et al. (2000)	Overall process	Children experience of therapy	Post-hoc session narrative	Unspecified	NA / Included
56. Sundet (2011)	Model	Client and therapist experience of post-modern therapy	Post-hoc session narrative	Unspecified	NA / Included
63. Ward & Wampler (2010)	Therapy concept	Conceptualisation of hope and interventions to increase hopefulness	Post-hoc session narrative	Unspecified	NA / Not included (quotes)
65. Yon et al. (2018)	Therapeutic relationship	Therapists' and family members' experience of therapists' challenge of cultural beliefs and maintenance of alliance	Post-hoc session narrative	Unspecified	NA / Included

Table S5
Overview of codes and abbreviations appearing in data extraction tables[5]

Table S3 axes	Code / abbreviation
Method: Methodology / Method of Analysis	CS: Case Study (5) Dialogue sequence analysis (1) DoMA: Domain Analysis (2) Ethnography (6) GT: Grounded Theory (17) IPA: Interpretative Phenomenological Analysis (2) Phenomenology (2) QCA: Qualitative Content Analysis (1) TA: Thematic Analysis (7)
Session format*[6]	Couple (10) Family (14) Mixed (5): combination of different formats of sessions Couple, family (1/5) Family, group, individual (1/5) Individual, couple, family (3/5) Network (1)
Patient population*	Adult (14) Adult and adolescent (2) Adult and child (5) Child (2) Child, adolescent and adult (3) Unspecified (4)

[5] Bracketed numbers denote the number of articles where each code was assigned. In certain cases, e.g. method of analysis, more than one code may have been assigned to the same article.
[6] Asterisk (*) denotes preset codes

Therapist population*	Co-therapy (2) Single (6) Therapeutic team (12) Unspecified (9) Unspecified/team implied (1)
Data / Data collection method	Audio-taped interviews (9) Focus groups (1) IPR interviews (Interpersonal Process Recall) (8) Non-specified type of interviews (2) Notes-written accounts (6) Semi-structured interviews (14) Video-recorded interviews (4)
Epistemology	Constructivist (4) Indirectly stated: Constructionist (3) Indirectly stated: Phenomenological (1) Social constructionist (3) Unstated (19)
Ethics*	Informed consent (8) IRB approval (3) Informed consent and IRB approval (9) Unclear (3) Unstated (7)
Therapy model / Approach	Collaborative (1) Eclectic/Integrated (5) Constructionist, feminist and SFT (1/5) Eclectic SFT (1/5) Milan, narrative, collaborative (1/5) Narrative, solution – focused, Milan, Structural (1/5) Variety of SFT models (1/5)

	Post-Milan (1) Narrative (2) Narrative/RT (1/2) Narrative (1/2) OD: Open dialogue (1) Post-modern (1) RT: Reflecting team (5) SCT: Systemic Couple Therapy (2) SCT/Constructionist (1/2) SCT/Dialogic (1/2) SFBT: Solution Focused Brief Therapy / Solution Focused (3) SFT: Systemic Family Therapy (5) SFT-Culturally engaged (1/5) SFT-Indirectly stated (1/5) SFT-Not specified (3/5) Variety of constructionist (2) Collaborative, Narrative, RT (1/2) Social constructionist, narrative, feminist and solution-focused (1/2) Variety of systemic and constructionist (2) Eclectic, integrated, structural, intergenerational, emotion-focused, feminist and narrative (1/3) Structural, strategic, solution-focused and experiential (1/3)
Quality appraisal*	CASP OK: No selection of No in CASP checklist (3) CASP #1: Lack of clear statement of research aim(s) (0) CASP #2: Inappropriateness of choice of qualitative methodology (0) CASP #3: Inappropriateness of research design (8) CASP #4: Inappropriateness of recruitment strategy (7) CASP #5: Data collection did not address research issue (5) CASP #6: Inadequate consideration of relationship between researcher / participants (12) CASP #7: Inadequate consideration of ethical issues (18) CASP #8: Insufficient rigour in data analysis (14) CASP #9: Unclear statement of findings (3) CASP #10: Unclear estimate of value of research (3)

Table S4 axes	Code / abbreviation

Focus of study in terms of process*	Intervention/technique (1) Model (8) Overall process (11) Problem talk (1) Therapy concept (5) Therapeutic dialogue (1) Therapeutic relationship (3)
Type of process discourse*	Post-hoc session narrative (27) Both (mostly post-hoc): Post-hoc session narrative and in-session discourse (3)
Transcription type	Unspecified (18) Verbatim (12)
Type of analysis / Evidence*	NA: Not applicable (29) Included: Excerpts of data included (23) Not included (quotes): Excerpts not included but quotes included (7)

Table S6
Studies' findings: Post – hoc narrative of change process conceptualization and experience (sample)

Reference	Type of process Process / change conceptualization	Perception of process (findings) Experience of process (findings)	Reviewer's comments

Table S7.1

Synthesis of (post-hoc narrative) studies' characteristics

Focus of study in terms of process	Participants (whose view on process is sampled)	Patient population	Therapist population	Session format	Therapy model / approach[7]
(1)[8] Intervention: 34[9]	(18) Client: 1, 6, 8, 9, 14, 15, 16, 17, 22, 30, 31, 34, 39, 45, 51, 53, 54, 55	(14) Adult: 1, 6, 8, 9, 14, 15, 16, 22, 26, 33, 45, 48, 51, 63	(2) Co-therapy: 48, 65	(10) Couple: 6, 8, 14, 15, 16, 22, 33, 48, 51, 63	(1) Collaborative: 19

[7] In cases where different models were sampled, more than one codes have been assigned to the same article

[8] Numbers in parenthesis indicate the sum of references where each code was assigned, reported after the semi-colons

[9] Numbers of references correspond to the ones reported in Tables S3 and S4 and in the reference list (Suppinfo, supplemental material).

(8) Model: 1, 19, 30, 39, 51, 52, 53, 56

(11) Overall process: 6, 8, 9, 17, 21, 31, 33, 35, 48, 54, 55

(3) Therapist: 5, 21, 63

(9) Client and therapist: 19, 20, 26, 33, 35, 48, 52, 56, 65

(2) Adult and adolescent: 53, 65

(2) Child: 31, 55

(6) Single: 8, 9, 22, 30, 33, 53

(12) Therapeutic team: 1, 5, 14, 15, 16, 20, 26, 34, 35, 39, 51, 54

(14) Family: 1, 5, 9, 26, 30, 31, 34, 35, 39, 45, 53, 55, 56, 65

(5) Mixed: 17, 19, 21, 52, 54:

- (1/5) Couple, family: 21
- (1/5) Family, group, individual: 17
- (3/5) Individual, couple, family: 19, 52, 54

(5) Eclectic/Integrated: 5, 8, 17, 22, 35

(1) Post-Milan: 34

(11) Overall process: 6, 8, 9, 17, 21, 31, 33, 35, 48, 54, 55

(1) Problem talk: 5

(5) Therapy concept: 14, 15, 16, 22, 63

(1) Therapeutic dialogue: 20

(3) Therapeutic relationship: 26, 45, 65

(5) Child and adult: 5, 17, 30, 35, 39

(3) Child, adult and adolescent: 34, 54, 56

(4) Unspecified: 34, 52, 54, 56

(9) Unspecified: 6, 17, 19, 21, 31, 45, 55, 56, 63

(1) Unspecified, team implied: 52

(1) Network: 20

(2) Narrative: 26, 39

(1) Open dialogue: 20

(1) Post-modern: 54

(5) Reflecting team: 1, 14, 15, 16, 51

(3) Solution Focused Brief Therapy: 30, 33, 53

(2) Systemic Couple

Table S7.2

Synthesis of (post-hoc narrative) studies' methodological characteristics and quality

Methodology / Method of analysis[10]	Epistemology	Data / Data collection method[11]	Transcription type	Evidence in analysis	Quality appraisal[12]
(5) Case Study: 14, 15, 16, 26, 53	(4) Constructivist: 14, 15, 53, 54	(9) Audio-taped interviews: 5, 6, 8, 9, 14, 15, 16, 19, 20	(18) Unspecified: 6, 8, 9, 14, 15, 16, 17, 21, 22, 33, 35, 45, 51, 53, 55, 56, 63, 65	(23) Included: Excerpts of data: 1, 14, 15, 16, 19, 20, 21, 22,	(3) CASP OK: No selection of No in CASP checklist: 1, 45, 54

[10] In cases where methodology and method of analysis differed, more than one codes were assigned to the same paper

[11] In cases where more than one data collection methods were deployed, more than one codes were assigned to the same paper

[12] More than one codes were assigned to the same paper

				26, 30, 33, 34, 35, 39, 45, 48, 51, 52, 53, 54, 55, 56, 65	
(1) Dialogical Analysis / Approach: 20	(3) Indirectly stated: Constructionist: 19, 51, 52	(1) Focus groups: 35	(12) Verbatim: 1, 5, 19, 20, 26, 30, 31, 34, 39, 48, 52, 54	(7) Not included (quotes): Excerpts not included but quotes included: 5, 6, 8, 9, 17, 31, 63	(0) CASP #1: Lack of clear statement of research aim(s)
(2) Domain	(1) Indirectly	(8) IPR interviews			(0) CASP #2: Inappropriateness of

Analysis: 51, 52	stated: Phenomenological: 1	(Interpersonal Process Recall): 1, 5, 14, 15, 16, 20, 22, 65	choice of qualitative methodology
(6) Ethnography: 17, 19, 30, 39, 51, 52	(3) Social constructionist: 6, 26, 31	(2) Non-specified type of interviews: 33, 35	(8) CASP #3: Inappropriateness of research design: 5, 9, 19, 31, 33, 34, 35, 65
(17) Grounded Theory: 5, 6, 8, 9, 17, 21, 22, 31, 33, 34, 35, 39, 48, 53, 55, 56, 63	(19) Unstated: 5, 8, 9, 16, 17, 20, 21, 22, 30, 33, 34, 35, 39, 45, 48, 55, 56, 63, 65	(6) Notes / written accounts: 17, 20, 26, 51, 52, 54	(7) CASP #4: Inappropriateness of recruitment strategy: 9, 19, 21, 35, 51, 52, 65
(2) Interpretative Phenomenological Analysis: 1, 30		(14) Semi-structured interviews: 1, 5, 6, 8, 9, 21, 26, 30, 34, 39,	(5) CASP #5: Data collection did not address research issue: 5, 17, 21, 31, 65

(2) Phenomenology: 54, 55

(1) Qualitative content analysis: 39

(7) Thematic Analysis: 14, 15, 16, 19, 26, 45, 65

45, 53, 55, 63

(4) Video-recorded interviews: 45, 48, 54, 63

(12) CASP #6: Inadequate consideration of relationship between researcher / participants: 5, 6, 9, 14, 15, 16, 20, 26, 33, 39, 53, 55

(18) CASP #7: Inadequate consideration of ethical issues: 5, 6, 8, 9, 15, 16, 17, 19, 21, 22, 26, 31, 33, 39, 51, 52, 56, 63

(14) CASP #8: Insufficient rigour in data analysis: 6, 9, 17, 20, 22, 26,

30, 31, 33, 34, 35, 39, 48, 55

(3) CASP #9: Unclear statement of findings: 5, 9, 20

(3) CASP #10: Unclear estimate of value of research: 5, 31, 33

Table S8

Stages and steps of analytic process

Stages of analysis	Steps in analytic process
Stage I	1. Reading the papers 2. Extracting the findings section-see Tables S3, S6 3. Coding authors' discourse, line by line, if possible, including in-vivo codes reported in papers' findings 4. Clustering codes in sub-themes under broader themes illustrating change processes, including facilitators and hindrances in respect of therapeutic interventions and therapists' ways of relating 5. Creating main themes with sub-themes (5 main themes, 33 sub-themes, 204 codes) depicting both reported changes and facilitators / hindrances.

Stage II	1. Comparing and contrasting the existing themes and sub-themes to develop a schema depicting different aspects of change processes, reporting facilitators and hindrances per each aspect (4 main themes and 12 sub-themes). 2. Re-screening data (i.e. studies' findings) to verify constructed schema (deductive mode of analysis): (a). to check for additional data to further include in our schema and/or for disconfirming cases. (b) to identify indicative extracts reported by authors. 3. Final schema of findings reported in the article.

List of synthesized references (including all 65 eligible studies)

Asterisk (*) denotes synthesized papers in the sub-analysis presented in this paper. Bracketed number next to asterisk indicates each paper's reference number corresponding to the numbers appearing in tables S3, S5, S7.1, S7.2., as well as in tables S3 and S4 in supplemental material.

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