Exploring how couples with histories of trauma respond to inpatient couple therapy, and the investigation of the reciprocal effects of alliances and couple satisfaction: A longitudinal study using complementary methods

By

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Summary

This process–outcome study was conducted within a naturalistic setting at the Family Unit, Modum Bad, Norway. The aim of the study was fourfold:

1) To evaluate the Family Unit's treatment program by assessing the participants' degree of mental and relational distress from intake to discharge and changes in distress taking place during treatment.

2) To investigate the predictive association of therapists' reports of patients' histories of childhood trauma on weekly patient-reported outcome.

3) To retrospectively explore a subsample of those patients with histories of childhood trauma about their experiences of receiving treatment at the Family Unit.

4) Apply dyadic analyses (Kenny et al., 2020) as a method of analyses to investigate actor–partner effects related to a) how the actor's (i.e., the individual) alliance to the therapist predicts his or her relationship satisfaction, b) how the actor's alliance to the therapist predicts his or her partner's relationship satisfaction, c) how the actor's relationship satisfaction predicts his or her alliance to the therapist, and d) how the actor's relationship satisfaction predicts his or her partner's alliance to the therapist.

In addition, while relevant for internal use in evaluating the Family Unit's treatment program, the findings are also considered useful for clinicians and researchers in other couple and family treatment settings. The research project applied a sequential design (Bailey-Rodriguez, 2021), hence, papers 2 and 3 builds upon the methodological implications brought to awareness and the findings of the paper previous to it. In Paper 1, we examined the predictive associations between childhood trauma and outcome, we found that having a history of childhood trauma predicted poorer relational outcomes compared with patients without such experiences. Paper 2, which aimed to further explore these

findings using qualitative methods, highlighted the relational difficulties that the couples in therapy experienced. These difficulties were prominent both regarding the relationship between spouses and between the individual patient and the therapist. More specifically, these findings concerning relational challenges were interpreted and conceptualized as varying degrees of split alliances (Bartle-Haring et al., 2012; Friedlander et al., 2018; Friedlander, Hynes, et al., 2021). These findings made us, as researchers, aware that we had to apply statistical methods that considered the reciprocal nature of alliances assessed in couple therapy. Further examination of the literature led us to learn how multilevel modeling (MLM; Curran & Bauer, 2011) could be adapted to analyze how couples change by applying a dyadic level of analysis (i.e., actor–partner effects; Kenny et al., 2020). Although, we were interested in further exploring the associations between childhood trauma, alliances, and outcome, we abandoned the trauma variable we had previously applied in Paper 1. This was partly due to its inaccuracy to represent the target phenomena (i.e., trauma), and partly because of the challenges of learning and applying a new statistical method. Subsequently, the dyadic analysis, which was presented in Paper 3, further illuminated nuances of the interplay between alliances and relationship satisfaction: The partners self-perceived alliance with the therapist is paramount for the for the other couple members perceived relationship satisfaction the following week.

In conclusion, our study has contributed to the literature by identifying and exploring how couples with histories of trauma experience relational challenges (i.e., split alliances) in residential therapy and how such challenges are related to poorer outcomes. Furthermore, the application of dyadic analyses as conceptualized within the actor–partner interdependence model (APIM; Kenny et al., 2020) presented novel results pertaining to working alliances. Our findings strengthened our conviction that mixed method research designs with the application of dyadic analysis are necessary when studying complex relational phenomena. Our position on the benefits of dyadic analysis is supported by the recommendations of Friedlander, Heatherington et al. (2021). Contrary to more traditional means of

analysis, which allows for the identification of change at the level of the individual, dyadic analysis has the benefit of furthering our understanding of how family systems change when responding to therapy. The application of dyadic analysis on longitudinal data lets us examine how systems change across time and thus has the potential to facilitate the development of more precise interventions, thereby improving outcomes for a wider range of patients. Including those that may have been defined as non-responders or otherwise treatment resistant. Finally, we may infer that as a program evaluation, this study presents satisfactory results for the 2018–2020 cohort of patients whom attended therapy at the Family Unit, demonstrating significant positive changes during the treatment period.

List of papers

Paper 1

Whittaker, K. J., Johnson, S. U., Solbakken, O. A., Wampold, B., & Tilden, T. (2021). Childhood trauma as a predictor of change in couple and family therapy: A study of treatment response. *Couple and Family Psychology: Research and Practice*. Advance online publication. https://doi.org/10.1037/cfp0000181

Paper 2

Whittaker, K. J., Stänicke, E., Johnson, S. U., Solbakken, O. A., & Tilden, T. (2022). Troubled relationships: A retrospective study of how couples with histories of trauma experience therapy. *Journal of Couple & Relationship Therapy*, 1-23. https://doi.org/10.1080/15332691.2022.2053262

Paper 3

Whittaker, K. J., Johnson, S. U., Solbakken, O. A., & Tilden, T. (2022). Treated together–changed together: The application of dyadic analyses to understand the reciprocal nature of alliances and couple satisfaction over time. *Journal of Marital and Family Therapy,* 1-16. https://doi.org/10.1111/jmft.12595

Abbreviations

APIM	Actor–partner interdependence model
DAS	Dyadic adjustment scale
FAD	Family assessment device
IST	Integrative systemic therapy
MLM	Multilevel modelling
PTSD	Posttraumatic stress disorder
RDAS	Revised dyadic adjustment scale
ROM	Routine outcome monitoring
STIC	Systemic therapy inventory of change
WAI	Working alliance inventory

1. Background

Approximately 40% to 50% of people who attend therapy for relational problems are better off than those who do not seek help (Shadish & Baldwin, 2003). But what about the 50%–60% that do not experience relief? What about the estimated 10% that presumably even deteriorate throughout treatment? Are we as healthcare workers and researchers not obliged to try to help them out of their predicament? Undeniably, so who are they, and how do we identify them, and what do we do? Routine outcome monitoring (ROM; Tilden & Wampold, 2017) can help us identify up to 50% of them (Mahon, 2020). But what characterizes the course of treatment of those who have less than optimal responses to therapy, or even worse, those that deteriorate as a consequence? Can such treatment trajectories be predicted? Off-course treatment trajectories may be predicted based on pretreatment distress levels (Boswell et al., 2015) or early alliance assessments (Flückiger et al., 2018; Friedlander et al., 2018). However, in the case of alliance, many factors have been implicated, such as involvement of family members, age of respondents, partner perception (Friedlander et al., 2018), and adverse childhood experiences (Anderson et al., 2020). Vrabel et al. (2010) showed that the coexistence of a personality disorder and childhood trauma was associated with poor treatment outcomes in the individual treatment of patients with eating disorders.

The association between trauma, intimate relationships and mental health has been extensively documented (Beatson & Taryan, 2003; Chapman et al., 2004; Cloitre et al., 2009; Danese & Tan, 2014; Grubaugh et al., 2011; Herman, 1992; Johnson et al., 1999; Palitsky et al., 2013; Van Nieuwenhove & Meganck, 2017). Up to 66% of people who seek mental health treatment have been exposed to adverse childhood experiences (Grubaugh et al., 2011). Such as adverse childhood experiences include but are not limited to physical or sexual maltreatment or abuse, various forms of neglect, or witnessing domestic violence. At our inpatient clinic, the Family Unit, which is also our research context (further description will be provided in subsection 3.2), approximately 70% of families have at least one adult

member who has been the victim of sexual and/or physical abuse during childhood (Whittaker et al., 2021). The literature covering this topic may be sufficient to motivate our research project, but we were also inspired by the findings of Vrabel's PhD project. Vrabel et al. (2010) found that patients at Modum Bad's Eating Disorder Unit who had histories of trauma and fulfilled the criteria of avoidant personality disorder did not respond as well to treatment as those who did not have such a combination of adversities. Vrabel's findings led to tailoring the treatment program to be more suitable for that identified subgroup of patients at the Eating Disorder Unit. Given how diverse the patient population at the Family Unit is and how little we know about how different subgroups respond to treatment, coupled with an inconsistent clinical impression of how patients with histories of trauma experience therapy, we needed to systematically examine the outcomes of this subgroup of patients.

Several theoretical frameworks informed our line of inquiry; perhaps the most central was family systems theory (Priest, 2021), especially the concepts of restraints/constraints, cybernetic explanations/negative explanations, hierarchy of systems, feedback loops, and circularity. Although numerous iterations of family systems theory exist (Carr, 2016), certain principles can be traced back to von Bertalanffy's general systems theory (1950, 1968). Von Bertalanffy (1950) defined a system as a complex of interacting elements, with interaction referring to the relation between elements. Regarding family systems theory, such elements are family members (Priest, 2021).

Although not central to the conduct of our research, attachment theory (Bowlby, 1969) has been invaluable in our clinical understanding of the interplay between childhood trauma and adult relational functioning. From the perspective of family systems theory, attachments may be understood as the patterns and processes that structures a family (Priest, 2021). Attachment relates to the emotional bond (i.e., feelings of trust, support, safety, attunement, and togetherness) initially established early in life (i.e., caregiver and child), but which when internalized as an internal working model keeps influencing us across our life spans (Ainsworth, 1985). Given the importance of healthy

attachments for our psychological and relational wellbeing, severe abuse of such trusting bonds during childhood may have detrimental effects on adult mental, relational, and physical health, increasing the risk of developing posttraumatic stress disorder (PTSD) and what has become known as complex PTSD (Cloitre et al., 2009). Furthermore, expressions of trauma (i.e., reliving aspects of what happened, heightened alertness, avoidance, difficulties in emotional regulation), which may occur in the wake of a single traumatic incident, are sometimes more severe in instances of complex PTSD. Including typical symptoms of trauma, people who suffer from complex PTSD often have low self-esteem, difficulties in numerous areas of life (e.g., parenting, work, and relationships), and experience other comorbid disorders, including physical illness (Cloitre et al., 2009; Freyd, 1996; Herman, 1992; Suardi et al., 2017; Van Nieuwenhove & Meganck, 2017).

Another construct of importance for the study has been the concept of the working alliance (Bordin, 1979; Friedlander et al., 2018; Pinsof et al., 2008), which from the perspective of psychotherapy may be understood as bridging childhood trauma and attachment to relational functioning. The reasoning being that in both the therapeutic relationship and the romantic committed relationship the relational dimensions of agreement and emotional security are of consequence. The application of the multiple theories previously mentioned to comprehend our target objective has the potential lead to confusion, but by adopting the metatheory from integrative systemic therapy (IST; Pinsof et al., 2018) and translating it into a paradigm of research, I aimed to minimize any such confusion. IST is an approach to solving people's problems. It combines multiple frameworks on how reality manifests itself and how we, as human beings, are both a part of said reality and in interaction with it. In the following subsections, I will expound upon the concepts related to developmental psychology including childhood trauma and developmental trajectories, the working alliance, and the epistemology and ontology that underlines IST. The metaphysical assumptions that are incorporated into IST allow for the integration of multiple frameworks in clinical practice and are also applicable to guide research. The approach to

research I propose may be understood as a further development of the paradigm of family psychology, which Jay Lebow and William Pinsof presented in 2005. I argue that IST is, in part, a reiteration of those assumptions that Lebow and Pinsof put forward almost two decades ago.

Just as I saw the necessity of applying several theoretical frameworks to understand the phenomena of interest, I believed that IST, when adopted as a paradigm of research, would facilitate the use of complementary methods if such an approach to research was deemed appropriate. The appropriateness of such an application of methods would be decided by the research questions raised, and the research questions posed in both Papers 2 and 3 were adjusted according to the results of the study prior to it. My reasoning was based on the understanding of the inherent complexity of relational phenomena and the heterogeneous population that the Family Unit services. If complementary methods were to be applied, I could examine such phenomena from different perspectives both within a study such as in Paper 2 and across studies, thus allowing method triangulation (Fielding, 2012). Perhaps the greatest advantage of applying a complementary methods approach was that it allowed for a sequential design (Bailey-Rodriguez, 2021)—a design befitting my explorative attitude toward conducting science. This approach to research fits well with the assumptions underlying IST (Pinsof et al., 2018), such as the concepts of *progressive knowing* (i.e., additional perspectives accumulate greater understanding of reality) and *recursive influence* (e.g., the interaction of such perspectives). In a sequential design, various methods may be implemented at different stages in a study. This enables alternative perspectives on how phenomena may be understood and gives rise to new research questions and thus motivates further adaptation of methods in service of seeking answers to those questions. Regarding my project, the applied methods would evolve and become better adapted to investigate relational phenomena through the timeline of the PhD project. In the beginning, well-known quantitative methods were applied, followed by qualitative methods. Finally, I applied dyadic analyses, a

methodological adjustment to the statistical procedures I already knew that would allow for a better understanding of relational processes, and how they are associated with the outcomes of therapy.

Even though my entrance into the couple and family therapy field builds upon current trends, its historical development needs to be acknowledged. Hence, I consider this project to be anchored in historical roots, as well as contributing toward a promising future.

1.1 Historical developments of couple and family therapy and research

Systemic couple and family therapies, as we recognize them today, started to emerge in the 1950s as alternatives to the dominant individual-oriented psychoanalytic perspective. In this thesis, the terms *couple and family therapy*, *systemic therapy*, and *relational therapy* will be used interchangeably to address therapies that target interactional patterns between family members with the objective of alleviating mental and/or relational distress. When the term *couple therapy* is used, it exclusively relates to relational therapy conducted in the couple context (i.e., a committed couple is the client). These therapies came out of an intellectual movement in the post-Second World War era (Johnsen & Torsteinsson, 2012). This movement is influenced by ideas coming forth from a diversity of fields, including general systems theory (von Bertalanffy, 1950), cybernetics (Wiener, 1948), and ecology (Bateson, 1972). Of especial interest to this fledgling therapy field is how these ideas were related to relational systems, specifically those comprising families, and how they relate to society and societal change (Haukelien & Vike, 2018).

A couple and family therapist is in contrast to an stereotypically depicted individually oriented therapist (e.g., the passive psychoanalyst), an active therapist ready to direct the conversation between the multiple people that are attending therapy. The basic interventions of many relational therapists are reframing and enactment, as well as a high capacity for tracking and naming interactions between participants (Heatherington et al., 2015; Sprenkle et al., 2009). Reframing is typically used to reformulate subjective statements into relational terms (e.g., “So when she accuses you of not caring

about her, it isn't so? You are actually feeling sad?"), whereas the latter is used to set up a novel interaction between attending clients (e.g., "Could you tell her that the reason you don't respond isn't because you don't care about her, but that you are actually overwhelmed by sadness?"). Therefore, a couple and family therapist should be attentive not only to the verbal and non-verbal communication of the individual but also to all communications occurring among those participating. Many people attending therapy commonly have difficulties themselves, either intrapsychic or in other areas of their lives, which may adversely influence the interactions within the group. To further compound the complexities of relational therapy, representatives from different generations often attend therapy together, to the effect that the therapist is continually challenged to adapt to the many situations that may arise. To be able to manage such diversity of people and tasks, the couple and family therapist needs to have some knowledge about many different theoretical frameworks and intervention strategies, including family systems theory, developmental psychology, psychopathology, and cognitive, emotional, and behavioral therapies. Although relational therapy may be challenging, it is deeply rewarding for those who persist.

In its infancy, practitioners and theorists of family therapy had little interest in researching what was practiced and would rather prioritize model development. This would later be rectified from the 1980s onwards, with a huge push toward documenting the effectiveness of what had become a multiplicity of therapy models. Today, such documentation is readily available and summarized in several meta-analyses, handbooks, and literature reviews (e.g., Carr, 2019a; Carr, 2019b; Gurman et al., 2015; Pinquart et al., 2016; Sexton & Lebow, 2015; Shadish & Baldwin, 2005; Shadish & Baldwin, 2003; Shadish et al., 1995). Although ample evidence exists to support the statement that the majority of those who seek treatment for relational distress are better off than those who do not, there is still a large minority of clients who do not significantly improve (Mahon, 2020).

Why some people do not respond to treatment is an expansive question that requires considerable research to answer. However, some factors such as childhood trauma (e.g., Anderson et al., 2020; Dalton et al., 2013) and unrepaired alliance ruptures (e.g., Friedlander et al., 2018; Friedlander, Hynes, et al., 2021), have been associated with poor outcomes. I argue that there is an ethical imperative to broaden our knowledge of phenomena related to suboptimal treatment responses to help alleviate suffering. In practical terms, this may be defined as the process of identifying predictors and mediators that constrain outcomes. Identifying subgroups that do not respond to treatment and determining why they do not improve as anticipated may lead to the development of interventions to lift such constraints and thereby increase treatment responses.

1.2 Theory of constraints

The theory of constraints (Breunlin, 1999) postulates that patients present problems in therapy as a result of not being able to solve them. From the perspective of the theory of constraints, patients are constrained from deploying their own resources into resolving their problems. What resources the patients are constrained from having access to has a huge span of variation limited only by the human experience. Thus, constraints can vary from their psychological and/or physiological capacities, to constraints on resources that reside in family constellations or even at a societal level. It all depends upon the idiosyncrasies of the persons attending therapy and the societies they inhabit (Pinsof et al., 2018). In addition to being a part of what motivates patients to seek therapy, constraints are also encountered in therapy and are a way of conceptualizing what might be impeding therapy progression. Within the context of this thesis, childhood trauma and challenges to alliances may be conceptualized as constraints. In the following sections, I will provide a description of how such factors may potentially be negatively associated with therapy, thus constraining outcomes.

1.3 Concept of childhood trauma

Achieving consensus on what constitutes as childhood trauma and abuse has been challenging, because any such definition is fashioned by a number of factors including cultural and legal practices, history, as well as a host of other contextual influences (Miller-Perrin & Perrin, 2012). In societies where a majority of health care practitioners are informed by the medical model, the concept of trauma is most often associated with expert definitions such as the one found in the Diagnostic and statistical manual of mental disorders (DSM-5; American Psychiatric Association, 2013). The DSM-5 defines PTSD according to diagnostic criteria including exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following categories: (1) personal experience of the traumatic event, (2) witnessing the event as it happened, (3) learning that a close friend or family member experienced a violent or accidental trauma, and (4) repeated or prolonged exposure to distressing details of the traumatic event.

The challenge of defining trauma is further compounded by the subjective experience of what may be perceived as a life-threatening event, thus traumatic events may vary greatly from natural disasters, to neglect caused by absent parenting or the severe lack of knowledge about children's emotional and physical needs, to accidents and bullying, and to the more sensationalistic and horrific stories of sexual and physical abuse that are typically covered in the media (Miller-Perrin & Perrin, 2012). From research it is known that being exposed to traumatic events during childhood either accidental or intentional are not necessarily associated with the onset of PTSD. Epidemiological studies (Kessler, 2000; Sayed et al., 2015) show that the rate of exposure to trauma is substantially higher than the prevalence of PTSD. This indicates that most people including children and adolescents do not develop PTSD following traumatic events. Subsequently, childhood trauma has also been implicated in the development of many different psychiatric disorders besides PTSD, including mood disorders, eating disorders, substance abuse disorders, personality disorders, anxiety disorders, and dissociative disorders (Boroujerdi et al., 2019; Danese & Tan, 2014; Herman, 1992; Infurna et al., 2016; Johnson et al., 1999;

Kessler et al., 2010; Otte et al., 2016; Palitsky et al., 2013). Adults who have endured childhood abuse also have a heightened risk of experiencing detrimental effects to physical health (Felitti et al., 2019). In contrast, other children (and adults) exposed to traumatic events go on to live their lives seemingly unscathed or in some instances even experience positive outcomes such as increased resilience, posttraumatic growth, and personal transformation (Tedeschi & Calhoun, 2004; Zoellner & Maercker, 2006). This has led to some researchers preferring the term potential traumatic event to signify these differential outcomes (Bonanno & Mancini, 2012). The concept of a potential traumatic event is in accordance with the concept of multifinality from developmental psychology, which posits that specific contextual, experiential, or individual factors can heighten vulnerability to various forms of psychopathology in both children, adolescent and adult populations (Cicchetti & Rogosch, 1996).

In a review of 24 studies of childhood abuse conducted in Nordic countries, the prevalence rates of intrafamilial sexual abuse ranged from 0.2% to 1.2%, severe physical abuse from 3% to 9%, and witnessing domestic violence from 7% to 12.5% (Kloppen et al., 2015). A Danish report presented prevalence rates of 15% for neglect and 23% for emotional abuse before the age of 12 (Christoffersen, 2010). According to betrayal trauma theory (Freyd, 1996), abuse is especially damaging to a child's developing trust if it is committed by a significant other, one whom the child is otherwise dependent upon. It has been proposed that children who suffer intrafamilial abuse suffer greater emotional and physical injuries resulting from intrusion (i.e., severity of the abuse) compared to children who suffer extrafamilial abuse. In contrast, victims of extrafamilial abuse often suffer from greater use of force (i.e., verbal and physical violence) committed by the perpetrator and are older than victims of intrafamilial abuse (Fischer & McDonald, 1998). However, all forms of childhood abuse are related to the development of psychopathology, and sexual and/or emotional abuse is highly associated with an increased risk of developing PTSD (Messman-Moore & Bhuptani, 2017).

One factor that has been shown to influence a person's trajectory following a potentially traumatic event is the presence of protective factors, such as social support, positive coping strategies, and adaptive cognitive processes (Bonanno & Mancini, 2012; Masten et al., 1990). These protective factors can help individuals to buffer the negative effects of trauma and facilitate positive outcomes such as resilience. Conversely, the factors that have been most highly associated with the development of PTSD in adult populations is rape and intimate partner violence (Kessler et al., 2018). Further, negative outcomes following trauma may be categorized as chronic dysfunction (i.e., onset of symptoms of mental and relational distress which are within an expected timeframe and in accordance with diagnostic criteria) and delayed reactions (i.e., symptoms are subthreshold following the traumatic event but increase after an extended period of time). A key factor as to why some develop maladaptively as a response to trauma is associated with co-occurrence of potentially traumatic events such as the occurrence of multiple adverse events or chronic victimization such as deprivation of liberty combined with ongoing abuse (van der Kolk et al., 2009). Other factors associated with symptom development are individual differences related to both intrapersonal (e.g., disposition, personality) and interpersonal dimensions (e.g., access to social support, family interactions; Bonanno & Mancini, 2012). Differences in the impact of trauma has also been associated with the age that the victimization happened, such as maltreated toddlers and infants having greater risk of acquiring an insecure attachment style compared to those who are exposed to abuse at later stages in life. Although age does matter, of greater influence is probably the extent of the abuse (Manly et al., 2001).

A systemic addition to a developmental understanding of trauma may be supported by Hobfoll's theory of conservation of resources (1989). This theory when applied to the development of posttraumatic symptoms proposes that an initial loss of resources (e.g., psychological, social support, security, financial) prior or following a traumatic event predisposes the affected individual to continued losses of resources when presented with new adverse events. Thus, the initial loss of resources triggers

a potential cascade of resource losses continually depriving the victim of the resources needed to handle their misfortunes. A recent study by Banford Witting and Busby (2019) which based its research question on the theory of conservation of resources (Hobfoll, 1989) found that exposure to intrafamilial physical and sexual abuse, had both direct and indirect negative effects for the trauma survivor and their partner as well as on their resources as a couple (i.e., ability to cope with additional challenges). Overall, we know that various potential traumatic events during childhood and adolescents may be detrimental to their development and associated with an array of mental, neurological, and relational problems.

As mentioned, there are multiple negative outcomes associated with abuse, hence trauma-spectrum disorders have been proposed as suitable term to encompass this variation (Bremner, 2016). However, in this thesis the term childhood trauma is preferred when indicating association to this broad range of outcomes due to its extensive use in clinical settings and by the general population. In particular, the definition as applied in this thesis refers to childhood trauma as the adverse aftereffects experienced in adulthood as a consequence of having been sexually and/or physically abused in childhood and/or adolescents, often with instances of coexistent emotional abuse and/or neglect.

1.4 Childhood trauma as a constraint to adult relational functioning

People with psychiatric disorders who seek treatment generally report lower marital satisfaction, as do their partners, compared with couples without a member suffering from a psychiatric disorder (Whisman et al., 2004). Measures of relational distress are highly correlated with perceived individual distress (Funk & Rogge, 2007). People in committed but troubled relationships have a four times higher likelihood of having an affective disorder than people in non-troubled relationships (Goering et al., 1996). Such findings may be interpreted in a number of ways: Relational distress may be a contributing factor in the development and maintenance of psychiatric disorder; psychiatric disorders may lead to an increase in relational distress; or most likely, a bidirectional association between

relational distress exacerbating psychiatric disorder and vice versa (Whisman et al., 2012; Whisman et al., 2000; Whisman et al., 2004). Although it has been methodologically challenging to evidence the link between childhood trauma and adult relational functioning, this link has been strengthened this past decade due to improved research designs and methods including longitudinal studies, multilevel modelling and dyadic analysis (Banford Witting & Busby, 2019; Bremner, 2016; Trickett et al., 2011). For instance, Trickett et al.`s (2011) report on a 23-year longitudinal study gathered that participants who had been sexually abused (all females initially aged 6 to 16 years) experienced more problems in adulthood than the comparison group including higher prevalence of domestic violence, poorer social adjustment, sexual difficulties, and victimization of own offspring. Even though adults who have suffered childhood abuse have a higher risk of struggling with their intimate relationships, one should not conclude that they eschew engaging in romantic relationships (Colman & Widom, 2004).

Although**,** childhood abuse has been negatively associated with mental health and relational functioning, the number of treatment approaches that target the relational aspects of trauma is underwhelming. This is arguably problematic given that relational distress is a core aspect of the symptomatology of complex PTSD (Cloitre et al., 2009; Herman, 1992; Van Nieuwenhove & Meganck, 2017). The focus of research has mainly been on individual treatment approaches, thereby leaving those who are primarily in need of help for their ongoing relational distress without adequate treatment. That is not to say that useful psychotherapeutic treatment does not exist, just that options are lacking, especially for those who would potentially benefit from or seek a family-oriented treatment approach. Of the treatments that seek to alleviate posttraumatic stress symptoms and relational distress, only a few randomized controlled trials have been conducted. One of those trials was on emotionally focused therapy developed by Sue Johnson (2002, 2012). The study conducted by Dalton et al. (2013) resulted in a medium effect size (d = .62) on relational distress across the entire sample and a strong effect size (d = 1.00) for women who had experienced childhood sexual abuse. However, the results for reduction of

posttraumatic stress symptoms were non-significant. Another trial targeting posttraumatic stress symptoms and relational distress was on the use of cognitive–behavioral conjoint therapy for PTSD, an approach developed by Candice Monson and Steffany Fredman (2012). In this sample, the reduction in relational distress was also medium (*d* = .64) for the identified patient. The effect sizes for the reduction of posttraumatic stress symptoms were large (*d* = 1.61; Monson et al., 2012). The claim that cognitive–behavioral conjoint therapy may reduce posttraumatic stress symptoms has also gained further support in a randomized controlled trial conducted by Macdonald et al. (2016). In an emotionally focused therapy pilot study (Weissman et al., 2018) with a comparable population (i.e., participants recruited from a veteran's hospital) to the conjoint therapy for PTSD trials, similar results were found: With large effect sizes on both the reduction of posttraumatic stress symptoms (*d* = 1.11) and relational distress (*d* = .96). Although these results are promising, they should also motivate further research, especially given that only one of the cited studies explicitly targeted survivors of childhood trauma, and with disappointing results. In a study by Anderson et al. (2020), adverse childhood experiences were associated with men's difficulties in establishing an adequate alliance with their therapist in couple therapy. Since couple therapy is an approach that targets relationships, it is of interest to examine how survivors of childhood trauma respond to treatment. Possible implicated processes could be those that are perceived as being relational transactions including establishing and maintaining a therapeutic alliance with a therapist and/or their partner. Although the patient population at the Family Unit represents great variation in terms of presented problems, family constellations, and cultural and religious backgrounds, a large subgroup of this population shares a common denominator—they have experienced childhood trauma. Beyond our own clinical experiences, we do not know how such a subgroup fares in therapy compared to the overall patient population. Thus, I aimed to examine whether patients with early childhood trauma responded differently to therapy compared to those patients who had not reported such experiences.

1.5 Concept of alliance

As foreshadowed, a concept that would prove important for our study was the component of the therapeutic relationship dubbed alliance, sometimes also called a therapeutic alliance or working alliance (Bordin, 1979; Johnson & Wright, 2002). In the field of psychotherapy, including couple and family therapy, a large body of research literature associating strong alliances with good outcomes has been amassed over the past several decades (Flückiger et al., 2018; Friedlander et al., 2018). Alliance refers to the emotional bond between the therapist and the client, such as a sense of connection and to what extent they agree on the tasks and goals of therapy (Bordin, 1979). One of the most widely used self-report questionnaires that aims to capture the quality of an alliance is Horvath and Greenberg's working alliance inventory (WAI; 1989). The items that constitute the WAI cover the dimensions of bonds, tasks, and goals, as proposed by Bordin (1979). An example of an item from the WAI is: "The therapist and I are working towards mutually agreed upon goals." Clients are instructed to assess the included statements on a 7-point Likert-type scale ranging from negative to positive answer options (Hatcher & Gillaspy, 2006).

Whereas the term "working alliance" originated in the psychodynamic tradition (Greenson, 2008; Sterba, 1934), the concept of a real relationship was given special importance by proponents of the humanistic tradition (Doran, 2016). Rogers (1951) proposed that it was the real relationship between the therapists and the client that facilitated change, a position held to varying degrees by many to this day (e.g., Duncan et al., 2010; Gelso, 2014; Lambert, 2016; Wampold & Imel, 2015). Not only has the importance credited to the relationship between therapist and client fluctuated throughout the century, but how it has been conceptualized, operationalized, and ultimately applied to therapy has also undergone changes (Bordin, 1979; Doran, 2016; Safran & Muran, 2000). At present, the alliance has become established as a common factor both in individual therapy and couple and family therapy (Sprenkle et al., 2009; Wampold & Imel, 2015). This means that it is accepted that some level of an

alliance is a prerequisite for a good outcome of therapy. However, the extent of the alliance's influence on outcomes and the mechanisms leading to this association is still an ongoing topic of debate (e.g., Del Re et al., 2021; Flückiger et al., 2018; Friedlander et al., 2018; Li et al., 2021; Sprenkle et al., 2009; Wampold & Imel, 2015).

1.6 Concept of systemic alliance

In the 1980s, Pinsof and Catherall (1986) were the first to reformulate and adapt the concept of working alliance (Bordin, 1979), to fit the realities of couple and family therapy. Before Pinsof and Catherall (1986) presented the integrative psychotherapy scale, which included alliance scales adapted for couple and family therapy, research on the working alliance had mainly been the undertaking of individually oriented psychotherapy researchers. Prior to Pinsof and Cathrall's (1986) contribution, the concept of alliance and how it related to therapy had been discussed by couple and family theorists but had not yet been widely applied (Rait, 2000). Other related concepts were perhaps more popular among therapists, such as Minuchin's concept of "joining" (Minuchin, 1974) or Ackerman's reflections on how to establish "therapeutic rapport" (Ackerman, 1966). Although Pinsof and Catherall's (1986) initial conceptualization of systemic alliance, which was later reiterated as the integrative psychotherapy alliance scale (Pinsof et al., 2008), was the first systemic extension of the working alliance, others have also developed systems for evaluating alliances in family therapy since (e.g., Friedlander et al., 2006).

The systemic extension of the working alliance proposed by Pinsof et al. (2008, 2018) includes the well-established self-therapist domain (i.e., the alliance between therapist and client), and adds three more interpersonal systems (i.e., other-therapist, group-therapist, and within-system) in an attempt to capture the complexity of multiple alliances. Other-therapist refers to how a family member evaluates another family member's alliance with the therapist. Group-therapist refers to how an individual family member assesses their alliance as a family with the therapist, whereas within-systems

is the self-assessment of the alliance each family member has with one another, for instance, to what extent they agree upon their therapeutic goal. Tilden et al. (2021) supported earlier claims (Pinsof et al., 2008) that these interpersonal systems, except for within-systems alliance, can predict outcomes. Although the authors proposed that this may be due to within-system difficulties, which may have been the very reason why the couples participating in the study sought out therapy to begin with, they suggest that within-system alliance may be of greater importance later in therapy (i.e., an indication of improvement instead of a perquisite for improvement). Although their proposition is intriguing and may hold promise, I would argue that their lack of a finding may also be due to their methods of analysis, which were conducted at the individual level and only incorporated a limited number of time points, as will be expounded upon in succeeding sections.

Although Tilden et al. (2021) could not find any evidence for the predictive power of within-alliance, other studies (Friedlander et al., 2018; Friedlander, Hynes, et al., 2021) have evidenced that a weak alliance within the dyad and between either one or both dyad members and their therapist is negatively associated with outcome and heightens the risk of drop-out. A related finding is that poor outcomes are associated with hostile interactions between the therapist and his or her clients (Binder & Strupp, 1997; Von Der Lippe et al., 2008). In extension, I postulate that inadequately addressed hostility within dyads may also negatively affect the outcome of therapy.

1.7 Inadequate alliance as a constraint to outcome of therapy

Building on Bordin's (1979) concept of alliance, Muran and Safran (2000) conceptualized ruptures in alliance as either disagreement about tasks or goals or experiencing problems in the bond dimension. They also pointed out that a strain in either of the three dimensions may be negatively associated with one of the other (e.g., not having understood the tasks of therapy may affect the client's trust in the therapist). When the therapist does not adequately handle such disagreements either

directly or indirectly (i.e., the rupture is not repaired) and especially if unrepaired ruptures occur several times throughout therapy, the assumption is that they may have deleterious effects on the outcome or may cause drop-out. Alliance ruptures may also occur in a within-system, and as most couple therapists can ascribe to, it is not uncommon that couples that seek therapy are not in agreement on what the goal of therapy is (i.e., what the problem to be solved is) or are otherwise experiencing a lack of trust in one another (i.e., thereby reducing the quality of the emotional bond between). As such, the first step in couple therapy is often to come to agreement on what the presenting problem is and, therefore, what the goal of therapy is. If coming to an agreement on the presented problem is impossible, further exploration might lead to the acknowledgement that the problem is a lack of trust; thus, the couple may come to an agreement that the goal of therapy is to re-establish trust (Pinsof et al., 2018).

In most cases, the focus of therapy will be the result of a more or less continuous negotiation between all who engage directly in therapy, including the therapist, as well as rupture and repair cycles (Safran & Muran, 2000) following lack of agreement or an unsatisfactory quality of bond (e.g., “I don’t feel understood in this therapy”). Another potential constraint to outcome that is unique to conjoint therapies is a split alliance. A split alliance may be defined as a one-sided alliance between the therapist and one member of the couple or family and has been shown to be a predictor of poor outcomes (Bartle-Haring et al., 2012; Friedlander et al., 2018; Friedlander, Hynes, et al., 2021). Considering how exposure to childhood trauma may be negatively associated with adult relational functioning, such adverse experiences may increase the risk of ruptures and splits in alliances (i.e., trust issues). As mentioned, Anderson et al. (2020) found that men who had experienced adverse childhood experiences actually did have challenges in establishing alliances with their couple therapists. Thus, the interwovenness of past trauma and working alliances and how they potentially constrain outcomes of therapy need to be further examined. Subsequently, if we want to identify predictors of change (or lack

thereof; i.e., constraints) such as the ones postulated (i.e., “exposure to trauma,” “unrepaired alliance ruptures,” and “split alliances,”), we must also define the outcomes of therapy.

1.8 Assessment of outcomes

In systemic and relational therapies, little agreement has been made regarding the definition of outcomes. Thus, one may question if an outcome is the state of something at the end of therapy that is representative of what has occurred during therapy, or whether it may even be independent of therapy. Further, it may be inquired if outcome is best assessed at the end of therapy or is best assessed continuously throughout therapy. In extension one might have to consider whose assessment of outcome is the most valid. Possibilities ranging from but not limited to the patient, the therapist, to the patient’s spouse, or even a researcher. Although little consensus may exist on what outcomes are in couple and family therapy, perhaps the most agreement to be found on the topic is among those who apply quantitative methods to study outcomes. For example, the dyadic assessment scale (DAS; Spanier, 1976) is one of the most widely used measurements of outcome in couple therapy research (Graham et al., 2006). It is a questionnaire that, together with the family assessment device (FAD; Epstein et al., 1983) and the working alliance inventory (Horvath & Greenberg, 1989), has also been central in our studies.

In contrast, critique has been raised by postmodernists who are of the conviction that quantitative assessments are nonsensical. This assumption is based on the recognition that any direct knowing of reality is unconceivable (Anderson & Goolishian, 1988; Hoffman, 2001). The postmodern critique has greatly influenced many recent advances in family therapy (Priest, 2021) and given the preferential treatment postmodern therapies give to language above other types of behavior (Anderson & Goolishian, 1988; De Shazer et al., 2021; Epston & White, 1990), no systematic evaluation of outcomes is applied in many clinical contexts (i.e., use of pre- and posttreatment, and intersession questionnaires). Thus, a great portion of clinicians are thereby inclined to solely trust their intuition

when evaluating the outcome of therapy. Intuition, although not necessarily a problem in itself given that all clinicians use it daily when practicing therapy, has been shown to be not so reliable when dealing with complex clinical issues such as evaluating treatment outcomes (Saposnik et al., 2016; Walfish et al., 2012).

Gurman and Kniskern (1978) proposed that outcomes in couple and family therapy should not only be evaluated at one level of the family system, but that assessment should represent all subsystems of the family system (e.g., the individual, dyad, and family). These recommendations are in line with assumptions posited by family systems theory (Priest, 2021): Family systems are constituted of members that contribute uniquely, and the total sum of these contributions equates to something qualitatively different than any sole members' individual contribution. Thus, changing a single member's contribution may also be associated with changes in the overall family system and its constituent subsystems (e.g., parent or sibling subsystem) and vice versa. Such influences are potentially patterned into recursive and differentially reciprocal sequences of behavior—from moment to moment, from hours to days, and into routines and life cycles (Pinsof et al., 2018).

As mentioned, Gurman and Kniskern (1978) proposed that assessments should not only be oriented toward progress but should also take deterioration of the family system and its constituent subsystems into account. Research on deterioration in couple and family therapy is sparse, but some evidence substantiates its occurrence. In a study by Halford et al. (2011), deterioration was classified according to two different criteria: stringent, in which either partner reported a 7-point decrease on the dyadic adjustment scale (DAS; Spanier, 1976); or lenient, in which both partners reported a 7-point decline on the DAS. In this study, 25% (n = 32) and 12% (n = 16) deteriorated in the stringent and lenient criteria, respectively (Halford et al., 2011). At the Family Unit, having replicated a previous study, Tilden et al. (2020) presented sufficient evidence for the effectiveness of the couple and family treatment offered at Modum Bad, with effect sizes from admission to discharge ranging from .47 to .72 on

measures of dyadic adjustment and depressive symptoms, respectively, and .59 to .66 at the three-year follow-up. By applying the same criteria as Halford et al. (2011), Tilden et al. (2020) identified that approximately 41% and 34% of the participants in the original and the replication study were considered to have recovered accordingly, whereas approximately 5% and 10% were consequently considered to have deteriorated, as assessed with the revised DAS (RDAS; Busby et al., 1995). At the three-year follow-up, the portion of those identified as deteriorated had increased to approximately 10% and 20%.

Although assessing for deterioration is arguably warranted and in no need for further argument beyond our ethical responsibility as health professionals to do no harm, the importance of such assessment also has its rationale in family systems theory (Priest, 2021). Bateson (1972) proposed the idea of cybernetic explanations. A cybernetic explanation entails that the occurrence of an event is the result of the cessation of another event. Translated to psychotherapy, this would entail that the desired change is not occurring because it is restrained. This concept was later reintroduced as the theory of constraint (Breunlin, 1999), which is one of the five theoretical pillars of integrative systemic therapy (IST; Pinsof et al., 2018), which will be presented later. As mentioned previously, the theory of constraint proposes that outcomes may be constrained by a number of factors occurring at different levels of the system.

As well as taking both progress and deterioration into account when assessing outcomes, any variable considered will in all likelihood contain more than one kind of information about an event, state, or trait. Thus, the process of interpreting complex interpersonal phenomena and hidden mental processes coded within a variable inevitably results in the loss of richness of human experience (Toomela, 2008). Add on to this the inherent challenges of assessing a family or group (i.e., the assessment of multiple participants outcomes), and it is understandable why many clinicians are either skeptical or otherwise find outcome measures too cumbersome to use (Garland et al., 2003; Hatfield & Ogles, 2004).

To further compound the difficulty of assessing outcomes, conducting assessments is even more challenging in clinical practice than in a research context. Although assessing outcomes in itself may be thought of as taxing, it may become even more so in the clinical context because of severe time constraints and greater resource limitations. When a person's mind is strained and stressed, it is prone to defaulting to biased cognitions (i.e., anchoring, information bias, overconfidence, premature closure, representativeness, and confirmation bias), causing skewed assessments that are potentially related to errors in treatment (Saposnik et al., 2016). Consequently, we need ways to counterbalance our biased thinking, such as a structured and accurate assessment of family systems that are transferable to clinical practice. Qualitative methods, such as interviewing and text and video analysis, definitely have their advantages when exploring relational phenomena, proving themselves as highly useful at identifying possible predictors and mediators of change (Kazdin, 2007). However, taking full advantage of cutting-edge statistical methods in analyzing longitudinal data has huge potential to deepen our understanding of how family systems change over time (Friedlander, Heatherington, et al., 2021). Notably, clinicians and researchers are increasingly finding useful ways to deploy such technologies (e.g., feedback systems and video and audio analysis). For example, the tandem use of routine outcome monitoring (ROM; Tilden & Wampold, 2017) and videotaped therapy sessions may be employed to tailor therapy according to clients' idiosyncrasies, facilitate supervision and guide deliberate practice (i.e., skills training). Hence, advancing the therapist's competencies and thus improve outcomes (Goldberg et al., 2016; Rousmaniere et al., 2017). In a recent meta-analysis, the use of ROM was associated with reducing the differences between the less and more effective therapists and, according to the authors, leading to better psychological treatment (Delgadillo et al., 2022).

Since Gurman and Kniskern (1978) initially proposed the assessment of multiple levels of the system involved in therapy, huge developments in statistical analysis have occurred. Today, data collected from both different and within the same levels of a system can be analyzed, and whether these measures

have a reciprocal association with one another can also be examined (Kenny et al., 2020). Surprisingly, such examination of the nonindependence of observations (as explained below) has rarely been conducted within couple and family therapy process–outcome research. Such an oversight may be considered odd since one would assume that researchers inclined to think systemically would first and foremost be interested in examining such reciprocal effects. The error of not taking reciprocity into account may even be the very reason why a substantial portion of couple and family therapists feel estranged from the quantitative community and their methods of inquiry. No matter the reasons for this oversight, I propose: If couple and family researchers who apply quantitative methods want to be systemic, they need to redeem themselves of their erroneous ways. As it now stands, I argue that a great portion of the outcome research on couple and family therapy is of questionable validity and of limited value because of presumptions that will be thoroughly discussed in the following sections (Lorås et al., 2023; Tilden et al., 2022; Whittaker et al., 2023)

1.9 Nonindependence of observations

In practical terms, nonindependence, as presented by Kenny et al. (2020), implies that people who are in the same condition or are akin, such as members of the same family seeking therapy together, will have assessments contingent on one another compared to strangers who attend individual therapy. Therefore, applying statistical methods that allow for the testing of such assumed correlations, that is, a test of nonindependence, should be applied when analyzing quantitative data (Kenny et al., 2020). This is easily exemplified within the boundaries of couple therapy. As discussed earlier, the most commonly used outcome instrument in couple therapy is the RDAS (Busby et al., 1995), a questionnaire that is usually completed by both members of a dyad regarding their relationship satisfaction. Although we can assume that a degree of correlation between spouses' assessments on such an instrument is hardly controversial, the potential reciprocity of scores cannot be handled by traditional multivariate analyses (Kenny et al., 2020). Such analyses, when applied to psychotherapy, are based on assumptions rooted in

what one might call an individual-oriented paradigm of psychology (i.e., the assumption of the independence of observations). Consequently, even if consensus on what measures of outcome to be used in couple and family research and practice exists, the results of such evaluations are of little interest if they are founded upon the assumption of the independence of observations. At best, research guided by such an assumption would apply methods to analyze outcomes that would only be able to show how individuals change from one point to another (and usually just at two time points) in accordance with the nomothetic approach (i.e., with the objective of making general predictions about the population; Beltz et al., 2016). Such methods are not able to divulge how dyads change across time and are therefore of limited interest beyond illustrating the general efficacy of treatments.

Alternatively, in agreement with that has been recommended by Friedlander, Heatherington, et al. (2021), it is possible to conduct couple and family therapy research within a paradigm founded on the assumption of nonindependence. Within this paradigm, the applied methods of assessment and analyses would befit the relational phenomena of interest, thereby taking the assumed nonindependence of data into account. To do so, one would need a dyadic approach to data handling and analysis (Bolger & Laurenceau, 2013; Kenny et al., 2020), thus enabling the examination of research questions, such as: Do family members that attend therapy together change together?

In summary, all practitioners of systemic therapies, including couple therapy, recognize an interdependence of observations (i.e., a change in conjoint therapy is contingent on all persons participating). Kenny et al. (2020) termed this nonindependence. The term nonindependence is preferred over the term interdependence; although the latter is more colloquial, it is often used to refer to the mutual influence of group members over time, thus not taking into consideration other patterns of association (Thibault & Kelley, 1978). Nonindependence refers both to a theoretical lack of the independence of data, which is assumed, and to a statistical lack of the independence of data, which is assessed. Contrary to the central assumption in linear quantitative methods—that observations (i.e.,

data) are independent from one another (Kenny et al., 2020)—the fundamental assumption when conducting systemic research is that observations are nonindependent. In fact, I argue that theoretical nonindependence is the very foundation any therapy approach informed by family systems theory (Priest, 2021): The core rationale of couple and family therapy is based on the assumption that members of the same system influence one another (Carr, 2019a; Carr, 2019b; Pinsof et al., 2018; Priest, 2021; Sprenkle et al., 2009), thus dictating how we understand problems as relational or embedded in relationships, thereby becoming the targets of interventions.

1.10 Conceptualizing nonindependence

Nonindependence may come from various sources, such as compositional effects (e.g., similarity in personality; Klohnen & Luo, 2003), common fate (e.g., shared contextual factors; Ledermann et al., 2010), and actor-partner effects (e.g., effect of depression on marital satisfaction; Kenny, 1996; Kenny et al., 2020). Compositional effects are not of particular interest to systemic therapy researchers, as they likely represent traits that are not malleable and thus do not greatly determine how systems change over the time span of therapy (Kenny, 1996). Systemic therapy researchers should consider when to apply the common fate model (Galovan et al., 2017; Quirk et al., 2021), the actor–partner interdependence model (APIM; Kenny et al., 2020), or the social relations model (Kenny et al., 2020; Kenny & La Voie, 1984). The main reason to select one model over the other is related to research questions entailing what level of the system one is aiming to examine, such as the individual (e.g., rumination), dyadic (e.g., trust), or family (e.g., functioning) level. Notably, the level of measurement and the level of analysis should not be confused. Level of measurement refers to what level of the system the data is collected from, whereas level of analysis may occur at an individual or dyadic level, depending on the level of measurement. For instance, the assumed reciprocity of intrapsychic processes' association with outcome may still be analyzed at a dyadic level, as is often the case when the APIM (Kenny et al., 2020) is applied even though the processes are measured at the individual level.

For example, when examining the partner effect of depression on spouses' relationship satisfaction, the level of analysis is considered dyadic because the variance is explained at the couple level even though the process variable is measured at the individual level.

When selecting the appropriate model to apply to the data, the researcher should make certain considerations. As with the selection of any research method, model selection should come after research questions have been posed (Galovan et al., 2017). A common fate model may be preferable when one wants to investigate the associations regarding a shared variable, such as system-alliance (e.g., couples' or families' aggregated score of their alliance with the therapist; Pinsof et al., 2008) or relationship length on an applicable dependent variable. Conversely, if the predictive variable is not shared but is self-referential (i.e., at the individual level of measurement), the APIM is most likely a better fit than a common fate model. For instance, the association of self-reported depression with couple satisfaction is best conceptualized within the APIM framework (i.e., actor–partner effects) and not within the common fate model (i.e., common fate effect), with the latter being preferable when the predictive variable is shared. Selecting the APIM is also supported if couples' assessments of reported variables are negatively correlated or are otherwise inconsistent across partners (i.e., individual not shared). In summary, the APIM is the model best suited to analyzing the interrelatedness of dyad members when a predictive variable is constituted by data collected at the individual level of measurement, thus allowing for the examination of dissimilarities within a system. However, the common fate model is better suited to exploring associations about nonindependence when the predictive variable is representative of data at the system level of measurement, thereby capturing similarities within a system (Galovan et al., 2017).

In social psychology in particular, and in the interdisciplinary field known as relationship studies, the APIM (Kenny et al., 2020) has been widely applied (Joel et al., 2020). Although, such models as the APIM are increasingly used in clinical disciplines including couple and family therapy (e.g., Anderson et

al., 2020; Anderson & Johnson, 2010; Banford Witting & Busby, 2019) and psychotherapy in general (e.g., topics related to alliance and group processes; Kivlighan et al., 2016; Kivlighan et al., 2014; Li, 2022; Li et al., 2021), further dissemination of models that consider nonindependence should be prioritized (Friedlander, Heatherington, et al., 2021). In our own work, we have thus far applied the APIM to examine reciprocal effects within dyads attending couple therapy. As we expand our studies to include extended systems (i.e., examination of interactions between more than two family members) and, in the future, incorporate therapist variables and/or self-report from children and adolescents, we will look toward applying variations of the social relations model (Kenny et al., 2020) as a conceptual framework for analysis. In the future, we might consider a research design conceptualized within the common fate model to answer certain research questions, such as how dual trauma (i.e., both members of a dyad have histories of trauma) or financial burden is associated with outcomes. In conclusion, I will support my argument by citing Friedlander, Heatherington, et al. (2021, p. 570): "(…) we recommend that researchers embrace *analyses that explicitly account for dependent data,* such as the actor-partner interdependence model (APIM) (Kenny & Kashy, 2010)". However, to unlock the full potential of these discussed models, data needs be collected accordingly. Hence, data should be collected frequently and be representative of the levels of the system of interest.

1.11 Data collection as a part of clinical practice

Four decades after Gurman and Kniskern (1978) made their recommendations, technological advancements and routines related to the assessment of couples and families have greatly improved. Tracking therapeutic processes and outcomes has become increasingly common through the application of ROM (Tilden & Wampold, 2017). Efforts to implement ROM in family services throughout Norway have generated large quantities of data collected from family members attending therapy together. This has led to several prominent research projects within the field of couple and family therapy in Norway. Two noteworthy projects of the past decade have been the "Client directed outcome informed couple

therapy" (Anker et al., 2009) and "the STIC multicenter project" (Tilden et al., 2020). The former was the largest randomized clinical trial of its kind, employing the outcome rating scale (Miller et al., 2003) and the Locke–Wallace martial adjustment test (Locke & Wallace, 1987) to investigate the efficacy of ROM versus treatment as usual. In a similar fashion, this was also done in "the STIC multicenter project" (Tilden et al., 2020). By contrast, the feedback system used in the multicenter project—the systemic therapy inventory of change (STIC; Pinsof et al., 2015)—is a far more advanced feedback system than the one used by Anker et al. (2009). The STIC (Pinsof et al., 2015) covers the individual, dyadic, and family levels of measurement, assesses for problems, and gathers information related to the resources of the clients. Notwithstanding how extensive these research projects were and how well they were managed, they still did not take advantage of the potential of the longitudinal data collected. Only one of the analyses conducted within these projects considered the nonindependence of data. This was done by Anker et al. (2010); however, the APIM analysis performed was not clearly presented, and the significance of the study (i.e., use of dyadic analysis and the partner effects identified) has, to my knowledge, not been widely disseminated. As for the rest, the only thing that was tested was the efficacy of ROM at a nomothetic level (Anker et al. [2009] found support for the use of ROM to better outcomes when compared to treatment as usual, whereas Tilden et al. [2020] did not find a significant difference between the ROM condition and the treatment as usual). Although their data collection strategies would have made dyadic analyses ideal and could have thus revealed patterns of reciprocity, this potential was not delivered upon.

Together with clinical interviews, clinical observations, and structured interviews (e.g., the structured Interview [Watzlawick, 1966] or the marriage checkup [Cordova et al., 2014]), and self-report questionnaires (e.g., the family adaptability and cohesion evaluation scale [Olson et al., 2019] or the FAD; [Epstein et al., 1983]), many ways can be used to assess couples and families. However, if these tools of assessment are not applied frequently, as is the case with ROM, how a family system changes

across time cannot be evaluated. Naturally, one may argue that both clinical interviews and observations are implemented frequently as part of routine clinical practice, but if data are not collected systematically (e.g., at predetermined time points), they are of little use for predicting change. That is not to say that longitudinal studies are always best served by the application of standardized questionnaires. For example, longitudinal social interaction diary studies (Nezlek, 2020) are also a good way to collect data to conduct dyadic analyses. For instance, data can be collected according to an interval contingent design; each member of a dyad receives a prompt at set time points, with the instruction of describing aspects of their relational interactions that were the target objectives of the study. Such studies, including those that apply ROM, may with greater ease be conducted with the use of mobile devices, which not only allow for the completion of online questionnaires but may also be used to collect visual and audio data, as well as data based on global positioning and the motion of the device itself (Bolger & Laurenceau, 2013).

Although alternative data collection strategies exist, the use of ROM in a clinical unit where such a tool is already implemented in daily practice has clear advantages. In addition to using already established infrastructure and routines to gather data, ROM also has the potential to reduce the scientist–practitioner gap through the promotion of practice-oriented research. Practice-oriented research is a type of research inviting clinicians to be involved in conducting research within the natural context of clinical practice and routines (Castonguay & Muran, 2015). Practice-oriented research has been proposed to foster collaboration between clinicians and scientists because of their shared interest in the same targets (e.g., therapeutic processes; Morrow-Bradley & Elliott, 1986; Safran et al., 2011).

Although the benefits of ROM as a clinical tool may have been initially exaggerated (Pejtersen et al., 2020), it is still useful for clinicians that employ such systems as a part of their practice (Solstad et al., 2019; Tilden & Wampold, 2017; Tilden et al., 2020). Based on a study by Walfish et al. (2012) it may be assumed that clinicians in general are only able to identify 2.5.% of patients that deteriorate. This

implies that up to approximately 97.5% of those that deteriorate during treatment are not identified by their respective therapist. Another interesting study (Hannan et al., 2005) showed that clinicians were only able to predict three out of 550 (0.01%) patients as deteriorated, even though they were prior informed of the base deterioration rate of 8%. With the use of ROM, clinicians' ability to identify off-track clients may be as high as 85% (Lambert & Harmon, 2018). Off-tack treatment trajectories are identified by alerting the therapist that his or her patient is possibly deteriorating (e.g., increase of suicidal ideation or suspected occurrence or risk of partner violence) or at risk of drop-out. In accordance with feedback theory (Sapyta et al., 2005), such information should prompt the therapist, in collaboration with clients, to change the ongoing behavior to be realigned with the treatment goals (i.e., the client is motivated by the reduction of cognitive dissonance). Thus, some benefits of ROM include its potential to reduce clinicians' overconfidence (Saposnik et al., 2016; Sapyta et al., 2005) and its ability to allow clients to give feedback that may serve to instigate conversations on related sensitive topics that are not readily available (Solstad et al., 2019). Examples of such topics are those that may possibly be perceived as shameful (e.g., relapse of addiction or sexual dysfunction) or are otherwise relationally difficult to handle (e.g., rupture of the alliance or lack of trust in spouse).

For those who have come to rely on ROM systems to gather research data, they have become indispensable. As noted, ROM is not the only tool that may be used to collect longitudinal data, but it is perhaps one of the few tools that may be reliably used to collect data systematically and frequently over prolonged periods of time. Other modes of data gathering that may serve a similar purpose (i.e., examination of therapeutic processes) are those applied when collecting qualitative data (Kazdin, 2008), including audio and/or video recordings of therapy sessions and in-depth interviews. Although such methods tap into different modalities (i.e., audiovisual perception and long-term memory recall), they may ideally be used to triangulate data either in a merged and/or sequential design (Bailey-Rodriguez, 2021; Fielding, 2012). As an example of how merged methods can be applied to build an advanced

multimodal hierarchical model to perform dyadic analysis, I refer to Paz et al.'s (2021) cutting-edge psychotherapy study. As discussed, a multitude of methods can be used when examining relational and mental processes; however, the application of any method should be done with an awareness of its underlying assumptions.

1.12 Paradigm of systemic family research

Positioning oneself explicitly within a paradigm promotes a clear understanding of the underlying assumptions that serve to guide one's scientific inquiry (Gannon et al., 2022). Such an awareness to self-positioning is in accordance with the process of reflexivity (Finlay, 2002). Finlay (2002) defined reflexivity as "thoughtful, conscious self-awareness" (p. 532). As the project progressed, my awareness of these assumptions gradually grew. An important realization that would be pivotal for how I would position myself as a researcher and develop a suitable methodology, came with the attempted interpretation of the findings from the first paper. In Paper 1, the analysis was conducted at the individual level, even though the outcome data were at the dyadic level of measurement. Consequently, the results were nearly impossible to conceptualize and discuss in relational terms. Further reading of what Lebow and Pinsof (2005) had called "The Scientific Paradigm of Family Psychology" and the work of Kenny et al. (2020), heightened my awareness of certain assumptions that are important when researching relational phenomena. As implied, Lebow and Pinsof (2005) proposed "The Scientific Paradigm of Family Psychology" as an alternative to the prevailing paradigm, surmising their position as follows:

"There are several pragmatic implications to the interactive constructivist position and the notion of progressive, but partial or incomplete, scientific knowledge. Quantification does not necessarily imply objectivity. It is a tool to help us understand and manipulate reality, but it does not confer an inherent objectivity on the knowledge it generates. As a consequence, this paradigm incorporates both quantitative and qualitative methods. They are not incompatible. On the contrary,

within this paradigm, they exist in a circular, reiterative relationship. They generate somewhat different, yet compatible types of knowledge that are complementary and mutually enriching" (p. 8).

As well as embracing the tenets that Lebow and Pinsof (2005) described as "The Scientific Paradigm of Family Psychology," to their summary, I would add the necessity of explicitly adopting the assumption of nonindependence of observations if one aims to examine the reciprocal world of human relationships. As argued by Kenny et al. (2020), the study of nonindependence is the focus of any research that wants to examine dyads. This approach to relational research has, to my knowledge, been unapplied in all couple and family therapy research programs and is something I consider a grave oversight. Nonindependence of observations needs to be understood by all researchers within the field irrespective of methodological preferences and further applied statistically by those that use quantitative methods. I would argue that this is a clear consequence of adhering to what I am about to suggest. A proposition which is based on Pinsof et al.'s (2018) reiteration of the scientific paradigm of family psychology as presented in *Integrative Systemic Therapy: Metaframeworks for problem solving with individuals, couples and families*. This reiteration of the scientific paradigm of family psychology called *the Five Pillars* (which will be described in the next subsection), is suitable to serve as an epistemological and ontological foundation for my proposed updated research paradigm henceforth known as *the paradigm of systemic family research*.

Although the essence of Lebow and Pinsof`s (2005) proposition is intact in this reiteration, changes have been made to further align their contribution with systemic concepts. Thus, in this current descriptor of the paradigm the term "psychology," which has the connotation that there is a proclivity toward the individual's intrapsychic reality, has been replaced with the term "systemic" to strengthen the link between research and systemic concepts. Even though I also acknowledge and subscribe to the understanding of the interaction between the intrapsychic and the interpsychic phenomena, I avoid giving either dimension of human experience priority.

Although the paradigm of systemic family research proposes methods that are applicable to examining relationships of any degree of closeness, including collegial or peer relationships, the inclusion of the term *family* is preferred because of the topics and phenomena with which couple and family therapists are interested. An example of such a topic is intrafamily abuse and how it is associated with the quality of close romantic relationships of survivors of such trauma in adulthood. By exploring such topics, hypotheses can be tested within the framework of family systems theory (Priest, 2021). As such, the aim of the paradigm of systemic family research can be understood to be in the service of confirming, disconfirming, or further developing family systems theory as a relevant framework to understand relational phenomena (Whittaker et al., 2023). In the following section, I shall go further in depth into the assumptions that underlie the paradigm of systemic family research.

1.13 Five pillars

The core theories (i.e., epistemology and ontology) proposed by Lebow and Pinsof in "Family Psychology: The Art of the Science" (2005) are reiterated as the Five Pillars in "Integrative Systemic Therapy: Metaframeworks for Problem Solving With Individuals, Couples, and Families" (Pinsof et al., 2018). The five pillars may be considered an integration of family systems theory with perspectives from the postmodern movement and by doing so reconciling their differences and thereby moderating some of the more radical social constructionist viewpoints often associated with the latter, as well as aligning family systems theory with the values of present-day society.

Five conceptual pillars underpin IST and, in extension, the proposed paradigm of systemic family research. The five pillars expound on why certain theories or treatment strategies are prioritized above others and act as the foundation for the multiplicity of frameworks that make up the IST perspective. As mentioned above, I also consider these metaphysical assumptions to support the proposed paradigm of systemic family research. Although, the experience I had conducting and writing-up the study described

in Paper 1 was essential to my contribution to the paradigm of systemic family research, the paper in itself was not informed by it. However, Paper 2 and Paper 3 were intentionally aligned with the underlying metaphysical assumptions of the paradigm of systemic family research. It is also worth mentioning, that the five pillars I will be expounding upon in the following is a multifaceted lens which presently has changed my perception and understanding of the contents of Paper 1 since its publication.

The epistemological pillar pertains to how knowledge about reality is obtained (i.e., its epistemological stance)—the recognition that an objective reality exists but which is only partially accessible to any given individual. Thus, we recognize the existence of objective reality, but the world as we know it is always perceived and understood through the lens of subjectivity. Objective reality, although ultimately unknowable, may thus be understood as being a continuous intersubjective process resulting in cognitive approximations of the environment that allow the organism to interact and physically manipulate it (Lebow & Pinsof, 2005). As indicated, this epistemological stance, with its emphasis on the social aspect of knowing reality, shares commonalities with the postmodernist perspective but moderates it by acknowledging the existence of an objective reality that may be at least partially known. Consequently, from a purely postmodernist point of view, one would not, as a therapist, be interested in underlying psychological structures (e.g., structural theory; Marcus, 1999), and as a scientist, one would not research latent variables (such as anxiety or depression). Instead, one would be interested in the meaning and structure of the stories that clients and informants told them. From the perspective of postmodern critique, language shapes the experiences that we call reality. Thus, this scope of interest gives preference to language as the medium of relating meaning and structuring reality, and thereby has been the target of research (Priest, 2021). According to the epistemological pillar, one would not be beholden to such limitations, as would be the consequence of adhering to a strictly postmodern perspective. Through the lens of the epistemological pillar, one could be interested as a therapist and a scientist in both narratives and underlying psychological structures without

sacrificing one out of preference for the other. The epistemological pillar shares commonality with the epistemological stance of paradigm pragmatism (Maarouf, 2019), both subsequently allowing for the application of a range of methods to collect and analyze data. Therefore, research or practice grounded in the epistemological pillar is not an either-or venture—when it comes to the selection of methods of inquiry, it embraces multimodality (Pinsof et al., 2018).

The hallmark of the epistemological pillar is that reality as it may be known is more accessible when more people convene and share their subjective experience. Thus, this enables the combination of elements from both modernism and postmodernism. This suggests that reality, as we perceive it, is the result of intrapsychic and interpsychic processes interacting recursively with one another and the environment, from micro to macro (i.e., person/biology, dyadic relationships, family, community, public spaces, and civilization) and in time (from one moment to another and across generations). The attentive reader may recognize the similarity between the five pillars of IST and other theoretical frameworks assumptions about reality, such as Bronfenbrenner's (1986) ecological perspective. Both IST and Bronfenbrenner's (1986) ecological perspective propose that reality is composed of multisystemic interactions within the dimension of time. The argument may be made that the advantage of IST compared to similar approaches is its emphasis on integration and how the interplay of the different components of IST outlines a process of how to combine and reconcile the dissimilarities of a multitude of perspectives (Pinsof et al., 2018).

As the majority of the field of psychotherapy is perceivably moving forward toward integration (Norcross et al., 2013), and thereby beyond decades of debate relating to what therapy models are most efficacious. I would argue that epistemological stances similar to the one presented are becoming the very cornerstone of all contemporary relational and systemic therapies. In relation to scientific endeavors, I would propose that the consequence of adhering to such a epistemological stance is the realization that no single theoretical framework will capture all the nuances of social and relational

phenomena. In extension, such a take on reality not only suggests that mixed method designs are preferrable, contingent on the research question raised, but also that integration of multiple theoretical frameworks are advantageous to interpreting and understanding findings from such research.

The ontological pillar of IST connects the paradigm of systemic family research to systems theory (von Bertalanffy, 1950, 1968) and cybernetics (Wiener, 1948) and serves to describe the interaction between people. From this perspective, every aspect of human life, from the individual to the family and through society may all be conceptualized as systems made up of subsystems. More than one system or subsystem may influence another system or subsystem. “The whole is always more than the sum of its parts” is an axiom sometimes credited to Aristotle, which rings true in describing this ontological stance. Systems are organized in such a manner that boundaries and power matter, and behavior may only be understood in the context of systems. Feedback from systems (e.g., ROM or verbal and/or non-verbal communication) gives the information needed to understand the relationship between subsystems (e.g., a family and its constituent family members). Within systems, a driving force toward morphogenesis (i.e., change) and a pull toward homeostasis (i.e., stand still) may both exist. The ontological pillar of IST orients research conducted within the paradigm of systemic family research toward examining how people who are tightly knitted together influence one another within their social environments. This interaction between family members is thereby often the target of research.

The sequence pillar breaks down the relationship between subsystems and systems into sequences and thus places phenomena of interest (i.e., patterns of reciprocity) within the dimension of time. By delimiting behavior into sequences, we can identify and target recursive patterns of thought, emotion, and behavior. The phenomena we seek to understand when we engage in research are embedded in such sequences. For instance, a line of inquiry could be how depressive thoughts, emotions, and behaviors are possibly embedded in family members interactions with one another (i.e., their problem sequence). Another example could be to be to examine sequences between patient and

therapist and how they are associated with outcome. Therapeutic interventions aim to change or modify such sequences to improve both individual and relational distress, and therefore such interventions may also be the target of study.

The constraint pillar is informed by Bateson's (1972) concept of a negative explanation originally known as a cybernetic explanation. A negative explanation proposes that an occurrence is the result of the cessation of a constraint. By contrast, a positive explanation is a formulation of the preconditions that need to manifest before a given occurrence. The constraint pillar gives preference to negative explanations rather than positive explanations (i.e., causal explanations). This theory of change, as introduced earlier, is also known as *the theory of constraints* (Breunlin, 1999). Constraints may be conceptualized as "something" that gets in the way of the client system (e.g., a family) from solving the problem it presents in therapy. The constraint pillar informs the hypothesizing process inherent both in therapy and research on *what* the constraints are composed of and *where* such constraints are located. Constraints may manifest anywhere within a system and can range from being a genetic disorder constraining an individual's capacity to break down essential amino acids resulting in severely impeded cognitive development to an undisclosed affair creating emotional distance in a couple's relationships, or the lack of affordable healthcare's detrimental effect on local communities. In all these examples, one may postulate that removing the specific constraint would either directly solve or allow for the implementation of strategies targeting the presented problem (i.e., restricting phenylalanine in diet, disclosing the affair, and changing government policy).

The constraint pillar is of immense value when designing a research project aimed at identifying non-responders or those who deteriorate during treatment, as it prompts the formulation of research questions as negative explanations. The constraint pillar also directly promotes engagement with informants to identify constraints, and this intentional stance, in conjunction with the epistemological and the ontological pillars, asserts that research is a collaborative project between researcher and

informants. Collaboration between researcher and informant in qualitative research may be understood as a dialogic process that is based on the trust the informant has in the researcher, allowing memory recalls and storytelling (Russell & Kelly, 2002). Furthermore, co-creation is not unique to qualitative research; it also occurs when quantitative methods are applied. This is especially the case in practice-oriented research (Castonguay & Muran, 2015), given that the roles of researchers and clinicians often overlap; since, interactions between researchers and the patients/informant are frequent. Subsequently, research guided by the theory of constraint (Breunlin, 1999) has the potential to result in practical implications. Thereby, facilitating the development of strategies to improve the quality of life of people by identifying subgroups of populations who previously have had less than optimal responses to therapy and/or community interventions.

The causality pillar emphasizes the recursive influence that subsystems and systems have on each other (i.e., nonindependence). This understanding of causality does not necessarily mean that all subsystems and systems have an equal amount of influence on other subsystems and systems. A statement supported by *the ontological pillar* implies that systems and subsystems often have an unequal amount of influence on each other (i.e., power matters). In an earlier iteration, Pinsof (1995) called this concept *differential causality*. This concept expands upon the theory of mutuality (i.e., as presented earlier in the subsection "Nonindependence of data"), which proposes that subsystems within a system have mutual influence on each other. A test of nonindependence of observations as previously described, may thus be understood as a way of examining the assumption the causality pillar proposes – that systems and subsystems influence one another reciprocally. Furthermore, positioning oneself as a systemic researcher is to acknowledge that us as researchers and our research projects also become influenced and influence others through interactions with our environment (e.g., participants, colleagues, work conditions). Thereby, in accordance with the five pillars we should respond

appropriately to ensure the quality of our research, such as practicing reflexivity and transparency (see subsection 3.8.4) and applying research designs that are malleable (see subsection 3.3).

In summary, these five pillars evidently have practical implications for how therapy is conducted. Furthermore, they are quintessential as underlying assumptions of the systemic family research paradigm, as they neatly compromise key ideas of systemic thinking, acknowledging the concept of reciprocity (i.e., nonindependence) and its many potential consequences. The paradigm of systemic family research has throughout my PhD period become of ever greater importance for how I conduct (e.g., selecting research designs and methods) and understand research (e.g., interpretate and disseminate).

1.14 Background summary

Victims of childhood trauma are at greater risk of experiencing mental and relational distress than those who do not have such a background. Given how such traumas are often perpetrated by people whom the victims trust and how such emotional injuries are associated with relational functioning, relational therapies such as couple and family therapy may be both a context of healing and/or one that poses a great challenge. How to best inquire into such phenomena, which are inherently complex, is still being debated within the field. A majority of those applying quantitative methods have not considered the assumption of nonindependence (i.e., that observations of those who seek therapy together are interdependent), whereas the remaining researchers have solely relied upon qualitative methods. Given the intricacy of couple and family therapy, as exemplified by the topic covered in this thesis (i.e., how childhood trauma is associated with processes and outcomes of couple and family therapy), I propose that a paradigm of systemic family research informed by the five pillars of IST best serves to guide such inquiries. To commit to such a program of science, we need to have a clear distinction between the levels of the system assessed and apply the corresponding concept of analysis. Depending on the

research question, complementary methods should also be applied, not only in the service of data convergence, but also because of the proposed advantage the application of multiple perspectives may grant when investigating how relational systems change across time.

2. Objectives

Important questions remain unanswered about our understanding of the consequences of childhood trauma and how it is associated with outcomes in couple and family therapy. A history of exposure to adverse childhood experiences is frequent for those who seek mental healthcare for treatment. Those who have such histories are at greater risk of experiencing relational distress in intimate relationships. Given this literature on survivors of trauma and the knowledge gap on how this subgroup fares in couple therapy, especially in a naturalistic setting, we aimed to examine how patients with histories of childhood trauma respond to and experience treatment. Specifically, we wanted to examine the following:

1. To evaluate the Family Unit's treatment program by assessing the participants' degree of mental and relational distress from intake to discharge and changes in distress taking place during treatment.
2. To investigate the predictive relationship of therapists' reports of patients' histories of childhood trauma on weekly patient-reported outcome.
3. To retrospectively explore a subsample of those patients with histories of childhood trauma about their experiences of receiving treatment at the Family Unit.
4. Apply dyadic analyses (Kenny et al., 2020) as a method of analyses to investigate actor–partner effects related to a) how the actor's (i.e., the individual) alliance to the therapist predicts his or her relationship satisfaction, b) how the actor's alliance to the therapist predicts his or her partner's relationship satisfaction, c) how the actor's relationship satisfaction predicts his or her alliance to the therapist, and d) how the actor's relationship satisfaction predicts his or her partner's alliance to the therapist.

2.1 Paper 1: Examining treatment response

At the time of the study, no inquiry was made on how a subgroup of patients characterized by histories of childhood trauma responded to couple and family therapy at an inpatient clinic servicing a heterogenic patient population. Testing whether subgroups of patients admitted responded differently to the treatment on offer was crucial to allow for tailoring of therapy to potentially increase treatment response. Therefore, the study aimed to test whether childhood trauma was a predictive of outcome on individual, dyadic, and system levels of measurement. Specifically, we aimed to test whether:

1. Participants with a history of childhood trauma experience impaired progress throughout treatment, as well as pre-post outcome, on the individual, dyadic, and system level of measurement in couple and family therapy compared with participants without a history of childhood trauma.

2.2 Paper 2: Recall of treatment experience

Following up on the results of Paper 1, we aimed to explore what the results meant for the patients it pertained to. The paper aimed to examine the results of Paper 1 in collaboration with former patients at the Family Unit. These former patients had been identified as belonging to the subgroup of patients who had histories of childhood trauma and who had not responded to treatment as assessed on the applied measurement of family functioning. Specifically, we wanted to explore the following:

1. How do the participants perceive the outcome of the treatment they received?
2. How do the participants perceive their collaboration with their partner and with their therapist?
3. How do the participants perceive the association of past trauma with the therapeutic process?

2.3 Paper 3: Examining actor–partner effects

Having identified in Paper 2 the possible occurrence of split alliances and their implications for poor outcomes, we aimed to further examine the interplay between alliances and outcomes. At this stage of the project, we did not want to analyze data at the individual level. Because of the findings of Paper 2, the challenges offered by learning a new method of analyses, and our limited sample size, “trauma” as a predictor of outcome was omitted. Thus, our aim in Paper 3 was to identify the effects of reciprocity (i.e., actor-partner effects) on measures of working alliance and couple satisfaction. Specifically, we wanted to examine the following:

1. Does an individual’s alliance with the therapist predict his or her own couple relationship satisfaction across time? (Actor effect)
2. Does an individual’s alliance with the therapist predict his or her partner’s couple relationship satisfaction across time? (Partner effect)
3. Does an individual’s couple relationship satisfaction predict his or her own alliance with the therapist across time? (Actor effect)
4. Does an individual’s couple relationship satisfaction predict the alliance of their partner with the therapist across time? (Partner effect)
5. Are any actor and partner effects associated with dyad role as distinguishable by gender?

3. Methods

In this section I will describe the research design, the participants, the research context and treatment, as well as the measurements, and the methods applied in the three papers that constitute this thesis. Ethical considerations will also be summarized.

3.1 Ethical considerations

This study focused on patients and their families referred for treatment because of their psychological and relational difficulties. Given the sensitive topics examined, including histories of past childhood abuse, ethical considerations have been of great importance to every aspect of the study. The project was approved by the data protection ombudsman at Modum Bad and by the Norwegian Regional Ethical Committee (2018/148/REK sør-øst A) and in compliance with the Helsinki Declaration of 1975, as revised in 2008. Beyond securing the collected patient data and complying with ethical standards, we considered it our ethical responsibility to assure that our research would also be perceived as relevant and in consideration of those that received treatment at the Family Unit. Therefore, two experience consultants (Gunn Helen Kristiansen and Therese Johnson) were employed to act as special advisors to the project.

3.2 Research setting

Modum Bad is a psychiatric center, primarily offering inpatient treatment, located in a rural area of Vikersund outside of Oslo. Modum Bad was founded in 1957 to provide nationwide mental health care and preventive services. The Family Unit was established at the hospital in 1968 based on observations that the founder of Modum Bad, Gordon Johnsen, had made of how the involvement of patients' family members benefited their treatment. Novel thinking may thus be claimed to be a part of Modum Bad's heritage since its early beginnings, thereby paving the way for what has become an institution where both clinicians and patients are involved in the continued development of its services, promoting a culture of practice-oriented research par excellence.

From its inception, the Family Unit has offered highly specialized treatment for couples and families experiencing co-existent relational and mental distress. Treatment is covered by national insurance and is therefore free of charge. Patients who receive treatment at the Family Unit stay for approximately 6–12 weeks. Children between the ages of 1 and 16 years accompany their parents during hospitalization but are not the main recipients of therapy. The children attend the kindergarten, or the school located on the hospital's grounds. All patients are referred to the Family Unit by their general practitioner, often in collaboration with social services, family consultant services, or local mental healthcare providers. The criteria for hospitalization are that at least one of the adults needs to be diagnosed with a mental disorder according to the International Classification of Disease (World Health Organization, 1992) and that the couple or family suffers from coexistent relational distress. Before any planned hospitalization at the Family Unit is considered, the presenting problem has to be previously assessed, and prior treatment attempts must have been made at a local mental healthcare provider but without success. It is not uncommon for one of the adults to have previously been hospitalized at a residential clinic. Multi-problem families, including children who suffer from defined disorders, occur frequently among families hospitalized at the Family Unit. Families who have members who are actively suicidal, psychotic, or experiencing ongoing substance abuse are not admitted to the Family Unit, and neither are families with ongoing interpersonal physical violence. This unique context in which they receive treatment is the basis of the current research project.

3.3 Research design

To address the research questions mentioned in subsections 2.1, 2.2, and 2.3, we used a research design that allowed us to adapt our methods of inquiry to our findings as they unfolded. The research design was longitudinal so that we could unlock the potential of our naturalistically collected data in the examination of therapy processes and outcomes. In the autumn of 2018, we designed a research project called "Do couples and families with histories of childhood trauma need tailored therapy?". Our three

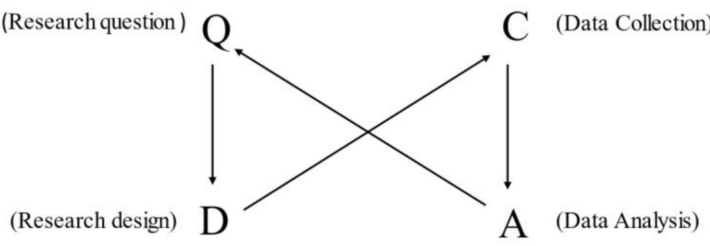
planned studies would transpire according to a sequential mixed methods design (Bailey-Rodriguez, 2021), with priority given to quantitative methods. All participants in all three studies were recruited from patients seeking treatment at the Family Unit.

Studies 1 and 3 used data collected from ROM practices at the unit, whereas the participants of the Study 2 would be recruited based on the findings of Study 1. The statistical results from Study 1 would form the basis of the research questions put forward in Study 2. This approach to sequencing studies where one study (often quantitative) is used to construe research questions for a following study (often qualitative) is referred to as a sequential explanatory design; it is useful when the goal is to deepen an understanding of a phenomenon, for instance, specific therapeutic processes (Bailey-Rodriguez, 2021; Kazdin, 2008). Such a design also serves to adapt current hypotheses and produce new ones as new knowledge is accrued. In the current project, the findings of Study 1 (i.e., families with trauma histories who do not respond to treatment on a systems level of measure) would motivate the research question posited in Study 2 (i.e., How do they, as former patients, understand the findings of Study 1?), which would again incentivize the research question in the third study (i.e., What are the patterns of reciprocity within dyads on measures of alliance and couple satisfaction?). The sequential and exploratory nature of the project bears resemblance to a qualitative approach to analysis that instigates the investigator to revisit and update previous assumptions as the process of inquiry unfolds. This process of analysis, which involves looking at the part and the whole and back again, can be described as "the hermeneutic circle" (Gadamer, 2013), a process that arguably bears resemblance to the concept of circularity (i.e., the causality pillar; Pinsof et al., 2018), as discussed previously. Our approach to research can also be conceptualized within the IST blueprint of therapy (Breunlin et al., 2011; Pinsof et al., 2018). In this reiteration of the blueprint of therapy, which I have renamed the blueprint of research (see Figure 1), the starting point is usually the raising of a research question (Q), which is followed by the planning of a research design (D), which consequently dictates both what data

are collected and how they are collected (C). After data collection, data analysis (A) leads to confirmation or disconfirmation, or adjustment of the initial research question, or the proposition of a new question, thus beginning a new sequence of inquiry.

Figure 1.

IST Blueprint for Research



Adapted from: "Integrative Problem Centered Metaframeworks I" by D. Breunlin, W. Pinsof, W. Russell, and J. Lebow, 2011, *Family Process*, 50, p. 300. Copyright 2011 by John Wiley & Sons.

3.4 Participants

All patients referred to the Family Unit were informed of the ongoing research project at intake and asked to sign informed consent forms supplied online. Over the project period, 155 participants were recruited and completed pre- and posttreatment questionnaires and weekly self-reports (ROM). The participants although mainly consisting of committed different-sex couples, also included two same-sex couples and seven single household. The average relationship length was 7.16. The average age of the participants was 40.29, ranging from participants in their mid-twenties to their early sixties. A small subsample (n = 9) also underwent a semi-structured interview. Table 1 presents the inclusion and exclusion criteria for each study, and Figure 2 shows a flowchart diagram of participant inclusion.

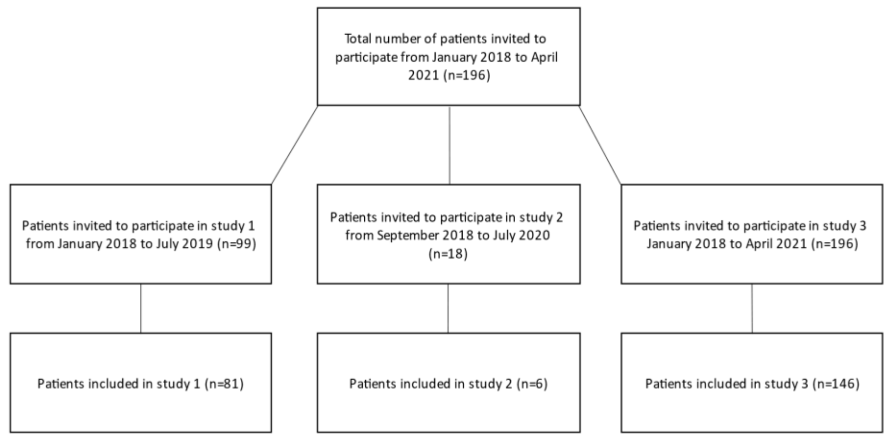
Table 1.

Inclusion criteria

	Inclusion criteria
Study 1	Above the age of 18 years
Study 2	Above the age of 18 years, at least one member of the dyad exposed to abuse during childhood, both dyad members within clinical range as assessed with FAD posttreatment
Study 3	Above the age of 18 years, in treatment with an opposite-sex partner

Figure 2.

*Patient flow in "*Do couples and families with histories of childhood trauma need tailored therapy?"



3.4.1 *Paper 1*

This paper was based on weekly data and pre- and posttreatment psychometric data. As part of the diagnostic assessment, all patients were screened for earlier abuse. This information (i.e., from the therapist report, described later) was used to identify a subsample constituting those who had experienced childhood abuse. The total sample of 81 consisted of 36 different-sex dyads, 7 single-household providers, and 2 individuals who were a part of a dyad, but their spouses had not consented to participate in the study.

3.4.2 *Paper 2*

This paper was based on interview data collected from six participants (i.e., three couples). Initially nine participants were interviewed, but three of the interviews were excluded from the data material. All the participants were strategically selected according to deviant case analysis (Seawright & Gerring, 2008). This means that they were selected to be in the study on the basis that they met the inclusion criteria, indicating that they belonged to a subgroup of the patient population at the Family Unit. These inclusion criteria were having experienced childhood abuse and having scored within the clinical range on the FAD pre- and posttreatment. The three participants who were interviewed but excluded from the data material were done so for the following reasons: A) One of the couples had not themselves experienced trauma. B) The partner of the one that was interviewed was not able to attend her scheduled interview because of severe relapse of symptoms, rescheduling was tried but not possible for the same reason.

3.4.3 *Paper 3*

This paper was based on weekly data. The sample consisted of 73 different-sex dyads. The excluded persons consisted of 2 same-sex couples, single household providers and those who had partners who had not consented to participate (i.e., incomplete dyads).

3.5 Treatment

During the period when the project was ongoing, the Family Unit had 12 therapists (of whom 66.67% were women with an average age of 43.58 years, and with an average length of education including continuing education as clinicians of 7.16 years), servicing each of the nine families committed at any given time. The therapists represent diverse backgrounds both personally (e.g., nationalities, religious and non-religious belief systems, and sexual orientations) and professionally (i.e., nurses, psychologists, psychiatrists, pedagogues, and social workers). Most of the therapists have formal training in couple and/or family therapy and identify as family therapists. As follows, when the term family therapist is used, it could refer to any of the clinicians at the Family Unit. The families were treated by at least two therapists (either a psychologist, psychiatrist, or a social worker with further education in family therapy, coupled with a specialist nurse with or without further education in family therapy). Couple and family therapy as applied within this unit should be understood as an integrated part of a comprehensive treatment program, thus comprising a greater variety of treatment components than is common within regular outpatient couple and family therapy services. Such components include semiweekly couple and/or individual therapy sessions, a weekly art therapy session, a weekly psychoeducation session, semiweekly physical exercise sessions, and at least one reflective team session per treatment course. The following is a description of how a typical week at the Family Unit might transpire.

Every morning starts with medicine delivery, if applicable. On Mondays, this is followed by a 90-minute individual, couple, or family talk therapy session, depending on the presenting problem. As the day progresses, adult patients are prompted to complete the week's outcome ratings (ROM; capturing individual and relational distress) via a link delivered to their mobile device. In their spare time, patients

are welcome to make use of the units' arts and crafts facilities or spend their time as they see fit. Tuesdays begin with a 120-minute art therapy session, which is followed by 60 minutes of exercise. Wednesdays start with a 90-minute psychoeducation session, followed by extra talk therapy sessions, as required. Just like Monday, adult patients get a prompt to fill out questionnaires on their mobile devices, but this time, the questions are related to therapy processes (e.g., alliance, emotions, and cognitions). Thursdays follow the same routine as Mondays, except that patients are not prompted to fill out online questionnaires. Fridays only have an exercise session scheduled, but other appointments are made as required. Every day, there is contact between the families and their designated milieu therapist, and appointments are made as needed to work on problems they are experiencing in their "home environment" (each family lives in their own cottage at the hospital grounds).

Although the adult family members are the primary recipients of therapy at the Family Unit, the ethos of the treatment is holistic, in the sense that the clinicians seek to understand the "family as a whole." This is reflected in the integration of systemic and individual perspectives. Thus, the range of intervention strategies applied is drawn from individual, couple, and family therapy models. All therapists participate in biweekly peer counseling with an external supervisor and weekly internal supervision, making use of the information from patients' structured feedback. As this project was naturalistic, plural and non-manualized therapeutic approaches were applied; thus, no adherence to any specific couple and family therapy model was monitored.

3.6 Measurements

In the following subsections all measurements applied in Papers 1, 2, and 3 will be described.

3.6.1 *Individual-level pre- and posttreatment outcome assessment*

The Beck depression inventory (Beck et al., 1996) is a widely used 21-item questionnaire used to assess symptoms of depression. The sum score expresses the depth of the depression, graded from no

clinical depression (0 – 9) through mild (10 – 19), moderate (20 – 29), and severe depression (30 – 63). The scale has demonstrated sufficient reliability and validity (Lykke et al., 2008; Osman et al., 2004). Paper 1: The Cronbach's α was .91 at admission.

The symptom check list (Derogatis et al., 2000) is a questionnaire for measuring symptoms of distress and changes, scoring 90 items on a scale of 0 to 4, with a cut-off of 1.0. The higher the score, the greater the degree of distress. The global severity index is the mean score across all items of the symptom check list and is commonly used as a screening tool. The Symptom Check List has been found to have good psychometric properties (Schmitz et al., 2000). Paper 1: Cronbach's α was .98 at admission.

The inventory of interpersonal problems (Horowitz et al., 1988) is a 64-item self-report questionnaire with a scale of 0 (not at all) to 4 (very much), addressing problems one might have in relation to others and reflecting one's personality traits. Higher scores indicate greater interpersonal problems. The items are organized into two dimensions—nurturance versus detachment and dominance versus submission—creating four poles. In the circumplex model, the eight subscale items are: domineering, vindictive, cold, socially avoidant, nonassertive, exploitable, overly nurturant, and intrusive. The questionnaire has been found to have a high psychometric quality (Horowitz et al., 1988). Paper 1: Cronbach's α was .95 at admission.

The posttraumatic check list for DSM-5 (Weathers et al., 2013) is a 20-item self-assessment questionnaire tapping posttraumatic symptoms corresponding to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; American Psychiatric Association, 2013) symptom criteria for PTSD. The scale ranges from 1 (not at all) to 5 (extremely). A total symptom score of 0 to 80 can be obtained by summing the scores for each of the 20 items (higher is worse). A cutoff score of 31–33 suggests probable PTSD. The posttraumatic check list has been found to have robust psychometric properties (Blevins et al., 2015). Paper 1: Cronbach's α was .95 at admission.

3.6.2 *ROM measurements at the individual level of assessment*

The patient health questionnaire-9 (Kroenke et al., 2001) is a nine-item depression module of the patient health questionnaire. The scale range is from 0 to 3 (higher is worse), in accordance with the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 2000) criteria. Scores of 10, 15, and 20 represent cut-off points for mild, moderate, and moderately severe depression, respectively. The Patient Health Questionnaire-9 has shown satisfactory psychometric properties (Kroenke et al., 2001). Paper 1: Cronbach's α was .89 at admission.

The generalized anxiety disorder screener (Spitzer et al., 2006) is a questionnaire consisting of seven items to assess the symptoms of anxiety and generalized anxiety disorder (Johnson et al., 2019). The scale range is from 0 to 3 (higher is worse) in accordance with the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 2000) criteria. Scores of 5, 10, and 15 are interpreted as the cut-off points for mild, moderate, and severe anxiety, respectively. Cut-off scores have been found to vary. In a recent study, scores above 8 points were found to indicate the presence of an anxiety disorder (Johnson et al., 2019). The Generalized Anxiety Disorder Screener has shown good reliability and construct validity (Johnson et al., 2019; Löwe et al., 2008). Paper 1: Cronbach's α was .87 at admission.

The WAI (Horvath & Greenberg, 1989) is a widely used questionnaire to assess the therapeutic alliance between a therapist and a client. Seven items (two goal-, two task-, and three bond-related questions) from the WAI were included in the battery of questionnaires that constituted our ROM system. Higher scores on the WAI represent a stronger working alliance. Studies on short versions of the WAI have demonstrated good psychometric properties (Hatcher & Gillaspy, 2006; Munder et al., 2010). Paper 3: Cronbach's alpha was .88 at admission and .90 at the end of treatment.

3.6.3 ROM measurements at the dyadic/family level of assessment

The RDAS (Busby et al., 1995) is a widely used 14-item questionnaire that provides a global measure of each partner's assessed consensus, satisfaction, and cohesion toward their spouse. The scoring range is 0–69, with higher scores representing better adjustment and with 48 as the cut-off. The RDAS has been found to have acceptable psychometric properties (Busby et al., 1995). Paper 1: Cronbach's α was .79 at admission. Paper 3: Cronbach's alpha was .81 at admission and .85 at the end of treatment.

The general functioning subscale of *the FAD* (Epstein et al., 1983) is a 12-item questionnaire widely used as a brief version of the FAD to assess the overall health/pathology of a family. The scoring range is from 12 to 48. The scale range is 1–4, the cut-off is 2, with higher scores indicating worse conditions. The general functioning subscale is considered a valid and reliable tool for assessing a range of families (Kabacoff et al., 1990). Paper 1: Cronbach's α was .86 at admission.

3.6.4 *Other assessments*

The international neuropsychiatric interview, also known as the MINI (Sheehan et al., 1998), is used to screen all patients at the Family Unit. The MINI is a semi-structured interview that is widely used within mental healthcare as a tool to help set a useful psychiatric diagnosis in accordance with the International Classification of Disease-10 (World Health Organization, 1992).

The therapist report is a form filled out by the therapist at the end of treatment documenting psychiatric diagnosis, medication use, past traumatic experiences, previous histories of addiction, self-harm, and suicidal behavior.

In Paper 2, participants took part in a *qualitative in-depth interview* developed by the authors. The interview was constructed with the intention of engaging the participant to reflect upon past

experiences of having received treatment at the Family Unit. All interviews started with the interviewer (Terje Tilden and Kristoffer Whittaker), reacquainting the participant with the FAD and their last score completed during treatment. All participants voluntarily filled out the questionnaire again. The questionnaire was promptly scored by the interviewer and then shared with the participant. The following collaborative reflection on these results was the starting point of all the interviews. Next, the participants were encouraged to explore the collaboration they had with their therapists and partner during treatment. At an opportune moment, all participants were asked to reflect upon any childhood trauma they or their partner had experienced and how it may have had ramifications on their therapeutic process. All interviews were tape recorded and transcribed verbatim by the first author. All interviews were anonymized.

3.7 Method triangulation

My intention behind applying method triangulation (Fielding, 2012) is twofold: 1) Given the complexity of the therapy processes in couple and family therapy and how they relate to outcome, method triangulation allows for the development of a prismatic understanding of the phenomena of interest. In practical terms, this means introducing our assumptions about a patient's outcome based on the statistical analysis of Paper 1 in the interviews conducted in Paper 2. 2) The following conversation and the completion of the FAD at the beginning of the interview allowed us to examine the validity of the findings of Paper 1 and further discuss its implications in light of the findings of Paper 2. This approach to mixed methods may be considered method triangulation within a sequential explanatory design (Bailey-Rodriguez, 2021). Such use of mixed methods is of value when examining the validity of quantitative methods, especially when trying to identify a target population (Hesse-Biber, 2010). Notably, effective data integration should be guided by a theoretical understanding of both the phenomenon of interest and an awareness of the underlying assumptions of the methods used in the investigation. This is because the study may have resulted in contradictory findings. On the matter,

Fielding (2012, p. 125) explains, “The contradiction reflects epistemologically based differences that cannot be resolved empirically, only conceptually.”

3.8 Methods of analysis

All statistical analyses were performed using SPSS v. 25 (IBM, 2017) and 27 (IBM, 2020). The qualitative analysis was facilitated using Nvivo 12 (QSR International, 2018).

3.8.1 *Multilevel modeling*

In Paper 1, the hypothesis was investigated by applying longitudinal multilevel modeling (MLM) and an independent-samples t-test. The t-test was used to detect changes from pre- to posttreatment on a group level, whereas the MLM was used to detect changes continuously throughout treatment at the level of the individual. Although t-tests serve a purpose when examining change at an aggregated level (i.e., nomothetic) and between-subject data from one point to another, they are not suitable when aiming to analyze sequences of measurements collected frequently, representing within-subject data. These nested data (i.e., observations within subjects) are best analyzed using MLM or similar methods that can separate change processes for each subject either at the individual level (i.e., observations within-persons) or as described later at the dyadic level of analysis (observations within-dyads; Bolger & Laurenceau, 2013). Within the MLM framework, this operation is termed disaggregation.

To exemplify the necessity of disaggregating levels of effect in the context of this study, consider the following: As reviewed earlier, the majority of people suffering coexistent relational problems and mental distress tend to be better off as a consequence of attending couple and family therapy, but at the same time some people attending the same treatment deteriorate. The overall trend for the group (i.e., most get better) represents the between-subject level, whereas the intraindividual trajectory (i.e., some get worse) represents the within-subject level. The ability MLM has to disaggregate within-subject and between-subject levels of effect has the potential to identify those that have a suboptimal

treatment response, something which is not possible if between-subject designs are solely relied upon (Curran & Bauer, 2011). By enabling the examination of an assumed temporal relationship between two variables, both descriptively and in terms of causal analysis, the use of MLM can allow the investigation of how an outcome *Y* changes over time and how this change is contingent upon changes in a presumed process variable *X* (Bolger & Laurenceau, 2013). Regarding our study, the MLM can thus be used to identify subgroups of patients with different treatment trajectories, such as those patients who have histories of childhood trauma.

Expounding upon the aforementioned but in terms of model parameters, two important components of MLM are that the value of the intercept (e.g., initial levels of distress) and the slope (e.g., response to treatment) may vary randomly across subjects, known as random effects. Traditional regression models only include fixed effects and may therefore only consider intercept, group, time, and group-by-time interaction (Bolger & Laurenceau, 2013). Thus, MLM considers how some subjects may have higher intercepts whereas others may have lower intercepts (e.g., some patients are more distressed than others at intake) and how some subjects may have steeper slopes than others (i.e., some patients have poorer response to treatment than others). A great advantage that MLM has over traditional models for frequent measures, such as ANOVA, is how MLM effectively manages missing data. The management of missing data in MLM is based on maximum likelihood. Maximum likelihood is considered "state of the art" for handling missing data (Schafer & Graham, 2002). Maximum likelihood uses all the available data, complete and incomplete, to identify the parameter values that have the highest probability of producing the sample data without resorting to listwise deletion. In contrast, ANOVA removes any incomplete cases from the analysis, thus relying on multiple imputations to obtain a complete dataset. Maximum likelihood is preferable to multiple imputations when using longitudinal data (Shin, 2017). ANOVA may be more accurate for smaller sample sizes (Maas & Hox, 2005). Although this may most likely by remedied within an MLM framework by the application of Bayesian methods

(which is not an option in any current version of SPSS) instead of frequentist methods (Zyphur & Oswald, 2015). Longitudinal designs in general are not without their drawbacks, including the high cost of running long-term studies, management of large amounts of data, the need for advanced statistical know-how, and the risk of introducing selective attrition (Curran & Bauer, 2011).

The statistical analysis performed in Paper 1 was performed at the individual level of analysis because of the heterogeneity of the sample. Given that the dataset included frequent assessments from the beginning of treatment until the end of treatment, it can be analyzed as a two-level structure (weekly observations nested within individual participants) using longitudinal MLM (Curran & Bauer, 2011). With up to 12 measurement waves, the dataset met the requirements proposed by Singer and Willett (2003) for the application of MLM. The predictor variable (childhood trauma) was constructed with information gathered from the therapist's report. This variable was added as a fixed effect to assess the main effects and interactions for all frequent measurements. The predictor variable allowed for the detection of systematic differences in estimated scores throughout therapy between those participants who had reported childhood sexual and/or physical abuse and those who had not reported exposure to such experiences.

3.8.2 *Dyadic analysis*

Similar to Paper 1, Paper 3 also applied MLM, but did so at a dyadic level of analysis. To be able to perform a dyadic data analysis in SPSS (IBM, 2020), the researcher should organize the dataset in a pairwise data structure, as suggested by Kenny et al. (2020). The pairwise restructuring also resulted in a long-format dataset, which is a prerequisite for longitudinal data analysis. Following the steps proposed by Kenny et al. (2020), we conducted a cross-lagged regression analysis as a two-level structure (weekly observations nested within subjects; i.e., dyads) conceptualized within an APIM framework. Notably, no random effects were observed at the between-subjects level in this model because all the residuals go

toward explaining the covariation within dyads (Bolger & Laurenceau, 2013). Kenny et al.'s (2020) approach to dyadic cross-lagged regression analysis recommends starting model building with a fully saturated model, then simplifying the model if it does not run. This approach to model building will likely result in a model that will not converge if the study has underpowered effects. However, given how complex the model is when fully saturated (with potentially 30 parameters), simplifying the model by selecting a less complex covariance structure and/or by removing redundant parameters should not be too problematic (Kenny et al., 2020). The latter was done with the model we ran in Paper 3. A strategy to help identify what parameters to remove, such as random effects that lack variance or are underpowered, is to visualize them by creating a scatterplot. The more stable an effect becomes, the more difficult it is to model (Bolger & Laurenceau, 2013). However, similar to the MLM presented for the individual level of analysis, Bayesian methods may be used instead of frequentist methods to negate the problem of having underpowered effects, thus enabling the running of a more complex model (Zyphur & Oswald, 2015).

For our study, a dummy variable (gender) was constructed to distinguish between two members from the same dyad. The primary reason for using gender as the distinguishable variable instead of other variables of interest was because it granted the highest possible sample size, consequently only two couples had to be excluded from the analysis. Since the patient population represents great variation on other potentially meaningful variables such as the presence of a psychiatric disorder or trauma, selecting such a variable as the distinguishing variable would have resulted in a reduction of sample size. Although conducting an analysis based on non-distinguishable dyads could have been an option the loss of excluding two couples seemed limited compared to what was gained by including a distinguishable variable. Thereby, the inclusion of a dummy variable permitted the assessment of the explained variance of each dyad members' estimated scores and to what extent these scores were correlated. The resulting correlation coefficient is our measure of nonindependence (Kenny et al., 2020).

Further, I could hence implement test statements that were necessary to assess if differences between dyad members were significant. Thus, allowing for easier interpretation of the results (i.e., whether one effect is stronger than the other).

3.8.3 *Qualitative methods*

In Paper 2, a qualitative analysis was performed on the data material collected from the interviews. The analysis process was mainly informed by Braun and Clark's (2006) demarcation of thematic analysis, but was also influenced by interpretative phenomenological analysis, as conducted by Stänicke et al. (2020). The data analysis consisted of interpretation of the participants' experiences and ways of making meaning (double hermeneutic; Smith, 2003), and the analysis unfolded across several steps and phases.

The application of NVivo 12 (QSR International, 2018) assisted the process of indexing and categorizing the interview material to establish a framework of ideas about it. Throughout the analyses, the researchers checked whether their team members' interpretations of the text converged or diverged from one another and if they were plausible and understandable (research triangulation; Flick, 2018). Throughout the remainder of the writing process, we continued to discuss multiple interpretations, which ended in consensus (all five agreed) or the integration of nuances (one or two disagreed), such as renaming, rearranging, and adding or merging topics, themes, and subthemes, thereby strengthening trustworthiness (Levitt et al., 2016).

3.9 Reflexivity

An important part of qualitative research is reflexivity (Finlay, 2002). As previously stated, Finlay (2002) defined reflexivity as "thoughtful, conscious self-awareness" (p. 532). The study presented in Paper 2 entailed the design of the interview guide and other preparations necessary to conduct the interviews. To help me raise awareness of potentially related caveats this step of the study included collaboration with the experience consultants attached to the project. Furthermore, of importance was being reflexive

of the actuality that both investigators conducting the interviews were also involved in analyzing and writing the paper. This being Terje Tilden and myself, we had to be especially attentive to how our observations, thoughts, feelings, and actions influenced the interview situation, the data management and analysis, and the interpretation of the results (Flick, 2018). Mason (2006) argued that reflexivity needs to be at the core of any mixed methods approach and go beyond the limitations of qualitative thinking. Thus, we aimed to be reflexive throughout all phases of the project to safeguard its trustworthiness (Charmaz, 2014). Reflexivity was a major part of but not only limited to the qualitative phase of the study as described. Reflexivity was extended to the management, analysis, and interpretation of quantitative data and to our positions at the hospital in relation to the patients and colleagues we were in contact with throughout the project period (Finlay, 2002, 2012). This stance which may be referred to as the concept of *positional* reflexivity is an important principle in systemic practice in general (Lini & Bertrando, 2022; Stokkebekk et al., 2022). In positioning myself as a systemic (and multi-methodological) researcher I have tried to be transparent in my choices of methodology and regarding the choices I have made during the research process. Of great help to the process of reflexivity was the inclusion of the aforementioned experience counselors, as well as conversations with patients, discussions with colleagues and supervisors, whose input raised my awareness of what ramifications our research would have both for our ongoing research, clinical practice, and potentially for the patient population with whom we were interacting.

4. Findings

In the following section I will summarize the main findings of the three papers that constitute this thesis.

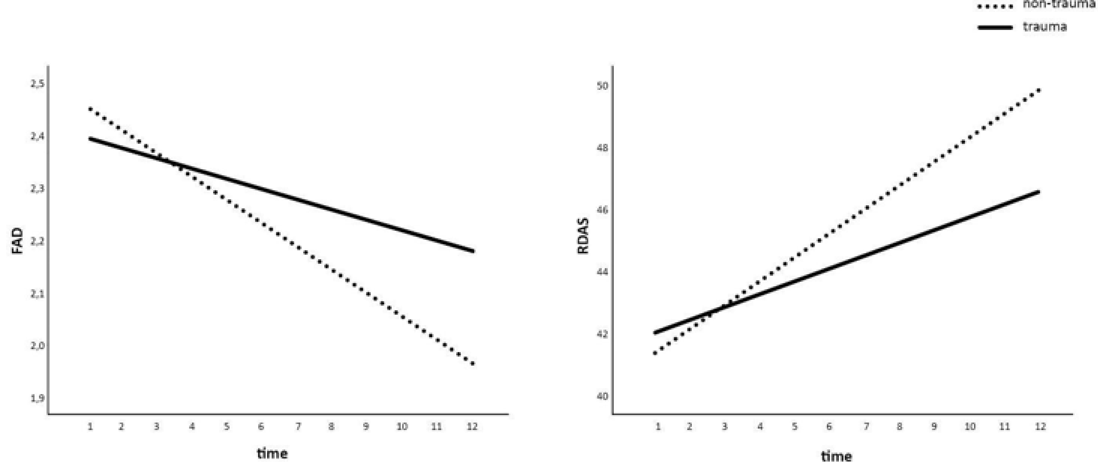
4.1 Summary of Paper 1

Childhood trauma as a predictor of change in couple and family therapy.

The paper aimed to test whether patients who had reported histories of childhood abuse responded differently on outcome measures compared to those who had not reported such experiences. Patients' (N = 81) ROM assessments were collected at the individual, dyadic, and family levels of assessment. The results of the study showed that patients with histories of trauma responded just the same as everyone else at the individual and dyadic levels of measurement (i.e., they had the same decrease in individual symptoms, such as depression, as those who had not reported childhood trauma experiences). At the family level of assessment, as measured with the FAD, they did not improve at the same rate as those without experiences of trauma. Thus, patients with histories of childhood trauma were estimated to still be in the clinical range at the end of treatment, as assessed frequently with the FAD. The results from this paper are visualized in Figure 1.

Figure 1.

Response to treatment on the dyadic and system levels of outcome



Note. FAD = Family Assessment Device (lower is better); RDAS = Revised Dyadic Adjustment Scale (higher is better). Non-trauma = no history of child abuse; trauma = history of childhood abuse. Y-axis = dependent outcome; X-axis = weekly point of measurement. The figure illustrates how patients with a history of trauma respond to treatment across time compared to patients who do not have a history of trauma. The interaction effect between trauma and time on the FAD (left side) is statistically significant ($p < .05$). The interaction effect between trauma and time on the RDAS is not statistically significant. Those with histories of trauma do not gain as much on the dyadic and the system level of outcome as those participants who have not suffered such abuse.

4.2 Summary of Paper 2

A retrospective study of how couples with histories of trauma experienced therapy

Paper 2 follows up the previous paper with the aim of furthering our understanding of why some patients with histories of trauma do not respond to treatment at the family level of measurement. Three couples (N = 6) were recruited based on the criteria identified in Paper 1 (i.e., childhood trauma and clinical FAD at pre- and posttreatment). Each couple member was interviewed individually, and they

were prompted to reflect upon their FAD outcome scores at the end of the treatment and how they scored at the time of the interview. Our qualitative analysis resulted in five themes organized under three topics covering “Outcome of Therapy,” “Relationships in Therapy,” and “Impact of Trauma.” The findings of the study showed that the participants, although generally satisfied with the treatment they had received, had experienced difficulties related to their collaboration with the therapist and, in some cases, with their spouse. In particular, the participants confirmed the results of Paper 1 (i.e., they had not significantly improved on the family level of measurement). They also reflected upon difficulties that they had either experienced themselves or they had perceived their partners experiencing in collaborating with their therapists about therapy. These findings indicate that all couples had undergone some extent of split alliance with their therapist. A split alliance for all participants moved the treatment in a more individually oriented trajectory, either from the onset of therapy or gradually during therapy. Either way, the individual focus seemed to lessen attentiveness to the relational aspect of the treatment. The participants gave little importance to how trauma might have been related to therapy. However, they were more sharing on how such experiences had repercussions on their self-knowledge, such as why they themselves had been abusive in the past.

4.3 Summary of Paper 3

The application of dyadic analysis to understand the reciprocal nature of alliances and couple satisfaction

Building upon our findings from Papers 1 and 2, we aimed to conduct a quantitative longitudinal study to examine the interaction between alliances and couple satisfaction. To explore the nuances of such interactions, we adjusted our analysis strategy to enable data analysis at the dyadic level. In our first analysis, the WAI was applied as the process variable, whereas the RDAS was used as the outcome variable. The analysis was promptly rerun with the RDAS, which was implemented as the independent

variable and the WAI as the dependent variable. Our findings showed that partner effects were positively associated with outcomes, while actor effects (except for females actor effect on the RDAS) were negatively associated with outcomes in both analyses. Consequently, how one's spouse responds to therapy (e.g., alliance with therapist) was found to be the greatest predictor of a positive outcome assessed at the dyadic level outside of the effect of time. This was especially true for male partners (i.e., males' alliance with the therapist significantly predicted spouses' relationship satisfaction).

5. Discussion

Couple and family therapy shows satisfactory outcomes (Shadish & Baldwin, 2003). However, one task of research is to investigate how treatment results can be improved. In particular, this implies the need for enhanced understanding of who does not benefit from treatment as much as intended and the reasons why this occurs. In this discussion section I will address the findings of the studies presented in this thesis and deliberate about limitations embedded in established research methods, as well proposing promising approaches.

As a naturalistic study, despite the intake criteria applied at the Family Unit, the study sample constitutes heterogeneity with respect to the types of presented problems and levels of individual and relational distress. Thus, research results according to a nomothetic approach, as is common when applying quantitative methods, are often represented as means (averages) for the sample studied. Even though the standard deviation indicates some variation within such a sample, these results still hide possible outcomes of subgroups within the sample, such as who experienced a desirable change, who was unchanged, and who deteriorated during treatment. A better understanding of how subgroups of patients respond to and experience couple and family therapy is therefore vital to optimize treatment. Subgroups and their associated trajectories may be examined by applying a similar approach to analysis as the one presented in Paper 1 (i.e., independence of observations is assumed). Although such methods are valuable for hypothesis testing in accordance with the nomothetic approach, they are not capable of examining outcomes at the dyadic level of analysis or exploring potential mechanisms of change related to dyadic outcomes (Kenny et al., 2020). However, given the assumed reciprocal nature of the phenomena examined in couple and family therapy (i.e., how intra- and interpsychic processes of those attending therapy are related to outcomes), which was also evidenced in Paper 2, we wanted to explore how we could examine such assumed reciprocal effects in treatment and how they are related to outcomes. To increase our understanding of the outcomes of couple and family therapy, we needed

to take nonindependence of observations into account, and thus apply dyadic analysis when analyzing our dataset, as done in Paper 3.

My methodological "journey" from realizing the limitations in standard quantitative research approaches as applied in Paper 1, via the qualitative study presented in Paper 2, to the resolution of applying dyadic analysis as was done in Paper 3 will form the back-curtain for this discussion. I will in the following address how the results of the papers relate to one another and to the aims of the study: 1) To evaluate the Family Unit's treatment program by assessing the participants' degree of mental and relational distress from intake to discharge and changes in distress taking place during treatment (Paper 1). 2) To investigate the predictive relationship of therapists' reports of patients' histories of childhood trauma on weekly patient-reported outcome (Paper 1). 3) To retrospectively explore a subsample of those patients with histories of childhood trauma about their experiences of receiving treatment at the Family Unit (Paper 2). 4) Apply dyadic analyses (Kenny et al., 2020) as a method of analyses to investigate actor–partner effects related to outcome (Paper 3). Further, methodological challenges and limitations will be discussed as well as challenges concerning my role as both a clinician and a researcher.

5.1 Exploring outcomes

While Paper 1 showed how patients at the Family Unit generally respond positively to treatment on assessments of both individual and relational measures of distress, it also unveiled that those patients with experiences of childhood trauma responded differently to therapy. Specifically, they had less gains on assessment of family functioning as measured with the FAD. Paper 2 aimed to further explore those results by applying a merged method approach. Both the FAD results from the end of treatment and an FAD questionnaire completed at the time of the interview were used as starting points for the interviews. The findings from Paper 2 further supported the results of Paper 1 that patients with

childhood trauma experiences had poorer responses on measures at the family level of assessment. None of the former patients participating in the second study were explicit about how past trauma may have been associated with their therapy. Instead, the conversations and reflections were mostly about how they related to the therapist and what the focus of therapy had (or had not) been. A common thread in the findings from Paper 2 was that the degree of agreement on goals or tasks between the therapist and one member of the dyad was greater than the agreement between the therapist with that of his or her spouse. We refer to such unbalanced alliances as split alliances, a phenomenon that has been well documented in the literature and associated with poor outcomes (Friedlander et al., 2018). Our interpretation of the data led us to propose that unhandled split alliances are negatively associated with outcomes in couple therapy. One implication of split alliance is that the therapist targets the problems of one individual at the expense of attentiveness to the problems of the relationship. Further, we propose that this finding may at least partially explain why some couples who were hospitalized at the Family Unit did not respond to treatment on outcomes measured at a family level and to a lesser extent at the dyadic level (i.e., couple satisfaction). Notably, all participants in Paper 2 indicated that they wished they had gotten better follow-up care posttreatment. In extension, how the participants scored on the FAD at the time of the interview (i.e., decreased family functioning) bore resemblance with those in the study of Tilden et al. (2020), who showed a decrease in relationship satisfaction one year after treatment at the Family Unit. Hence, improving how patients are followed up posttreatment may have potential to positively affect how they perceive their outcome. Although these findings are inconclusive, they do still grant us a better understanding of the nuances in how outcomes may be perceived in couple and family therapy. I propose that of even greater interest is how these findings helped us identify possible constraints to outcomes, namely inadequate therapeutic relationships.

5.2 Therapeutic relationships association with outcomes

In line with the concepts presented in subsection 1.13 the *five pillars* and in subsection 3.8.4 on *reflexivity*, which constitutes the understanding that the researcher is inevitably affected by his or her own research process, the appropriate adjustments were made to ensure the quality of Paper 3. Hence, I decided to exclude the trauma construct to prioritize the examination of the association between relational processes in therapy (i.e., alliances) and dyadic outcome (i.e., relationship satisfaction). The reason for this decision was threefold: 1) The participants in Paper 2 did not explicitly share how their past trauma experiences were associated with the therapeutic process and rather chose to talk about how relational interactions (e.g., to what extent there was agreement upon the goal of therapy, they mismatched with their therapist) had governed the direction of therapy (e.g., how it became individually oriented, lacked defined goal achievement). 2) I did not consider the trauma variable as an accurate predictor of trauma something hours of contemplation, conversations with patients both participating in the study and outside of it had finally led me to conclude. 3) Throughout Papers 1 and 2, I stressed the importance of assessing the family system at multiple levels but had thus so far had only conducted analyses at the individual level. However, given that I had once again stumbled upon the importance of a strong alliance in therapy in Paper 2, I aimed to perform a dyadic analysis using alliance and couple satisfaction as predictive variables. Given my limited experience with conducting dyadic analyses and the two other reasons previously stated I was further convinced that it was best to omit the trauma variable and prioritize examining the interplay between individual processes and dyadic outcome in Paper 3.

The dyadic analysis was conceptualized within the APIM (Kenny et al., 2020), allowing me to test for the nonindependence of data and thus examine the proposed reciprocal effects (i.e., actor–partner effects) across time. The dyadic analysis revealed a nuanced interplay between alliances and couple satisfaction. In particular, the results showed that the partner effects (i.e., to what extent his or her own

score on outcome is predicted by his or her partners score on process) were positive predictors of outcome, while the actor effects (i.e., to what extent his or her own outcome score is predicted by his or her own process score) were negative. These negative actor effects are hard to explain. The one pertaining to the female dyad members negative association between her estimated alliance score and her couple satisfaction score may perhaps be understood in overall pattern of change to be proposed further on. As for the male dyad members negative association between his estimated alliance score and his couple satisfaction score, I can make no sensical interpretation. This finding which I consider problematic, is at odds with the results from a large body of research presenting overwhelming evidence for the association between alliance and outcome (Flückiger et al., 2018; Friedlander et al., 2018; Horvath & Symonds, 1991). In hindsight, I profess that this finding was also underappreciated as it was presented in Paper 3. Although, the actor effects for the male dyad member are negatively associated with outcome, the overall trend taking time and partner effects into consideration, is that hospitalization at the Family Unit is generally associated with positive outcomes as not only evidenced by my studies but also those of Tilden et al. (2020, 2021). Interestingly, Tilden et al. (2021) found that the three dimensions of alliance included in their study had different associations with outcome. Within-system alliance (i.e., alliance between dyad members) was found to be not predictive of outcome, while self-therapist and other-therapist alliance was predictive of outcome. The two latter sharing similarities with the conceptualization of alliance used in Paper 3. Both trying to replicate the results presented in Paper 3 in other populations and applying different analysis strategies would be necessary to gain better understanding of the proposed negative actor effects (and the positive partner effects).

Regarding partner effects, the analysis showed that the males' alliance with the therapist was predictive of his spouse's couple satisfaction. This finding coincides with results from similar studies (Friedlander et al., 2018; Glebova et al., 2011) that have found that the male partners alliance with the therapist is detrimental to outcome in couple therapy. The male partners alliance is seemingly of

greatest importance to outcome in the beginning of therapy. The results from our study also showed a male partner effect of couple satisfaction strengthening the alliance, but this effect was not significantly different between dyad members. In the context of the literature on the working alliance (Flückiger et al., 2018; Friedlander et al., 2018; Horvath & Symonds, 1991), the results of the analysis presented in Paper 3 may initially seem counterintuitive. However, from the perspective of couple therapy, and especially from the viewpoint of a clinician, the partner effects do make sense: How your partner responds to therapy is predictive of outcome, and getting the male partner engaged in therapy is especially important for his spouse's relationship satisfaction.

These negative actor effects and positive partner effects are contradictory to studies from the field of social psychology, who mostly find support for actor effects as predictive of relationship satisfaction (Joel et al., 2020). I postulate, this could be because there are a fundamental differences between how such studies in social psychology are conducted in comparison to clinical studies, the latter being therapist directed and interventional in nature. Other clinical studies, both does applying dyadic analysis and other methods of investigation do support the proposition that partners involvement is of consequence to the outcome in couple therapy (e.g., Anderson et al., 2020; Anderson & Johnson, 2010; Glebova et al, 2011; Friedlander et al., 2018; Piros, 2008; Symonds & Horvath, 2004). Of note, Anderson et al. (2020) performed a study applying dyadic analysis which showed the importance of attending to the alliance of the partner who felt pressured to attend couple therapy and who also had a history with adverse childhood experiences. I do propose that there are reasons to suggest that the patient population at the Family Unit shares some commonality (i.e., experiencing pressure to attend therapy, and having histories of childhood trauma) with the sample included in the study of Anderson et al. (2020). Taking these studies and our own findings presented in Paper 3 into consideration, I believe that further examination of actor-partner effects is warranted in clinical settings.

In summary, the findings of all three papers may be compiled as follows: In general, patients undergoing inpatient couple and family therapy at Family Unit respond positively to treatment. However, patients with histories of childhood abuse have poorer results on outcome measured at a dyadic and family level of assessment. For the latter measurement, the results were statistically significant, as analyzed at the individual level. In our follow-up qualitative paper, members of the identified subgroup were interviewed, and the results of the first paper were confirmed. Paper 2 further implicates the therapeutic alliance between the therapist and each member of the dyad. Split alliances were prone to occur in this subgroup of patients and were associated with poor outcomes. In our third and final paper, we examined the alliance between each member of the dyad and the therapist and how it related to couple satisfaction. The results of the dyadic analysis showed that partner effects had greater positive association with outcomes than actor effects, the latter were to a greater degree associated with less therapeutic gains.

5.3 Process–outcome research

In trying to gain a better understanding of what *outcomes* are, one cannot exclude understanding what *processes* are, given that the two are invariably linked (Kazdin, 2007). This is perhaps best illustrated through the lens of a specific therapy model. For instance, in emotionally focused therapy (Johnson, 2012), the assumption is that couples attending therapy are dissatisfied with their relationships because they are emotionally unavailable to another. This lack of emotional availability is what drives the problematic interactional pattern between them. Through a series of steps (i.e., processes) related to emotional reactivity and underlying feelings of vulnerability, the therapist helps the couple become more emotionally available to one another, thereby reducing conflict and thus increasing relationship satisfaction (i.e., the assessed outcome). Within such a framework is a clear understanding of what a good outcome should look like (e.g., increased emotional availability); hence, therapy is guided by the model and thereby in extension by the therapist. Testing such models has been critical to prove the

efficacy of couple and family therapies, and great effort has been made to that extent, as evidenced by several meta-analyses and reviews compiling such studies (e.g., Carr, 2019a; Carr, 2019b; Pinquart et al., 2016; Shadish & Baldwin, 2003; Wiebe & Johnson, 2016). However, specific models are, at best, only faceted representations of reality and are applied with greater flexibility in clinical practice than in randomized controlled trials. In addition, the number of therapists who identify with being integrative is growing (Lebow, 2019; Norcross et al., 2013). The knowledge that a number of factors are associated with therapists' competency in delivering therapy (e.g., feedback from patients, quality of supervision, and deliberate and sustained practice of micro-skills; Power et al., 2022) and the argument for conducting naturalistic studies to understand the link between therapeutic processes and how they relate to outcomes becomes apparent. Merely relying on randomized controlled trials to improve treatment is not enough and is also not financially sustainable, given their high costs. Throughout the three papers that constitute this thesis, processes and outcomes have been examined and discussed quantitatively as they relate to both the level of assessment (Gurman & Kniskern, 1978) and the level of analysis (Kenny et al., 2020). Outcomes have also been investigated qualitatively, taking into consideration the participants' experiences and ways of making meaning (Smith, 2003).

Throughout this thesis I have argued the necessity of considering the nonindependence of observations when examining processes and outcomes in couple and family therapy. The argument assumes that family members who participate in therapy together undergo processes and experience outcomes that are contingent upon one another (Kenny et al., 2020). Hence, the assumption of nonindependence should when possible be put to the test. In clinical practices quite often, the necessary data will be available. For instance, ROM is applied in many clinics both nationally and internationally in an effort to improve outcomes in couple and family therapy (Tilden & Wampold, 2017; Tilden & Whittaker, 2022), thereby engaging clinicians in developing hypotheses regarding treatment, the sheer amount of data generated is not taken advantage of. This is a missed opportunity to apply

research methods such as dyadic analysis to formally examine such hypothesized associations raised in clinical practice, implying that there is untapped possibility in practice-oriented research (Castonguay & Muran, 2015). The argument maybe made that those clinicians that engage with ROM are also inherently drawn toward hypothesizing about associations between different family members' scores, both on assessment of processes and outcomes. Hence, their involvement in research would potentially be invaluable when seeking to improve treatments.

Although I propose the benefits of testing for nonindependence, I did not consider its application in Paper 1. However, the multilevel analysis applied at the individual level did present results entailing the importance of assessing multiple levels of a system attending therapy. Specifically, the assessment of multiple levels of a family system may show how families could improve on some level of assessment but not on another. The inclusion of measurements that consider all subsystems of the family system that are engaging in therapy when assessing outcomes has great clinical value (Gurman & Kniskern, 1978).

Lack of change on one or multiple levels is in the context of this thesis understood as a constraint (Breunlin, 1999). The results from Paper 1 coincide with Gurman and Kniskern's (1978) recommendations regarding assessment of all relevant levels of a system. The challenges related to interpreting the results of Paper 1 in relational terms motivated me to design a qualitative study to improve our understanding of the processes involved and the outcomes they were associated with (i.e., what and were where the constraints?). This development of the study incentivized me to interact directly with the patients who had participated in Paper 1 heightening my understanding of how they had experienced treatment and helping me identify possible constraints to their outcomes. The relational complexity unveiled in the qualitative study, and how it implicated the role of therapist, further spurred me on to advance my competencies in dyadic analysis so I could better understand the processes and outcomes of couple therapy. Both Papers 2 and 3 show how outcomes are the results of

interactional processes, with Paper 2 underscoring how the perception of the therapy and its outcome may vary between dyad members and Paper 3 indicating how both actor *and* partner effects (i.e., alliances) were associated with outcome (i.e., relationship satisfaction). All three papers arguably demonstrate how individual idiosyncrasies (i.e., the capacity to establish and maintain therapeutic alliances, adverse childhood experiences, and personal history), including actor-partner effects, are associated with outcomes in couple and family therapy.

As has been presented, quantitative methods are not the only way to explore associations between processes and outcomes, qualitative methods are also of great value. Qualitative methods have their own benefits such as being well suited to identify potential processes of change (Kazdin, 2008), and when implemented as interviews or as video and/or audio analysis, share many commonalities with talk therapy. Thus, both quantitative and qualitative methods, preferably merged or applied sequentially, are integral to practice-oriented research. Practice-oriented research may thus not only facilitate the reduction of the scientist–practitioner gap (Castonguay & Muran, 2015), but may also help us answer research questions related to association between processes and outcomes. Process–outcome studies conducted at the individual level of analysis have been hailed as being of importance to potentially identify mechanisms of change within individual-oriented therapy, and speed the reduction of the scientist–practitioner gap by appealing to clinicians' interests (i.e., therapeutic processes; Castonguay & Muran, 2015; Kazdin, 2007; Kazdin, 2008). Hence, I argue that process–outcome studies considering nonindependence will conceivably have the same impact within the field of couple and family therapy.

5.4 The many roles of a clinical researcher

As a clinical researcher I have tried to be attentive on how different methods have been implemented in the study. Trans-methodological reflexivity (Whittaker et al., 2023) entails the process of the researcher reflecting critically on oneself as a researcher (Lincoln et al., 2018) and as a general research skill

(Finlay, 1998) relevant not only to qualitative methodology but also to quantitative methodology (Jamieson et al., 2023). Furthermore, it incorporates positional reflexivity, also referred to as an important principle in systemic practice in general, meaning the clinical researcher's awareness of that they themselves are a part of the system she or he is studying (Lini & Bertrando, 2022; Stokkebekk et al., 2022). Incorporating these skills into my own research practice is an ongoing process. As mentioned in the methods section I have tried to be conscious of my multiple roles as a researcher, clinician, and at times as a clinical supervisor. I have also spent time on reflecting how the different methods are best implemented sequentially as the research project has unfolded (Bailey-Rodriguez, 2021). Consequently, this led to the inclusion of the FAD in Paper 2, and eventually to the trauma variable being omitted in Paper 3.

Regarding my affiliation to the Family Unit, at the time of officially starting the project (mid-September 2018) I had no clinical tasks related to currently hospitalized patients, hence any conflict of roles or ethical dilemmas specific to being a clinician in my own research project was minimized. As a systemic researcher it would be naïve of me not to acknowledge that I could have influenced the participants that I interacted with (and vice versa), however I was not aware of any problems that arose and that could have had a negative impact on either them or the research process. It could be that participants consented to be a part of our study because they had concerns that not consenting would affect their treatment or any future readmission, but all participants were thoroughly informed beforehand that this was not the case. Consent forms for all quantitative data are also handled online and are usually not checked before data is exported from the system for analysis. There is no reason why any staff with access to such data, including researchers, would look this data up before export. Conversely, it could be argued that participants consent to take part out of gratitude and that this attitude would somehow impact the results (i.e., social desirability). Although possible, I have no evidence of this. To the contrary, in Paper 2 when the participants started to feel more at ease with the

interview situation my impression was that they were honest and almost unbashful in their critique of the treatment they had received. The closest I got to experiencing that my dual role became an issue was related to the quantitative data material, which included three couples and one single parent who had been in my care prior. Such a circumstance was possible since we included data going back eight months from the official start of the project (which also was when I left my clinical position for a research position). Luckily none of my former patients fit the criteria to be invited to participate in the second paper. Although, my supervisor Terje Tilden was prepared to conduct the interviews if necessary. Any issue regarding the inclusion of my former patients was resolved by anonymizing all participants according to our routines.

In this thesis the case has been made for practice-oriented research (Castonguay & Muran, 2015). This approach to research has its advantages when conducting clinical research, such as in-depth understanding of the patient population, the treatment at offer and its accompanying routines, as well as the ease of data collection. This close affiliation with the research setting (i.e., the Family Unit), also requires a heightened awareness of inhabiting dual roles. Although I cannot pinpoint any disadvantages regarding my dual role or my contact with the participants, I did find it challenging to handle the findings in Paper 2 as it implicated several therapists of whom I had also earlier worked with at the clinic. Given that the findings did not put these therapists in a favorable light, it caused me a lot of anxiety thinking that they might read the paper and recognize themselves. I spent a lot of time discussing this predicament with my supervisors and ended up going forward as planned with the paper. However, the decision was made to withhold as much information about the therapists and their patients as possible. The peer-reviewers of the paper did initially want more information about these therapists, but they accepted my arguments based on my concerns. Hence, I have also decided to withhold any additional information about the therapists and the patients included in Paper 2 in the thesis.

5.5.1 Clinical implications

Although the following interpretation of the findings and its proposed clinical implications are assumptive and the negative actor effect is not considered, it is still an interpretation which I argue makes sense based on my colleagues and my own many years of clinical experience. I acknowledge that the following narrative is one of many ways the findings of the papers may be interpretated and coherently presented, this is my attempt at making sense of them. Thus, the combined findings of all three papers may be retold as two contrasting vignettes: A heterosexual cisgender couple seeks therapy. Part of the presented problem is related to the female member's history of being a victim of childhood abuse. The symptoms of trauma have taken their toll on both the identified patient and her spouse. The partner resents his wife for the distress they both feel and how it affects their daily family life. He knows that it is not his wife's fault, and that she is a victim, but he has become tired and distraught of her not getting better during the years they have been together as a couple. His wife objects to his point of view accusing him of not caring and of harboring her ill will. Nevertheless, she silently blames herself for the suffering of her family, flooded with feelings of shame. She wants her health to return, but the help she has received has only brought her so far. They are both unhappy, and they both acknowledge that change for the better has to take place if their marriage is to survive. This case description, as well as being representative of the clinical population at the Family Unit, is also supported by a body of evidence (e.g., Banford Witting & Busby, 2019; Bremner, 2016; Cloire et al., 2009; Trickett et al., 2011). In this example, according with our findings presented in Paper 2, the therapist is not able to navigate the couple's differing perspectives either at the onset or as the therapy develops. Thus, a shared therapeutic project is not agreed upon. The therapist who is not able to handle the couple's disagreement is thus prone to join one member at the expense of the other as the divide between the couple grows. The split that manifests when the neutral stance of the therapist is broken, and he/she consciously or subconsciously joins with one member of the dyad at the expense of a relational focus, it

is something we identify as a constraint (one of possibly many; Breunlin, 1999) to therapy. Given that no successful attempt at reorienting the therapy toward a relational focus occurs (e.g., rebalancing the alliance), the therapy slides toward becoming individually oriented. Although not assessed in our own study, it is likely that in couple therapies were split alliances occur there is also a low within-system alliance (i.e., alliance between dyad members) that is a possible precursor for the split (Friedlander, Hynes; 2021). From the perspective of integrative systemic therapy (Pinsof et al., 2018) any of these states of unsatisfactory alliances (i.e., low within system alliance or split alliance) may be considered as constraints. Consequently, the couple is not given the opportunity to adequately work on their relational difficulties and therefore has a poor response to the treatment, as measured by relational assessments of outcome. As the findings of Paper 2 shows, the couple in this example still had low scores on the same relational assessments of outcome (e.g., the FAD) at a follow-up appointment.

Conversely, the therapy can take a different trajectory. In this instance, the therapist and the wife quickly establish good rapport, and with slight extra attentiveness from the therapist to the husband's complaints and worries, they also seem to establish a solid bond. Male dyad members alliance scores have been shown to be the most predictive of outcome across several studies (Friedlander et al., 2018; Glebova et al., 2011), including our own study as described in Paper 3. In this example, the therapist is tentative of this finding and picks up on the husband's reluctance to attend therapy. Thus, the therapist puts extra effort toward making sure the husband feels comfortable in the initial sessions, and clearly stating the rationale behind the interventions and how they are connected to the problem they as a couple are presenting in therapy. Within the first couple of sessions the husband's reluctance diminishes. This change is further supported by the ROM-system the therapist uses, something the therapist shares with the couple. Seeing how her husband engages with the therapy is something that in itself strengthens the wife's commitment to her marriage. She perceives this as her husband's willingness to partake in a joint effort to change. Perhaps it is communicated that he is willing

to shoulder his part of the responsibility for the problems they are suffering. Maybe her own feelings of shame are lessened when she receives confirmation that she is not the one to blame. As the therapy continues to progress, they stay motivated and work diligently together with their therapist. The therapist makes sure that therapy always makes sense to the couple. Whenever misunderstandings occur (and they do), the therapist is quick to resolve them. This attentiveness to common factors and its importance for therapeutic change has been expounded upon in the works of both Sprenkle et al., (2009) and Wampold and Imel (2015). As a consequence, the couple gradually starts to acknowledge that their problem resides within the interactions of their relationship—fueled by unmet emotions and needs. This is a great shift for the couple who were previously entrenched in the point of view that it was the person who was the source of the problem. This newfound understanding lessens the burden of trauma. It further reduces feelings of shame, guilt, and anger and helps them develop new ways to interact with one another (Johnson, 2002; Sprenkle et al., 2009). Although the findings presented in Paper 3 are best assumed inconclusive, I do venture to propose that these new relational experiences make the couple in the example increasingly more satisfied with their relationship and less reliant on their therapist. By the time their therapy is terminated, they are both happy with the outcome. A follow-up appointment later confirms these changes.

5.5.2 *To tailor or not to tailor*

The title of the PhD-project was "Do couples and families with histories of childhood trauma need tailored therapy?", the overall aim of the project being as the title implies to evaluate if such families need adjustments done regarding the treatment the Family Unit has to offer. Even though the title of the project may be understood as partially rhetorical, since I am convinced that most families have idiosyncrasies that entail some degree of tailoring. However, the question still does merit an answer because our knowledge of how such families respond to therapy is limited (Macdonald et al. 2016; Monson et al., 2012; Weissman et al., 2018).

In order to try to answer the question posed I take a bird`s eye view on the issues raised throughout these three studies. First, we should consider the possibility that a mismatch exists between the population seeking treatment at the Family Unit and the treatment at offer resulting in subgroups of patients (e.g., those with histories of childhood trauma) to not respond to treatment as expected. Perhaps these patients are not getting the treatment they need? The main context within which therapy is delivered is in a couple's context, whereas other components, such as family therapy or individual therapy, may be supplemented, depending on the presented problems. Although such adjustments are possible, they are contingent on the therapist being responsible for the treatment. Even though one therapist is responsible for the treatment she or he does not work alone but is accompanied by a co-therapist, who usually has a background as a nurse and has either undergone or is undergoing training in family therapy. As presented in Paper 2, little tailoring was made in the therapy for those identified as the poor outcome subgroup. Whatever was done came across in the interviews as haphazardly and was not focused on the couples' relational problems or on taking care of the dyad member who felt out of place in the therapy. From previous research, we know that focusing on the problem is beneficial for the outcome of therapy (Yulish et al., 2017) and that being in agreement on what the goal is (i.e., shared agreement on what the problems are) is predictive of outcome (Friedlander et al., 2018). The therapist is not necessarily to blame for the lack of focus on the presented problem or its related constraints, as there are a multitude of reasons why therapy might go astray. For instance, to my knowledge none of the therapists at the Family Unit routinely practice any of the supposedly trauma-sensitive couple therapies (Monson & Fredman, 2012; Johnson, 2002) reviewed in the background section, rather choosing to practice therapy according to their particular therapist education and/or ongoing education. Such an approach to practicing therapy comes with the risk of mismatching between therapist and patients, especially if the treatment is not adequately tailored during treatment. I argue that this was the case for at least two of the couples that participated in Paper 2.

A timely question to raise taking the findings of the three papers into account is: Do couples and families who do not respond to treatment, as assessed on a family-level measurement, actually have problems related to family functioning? Or what if the applied instruments do not capture the change of interest? It could be the situation that relevant change is not captured by the measurements used at the Family Unit but given how these standardized instruments are disseminated and applied worldwide this is hard to conceive, also the sequential research design allowed us to confirm the FAD (Epstein et al., 1983) scores presented in Paper 1 in Paper 2 (reliability and validity will be discussed in subsection 5.6). For the sake of argument, let's consider that the measurements (i.e., the FAD) actually does assess for some of the problems the families are presenting in therapy (e.g., a variety of intimate relational conflicts). Do such problems receive enough attention in therapy? Answering either yes or no to the latter question could conceivably have different consequences, for instance, the treatment program offered at the Family Unit is perhaps not flexible enough and could to a larger extent either be more individual oriented or conversely involve more whole-family work (Breunlin & Jacobsen, 2014) if it was warranted. Such a shift from one context of treatment to another, i.e., from couple focused therapy to an individual or family-oriented therapy, would be done deliberately dependent on the presented problem or identified constraints (Pinsof et al., 2018). Although family sessions do occur on a regular basis at the Family Unit, they are seemingly seldom prioritized, which is underscored by the fact that it is the adults who are the ones formally receiving therapy. What if these preferences and structures represent constraints on outcomes? What if the families with suboptimal responses to therapy in actuality need another modality of treatment such as work with the whole family system or, indeed, with an extended family system? Would an inflexible therapist system be able to shift the treatment context if needed? Would such inflexibility potentially lead to a ruptured alliance? To be able to make such a shift the therapist would have to become aware of such a need and given what we know about

therapists' ability to identify deterioration (Hannan et al., 2005; Walfish et al., 2012), the odds are not good if ROM is not adhered to (Tilden & Wampold, 2017).

The use of structured feedback (i.e., ROM) is promoted in IST (Pinsof et al., 2018), and there are several guidelines used to help the therapist structure therapy and optimize outcomes. Two prominent ones are *the alliance–priority guideline* and *the interpersonal guideline*. The former dictates that the alliance should be prioritized above all else as long as such a prioritization aids in the resolution of the client's problem. ROM is vital in helping the therapist follow this guideline. The latter guideline dictates that all those involved in the presented problem and its solution should always be invited to participate in the direct client system (i.e., to attend therapy; Pinsof et al., 2018), which again calls for the use of structured feedback to monitor relevant therapeutic processes and outcomes and identify potential constraints.

Beyond occurring in therapy, constraints may exist at any level in a system (Breunlin, 1999; Pinsof et al., 2018). Great constraints do in all likelihood exist in how the mental health care system is structured and organized within the Norwegian public welfare system at the national level. Also, there is no reason to believe that constraints do not exist at the Family Unit, for instance, in how the unit is organized and how it is financed, or to what extent different professions are able to collaborate skillfully or are as previously mentioned are overly loyal to specific therapy models. However, such challenges should be formulated as a probable constraints to treatment outcomes that have the potential to be overcome, such an attitude allows for agency instead of just accepting them as limitations.

In returning to the findings of Paper 2, two of the couples represented would possibly have better outcomes if preference were not granted to the couple context of treatment. Although not explicitly stated in the material included in the paper, one of the couples talked about wishing that they received more attention to the relationship between them and their children, whereas the other couple

in general missed a more relational approach. Both these couples had kids hospitalized along with them, whereas the last of the couples included in the sample was undoubtedly what I would call a clear-cut candidate for couple therapy. Despite these differences in the findings, a shared commonality exists among the patients interviewed and who had not responded to treatment: They all acknowledged that they did not reach their therapy goals. What is abundantly clear by now is that not responding to a level of assessment in therapy that is associated with their reason for hospitalization (e.g., high family conflict) as monitored by the units ROM-system, is likely an indication that the couple or family who are taking part in therapy are not experiencing that their goals are being realized. In such instances, therapy needs to be tailored to bring them back on track. The therapist should make use of available tools (i.e., ROM) to make sure the therapy is progressing (Tilden & Wampold, 2017). The use of ROM will increase the chance of the therapist to tailor therapy and thereby improve outcomes (Lambert & Harmon, 2018; Tilden & Wampold, 2017). To my knowledge the use of ROM at the Family Unit has dwindled these past years for a number of reasons including the implementation of a cumbersome and user-unfriendly system, and the lack of what could be called a structured feedback champion (Valla, 2014). The latter referring to an appointed person who is responsible for making sure that all clinicians know how the ROM-system works. Further examination of this decline in the use of ROM at the Family Unit would be of interest. Finally, to reassess the answer to the question: “Do couples and families with histories of childhood trauma need tailored therapy?”, it is unequivocally yes. However, the contents of any tailoring are dependent upon the specific couple or family, what they present as a problem, how this problem continues to manifest during therapy, and their interactions with their therapist system.

5.5.3 *Couple therapy and the treatment of trauma*

The findings of this study and how they relate to trauma vary depending on what level of the system is assessed. How one understands the processes that are associated with outcomes is again dependent on the level at which the analysis is conducted (i.e., the individual or the dyadic level; Kenny et al., 2020). At

the individual level, the findings indicate that the population who seeks couple and family therapy at the Family Unit do experience relief for their mental distress, including those with histories of trauma. However, as stressed throughout this thesis, they do not get the same relief on dyadic levels of assessment. These findings are further supported by the merged methods findings in Paper 2. Although trauma patients have reduced individual symptoms, we can assume that their relational problems were not adequately the target of interventions, or the interventions that were implemented were mismatched or otherwise inaccurate. Based on the research design and the lack of adherence to any specific treatment model, we cannot draw any conclusions related to treatment strategies and interventions. Nevertheless, these findings indicate that couple therapy, as a treatment approach, may be effective in reducing individual distress, including instances when childhood trauma is involved. The literature on the topic also gives hope that couple therapy may reduce both mental and relational distress (e.g., Carr, 2019a; Dalton et al., 2013; Liebman et al., 2020; Monson et al., 2012; Ruhlmann et al., 2018; Weissman et al., 2018), although the guidelines on the treatment of trauma do not yet reflect these developments (Hamblen et al., 2019).

As mentioned earlier, I would argue that a positive treatment response is contingent upon the participation of all those directly involved in implementing the solution to the problem, as proposed by Pinsof et al. (2018). Such an argument is contingent upon all those attending therapy, that they agree on what the goal of the therapy is. If the presented problem is relational in nature and entrenched within the interactions of the patient's seeking treatment, I would extend this to not having separate individual goals. In practice, this means that therapists should request that patients refrain from formulating goals related to personal development or otherwise focus upon themselves and rather negotiate between themselves to agree upon relational goals of therapy. This is not to say that individual mental distress should be neglected, but rather that it is the therapist's responsibility to reframe problems into relational terms. For instance: "It must be so painful for the both of you when the trauma of the past

invades the present and you both lose contact with one another." In the course of couple and family therapy, I would argue that targeting solely a family member's individual problems for an extended period of time should only occur when it has been identified as a constraint. In those instances, it should also be evaluated if a therapeutic shift (i.e., change of treatment modality) from a couple context to an individual-oriented context is called for. Such a shift is not intended to last for the entire course of therapy, but only for the number of sessions it takes to lift the constraint (Pinsof et al., 2018). For example, a person with highly negative self-talk (i.e., the identified constraint) could possibly be better equipped to handle couple sessions if the impact of this self-beratement was lessened in an individual therapy such as internal family systems (Anderson, 2021).

Being united against their problem, especially in the case of trauma and supported by a sensitive therapist, is perhaps the most important element to heighten the likelihood of successful treatment (Johnson, 2002). Being a sensitive therapist means being emotionally attuned and attentive to patients' states and reactions and responding accordingly (Johnson, 2012). Further, as indicated by the findings in Paper 2, it entails the capacity on the part of the therapist to relent on one's preferred method when it does not match the patients' problems (e.g., lack of agreement on tasks), idiosyncrasies (e.g., the therapist's style makes the patient feel insecure), or otherwise ceases to have the intended effect.

To help support such decisions, the therapist is reliant on receiving feedback. Feedback in therapy naturally occurs all the time both in and outside of therapy, but it needs to be structured somehow; if not, it is going to be difficult for the therapist to attend to the continuous flow of information and act accordingly (Pinsof et al., 2018). That is not to say that the therapist from novice to master does not respond appropriately to verbal, non-verbal communication, and intuit emotional cues in therapy, but to underscore the importance of also having an overview of how the therapy is unfolding at a macro level for all those involved and across time (i.e., at all relevant levels of the system; Gurman & Kniskern, 1978; Pinsof et al., 2018). In addition to monitoring treatment trajectories in a more general

sense (e.g., response or lack thereof; Tilden & Wampold, 2017), ROM may be potentially used in concert with other modes of collecting information (e.g., semi-structured interviews, additional questionnaires, video recordings, and interventions) to identify constraints (Pinsof et al., 2018). Although, in need of further research, Paper 1 suggests that a lack of treatment response as measured by frequently collected assessments (i.e., ROM) of family functioning may indicate a history of trauma (i.e., a possible constraint).

Finally, as presented in Paper 3, attending to the alliance with the therapist is important in couple therapy, especially the alliance of the male dyad member since improvement of his spouse's relationship satisfaction seems to be reliant upon it. This suggestion is supported by a number of studies presented in Friedlander et al.`s (2018) meta-analysis on the topic of alliances in couple and family therapy. However, this recommendation should be heeded with care, since the evidence is inconclusive and has features that are still unexplained such as the negative actor effect of the male dyad member. The particularities of the selected patient population attending treatment at the Family Unit should also be considered, hence generalization of the results should only be done to similar populations such as those consisting of couples seeking specialized mental healthcare (i.e., couples with histories of trauma, symptoms of mental illness, and co-existent relational distress).

5.6 Reliability and validity of the study

Given the naturalistic nature of the study (e.g., no adherence to a specific therapy model) and its clinical population (i.e., referred from local couple and family services), there is no apparent reason to believe that the couple therapy they have received previous to admission differs too drastically from the one received at the Family Unit. Although, insulating the effect of the couple therapy from the overall effect of the treatment program is not possible with the current design, I do propose that gains the participants have likely received from other treatment components (e.g., physical exercise) are better assessed with questionnaires not used in this study (i.e., questionnaires more accurate at assessing such

outcomes). Hence, similar questionnaires as those applied at the Family Unit (e.g., the FAD and RDAS) may also be useful in related treatment settings if one aims to assess the multiple levels of the family system (Gurman & Kniskern, 1978). Such a claim is supported by the high levels of Cronbach's alpha measured across all questionnaires used in the study (see subsection 3.6 Measurements). A high alpha indicates that each item is highly related to the rest of the items of the questionnaire (i.e., reliability), indicating that all items measure different aspects of the same phenomenon (e.g., couple satisfaction) that the instrument aims to target (i.e., validity). As described in the subsection 3.6 *Measurements*, the psychometric properties of the questionnaires applied in this study have found to be satisfactory in other studies (e.g., Busby et al., 1995; Hatcher & Gillaspy, 2006; Kabacoff et al., 1990). Although, we had no intention of implementing any additional questionnaires as a part of this study we did consult with two experience counselors on the contents of the questionnaires used at the Family Unit, no objections to the contents were made. In Paper 3, the Cronbach's alpha was also measured at the end of treatment, and these measurements were also found to be acceptable, indicating internal consistency in the questionnaires. Even though it is probable that there exists some individual variations in how the questionnaires were understood, any such influence was considered minimal, given our acceptable levels of Cronbach's alpha. Hence, the questionnaires applied may be considered reliable, thus strengthening the validity of the study (Tavakol & Dennick, 2011).

As predicted, a poorer response on the family level of assessment, as presented in Paper 1, was challenging to interpret in relational terms. Furthermore, as previously mentioned, the prominent reason for this is that the analysis was conducted at the individual level. However, limiting myself to the context of the Family Unit, I was still able to advance several hypotheses, including: 1) The relational difficulties were not targeted adequately. 2) The identified subgroup needed a higher frequency of sessions or longer hospitalizations than those who had not been exposed to childhood trauma. 3) The poorer response was due to a higher proportion of psychiatric diagnoses in the subgroup than in the

non-trauma sample. 4) Couples with histories of trauma need more time posttreatment to integrate and utilize new competencies and patterns of behavior. 5) One or several confounding variables are also associated with treatment outcomes (e.g., events outside therapy sessions or hospital grounds are affecting outcomes, thereby threatening the internal validity of the study). The last possibility is highly likely in most psychotherapy studies, especially those conducted within a naturalistic context. However, an inpatient treatment context is most likely associated with some confounding factors that an outpatient treatment has less of, such as greater social contact with other patients and staff, as well as close collaboration with other arenas such as the hospital kindergarten and school (Haukelien & Vike, 2018). Furthermore, the results of Paper 1 were difficult to interpret because the construed trauma variable was defined on the basis of information from a lenient screening process as a part of the daily clinical practice at the unit (i.e., no inter-rater agreement was systematically applied, thereby threatening the construct validity, meaning that the construed trauma variable was likely inaccurate). Because both the overall sample and the trauma subsample were relatively small, the study had a risk of making a type II error (i.e., skewing the results and thereby threatening the statistical conclusion validity; Shadish et al., 2002). The issue of power which is related to sample size and potentially underpowered effects will be discussed in the next subsection concerning methodological challenges and limitations.

The application of a mixed method sequential design together with method triangulation arguably allows for an examination of the overall validity (i.e., internal validity, construct validity, and statistical conclusion validity; Shadish et al., 2002). An advantage such a design has compared to of a research project which is comprised of several single design studies (Bailey-Rodriguez, 2021; Fielding, 2012). For instance, even though the sample included Paper 2 was fairly small, it still consisted of a substantial part of the subgroup they were drawn from. All participants in Paper 2 (also those who had been interviewed but were not included in the final paper) did confirm and expound upon the FAD

scores they had submitted at the end of treatment in the interviews. Although, the interviews did raise question concerning the construct validity of the trauma variable, it arguably also did strengthen the statistical and construct validity of the FAD concerning it use to identify the trauma subgroup and to assess this subgroups family functioning. Such discoveries allow for adjustments to the research design such as omitting constructs that are deemed as having low construct validity (i.e., the trauma variable), or in other instances replacing questionnaires with ones that are considered more reliable (e.g., we are presently implementing the couple therapy alliance scales [Pinsof & Catherall, 1986] in the Family Unit). As long as one is not prone to applying methods triangulation to confirm a specific point of view (i.e., the belief in a single truth), such a methodological approach may increase the likelihood of capturing a more complete picture of the target phenomenon, hence increasing a study's validity (Moon, 2019).

5.7 Methodological challenges and limitations

As outlined previously, at the time of the study the treatment offered at the Family Unit could best be described as integrative. Thus, clinicians at the unit could not agree upon a specific model that could predict the outcome of therapy. Just as the patient population could be described as heterogeneous, so could the pool of therapists at the unit. Add on to this the many components that constitute the treatment program at the Family Unit and it is impossible to attribute if the treatment effect documented in this study is the result of any one of them. Most likely several components contribute to the effect of the treatment (Haukelien & Vike, 2018). Although it may be argued that this is a limitation to the generalizability of the study, the treatment offered at the Family Unit shares many commonalities with couple and family treatments as it is provided to the general population. It is assumed that both specific factors (i.e., therapy models, and treatments strategies) and common factors such as the alliance (Bordin, 1979) and treatment expectations (Wampold & Imel, 2015) are of importance to outcome in any context of treatment. For instance, despite differences in theoretical orientations there are among the staff at the Family Unit including clinicians, sports pedagogues and art therapists, there is

a joint focus on the importance of having a shared sense of purpose and positive expectations while hospitalized, an attitude that is likely not unique to our research context. The Family Unit, just like any naturalistic treatment context is affected by a host extratherapeutic factors, for example social support or lack thereof (Zimmerman et al., 2021).

In the Family Unit, quantifiable outcomes are assessed at all levels of the family system. However, only information from the adults was collected, as is the routine at the unit. This can be considered a limitation, both regarding treatment and our research, especially if the presenting problem also involved or affected the children of the family. It can also be understood as a constraint at the system level (Pinsof et al., 2018), resulting from how public mental healthcare services are organized in Norway (i.e., patients are normally referred to age appropriate clinical units). Both the lack of treatment response at the family level and too little attention given to the parent–child subsystem was indicated in both the findings of Papers 1 and 2. The lack of systemic feedback from children further inhibited our capacity to formulate and test hypotheses related to the family system level, as represented by all its constituent subsystems (Pinsof et al., 2018). Therefore, the application of the social relations model (Kenny et al., 2020) or its equivalent to understanding how families change across time was not possible with the current data collection practice. The capacity to gather data from all members hospitalized at the Family Unit would have benefited our further understanding of what outcomes are and the processes involved.

Throughout this thesis, I have argued that analysis at the individual level is an erroneous approach if the aim is to examine how couple and family systems change over time (Kenny et al., 2020). Another point of contention raised in Paper 1 was how to construe a trauma variable. Although we confirmed in Paper 2 that the participants that were interviewed had been exposed to trauma during childhood, one couple had been excluded from the dataset because they had themselves not been the targets of sexual or physical abuse. In hindsight I should have further discussed with my supervisors on

how to handle patients who had witnessed or had intimate knowledge of traumatic events and thereby were defined (and possibly rightly so) as having been exposed to trauma. Hence, the trauma predictor (i.e., personal exposure to sexual and/or physical abuse) applied in the Paper 1 analysis did in all likelihood not accurately reflect the trauma variable we thought we had constructed (i.e., having experienced physical and/or sexually abuse directly to their person). Further, given that this was a naturalistic study which was designed to impinge as little as possible on daily clinical routines and practice no interrater agreement was sought. Hence, we should have been more conservative in the conclusions we presented in Paper 1. For instance, in the article we stressed the need for assessing for trauma if the goal of the therapy was to improve family functioning, given the likely inaccuracy of the trauma variable such a claim although done in good faith is at worst spurious. In hindsight I would not have constructed and applied such a predictor variable based on the information we had at hand. This was also one of the reasons why I decided to discard the variable in Paper 3.

The difficulty of defining what constitutes childhood trauma for our trauma category bears resemblance to a decades-long discussion within the trauma field related to what differentiates PTSD from complex PTSD and how the latter is operationalized (e.g., Brewin et al., 2017; De Jongh et al., 2016; Herman, 1992; Luxenberg et al., 2001; Maercker et al., 2013; Resick et al., 2012). For the most part, the information was not verified, and the only source of that information was a questionnaire the therapist completed posttreatment (i.e., the therapist report). Furthermore, as may be deduced from the papers, 18% of therapist's reports had not been filed. Despite these missing reports, this was the information that was accessible and granted the biggest sample size when taking the target objective into account (i.e., childhood trauma). In the future, I hope to improve on this study in numerous ways so as not to be reliant upon these reports (which at present have been discontinued at the Family Unit) as they have proven to be inaccurate. One is to include a larger sample size and thereby make possible the use of PTSD diagnoses as a predictor variable instead of the trauma variable used in Paper 1. Such a sample

would also allow us to conduct a dyadic analysis using PTSD as a distinguishable variable. This application would also allow for the inclusion of same-sex couples and test for differences between dyad members by controlling for PTSD instead of the variable based on gender membership used in Paper 3. To my knowledge the use of Bayesian statistics instead of the frequentist approach used in the current study would also have reduced the sample size needed to conduct such a study, thereby perceivably making the application of PTSD as a distinguishable variable all the more applicable. Having a large enough sample size to explore how subgroups of patients respond to treatment has been a challenge throughout the whole study and this challenge was not optimally resolved as can be concluded from what was experienced in conducting both quantitative studies (i.e., Paper 1 and 2).

A limitation of Paper 2 was the lack of set timepoints for conducting the interviews. Set time points could have made it easier to compare the outcome assessments collected (i.e., FAD) and interviews conducted (e.g., identifying shared themes). We tried to conduct couples' interviews, but only two were completed, and only one was considered usable. A larger sample, a more thorough interview protocol, and more experienced interviewers could have made such an approach more viable. Another challenge was how questions related to trauma gave little response, and given the nature of the phenomena, this was not necessarily strange. Being more attentive to non-verbal cues may have opened up the questioning or lent themselves to interpretation. Hence, having the aid of a visual recording would have been beneficial. Although not experienced as an issue in the interview sessions, a lack of trust in the interviewer could have been a barrier for the sharing of sensitive information related to trauma. As with Paper 1, Paper 2 could have also been improved by using PTSD as an inclusion criterion. We can assume that having only subjects who had a PTSD diagnosis in the sample would have made it easier to recognize commonalities across the sample that could be related to how trauma was associated with the experience of therapy. It has also been noted that the methods section in Paper 2 (thereby in extension albeit to a lesser degree also the findings section) was hard to follow, more

specifically there was a lack of description of the analysis procedure. Especially, it has been pointed out that it is unclear how the codes are related to the subthemes. Although I agree that this might be the case, it is worth noting that Braun and Clarke (2019) have themselves stated that researchers using thematic analysis may become too fixated on the link between codes and themes (e.g., overly reliant on counting instances of specific words to identify a theme). Hence, the researcher does not allow him or herself to apply his or her in-depth knowledge about the examined phenomenon when interpreting codes and selecting the appropriate themes. This was not a point of contention during the peer-review of Paper 2 either. Although, paper 2 could be improved upon I am still convinced that the contents of the paper have merit.

Paper 3 represents a big improvement on the quantitative methods used in Paper 1. Although the quantitative methods used in Paper 1 have their merits, they are not capable of examining how couples change at the dyadic level of analysis. However, improvements may still be made regarding our application of dyadic analysis. First, tools for assessing the alliance could be improved upon. The WAI, which was the questionnaire used, is designed for individual therapy and does not take systemic alliances into consideration. For instance, using one of the iterations of systemic alliance questionnaires developed by Pinsof et al. (2008) to collect data would be advantageous. Collecting data on other relational systems besides the self-therapist domain would be a huge improvement and one that would further help reveal the nuances of the interplay between alliances and outcomes. Second, the trauma variable was also not included in Paper 3 for several reasons. These reasons have already been described. In summary, the trauma variable has been proven to be inaccurate (e.g., participants who had been included in the category had not necessarily themselves been exposed to abuse; secondary traumatization is not recognized in the therapist report). The alternative, using a PTSD diagnosis as a predictive variable, was still not possible because of the studies' small sample size. Although Paper 3, had nearly double the number of participants from Paper 1, the actual sample size was halved as a

consequence of analyzing at the dyadic level. As mentioned previously, I would like to perform dyadic analyses using PTSD as a distinguishable variable in the future.

As described in the Methods section, Bayesian methods would be an improvement on the frequentist methods used in this study. The application of Bayesian methods would consequently be less work intensive, and because of how they handle smaller sample sizes, such methods would better manage the complexities related to dyadic analysis. Regarding Paper 3 it is difficult to know if the analysis was adequately powered since no power test was conducted beforehand to estimate the required sample size. In naturalistic studies it is often the case that power is not estimated before they are conducted. The reason for this is that you are not able to recruit patients beyond those that are already participating in treatment. Before conducting the study, we can only guess how many participants will participate based on previous hospitalizations, we have no way of increasing sample size beyond the passing of time (i.e., daily running of the hospital). Further restrictions to sampling are enforced by the project timeline (usually three years for a PhD project). At the time of conducting the analysis described in Paper 3, I was also not aware of the prospect of doing a power analysis on dyadic data. It was not until attending a course on the topic of dyadic analysis presented by Niall Bolger that I became I aware of the possibilities granted by Bayesian statistics to run power analyses on dyadic datasets. Even though I do now realize that there are better ways of conducting the study presented in Paper 3, I do believe that the methods and findings presented in the Paper 3 still have value. Not only because of how it was applied to a clinical population, but also for me personally. Case in point, learning how run a dyadic analysis in SPSS with all the adjustments needed has deepened my understanding of dyadic analysis and its applicability to field of couple and family therapy. Coming back to the matter of the sample size in Paper 3, the review in Kenny et al.`s seminal book Dyadic Data Analysis (2020), although not recently compiled, does include studies with the number of dyads ranging from 25 to 411. They determine that with a sample of 80 (which they estimate is the typical sample size when studying

dyads), it appears that there is sufficient power if the correlation is large. In Paper 3, which included 73 dyads, the effect size of the correlation between the dyad members scores was large according to Cohen`s d when the WAI was the covariate. Conversely, when the RDAS was applied as the covariate the effect size was medium. Notwithstanding that no power test was conducted, it does appear the main finding in Paper 3 regarding the predictive value of the alliance on couple satisfaction was adequately powered.

Regarding what I am convinced is the way forward both when it comes to power tests and handling potentially underpowered effects, I refer to the use of Bayesian statistics. In practical terms, this means using a different software package than SPSS, for instance, Mplus (Muthén & Muthén, 1998–2011). Although the interpretation of output resulting from Bayesian methods comes with its own challenges (e.g., increased risk of type 1 error), they are minimized by having a good theoretical understanding of the examined phenomenon and well-founded hypotheses (personal communication with Niall Bolger, August 2022). Although I acknowledge that there is room for many improvements in the current design and methods used, I am confident that the results produced, and the methods demonstrated have the potential to contribute to the field. In particular, the application of dyadic analyses is absolutely necessary if we want to deepen our understanding of how systems change, either in couple or family therapy, as recommended by Friedlander, Heatherington et al. (2021). These results may not be generalizable to a setting outside of Modum Bad, but this statement is as mentioned earlier, easily contradicted: The processes and how they relate to outcomes are well established and known to be relevant in any therapeutic context or practice (Davis et al., 2012; Flückiger et al., 2018; Friedlander et al., 2018; Sprenkle et al., 2009; Wampold & Imel, 2015). This project has additionally demonstrated the benefits of using complementary methods, such as method triangulation and sequential design, to hone research questions, improve upon methodology, and thus heighten research quality.

5.8 Conclusion

This study has provided new knowledge on how couples with and without histories of trauma respond to and experience therapy. Consequently, it also sheds light on how we may understand outcomes. In this thesis, I have discussed how processes and outcomes may be examined both qualitatively and quantitatively and how they may be assessed at different levels of the system (i.e., individual, couple/dyadic, and family/system) at both pre- and posttreatment and at multiple timepoints. Finally, I have expounded upon the consequences of analyzing quantitative data at different levels of analysis (i.e., individual vs. dyadic). All these methods and research approaches have distinct implications for how we understand outcomes of couples therapy and, consequently, how to further improve treatment.

We found that patients attending couple and family therapy with histories of trauma responded less to treatment on the dyadic and family levels of assessment. Further, the results in Paper 1 were verified in the findings presented in Paper 2. In addition to supporting the findings in Paper 1, Paper 2 also identified that constraints to outcome may be associated with split alliances. The findings in paper 2 encouraged us to conduct a dyadic analysis in Paper 3 to examine actor–partner effects using self-therapist alliances as predictors of couple satisfaction across time. Consequently, Paper 3 showed that partner effects had a stronger positive association with couple satisfaction than actor effects. In the future, we aim to both reintroduce trauma as a predictor and adjust our analysis strategy to enable the identification of split alliances.

Our research implies that the outcomes assessed in this study may be understood as associated with elaborate processes unfolding across time and that have repercussions upon how people reflect upon themselves and their committed relationships during the past, present, and future. Outcomes, quantitative or qualitative, represent how people function in their lives, how they feel and think about themselves, and perhaps of extra importance given the topic of this thesis—how they feel, think, and function with their loved ones. In the context of this study, outcomes that are assessed as less than

optimal by both patients and researchers are associated with failure in establishing a joint collaborative process of all directly involved in therapy. By refining such methods as those applied sequentially in this study, we may in the future, with higher accuracy and validity, examine phenomena that are the building blocks of human relational experiences and how they relate to treatment outcomes. The application of the dyadic analysis allowed us to more accurately understand how couples change throughout therapy, whereas in-depth interviewing allowed us conduct thorough investigations to understand the phenomena as recalled from memory.

In culmination, by detailing how one may conduct scientific inquiry from a paradigm of systemic family research, I hope to inspire other researchers, just as I was inspired both by my peers and seniors, to follow suit. I add my voice to the many before who have pondered the question, “What are outcomes?” concluding that outcomes are highly idiosyncratic to every individual, couple, or family who seek and go through therapy. Although experiences are personal and contingent on a number of factors, including personal developmental histories, cultural backgrounds, and biological differences, similarities still exist in the processes undergone and their association with self-perceived outcomes. This combination of what it is both similar and unique regarding couples and families in therapy lends itself to a scientific program that has the hallmarks of being multi-methodological and guided by systemic concepts—either one prescribes to the paradigm of systemic family research or its equivalent.

6. References

Ackerman, N. W. (1966). Family psychotherapy—theory and practice. *American Journal of Psychotherapy, 20*(3), 405-414. https://doi.org/10.1176/appi.psychotherapy.1966.20.3.405

Ainsworth, M. D. (1985). Attachments across the life span. Bulletin of the New York Academy of Medicine, *61*(9), 792–812.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed.).

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).

Anderson, F., G. (2021). *Transcending Trauma: Healing Complex PTSD with Internal Family Systems*. PESI Publishing.

Anderson, S. R., Banford Witting, A., Tambling, R. R., Ketring, S. A., & Johnson, L. N. (2020). Pressure to attend therapy, dyadic adjustment, and adverse childhood experiences: Direct and indirect effects on the therapeutic alliance in couples therapy. *Journal of Marital and Family Therapy*, *46*(2), 366–380. https://doi.org/10.1111/jmft.12394

Anderson, S. R., & Johnson, L. N. (2010). A dyadic analysis of the between-and within-system alliances on distress. *Family Process*, *49*(2), 220-235. https://doi.org/10.1111/j.1545-5300.2010.01319.x

Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process, 27*(4), 371-393. https://doi.org/10.1111/j.1545-5300.1988.00371.x

Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: a randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology, 77*(4), 693. https://doi.org/10.1037/a0016062

Anker, M. G., Owen, J., Duncan, B. L., & Sparks, J. A. (2010). The alliance in couple therapy: Partner influence, early change, and alliance patterns in a naturalistic sample. *Journal of Consulting and Clinical Psychology, 78*(5), 635. https://doi.org/10.1037/a0020051

Bailey-Rodriguez, D. (2021). Qualitatively driven mixed-methods approaches to counselling and psychotherapy research. *Counselling and Psychotherapy Research*, *21*(1), 143-153. https://doi.org/10.1002/capr.12383

Banford Witting, A., & Busby, D. (2019). The long arm of trauma during childhood: Associations with resources in couple relationships. *Journal of Marital and Family Therapy*, *45*(3), 534-549. https://doi.org/10.1111/jmft.12354

Bartle-Haring, S., Glebova, T., Gangamma, R., Grafsky, E., & Delaney, R. O. (2012). Alliance and termination status in couple therapy: A comparison of methods for assessing discrepancies. *Psychotherapy Research, 22*(5), 502-514. https://doi.org/10.1080/10503307.2012.676985

Bateson, G. (1972). *Steps towards an Ecology of Mind: collected essays in anthropology, psychiatry, evolution and epistemology*. Ballantine Books.

Beatson, J., & Taryan, S. (2003). Predisposition to depression: The role of attachment. The Australian and New Zealand Journal of Psychiatry, *37*(2), 219–225. https://doi.org/10.1046/j.1440-1614.2003 .01126.x

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). Beck depression inventory-II. *San Antonio, 78*(2), 490-498. https://doi.org/10.1037/t00742-000

Beltz, A. M., Wright, A. G., Sprague, B. N., & Molenaar, P. C. (2016). Bridging the nomothetic and idiographic approaches to the analysis of clinical data. *Assessment, 23*(4), 447-458. https://doi.org/10.1177/1073191116648209

Bertalanffy, L. V. (1950). An outline of general system theory. *The British Journal for the Philosophy of Science*, *1*(2), 134–165. https://doi:10.org/1093/bjps/i.2.134

Bertalanffy, L. V. (1968). *General system theory*. George Braziller.

Binder, J. L., & Strupp, H. H. (1997). " Negative process: A recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults. *Clinical psychology: Science and Practice, 4*(2), 121. https://doi.org/10.1111/j.1468-2850.1997.tb00105.x

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The posttraumatic stress disorder checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress, 28*(6), 489-498. https://doi.org/10.1002/jts.22059

Bolger, N., & Laurenceau, J.-P. (2013). *Intensive longitudinal methods: An introduction to diary and experience sampling research*. Guilford Press.

Bonanno, G. A., & Mancini, A. D. (2012). Beyond resilience and PTSD: Mapping the heterogeneity of responses to potential trauma. *Psychological trauma: Theory, research, practice, and policy*, *4*(1), 74. https://doi.org/10.1037/a0017829

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252. https://doi.org/10.1037/h0085885

Boroujerdi, F. G., Kimiaee, S. A., Yazdi, S. A. A., & Safa, M. (2019). Attachment style and history of childhood abuse in suicide attempters. *Psychiatry Research, 271*, 1-7. https://doi.org/10.1016/j.psychres.2018.11.006

Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. J. P. r. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy research*, *25*(1), 6-19. https://doi.org/10.1080/10503307.2013.817696

Bowlby, J. (1969). Bowlby, J. (1969). *Attachment and loss* (Vol. 1). Basic Books

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative research in sport, exercise and health*, *11*(4), 589-597. https://doi.org/10.1080/2159676x.2019.1628806

Bremner, D. J. (2016). Traumatic stress from a multilevel developmental psychopathology perspective. *Developmental psychopathology*, 1-39. https://doi.org/10.1002/9781119125556.devpsy309

Breunlin, D. C. (1999). Toward a theory of constraints. *Journal of Marital Family Therapy, 25*(3), 365-382. https://doi.org/10.1111/j.1752-0606.1999.tb00254.x

Breunlin, D. C., & Jacobsen, E. (2014). Putting the "family" back into family therapy. *Family Process*, *53*(3), 462-475. https://doi.org/10.1111/famp.12083

Breunlin, D. C., Pinsof, W., Russell, W. P., & Lebow, J. (2011). Integrative problem-centered metaframeworks therapy I: core concepts and hypothesizing. *Family Process, 50*(3), 293-313. https://doi.org/10.1111/j.1545-5300.2011.01362.x

Brewin, C. R., Cloitre, M., Hyland, P., Shevlin, M., Maercker, A., Bryant, R. A., … & Reed, G. M. (2017). A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD. *Clinical Psychology Review*, *58*, 1-15. https://doi.org/10.1016/j.cpr.2017.09.001

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology, 22*(6), 723. https://doi.org/10.1037/0012-1649.22.6.723

Busby, D. M., Christensen, C., Crane, D. R., & Larson, J. H. (1995). A revision of the Dyadic Adjustment Scale for use with distressed and nondistressed couples: Construct hierarchy and multidimensional scales. *Journal of Marital and Family Therapy, 21*(3), 289-308. https://doi.org/10.1111/j.1752-0606.1995.tb00163.x

Carr, A. (2016). The evolution of systems theory. In T. L. Sexton & J. Lebow (Eds.), *Handbook of family therapy, the science and practice of working with families and couples*. Routledge.

Carr, A. (2019a). Couple therapy, family therapy and systemic interventions for adult-focused problems: The current evidence base. *Journal of Family Therapy*, *41*(4), 492-536. https://doi.org/10.1111/1467-6427.12225

Carr, A. (2019b). Family therapy and systemic interventions for child-focused problems: The current evidence base. *Journal of Family Therapy*, *41*(2), 153-213. https://doi.org/10.1111/1467-6427.12226

Castonguay, L. G., & Muran, J. C. (2015). Fostering collaboration between researchers and clinicians through building practice-oriented research: An introduction. *Psychotherapy Research*, *25*(1), 1-5. https://doi.org/10.1080/10503307.2014.966348

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders*, *82*(2), 217–225. https://doi.org/10.1016/j.jad.2003.12.013

Cicchetti, D., & Rogosch, F. A. (1996). Equifinality and multifinality in developmental psychopathology. Development and Psychopathology, 8(4), 597-600. https://doi:10.1017/S0954579400007318

Cloitre, M., Stolbach, B. C., Herman, J. L., Kolk, B. v. d., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress, 22*(5), 399-408. https://doi.org/10.1002/jts.20444

Colman, R. A., & Widom, C. S. (2004). Childhood abuse and neglect and adult intimate relationships: A prospective study. *Child Abuse & Neglect, 28*(11), 1133-1151. https://doi.org/10.1016/j.chiabu.2004.02.005

Cordova, J. V., Fleming, C., Morrill, M. I., Hawrilenko, M., Sollenberger, J. W., Harp, A. G., Gray, T. D., Darling, E. V., Blair, J. M., & Meade, A. E. (2014). The Marriage Checkup: a randomized controlled trial of annual relationship health checkups. *Journal of Consulting and Clinical Psychology, 82*(4), 592. https://doi.org/10.1037/a0037097

Curran, P. J., & Bauer, D. J. (2011). The disaggregation of within-person and between-person effects in longitudinal models of change. *Annual Review of Psychology*, *62*, 583–619. https://doi.org/10.1146/annurev. psych.093008.100356

Dalton, E. J., Greenman, P. S., Classen, C. C., & Johnson, S. (2013). Nurturing connections in the aftermath of childhood trauma: A randomized controlled trial of emotionally focused couple therapy for female survivors of childhood abuse. *Couple and Family Psychology: Research and Practice, 2*(3), 209. https://doi.org/10.1037/a0032772

Danese, A., & Tan, M. (2014). Childhood maltreatment and obesity: Systematic review and metaanalysis. *Molecular Psychiatry*, *19*(5), 544–554. https://doi.org/10.1038/mp.2013.54

Davis, S. D., Lebow, J. L., & Sprenkle, D. H. (2012). Common factors of change in couple therapy. *Behavior Therapy*, *43*(1), 36-48. https://doi.org/10.1016/j.beth.2011.01.009

Delgadillo, J., Deisenhofer, A.-K., Probst, T., Shimokawa, K., Michael, L., & Kleinstäuber, M. (2022). Progress feedback narrows the gap between more and less effective therapists: A therapist effects meta-analysis of clinical trials. *Journal of Consulting and Clinical Psychology*, *90*(7), 559. https://doi.org/10.1037/ccp0000747

De Jongh, A. D., Resick, P. A., Zoellner, L. A., Van Minnen, A., Lee, C. W., Monson, C. M., ... & Bicanic, I. A. (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety*, *33*(5), 359-369. https://doi.org/10.1002/da.22469

Del Re, A., Flückiger, C., Horvath, A. O., & Wampold, B. E. (2021). Examining therapist effects in the alliance–outcome relationship: A multilevel meta-analysis. *Journal of Consulting and Clinical Psychology*, *89*(5), 371. https://doi.org/10.1037/ccp0000637

Derogatis, L. R. (2000). SCL-90-R. In A. E. Kazdin (Ed.), *Encyclopedia of psychology* (Vol. 7, pp. 192–193). American Psychological Association. https://doi.org/10.1037/10522-079

De Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I. K. (2021). *More than miracles: The state of the art of solution-focused brief therapy*. Routledge.

Doran, J. M. (2016). The working alliance: Where have we been, where are we going? *Psychotherapy Research, 26*(2), 146-163. https://doi.org/10.1080/10503307.2014.954153

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works in therapy*. American Psychological Association.

Epstein, N. B., Baldwin, L. M., & Bishop, D. (1983). The McMaster family assessment device. *Journal of marital and family therapy*, *9*(2), 171-180. https://doi.org/10.1111/j.1752-0606.1983.tb01497.x

Epston, D., & White, M. J. N. Y. (1990). Narrative means to therapeutic ends. W. W. Norton.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (2019). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 56*(6), 774-786. https://doi.org/10.1016/j.amepre.2019.04.001

Fielding, N. G. (2012). Triangulation and mixed methods designs: Data integration with new research technologies. *Journal of Mixed Methods Research, 6*(2), 124-136. https://doi.org/10.1177/1558689812437101

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), 531-545. https://doi.org/10.1177/104973202129120052

Finlay, L. (2012). Five Lenses for the reflexive interviewer. In J.F. Gubrium, J.A Holstein, A.B. Marvasti, & K.D. McKinney (Eds.), *The Sage handbook of interview research: the complexity of the craft*, 317-332. Sage Publishing House.

Finlay, L. (1998). Reflexivity: An essential component for all research? *British Journal of Occupational Therapy*, 61(10), 453–456. https://doi.org/10.1177/030802269806101005

Fischer, D. G., & McDonald, W. L. (1998). Characteristics of intrafamilial and extrafamilial child sexual abuse. *Child Abuse & Neglect, 22*(9), 915-929. https://doi.org/10.1016/s0145-2134(98)00063-5

Flick, U. (2018). *An introduction to qualitative research*. Sage.

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316. https://doi.org/10.1037/pst0000172

Freyd, J. J. (1996). Betrayal trauma. *Encyclopedia of Psychological Trauma*. Harvard University Press.

Friedlander, M. L., Escudero, V., Horvath, A. O., Heatherington, L., Cabero, A., & Martens, M. P. (2006). System for observing family therapy alliances: A tool for research and practice. *Journal of Counseling Psychology, 53*(2), 214. https://doi.org/10.1037/0022-0167.53.2.214

Friedlander, M. L., Escudero, V., Welmers-van de Poll, M. J., & Heatherington, L. (2018). Meta-analysis of the alliance–outcome relation in couple and family therapy. *Psychotherapy, 55*(4), 356. https://doi.org/10.1037/pst0000161

Friedlander, M., Heatherington, L., & Diamond, G. (2021). Systemic and conjoint couple and family therapies: Recent advances and future promise. In *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 539-581). Wiley.

Friedlander, M. L., Hynes, K., Anderson, S., Tambling, R., Megale, A., Xu, M., & Peterson, E. K. (2021). Examining Behavioral Manifestations of Split Alliances in Four Couple Therapy Sessions. *Journal of Couple & Relationship Therapy*, 1-24. https://doi.org/10.1080/15332691.2021.1876593

Funk, J. L., & Rogge, R. D. (2007). Testing the ruler with item response theory: Increasing precision of measurement for relationship satisfaction with the Couples Satisfaction Index. *Journal of Family Psychology, 21*(4), 572. https://doi.org/10.1037/0893-3200.21.4.572

Gadamer, H. G. (2013). *Truth and method*. A&C Black.

Galovan, A. M., Holmes, E. K., & Proulx, C. M. (2017). Theoretical and methodological issues in relationship research: Considering the common fate model. *Journal of Social and Personal Relationships, 34*(1), 44-68. https://doi.org/10.1177/0265407515621179

Gannon, M. J., Taheri, B., & Azer, J. (2022). Contemporary Research Paradigms and Philosophies. In Okumus, F., Rasoolimanesh, M. and Jahani, S. (Eds.), *Contemporary Research Methods in Hospitality and Tourism*. Emerald Publishing Limited.

Garland, A. F., Kruse, M., & Aarons, G. A. (2003). Clinicians and outcome measurement: w'at's the use?. *The journal of behavioral health services & research*, *30*, 393-405.https://doi.org/10.1097/00075484-200310000-00004

Gelso, C. (2014). A tripartite model of the therapeutic relationship: Theory, research, and practice. *Psychotherapy Research, 24*(2), 117-131. https://doi.org/10.1080/10503307.2013.845920

Glebova, T., Bartle-Haring, S., Gangamma, R., Knerr, M., Delaney, R. O., Meyer, K., ... & Grafsky, E. (2011). Therapeutic alliance and progress in couple therapy: Multiple perspectives. *Journal of Family Therapy*, *33*(1), 42-65. https://doi.org/10.1111/j.1467-6427.2010.00503.x

Goering, P., Lin, E., Campbell, D., Boyle, M. H., & Offord, D. R. (1996). Psychiatric Disability in Ontario. *The Canadian Journal of Psychiatry*, *41*(9), 564–571. https://doi.org/10.1177/070674379604100924

Goldberg, S. B., Babins-Wagner, R., Rousmaniere, T., Berzins, S., Hoyt, W. T., Whipple, J. L., Miller, S. D., & Wampold, B. E. (2016). Creating a climate for therapist improvement: A case study of an agency focused on outcomes and deliberate practice. *Psychotherapy, 53*(3), 367. https://doi.org/10.1037/pst0000060

Graham, J. M., Liu, Y. J., & Jeziorski, J. L. (2006). The dyadic adjustment scale: A reliability generalization meta-analysis. *Journal of Marriage and Family, 68*(3), 701-717. https://doi.org/10.1111/j.1741-3737.2006.00284.x

Greenson, R. R. (2008). The working alliance and the transference neurosis. *The Psychoanalytic Quarterly, 77*(1), 77-102. https://doi.org/10.1002/j.2167-4086.2008.tb00334.x

Grubaugh, A. L., Zinzow, H. M., Paul, L., Egede, L. E., & Frueh, B. C. (2011). Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review*, *31*(6), 883–899. https://doi.org/10.1016/j.cpr.2011.04.003

Gurman, A. S., & Kniskern, D. P. (1978). Deterioration in marital and family therapy: Empirical, clinical, and conceptual issues. *Family Process, 17*(1), 3-20. https://doi.org/10.1111/j.1545-5300.1978.00003.x

Gurman, A. S., Lebow, J. L., & Snyder, D. K. (Eds.). (2015). *Clinical handbook of couple therapy*. Guilford Publications.

Halford, W. K., Hayes, S., Christensen, A., Lambert, M., Baucom, D. H., & Atkins, D. C. (2011). Toward Making Progress Feedback an Effective Common Factor in Couple Therapy. *Behavior Therapy*, *43*(*1*), 49-60. https://doi.org/10.1016/j.beth.2011.03.005

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology*, *61*(2), 155-163. https://doi.org/10.1002/jclp.20108

Hamblen, J. L., Norman, S. B., Sonis, J. H., Phelps, A. J., Bisson, J. I., Nunes, V. D., Megning-Viggars, O., Forbes, D., Riggs, D. S., & Schnurr, P. P. (2019). A guide to guidelines for the treatment of posttraumatic stress disorder in adults: An update. *Psychotherapy: Theory, Research, & Practice*, *56*(3), 359–373. https://doi.org/10.1037/pst0000231

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16*(1), 12-25. https://doi.org/10.1080/10503300500352500

Hatfield, D. R., & Ogles, B. M. (2007). Why some clinicians use outcome measures and others do not. *Administration and policy in mental health and mental health services research*, *34*, 283-291. https://doi.org/10.1007/s10488-006-0110-y

Haukelien, H., & Vike, H. (2018). Psykoterapeutiske offentligheter (Psychotherapeutic publics). *Fokus på familien, 46*(03), 228-247. https://doi.org/10.18261/issn.0807-7487-2018-03-07

Heatherington, L., Friedlander, M. L., Diamond, G. M., Escudero, V., & Pinsof, W. (2015). Years of systemic therapies research: Progress and promise. *Psychotherapy Research*, *25*(3), 348–364. https://doi.org/10.1080/ 10503307.2014.983208

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5*(3), 377–391. https://doi.org/10.1002/jts.2490050305

Hesse-Biber, S. (2010). Qualitative approaches to mixed methods practice. *Qualitative Inquiry*, *16*(6), 455-468. https://doi.org/10.1177/1077800410364611

Hoffman, L. (2001). *Family therapy: An intimate history*. WW Norton & Company.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56*(6), 885. https://doi.org/10.1037/0022-006x.56.6.885

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*(2), 223. https://doi.org/10.1037/0022-0167.36.2.223

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*(2), 139. https://doi.org/10.1037/0022-0167.38.2.139

IBM. (2017). IBM SPSS Statistics for Windows, Version 25.0. IBM Corp.

IBM. (2020). IBM SPSS Statistics for Windows, Version 27.0. IBM Corp.

Infurna, M. R., Reichl, C., Parzer, P., Schimmenti, A., Bifulco, A., & Kaess, M. (2016). Associations between depression and specific childhood experiences of abuse and neglect: a meta-analysis. *Journal of Affective Disorders, 190*, 47-55. https://doi.org/10.1016/j.jad.2015.09.006

Joel, S., Eastwick, P. W., Allison, C. J., Arriaga, X. B., Baker, Z. G., Bar-Kalifa, E., ... & Wolf, S. (2020). Machine learning uncovers the most robust self-report predictors of relationship quality across 43 longitudinal couples studies. *Proceedings of the National Academy of Sciences*, *117*(32), 19061-19071. https://doi.org/10.1073/pnas.1917036117

Johnson, S. M. (2002). *Emotionally focused couple therapy with trauma survivors: Strengthening attachment bonds*. Guilford Press.

Johnson, S. M. (2012). *The practice of emotionally focused couple therapy: Creating connection*. Routledge.

Johnson, J. G., Cohen, P., Brown, J., Smailes, E. M., & Bernstein, D. P. (1999). Childhood maltreatment increases risk for personality disorders during early adulthood. *Archives of General Psychiatry*, *56*(7), 600–606. https://doi.org/10.1001/archpsyc.56.7.600

Johnsen, A., & Torsteinsson, V. W. (2012). *Lærebok i familieterapi* (Textbook in family therapy). Universitetsforlaget.

Johnson, S. U., Ulvenes, P. G., Øktedalen, T., & Hoffart, A. (2019). Psychometric properties of the GAD-7 in a heterogeneous psychiatric sample. *Frontiers in Psychology, 10*, 1713. https://doi.org/10.3389/fpsyg.2019.01713

Johnson, L. N., & Wright, D. W. (2002). Revisiting Bordin's theory on the therapeutic alliance: Implications for family therapy. *Contemporary Family Therapy*, *24*(2), 257-269. https://doi.org/10.1023/A:1015395223978

Kabacoff, R. I., Miller, I. W., Bishop, D. S., Epstein, N. B., & Keitner, G. I. (1990). A psychometric study of the McMaster Family Assessment Device in psychiatric, medical, and nonclinical samples. *Journal of Family Psychology, 3*(4), 431. https://doi.org/10.1037/h0080547

Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3*, 1-27. https://doi.org/10.1146/annurev.clinpsy.3.022806.091432

Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist*, *63*(3), 146. https://doi.org/10.1037/0003-066x.63.3.146

Kelley, H. H., & Thibaut, J. W. (1978). *Interpersonal relations: A theory of interdependence*. Wiley.

Kenny, D. A. (1996). Models of non-independence in dyadic research. *Journal of Social and Personal Relationships, 13*(2), 279-294. https://doi.org/10.1177/0265407596132007

Kenny, D. A., & Kashy, D. A. (2010). Dyadic data analysis using multilevel modeling. In J. J. Hox & J. K. Roberts (Eds.) *Handbook of advanced multilevel analysis*, (pp. 335-370). Routledge.

Kenny, D. A., Kashy, D. A., & Cook, W. L. (2020). *Dyadic data analysis*. Guilford Press.

Kenny, D. A., & La Voie, L. (1984). The social relations model. In L. Berkowtiz (Ed.), *Advances in experimental social psychology* (pp. 141-182). Elsevier. https://doi.org/10.1016/s0065-2601(08)60144-6

Kessler, R. C. (2000). Posttraumatic stress disorder: the burden to the individual and to society. *Journal of Clinical Psychiatry*, *61*, 4-14.

Kessler, R., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Koenen, K. (2018). The Population Burden of Posttraumatic Stress Disorder. In E. Bromet, E. Karam, K. Koenen, & D. Stein (Eds.), *Trauma and Posttraumatic Stress Disorder: Global Perspectives from the WHO World Mental Health Surveys* (pp. 318-324). Cambridge: Cambridge University Press. https://doi:10.1017/9781107445130.024

Kessler, R. C., McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., Aguilar-Gaxiola, S., Alhamzawi, A. O., Alonso, J., & Angermeyer, M. (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *The British Journal of Psychiatry, 197*(5), 378-385. https://doi.org/10.1192/bjp.bp.110.080499

Kivlighan, D. M., Hill, C. E., Gelso, C. J., & Baumann, E. (2016). Working alliance, real relationship, session quality, and client improvement in psychodynamic psychotherapy: A longitudinal actor partner interdependence model. *Journal of Counseling Psychology, 63*(2), 149. https://doi.org/10.1037/cou0000134

Kivlighan, D. M., Marmarosh, C. L., & Hilsenroth, M. J. (2014). Client and therapist therapeutic alliance, session evaluation, and client reliable change: A moderated actor–partner interdependence model. *Journal of Counseling Psychology, 61*(1), 15. https://doi.org/10.1037/a0034939

Klohnen, E. C., & Luo, S. (2003). Interpersonal attraction and personality: What is attract—e--self similarity, ideal similarity, complementarity or attachment security? *Journal of Personality and Social Psychology, 85*(4), 709. https://doi.org/10.1037/0022-3514.85.4.709

Kloppen, K., Mæhle, M., Kvello, Ø., Haugland, S., & Breivik, K. (2015). Prevalence of intrafamilial child maltreatment in the Nordic countries: A review. *Child Abuse Review, 24*(1), 51-66. https://doi.org/10.1002/car.2324

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606-613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Lambert, M. J. (2016). The therapeutic alliance: An evidence-based guide to practice. *Psychotherapy Research, 26*(2), 259-261. https://doi.org/10.1080/10503307.2015.1031200

Lambert, M. J., & Harmon, K. L. (2018). The merits of implementing routine outcome monitoring in clinical practice. *Clinical Psychology: Science and Practice, 25*(4), 60. https://doi.org/10.1111/cpsp.12268

Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy*, *48*(1), 72. https://doi.org/10.1037/a0022238

Jamieson, M. K., Govaart, G. H., & Pownall, M. (2023). Reflexivity in quantitative research: A rationale and beginner's guide. *Social and Personality Psychology Compass*, 17(4), e12735. https://doi.org/10.1111/spc3.12735

Lebow, Jay L. (2019). Current issues in the practice of integrative couple and family therapy. *Family Process, 58*(3), 610-628. https://doi.org/10.1111/famp.12473

Lebow, J., & Pinsof, W. M. (2005). *Family psychology: The art of the science*. Oxford University Press.

Ledermann, T., Bodenmann, G., Rudaz, M., & Bradbury, T. N. (2010). Stress, communication, and marital quality in couples. *Family Relations, 59*(2), 195-206. https://doi.org/10.1111/j.1741-3729.2010.00595.x

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin*, *142*(8), 801–830. https://doi.org/10.1037/bul0000057

Li, X. (2022). The "dyadic dance": Exploring therapist–client dynamics and client symptom change using actor–partner interdependence modeling and multilevel mixture modeling. *Journal of Counseling Psychology*, *69*(4), 474. https://doi.org/10.1037/cou0000599

Li, X., O'Connor, S., Kivlighan Jr, D. M., & Hill, C. E. (2021). "Where is the relationship" revisited: Using actor-partner interdependence modeling and common fate model in examining dyadic working alliance and session quality. *Journal of Counseling Psychology, 68*(2), 194. https://doi.org/10.1037/cou0000515

Lincoln, Y. S., Lynham, S., & Guba, E. G. (2018). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. K. Denzin & Y. S. Lincoln (Eds.), The sage handbook of qualitative research (5th ed., pp. 108–150). Sage.

Lini, C., & Bertrando, P. (2022). Positional responsibility in systemic-dialogical therapy. *Journal of Family Therapy*, *44*(3), 339-350. https://doi.org/10.1111/1467-6427.12390

Liebman, R. E., Whitfield, K. M., Sijercic, I., Ennis, N., & Monson, C. M. (2020). Harnessing the healing power of relationships in trauma recovery: A systematic review of cognitive-behavioral conjoint therapy for PTSD. *Current Treatment Options in Psychiatry*, *7*(3), 203-220. https://doi.org/10.1007/s40501-020-00211-1

Locke, H., & Wallace, K. (1987). Marital adjustment test. In N. Fredman & R. Sherman (Eds.), *Handbook of measurements for marriage and family therapy*, 46-50. Brunner/Mazel.

Lorås, L., Whittaker, K., Stokkebekk, J., & Tilden, T. (2023). Researching what we practice: The paradigm of systemic family research: Part 1. *Family Process*. https://doi.org/10.1111/famp.12921

Löwe, B., Decker, O., Müller, S., Brähler, E., Schellberg, D., Herzog, W., & Herzberg, P. Y. (2008). Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. *Medical Care, 46*(3), 266-274. https://doi.org/10.1097/mlr.0b013e318160d093

Luxenberg, T., Spinazzola, J., & Van der Kolk, B. A. (2001). Complex trauma and disorders of extreme stress (DESNOS) diagnosis, part one: Assessment. *Directions in Psychiatry*, *21*(25), 373-392. https://doi.org/10.1002/jts.20047

Lykke, J., Hesse, M., Austin, S. F., & Oestrich, I. (2008). Validity of the BPRS, the BDI and the BAI in dual diagnosis patients. *Addictive Behaviors, 33*(2), 292-300. https://doi.org/10.1016/j.addbeh.2007.09.020

Maarouf, H. (2019). Pragmatism as a supportive paradigm for the mixed research approach: Conceptualizing the ontological, epistemological, and axiological stances of pragmatism. *International Business Research, 12*(9), 1-12. https://doi.org/10.5539/ibr.v12n9p1

Maas, C. J., & Hox, J. J. (2005). Sufficient sample sizes for multilevel modeling. *Methodology: European Journal of Research Methods for the Behavioral and Social Sciences*, *1*(3), 86. https://doi.org/10.1027/1614-2241.1.3.86

Macdonald, A., Pukay-Martin, N. D., Wagner, A. C., Fredman, S. J., & Monson, C. M. (2016). Cognitive–behavioral conjoint therapy for PTSD improves various PTSD symptoms and trauma-related cognitions: Results from a randomized controlled trial. *Journal of Family Psychology, 30*(1), 157. https://doi.org/10.1037/fam0000177

Maercker, A., Brewin, C. R., Bryant, R. A., Cloitre, M., van Ommeren, M., Jones, L. M., ... & Reed, G. M. (2013). Diagnosis and classification of disorders specifically associated with stress: Proposals for ICD-11. *World Psychiatry*, *12*(3), 198-206. https://doi.org/10.1002/wps.20057

Mahon, D. (2020). The Role of Practice-Based Evidence and Feedback Informed Treatment for Improving Therapy Outcomes. *Counseling and Family Therapy Scholarship Review, 3*(1), 2. https://doi.org/10.53309/osqk4162

Manly, J. T., Kim, J. E., Rogosch, F. A., & Cicchetti, D. (2001). Dimensions of child maltreatment and children's adjustment: Contributions of developmental timing and subtype. *Development and psychopathology*, *13*(4), 759-782. https://doi.org/10.1017/s0954579401004023

Marcus, E. R. (1999). Modern ego psychology. *Journal of the American Psychoanalytic Association*, *47*(3), 843-871. https://doi.org/10.1177/00030651990470031501

Mason, J. (2006). Mixing methods in a qualitatively driven way. *Qualitative Research*, *6*(1), 9-25. https://doi.org/10.1177/1468794106058866

Masten, A. S., Best, K. M., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and psychopathology*, *2*(4), 425-444. https://doi-org/10.1017/s0954579400005812

Messman-Moore, T. L., & Bhuptani, P. H. (2017). A review of the long-term impact of child maltreatment on posttraumatic stress disorder and its comorbidities: An emotion dysregulation perspective. *Clinical Psychology: Science and Practice, 24*(2), 154-169. https://doi.org/10.1111/cpsp.12193

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. A., & Claud, D. A. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of brief Therapy*, *2*(2), 91-100. https://doi.org/10.1016/j.jpsychires.2016.06.005

Miller-Perrin, C. L., & Perrin, R. D. (2012). *Child maltreatment: An introduction*. Sage Publications.

Minuchin, S. (1974). *Families & family therapy*. Harvard University Press.

Monson, C. M., & Fredman, S. J. (2012). *Cognitive-behavioral conjoint therapy for PTSD: Harnessing the healing power of relationships*. Guilford Press.

Monson, C. M., Fredman, S. J., Macdonald, A., Pukay-Martin, N. D., Resick, P. A., & Schnurr, P. P. (2012). Effect of cognitive-behavioral couple therapy for PTSD: A randomized controlled trial. *Jama*, *308*(7), 700-709. https://doi.org/10.1001/jama.2012.9307

Moon, M. D. (2019). Triangulation: A method to increase validity, reliability, and legitimation in clinical research. *Journal of Emergency Nursing*, *45*(1), 103-105. https://doi.org/10.1016/j.jen.2018.11.004

Morrow-Bradley, C., & Elliott, R. (1986). Utilization of psychotherapy research by practicing psychotherapists. *American Psychologist*, *41*(2), 188. https://doi.org/10.1037/0003-066x.41.2.188

Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., & Barth, J. (2010). Working Alliance Inventory-Short Revised (WAI-SR): Psychometric properties in outpatients and inpatients. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *17*(3), 231–239. https://doi.org/10.1002/cpp.658

Muthén, L. K., & Muthén, B. O. (1998-2011). *Mplus User's Guide.* Sixth Edition. Muthén & Muthén.

Nezlek, J. (2020). Diary studies in social and personality psychology: An introduction with some recommendations and suggestions. *Social Psychological Bulletin, 15*(2), 1-19. https://doi.org/10.32872/spb.2679

Norcross, J. C., Pfund, R. A., & Prochaska, J. O. (2013). Psychotherapy in 2022: A Delphi poll on its future. *Professional Psychology: Research and Practice*, *44*(5), 363. https://doi.org/10.1037/a0034633

Christoffersen, M. N. (2010). *Børnemishandling i hjemmet* (Domestic child abuse): *delrapport 1*. Det Nationale Forskningscenter for Velfærd. https://www.vive.dk/da/udgivelser/boernemishandling-i-hjemmet-0xg4onxk/

Osman, A., Kopper, B. A., Barrios, F., Gutierrez, P. M., & Bagge, C. L. (2004). Reliability and validity of the Beck depression inventory--II with adolescent psychiatric inpatients. *Psychological Assessment, 16*(2), 120. https://doi.org/10.1037/1040-3590.16.2.120

Olson, D. H., Waldvogel, L., & Schlieff, M. (2019). Circumplex model of marital and family systems: An update. *Journal of Family Theory & Review, 11*(2), 199-211. https://doi.org/10.1111/jftr.12331

Otte, C., Gold, S. M., Penninx, B. W., Pariante, C. M., Etkin, A., Fava, M., Mohr, D. C., & Schatzberg, A. F. (2016). Major depressive disorder. *Nature Reviews Disease Primers, 2*, 16065. https://doi.org/10.1038/nrdp.2016.65

Palitsky, D., Mota, N., Afifi, T. O., Downs, A. C., & Sareen, J. (2013). The association between adult attachment style, mental disorders, and suicidality: Findings from a population-based study. *Journal of Nervous and Mental Disease*, *201*(7), 579–586. https://doi.org/10.1097/NMD.0b013e31829829ab

Patomäki, H., & Wight, C. (2000). After postpositivism? The promises of critical realism. *International Studies Quarterly, 44*(2), 213-237. https://doi.org/10.1111/0020-8833.00156

Paz, A., Rafaeli, E., Bar-Kalifa, E., Gilboa-Schectman, E., Gannot, S., Laufer-Goldshtein, B., Narayanan, S., Keshet, J., & Atzil-Slonim, D. (2021). Intrapersonal and interpersonal vocal affect dynamics during psychotherapy. *Journal of Consulting and Clinical Psychology, 89*(3), 227. https://doi.org/10.1037/ccp0000623

Pejtersen, J. H., Viinholt, B. C. A., & Hansen, H. (2020). Feedback-informed treatment: A systematic review and meta-analysis of the partners for change outcome management system. *Journal of Counseling Psychology, 67*(6), 723. https://doi.org/10.1037/cou0000420

Pinsof, W. M. (1995). *Integrative problem-centered therapy: A synthesis of family, individual, and biological therapies*. Basic Books.

Pinsof, W. M., Breunlin, D. C., Russell, W. P., Lebow, J., & Chambers, A. L. (2018). *Integrative systemic therapy: Metaframeworks for problem solving with individuals, couples and families*. American Psychological Association.

Pinsof, W. M., Catherall, & D. R. (1986). The integrative psychotherapy alliance: Family, couple and individual therapy scales. *Journal of Marital and Family Therapy, 12*(2), 137-151. https://doi.org/10.1111/j.1752-0606.1986.tb01631.x

Pinsof, W. M., Zinbarg, R., & Knobloch-Fedders, L. M. (2008). Factorial and construct validity of the revised short form integrative psychotherapy alliance scales for family, couple, and individual therapy. *Family Process, 47*(3), 281-301. https://doi.org/10.1111/j.1545-5300.2008.00254.x

Pinsof, W. M., Zinbarg, R. E., Shimokawa, K., Latta, T. A., Goldsmith, J. Z., Knobloch-Fedders, L. M., Chambers, A. L., & Lebow, J. L. (2015). Confirming, validating, and norming the factor structure of systemic therapy inventory of change initial and intersession. *Family Process, 54*(3), 464-484. https://doi.org/10.1111/famp.12159

Pinquart, M., Oslejsek, B., & Teubert, D. J. P. R. (2016). Efficacy of systemic therapy on adults with mental disorders: A meta-analysis. *Psychotherapy Research, 26*(2), 241-257. https://doi.org/10.1080/10503307.2014.935830

Piros, J. (2008). Menns refleksjoner over erfaringer i parterapi–Hva stimulerer til positive endringer? (Men's reflections on how experiences in couple therapy–What stimulates positive change?). *Fokus på familien*, *36*(2), 148-161. https://doi.org/10.18261/issn0807-7487-2008-02-07

Power, N., Noble, L., Simmonds-Buckley, M., Kellett, S., Stockton, C., Firth, N., & Delgadillo, J. (2022). Associations between treatment adherence-competence-integrity (ACI) and adult psychotherapy outcomes: A systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology*, *90*(5), 427–445. https://doi.org/10.1037/ccp0000736

Priest, J. B. (2021). *The science of family systems theory*. Routledge.

QSR International. (2018) *Nvivo 12*. QSR International Pty Ltd.

Quirk, K., Drinane, J. M., Edelman, A., Chow, D., Lim, J., Chandra, D., Miller, S., & Owen, J. (2021). The Alliance–Outcome Association in Couple Therapy: A Common Fate Model. *Family Process*, *60*(3), 741-754. https://doi.org/10.1111/famp.12666

Rait, D. S. (2000). The therapeutic alliance in couples and family therapy. *Journal of Clinical Psychology, 56*(2), 211-224. https://doi.org/10.1002/(sici)1097-4679(200002)56:2<211::aid-jclp7>3.0.co;2-h

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., Mitchell, K. S., ... & Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: Implications for DSM-5. *Journal of Traumatic Stress*, *25*(3), 241-251. https://doi.org/10.1002/jts.21699

Rogers, C. (1951). *Client-centered therapy.* Houghton Mifflin.

Rousmaniere, T., Goodyear, R. K., Miller, S. D., & Wampold, B. E. (2017). *The cycle of excellence: Using deliberate practice to improve supervision and training*. Wiley.

Ruhlmann, L. M., Gallus, K. L., & Durtschi, J. A. (2018). Exploring relationship satisfaction and attachment behaviors in single-and dual-trauma couples: A pilot study. *Traumatology*, *24*(1), 27. https://doi.org/10.1037/trm0000129

Russell, G. M., & Kelly, N. H. (2002). Research as Interacting Dialogic Processes: Implications for Reflexivity. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *3*(3). https://doi.org/10.17169/fqs-3.3.831

Safran, J. D., Abreu, I., Ogilvie, J., & DeMaria, A. (2011). Does psychotherapy research influence the clinical practice of researcher–clinicians? *Journal of Clinical Psychology: Science Practice, 18*(4), 357-371. https://doi.org/10.1111/j.1468-2850.2011.01267.x

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide.* Guildford.

Saposnik, G., Redelmeier, D., Ruff, C. C., & Tobler, P. N. (2016). Cognitive biases associated with medical decisions: A systematic review. *BMC Medical Informatics and Decision Making, 16*(1), 1-14. https://doi.org/10.1186/s12911-016-0377-1

Sapyta, J., Riemer, M., & Bickman, L. (2005). Feedback to clinicians: Theory, research, and practice. *Journal of Clinical Psychology, 61*(2), 145-153. https://doi.org/10.1002/jclp.20107

Sayed, S., Iacoviello, B. M., & Charney, D. S. (2015). Risk factors for the development of psychopathology following trauma. *Current psychiatry reports*, *17*, 1-7. https://doi.org/10.1007/s11920-015-0612-y

Schafer, J. L., Graham, J. W. (2002). Missing data: our view of the state of the art. *Psychological Methods*, *7*(2), 147–177. https://doi.org/10.1037/1082-989x.7.2.147

Schmitz, N., Hartkamp, N., Kiuse, J., Franke, G., Reister, G., & Tress, W. (2000). The symptom check-list-90-R (SCL-90-R): A German validation study. *Quality of Life Research, 9*(2), 185-193. https://doi.org/10.1023/a:1008931926181

Sexton, T. L., & Lebow, J. (Eds.). (2015). *Handbook of family therapy*. Routledge.

Shadish, W. R., & Baldwin, S. A. (2003). Meta-analysis of MFT interventions. *Journal of Marital and Family therapy*, *29*(4), 547-570. https://doi.org/10.1111/j.1752-0606.2003.tb01694.x

Shadish, W. R., & Baldwin, S. A. (2005). Effects of behavioral marital therapy: a meta-analysis of randomized controlled trials. *Journal of Consulting and Clinical Psychology, 73*(1), 6. https://doi.org/10.1037/0022-006x.73.1.6

Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Houghton, Mifflin and Company.

Shadish, W. R., Ragsdale, K., Glaser, R. R., & Montgomery, L. M. (1995). The efficacy and effectiveness of marital and family therapy: A perspective from meta-analysis. *Journal of Marital and Family Therapy*, *21*(4), 345-360. https://doi.org./10.1111/j.1752-0606.1995.tb00170.x

Shin, T., Davison, M. L., Long, J. D. (2017). Maximum likelihood versus multiple imputation for missing data in small longitudinal samples with nonnormality. *Psychological Methods*, *22*(3), 426. https://doi.org/10.1037/met0000094

Singer, J. D., & Willett, J. B. (2003). *Applied longitudinal data analysis: Modeling change and event occurrence.* Oxford University Press.

Smith, J. A. (2003). *Qualitative psychology: A practical guide to research methods*. Sage Publications, Inc.

Solstad, S. M., Castonguay, L. G., & Moltu, C. (2019). Patients' experiences with routine outcome monitoring and clinical feedback systems: A systematic review and synthesis of qualitative empirical literature. *Psychotherapy Research, 29*(2), 157-170. https://doi.org/10.1080/10503307.2017.1326645

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and Family*, 15-28. https://doi.org/10.2307/350547

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine, 166*(10), 1092-1097. https://doi.org/10.1001/archinte.166.10.1092

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. Guilford Press.

Stänicke, L. I., Haavind, H., Rø, F. G., & Gullestad, S. E. (2020). Discovering one's own way: Adolescent girls' different pathways into and out of self-harm. *Journal of Adolescent Research, 35*(5), 605-634. https://doi.org/10.1177/0743558419883360

Sterba, R. (1934). The fate of the ego in analytic therapy. In *Classics in psychoanalytic technique*, 265-270. Rowman and Littlefield.

Stokkebekk, J., Törrönen, J., Emery, R. E., Iversen, A. C., & Hollekim, R. (2022). The heroic savior, the jungle guide and the beacon amidst a fog of uncertainty: Agency of fathers in prolonged postdivorce conflicts and their positioning of children. *Journal of Divorce & Remarriage*, *63*(7-8), 526-548. https://doi.org/10.1080/10502556.2023.2175556

Suardi, F., Rothenberg, M., Serpa, S. R., & Schechter, D. (2017). Trauma and parenting: Informing clinical practice with recent research findings. *Current Treatment Options in Pediatrics*, *3*(1), 1–14. https://doi.org/10.1007/s40746-017-0075-y

Symonds, D., & Horvath, A. O. (2004). Optimizing the alliance in couple therapy. *Family Process*, *43*(4), 443-455. https://doi.org/10.1111/j.1545-5300.2004.00033.x

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education*, *2*, 53. https://doi: 10.5116/ijme.4dfb.8dfd

Tedeschi, R. G., & Calhoun, L. G. (2004). " Posttraumatic growth: conceptual foundations and empirical evidence". *Psychological inquiry*, *15*(1), 1-18. https://doi-org/10.1207/s15327965pli1501_01

Tilden, T., Johnson, S. U., Hoffart, A., Zahl-Olsen, R., Wampold, B. E., Ulvenes, P., & Håland, Å. T. (2021). Alliance predicting progress in couple therapy. *Psychotherapy*. https://doi.org/10.1037/pst0000355

Tilden, T., Solem, M. B., Thuen, F., Lorås, L., Stokkebekk, J., & Whittaker, K. (2022). Å ta empirien på alvor v. 2.0. *Fokus på familien*, *50*(4), 315-333. https://doi.org/10.18261/fokus.50.4.5

Tilden, T., Theisen, M., Wampold, B. E., Johnson, S. U., & Hoffart, A. (2020). Individual distress and dyadic adjustment over the course of couple therapy and three-year follow-up: A replication study. *Psychotherapy Research, 30*(3), 375-386. https://doi.org/10.1080/10503307.2019.1645369

Tilden, T., & Wampold, B. E. (Eds.). (2017). *Routine outcome monitoring in couple and family therapy: The empirically informed therapist*. Springer.

Tilden, T., Wampold, B. E., Ulvenes, P., Zahl-Olsen, R., Hoffart, A., Barstad, B., Olsen, I. A., Gude, T., Pinsof, W. M., & Zinbarg, R. E. (2020). Feedback in Couple and Family Therapy: A Randomized Clinical Trial. *Family Process*, *59*(1), 36-51. https://doi.org/10.1111/famp.12485

Tilden, T., & Whittaker, K. J. (2022). Using ROM in family therapy. *Journal of Clinical Psychology*, *78*(10), 1973-1985. https://doi.org/10.1002/jclp.23398

Toomela, A. (2008). Variables in psychology: A critique of quantitative psychology. *Integrative Psychological and Behavioral Science*, *42*(3), 245-265. https://doi.org/10.1007/s12124-008-9059-6

Valla, B. (2014). *Videre: Hvordan psykiske helsetjenester kan bli bedre*. Gyldendal akademisk.

van der Kolk, B. A., Pynoos, R. S., Cicchetti, D., Cloitre, M., D'Andrea, W., Ford, J. D., & Teicher, M. (2009). Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V. *Unpublished manuscript.* https://complextrauma.org/wp-content/uploads/2019/03/Complex-Trauma-Resource-3-Joseph-Spinazzola.pdf

Von Der Lippe, A. L., Monsen, J. T., Rønnestad, M. H., & Eilertsen, D. E. (2008). Treatment failure in psychotherapy: The pull of hostility. *Psychotherapy Research, 18*(4), 420-432. https://doi.org/10.1080/10503300701810793

Van Nieuwenhove, K., & Meganck, R. (2017). Interpersonal Features in Complex Trauma Etiology, Consequences, and Treatment: A Literature Review. *Journal of Aggression, Maltreatment & Trauma*, 1-26. https://doi.org/10.1080/10926771.2017.1405316

Vrabel, K. R., Hoffart, A., Rø, Ø., Martinsen, E. W., & Rosenvinge, J. H. (2010). Co-occurrence of avoidant personality disorder and child sexual abuse predicts poor outcome in long-standing eating disorder. *Journal of Abnormal Psychology, 119*(3), 623. https://doi.org/10.1037/a0019857

Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports*, *110*(2), 639-644. https://doi.org/10.2466/02.07.17.pr0.110.2.639-644

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge.

Watzlawick, P. (1966). A Structured Family Interview. *Family Process*, *5*(2), 256–271. https://doi.org/10.1111/j.1545-5300.1966.00256.x

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM-5 (PCL-5). https://www .ptsd.va.gov/professional/assessment/adult-sr/ptsdchecklist.asp.

Weissman, N., Batten, S. V., Rheem, K. D., Wiebe, S. A., Pasillas, R. M., Potts, W., Barone, M., Brown, C. H., & Dixon, L. B. (2018). The effectiveness of emotionally focused couples therapy with veterans with PTSD: A pilot study. *Journal of Couple Relationship Therapy, 17*(1), 25-41. https://doi.org/10.1080/15332691.2017.1285261

Whisman, M. A., & Baucom, D. H. (2012). Intimate relationships and psychopathology. *Clinical Child and Family Psychology Review*, *15*(1), 4-13. https://doi.org/10.1007/s10567-011-0107-2

Whisman, M. A., Sheldon, C. T., & Goering, P. (2000). Psychiatric disorders and dissatisfaction with social relationships: Does type of relationship matter? *Journal of Abnormal Psychology*, *109*(4), 803. https://doi.org/10.1037/0021-843x.109.4.803

Whisman, M. A., Uebelacker, L. A., & Weinstock, L. M. (2004). Psychopathology and marital satisfaction: The importance of evaluating both partners. *Journal of Consulting and Clinical Psychology, 72*(5), 830. https://doi.org/10.1037/0022-006x.72.5.830

Whittaker, K. J., Johnson, S. U., Solbakken, O. A., Wampold, B., & Tilden, T. (2021). Childhood trauma as a predictor of change in couple and family therapy: A study of treatment response. *Couple and Family Psychology: Research and Practice*. Advance online publication. https://doi.org/10.1037/cfp0000181

Wiebe, S. A., & Johnson, S. M. (2016). A review of the research in emotionally focused therapy for couples. *Family Process*, *55*(3), 390-407. https://doi.org/10.1111/famp.12229

Wiener, N. (1948). *Cybernetics or Control and Communication in the Animal and the Machine*. MIT press.

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*. World Health Organization.

Yulish, N. E., Goldberg, S. B., Frost, N. D., Abbas, M., Oleen-Junk, N. A., Kring, M., ... & Wampold, B. E. (2017). The importance of problem-focused treatments: A meta-analysis of anxiety treatments. *Psychotherapy*, *54*(4), 321. https://doi.org/10.1037/pst0000144

Zimmermann, D., Wampold, B. E., Rubel, J. A., Schwartz, B., Poster, K., Schilling, V. N., ... & Lutz, W. (2021). The influence of extra-therapeutic social support on the association between therapeutic bond and treatment outcome. *Psychotherapy Research*, *31*(6), 726-736. https://doi.org/10.1080/10503307.2020.1847344

Zoellner, T., & Maercker, A. (2006). Posttraumatic growth in clinical psychology—A critical review and introduction of a two component model. *Clinical psychology review*, *26*(5), 626-653. https://doi-org/10.1016/j.cpr.2006.01.008

Zyphur, M. J., & Oswald, F. L. (2015). Bayesian estimation and inference: A user's guide. *Journal of Management*, *41*(2), 390-420. https://doi.org/10.1177/0149206313501200

7. Papers 1-3

Couple and Family Psychology: Research and Practice

Childhood Trauma as a Predictor of Change in Couple and Family Therapy: A Study of Treatment Response

Kristoffer J. Whittaker, Sverre Urnes Johnson, Ole André Solbakken, Bruce Wampold, and Terje Tilden

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I

II

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Troubled Relationships: A Retrospective Study of How Couples with Histories of Trauma Experience Therapy

Kristoffer J. Whittaker, Erik Stänicke, Sverre Urnes Johnson, Ole André Solbakken & Terje Tilden

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Troubled Relationships: A Retrospective Study of How Couples with Histories of Trauma Experience Therapy

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ABSTRACT

In the present study we aim to increase our knowledge of the relationship between childhood trauma and outcome in couple therapy. We sampled participants based on their sub-optimal responses to treatment as well as one member of the dyad having reported experiences of childhood trauma. Six participants constituting three couples were included. All data was analyzed using thematic analysis. Our main finding was that when couples are not able to agree on the goal of their therapy and this is not handled adequately by the therapist, the alliance tends to split. The therapy thus becomes more individually focused at the expense of the couple relationship. Generally, participants did not themselves assess their past traumas as having negatively impacted therapy giving instead credence as to how it has impacted their self-knowledge. In the future, longitudinal studies should be conducted to explore if there is an association across treatment between trauma and the therapeutic relationship, and the influence it might have on outcome. The findings of this study further support the already existing literature on the importance of alliance and elaborates upon how split alliances occur, develops, and constrains therapy.

KEYWORDS

Couple therapy; thematic analysis; inpatient treatment; childhood trauma; the therapeutic alliance

Introduction

The effectiveness of couple therapy (CT) is well documented (Barbato & D'Avanzo, 2008; Liebman et al., 2020; Wiebe & Johnson, 2016), but success rates ranging from 40 to 50% imply that not everyone benefits from this treatment approach (Shadish et al., 2003). Research has mainly focused on factors that may positively influence the outcome of CT (Heatherington et al., 2015). However, more knowledge of negative influences in CT is also needed, for instance addressing possible obstacles therapist may not

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be aware of (Pinsof et al., 2018; Rozental et al., 2018). Based on a previous study (Whittaker et al., 2021) which found that patients with a history of childhood trauma did not benefit as much from CT as those patients who did not have such experience, we wanted in the present study to inquire how couples in therapy with histories of trauma had experienced CT and how they were doing after treatment.

Background

CT refers to a broad range of therapeutic approaches which seek to alleviate relational and mental distress (Carr, 2019). One potential source of distress is childhood trauma creating relational injuries that further impact on these individuals' ability to build and maintain healthy relationships as adults with their partner and family (Chapman et al., 2004; Johnson, 2002). Thus, survivors of trauma have heightened risk of experiencing intimate relational distress (Colman & Widom, 2004; Taft et al., 2011), including disturbed parental capacities (Suardi et al., 2017). Partners of trauma survivors are also likely to be presenting symptoms (Shi, 2020). The presence of trauma among those with severe mental illness (SMI) has also tended to be overlooked (Mauritz et al., 2013). Prevalence studies have showed that among those who have a SMI as many as 66% have been sexually or physically abused during childhood (Grubaugh et al., 2011). Symptoms of trauma may be obscured by overlapping symptoms such as those presented for psychosis or borderline personality disorder (Cloitre et al., 2014). Another proposition for this poor recognition may be hesitance amongst clinicians to evaluate and treat trauma out of fear of incurring further distress (Mauritz et al., 2013).

Poorer outcomes in psychotherapy have been associated with patient traits and the therapeutic relationship (Lambert, 2013). Similarly in CT, alliance is the most researched predictor of outcome (Friedlander et al., 2018). Findings indicate that both a low alliance in general, and more specifically a split alliance (i.e., therapist has a good alliance with only one member of the couple) predicts poorer outcomes and dropout from therapy (Friedlander et al., 2018; 2021). Childhood trauma has been found as a predictor of the alliance for male participants in CT (Anderson et al., 2020). In a study where both members of the dyad reported histories of childhood abuse (Shi, 2020), traumatic childhood experiences predicted a range of mental distress symptoms. The presence of childhood trauma was also identified as predictor of poorer outcomes in CT at our clinic (Whittaker et al., 2021). However, the few studies conducted thus far regarding trauma and CT does not give

a clear understanding of how past trauma influences intra- and interpsychic functioning and how it relates to outcomes. For this reason, more research is required.

The Present Study

The present multiple case study (McLeod, 2010) is a continuation of a line of inquiry started in Whittaker et al. (2021), whom through statistical analyses (mixed models; Curran & Bauer, 2011) identified poorer treatment response to CT among survivors of childhood trauma. In the present study a mixed design prioritizing qualitative methods was applied (Bailey-Rodriguez, 2021). Participants were strategically selected according to deviant case analysis (DCA; Seawright & Gerring, 2008). The focus in the interviews was on patients' reflections of their treatment outcome and their experiences of collaborating with those involved in the therapy (i.e., partner and their therapist). We also wanted to invite the participants to inquire into the impact childhood trauma might have had on their treatment. The research questions were as follows:

1. How does the participant perceive the CT outcome?
2. How does the participant perceive the collaboration with their partner and their therapist?
3. How does the participant perceive the influence of past trauma on the therapeutic process?

By high`lighting six individual's (= three couples) narratives of inpatient CT, we present their experiences and explore differences in agreement concerning the outcome, relationships in therapy, and the impact of trauma.

Method

Ethics

The authors of this article applied and were granted an ethical approval for this study by the Regional Ethical Committee (REFNUM 2018/148). The first author (KJW) and last author (TT) who conducted the interviews were experienced clinicians with close ties to the Family Unit (FU). Thus, the mental wellbeing of the participants during the interview was supervised. Before any potentially distressing topic was raised the interviewers sought participants approval. All interviews ended with the researchers confirming that the participants were content.

Treatment Context

The FU is organized as a residential treatment unit within a psychiatric hospital for adults. Due to public health insurance the treatment is free of charge, and patients are on sick leave during hospitalization. All patients admitted are referred by their general practitioner in collaboration with either social services, family consultant services, or local mental healthcare providers. People with ongoing interpersonal violence, substance abuse, suicidal ideation, or psychosis are not admitted. For further description of the treatment program see Tilden, Gude, and Hoffart (2010) or Whittaker et al. (2021).

All treatments lasted from seven to fourteen weeks and took place as planned hospitalizations between the autumn of 2018 to summer of 2020. The principal recipients of the treatment were the adults although their children accompanied their parents during hospitalization. While the adults attended the therapy program their children attended the kindergarten or school located at the hospital grounds.

The main reason for participants to be admitted to the FU is because they sought to improve their relationship and/or functioning of their family. Also at least one member of the dyad had to fulfill the criteria of a psychiatric diagnoses according to the International Classification of Disease (ICD 11th rev.; World Health Organization, 1992). All participants had received individual and/or couple therapy before hospitalization at the FU, without satisfactory results. Represented diagnoses within the sample were, affective disorders, posttraumatic stress disorders, adjustment disorders, and one case of attention deficit and hyperactivity disorder. The psychiatric disorders and relational problems of the sample are typical of the patients that receive treatment at the FU.

Participants

The first author and the last author invited couples who were former patients at the FU to participate based on two inclusion criteria: 1) Former patients had to score within the clinical range on the Family Assessment Device (FAD; Epstein et al., 1983) at the end of treatment. The FAD is 12-item questionnaire widely used as a brief method to assess the overall health/pathology of a family. 2) At least one member of the couple needed to have a known history of childhood trauma.

A total of nine couples was invited, and of these, five couples gave their informed consent to participate, and two couples did not meet the inclusion criteria. Thus, a total of six participants (i.e., three couples) were included. The members of the three dyads were given aliases: i) Tara and Samuel, a couple in their thirties who had a few years previously emigrated

to Norway to seek employment. The couple struggled with the aftermath of adultery. At the time of hospitalization, they were not married and did not have children. Tara and Samuel were neither fluent in Norwegian nor English which degraded the quality of the data, but the inclusion of the couple's interviews still enriched the dataset. ii) Anita and Tom were a married couple in their fifties who had two school-age children in common. Anita and Tom struggled both with histories of trauma and had an emotional abusive marriage. iii) Maria and Peter, a married couple in their thirties were the parents of two preschoolers. Their marriage problems were characterized by an emotional and physical abusive relationship. Maria had on numerous occasions perpetrated physical violence toward Peter. She was herself a victim of childhood abuse and had emigrated to Norway as an adult. Her lack of fluency in Norwegian was compensated by her fluency in English. Additional information on each participant will be presented in the findings section.

Interviews

Participants took part in a qualitative in-depth interview developed by the authors (see appendix, supplementary material). The interview was constructed with the intention of engaging the participant to reflect upon past experiences of having received treatment at the FU. All interviews started with questions related to outcome and their present family situation. Next participants were encouraged to explore the collaboration they had with their therapists and partner during treatment. At an opportune moment all participants were asked to reflect upon any childhood trauma either they or their partner had experienced and how it may have impacted the therapeutic process.

Procedure

After each participant had consented to participate, a date for the interview was set. Due to the outbreak of the COVID-19 pandemic, two of the six interviews included were conducted through video consultation and via telecommunications. All remaining interviews were conducted either at hospital grounds or at the participants place of residence. All interviews took place within 18 months after treatment had ended and lasted from approx. 50 to 90 minutes. No incentives for participating were rewarded.

All interviews started with the interviewer (KJW or TT) reacquainting the participant with the FAD and their last score completed during treatment. All participants voluntarily filled-out the questionnaire again. The questionnaire was promptly scored by the interviewer and was then shared

with the participant. The following collaborative reflection of these results was the starting point of all the interviews. All interviews were tape-recorded and transcribed verbatim by the first author. All interviews were anonymized.

Data Analysis

The qualitative analysis of the collected data material was informed by Braun and Clark's (2006) demarcation of thematic analysis (TA), ensuring the quality of our findings. NVivo 12 was used to facilitate coding and organize the data. Another source of inspiration for how our analyses was conducted was the qualitative study of Stänicke et al. (2020). While reading the transcribed interviews during the data analysis, the first and the last author were observant of the descriptions and semantics the participants' used to reflect upon and give meaning to their experiences. During the interviews and data analysis, we had to be reflexive of our assumptions of the topic from clinical and developmental psychology, our understanding of psychotherapeutic processes based on our training as integrative- and couple and family therapists, as well as being males of Scandinavian descent. Heightened reflexivity was required by the first and last author because of their affiliation to the FU. The process of analysis which involves looking at the part and the whole and back again, can be described as "the hermeneutic circle" (Smith, 2003).

The data analysis consisted of several steps and phases, primarily conducted by the first author, who's interpretation of the participants' experiences and way of making meaning (double hermeneutic; Smith, 2003) was reflected upon, yet discussed and nuanced by the research team. Throughout the analyses researchers checked whether their team members' interpretations of the text converged or diverged from one another, and if they were plausible and understandable (research triangulation; Flick, 2018). First, both the first author and the last author read all interviews independently to identify preliminary codes and repeating ideas. Second, step one was promptly repeated. Third, the first author revisited all the tapes to verify the transcripts and wrote summaries of each interview. Fourth, the first and the last author met to analyze each case by case. Fifth, the research questions were revised. Sixth, the data material was imported into the analyses program NVivo 12 and was thus structured and organized. Seventh, the research questions were once again revised, followed by amendments to codes which were then organized into topics. Eighth, the topics were then discussed by the first author and last author. Ninth, the topics were discussed and nuanced in a meeting involving the whole research team (KJW, ES, SUJ, OAS, and TT). At this stage the

research team agreed to include only material from six interviews in the final draft. The team members drew on somewhat different theoretical and methodological perspectives, which enhanced the self-reflection and awareness to different ways of comprehending the data (Levitt et al., 2016). Tenth, the first author made alterations to the codes. Eleventh, the first author (KJW), last author (TT) and second author (ES) met once more to discuss and further nuance the topics and themes before step twelve, in which the first author made a draft of the manuscript. Thirteen, all coauthors read the draft, shared their reflections, and proposed revisions. Throughout the writing process we continued to discuss multiple interpretations, which ended in consensus (all five agreed) or the integration of nuances (one or two disagreed), such as renaming, rearranging, and adding or merging topics, themes and subthemes thereby strengthening trustworthiness (researchers and methodological integrity checks; Levitt et al., 2016).

Findings

Reading and discussing the interviews made the team aware of some compelling tendencies, of which one was that several participants blamed themselves for the less than a successful outcome of the treatment, seeing it as validating their own ineptness as an individual or as a couple. Another tendency was collaborative challenges within the dyads and between the individual participants and the therapist. Shared reflections showed that the therapeutic relationship between the participant and their therapist was in most cases just as central or even more so than their collaborative relationship with their partner. A third tendency was to give trauma limited significance regarding its impact upon therapy. Participants were more forthcoming in sharing how trauma had formed their self-knowledge, such as emotional reactivity or decision making. In general participants' capacity to articulate and reflect upon their experience of being hospitalized and the challenges they faced varied; some were able to express themselves clearly, while others struggled to voice their thoughts and differentiate feelings. Based on these impressions, we identified and explored similarities and differences in three topics, "Outcome of Therapy", "Relationships in Therapy" and "Impact of Trauma". Topics will be presented in this respective order. The first two topics include two themes while the last topic consists of one theme. All themes are presented as summarized text, explicitly stating the number of participants represented. Subthemes are associated with the theme and are illustrated by case examples. Case examples were chosen either because they represented a repetitive subtheme or because of its apparent

Table 1. Overview of topics, themes, subthemes, and codes.

Topic	Theme	Subtheme	Codes
Outcome of Therapy	Life After Therapy	"We still can't talk about it!", "It's very difficult to talk about our future", "If she had only given us a chance"	Better, Needs, Goals, Gains, Difficult, Failed, Understanding, New perspective, The problem, Attention/focus
	Coming Home	"Yes, it's still problematic in our family", "Where was the midwife?"	Difficult, Challenging, Misunderstandings, Triggered, Follow-up
Relationships in Therapy	Emotional Connections	"See me!", "They struggled", "They connected"	Challenging, Diagnoses, Overwhelmed Trust/safety, Needs, Failure/blame,
	Relational Breakdown and the Failure of not Renegotiating	"Feeling blamed", "Because of me", "I didn't know what to do"	Attention/focus, Goals, Approach, Failure/blame, More individual sessions, Family/children
Impact of Trauma	Trauma and Self-Knowledge	"Regression states", "My anger", "Hard love"	New perspective, Choices, Abuse, Diagnoses

importance to its associated theme. An example of the latter is the subtheme illustrated by the case example *If she had only given us a chance*. The authors have edited the case examples for coherency – removing redundant utterances and repetitions. See Table 1 for a complete overview of topics, themes, subthemes, and codes.

First Selected Topic: Outcome of Therapy

The First Theme: Life after Therapy

All couples expressed some ambivalence related to how they perceived the outcome of the treatment including the period after being discharged. Generally, all participants expressed satisfaction regarding the therapy sessions and the therapist, sharing how they benefited from treatment despite the FAD scores being in the clinical range both at the end of treatment, and at the time of the interview. Additionally, they had thoughts about how they could have benefited more from therapy, for instance about problems that either were not given adequate attention during hospitalization or were otherwise not prioritized.

"We Still Can't Talk About It!"

Tara grew up witnessing violence in her family of origin. She described an emotionally impoverished upbringing. Despite having a university degree from her native country, she held a position as a floor attendant in a town in Norway. She had no social network locally, beyond her partner Samuel. The depression Tara was suffering she attributed to her partner's past adultery. Although Tara expressed that improvement had occurred

for them after the treatment, they were still not able to talk about what she understood as the root of their relational problems – the affair: "There was something traumatic that happened in the beginning of our relationship". Tara had difficulties in finding words to express herself: "Because he wasn't faithful". When asked if the affair was a topic in therapy Tara explains: "The therapists asked if there was any topic that we absolutely didn't want to talk about and Samuel said he didn't want to talk about the affair". Tara went on to tell that she had some individual sessions where she was able to talk about the affair, but when asked if she wanted the topic to have received more attention during treatment she answered: "Yes".

"It's Very Difficult Talk about Our Future"

Samuel has a traumatic past which involved both his upbringing and the recent suicide of a close family member. During the interview he did not engage with the topic of past trauma when invited by the researcher. His main concern was on the present and the future and how Tara did not want to talk to him: "I've tried many times to talk to Tara about our problems, but she's really exhausted and doesn't want to talk". Samuel expounds upon how he had benefited from therapy: "I think that while we were at Modum Bad I learned quite a lot about what I can do about myself". He described how he had developed strategies to tackle his own disposition to ruminate, then he continued to talk about how he perceived his relational dispute: "I think a lot about family, kids and marriage, that kind of thing. Tara doesn't think about those things. Tara says she doesn't need those things, she wants to stay with me, but she doesn't need kids and family".

"If She Had Only Given Us A Chance"

Peter was raised in a household with a father who in periods excessively drank and acted demeaning toward him and his mother. Even though Peter was physically abused by Maria up until hospitalization, it was Maria who finally left the marriage: "After Modum Bad we should have deserved an honest try, but just two months later we were just going to separate? I thought that was ridiculous!". Despite being unhappy with the outcome of the therapy Peter talks about the therapy in positive terms: "The therapy was really good, but could the focus have been better? To that I would say – definitely, because in one way it failed. Even though the work done could have been better, the work that was done felt exceptionally good".

Second Theme: Coming Home

All participants addressed the feeling of not being prepared to make the transition back to their domestic, daily routines, describing the experience of relapse into dysfunctional patterns shortly after discharge. Aftercare by local health care providers was organized for three of the participants. What these participants received locally (i.e., individual therapy) was not a continuation of what they had received at the FU (i.e., couple therapy). All participants wished they had been followed-up closely by mental health care services.

"Yes, It's Still Problematic in Our Family"

Tom had previously been married, but the marriage had ended because he had exerted violence. He was himself brought up in a household where he was physically abused. He told about having difficulties relating to his anger and had once in the past been physically violent toward Anita. Tom spoke about being committed to control the destructive expression of his anger. According to Tom the physical violence was not ongoing in the household. Even though he understood his anger better after hospitalization, the couple still experienced conflicts: "We were discharged, and I still felt that we had issues that challenged us. And there was that fear of what would happen when we came out of this bubble." The "bubble" he is referring to is the hospital, Tom continued: "Because we knew we would face some challenges". Tom went on to describe the difference between being at the hospital and being back home: "At the hospital the setting is kind of right, we get to focus, but at home there is far less focus. So, the tools we had taken home with us, yeah, what happened to them? They just didn't appear when we needed them. They didn't appear at all and we were drawn back into our dysfunctional pattern". On returning home Tom discontinued therapy with his psychologist of many years.

"Where was the Midwife?"

Even though Maria did not get into details about her past, she confirmed having had a challenging upbringing which caused her to suffer severe aftereffects of posttraumatic stress. She was also open about her physical violence toward Peter. Even though their marriage broke down, Maria expressed satisfaction with the therapy: "I wouldn't change anything about the therapy, so I guess it was a success". Despite her apparent satisfaction with the treatment, she described difficulties related to returning home: "We came back home with an open can of worms, and we didn't know what to do with it". She used the following metaphor to describe her need for follow-up: "It's like when you have a baby and you come home by yourself, like you know, the midwife comes over and she's explaining.

I wish, I mean it's stupid because we're grown-ups and shouldn't need it, but it's really hard". After leaving the hospital Maria and Peter were scheduled to see their local Family Welfare Services, but they had to wait several months to get an appointment, and by that time Maria had decided to separate.

Second Selected Topic: Relationships in Therapy

First Theme: Emotional Connections

Differences in quality of therapeutic relationships was described by four of the participants. Tara and Samuel only talked about the collaborative aspects of the relationships with the therapist (i.e., what we did in therapy), not mentioning their partners' collaboration with the therapist. Anita described how she felt insecure relating to the therapist, her struggle to connect was also observed by her spouse. Peter described how his spouse had a better connection to their therapist than he himself had; a reflection which was confirmed by Maria. As we will discuss later, those that struggled the most in establishing rapport with their therapist did not attain the same quality of bond as their partners did with the therapist.

"See Me!"

Anita had a childhood marked by sexual abuse and she still suffered adverse aftereffects from these experiences. She had received therapy throughout her adult life and was well versed in the language of psychotherapy. Even though she still intermittently experienced debilitating trauma symptoms, the main reason for her and her husband's referral to the FU was the relational problems they suffered. Anita described how she and her husband reacted differently to the direct approach of the therapist: "I believe I became so overactivated. I wasn't able to handle it. Tom was able to handle it, even though it was challenging for him. But I wasn't able to, at least not in the beginning". Anita continued to burden herself: "It felt like a defeat. In a way I saw that I was the one who wasn't able to deal with it". She described having to turn her attention inwards to minimize the impact of her own preconceptions on her budding relationship with the therapist: "I had to go many rounds with her (referring to the therapist) within myself before I could engage in the therapy". Anita started to question the therapist's direct approach, if the therapist had been able to make adjustments – could things have been different: "I don't know, could it have been done some other way? Could I have found my footing a bit earlier, could I then have felt safe enough?". Anita went on to reflect upon quires she had raised at the end of the treatment: "I raised the question at the end – I, with my diagnosis, could the approach have

been such that I didn't have to get overactivated the whole time? And could I still have benefited from the therapist's method?" After conferring with the interviewer to make sure she was understood she continued to describe how she felt abandoned with her difficult feelings: "I did want the anxiety to arise, I did want it to be there, but it came up and then I felt all alone".

"They Struggled"

Tom spoke fondly about having a good working relationship with their therapist, but he saw how the therapist and Anita struggled to relate: "In the talk sessions we had with our therapist I got to do some work, but I do believe we suffered because Anita had a very hard time relating to the therapist". Tom went on to explain how he believed this impacted the therapy:

> "Anita had to catch-up because she had to work with her capacity to trust and communicate with our therapist, while I kind of matched with her straight away. So, we moved at different speeds regarding the couple therapy. I believe that might have been the reason why we didn't get as much benefit from the couple therapy as we might have done otherwise".

"They Connected"

Peter described how the therapist and Maria were able to connect in therapy: "It was really nice to see how the therapist was able to get a really good connection with my ex. How she was able to get under her skin in a very good and honest way." He continued to describe how the quality of his relationship with the therapist was not the same: "And then she didn't connect as well with me, it didn't sadden me. I truly felt like she didn't take sides, but I felt that she really connected with what my ex was feeling".

Second Theme: Relational Breakdown and the Failure of not Renegotiating

Discrepancies in the quality of the relationships between members of the dyad and the therapist and the lack of shared purpose seems to have had implications for the focus of the therapy. Although all participants described how the focus of therapy at some point strayed from being on the relational problems toward the individual problems, especially, the reflections of two couples exemplified this tilt. Maria and Peter saw this progression occur gradually and understood that it happened at the expense of attending to their dysfunctional pattern. While Tara and Samuel could from the onset not come to an agreement upon a common goal for therapy, and thus could not work on their relational problem. In both cases the

therapist seems not to have re-negotiated the therapy to accommodate both members of the dyad.

"Feeling Blamed"

Following his reflection on the emotional connection between Maria and the therapist, Peter expressed how he had experienced the progression of the therapy: "My ex has really visible issues, that are easy to address. My issues are perhaps more hidden. And there are things that I'm probably not aware of when it comes to my family and upbringing. So, it became quite a challenge when the therapist was trying to find my faults to weigh up against my ex's".

Peter's continued reflection related to how he experienced that Maria's individual problems had taken precedence over the family dynamics as the focus of the therapy. He tried to bring his grievance up in a session:

> "One would go to a psychologist or some other place if one needs fix one's problems, but here it's the family dynamics that are important, but she was focused on getting better herself. And of course, that is important, but I was criticized because I brought it up in therapy. I remember the therapist becoming annoyed with me because I mentioned it".

The interviewer followed-up by asking if adjustments were made to pivot the therapy toward working with the relationship, Peter answered: "It continued, it wasn't handled. Instead, I was told that I was being selfish, maybe not in those words but I was given the impression that it was very wrong of me to bring it up". Continuing to reflect upon this Peter said: "But I remember thinking, it's not selfish of me to mention it, of course I wish she would get better, but I don't believe we shall get where we want to be as a family if we don't have a shared focus".

"Because of Me"

When Maria talked about the focus of the therapy, she shared a similar perception as Peter: "I learned so much about myself and things that I didn't even really know. But I do wish it was more focused on us as a couple. I mean, it was mostly focused on me, but not because of Modum Bad or the therapist, but because … . I feel it's just a dynamic. Because of us being there, because of me, so I think it was very focused on me". When questioned if she had wanted the focus of the therapy to be different, she initially agreed, but then expounded upon the importance of the attention she received:

> "I think so… . There was a time I realized that I was getting a lot of help because it was so focused on me, and then I just embraced it. And I was like, you know, if I'm going to be here and the problem is me, then I want all the help I can get. I

> even said to the therapist because she asked me a question and I said – I honestly don't care if it's about me, because I'm in my late thirties and I want to get better. I'm tired of living the way I've been living!"

"I Didn't Know What To Do!"

Samuel did not raise the issue of his infidelity during the interview but shared how he wanted more individual sessions as a response to the communication challenges the couple experienced. In reflecting upon how he could have benefited more from therapy Samuel shared the following reflection:

> "Especially during the period when we were at Modum Bad … . We thought about our problems a lot and sometimes there was a lot of chaos in my head. And many times, I thought, I don't really know how I'm supposed to talk to Tara or even if I should! Maybe I need to rethink, maybe I just need to think about what the therapist told me. There was a lot of chaos in my head and therefore I believe that maybe more individual therapy would have been helpful".

Third Selected Topic: Impact of Trauma

Theme: Trauma and Self-Knowledge

Five out of six participants could not clearly express if traumatic childhood experiences had affected the therapeutic process (e.g., trust, shared sense of purpose). The exception was Anita who referred to her diagnosis as making her in need of special care from the therapist. However, majority of findings regarding the impact of trauma referred to participants acquiring self-knowledge about how their trauma had influenced their emotional patterning and choices in life.

"Regression States"

Maria reflected upon an incident in therapy were the therapist offered her a new perspective on trauma: "There was a session where we talked about regression and how we act when we regress. The therapist was explaining the steps, the physiology and everything that comes with regressing and it made so much sense to me … . Because it felt like in a lot of my days, I was regressing the whole time – like I couldn't think straight. And when she told me, I can become aware of these things, so I can pick up on things, so I can try to change". Maria goes on to share the importance of this piece of psychoeducation: "For me, that was the biggest thing, when the therapist explained to me about regression states".

"My Anger"

Anita did not believe that her current relational problems with her spouse was directly related to the trauma she was exposed to during childhood. However, the intensity of the anger she felt when arguing she granted might have been influenced by the abuse she had suffered: "Maybe I believe, yes surely, the force of the anger I feel has root in the abuse. The power of my anger I could get from the abuse, but I don't think it overshadowed the therapy." She went on to reflect upon where she was in the process of healing from her trauma: "I'm not saying I'm done processing, certainly I'm not, but I've done a lot of work".

"Hard Love"

Peter explained how he several months after hospitalization was still processing the breakup of his marriage. He talked about how he spent time figuring out what went wrong in his marriage. One discovery he shared was how he has become aware of the similarity between the approval he sought in his relationships to his former wife and the love he longed for from his father:

> "When you have an upbringing where love is … One day it could be hell, and then the next day he would come and say he (referring to his father) was sorry. When a child learns to live in such a world, in world where love is unstable… . That's what I got used to. That is the way I've learned to be loved, so then it's easy to make that same choice again (referring to his ex-wife)".

Discussion

The present multiple case study highlights how couples, from their own perspective, experienced receiving intensive, residential CT. The findings of this study add nuance to our current understanding of what are good or poor outcomes in CT. The study serves to elaborate on our understanding of the relationship between trauma and the establishment and maintenance of the therapeutic alliance (Bordin, 1979; Pinsof et al., 2008) and how they interact to influence outcomes.

What are Outcomes?

All participants showed no apparent improvement on family functioning as assessed by self-report questionnaire at the end of treatment and at the time of the interview. Overall, all scores on the FAD were further verbally substantiated by the participants. This finding is in line with previous studies (Tilden, Gude, Hoffart, & Sexton, 2010; Tilden, Gude, Sexton,

et al., 2010), that also recruited participants who had received treatment at the FU. However, despite not having reliably improved according to the FAD, all the participants in the present study mentioned that some positive changes had occurred such as adapting better strategies to handle mental distress, greater understanding of oneself, and/or improved communication. Thus, it makes sense not to talk about outcome of CT as occurring on one level such as benefitting relational functioning or improvement of mental health, but rather as occurring at multiple levels of the family system (Gurman & Kniskern, 1978; Whittaker et al., 2021).

Relationships in Therapy

Our findings share some similarities with previous qualitative studies (e.g., Binder et al., 2009; Østlie et al., 2018) on how patients have experienced psychotherapy, such as the importance of the relationship to the therapist and the perception of the therapist as a person. Our findings also coincide with quantitative studies that indicate that the person of the therapist and his or her ability to establish and maintain a therapeutic relationship is a strong predictor of outcome (e.g., Friedlander et al., 2018; Wampold & Imel, 2015).

All the participants of the study shared reflections on how they and/or their partner struggled to negotiate the alliance both within the subsystem of the couple relationship (Pinsof et al., 2018) and individually with their therapist. The case of Peter and Maria addressed how agreement about the goal of therapy deteriorated throughout treatment until there was a one-sided focus on Maria's individual problems. In the case of Tara and Samuel, they did not agree on what the presented problem was, which was not handled by the therapist who sided with Samuel. As for Tom, Anita, and their therapist, they all agreed upon the goal of the therapy, however the therapist's direct approach was a better fit for Tom. The therapist's inability to adapt her approach to accommodate Anita's emotional needs compromised the alliance between them. These failures to establish and maintain the alliance with both members of the dyad may be considered a split alliance, which is a predictor of poorer outcome (Bartle-Haring et al., 2012; Flückiger et al., 2018; Friedlander et al., 2021). Our finding indicates therefore that a split alliance implies a greater focus on individual problems at the expense of relational problems.

The Impact of Trauma

There exists numerous theories on how traumatic events lead to distress both within the field of clinical psychology (e.g., Ehlers & Clark, 2000;

Van der Kolk, 1994) and couple and family therapy (e.g., Banford Witting & Busby, 2019; Henry et al., 2011). Even though such contributions are of value, we suggest that theories from developmental psychology are complementary for understanding childhood traumas impact on interpersonal functioning and self-understanding. The perspective afforded by developmental psychology also appears to make sense for most of the participants in this study who themselves attach meaning to their childhood experiences.

Childhood abuse survivors' difficulty to trust others is well established in the literature on developmental trauma (e.g., Freyd, 1996; Stein & Allen, 2007), a constraint which is also reflected in the research on the alliance (Anderson et al., 2020). This is exemplified in the case of Anita and her struggle to bond with her therapist where she felt intimidated by the therapist causing her to get overactivated. The therapist's failure to adjust the treatment may have jeopardized Anita to become re-traumatized, and if so, this is associated to poor outcomes (Doob, 1992).

Samuel, the only one who withheld sharing reflections on past trauma instead became occupied talking about his ongoing relational problems. This could be explained due to language barriers and/or avoidant coping strategies (Muller, 2009). Further, hesitance on sharing trauma-related material could also result from lack of trust to the interviewers. The pacing of the interview could also have been an issue. Alternatively, trauma-related information may not have been forthcoming because of a restricted capacity to mentalize – a disadvantage related to having been exposed to traumatic events during childhood (Stein & Allen, 2007). By mentalizing we attribute a person's capacity to interpret one's own behavior or the behavior of others, based on intentional mentals states, such as needs, thoughts, and emotions (Fonagy et al., 1991). A notable exception was Peter who shared discoveries he had made about himself in the period after treatment, linking past experiences to present functioning. However, based on the impression Peter gave during the interview and available background information it is possible to infer that he was the person in the sample who had suffered the least abuse, thus apparently his capacity to mentalize had not been compromised (Herman, 1992; Stein & Allen, 2007). Tom also spoke about reenactment of trauma (Ney, 1988). He was himself a victim of childhood abuse and had turned into a perpetrator as an adult. Ample evidence exists to support the victim perpetrator cycle of physical abuse (Cordero et al., 2012; Widom & Wilson, 2015).

Clinical Implications and Future Research

By understanding what does not work in therapy, we as researchers and clinicians may develop better interventions and help adjust ongoing

practices to accommodate the needs of patients (Pinsof et al., 2018). In some approaches specific interventions are perceived as being the most important facilitators of change, sometimes at the expense of other therapeutic processes (Wampold & Imel, 2015). As our findings suggest, a particular therapeutic approach may not be a good fit for both members of a dyad. We would argue that the therapist should prioritize the establishment of an emotional bond and use it as a platform to negotiate the tasks and goals of the therapy (i.e., what therapy approach would be most beneficial given the couples' idiosyncrasies?). We further propose that this is especially the case if there is a history of trauma as a feeling of safety seems to be a precondition for any further interventions to be successful. A more general suggestion regards the assumption that the effectiveness of couple therapy relies upon an active therapist. An active therapist is considered by many to be a common factor in couple therapy (Sprenkle et al., 2009), an assumption which we also share but which we would like to nuance; therapists should be aware that for some patients with past trauma an overly direct approach might exacerbate trauma symptoms. We speculate that this might be because it inhibits the feeling that the therapeutic relation is a safe space if the therapist is experienced as too confrontational.

Further, couple therapists should be alert if they notice that they are taking sides or if ongoing therapy is becoming overly focused upon individual problems, likely it is at the expense of relational problems (Carr, 2019; Friedlander et al., 2018; Shadish et al., 2003). Such a focus upon individual problems may be an indication that the alliance is split or is in the process of becoming so. One potential negative effect of a split alliance is an increased sense of loneliness. Loneliness has been associated with the onset and preservation of trauma symptoms (Dagan & Yager, 2019). As clinicians we should thus monitor patients' progress (Tilden & Wampold, 2017) and invite them to participate in discussions on what they as a couple hope to achieve as a result of therapy. Relational problems will most likely only be alleviated if they are stated in relational terms and not as being the problem of one member of the dyad (Sprenkle et al., 2009). Failing to do so, especially with couples who have histories of trauma, may lead to re-traumatization and poorer outcomes. Given our findings we also want to stress the necessity of adequate follow-up for families who have received inpatient treatment to maintain positive therapeutic gains and prevent relapse.

To further elaborate on how couples and family systems who are affected by trauma change, researchers should use mixed methods integrating quantitative and qualitive research (Ivankova et al., 2006; Seawright & Gerring, 2008). For example, the findings in this study may inform the

hypothesizing of the relationship between trauma and the alliance which may be explored using a longitudinal quantitative design. Such a design may be suited to answer questions about the magnitude of the proposed trauma – alliance association and its relationship to outcome.

Limitations

Our findings may be considered limited because of the sampling techniques that were applied. The idiosyncrasies of the resulting sample make the findings less generalizable than if we were to implement broader inclusion criterions. However, better understanding the characteristics of a deviant sample helps generate important hypotheses, and since the sample is commonplace in a clinical situation the findings may be of interest to clinicians. The quality of the data may also have become degraded due to several reasons, for instance, the time interval from end of treatment to the interview was circumstantial, likely to cause variation in the quality of recall.

Telecommunications and videoconferencing were the only options for two of the interviews because of the outbreak of the COVID-19 pandemic, which may have affected the quality of the interviews. Language was likely also a barrier which may have negatively affected the quality of the data. For those participants in our sample with a different cultural background, one may speculate whether having received similar treatment within their culture of origin could have resulted in a different therapy outcome. But given the rarity of the phenomenon we wished to explore these were compromises we had to make to complete the study within the allocated time.

Conclusion

When couples' disagreement on what is the goal of therapy is not handled adequately by the therapist, the alliance may become split. Our findings support and extend the study by Whittaker et al. (2021) where a subgroup of patients with histories of childhood trauma who attended CT did not benefit as much as patients who did not have such experiences. One may hypothesize that failure to renegotiate the split alliance promotes a more individual-oriented therapy at the expense of alleviating relational distress. This process is most likely influenced by past trauma, but the magnitude of this association is unknown.

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References

Anderson, S. R., Banford Witting, A., Tambling, R. R., Ketring, S. A., & Johnson, L. N. (2020). Pressure to attend therapy, dyadic adjustment, and adverse childhood experiences: Direct and indirect effects on the therapeutic alliance in couples therapy. *Journal of Marital and Family Therapy*, *46*(2), 366–380. https://doi.org/10.1111/jmft.12394

Bailey-Rodriguez, D. (2021). Qualitatively driven mixed-methods approaches to counselling and psychotherapy research. *Counselling and Psychotherapy Research*, *21*(1), 143–153. https://doi.org/10.1002/capr.12383

Banford Witting, A., & Busby, D. (2019). The long arm of trauma during childhood: Associations with resources in couple relationships. *Journal of Marital and Family Therapy*, *45*(3), 534–549. https://doi.org/10.1111/jmft.12354

Barbato, A., & D'Avanzo, B. (2008). Efficacy of couple therapy as a treatment for depression: A meta-analysis. *The Psychiatric Quarterly*, *79*(2), 121–132. https://doi.org/10.1007/s11126-008-9068-0

Bartle-Haring, S., Glebova, T., Gangamma, R., Grafsky, E., & Delaney, R. O. (2012). Alliance and termination status in couple therapy: A comparison of methods for assessing discrepancies. *Psychotherapy Research: Journal of the Society for Psychotherapy Research*, *22*(5), 502–514. https://doi.org/10.1080/10503307.2012.676985

Binder, P.-E., Holgersen, H., & Nielsen, G. H. s. (2009). Why did I change when I went to therapy? A qualitative analysis of former patients' conceptions of successful psychotherapy. *Counselling and Psychotherapy Research*, *9*(4), 250–256. https://doi.org/10.1080/14733140902898088

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252–260. https://doi.org/10.1037/h0085885

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Carr, A. (2019). Couple therapy, family therapy and systemic interventions for adult-focused problems: The current evidence base. *Journal of Family Therapy*, *41*(4), 492–536. https://doi.org/10.1111/1467-6427.12033

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders*, *82*(2), 217–225. https://doi.org/10.1016/j.jad.2003.12.013

Cloitre, M., Garvert, D. W., Weiss, B., Carlson, E. B., & Bryant, R. A. (2014). Distinguishing PTSD, complex PTSD, and borderline personality disorder: A latent class analysis. *European Journal of Psychotraumatology*, *5*(1), 25097. https://doi.org/10.3402/ejpt.v5.25097

Colman, R. A., & Widom, C. S. (2004). Childhood abuse and neglect and adult intimate relationships: A prospective study. *Child Abuse & Neglect*, *28*(11), 1133–1151. https://doi.org/10.1016/j.chiabu.2004.02.005

Cordero, M. I., Poirier, G. L., Marquez, C., Veenit, V., Fontana, X., Salehi, B., Ansermet, F., & Sandi, C. (2012). Evidence for biological roots in the transgenerational transmis-

sion of intimate partner violence. *Translational Psychiatry*, *2*(4), e106. https://doi.org/10.1038/tp.2012.32

Curran, P. J., & Bauer, D. J. (2011). The disaggregation of within-person and between-person effects in longitudinal models of change. *Annual Review of Psychology*, *62*, 583–619. https://doi.org/10.1146/annurev.psych.093008.100356

Dagan, Y., & Yager, J. (2019). Addressing loneliness in complex PTSD. *The Journal of Nervous and Mental Disease*, *207*(6), 433–439. https://doi.org/10.1097/NMD.0000000000000992

Doob, D. (1992). Female sexual abuse survivors as patients: Avoiding retraumatization. *Archives of Psychiatric Nursing*, *6*(4), 245–251. https://doi.org/10.1016/0883-9417(92)90068-T

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*(4), 319–345. https://doi.org/10.1016/S0005-7967(99)00123-0

Epstein, N. B., Baldwin, L. M., & Bishop, D. (1983). The McMaster family assessment device*. *Journal of Marital and Family Therapy*, *9*(2), 171–180. https://doi.org/10.1111/j.1752-0606.1983.tb01497.x

Flick, U. (2018). *An introduction to qualitative research*. Sage.

Flückiger, C., Del Re, A., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316–340. https://doi.org/10.1037/pst0000172

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, *12*(3), 201–218. https://doi.org/(199123)12:3<201::aid-imhj2280120307>3.0.co;2-7

Freyd, J. J. (1996). Betrayal trauma. In *Encyclopedia of psychological trauma*. Harvard Univeristy Press.

Friedlander, M. L., Escudero, V., Welmers-van de Poll, M. J., & Heatherington, L. (2018). Meta-analysis of the alliance-outcome relation in couple and family therapy. *Psychotherapy*, *55*(4), 356–371. https://doi.org/10.1037/pst0000161

Friedlander, M. L., Hynes, K., Anderson, S., Tambling, R., Megale, A., Xu, M., & Peterson, E. K. (2021). Examining behavioral manifestations of split alliances in four couple therapy sessions. *Journal of Couple & Relationship Therapy*, 1–24. https://doi.org/10.1080/15332691.2021.1876593

Grubaugh, A. L., Zinzow, H. M., Paul, L., Egede, L. E., & Frueh, B. C. (2011). Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review*, *31*(6), 883–899. https://doi.org/10.1016/j.cpr.2011.04.003

Gurman, A. S., & Kniskern, D. P. (1978). Deterioration in marital and family therapy: Empirical, clinical, and conceptual issues. *Family Process*, *17*(1), 3–20. https://doi.org/10.1111/j.1545-5300.1978.00003.x

Heatherington, L., Friedlander, M. L., Diamond, G. M., Escudero, V., & Pinsof, W. M. J. P. R. (2015). 25 years of systemic therapies research: Progress and promise. *Psychotherapy Research : Journal of the Society for Psychotherapy Research*, *25*(3), 348–364. https://doi.org/10.1080/10503307.2014.983208

Henry, S. B., Smith, D. B., Archuleta, K. L., Sanders-Hahs, E., Goff, B. S. N., Reisbig, A. M. J., Schwerdtfeger, K. L., Bole, A., Hayes, E., Hoheisel, C. B., Nye, B., Osby-Williams, J., & Scheer, T. (2011). Trauma and couples: Mechanisms in dyadic functioning. *Journal of Marital and Family Therapy*, *37*(3), 319–332. https://doi.org/10.1111/j.1752-0606.2010.00203.x

Herman, J. L. J. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5*(3), 377–391. https://doi.org/10.1002/jts.2490050305

Ivankova, N. V., Creswell, J. W., & Stick, S. L. (2006). Using mixed-methods sequential explanatory design: From theory to practice. *Field Methods*, *18*(1), 3–20. https://doi.org/10.1177/1525822X05282260

Johnson, S. M. (2002). *Emotionally focused couple therapy with trauma survivors: Strengthening attachment bonds*. Guilford Press.

Lambert, M. J. (2013). Outcome in psychotherapy: The past and important advances. *Psychotherapy (Chicago, IL)*, *50*(1), 42–51. https://doi.org/10.1037/a0030682

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin*, *142*(8), 801–830. https://doi.org/10.1037/bul0000057

Liebman, R. E., Whitfield, K. M., Sijercic, I., Ennis, N., & Monson, C. M. (2020). Harnessing the Healing power of relationships in trauma recovery: A systematic review of cognitive-behavioral conjoint therapy for PTSD. *Current Treatment Options in Psychiatry*, *7*(3), 203–218. https://doi.org/10.1007/s40501-020-00211-1

Mauritz, M. W., Goossens, P. J., Draijer, N., & Van Achterberg, T. (2013). Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology*, *4*(1), 19985. https://doi.org/10.3402/ejpt.v4i0.19985

McLeod, J. (2010). *Case study research in counselling and psychotherapy*. Sage Publications.

Muller, R. T. (2009). Trauma and dismissing (avoidant) attachment: Intervention strategies in individual psychotherapy. *Psychotherapy*, *46*(1), 68–81. https://doi.org/10.1037/a0015135

Ney, P. G. (1988). Transgenerational child abuse. *Child Psychiatry and Human Development*, *18*(3), 151–168. https://doi.org/10.1007/BF00709728

Østlie, K., Stänicke, E., & Haavind, H. (2018). A listening perspective in psychotherapy with suicidal patients: Establishing convergence in therapists and patients private theories on suicidality and cure. *Psychotherapy Research: Journal of the Society for Psychotherapy Research*, *28*(1), 150–163. https://doi.org/10.1080/10503307.2016.1174347

Pinsof, W. M., Breunlin, D. C., Russell, W. P., Lebow, J., & Chambers, A. L. (2018). *Integrative systemic therapy: Metaframeworks for problem solving with individuals, couples and families*. American Psychological Association.

Pinsof, W. M., Zinbarg, R., & Knobloch-Fedders, L. M. J. F. P. (2008). Factorial and construct validity of the revised short form integrative psychotherapy alliance scales for family, couple, and individual therapy. *Family Process*, *47*(3), 281–301. https://doi.org/10.1111/j.1545-5300.2008.00254.x

Rozental, A., Castonguay, L., Dimidjian, S., Lambert, M., Shafran, R., Andersson, G., & Carlbring, P. (2018). Negative effects in psychotherapy: Commentary and recommendations for future research and clinical practice. *BJPsych Open*, *4*(4), 307–312. https://doi.org/10.1192/bjo.2018.42

Seawright, J., & Gerring, J. (2008). Case selection techniques in case study research: A menu of qualitative and quantitative options. *Political Research Quarterly*, *61*(2), 294–308. https://doi.org/10.1177/1065912907313077

Shadish, W. R., Baldwin, S. A. J. J. M., & Therapy, F. (2003). Meta-analysis of MFT interventions. *Journal of Marital and Family Therapy*, *29*(4), 547–570. https://doi.org/10.1111/j.1752-0606.2003.tb01694.x

Shi, L. (2020). Trauma symptoms and relationship satisfaction: An examination of self and partner contribution in dual-trauma outpatient clinical couples. *The American Journal of Family Therapy*, *49*(1), 1–15. https://doi.org/10.1080/01926187.2020.1845251

Smith, J. A. (2003). *Qualitative psychology: A practical guide to research methods*. Sage Publications.

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. Guilford Press.

Stänicke, L. I., Haavind, H., Rø, F. G., & Gullestad, S. E. (2020). Discovering one's own way: Adolescent girls' different pathways into and out of self-harm. *Journal of Adolescent Research*, *35*(5), 605–634. https://doi.org/10.1177/0743558419883360

Stein, H., & Allen, J. G. (2007). Mentalizing as a framework for integrating therapeutic exposure and relationship repair in the treatment of a patient with complex posttraumatic psychopathology. *Bulletin of the Menninger Clinic*, *71*(4), 273–290. https://doi.org/10.1521/bumc.2007.71.4.273

Suardi, F., Rothenberg, M., Serpa, S. R., & Schechter, D. (2017). Trauma and parenting: Informing clinical practice with recent research findings. *Current Treatment Options in Pediatrics*, *3*(1), 1–14. https://doi.org/10.1007/s40746-017-0075-y

Taft, C. T., Watkins, L. E., Stafford, J., Street, A. E., & Monson, C. M. (2011). Posttraumatic stress disorder and intimate relationship problems: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *79*(1), 22–33. https://doi.org/10.1037/a0022196

Tilden, T., & Wampold, B. E. (Eds.). (2017). *Routine outcome monitoring in couple and family therapy: The empirically informed therapist*. Springer.

Tilden, T., Gude, T., & Hoffart, A. (2010). The course of dyadic adjustment and depressive symptoms during and after couples therapy: A prospective follow-up study of inpatient treatment . *Journal of Marital and Family Therapy*, *36*(1), 43–58. https://doi.org/10.1111/j.1752-0606.2009.00187.x

Tilden, T., Gude, T., Hoffart, A., & Sexton, H. (2010). Individual distress and dyadic adjustment over a three-year follow-up period in couple therapy: A bi-directional relationship? *Journal of Family Therapy*, *32*(2), 119–141. https://doi.org/10.1111/j.1467-6427.2010.00490.x

Tilden, T., Gude, T., Sexton, H., Finset, A., & Hoffart, A. (2010). The associations between intensive residential couple therapy and change in a three-year follow-up period. *Contemporary Family Therapy*, *32*(1), 69–85. https://doi.org/10.1007/s10591-009-9104-8

Van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry*, *1*(5), 253–265. https://doi.org/10.3109/10673229409017088

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge.

Whittaker, K. J., Johnson, S. U., Solbakken, O. A., Wampold, B., & Tilden, T. (2021). Childhood trauma as a predictor of change in couple and family therapy: A study of treatment response. *Couple and Family Psychology: Research and Practice*. https://doi.org/10.1037/cfp0000181

Widom, C. S., & Wilson, H. W. (2015). Intergenerational Transmission of Violence. In: Lindert J., Levav I. (eds) Violence and Mental Health (pp. 27–45). Springer. https://doi-org.ezproxy.uio.no/10.1007/978-94-017-8999-8_2

Wiebe, S. A., & Johnson, S. M. (2016). A review of the research in emotionally focused therapy for couples. *Family Process*, *55*(3), 390–407. https://doi.org/10.1111/famp.12229

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines* (Vol. 1). World Health Organization.

III

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ORIGINAL ARTICLE

Treated together–changed together: The application of dyadic analyses to understand the reciprocal nature of alliances and couple satisfaction over time

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Abstract
In a Norwegian study of 73 couples attending a residential couple therapy program lasting between 6 and 12 weeks, weekly self-report data on therapy alliance and couple satisfaction were collected using routine outcome monitoring (ROM). The aim was to show how dyadic analyses could be applied to examine the predictive association between alliances and couple satisfaction. Results showed that improved alliance between dyad members and their couple therapist predicted their spouses' couple satisfaction. Furthermore, improved couple satisfaction predicted improvement in spouse's alliance. The clinical implication of these findings should heighten awareness to the importance of establishing and maintaining the alliance of male partners in couple therapy, something that predicts their spouses' couple satisfaction. These findings help nuance the already existing literature on the working alliance. Furthermore, we propose that

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dyadic analyses should be widely used in any psychotherapeutic research that aims to understand the reciprocal effects of dyads.

KEYWORDS

clinical evidence-based, outcomes, populations assessment/diagnosis, research couples, research process, theory/model

A major limitation of quantitative research conducted within the field of couple therapy is that it has been done almost exclusively at the individual level of analysis. The individual level refers to changes in self-perceived intrapsychic or interpsychic functioning which is analyzed without taking the reciprocal nature of relationships into account (Kenny et al., 2020). Of particular interest to researchers and practitioners of couple therapy are effects of reciprocity at the dyadic level (e.g., increased relationship satisfaction) or family level (e.g., improved family functioning; Gurman & Kniskern, 1978). The approach of solely considering the individual level ignores reciprocal effects (i.e., how dyad members' behaviors influence on one another) thus constituting a restriction because it only reveals how an individual respondent changes from one point of assessment to another. Although this is a known limitation within the field of couple therapy research it is either dealt with by handling quantitative data insufficiently or by shunning such methods altogether (Ochs et al., 2020). Examples of the former are averaging outcome scores between dyad members or running separate analyses for husbands and wives. In both these examples one does not account for interdependence between scores (i.e., nested data) and as such the phenomenon of interest, that is, the reciprocal nature of relationships, is omitted as the object of research (Kenny et al., 2020).

In this article, we aim to present an alternative to analyzing data at the individual level and we will be doing so by investigating the associations between therapeutic alliance (i.e., the emotional bond between the therapist and client, and their agreement upon the tasks and goal of therapy; Bordin, 1979) and couple relationship satisfaction. Even though a large body of literature has been dedicated to this topic, demonstrating that the strength of the alliance between the therapist and the client is predictive of the treatment outcome (Del Re et al., 2021; Flückiger et al., 2018; Friedlander et al., 2018), our study objective is to further nuance such findings by showing how dyadic analysis (Kenny et al., 2020) can be applied to identify reciprocal effects across time.

Dyadic analyses (Kenny et al., 2020) is a methodological adaptation to already existent statistical approaches such as mixed modeling (MM; Curran & Bauer, 2011) or structural equation modeling (SEM; Weston & Gore, 2006). As the name of the methods collectively known as dyadic analysis implies, it shifts the level of analysis from the individual to the dyadic. Dyadic analyses are applicable to data collected at one or several timepoints to inquire into a suggested covariation between dyad members. The use of dyadic analyses as a tool to analyze longitudinal data is of great interest. Such longitudinal studies have the potential of identifying moderators and mediators (i.e., processes) of treatment outcomes across time (Kazdin, 2007). As the implementation of routine outcome monitoring (ROM; Tilden & Wampold, 2017) is becoming standard practice within many clinics, the generation of frequently collected data has soared. Such data are applicable within longitudinal research designs to increase our understanding of how systems change over time. In the present study,

we are examining how reciprocal effects evolve over time and have thereby chosen to conceptualize the nested nature of dyadic data within the framework of the actor-partner interdependence model (APIM; Cook & Kenny, 2005). In the APIM reciprocal effects are named actor-partner effects (Cook & Kenny, 2005). See Figure 1 for a visual representation of the APIM. If instead change is assumed to occur in a deterministic fashion a dyadic growth curve model may be suitable. We refer to Kenny et al. (2020) for an in-depth discussion on how to select the best fitting model for longitudinal dyadic datasets.

Contrary to the central assumption in linear quantitative methods—that observations (i.e., data) are independent from one another (Kenny et al., 2020), the fundamental assumption of the APIM is nonindependence of data. Nonindependence proposes that people who are in the same condition, such as a couple attending therapy together, would have interdependent outcome scores. Thus, their behaviors during therapy (e.g., their alliances with their couple therapist) may not just predict their own outcome (e.g., relationship satisfaction) but also the outcome of their partner. Dyadic analysis allows for testing of such assumed reciprocal effects, that is, a test of nonindependence.

Nonindependence may originate from different sources such as compositional effects (e.g., similarity in personality; Klohnen & Luo, 2003), common fate (e.g., shared contextual factors; Ledermann et al., 2010) and actor-partner effects (e.g., effect of husbands depression on spouses marital satisfaction; Kenny, 1996; Kenny et al., 2020). Compositional effects are not of particular interest to couple therapy researchers as they likely represent traits that are less malleable and thus do not greatly impact how such systems change over the timespan of therapy (Kenny, 1996). In the following, we will only be discussing actor-partner effects as a source of nonindependence within the APIM. For a detailed discussion on when to choose the common fate model rather than the APIM, we refer to Galovan et al. (2017) for further reading.

As can be inferred from several meta-analyses within the couple therapy research literature (Rathgeber et al., 2019; Roddy et al., 2020; Shadish & Baldwin, 2003; Shadish & Baldwin, 2005)—a vast majority of studies applied research designs neglecting the investigation of reciprocal effects. At best such studies show how individuals change from one point to another (usually just two timepoints) in accordance with the nomothetic approach (i.e., with the objective of making general predictions about the population; Beltz et al., 2016). They do not divulge how dyads change across time and are thereby of limited interest beyond illustrating the general efficacy of treatments. Although there exists a growing body of research that applies dyadic

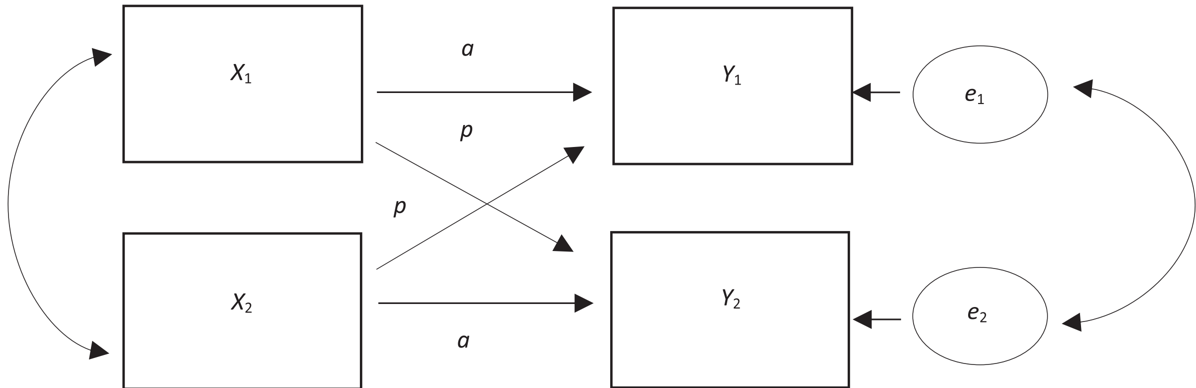

FIGURE 1 APIM for overtime data. X = process variable; Y = outcome variable; a = actor effect; p = partner effect; e = error. In a cross-lagged design, this pattern is repeated with Y variable being lagged one timepoint after the X variable. The presented model is adapted from Kenny et al. (2020).

analyses to study reciprocal effects, most of them are within the fields of social psychology, and family and developmental studies (Kenny et al., 2020). Despite the benefits of dyadic analyses being apparent, its application in couple therapy research has to the authors' knowledge so far been sparse.

Anderson and Johnson (2010) seminal paper on therapeutic alliances was most likely the first scientific publication to introduce the APIM to the field of couple therapy. A common drawback of the studies conducted (e.g., Anderson & Johnson, 2010; Anderson et al., 2020; Bergeron et al., 2020)—is that they include a limited set of assessment points. Essentially, this means they reveal reciprocal influences, but not across time. In our present study, we aim to show how dyadic analyses may be used in a longitudinal design to address therapeutic alliances and relationship satisfaction as the objectives measured frequently throughout the course of treatment. Hence, we examine how members of dyads reciprocally influenced each other when they conjointly attended intensive inpatient couple therapy. The high frequency of assessment points and juxtapositioning of the outcome variable with the process variable was done with the intention of further investigating the link between alliances and relationship satisfaction. Hence the goal of this study is twofold, both echoing the purpose of Anderson and Johnson (2010) pioneering work and expanding upon their research questions. First, we will do so by familiarizing readers with dyadic analyses and how it may be applied by using MM and conceptualized within the APIM to study processes and outcomes in couple therapy. MM was chosen as it is considered the most flexible approach to estimating the APIM (Kenny et al., 2020). Second, we will advance knowledge of how therapist-client alliances are associated with relationship satisfaction across time in the context of inpatient couple therapy. In accordance with this latter aim, we will investigate the following research questions:

1. Does the individual's alliance with the therapist predict his or her own couple relationship satisfaction across time? (Actor effect).
2. Does the individual's alliance with the therapist predict their partner's couple relationship satisfaction across time? (Partner effect).
3. Does the individual's couple relationship satisfaction predict his or her own alliance with the therapist across time? (Actor effect).
4. Does the individual's couple relationship satisfaction predict the alliance of their partner with the therapist across time? (Partner effect).
5. Are any actor and partner effects influenced by gender? (Gendered).

METHODS

Ethical approval

The authors of this article applied for ethical approval of this study. The subsequent approval was granted by the Regional Ethical Committee (REFNUM 2018/148).

Treatment

This is a naturalistic study of couple therapy in a residential clinic within the Norwegian Public Healthcare system, the Family Unit (FU) at Modum Bad Psychiatric Center, located in

Vikersund, Norway. Due to public health insurance treatment is free of charge. Couples stayed at the FU for approximately 6–12 weeks. They were referred to the FU by their general practitioner, often in collaboration with local mental healthcare providers. Although children ranging from 1–16 years of age also accompany their parents during hospitalization, they are not actively involved in therapy and are therefore not further discussed. The criteria for hospitalization were that at least one member of the couple was diagnosed with a mental disorder according to the International Classification of Disease 10th ed. (ICD-10; World Health Organization, 1992) and that they suffered from coexistent relational distress (e.g., extensive verbal abuse, problems with intimacy, the stress of parenting, or extramarital affairs). All who applied for hospitalization at the FU were interviewed by staff about their psychiatric and relational histories to assess if the treatment program was suitable for them. Before considering hospitalization at the FU, it was assessed that prior treatment provided by local mental healthcare was unsuccessful. All hospitalizations at the FU were planned. People who were actively suicidal, psychotic, or had ongoing substance abuse were not admitted to the FU, and neither were couples with ongoing interpersonal physical violence.

The FU has a total of 12 therapists (of whom 66.67% were women, with the average age of 44.58, and with 7.16 years average length of basic and ongoing education as mental healthcare professionals) servicing each of the nine couples committed at any given time. All the couples were treated by at least two therapists (either a clinical psychologist, psychiatrist, or family therapist coupled with a specialist nurse and/or family therapist). A medical doctor examined all patients at intake. Couple therapy as applied within this unit should be understood as an integrated part of a comprehensive treatment program, thus comprising a greater variety of treatment components than what is common within regular outpatient couple therapy services. Such components include semiweekly couple therapy sessions (e.g., emotionally focused, psychodynamic, and collaborative), a weekly art therapy session, a weekly psychoeducation session, and semiweekly physical exercise sessions. The treatment program offered at the FU although targeting the couple relationship does not adhere to a specific therapeutic model but is best understood as the integration of the systemic and individual perspectives. Thus, a range of intervention strategies applied was drawn from individual, couple, and family therapy models. For a detailed description of the treatment program, we refer to Tilden (2008). All therapists participated in a biweekly peer-counseling with an external supervisor, and weekly supervision making use of the information from patients' structured feedback with an internal supervisor. As this project was naturalistic and plural, non-manualized therapeutic approaches were applied, thus no adherence to any specific couple therapy model was monitored.

Participants

All patients hospitalized at the FU between January 2018 and April 2021 were eligible for inclusion. Of the 196 patients invited to participate in the current study, 169 gave their informed consent. A further 23 were excluded because they did not meet the inclusion criteria, either because they were not hospitalized with their spouse or because they were not in a heterosexual relationship. Thus, 146 individuals constituting 73 heterosexual couples made up the present sample. The mean age was 40.99 years (SD 7.56, range 24–61). A total of 74.7% of the participants were either before or during hospitalization diagnosed with a psychiatric disorder, 23.7% fulfilled the criteria for two diagnoses, while 4.8% fulfilled the criteria for three diagnoses. The most common category of diagnoses was affective disorders (34.2%) and

adjustment disorders (33.5%) including posttraumatic stress disorder (PTSD). A significant higher proportion of women (83.5%) had such diagnosis than men (65.7%, χ^2, $p = 0.014$).

Of the 146 participants, 82.1% ($n = 120$) had completed a form on medication use during treatment. Of these respondents, 34.9% reported the use of medication at intake (18.3% antidepressants, 8.3% analgesics, 5% antianxiety, and 3.3% hypnotics). A further 12.5% reported using a second medication (7.5% hypnotics, 3.3% antianxiety, and 1.7% analgesics), while 5.8% of these participants used three or more medications (3.3% hypnotics and 2.5% analgesics) at the time of hospitalization. At the end of treatment, 32.5% reported using a medication. The use of a second medication had been reduced to 9.2%, while the use of three or more medications had been reduced to 5%. However, these reductions from pretreatment to posttreatment on medication use both in general as well as the use of a second medication (from 34.9% to 32.5%, and from 12.5% to 9.2%, respectively) were nonsignificant (χ^2 0.15, $p = 0.69$ and χ^2 0.67, $p = 0.41$, respectively).

Of those participants that had completed, the form on medication use ($n = 120$), 18.3% reported to their therapist that they had been the victim of sexual abuse during childhood, while 19.7% had been exposed to childhood physical abuse, and a further 48.3% reported having experienced other traumatic events during childhood. More than half (54.6%) of the respondents had experienced incidents of repeated trauma during childhood. Of the households ($n = 60$) represented by these respondents, 41.6% had an adult family member (i.e., parent or spouse) who had been exposed to repeated traumatic events during childhood. For exposure to repeated traumatic events during the adulthood, the amount households affected are 36.6%. A number of participants out of the these 82.1% had also been forthcoming in divulging histories of addiction (15.8%), and/or self-harm (14.2%), and/or attempts at suicide (7.5%).

Procedure

Systematic collection of frequent measurements and their application as feedback in therapy sessions, supervision, and data in research has been a longstanding practice at the FU. Frequent measurements were conducted every week during hospitalization. All questionnaires were self-report and completed online.

Weekly measures

The Revised Dyadic Adjustment Scale (RDAS; Busby et al., 1995) is a widely used 14-item questionnaire providing a global measure of each partner's assessed consensus, satisfaction, and cohesion toward their spouse. The scoring range is 0–69 with higher scores representing better adjustment and with 48 as a cutoff. The RDAS shows acceptable psychometric properties (Busby et al., 1995). Cronbach's alpha was at admission 0.81 and 0.85 at end of treatment.

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) is a widely used questionnaire to assess the therapeutic alliance between the therapist and client. Seven items (two goal, two task, and three bond-related questions) from the WAI were included in the battery of questionnaires that the participants completed weekly. Studies on short versions of the WAI have demonstrated good psychometric properties (Hatcher & Gillaspy, 2006; Munder et al., 2010). Higher scores on the WAI represent a stronger working alliance. Cronbach's alpha was at admission 0.88 and 0.90 at end of treatment.

Statistical analyses

The data set includes frequent assessments from the beginning of treatment until the end of treatment and was analyzed as a two-level structure (weekly observations of participants nested within their respective dyads) using longitudinal MM (Curran & Bauer, 2011). With up to 12 measurement waves the data set meets the requirements proposed by Singer et al. (2003) for the application of MM. To be able to perform a dyadic data analysis the data had to be organized in a pairwise data structure as suggested by Kenny et al. (2020). The pairwise restructuring also resulted in a long-format data set—a prerequisite for longitudinal data analysis. A webinar created by West and Thorson (2017a) gives a practical guide on how to restructure from an individual format to a pairwise format.

Unlike traditional models for frequent measures, MM's can effectively manage missing data, because it is based on maximum likelihood (ML). ML is considered "state of the art" for handling missing data (Schafer & Graham, 2002). ML uses all the available data, complete and incomplete, to identify the parameter values that have the highest probability of producing the sample data. Thus, all 73 dyads participating in the study were included even if data was partially missing. Research indicates that ML is preferable to multiple imputations when using longitudinal data (Shin et al., 2017).

A dummy variable (gender) was construed for distinguishing between two members from the same dyad. The primary reason for using gender as the distinguishing variable instead of other variables of interest such as the presence of a psychiatric disorder, was because it granted the highest possible sample size and allowed for interpreting the data within a gender framework. More importantly, the inclusion of a dummy variable permitted the assessment of the explained variance of each dyad member's estimated scores and to what extent these scores correlated. The resulting correlation coefficient is our measure of nonindependence (Kenny et al., 2020).

All process variables were mean centered. In our first analyses, the WAI constituted the process variable and the RDAS was used as the outcome variable. We then reran the analyses by applying the RDAS as the predictor variable and the WAI as the outcome variable. This was done to investigate other patterns of influence than those generally assumed in the literature on the working alliance (i.e., the alliance as a predictor of outcome; Flückiger et al., 2018; Friedlander et al., 2018).

Timepoints were centered, and a dummy variable we called obs_id was construed to give every dyad a unique id for every timepoint. We time-lagged the mean-centered process variables to allow for cross-lagged regressions analysis for the estimation of how scores from one timepoint predict the estimated scores at the following timepoint. The time-lag procedure we adhered to is described by West and Thorson (2017b). The APIM served as the conceptual model for the cross-lagged regressions analysis. The equation for this model is:

$$Y_{1ti} = c_{1i} + a_{1i} Y_{1,t-1,i} + p_{12i} Y_{2,t-1,I} + e_{1ti}$$

$$Y_{2ti} = c_{2i} + a_{2i} Y_{2,t-1,i} + p_{12i} Y_{1,t-1,I} + e_{2ti}$$

In our analysis, i represents the dyad while the $Y's$ represents the assessed variable of each dyad member at timepoints t and $t-1$ (i.e., time-lagged by 1). The $a's$ represent the actor effects and the $p's$ represent partner effects, while e represents the error terms for each member of the dyad. The intercept of each dyad member is denoted by c_1 and c_2 respectively. According to our equation, there are six parameters (two actor, two partner, and two intercepts) that may vary across dyads as well as covary with each other. The two error terms (one for each dyad member) are of special importance as they potentially correlate. This correlation between error

or r_{ee}, measures to which extent the two members of a dyad are similar or not from one timepoint to another (i.e., assessment of nonindependence).

Following the steps proposed by Kenny et al. (2020), we were able to analyze our data within a cross-lagged framework in SPSS v. 27. Kenny et al. (2020) approach to dyadic cross-lagged regressions analysis recommends starting modelbuilding with a fully saturated model, simplifying the model if it does not run. In our study's model, the random effects were removed. This decision was made because the results after applying random effects were not a definitive positive even though all convergence criteria were satisfied. This implied that the validity of the results could not be ascertained. On further inspection of the output, it became clear that the random effects were either not significant or were otherwise considered redundant. Running the model without random effects resulted in no further hindrances. Thus, their removal resulted in a more parsimonious model. The applied covariance structure CSH (compound symmetry: heterogenous) produces separate error variances for each dyad member, which is central to establish the degree of nonindependence between member scores. We also implemented test statements which are necessary to assess if differences between dyad members were significant. Thus, the results from the test statements further controlled for gender allowing for easier interpretation of the results (i.e., whether the one effect is stronger than the other). We refer to a webinar by David Kenny (2015) for a step-by-step walkthrough on how to build a MM including test statements and interpreting the output.

RESULTS

Descriptive statistics

See Table 1 for descriptive statistics of the included variables on the individual level of assessment. See Table 2 for Pearson's correlations of the included variables on pre- and posttest assessments.

Test of nonindependence

The dyadic analyses showed that the error variances for the females were slightly higher than the error variances for males when the WAI was considered as the covariate ($e_1 = 67.48$,

TABLE 1 Descriptive statistics on the individual level.

Instrument	Type of test	*N*	*M* (*SD*)	Range
RDAS	Pretest	136	39.48 (7.85)	20–55
	Posttest	132	46-05 (7.6)	21–61
WAI	Pretest	129	37.12 (7.27)	7–49
	Posttest[a]	63	44.54 (5.61)	17–49

Abbreviations: *M*, mean; *N*, total sample; RDAS, Revised Dyadic Adjustment Scale; *SD*, standard deviation; WAI, working alliance inventory.

[a]There are less completed WAI questionnaires at posttest since it is scheduled after the patients have had their last couple session, many have therefore assumingly chosen not to fill out the questionnaire.

TABLE 2 Pearson correlations.

	RDAS pretest	WAI pretest	RDAS posttest	WAI posttest
RDAS pretest	–	−0.03	0.43**	0.08
WAI pretest	−0.03	–	0.04	0.36**
RDAS posttest	0.43**	0.04	–	0.16
WAI posttest	0.08	0.36**	0.16	–

Abbreviations: RDAS, Revised Dyadic Adjustment Scale; WAI, Working Alliance Inventory.

**$p < 0.01$.

$e_2 = 61.6$, respectively). According to Cohen (1992) the correlation between these error variances may be assessed as large ($d = 0.59$, $p < 0.001$). When the RDAS was applied as the covariate the results were similar, but the males' error variances were slightly higher than their partners' ($e_2 = 30.08$, $e_1 = 24.08$, respectively). The correlation between these scores may be considered medium ($d = 0.34$, $p < 0.001$). These results suggest that these scores between dyad members are nonindependent.

The RDAS as the outcome variable with the WAI as the process variable

The results of the dyadic analyses show that there was a main effect of gender on the intercept of the RDAS (estimates of 40.28, $p < 0.001$, and 42.73, $p < 0.001$ for females and males, respectively). Our test statements show that the difference between these estimated scores on the intercept was significant (estimate 2.45, $p < 0.001$). There was also a significant and positive main effect of time on the estimated RDAS scores (estimate 0.31, estimate $p = 0.005$).

There was a significant negative actor effect regarding the males' WAI scores' influence on the RDAS scores from one week to the next (estimate −0.31, $p < 0.001$). Further, there was a positive partner effect of the males' WAI scores' influence on the females' RDAS scores from one week to the next (estimate 0.25, $p = 0.001$). These gendered actor and partner effects were further supported by the test statements (estimate −0.34, $p = 0.002$, and estimate 0.22, $p = 0.042$, respectively). The average actor and partner effects according to the test statements were also significantly different between genders (estimate −0.14, $p = 0.007$, estimate 0.14, $p = 0.007$, respectively).

The WAI as the outcome variable and the RDAS as the process variable

The results of the dyadic analyses show that there was a main effect of gender on the intercept of the WAI (estimate 42.48, <0.001 and estimate 41.97, $p < .001$ for females and males, respectively). Our test statements show that the difference between these scores on the intercept was nonsignificant ($p = 0.1$). There was a significant positive main effect of time on the estimated WAI scores (estimate 0.22, $p = 0.003$).

There was a significant negative actor effect of the females' RDAS scores' influence on the WAI scores from one week to next (estimate −0.18, $p < 0.001$). There was also a significant positive partner effect of the males' RDAS scores on their partners' WAI scores from one week to the next (estimate 0.15, $p = 0.007$). The gender difference for the actor effect was further

TABLE 3 Influence of the covariate on the dependent variable.

Dependent variable	WAI	RDAS
Fixed parameters		
Intercept female	42.48** (0.44) [41.61–43.36]	40.28** (0.69) [38.91–41.64]
Intercept male	41.97** (0.45) [41.09–42.86]	42.73** (0.67) [41.42–44.04]
Time	0.22* (0.07) [0.08–0.37]	0.31* (0.11) [0.10–0.53]
Actor effect, female	−0.18** (0.05) [−0.28 to −0.09]	0.03 (0.07) [−0.11 to 0.16]
Actor effect, male	−0.02 (0.05) [−0.12 to 0.07]	−0.31** (.08) [−0.47 to −0.15]
Partner effect, female	0.06 (0.04) [−0.02 to 0.15]	0.02 (0.07) [−0.12 to 0.17]
Partner effect, male	0.15* (0.06) [0.04–0.26]	0.25** (0.08) [0.1–0.4]
e_1	24.08** (1.65) [21.05–27.54]	67.48** (4.6) [59.04–77.12]
e_2	30.08** (2.08) [2.27–34.44]	61.6** (4.18) [53.93–70.37]
r	0.34** (0.05) [0.25–0.43]	0.59** (0.04) [0.52–0.65]

Note: The covariate for the RDAS is the WAI and v.v. e_1 = The variance of the female; e_2 = The variance of the male; r = the correlation between e_1 and e_2 and is a measure of nonindependence; 95% confidence interval is given in brackets.

Abbreviations: RDAS, Revised Dyadic Adjustment Scale; WAI, Working Alliance Inventory.

*$p < 0.01$; **$p < 0.001$.

supported by the test statements (estimate 0.16, $p = 0.018$), while the proposed gender difference of the partner effect was nonsignificant ($p = 0.204$). The average actor and partner effects were significantly different between genders (estimate −0.10, $p = 0.003$, and 0.11, $p = 0.003$, respectively). See Table 3 for an overview of the results of the cross-lagged dyadic analyses.

DISCUSSION

The purpose of the present study was twofold: Partly to present and exemplify how dyadic analysis and the APIM may be applied to longitudinal data, and to further examine how the working alliances between clients and therapists are associated with couple satisfaction. Our results indicate that the estimated scores of dyad members were nonindependent, ranging from medium (the WAI as the dependent variable) to large (the RDAS as the dependent variable) effect sizes (Cohen, 1992). Given these results we should be able to induce that scores from members of the same dyad were interdependent on one another, indicating that the conditions for interpreting actor and partner effects were met.

As the results of the analysis show dyads improved on both measures of the alliance and couple satisfaction as an effect of time, this finding coincides with the literature on the effectiveness of couple therapy (Barbato & D'Avanzo, 2020; Heatherington et al., 2015; Roddy et al., 2020; Shadish & Baldwin, 2003). Of greater interest are the actor-partner effects: There was a significant propensity for actor effects to be related to a negative influence on the dependent variable, conversely the partner effects were associated with a positive influence. Specifically, males' estimated alliance scores had a negative influence on their reported couple satisfaction when assessed a week later. For females, the significant actor effect was that their

reported couple satisfaction negatively impacted their alliance with their therapist the week after. The test statements supported a gender difference for these actor effects.

Interestingly, both significant partner effects were related to how the males' estimated scores on the WAI and the RDAS positively predicted the females' respective dependent variable (i.e., the RDAS and the WAI) a week later. A stronger alliance between males and their therapist positively predicted the females' reported couple satisfaction, and the more satisfied the males were with their couple relationship yet the stronger their partners' alliances became with their therapist. According to the test statements, support was yielded for gender differences in how the WAI predicted the RDAS, but not conversely.

In general, these results support the body of literature which associates alliance with the outcome (Flückiger et al., 2018; Friedlander et al., 2018), but also bring nuance to how we may understand this interplay from a systemic perspective. More specifically regarding couple therapy, these results indicate that there is not a direct path of positive influence between the individual member of a dyad's alliance (i.e., actor effect) with their therapist, and the couples' perceived relationship satisfaction. On the contrary, actor effects seem to have a negative impact on the outcome. Instead, partner effects are those that most positively influenced the individuals' perceived alliance with the therapist and their couple's satisfaction. As our findings indicate: Strengthening of the male alliance in therapy predicts an increase in his spouse's couple relationship satisfaction—suggesting that establishing a strong alliance with the male member of the dyad may play a crucial role in facilitating a positive outcome of couple therapy. This interpretation finds support from previous studies (Halford et al., 2016; Symonds & Horvath, 2004). Alternatively, these indicated gendered effects may possibly be understood as an expression of interactional patterns (e.g., demand-withdraw or pursuer-distancer interactions; Betchen & Ross, 2000; Heavey et al., 1995) and/or attachment styles (Hazan & Shaver, 1987; Simpson, 1990).

Due to western culture's inclination towards linear thinking (Yama & Zakaria, 2019) it may be hard to explain why actor effects are associated with negative influence while partner effects are related to positive influences on the dependent variable. The established literature promoting the working alliance as a predictor for the outcome (Flückiger et al., 2018; Friedlander et al., 2018) makes this explanation especially challenging. Initially one may assume that a strong client-therapist alliance experienced by either member of the dyad would have the same effect on the outcome, but as the results of this study suggest, this is not the case. A way of making sense of the actor-partner effects identified in this study may be to consider them as a pattern of contrasts. According to Kenny et al. (2020) contrast effects occur when an individual's responses reverse over repeated interactions. One possible explanation for such a pattern is that female participant in our sample had a higher frequency of psychiatric diagnoses than their spouses and were thereby initially perceived as "the identified patient" by their spouses. As the therapy progressed and the male's alliance with the therapist gained in strength, it is plausible that the presented problem was concurrently reframed from a problem understood as being innate to the individual, to a problem being understood in relational terms (i.e., to a problem occurring between them). One may assume that this unfolding of the therapeutic process thus influenced an increased understanding of their own contribution to their relational problems—a precondition for them to fully engage in therapy. Such an interpretation may also explain why the women's actor effects consisted of gained couple satisfaction exerting a negative influence on their alliance with their therapist: As they witnessed their spouse getting more engaged in therapy (i.e., males partner effect of the alliance positively predicted spouses' couple satisfaction) they had less immediate need of support from

their therapist. This was reflected in slight but significant decreases in women's alliance scores across time as they became more satisfied with their partners, that is, experiencing greater support from them. In summary, as the therapy progressed the female members' assessment of the alliance with the therapist reversed as the dyads' couple satisfaction concurrently increased (i.e., signifying less dependence upon the therapist and greater trust in their partners). Although this emergent understanding of change constitutes a hypothesis that needs to be tested, we believe it convenes with the systemic assumptions of circularity that underpin couple therapy (Pinsof et al., 2018; Sprenkle et al., 2009). Further, indirect support for this interpretation may be found when assessing the intercepts of dyad members—they indicate that women are more dissatisfied at the start of therapy (i.e., the complainant) while males have a lower initial alliance with their therapist (i.e., the withdrawer). Similar findings have also been documented elsewhere in the literature on couple therapy (Friedlander et al., 2018; Jackson et al., 2014). In elaboration, women are more dissatisfied with their relationships at the start of therapy and are also disproportionally the ones that initiate couple therapy compared to their male counterparts (Boisvert et al., 2011; Doss et al., 2003). Further, evidence also suggests that men often are the ones that experience pressure to attend therapy, which initially may challenge alliance formation with their therapist (Halford et al., 2016). However, recent research has also implicated previous trauma as a variable that negatively influences men's alliance at the beginning of therapy (Anderson et al., 2020).

Overall, the literature seems to align with our interpretation that males' alliance with the therapist in couple therapy seems central to the outcome. Our emergent model of change does not predict males couple satisfaction beyond time in therapy. Most likely there are other factors that contribute such as trauma, family functioning, a decrease of symptoms of mental distress, or increase in wellness not taken into account of in the current research design. Even if future research does not support our interpretation, but rather reveals other variables as mechanisms of change, the actor-partner effects as presented in this study still indicate that the change individuals and couples undergo in conjoint therapy is highly associated with how their partner responds to therapy.

Clinical implications

The results of this study suggest that it is especially important for any couple therapist to assure that the male client is engaging with the therapy as this may facilitate the relationship satisfaction of his female spouse. As therapy progresses the therapist should continue to monitor alliances and outcomes and adjust to accommodate the client's needs to the extent that it is in service of the treatment. The application of routine outcome monitoring (ROM) in its various guises has proven to be an effective tool to identify therapies that are off-track (Lambert & Shimokawa, 2011) and may therefore be applied to monitor the establishment and maintenance of the alliance. Even though client self-report questionnaires are preferable to direct questioning by the therapist (Tilden & Wampold, 2017), we believe that any effort to handle and maintain the alliance is better than negligence. There exists examples in the literature on how such feedback may be collected verbally in-session with clients (e.g., “was there a certain event in this session that was more important for you than any other?”; McLeod., 2017), and we encourage adjusting these so they suit couple therapy (e.g., circular questioning; “could you tell your partner what you thought was the most important event in this session for them?”).

Limitations

Even though this study successfully shows how cutting-edge statistical methods may be applied to study reciprocal effects, the current research design could have been improved. Since the study aimed to be practice-oriented, the measurements used were already implemented at the clinic. Thus, the assessment of the alliance is done with the WAI (Horvath & Greenberg, 1989) only. The WAI is not designed to be used in couple therapy and thus lacks questions related to different subsystems of the clients-therapist system (Pinsof et al., 2008). Implementing systemic measures of alliances and analyzing such data with dyadic analyses within the APIM would be a great advantage over the measurements used in the current study.

There are also several factors related to psychiatric disorders and past histories of trauma that may potentially have impacted the results of this study. We mention this since most of the sample do fulfill the criteria for a psychiatric diagnosis according to the ICD-10 (World Health Organization, 1992) and at least half of the sample has been exposed to a traumatic experience. From the literature, we know that there is a negative association between mental distress and couple satisfaction (Whisman & Baucom, 2012; Whisman et al., 2000), as well as a suggested link between trauma and alliance formation in couple therapy (Anderson et al., 2020). We are thus cautious in generalizing our findings to other populations. We only included heterosexual couples because gender was the obvious distinguishing variable, thus our findings may not be generalizable to couples with a different sexual orientation. However, since there is evidence for the association between the occurrence of psychiatric symptoms and relationship discord across cultures and ethnicities (McShall & Johnson, 2015), one would anticipate finding variations of the identified pattern of reciprocal effects (i.e., the proposed importance of the partners' responsiveness to therapy) that share commonalities in other comparable populations.

Even though we acknowledge that the uniqueness of the treatment program that is on offer at the FU might limit the generalizability of the results, we propose that the patterns of associations of alliances and couple relationship satisfaction identified would likely be similar in other contexts of treatment (e.g., outpatient). Studies from other contexts on the alliance in couple therapy show similar results as our study, hence supporting such an interpretation (e.g., Anderson et al., 2020; Halford et al., 2016). Lastly, the naturalistic design of this study may also limit generalizability because several indirect effects are not accounted for (e.g., what interventions were implemented by the couple therapist?). Although this is a valid argument, we believe that naturalistic studies using quantitative methods as presented in this study are of value since they do with accuracy reflect how dyads change across time (Kenny et al., 2020).

CONCLUSION AND FUTURE RESEARCH

The results of this study show how the method of dyadic analysis is applicable to examine phenomena such as alliances and their interplay with couple satisfaction. Our findings indicate that the alliance and couple satisfaction scores of dyad members are highly interdependent. Furthermore, our analysis suggests that engaging the male member of a dyad in the therapeutic process, as measured by the working alliance, seems to be essential for a successful therapeutic outcome. To our knowledge this detailed finding, although familiar to the experienced clinician, is novel within the field of couple therapy research. Our nuanced results are achieved by using dyadic analysis—a statistical approach that is applicable to any researcher who is interested in reciprocal effects when for instance studying couple relationships, co-parenting, parent-child transactions, or

the therapist-client working alliance. Future research applying dyadic analysis to already well-researched phenomena (e.g., therapeutic alliances) and underresearched populations (e.g., ethnic minorities, same-sex couples, and survivors of trauma) will likely amount to new knowledge of importance and contribute to moving the field of couple and family therapy forward.

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REFERENCES

Anderson, S. R., Banford Witting, A., Tambling, R. R., Ketring, S. A., & Johnson, L. N. (2020). Pressure to attend therapy, dyadic adjustment, and adverse childhood experiences: Direct and indirect effects on the therapeutic alliance in couples therapy. *Journal of Marital and Family Therapy*, *46*(2), 366–380. https://doi.org/10.1111/jmft.12394

Anderson, S. R., & Johnson, L. N. (2010). A dyadic analysis of the between-and within-system alliances on distress. *Family Process*, *49*(2), 220–235. https://doi.org/10.1111/j.1545-5300.2010.01319.x

Barbato, A., & D'Avanzo, B. (2020). The findings of a Cochrane meta-analysis of couple therapy in adult depression: Implications for research and clinical practice. *Family Process*, *59*(2), 361–375. https://doi.org/10.1111/famp.12540

Beltz, A. M., Wright, A. G., Sprague, B. N., & Molenaar, P. C. (2016). Bridging the nomothetic and idiographic approaches to the analysis of clinical data. *Assessment*, *23*(4), 447–458. https://doi.org/10.1177/1073191116648209

Bergeron, S., Brassard, A., Mondor, J., & Péloquin, K. (2020). Under, over, or optimal commitment? Attachment insecurities and commitment issues in relationally distressed couples. *Journal of Sex & Marital Therapy*, *46*(3), 246–259. https://doi.org/10.1080/0092623x.2019.1683664

Betchen, S. J., & Ross, J. L. (2000). Male pursuers and female distancers in couples therapy. *Sexual and Relationship Therapy*, *15*(1), 15–31. https://doi.org/10.1080/14681990050001538

Boisvert, M.-M., Wright, J., Tremblay, N., & McDuff, P. (2011). Couples' reports of relationship problems in a naturalistic therapy setting. *The Family Journal*, *19*(4), 362–368. https://doi.org/10.1177/1066480711420044

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practic*, e163252. https://doi.org/10.1037/h0085885

Busby, D. M., Christensen, C., Crane, D. R., & Larson, J. H. (1995). A revision of the dyadic adjustment Scale for use with distressed and nondistressed couples: Construct hierarchy and multidimensional scales. *Journal of Marital and Family Therapy*, *21*(3), 289–308. https://doi.org/10.1111/j.1752-0606.1995.tb00163.x

Cohen, J. (1992). A power primer. *Psychological Bulletin*, *112*(1), 155–159. https://doi.org/10.1037/0033-2909.112.1.155

Cook, W. L., & Kenny, D. A. (2005). The actor–partner interdependence model: A model of bidirectional effects in developmental studies. *International Journal of Behavioral Development*, *29*(2), 101–109. https://doi.org/10.1080/01650250444000405

Curran, P. J., & Bauer, D. J. (2011). The disaggregation of within-person and between-person effects in longitudinal models of change. *Annual Review of Psychology*, *62*, 583–619. https://doi.org/10.1146/annurev.psych.093008.100356

Doss, B. D., Atkins, D. C., & Christensen, A. (2003). Who's dragging their feet? Husbands and wives seeking marital therapy. *Journal of Marital and Family Therapy*, *29*(2), 165–177. https://doi.org/10.1111/j.1752-0606.2003.tb01198.x

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316–340. https://doi.org/10.1037/pst0000172

Friedlander, M. L., Escudero, V., Welmers-van de Poll, M. J., & Heatherington, L. (2018). Meta-analysis of the alliance–outcome relation in couple and family therapy. *Psychotherapy*, *55*(4), 356–371. https://doi.org/10.1037/pst0000161

Galovan, A. M., Holmes, E. K., & Proulx, C. M. (2017). Theoretical and methodological issues in relationship research: Considering the common fate model. *Journal of Social and Personal Relationships*, *34*(1), 44–68. https://doi.org/10.1177/0265407515621179

Gurman, A. S., & Kniskern, D. P. (1978). Deterioration in marital and family therapy: Empirical, clinical, and conceptual issues. *Family Process*, *17*(1), 3–20. https://doi.org/10.1111/j.1545-5300.1978.00003.x

Halford, T. C., Owen, J., Duncan, B. L., Anker, M. G., & Sparks, J. A. (2016). Pre-therapy relationship adjustment, gender and the alliance in couple therapy. *Journal of Family Therapy*, *38*(1), 18–35. https://doi.org/10.1111/1467-6427.12035

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research*, *16*(1), 12–25. https://doi.org/10.1080/10503300500352500

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, *52*(3), 511–524. https://doi.org/10.1037/0022-3514.52.3.511

Heatherington, L., Friedlander, M. L., Diamond, G. M., Escudero, V., & Pinsof, W. (2015). Years of systemic therapies research: Progress and promise. *Psychotherapy Research*, *25*(3), 348–364. https://doi.org/10.1080/10503307.2014.983208

Heavey, C. L., Christensen, A., & Malamuth, N. M. (1995). The longitudinal impact of demand and withdrawal during marital conflict. *Journal of Consulting and Clinical Psychology*, *63*(5), 797–801. https://doi.org/10.1037/0022-006x.63.5.797

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223–233. https://doi.org/10.1037/0022-0167.36.2.223

Jackson, J. B., Miller, R. B., Oka, M., & Henry, R. G. (2014). Gender differences in marital satisfaction: A meta-analysis. *Journal of Marriage and Family*, *76*(1), 105–129. https://doi.org/10.1111/jomf.12077

Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clincal Psychology*, *3*, 1–27. https://doi.org/10.1146/annurev.clinpsy.3.022806.091432

Kenny, D. A. (1996). Models of non-independence in dyadic research. *Journal of Social and Personal Relationships*, *13*(2), 279–294. https://doi.org/10.1146/annurev.clinpsy.3.022806.091432

Kenny, D. A. (2015). Using Multilevel Modeling: Two Intercept Method. [Webinar]. David A. Kenny's Homepage. https://davidakenny.net/webinars/Dyad/Standard/MLM_Distinguishable/MLM_Distinguishable.html

Kenny, D. A., Kashy, D. A., & Cook, W. L. (2020). *Dyadic data analysis*. Guilford Press.

Klohnen, E. C., & Luo, S. (2003). Interpersonal attraction and personality: What is attractive: Self similarity, ideal similarity, complementarity or attachment security? *Journal of Personality and Social Psychology*, *85*(4), 709–722. https://doi.org/10.1037/0022-3514.85.4.709

Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy*, *48*(1), 72–79. https://doi.org/10.1037/a0022238

Ledermann, T., Bodenmann, G., Rudaz, M., & Bradbury, T. N. (2010). Stress, communication, and marital quality in couples. *Family Relations*, *59*(2), 195–206. https://doi.org/10.1111/j.1741-3729.2010.00595.x

McLeod, J. (2017). Qualitative methods for routine outcome measurement, *The cycle of excellence: Using deliberate practice to improve supervision and training* (pp. 99–122). John Wiley & Sons.

McShall, J. R., & Johnson, M. D. (2015). The association between relationship distress and psychopathology is consistent across racial and ethnic groups. *Journal of Abnormal Psychology*, *124*(1), 226–301. https://doi.org/10.1037/a0038267

Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., & Barth, J. (2010). Working Alliance Inventory-Short Revised (WAI-SR): Psychometric properties in outpatients and inpatients. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *17*(3), 231–239. https://doi.org/10.1002/cpp.658

Ochs, M., Hornová, L., & Goll-Kopka, A. (2020). Systemic practitioner research–some (epistemological) considerations and examples, *Systemic research in individual, couple, and family therapy and counseling* (pp. 165–189). Springer. https://doi.org/10.1007/978-3-030-36560-8_10

Pinsof, W. M., Breunlin, D. C., Russell, W. P., Lebow, J., & Chambers, A. L. (2018). *Integrative systemic therapy: Metaframeworks for problem solving with individuals, couples and families*. American Psychological Association.

Pinsof, W. M., Zinbarg, R., & Knobloch-Fedders, L. M. (2008). Factorial and construct validity of the revised short form integrative psychotherapy alliance scales for family, couple, and individual therapy. *Family Process*, *47*(3), 281–301. https://doi.org/10.1111/j.1545-5300.2008.00254.x

Rathgeber, M., Bürkner, P. C., Schiller, E. M., Holling, H. (2019). The efficacy of emotionally focused couples therapy and behavioral couples therapy: A meta-analysis. *Journal of Marital and Family Therapy*, *45*(3), 447–463. https://doi.org/10.1111/jmft.12336

Del Re, A., Flückiger, C., Horvath, A. O., & Wampold, B. E. (2021). Examining therapist effects in the alliance–outcome relationship: A multilevel meta-analysis. *Journal of Consulting and Clinical Psychology*, *89*(5), 371–378. https://doi.org/10.1037/ccp0000637

Roddy, M. K., Walsh, L. M., Rothman, K., Hatch, S. G., & Doss, B. D. (2020). Meta-analysis of couple therapy: Effects across outcomes, designs, timeframes, and other moderators. *Journal of Consulting and Clinical Psychology*, *88*(7), 583–596. https://doi.org/10.1037/ccp0000514

Schafer, J. L., Graham, J. W. (2002). Missing data: our view of the state of the art. *Psychological Methods*, *7*(2), 147–177. https://doi.org/10.1037/1082-989X.7.2.147

Shadish, W. R., & Baldwin, S. A. (2003). *Meta-analysis of MFT interventions*, *29*(4), 547–570. https://doi.org/10.1111/j.1752-0606.2003.tb01694.x

Shadish, W. R., & Baldwin, S. A. (2005). Effects of behavioral marital therapy: A meta-analysis of randomized controlled trials. *Journal of Consulting and Clinical Psychology*, *73*(1), 6–14. https://doi.org/10.1037/0022-006x.73.1.6

Shin, T., Davison, M. L., Long, J. D. (2017). Maximum likelihood versus multiple imputation for missing data in small longitudinal samples with nonnormality. *Psychological Methods*. *22*(3), 426. https://doi.org/10.1037/met0000094

Simpson, J. A. (1990). Influence of attachment styles on romantic relationships. *Journal of Personality and Social Psychology*, *59*(5), 971–980. https://doi.org/10.1037/0022-3514.59.5.971

Singer, J. D., Willett, J. B., & Willett, J. B. (2003). *Applied longitudinal data analysis: Modeling change and event occurrence*. Oxford University Press.

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. Guilford Press.

Symonds, D., & Horvath, A. O. (2004). Optimizing the alliance in couple therapy. *Family Process*, *43*(4), 443–455. https://doi.org/10.1111/j.1545-5300.2004.00033.x

Tilden, T. (2008). Integrative practice: Presentation of an inpatient family therapy program. *Journal of Family Psychotherapy*, *19*(4), 379–403. https://doi.org/10.1080/08975350802475106

Tilden, T. & Wampold, B. E. (Eds.). (2017). *Routine outcome monitoring in couple and family therapy: The empirically informed therapist*. Springer.

West, T., & Thorson, K. (2017a). Restucturing data from individual format to person period pairwise format. [Webinar]. West Interpersonal Perception Lab. https://youtu.be/dgNPfELcKm8

West, T., & Thorson, K. (2017b). Lagging variables in SPSS and SAS. [Webinar]. West Interpersonal Perception Lab. https://youtu.be/y3rxTDvRREE

Weston, R., & Gore, Jr. P. A. (2006). A brief guide to structural equation modeling. *The Counseling Psychologist*, *34*(5), 719–751. https://doi.org/10.1177/0011000006286345

Whisman, M. A., & Baucom, D. H. J. (2012). Intimate relationships and psychopathology. *Clinical Child and Family Psychology Review*, *15*(1), 4–13. https://doi.org/10.1007/s10567-011-0107-2

Whisman, M. A., Sheldon, C., & Goering, P. (2000). Psychiatric disorders and dissatisfaction with social relationships: Does type of relationship matter? *Journal of Abnormal Psychology*, *109*(4), 803. https://doi.org/10.1037/0021-843x.109.4.803

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines* (Vol. 1). World Health Organization.

Yama, H., & Zakaria, N. (2019). Explanations for cultural differences in thinking: Easterners' dialectical thinking and Westerners' linear thinking. *Journal of Cognitive Psychology*, *31*(4), 487–506. https://doi.org/10.1080/20445911.2019.1626862

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