The Discursive Performance of Change Process in Systemic and Constructionist Therapies: A Systematic Meta-Synthesis Review of In-Session Therapy Discourse

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Abstract

Despite the emphasis of systemic and constructionist approaches on discourse and interaction, to date there has been no comprehensive overview of how change process is performed within in-session therapeutic dialogue. In this paper we present a qualitative meta-synthesis of 35 articles reporting systemic and constructionist therapy process data from naturally occurring therapeutic dialogue. The studies were selected following the screening against eligibility criteria of a total sample of 2977 studies identified through a systematic search of PsycINFO and MEDLINE databases. Thematic analysis of the 35 studies' findings identified four main themes depicting change process performance; (a) shifting to a relational perspective, (b) shifting to non-pathologizing therapeutic dialogue, (c) moving-forward dialogue, and (d) the dialogic interplay of power. Findings highlight the interactional and discursive matrix within which systemic and constructionist change process occurs. Findings illuminate the value of qualitative research studies sampling naturally occurring therapeutic discourse in bringing this matrix forth, particularly when utilizing discursive methodologies like conversation or discourse analysis.

Keywords: change; constructionist therapy; discourse; psychotherapy process; systematic meta-synthesis review; systemic therapy

In this paper we present a meta-synthesis of qualitative studies focused on systemic and constructionist therapy process, which have utilized in-session discourse. Our aim is to depict how change is performed within naturally occurring therapeutic dialogue.

As clinicians and researchers, we acknowledge the highly interpretative and recursive "nature" of meaning-making processes, which we see exemplified in systemic family therapy models (see Sexton & Lebow, 2015 for an overview) that draw on systemic and discursive theories. In this paper we refer to such models as "systemic and constructionist approaches". Despite their differences, these approaches share an emphasis on the performative aspects of language use, viewing such use as both representational and a form of social action (Austin, 1963). Thus, we influence each other through communicative and interpretative work, such as by negotiating the process, meanings and discursive positions possible within talk-in-interaction, including therapy (Strong & Smoliak, 2018). Accordingly, systemic and constructionist approaches emphasize how change process is discursively and interactionally performed within therapists' and clients' interrelated discursive practices. Such approaches, conceptualize change process as performed in shifts towards relational perspectives concerning the reported difficulties and towards polyphonic and non-pathologizing discourse, highlighting the significance of therapist's multi-partial and collaborative stance, coupled with an emphasis on strengths and positives (Strong & Smoliak, 2018). Consequently, this discursive perspective looks beyond discrete communicative actions (or "motives") to focus on how therapist and clients respond to each other while jointly performing process and change, making it difficult to separate process from outcome in their micro-interactions.

"Change process research" (CPR), coined to capture the inseparability between process and outcome, refers both to "in-therapy processes which bring about change", but also to "the unfolding sequence of client change" (Elliott, 2010, p. 123). CPR has utilized a variety of quantitative and qualitative methodologies, although the use of the latter has been marginal (Elliot, 2010). CPR of systemic and constructionist therapy has mostly utilized quantitative approaches, contributing valuable insight on how and why change occurs (Sexton & Datchi, 2014). Few qualitative studies have captured the overall experience of what has been helpful / unhelpful in therapy by leaning on client and therapist retrospective accounts (Tseliou, Burck, Forbat, Strong, & O'Reilly, in review; Franklin, Zhang, Froerer, & Johnson, 2017). Such research has contributed to an inductive, bottom-up perspective, illuminating how change process is conceptualized, narrated and experienced by therapists or clients. However, there is still a lack of adequate insight into how change process is performed in the "here and now" of naturally occurring therapeutic dialogue (Lee & Horvath, 2014). By performance, we refer to discursive micro-interactions, observably transpiring between clients and therapists when responding to each other. A marginal trend in qualitative change process research has focused on the sequential analysis of client and therapist micro-interactions by analyzing naturally occurring therapeutic discourse (Elliot, 2010). Interrogating data generated from actual therapeutic dialogue enables examining change processes as interactional accomplishments performed discursively. Such studies have mostly used discursive methodologies, like Conversation Analysis (CA) and Discourse Analysis (DA) argued as epistemologically and theoretically syntonic with systemic and constructionist premises (Strong & Smoliak, 2018; Tseliou & Borcsa, 2018).

To date, not many formal syntheses of research have focused on in-session dialogue. The few exceptions include a study on solution focused brief therapy process (Franklin et al., 2017) and a narrative review of findings of CA studies of family therapy, but these studies do not attend to change process (Ong, Barnes, & Buus, 2019b). Two methodological reviews (Ong, Barnes, & Buus, 2019a; Tseliou, 2013) reported the use of CA/DA to examine in-session dialogue, again without focusing on change process.

Therefore, there has been no comprehensive review of how systemic or constructionist change process is performed within in-session dialogue. We thus lack adequate insight of how therapists and clients reflexively use language, in discursively performing and interactionally accomplishing change process. Such insight can provide interested clinicians with sensitizing concepts by allowing access to nuanced and often obscured aspects of in-session change processes. Consequently, we conducted a meta-synthesis of qualitative research studies of systemic and constructionist therapy process, which sampled in-session discourse. The 35 papers reported here were identified as a sub-set of 65 studies in a broader systematic review, investigating how systemic and constructionist process is conceptualized, experienced and performed across models/approaches (Tseliou et al., in review). The remaining 30 papers focus on retrospective accounts and are synthesized in another article (Tseliou et al., in review).

With the sub-group analysis presented here we aimed to capture how change process is sequentially produced in talk irrespective of therapists' and clients' theories of change. Our focus has been on how therapy is sequentially and discursively performed within therapist and client micro-interactions and on the accomplishment of processual change.

Given international standards in reporting systematic reviews, we inevitably reiterate the methods reported in our other article (Tseliou et al., in review).

Method

Design

We conducted a systematic review with a scoping aspect (Levac, Colquhoun, & O'Brien, 2010; The Joanna Briggs Institute Reviewers' Manual 2015) for mapping the field of qualitative research of systemic and constructionist therapy process. We followed a meta-synthesis methodology, which allows for systematically synthesizing qualitative research findings by leaning on diverse epistemological and methodological perspectives (Sandelowski & Barroso, 2007; Chenail et al., 2012; Willig & Wirth, 2018). By meta-synthesis we refer to an approach aiming to gain new insight on phenomena as opposed to simply providing a summary of studies' findings (Chenail et al., 2012; Willig & Wirth, 2018). We followed standard procedures for searching, screening, data extraction and synthesis reported in the related literature (Higgins & Green, 2011; Moher et al., 2015; Shamseer et al., 2015) not as a means to secure objectivity but rather to ensure robustness and clarity in our methodological procedures, acknowledging the interpretative aspect of our meta-synthesis (Paterson, Thorne, Canam, & Jillings, 2001). In line with best practice, we prospectively registered the review with the PROSPERO database (CRD42018097369). Aligned with criteria for good quality practice in qualitative research (e.g, Willig, 2013), we provide a detailed report of our procedures below to offer transparency of our process.

Search Strategy

Following a pilot search in the PsycINFO and MEDLINE databases (EBSCOhost) in June 2018, we performed a final, extended search in July 2018, without posing any publication date limitations. The search terms are provided in Table S1[1], SuppInfo, supplemental material. 65 studies were judged eligible for synthesizing from a total sample of 3343 results (2660 PsycINFO, 683 MEDLINE). Here, we synthesize 35 papers (see Figure 1 for PRISMA flow diagram), sampling naturally occurring in-session discourse (for the synthesis of the remaining 30, see Tseliou et al., in review). "Naturally occurring" refers to data which was not specifically generated for research, but are real-world and thus naturalistic therapeutic interactions (Kiyimba, Lester, & O'Reilly, 2019).

Insert Figure 1 here.

Inclusion and Exclusion Criteria

For inclusion criteria we followed the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) framework (Cooke, Smith, & Booth, 2012) (see Table S2, SuppInfo, supplemental, for a detailed overview). We sampled primary qualitative research studies of systemic and constructionist therapy process published in English, in peer-reviewed journals (Tseliou et al., in review).

We operationalized change process as referring to in-therapy unfolding of processes bringing about change and sequences of change, trying to be as inclusive as possible in accordance to conceptualizations of change process (e.g., Elliott, 2010; Franklin, et al., 2017). This resulted in the inclusion of studies investigating change

[1]Tables and Figures follow the same format as in our other article (Tseliou et al., in review).

process including the discursive performance or narrative of therapy techniques, interventions and the therapeutic relationship. We included studies reporting first-order cybernetic models and post-modern developments, which espouse systemic, constructionist or dialogic theories for treatment (Sexton & Lebow, 2015). By leaning on pragmatic, structural and post-structural and dialogic discourse theories, such models/approaches undertake the discursive view of change process, which is our focus here, in that they acknowledge that communicative interaction is how relational processes are performed and changed. Thus, we excluded behavioural or psychodynamic family therapy models/approaches and integrated/mixed-model manualized treatments including behavioural or psychodynamic approaches, as well as consultation and role-play settings. We included any type of session format, client population, therapy setting and reported problem (Tseliou et al., in review).

We included papers explicitly reporting the use of a systematic, hermeneutic qualitative research method (Willig, 2019). We excluded mixed method studies and clinical or quantitative case studies. We also excluded systematic reviews and meta-analyses as our interest was in primary investigations.

We sampled studies analysing only qualitative data, collected by observation (including audio/videotaped sessions) and by self-report (interviews / focus groups). Here, however, we synthesize only the first sub-group (criterion 8, Table S2, SuppInfo, supplemental material) focusing on in-session change process data.

Procedure of Screening

The 3343 results were screened for duplicates and all team members screened the 2977 selected titles and abstracts against inclusion/exclusion criteria, indicating their rationale for exclusion. Other team members cross-checked reviewers' screening and

the lead author verified screening to secure consistency. Cases of disagreement were resolved via discussion and comparison against the criteria. 65 articles (for a full list see SuppInfo, supplemental material) were judged as eligible for synthesizing following a similar screening process of 309 articles which were judged as eligible for full-text screening. Here we present the sub-group analysis of 35 out of 65 papers, focusing on studies sampling in-session therapeutic dialogue as data (see SuppInfo for Tables S3, S4 and the list of synthesized references).

Data Extraction

We performed data extraction utilizing bespoke tables devised by the lead author, which were piloted by all team members and revised following group discussion. The tables provide information on studies' characteristics, quality and data sampling, i.e. post-hoc narrative or in-session discourse (see Tables S3 and S4, SuppInfo, supplemental). The findings of the studies synthesized here were extracted in Table S6 (SuppInfo, supplemental). We extracted data both inductively and deductively. For example, we used pre-defined codes like "individual/couple/family/network/group" to code session format (Table S3, SuppInfo, supplemental) but also verbatim extracts of the articles to extract findings (Table S6, SuppInfo, supplemental) (S5 presents an overview of codes and abbreviations of Tables S3 and S4, SuppInfo, supplemental). The lead author performed data extraction of 50% of the articles and other team members of the rest 50%. Data extraction was cross-checked, with the lead author cross-checking data extraction and two team members (authors 2 and 4) cross-checking the lead author's data extraction. We resolved disagreements via discussion and the lead author refined the final tables.

Data extraction of qualitative studies' findings was not a straightforward task (see also, Chenail, et al., 2012; Timulak, 2009) for several reasons. These include the variability of the type of findings stemming from each study's analytic method, the scattering of data within analytic claims and the extensive reports of findings. We devised a set of criteria, while deploying various strategies depending on each paper's particularities. Strategies included the verbatim extraction of analysis in as much detail as possible and the extraction of all text when excerpts were imbedded with analytic claims but the extraction of only analytic claims or simply categories / themes if there was no further analysis included. In CA/DA studies we decided to extract only the main analytic claims either from the findings or the discussion section, given the detailed, sequential, micro-analysis included.

Quality Appraisal

Quality appraisal in systematic reviews of qualitative research poses serious challenges due to the different epistemological traditions in qualitative research (Willig, 2013). We conducted quality appraisal using CASP (Critical Appraisal Skills Programme, 2017) not as a tool for exclusion (Willig & Wirth, 2018) but rather as an indicator to the reader of the studies' methodological rigour (Tseliou et al., in review).

We utilized two further quality criteria including whether the study reported evidence (i.e. inclusion of extracts), as well as the type of analysis (i.e. sequential or not) when applicable, like in CA/DA studies, where this is considered a quality criterion (see also Ong et al., 2019a) (see Table S4, SuppInfo, supplemental). For final decisions concerning studies' quality appraisal see the column "quality appraisal" (Table S3, SuppInfo, supplemental). In Table S7.2 (SuppInfo, supplemental) we present an overview of quality appraisal of the studies synthesized here.

Method of Analysis

We broadly followed thematic analysis (Braun, & Clarke, 2006) from a descriptive-interpretative perspective (Timulak, 2009), treating authors' discourse as data. We conducted two sub-analyses of the 65 studies acknowledging the tensions in synthesizing findings from qualitative studies deploying different methods for the analysis of different types of data (Timulak, 2009). Of the sub-sample of 35, 3 articles (27, 49 and 50 in Table S3, SuppInfo) used both in-session and retrospective data. These 3 papers are reported here, since their primary data was in-session dialogue. Given the inherent problems in re-analysing extracts without their discursive frame (Willig & Wirth, 2018) we refrained from this practice when synthesizing studies. We performed analysis in two stages. In stage one, we started with open coding, i.e. the assignment of codes, mostly in vivo, to the studies' extracted text with as much detail as possible per each paper. Initial codes were subsequently grouped in clusters under broader, main themes via a process of comparison and contrasting among each paper's codes and consequently across papers, while trying to retain as much variability as possible. This process resulted to an initial map of themes and sub-themes, mostly aggregating, depicting evidence of change processes but also concrete, therapists' and clients' discursive practices. All group members verified analysis performed by the lead author and cross-checked in detail by author 2. In stage two, we compared and contrasted main themes and sub-themes, aiming to come up with a synthesis depicting different facets of change processes. Analysis resulted to a revised map of main themes and sub-themes, depicting therapists' and clients' discursive practices across different aspects of change process discursive performance. We then engaged into a deductive mode of analysis, by screening our data against our revised

map to check for additional and/or disconfirming cases. We also screened the sampled papers once more focusing on therapists' and clients' discursive practices, while making additional notes and selecting excerpts of data indicative of the reported change processes, finally concluding with the main themes and sub-themes reported below (for a detailed account, see Table S8, SuppInfo). All group members verified analysis performed by the lead author and cross-checked by authors 2 and 3.

Reflexivity

Aligned with a constructionist perspective, we view our meta-synthesis as itself a discursive construction shaped by our epistemological, theoretical and methodological preferences. Our own systemic and constructionist lenses shaped our choice to focus on systemic and constructionist therapy and our coding process inevitably reflects the meeting between authors' discourse and our own preferences. This meeting coupled with the polyphonic process we followed to address our different perspectives, constructed the following narrative of how systemic and constructionist change process is discursively performed and interactionally accomplished.

Findings

Overview of Studies' Characteristics and Quality

Tables S7.1. and S7.2 (included in SuppInfo, supplemental, due to space constraints) present an overview of the 35 studies' characteristics.

Studies' publication dates ranged from 1992 to 2018. In 33/35 studies the patient population included adults: only adults (10/35) or conjointly with adolescents (11/35), with children (8/35) and both with children and adolescents (4/35). Of the 35 studies, 22 sampled constructionist approaches, reporting verbatim, "collaborative" (6), "solution focused" (4), "reflecting teams" (3), "dialogical" (4), "narrative" (2),

"open dialogue" (2) and "variety of postmodern" (1), whereas 6/35 sampled systemic, verbatim reporting "Milan/post-Milan" (3), "Structural" (1) and "variety of systemic models" (2), 5/35 systemic family therapy (verbatim reporting "SFT") without further specifying the model/approach and 2/35 an eclectic/integrated approach of systemic and constructionist models (verbatim reporting "eclectic" and "SCT integrated" (see Tables S3, S5, S7.1 for further details). 11/35 studies sampled therapeutic teams, 6/35 co-therapy, 15/35 a single therapist and 3/35 unspecified. Studies' focus varied with 12/35 investigating therapeutic dialogue, 6/35 therapeutic interventions/techniques, 4/35 the therapeutic relationship, 4/35 problem talk, 3/35 the model, 2/35 the overall process and 4/35 a therapy concept. 27/35 studies focused on therapist and client interaction by analyzing the contribution of both sides, given that 29/35 deployed CA/DA or dialogic analysis methodologies, which share a preference for naturally occurring data. Correspondingly, video-recorded (26/35) and audio-recorded therapy sessions (4/35) was the preferred type of data with 22/35 studies including verbatim transcription of which 12 followed the Jeffersonian type. 21/35 studies included sequential analysis with evidence, i.e. analyzed excerpts of data. 19/35 did not explicitly state their epistemological preferences. 27/35 studies were assessed as inadequately explaining ethical issues according to CASP, as only 5/35 reported both informed consent and approval procedures. 23/35 studies were assessed as inadequately addressing researcher and participants' relationship, as a consequence of selecting recorded sessions as data. Finally, 15/35 studies were assessed as bearing flaws in research design and 18/35 as presenting insufficient rigor in analysis.

Qualitative Meta-Synthesis of In-Session Process Discourse

Thematic analysis identified 4 main themes and 12 sub-themes synthesized from an initial pool of 196 codes. Figure 2 presents an overview of main themes, sub-themes and the synthesized references assigned themes/sub-themes. All main themes depict *change process as a discursive, relational accomplishment* and include three sub-themes each. The first main theme, "Shifting to a relational perspective" synthesized from 16 papers, illustrates shifts towards relational constructions of reported problems and related challenges. Theme 2, "Shifting to non-pathologizing therapeutic dialogue", synthesized from 16 papers, shows shifts towards non-pathologizing, empowering and resourceful dialogue. Theme 3, "Moving-forward dialogue", synthesized from 22 papers unpacks change process as a movement away from stuck or unhelpful dialogue. Finally theme 4, "The dialogic interplay of power", synthesized from 18 papers, highlights the shifting balance concerning clients' and therapists' power positions.

Insert Figure 2 here.

Below we present main themes as shown in figure 2. We refrained from in-text citations due to space limitations. Instead we indicate studies' reference number as appearing in Table S3 (SuppInfo, supplemental). To illustrate each sub-theme, we cite verbatim data extracts reported by authors, retaining the original transcription style and formatting. Readers may wish to refer to Jefferson (2004) for the highly detailed transcription notation in CA/DA studies. Due to space limitations, we have restricted reporting to one indicative exemplar for each sub-theme, without reporting analysis.

Theme 1. Shifting to a relational perspective.

The three sub-themes of this main theme depict change process as shifts *towards a relational/interactional perspective* interwoven with the challenging process of

therapists' attempts to *introduce a systemic view against family members' linear perspectives*.

Shifting towards flexibility and celebrating difference. Seven studies illustrate *shifts towards less rigidity* and more uncertainty in family members' discourse coupled with new ways of understanding (61). Family members gradually *celebrate difference* by acknowledging the validity of other, different perspectives, including problem constructions (13), leading to the widening of beliefs and to new understandings (28). For example, this is depicted in shifts from an insistent to a tentative turn design in family members' discourse (11).

Studies' findings identify certain therapist discursive practices facilitating the accomplishment of such shifts. These include the clarifying and challenging of repetitive, problematic behavioral and conceptual patterns which have contributed to difficulties (24, 28), by asking about the future or by offering new perspectives and by consolidating clients' efforts to change (24). Such challenging is performed while working toward an in-depth understanding of family members' problems (38) by e.g., utilizing questions which build relationships (38) or by inviting family members to reflect on such patterns (4).

One study particularly highlights how therapist's use of inclusive or exclusive language which values differences and emphasizes either connectedness between family members or disconnectedness challenges family members' rigid beliefs and creates multiple positions for clients to choose when speaking about oneself and each other (61). In the following extract, as argued (61), the therapist values differences while trying to emphasize connectedness in highlighting common feelings.

Extract 1 (study 61, p. 435)

Therapist: My guess is, (husband), at some point that has been for you a feeling that you've gone through, too. You said you understand how, you can understand from (wife)'s perspective.
Husband: I guess the feelings, yeah.
Wife: Right. I think he's so afraid, you know, and he has to prove himself so much, so quickly, that...it's just out of worry, you know, fear.
Therapist: I'm hearing from both of you tonight that there's a lot of fear...And that you're hurting.

Negotiating systemic epistemology. Six studies illustrate a process of *negotiation between therapists' systemic epistemology* performed in their attempts to introduce a systemic, relational view of the presenting difficulties *and family members' linear epistemology*. Such negotiation seems interrelated with a process of negotiation of blame and accountability, including both therapists' and family members' contributions within problem talk (46). Family members engage in a process of constructing and deconstructing accusations (13) while negotiating blame and accountability (23, 43). Therapists promote relational responsibility concerning the presenting difficulties by respecting each member's view (43) or by inviting family members' reflection concerning responsibility (59). In dialogic therapies such invitation may include the use of "multi-voiced addressee" (59, p. 229) discursive strategy where the therapist indirectly refers to other family members while talking to one family member or while talking to another therapist within a therapy team members' discussion. However, family members sometimes consider therapists' discursive moves as attributing blame and responsibility to them (46). They attempt to disavow responsibility (59) by engaging in further blaming of the identified patient, thus forwarding a linear perspective concerning the reported difficulties (46). For

example, parents engage in further blaming of their child by employing various discursive strategies like the inference of causal explanations or the drawing on third party evidence and the description of extreme behaviors (41).

The following extract illustrates family members' linear perspective concerning the reported difficulties when responding to therapist's use of a circular question. Such perspective is illustrated in their constructing a factual account (46) by means of a vivid description of the identified patient's problematic behavior, that is a "real" and difficult to refute account.

Extract 2 (part of Extract 1, study 46, p. 476)

339 Th: Were you working and did you have any help?
340 M: Em (.) a babysitter was taking care of him.
341 Th: And was he naughty with her, as well?
342 M: He was naughty, he was hyperactive but I used to
343 realize that he didn't have this sense of danger. That
344 is, there might have been a dog around there, that he
345 wouldn't know, and even when he was only three years
346 old, I remember that he might go he would rush against
347 it (.) some children feel afraid if they see such a huge
348 dog (.) He would go he would touch the dog, he would
349 touch the dog's face, he would fondle him (.) once a dog
350 bit him (.) he didn't (.) he wasn't afraid while the dog
351 was biting him (.) he would get near the dogs again
352 afterwards. Then, he would chat with anyone around.

Shifting to relational construction of problems. Ten studies illustrate shifts concerning talk about the reported difficulties towards more *relational constructions*. A key facet concerning therapist discursive contributions is the *performance of multi-partiality* (10). Two studies illustrate such performance by use of circular questioning,

e.g., problem definition or explanation questions (13) and reflexive questioning (50). Another study (59) illustrates how the engagement of therapy team members in meta-dialogue, i.e. in dialogue about therapeutic dialogue, plays a key role in performing multi-partiality and facilitates clients' reflexive positioning.

Additional therapist's discursive practices include: (a) the *performance of collective soliciting*, that is inviting more than one family members to respond to a question by addressing questions to all family members (11), (b) *identifying and exploring families' beliefs* and those inherited from their families of origin *in a neutral way* (28), while *validating each family member's view* and securing *equal therapeutic alliances* (43), (c) *relationally connecting family members* and thus *fostering alliances between them* (25) and (d) *focusing on the relational patterns* in the present moment during the session (60). For example, the therapist may display empathy, construct the problem in a family focused way, or engage into a feelings-focused discourse (41), as illustrated below.

Extract 3 (extract 20, study 41, p. 173)

FT: HOW do you a::ll know how much you care for each other (.) how do you actually show it without ↑anno:ying =

Dad: = Well the:se two (0.4) give me love and kisses and cuddles an' she just give ya > she'll give you a cuddle< (0.2) or a peck on the chee:k he don't do you (.) nothin'

Steve: ↑I'm too big for ↓that

Dad: ↑Yeah that's his ans- <"I'm too big for that">

FT: Are we ever too big t' want t' <fee:l loved>

Dad: No >we're not<

FT: I don't think so either

Theme 2. Shifting to non-pathologizing therapeutic dialogue.

This main theme depicts how systemic and constructionist change process entails *shifting towards non-pathologizing discourse*, including both the challenging of pathologizing discourses (societal level), but also the *empowering process of highlighting family members' resources and positives*, coupled with *shifts towards more agentic positions*.

Deconstructing pathologizing dominant discourses. Seven studies illustrated how change process discourse entails a process of *deconstruction of dominant, totalizing, pathologizing narratives*. The latter are depicted in the rigidity of diagnostic discourse (2) or in deficiency talk (36) which constructs problems as manifestations of individual psychopathology and self as the locus of problems (and solutions) drawing from a discourse of "individual shortcomings" (58, p. 92).

Four studies (4, 7, 23, 36) illustrated how family members gradually espouse alternative discourses in their in-session dialogue, while resisting internalized and oppressive discourses. Such shifts are depicted in conversations where speakers navigate between familiar and unfamiliar ways of speaking (36) and question the split between the personal and the social sphere regarding the reported difficulties, for example when problems with self-acceptance are discussed as arising from wider societal issues, such as homophobia (32).

One study (7) highlights therapists' contribution to the discursive performance of this process, when they shift the conversation from content to process by commenting on how family members talk instead of what they talk about. Another study (23) highlights therapist normalizing by making appeals to the common experience of hearing voices in the case of an identified patient with a psychiatric

diagnosis, whereas another (4) highlights how the therapist explicitly refers to dominant, pathologizing discourses.

Extract 4 (part of extract, study 4, p. 63)

That doesn't mean that I am pathetic, or that you are pathetic...I think it's helpful to sort of not see it as something that is wrong with me... but to see there are patterns here that we are all living out and we've been indoctrinated into following from the time we were little boys, and these have an effect on how we are in our relationships....

Towards resourceful and empowering dialogue. Systemic and constructionist change process entailed a shift from focusing on individually experienced negative feelings to a more positive and hopeful picture of family members in relation to each other (64). The findings of five studies highlight specific therapist discursive contributions performing the emphasis on strengths and positives. These include, providing feedback while discussing strengths and solutions (28, 29), highlighting family members' skills and resilience, like stoicism and coping thus enhancing hopefulness (29) and reframing, that is offering different, positive conceptualizations of problems (7). One study (61) illustrates empowering in the process of the therapist highlighting each member's contribution to the solution, using "you both" "you all" to promote joint work.

Therapists from different models utilize various discursive strategies. For example, one study focusing on SFBT (29), highlights how therapist use of scaling and questioning which invites the reporting of skills/resources increases hopefulness by enabling parents to perceive their situation with a 'sense of coherence' through empowerment. Another study (64) focusing on reflecting team settings, highlights

how the discursive practice of "pairing talk" by reflecting team members accomplishes the shift to resourceful dialogue and positivity. Firstly, during the session, the therapist validates family members' descriptions of problems by e.g., use of "mmm", "yeah". Then, in the reflecting team session, team members "pair" their talk with family members' talk, that is they revisit its content by reframing it in a positive way. The following extracts illustrate "paired talk" (64).

Extract 5a, (part of extract 1A, main session, study 64, p. 542)

```
1    P:   but that wouldn't have been that wouldn't have been
2         a problem for your Dad
3         (0.4)
4    Y:   yer they said it wouldn't but I reckon it would
5         (0.4) he's gonna put on a brave face where he won't
6         upset me but I actually reckon it would bother him
7    T2:  mmm
8         (1.0)
9    T2:  so you must know that he cares about you very much
10        then (.) even tho' sometimes you're fed up with
11        [`im c]os=
12   Y:   [Yer ]
13   T2:  he's so overprotective (0.3)
14        and he' [s str]ict
15   Y:            [Yeah ] (Nodding)
16   T2:  you still know that he loves you
17   Y:   (Nods)
18   T1:  °yeah°
```

Extract 5b (part of extract 1B, reflecting team session, study 64, p. 543)

```
1     T2:  it's just so easy to go rushing off ohh this is my
2          real Dad
3          (0.8)
4     T1:  umm
5     T2:  °kind of erm°
6          (1.9)
7     T1:  y[eah
8     T2:   [°stuffyou°
9          (0.5)
10    T1:  and kindof (0.5) err very thoughtful (.)
11         considering y'know she's said to us that she's also
12         been >very angry with err Dad<
13    T2:  yeah and he's over (0.4) so even thou he's over-
14         protective (0.9) umm an she thinks he's st:rict
15         (0.3) it's almost as if (0.3) at least she's
16         reassured that he loves her=
17    T2:  yeah
18    T1:  =from being like that really
19    T2:  yeah yeah
           (0.5)
```

The discursive accomplishment of relational agency. Eleven studies illustrate how change process discourse entails gradual shifts from less agentic towards more agentic positions of family members and identified patients. Identified patients, including those with a psychiatric diagnosis (2, 3, 7, 23, 37), are gradually positioned as subjects rather than "objects", thus enabled to take initiative for action (2). For

example, one study (23) depicts a gradual shift in how the client's identity is constructed from a constraining subject position associated to the psychiatric discourse to more complex, inclusive, and fluid subject positions. Therapist is shown as addressing the client as a subject owning experiences, to counter their positioning by psychiatric diagnosis, while exploring the content and the function of the voices they hear, in a playful and humorous way. Another study (25) highlights how therapists' selective joining with family members, leads to more agency for the identified patient, whereas another study (7) identifies how the shift towards agentic positions may be accomplished (a) by moving from a discourse of family members being controlled by the reported difficulties to the one of them being in charge and (b) by the therapist acknowledging family members' difficulties in constructing "problematic" behaviors as valid.

Furthermore, shifts towards agentic positions are coupled with the replacement of rigidity by fluidity and relationality in subject positioning promoting a *relational sense of self*, i.e. a sense of self which can also be attentive to others and connect with them (2, 32), as exemplified by the following extract (Daniel: therapist).

Extract 6 (part of extract, study 32, p. 442)

Daniel: You've been able to see what's going on with other people, haven't you, Olivia?

Olivia: Yes.

Miriam: A lot! (. . .) She's been looking at others, and she actually sees them. And that is very enriching to her; it's been an amazing help. (. . .)

Daniel: I am under the impression, Olivia, that your ability to see what's going on with other people has to do with an

ability to better see what's going on with yourself too. Does that make sense? Or, does it not?

Olivia: It does. It's not just about helping other people. When I help others, I also do something for me, because I am helping myself too. And, I no longer think about not being able to be myself anymore. Because I am a sure laugh too.

Finally, two further studies (11, 29) highlight how family members gradually gain relational agency, by legitimising other family members' responses while undertaking responsibility for active collaboration and two other studies (36, 44) illustrate how shifts towards relational agency seem coupled with an accomplishment of self-understandings which are more preferable to family members.

Theme 3. Moving-forward dialogue.

This main theme depicts change process as a process of moving-forward therapeutic dialogue, like *moving away from stuck or unhelpful dialogue*, *conversationally repairing alliance ruptures* and *moving from monologic to dialogic dialogue*.

Moving away from unhelpful dialogue. Eight studies illustrate shifts denoting the moving away from unhelpful dialogue. Such shifts include, moving the dialogue forward beyond impasses in conversation (10, 11, 12, 37) and family members' gradual shifts towards ways of talking which are more mutually acceptable (57). One dialogical study (27) identifies how shifting the impasse of a seemingly immovable conversation is performed in the movement from inner to outer dialogue. Another study (49) illustrates how the therapeutic dialogue may entail a "back and forth" process, marked by repairs, that is corrections of talk and hesitant markers, depicting the need for establishing safety as a prerequisite for moving forward.

Moving beyond impasses includes the managing of complex family dynamics (43) by the therapist, shown as inviting family members to consider a middle ground between conflicting positions so that they can engage in conversations which move things forward (12). Three studies (10, 11, 57) depict a number of therapist's discursive practices facilitating the opening of a middle ground, like *utilizing the ambivalence* in family members' talk or *the expression of weak agreements*, the *offering of a candidate, that is, a likely answer* included in the question posed, *extreme case formulations and use of humor* (to temper extreme cases and tension), as well as *attentive listening in a selective way*. Family members responded at times by undertaking similar or conflicting positions, by offering listener's responses, by reformulating therapist's language, by partially up-taking therapist's contributions, when showing acceptance but also reservations and by offering information (10).

The following extract illustrates therapist's use of client's expression of weak agreement (lines 224, 227) while providing candidate answers (line 228).

Extract 7 (extract 2, study 10, p. 292)

222 T: Oh! It sounds like you did a lot of work! (1)
223 B: {Bob sits up straight with a small smile}
224 J: *Mhmm* (.7)
225 T: Oh (2.4) you must feel (.) > pretty good about < (.6) what you've
226 done here eh? (1)
227 J: {Joe looking down at his bottle of pop}
228 T: ya no? (1.5)
229 J: *Ya* {Looking down and fiddling with bottle}(1)
230 T: Or do you feel like you were kind of forced into it? er:: (1.9)

Towards the conversational repair of alliance ruptures. Ten studies' findings indicate how *alliance* seems *jointly* and *discursively performed* by therapist and clients. Therapist contributions included efforts to build and maintain a strong therapeutic relationship (28, 57), e.g. empathizing with the family members, (4) posing questions which allow time to get to know them (38), showing responsiveness (24) and making family members feel validated by using similar language and confirmation which facilitates joining (25). One study (57) further showed how the strengthening of therapist and client alliance facilitated the building of alliances between family members.

Instances of misalignment and disengagement where, e.g., the therapist may exhibit limited reflection on family members' affects, experiences or concerns (24, 25, 42) were shown within in-session dialogue as leading to alliance ruptures during the process, including problems with joining or failure to track family members' contributions and thus coordinate (25, 37). Misalignment was conversationally evident, for example, in interrupted structural sequences and abrupt changes in the focus of family members' discourse (24). Another study (29) demonstrated alliance ruptures in SFBT therapy where seemingly some of its components, like future questions, place significant ethical and safety challenges regarding individuals with social communication difficulties, like children with autism.

Evidence from a CA study (37) demonstrates how therapist and family members jointly move through a phase of alliance rupture towards its repairing. The rupture is indicated by dis-preferred responses. For CA (Schegloff, 2007), conversations exhibit preference organization in that there are normative expectations regarding which responses are preferred. Dis-preferred responses may be marked for example with long pauses or with questions when answers are normatively expected.

Such dis-preferred responses indicate disaffiliation/misalignment. Study 37 illustrates how the therapist acknowledges such disaffiliation and then shares his own anxiety to re-establish joining and alliance with the family members.

However, as one study (42) demonstrates, alliance ruptures are not always repaired like in the case of children disengagement, despite therapist attempts to re-engage by, e.g., acknowledging the difficulty of being talked about negatively. Finally, another study (11, p. 70) depicts how the therapist may employ a "perturbed speech pattern", marked by non-verbal features like breath inhalations to secure engagement when introducing a delicate topic as illustrated in the following extract.

Extract 8 (study 11, p. 70)

T: **Okay** (*inhalation*) **no::w** (*vowel held*) (*pause of half a sec*) was this um whose idea was it do you think (*pause of 4/10 sec*) to make this contract? (*pause of 4 sec*)

BOB: **{Bob wringing his hands}**

T: Was it yours your mom's your dad's, the hospital staff (*pause of 8/10 sec*) your uncle's (*pause of almost 3/10 sec*)

JOE: The nurse's I guess (*pause of 7/10 sec*)

T: The nurses idea? (*pause of 4/10 sec*)

From monologue to dialogue. Eight studies illustrate the movement from monologue to dialogue. Such process entails the *performance of polyphony* (3, 32, 44, 59), especially in dialogical therapies. One study (44) illustrates such performance in team members' talk when engaged in open dialogue. Three studies (24, 44, 60) highlight how therapists' discursive contributions include reflexively acknowledging client's concerns and emotions (24), showing genuineness in attending to clients' voices by "talking as listening" ("dialogic listening") and paraphrasing clients' words (44, p. 431) while being directive as well as responsive and dialogic (60).

Accordingly, family members gradually shift toward heterogeneity in their voices (13) and acquire reflexivity regarding their communication.

Preferred ways of therapist language use for performing dialogic therapies include, (a). the use of certain conversational strategies which seem to allow for vulnerability talk, like topic switch, reversals (changes in meaning or introducing alternative meanings), continued engagement with the topic of discussion or identification (47) (b). the use of conversational resources creating dialogue between family members, allowing participants to position themselves in other voices (32) and (c.) the use of non-intrusive language including open-ended questions reflexively addressed to multiple persons facilitating client reflexive positioning (60), as exemplified in the following extract.

Extract 9 (part of extract, study 60, p. 284)

T1: Uhuh . . . can you help me understand a little bit more about what the difference is between this type of stress?

H: For me it is more stressing to argue with her than the extreme situations in which I have been in my job . . . during the military service (. . .).

T1: Yes, and how do you explain that to you, that this is more stressful compared to the extreme situations you were in?

H: Because . . . in my job you already expect that the situation won't be under your control . . . but . . . for me I should be able to control the results when I argue with her . . . it is very stressful to see that I can't control the arguments with her. . . .

One study (24) highlights how certain kinds of dialogue, like culturally significant dialogues, can challenge the smooth flow of conversation and lead to the reverse process, namely shifts from dialogue to monologue, important for therapists to

notice in the moment. It depicts differences in therapist's responsiveness between culturally relevant talk and non-cultural talk within the same session, like when the therapist responds with "Uhumm, Yeah, Right", illustrated as performing lack of responsiveness.

Theme 4. The dialogic interplay of power.

This fourth main theme reports systemic and constructionist change process by depicting discursive practices denoting the *shifting balance of power positioning* between clients and between the therapist and clients.

Sharing dominance. Six studies illustrate the delicate balance of *power* distribution between the therapist and family members and the shifts in participants' positioning concerning its allocation. They highlight how therapists seem to alternate between exercising power and striving for a more balanced power distribution. For example, couple therapy studies demonstrated the importance of the therapist exercising power and e.g., using directives to facilitate partners' accountability for the presenting difficulties (59) and prevent perpetuating inequality (60). One study (62) showed how the therapist utilized various discursive strategies to interrupt the perpetuation of power imbalance between couple partners and avoid speaking as if they were equal, including (a). the use of his/her voice to tone down or amplify, (b). the creation of space for the less-powerful voice, (c). the naming of power discrepancies and (d). the confirmation of the less powerful person's competence or encouraging the more powerful one to shift to a more relational perspective as exemplified in the following extract.

Extract 9 (study 62, p. 232)

Therapist: One of the things I wonder, Dave, is what you imagine Sonja would feel hearing or overhearing about a

conversation like that? What is your understanding of what would be troublesome for her about that?
Dave: [it is] probably like her past experiences with her other exes.

Other studies highlighted therapist efforts towards a more balanced power distribution between themselves and couple/family members (3, 10, 50, 62). For example, these included, inviting family members to become active participants in the session (10) and noticing and responding to cases where family members objected to how they were being positioned (50).

Sharing expertise. Eleven studies depicted how *expertise* seemed negotiated and at times *shared* between the therapist and family members. They highlighted how family members call for therapist expertise when asking for practical assistance (40), but also how therapist's positioning as expert and as non-expert can be constructed simultaneously (28, 61). For example, he/she may offer direct suggestions, guidance and interpretations in a tentative, flexible and democratic manner (28, 61) as illustrated in the following extract.

Extract 11 (study 61, p. 431)

Wife: I just want to be able to handle things again, to cope with things. I'm real good at avoiding things, just 'cause I can' handle it. I flat out can't handle it... I'm the first one to admit it, and I'll tell you when I can't handle it.
Therapist: See, I'm still confused. I guess I'm not clear on what you're doing that's not coping with what's going on.

Other studies highlighted the *mutuality in expertise performance* (13) illustrating how the therapist would strive to center client's knowledge alongside their own (4, 11, 12, 29) by acknowledging clients' expertise and potential to "teach" the

expert (29). For example, one study (4) reported therapist's use of direct declaration of clients' knowledge or invitation to clients to identify their own preferences.

Another paper (12) demonstrated the process of the therapist giving advice as a step-by-step collaborative, shared process with therapist and family members jointly arriving at a common ground. For example, the therapist would provide a conditional suggestion open to contestation, inviting family members to consider alternative views and thus "creating a balance between their authority and client's autonomy" (p. 337). Alternatively, the therapist would respond to partial uptakes by downgrading their views, incorporating the family's contributions and returning to earlier conversation to continue to develop co-construction of a mutual position.

The dynamic process of sharing expertise is further depicted in therapist's *both strategic and tentative use of language*. For example, one study (18) highlights nuances in therapist language use in SFBT indicating strategic use of language to actively pursue therapist's agenda, like pursuing a response repeatedly, using reformulations and offering a candidate answer or answering himself/herself the questions posed and overlapping talk. Two further studies illustrated how therapist use of interruption signaled maintaining authority (10) and how not sharing expertise and directly stating for family members what can be done or not indicates attempts to manage family members' expression of complaints (40). On the other hand, tentative use of language seems to include invitations to speak (10), as well as repairs (57), i.e. corrections of utterances, and subtly inviting changes in meaning (47).

Collaboratively building shared language. Eight studies illustrate the nuanced discursive work performing a *collaborative building of shared language*. Therapists' discursive contributions include: (a). using reformulations, i.e. repeating previous statements by adding new meaning to incorporate family responses and

facilitate shifts towards shared understanding (10), (b). explicitly acknowledging the difficulty for family members to listen to being talked about negatively (42), (c). using rapport building or agenda setting questions (29), (d). carefully monitoring clients' language to build common ground for a "future plan", like in SFBT when asking about exceptions (38), (e). meta-commenting and "fishing" (11, p. 73) by offering suggestions to test the ground before reaching common understanding (11), (f). slowly building a question for one member while staying connected to others to accomplish a shared curiosity and shared language by trying to edit their talk in order to fit their co-conversants (11, 57) and (g). exhibiting uncertainty and a not-knowing stance, while simultaneously trying to validate each family member's view and at times de-escalate conflict (61). In other cases (24), dismissing or over-talking may hinder the building of common language and indicate a struggle for dominance.

The following extract illustrates "fishing".

Extract 12 (study 11, p. 73)

488 T: that you can actually talk (*emphasis added*) to them
489 about some issues (*1 sec pause*)do you trust him? (*pause of*
490 *2.1 sec*)
491 JOE: **Ya I guess** {*spoken softly shrugs and remains playing*
492 *with the label on the bottle*}
493 T: You don't sound too convinced (*pause of 2.1 sec*) or do
494 you think that (*inhalation*) You'd like to see your dad
495 (*emphasis added*) make some commitments to work towards (*1*
496 *sec pause*) you know showing you (*emphasis added*) that he
497 is willing to hear you in (*1 sec pause*) in new ways or
498 something? (*pause of 16.5 sec*)
499 T: Or d you think that I'm getting into dangerous

450 territory by even raising this? (*spoken quickly*) (*pause of*
451 *2.1 sec*)

Discussion

Our qualitative meta-synthesis illuminated how change process is discursively and sequentially performed by depicting various concrete therapist and clients' discursive moves within naturally occurring data.

Clinical implications

By illustrating the scope of how in-session change process discourse has been qualitatively researched, our synthesis highlights what in-session dialogue tells us about discursive practices in systemic and constructionist therapy. Our synthesis offers examples of the in-session, discursive performance of small outcomes, thus offering valuable insight to clinicians interested to reflect on their conversational therapeutic practices. By illuminating the performative aspects of language use, our synthesis draws therapists' attention to the nuanced, rhetorical aspects of clients' and their own use of language thus increasing their ability to monitor clients' discursive practices and to use language reflexively and, therefore, enhancing therapist's reflexive self-and other monitoring.

Our synthesized discursive studies highlight the situated and context-bound nature of therapists' and clients' discursive practices (Parry & Land, 2013). For example, the same discursive construction, e.g. therapist's use of a candidate answer, is shown as facilitating moving away from stuck dialogue (10) and as contributing to the strategic pursuing of therapist's agenda (18). Rather than providing "recipes" for practice, our findings equip clinicians with sensitizing concepts to reorient to in their

own clinical practice. More specifically, our findings illuminate the challenges inherent in systemic therapists' effort to forward a relational perspective concerning the reported difficulties. On the one hand, they illustrate how certain therapist discursive moves, like the performance of multi-partiality by means of collective soliciting, that is inviting more than one family members to respond to a question (11) contribute to the shifting towards more relational constructions. On the other, our findings alert clinicians to nuances in family members' responses, like the construction of hard to refute accounts about the identified patient's problematic behaviour. Such accounts suggest that therapist discursive moves aiming to establish a relational understanding of psychological symptoms are not always responded to by family members as intended, but as allocating blame to them for the presenting difficulties (Ong et al., 2019b; Patrika & Tseliou, 2016).

Our findings further alert clinicians to certain ways of language use suggestive of pathologizing discourses, like when drawing from discourses where psychological symptoms are constructed as deficits of an individual (58). They further provide examples of therapists' engaging into resourceful dialogue like in the case of reflecting teams' "pairing talk" (64), or when making explicit reference to the restraining effects of pathologizing, societal discourses (4).

Furthermore, our synthesis familiarizes clinicians with the subtleties of in-session discourse denoting stuck or unhelpful dialogue, but also with ways for moving such dialogue forward. For example, CA synthesized studies demonstrate how clinicians may contribute to conversational stuckness by showing limited reflection to family members' abrupt changes of focus in talk (24) and how family members' dis-preferred responses indicate alliance ruptures (47). They further illustrate discursive practices which move the therapeutic dialogue forward, like the therapist employing a

"perturbed speech pattern" with pauses and inhalations (11, p. 70) or engaging into dialogic listening (44) in dialogic therapies.

Finally, our findings highlight the dynamic interplay of power and expertise positioning concerning the therapist and client. Certain findings of the synthesized studies challenge the post-modern imperative (Anderson, 2005) to share and mutually perform expertise. Our synthesis highlights how the lack of the therapist issuing directives may contribute to the perpetuating of inequality between partners in couple therapy or how the therapist may at times need to attend to family members' calls for practical assistance by undertaking the role of an expert. Other studies offer support to post-modern mandates by depicting the sharing of expertise by means of the therapist self-positioning as both an expert and non-expert, when, for example, they offer guidance in a tentative manner (61).

Limitations

Conducting this review has been a multi-level challenge, bearing a number of limitations, like our decision to synthesize the findings from studies deploying different methodologies, espousing different discourse theories. Furthermore, the screening of the synthesized articles against quality criteria underlined several shortcomings aligned with the findings of methodological reviews (Ong et al., 2019a; Tseliou, 2013). However, most CASP criteria are not necessarily syntonic with methodologies like CA/DA (Ong et al., 2019a; Tseliou, 2013) and studies scoring low quality marks may also reflect the limitations of CASP. Moreover, our selection of thematic analysis for synthesizing CA/DA studies' findings has possibly restricted the potential to depict findings in ways syntonic with such methodologies. Existing reviews have followed similar procedures (e.g. Ong et al, 2019b) despite calls for specific procedures needed in synthesizing CA/DA findings (Parry & Land, 2013).

Devising methodological procedures for synthesizing qualitative research findings especially concerning discursive methodologies remains a challenging and not yet accomplished project, which we hope we will see developing in the future. The broad scope of our review, the wide focus of our research question and our choice to synthesize studies across systemic and constructionist therapeutic models and approaches has, further, posed challenges, concerning the process of synthesizing but also the reporting of our review. For example, our choice to synthesize systemic and constructionist approaches can be questioned given the extensive discussion concerning their differences in the field and the conceptual diversity of the term "systemic". Furthermore, our broad scope limited the potential for a more detailed reporting but also for investigating and reporting the performance of certain change process aspects within specific models/approaches, which we think should be pursued in the future. Finally, we acknowledge that our synthesis does not provide specific answers to significant questions concerning systemic and constructionist change process performance, like what accounts for congruence or non-congruence between therapists' and client's discursive contributions performing change process, which we hope we will see guiding future research.

Conclusion

By synthesizing findings from qualitative research studies sampling in-session discourse, we have drawn attention to the complex, recursive aspects of change process in systemic and constructionist therapies. Providing empirical evidence from discursive research studies foregrounds the subtle discursive work, which is often taken for granted in everyday clinical practice. Such scrutiny of the therapeutic dialogue as change process unfolds enables practitioners to become more reflexively

aware of their own fine, often obfuscated contributions to the overall pattern of how therapy evolves (Ong et al., 2019b; Strong & Smoliak, 2018; Tseliou, 2013). Consequently, clinicians can perform discursive therapy more intentionally and more responsively. Similarly, change process researchers can further pursue the unique potential which in-session discourse offers for investigating systemic and constructionist change process as an interactional, discursive accomplishment. We hope that this qualitative meta-synthesis will inspire both.

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Figure 1. Stages and results of search strategy and screening

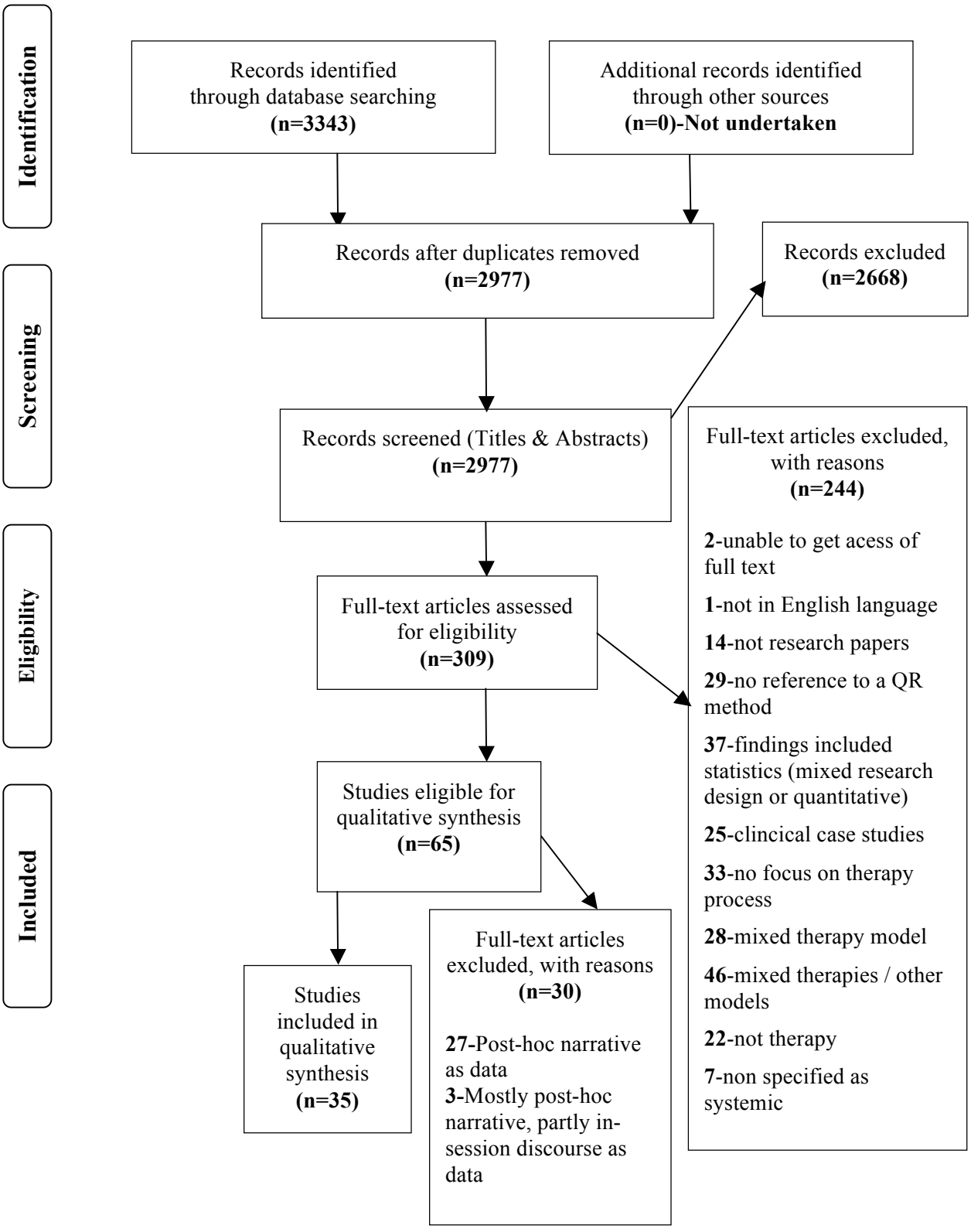

Figure 1. PRISMA flow chart. Adapted from Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

Figure 2. Main themes and sub-themes

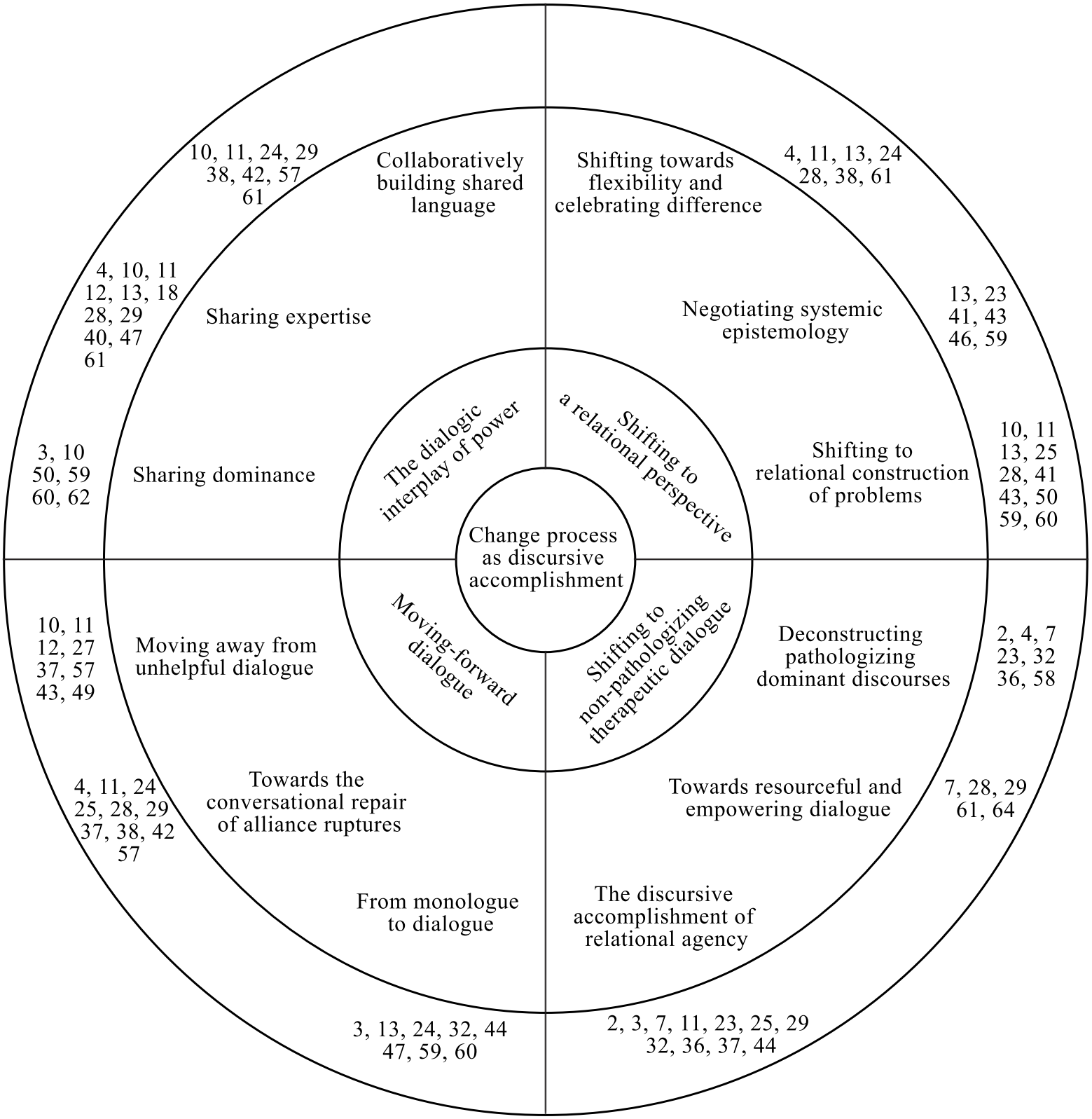

Figure 2. Synthesis of studies' findings.

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

Legend for supplemental material

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

Table S1

Search terms of final search

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

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

Table S2

Inclusion / exclusion criteria

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

Analysis, Thematic analysis, Narrative analysis / Inquiry, Ethnography, Action research, Framework analysis, Recursive frame analysis, (Hermeneutic) Case studies	designs including findings from statistical analysis Clinical case studies and quantitative research case studies	hermeneutic qualitative research tradition
Qualitative data collected by means of: observation (including audio/videotaped sessions) and self-report (interviews / focus groups)	Quantitative data	
6. Phenomenon of interest:		
Systemic and constructionist couple and family therapy process:		
Explicit reference to systemic couple / family therapy or to a systemic or constructionist couple and family therapy model (including literature review): Structural, Strategic, MRI, Milan, Post-Milan, Reflecting Teams approach, Open	Family based interventions with mixed / integrated models including other approaches (e.g., CBT) Studies with mixed	Aim to capture process in systemic, constructionist terms

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

Single therapists or therapeutic teams, leading therapists or any therapist including trainees	Consultation, role-play, settings	Peculiarities in the setting

8*. Type of data:

In-session discourse (observation, audio/video taped sessions)	Post-hoc narrative of therapy process (interviews, focus groups, written accounts, IPR interviews)	To capture change process within in-session therapy discourse

Table S3

Study characteristics I[1]

Reference (Author / year of publication)	Aim / research question(s)	Method		Sample characteristics			Data / Data collection method	Epistemology	Ethics	Therapy model / approach	Quality appraisal
		Methodology	Method of analysis	Patient population / referral problem	Session format	Therapist population					
2[2]. Avdi (2005)	Exploration of discursive negotiation of agency in cases with psychiatric diagnosis (496)	DA (496)	DA/ PDA (496)	Child and adult /Child autism-psychosis (498)	Family (497)	Therapeutic team (497)	12 transcribed, videotaped sessions from 1 case (498)	Social constructionist (abstract)	Informed consent (497)	Milan (497)	CASP: #6, #7
3. Avdi, Lerou & Seikkula (2015)	Exploration of usefulness of dialogical theory for investigation of therapy process for psychosis and exploration of "dialogical features that seem to be	DLA (331)	DIHC (332)	Adult / psychosis (331)	Couple (331)	Co-therapy (332)	3 transcribed videotaped sessions from 1 case (332)	Indirectly stated: social constructionist (331)	Informed consent (332)	OD (332)	CASP: #6, #7, #8

[1] For code abbreviations see Table S5

[2] Numbers of references correspond to the ones appearing in Tables 1.1, 1.2 and 3 in the paper, and in the reference list included in Suppinfo2, supplemental material

	associated with the emergence of new narratives and new self-positions in the clients' talk" (331)										
4. Béres & Nichols (2010)	To compare group narrative therapy for men with abusive behaviours with psychoeducational / cognitive behavioral approaches (60, 61)	CS (62)	Phenomenological content analysis /QCA (62)	Adult / Men with abusive behaviours in intimate relationships (62)	Group (61)	Co-therapy (62)	12 transcribed audio-taped sessions from 1 group (62)	Unstated	Informed consent (62)	Narrative (61)	CASP: #3, #6, #7, #8, #9, #10
7. Burck et al. (1998)	Investigate therapist's contributions to change in family therapy process (255)	GT/ DA (254, 255)	DA (255)	Child and adult/ Concerns about parenting (256)	Family (256)	Co-therapy (256) .	Transcribed sessions (unclear number) from 1 case (254)	Unstated	Unstated	Indirectly stated: language/narrative approaches (254)	CASP: #3, #6, #7, #8
10. Couture (2006)	Investigation of "how family members and therapist move beyond impasses in process" (287)	CDA / CA (286)	CDA / CA (286)	Adolescent and adult / adolescent self harming behaviour (289)	Family (287)	Single, renowned (287)	Segments from one videotaped, transcribed session with IPR procedure (287)	Unstated	Unstated	Indirectly stated: Collaborative (289)	CASP: #3, #4, #5, #6, #7, #8
11. Couture (2007)	Examination of conversational practices in family therapy multiparty	CDA / CA (65)	CDA / CA (65)	Adolescent and adult / adolescent self harming	Family (67)	Single, renowned (67)	Segments from one videotaped, transcribed session with	Unstated	Informed consent (67)	Collaborative (67)	CASP: #1, #3, #4, #5, #6, #7

	process talk (64)			behaviour (67)			IPR procedure (67)				
12. Couture & Sutherland (2006)	Investigation of communication processes involved in advice giving in family therapy (329)	CA (333)	CA (333)	Adolescent and adult / adolescent self harming behaviour (333)	Family (333)	Single, renowned (333)	Segments from one videotaped, transcribed session with IPR procedure (333)	Unstated	IRB approval (343)	Collaborative (328)	CASP: #3, #4, #5, #6, #7, #8
13. Diorinou & Tseliou (2014)	Investigation of role of circular questioning in therapy process at initial SFT sessions (107)	DA (107)	DPsy (Discursive Action Model) (108)	Adult / mental health problems (108)	Family (108)	Therapeutic team (108)	1 transcribed videotaped-session from 1 case sampled from 22 (108)	Social constructionist (107)	Informed consent (108)	Systemic – Milan model (108)	CASP: #7
18. Gale & Newfield (1992)	Exploration of the therapeutic process (how outcomes are conversationally achieved) in a solution-focused therapy session (153)	CA (154)	CA (154)	Adult / relationship problems (157)	Couple (157)	Single, renowned (157)	1 video-recorded, transcribed session (157)	Constructivist (163)	Unstated	SFBT (157)	CASP: #6, #7
23. Karatza & Avdi (2011)	Investigation of therapy process in families with psychosis and of DA's potential (215)	DA (215)	DA (219)	Adult / psychosis (218)	Family (218)	Therapeutic team (218)	7 videotaped, transcribed sessions (218)	Social Constructionist (217)	Informed consent (218)	Systemic/ RT (218)	CASP: #6, #7
24. Lee & Horvath (2014)	Investigation of micro-interactional patterns in terms of therapist cultural	CA / SASB (196)	CA / SASB (197)	Adult / parenting problems (depression in one case) (197)	Individual / (couple in one case for one	Single (197)	8 videotaped, transcribed, first sessions of 3 cases and selection of 20 episodes in	Unstated	IRB approval (197)	SFBT (197)	CASP: #3, #4, #6, #8

	responsiveness in cross-cultural therapist-client dyads (196)				session) (197)		total for micro-analysis (197-198)				
25. Lee et al. (2018)	Investigation of discursive process of joining in cross-cultural family therapy encounters (149)	CS (152)	CA (p. 154) / PDA (155)	Adolescent and adult / school absence (153)	Family (153)	Single (153)	12 audio-taped, transcribed sessions of 1 case (p. 157) selected from larger pool (152)	Indirectly stated: Social constructionist (155)	IRB approval (152)	"Eclectic", SFBT and narrative (154)	CASP: #6
27. Lidbom et al. (2015)	Exploration of contribution of participants' inner dialogues to significant dialogical sequences in network therapy (122)	DLA / phenomenology / DIHC (124)	DLA / phenomenology / DIHC (124)	Adolescent and adult / adolescent mental crisis (123-125)	Network (123)	Single, co-therapy (124)	6 videotaped sessions of 6 cases and video-recorded interviews with each participant (a type of IPR procedure) transcribed (124)	Unstated	IRB approval and informed consent (124)	Dialogic network therapy (122)	CASP: #2, #3, #4, #5, #6, #8
28. Liu et al. (2013)	Exploration of systemic family therapy interventions in Chinese practice (450)	TA / Exploratory design (450)	TA (451)	Child, adolescent and adult / variety of referral problems (450)	Family (450)	Single (450)	20 videotaped, transcribed, sessions from different stages of therapy of 14 cases with 5 therapists (450)	Unstated	Unstated	Variety: Milan and Integrated (systemic-structural) (451)	CASP: #2, #6, #7
29. Lloyd & Dallos (2006)	Description of content and process of initial	CS (371)	TA (Abstract)	Child and adult / child ID	Family (372)	Single (14 of study 31)	7 audio-taped, transcribed, initial, SFBT	Unstated	IRB approval and	SFBT (Abstract)	CASP: #6, #8

	SFBT family sessions with children with Intellectual Disability (ID) (371)			(372)			sessions (372)		informed consent (372)		
32. Martins et al. (2017)	Investigation of change in family therapy by focusing on therapeutic conversation (434)	DA (436)	DA (436)	Adult / Unspecified (435)	Family (435)	Therapeutic team (435)	33 audio-recorded, transcribed family sessions of 3 cases (435)	Social constructionist (436)	IRB approval and informed consent (435)	RT (435)	CASP: #4, #8, #9
36. Mudry et al. (2015)	Investigation of conversational performance of Internalized Other Interviewing (IOI) (171)	DA (169)	NA, CDA, DA (ethnomethodologically informed) (169)	Adolescent and adult (169)/ Unspecified	Family (169)	Single, renowned (169)	1 transcribed excerpt from 1 videotaped session (171)	Indirectly stated: Social constructionist (169, 180)	Unstated	Constructionist (180)/ collaborative (181)	CASP: #3, #6, #7
37. Muntigl & Horvath (2016)	Study of conversational performance of alliance (management of alliance rupture) in structural family therapy (104)	CA (106)	CA (105)	Adolescent and adult/ addiction with alcohol (106)	Family (105)	Single, renowned (105)	First 5 minutes of 1 videotaped, transcribed session (105)	Unstated	Unstated (Demonstration tape)	Structural (105)	CASP: #4, #6, #7
38. Nau & Shilts (2000)	Investigation of use of "miracle question" by renowned SFBT therapists (130)	Unspecified	TA (abstract) / DoMA (131)	Unspecified	Individual, couple, family (131)	Single, renowned (130)	4 videotaped, sessions (130)	Unstated	Unstated	SFBT (130)	CASP: #3, #6, #7, #8, #9
40. O'Reilly (2005)	Investigation of therapeutic	DA (373)	CA / DPsy (373)	Child and adult /	Family (374)	Therapeutic team	22 hours of videotaped,	Indirectly stated:	Informed consent	SFT (374)	CASP: #4, #7

	process of complaining (373)			child behavioural disabilities (374)		(374)	transcribed sessions of 4 cases (374)	Social constructionist (373)	(374)		
41. O'Reilly (2014)	Exploration of "parental accounts in family therapy" (164)	DPsy (164)	CA / DPsy (164)	Child and adult / child behavioral disabilities (164)	Family (164)	Therapeutic team (164)	22 hours of videotaped, transcribed sessions of 4 cases (164)	Social constructionist (164)	Informed consent (165-166)	SFT (164)	CASP: #4, #7, #8
42. O'Reilly & Parker (2013)	Investigation of alliance with children in therapy and of management of ruptures in alliance by therapist (493)	CA (494)	CA (494)	Child and adult / child physical and mental difficulties (493-494)	Family (493)	Therapeutic team (493)	22 hours of videotaped, transcribed sessions of 4 cases (493)	"Deductive discursive epistemology" (493)	Informed consent (495)	SFT (493)	CASP: #4, #6, #7, #8
43. O'Reilly & Parker (2014)	Investigation of management of moral accountability/ appropriateness in talk for children in therapy process (289)	DA (290)	CA informed DA (290)	Child and adult / child physical and mental difficulties (291)	Family (290)	Therapeutic team (291)	22 hours of videotaped, transcribed sessions of 4 cases (290)	"Deductive discursive epistemology" (291)	Informed consent (290-291)	SFT (291)	CASP: #4, #6, #7, #8
44. Olson et al. (2012)	Investigation of shifts in dialogue in couple therapy process (421)	Qualitative CS (421)	DIHC (421)	Adult / depression (421)	Couple (421)	Co-therapy (425)	1 videotaped, transcribed session of 1 case (424)	Unstated	Informed consent (421)	OD (421)	CASP: #3, #4, #7, #8, #9
46. Patrika & Tseliou (2016)	Investigation of blaming sequences in	DA (468)	DPsy-DAM (474)	Child, adolescent and adult /	Family (471)	Therapeutic team (472)	9 videotaped, transcribed initial (1st and	Constructionist (484)	Informed consent (472)	Milan SFT (471)	CASP: #7

	problem talk at initial SFT sessions (471)			variety of referral problems (472-473)			2nd) sessions of 6 cases (471)				
47. Pote et al. (2011)	Investigation of the handling of vulnerability and protection issues in SFT concerning cases with Intellectual Disability (ID) (107)	TA / CA (Abstract)	TA / CA (107)	Adult / adult ID (107)	Family (107)	Therapeutic team (107)	4 videotaped, transcribed sessions of 3 cases (107)	Unstated	IRB approval and informed consent (107)	SFT (107)	CASP: #3
49. Rober et al. (2006)	Exploration of narratives concerning domestic violence in FT process (315)	NA / CA (315)	NA / CA (315)	Child and adult / child behavioural problems (317)	Family (317)	Single (317)	1 videotaped, transcribed session and notes on therapist reflection with IPR procedure (315)	Social constructionist (315)	Informed consent (317)	Dialogical (317)	CASP: #3, #7, #8
50. Sametband & Strong (2018)	Exploration of discursive negotiation of preferred cultural identities by immigrant family members in FT process (202)	DPsy (205)	DPsy (205)	Child, adolescent and adult (207) / mother-daughter arguments (208)	Family (206)	Unspecified	16 videotaped, transcribed therapy sessions and interviews with family members (similar to IPR procedure) of 9 cases (206-207)	Indirectly stated: Social constructionist (205-206)	IRB approval and informed consent form (206)	Collaborative (202)	CASP: #9
57. Sutherland & Couture	Investigation of use of language in post-modern	CA (212)	CA (212)	Adolescent and adult / Adolescent	Family (213)	Single, renowned (213)	Segments from one videotaped,	Unstated	Unstated	Post-modern / collaborati	CASP: #3, #6, #7

(2007)	therapy to identify how collaboration works (210)			self-harming behaviour (213)			transcribed session with IPR procedure (213)			ve (210)	
58. Sutherland et al. (2016)	Investigation of therapist-family interactions in diagnostic discussions (79)	CDA (82)	CDA (82)	Unspecified	Individual, couple, family (82)	Unspecified / trainee (81)	Excerpts (70 minutes) from videotaped, transcribed, conversations of 6 cases (82)	Indirectly stated: Constructionist (83)	IRB approval (82)	Variety: Post-modern (narrative, solution focused, collaborative, RT) (81)	CASP: #8, #9
59. Vall et al. (2014)	Exploration of how issues of responsibility, safety, and trust are dealt with in conjoint, dialogical therapy for psychological Interpersonal Partner Violence (IPV) (280)	DLA (278)	DIHC (279)	Adult / IPV (280)	Couple (280)	Co-therapy (281)	4 videotaped, transcribed sessions of 1 case (283)	Unstated	Informed consent (279)	Dialogical (Abstract)	CASP: #3, #4, #6, #7, #8
60. Vall et al. (2016)	Exploration of dominance and change in dialogical therapy for IPV (225)	DIHC (224)	DIHC (224)	Adult / IPV (225)	Couple (225)	Co-therapy (226)	4 videotaped, transcribed sessions of 1 case (227)	Unstated	Informed consent (225)	Dialogical (224)	CASP: #3, #7, #8
61. Vaughn (2004)	Development of theory for how therapist use of language may	GT & task analysis (426)	GT & task analysis (426)	Adult and adolescent /unspecified (427)	Couple / family (427)	Unspecified	Transcribed videotaped sessions: “31 episodes of	Unstated	Informed consent (427)	Variety: Systemic of various orientation	CASP: #6, #7

	influence clients to change (426, 428)						varying length from 18 different therapist-client systems" (427)			s (structural, emotionally focused, narrative, and symbolic experiential) (427)	
62. Ward & Knudson-Martin (2012)	Exploration of "how therapist actions impact the power dynamics in couple relationships" in therapy process (222)	GT (223)	GT (225)	Adult / issues of relationship stability and satisfaction (224)	Couple (223)	Single/ incl. trainee (224)	21 transcribed sessions from 15 cases with 11 therapists (223)	Unstated	Informed consent (223)	SCT Integrated: various orientations (experiential, structural, narrative, feminist/socioemotional) (224)	CASP: #6, #7
64. Williams & Auburn (2016)	Exploration of how positive connotation is 'talked into being' in RT process (535)	CA (538)	CA (538)	Child, adolescent and adult / variety of referral problems (540)	Family (539)	Therapeutic team (539)	5hrs of videotaped, transcribed sessions of 3 cases (539)	Unstated	Informed consent (539)	SFT / RT (538)	CASP: #7

Table S4

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

Reference (Author / year of publication)	Focus of study in terms of process	Phenomenon studied	Type of process discourse	Transcription type	Type of analysis / Evidence
2. Avdi (2005)	Problem talk	Diagnostic discourse / agency	In session discourse	Unspecified	Sequential / Included
3. Avdi, Lerou & Seikkula (2015)	Therapeutic dialogue	Change in dialogic features (dominance / responsiveness) in therapy process for psychosis	In session discourse	Verbatim	NA / Included
4. Béres & Nichols (2010)	Model	NT group sessions discourse	In session discourse	Verbatim	NA / Not included (quotes)
7. Burck et al. (1998)	Therapeutic dialogue	Contribution of therapist discourse to change	In session discourse	Verbatim	Non sequential / Included
10. Couture (2006)	Therapeutic dialogue	Conversational impasses	In session discourse	Verbatim (Jeffersonian)	Non sequential / Included
11. Couture (2007)	Therapeutic dialogue	Conversational impasses	In session discourse	Verbatim (Jeffersonian)	Non sequential / Included
12. Couture & Sutherland (2006)	Therapy concept	Advice giving	In session discourse	Verbatim (Jeffersonian)	Sequential / Included
13. Diorinou & Tseliou (2014)	Technique	Circular questioning	In session discourse	Verbatim	Sequential / Included
18. Gale & Newfield (1992)	Model	Therapist agenda in SFBT process	In session discourse	Verbatim (Jeffersonian)	Non sequential / Included
23. Karatza & Avdi (2011)	Overall process	Shifts in subject discourse positions related to psychosis	In session discourse	Verbatim (adapted Jeffersonian)	Sequential / Included
24. Lee & Horvath (2014)	Therapeutic relationship	Therapist cultural responsiveness	In session discourse	Verbatim-(Jeffersonian)	Non sequential / Included
25. Lee et al. (2018)	Technique	Joining	In session discourse	Verbatim	Sequential / Included
27. Lidbom et al. (2015)	Therapeutic dialogue	Inner dialogue	Both / In session IPR	Unspecified	Non sequential / Included
28. Liu et al. (2013)	Intervention	Therapist interventions	In session discourse	Verbatim	Non sequential / Included

29. Lloyd & Dallos (2006)	Model	Process of SFBT for ID	In session discourse	Verbatim	Non sequential / Included
32. Martins et al. (2017)	Therapeutic dialogue	Conversational resources	In session discourse	Verbatim	Non sequential / Included
36. Mudry et al. (2015)	Technique	IOP conversational practice	In session discourse	Verbatim	Sequential / Included
37. Muntigl & Horvath (2016)	Therapeutic relationship	Rupture in alliance / disaffiliation	In session discourse	Verbatim-(Jeffersonian)	Sequential / Included
38. Nau & Shilts (2000)	Technique	Miracle question	In session discourse	No transcription	NA / Included
40. O'Reilly (2005)	Problem talk	Complaining	In session discourse	Verbatim-(Jeffersonian)	Sequential / Included
41. O'Reilly (2014)	Problem talk	Blaming	In session discourse	Verbatim-(Jeffersonian)	Non sequential / Included
42. O'Reilly & Parker (2013)	Therapeutic relationship	Rupture in alliance with children	In session discourse	Verbatim-(Jeffersonian)	Sequential / Included
43. O'Reilly & Parker (2014)	Therapeutic dialogue	Appropriateness of talk	In session discourse	Verbatim-(Jeffersonian)	Non sequential / Included
44. Olson et al. (2012)	Therapeutic dialogue	Monological and dialogical dialogue	In session discourse	Verbatim	Sequential / Included
46. Patrika & Tseliou (2016)	Problem talk (blaming)	CQ and blaming sequences	In session discourse	Verbatim (adapted Jeffersonian)	Sequential / Included
47. Pote et al. (2011)	Therapy concept	Vulnerability talk	In session discourse	Verbatim (Jeffersonian)	Sequential / Included
49. Rober et al. (2006)	Therapeutic dialogue	Narratives concerning domestic violence	Both /In session IPR	Verbatim (adapted Jeffersonian)	Sequential / Included
50. Sametband & Strong (2018)	Therapeutic dialogue	Shifts in discursive construction of cultural identities	Both / In session IPR	Verbatim (Jeffersonian)	Sequential / Included
57. Sutherland & Couture (2007)	Therapeutic relationship	Collaboration	In session discourse	Verbatim (adapted Jeffersonian)	Sequential / Included
58. Sutherland et al. (2016)	Therapeutic dialogue	Diagnostic discourse	In session discourse	Unspecified	Sequential / Included
59. Vall et al. (2014)	Therapy concept	Responsibility, safety and trust in dialogic couple therapy for IPV	In session discourse	Unspecified	Sequential / Included

60. Vall et al. (2016)	Therapy concept	Dominance & dialogue in couple therapy for IPV	In session discourse	Unspecified	Sequential / Included
61. Vaughn (2004)	Therapeutic dialogue	Therapists' discourse and change	In session discourse	Unspecified	Sequential / Included
62. Ward & Knudson-Martin (2012)	Overall process	Therapists perpetuating and interrupting power balance in couple therapy	In session discourse	Unspecified	Sequential / Included
64. Williams & Auburn (2016)	Technique	Positive connotation in RT discourse	In session discourse	Verbatim (adapted Jeffersonian)	Sequential / Included

Table S5
Overview of codes and abbreviations appearing in data extraction tables[3]

Table S4 axes	Code / abbreviation
Method: Methodology / Method of Analysis	CA: Conversation Analysis (15) CDA: Critical Discourse Analysis (4) CS: Case Study (4) DA: Discourse Analysis (9) DIHC: Dialogical Investigation of Happenings of Change (5) DLA: Dialogical Analysis / Approach (3) DoMA: Domain Analysis (1) DPsy: Discursive Psychology (5) GT: Grounded Theory (3) NA: Narrative analysis (2) Phenomenology / Phenomenological content analysis (2) PDA: (Post-structuralist / Foucault type) (2) QCA: Qualitative Content Analysis (1) SASB: Structural Analysis of Social Behaviours (1) TA: Thematic Analysis (4)
Session format*[4]	Couple (6) Couple, family (1) Family (23) Group (1) Individual, couple (1) Individual, couple, family (2) Network (1)
Patient population*	Adult (10) Adult and adolescent (11) Child and adult (8)

[3] Bracketed numbers denote the number of articles where each code was assigned. In some cases, more than one code may have been assigned to the same article.
[4] Asterisk (*) denotes preset codes

	Child, adolescent and adult (4) Unspecified (2)
Therapist population*	Co-therapy (6) Single (15): Single (4) Single, co-therapy (2) Single, renowned (8) Single, trainee (1) Therapeutic team (11) Unspecified (2) Unspecified, trainee (1)
Data / Data collection method	Audio-taped sessions (4) Transcribed sessions (unspecified type of recording) (2) Videotaped sessions (26) Videotaped sessions with IPR (3)
Epistemology	Constructivist (1) Deductive discursive epistemology (2) Indirectly stated: Constructionist (6) Social constructionist (7) Unstated (19)
Ethics*	Informed consent (18) IRB approval (4) Informed consent and IRB approval (5) Unstated (8)
Therapy model / Approach	Collaborative (6): Collaborative (1/6) Constructionist /collaborative (1/6) Indirectly stated (2/6) Postmodern/collaborative (1/6)

	SFT-Collaborative (1/6) Dialogical (4): Dialogic Network Therapy (1/3) Dialogical (3/3) Eclectic/Integrated (2): SFBT and Narrative (1/2) SCT (Systemic Couple Therapy) various (experiential, structural, narrative, feministi/socioemotional) (1/2) Milan / Post-Milan (3) Narrative (2): Indirectly stated (1/2) Narrative (1/2) OD: Open dialogue (2) RT: Reflecting team (3) SFT not-specified: Systemic Family Therapy (5) SFBT: Solution Focused Brief Therapy / Solution Focused (4) Structural (1) Variety of systemic (2): Milan and systemic-structural (1/2) Structural, emotionally focused, narrative, and symbolic experiential (1/2) Variety of post-modern (narrative, solution focused, collaborative, RT) (1)
Quality appraisal*	CASP OK: No selection of No in CASP checklist (0) CASP #1: Lack of clear statement of research aim(s) (1) CASP #2: Inappropriateness of choice of qualitative methodology (2) CASP #3: Inappropriateness of research design (15) CASP #4: Inappropriateness of recruitment strategy (13) CASP #5: Data collection did not address research issue (4) CASP #6: Inadequate consideration of relationship between researcher / participants (23) CASP #7: Inadequate consideration of ethical issues (27) CASP #8: Insufficient rigour in data analysis (18) CASP #9: Unclear statement of findings (6) CASP #10: Unclear estimate of value of research (1)

Table S5 axes	Code / abbreviation

Focus of study in terms of process*	Intervention/technique (6) Model (3) Overall process (2) Problem talk (4) Therapy concept (4) Therapeutic dialogue (12) Therapeutic relationship (4)
Type of process discourse*	In-session discourse (32) Both: Mostly in-session discourse and partly post-hoc session narrative (3)
Transcription type	No transcription (1) Unspecified (7) Verbatim (10) Verbatim (Jeffersonian) (12) Verbatim (adapted Jeffersonian) (5)
Type of analysis / Evidence*	NA (Not applicable) / Included (Experts of data included) (2) NA (Not applicable) / Not included (quotes) (Excerpts not included but quotes included) (1) Non sequential / Included (Experts of data included) (11) Sequential / Included (Excerpts of data included) (21)

Table S6

Studies' findings: In session discourse of change process (sample)

Reference	Type of process Process / change conceptualization	Themes / theoretical model / categories	Conversational / discursive strategies or patterns / discourses	Reviewer's comments

Table S7.1

Synthesis of (in-session discourse) studies' characteristics

Focus of study in terms of process	Focus of study in terms of participants	Patient population	Therapist population	Session format	Therapy model / approach
(6)[5] Intervention/ technique: 13, 25, 28, 36, 38, 64	(27) Client and therapist: 2, 3, 4, 7, 10, 11, 12, 13, 23, 24, 25, 27, 32, 36, 37, 40, 41, 42, 43, 44, 46, 47, 50, 57, 59, 60, 61	(10) Adult: 3, 4, 13, 18, 23, 24, 47, 59, 60, 62	(6) Co-therapy: 3, 4, 7, 44, 59, 60	(6) Couple: 3, 18, 44, 59, 60, 62	(6) Collaborative: 10, 11, 12, 36, 50, 57

[5] For each code the reference numbers as well as the sum of references (in parenthesis) are provided

(3) Model: 4, 18, 29	(2) Client: 29, 49	(11) Adult and adolescent: 10, 11, 12, 25, 27, 32, 36, 37, 44, 57, 61	(4) Single: 24, 25, 28, 29	(1) Couple, family: 61	(4) Dialogical: 27, 49, 59, 60
(2) Overall process: 23, 62	(6) Therapist: 18, 28, 38, 58, 62, 64	(8) Child and adult: 2, 7, 29, 40, 41, 42, 43, 49	(2) Single, co-therapy: 27, 49	(23) Family: 2, 7, 10, 11, 12, 13, 23, 25, 28, 29, 32, 36, 37, 40, 41, 42, 43, 46, 47, 49, 50, 57, 64	(2) Eclectic/Integrated: 25, 62
(4) Problem talk: 2, 40, 41, 46		(4) Child, adult and adolescent: 28, 46, 50, 64	(8) Single, renowned: 10, 11, 12, 18, 36, 37, 38, 57	(1) Group: 4	(3) Milan / Post-Milan: 2, 13, 46
(4) Therapy concept: 12, 47, 59, 60		(2) Unspecified: 38, 58	(1) Single, trainee: 62	(1) Individual, couple: 24	(2) Narrative: 4, 7

(12) Therapeutic dialogue: 3, 7, 10, 11, 27, 32, 43, 44, 49, 50, 58, 61

(4) Therapeutic relationship: 24, 37, 42, 57

(11) Therapeutic team: 2, 13, 23, 32, 40, 41, 42, 43, 46, 47, 64

(2) Unspecified: 50, 61

(1) Unspecified, trainee: 58

(2) Individual, couple, family: 38, 58

(1) Network: 27

(2) Open dialogue: 3, 44

(3) Reflecting Team: 23, 32, 64

(5) Systemic family therapy-not specified: 40, 41, 42, 43, 47

(4) Solution focused brief therapy: 18, 24, 29, 38

(1) Structural: 37

Table S7.2

Synthesis of (in-session discourse) studies' methodological characteristics and quality

Methodology / Method of analysis[6]	Epistemology	Data / Data collection method[7]	Transcription type	Type of analysis/ Evidence	Quality appraisal[8]
(15) Conversation Analysis: 10, 11, 12, 18, 24, 25, 37, 40, 41, 42, 43, 47, 49,	(1) Constructivist: 18	(4) Audio-taped sessions: 4, 25, 29, 32	(1) No transcription: 38	(2) Not applicable[9] / Experts of data included: 3, 38	(0) CASP OK: No selection of No in CASP checklist

[6] The same paper was assigned more than one codes when methodology and method of analysis differed

[7] The same paper was assigned more than one codes when more than one data collection method was deployed

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

[9] The code "Not applicable" was assigned to studies which utilized methodologies not necessitating sequential analysis e.g. Thematic analysis

57, 64					
(4) Critical Discourse Analysis: 10, 11, 36, 58	(2) Deductive discursive epistemology: 42, 43	(2) Transcribed sessions (type of recording not specified): 7, 62	(7) Unspecified: 2, 27, 58, 59, 60, 61, 62	(1) Not applicable / Excerpts not included/quotes included: 4	(1) CASP #1: Lack of clear statement of research aim(s): 11
(4) Case Study: 4, 25, 29, 44	(6) Indirectly stated: Constructionist: 3, 25, 36, 40, 50, 58	(26) Videotaped sessions: 2, 3, 13, 18, 23, 24, 27, 28, 36, 37, 38, 40, 41, 42, 43, 44, 46, 47, 49, 50, 57, 58, 59, 60, 61, 64	(10) Verbatim: 3, 4, 7, 13, 25, 28, 29, 32, 36, 44	(11) Non sequential / Experts of data included: 7, 10, 11, 18, 24, 27, 28, 29, 32, 41, 43	(2) CASP #2: Inappropriateness of choice of qualitative methodology: 27, 28
(9) Discourse	(7) Social	(3) Videotaped	(12) Verbatim (Jeffersonian): 10,	(21) Sequential / Excerpts of data	(15) CASP #3: Inappropriateness

Analysis: 2, 7, 13, 23, 32, 36, 40, 43, 46	constructionist: 2, 13, 23, 32, 41, 46, 49	sessions with IPR: 10, 11, 12	11, 12, 18, 24, 37, 40, 41, 42, 43, 47, 50	included: 2, 12, 13, 23, 25, 36, 37, 40, 42, 44, 46, 47, 49, 50, 57, 58, 59, 60, 61, 62, 64	of research design: 4, 7, 10, 11, 12, 24, 27, 36, 38, 44, 47, 57, 59, 60
(5) Dialogical Investigation of Happenings of Change: 3, 27, 44, 59, 60	(19) Unstated: 4, 7, 10, 11, 12, 24, 27, 28, 29, 37, 38, 44, 47, 57, 59, 60, 61, 62, 64		(5) Verbatim (adapted Jeffersonian): 23, 46, 49, 57, 64		(13) CASP #4: Inappropriateness of recruitment strategy: 10, 11, 12, 24, 27, 32, 37, 40, 41, 42, 43, 44, 59
(3) Dialogical Analysis: 3, 27, 59					(4) CASP #5: Data collection did not address research issue: 10, 11,

(1) Domain Analysis: 38

(5) Discursive Psychology: 13, 40, 41, 46, 50

(3) Grounded Theory: 7, 61, 62

12, 27

(23) CASP #6: Inadequate consideration of relationship between researcher / participants: 2, 3, 4, 7, 10, 11, 12, 18, 23, 24, 25, 27, 28, 29, 36, 37, 38, 42, 43, 57, 59, 61, 62

(27) CASP #7: Inadequate consideration of ethical issues: 2, 3, 4, 7, 10, 11, 12, 13, 18, 23, 28, 36, 37, 38, 40, 41, 42, 43, 44, 46, 49, 57, 59, 60, 61, 62, 64

(18) CASP #8: Insufficient rigour in data analysis: 3, 4, 7, 10, 12, 24,

(2) Narrative analysis: 36, 49

(2) Phenomenology / Phenomenological content analysis: 4, 27

(2) Post-structuralist / Foucault type DA: 2, 25

(1) Qualitative Content Analysis: 4

(1) Structural

27, 29, 32, 38, 41, 42, 43, 44, 49, 58, 59, 60

(6) CASP #9: Unclear statement of findings: 4, 32, 38, 44, 50, 58

(1) CASP #10: Unclear estimate of value of research: 4

Analysis of Social

Behaviours: 24

(4) Thematic

Analysis: 28, 29, 38,

47

Table S8

Stages and steps of analytic process

Stages of analysis	Steps in analytic process
Stage I	1. Reading the papers 2. Extracting the findings section and in some cases parts of the discussion section (summary of findings)-see Tables S3, S6 3. Devising codes for authors' discourse, line by line, if possible and /or utilizing in-vivo codes (e.g., "fishing" "repair of alliance rupture") reported in papers' findings 4. Creating clusters of codes under broader themes illustrating conversational patterns / discursive practices 5. Creating main themes with sub-themes (4 main themes, 14 sub-themes, 196 codes) depicting both sequential change

but also therapists' and clients' discursive contributions to the building up of change, concerning aspects like the therapeutic relationship or therapeutic interventions.

Stage II

1. Comparing and contrasting the existing themes and sub-themes to develop a schema depicting change process as discursive performance, i.e. main themes depicting different aspects of sequential change process with sub-themes depicting clients' and therapists' discursive practices regarding each aspect (4 main themes and 12 sub-themes).
2. Re-screening data (i.e. studies' findings) to verify constructed schema (deductive mode of analysis): (a). to check for additional data to further include in our schema and/or for disconfirming cases (b). to identify further discursive practices (c). to identify indicative extracts

reported by authors.

3. Final schema of findings reported in the article (one main theme re-named from step 2).

List of synthesized references (including all 65 eligible studies)

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

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