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FAMILY PROCESS

ORIGINAL ARTICLE

Researching what we practice—The paradigm of systemic family research: Part 1

Lennart Lorås[1] | **Kristoffer Whittaker**[2,3] | **Jan Stokkebekk**[4] | **Terje Tilden**[5]

[1]Western Norway University of Applied Sciences, Bergen, Norway

[2]Research Institute at Modum Bad Psychiatric Clinic, Vikersund, Norway

[3]Department of Psychology, University of Oslo, Oslo, Norway

[4]The Office for Children, Youth and Family Affairs (Bufetat), Oslo, Norway

[5]The Research Institute, Modum Bad Psychiatric Center, Vikersund, Norway

Correspondence
Lennart Lorås, Western Norway University of Applied Sciences, PB 7030, 5020 Bergen, Norway.
Email: lennart.loras@hvl.no

Abstract

This is part 1 of two articles that focus on the ideological and philosophical preference regarding how to relate to and conduct research in the field of systemic couple and family therapy. Thus, this article outlines the theoretical groundwork for part 2 of "Researching what we practice" in the same journal. *Research* in certain areas of systemic couple and family therapy (CFT), such as that influenced by social constructionism and postmodernism, has a different epistemological tradition than in the natural sciences. Thus, only research from a narrow, selected spectrum of epistemologies has been incorporated as a key source in the knowledge base of systemic CFT. The consequence is that the field of postmodern systemic CFT risks promoting only a limited range of research designs and knowledge while excluding other designs and knowledge types, reasoning that these are less useful in clinical practice. The rationale behind this perspective is derived from ideology and philosophy rather than scientific criteria. Accordingly, in our field of study, different epistemological perspectives are easily viewed as dichotomous, thus causing professional gaps in our field. This tendency constrains the mutual exchange and development that are needed. We present a possible way out of this dichotomized deadlock, first and foremost by acknowledging – and encouraging the use of – the great variety and breadth of existing research and knowledge. Referring to the guiding principles of evidence-based practice, we argue that this would endow the systemic CFT therapist and researcher with a greater knowledge base and range of research methodologies. This could help improve the

quality of treatment provided to our clients and enhance the legitimacy of postmodern systemic CFT as a branch of psychotherapy.

KEYWORDS
epistemology, evidence-based practice, ontology, postmodernism, systemic couple and family therapy

INTRODUCTION

Systems theory was introduced into the research and practice of couple and family therapy in the 1950s by Bateson, Jackson, Watzlawick, and Bowen and, later, by Minuchin, Patterson, and others (Carr, 2012). The main insight that united these pioneers was that human problems are essentially interpersonal rather than intrapersonal. This understanding requires an approach to intervention that directly addresses the relationships between people. Thus, systems theory represented an antithesis to the dominant model of the time, which focused on linear causality (i.e., in child development) (Tilden et al., 2022).

The early pioneers emphasized the importance of research as a starting point for improving practice. The best known of these is probably the Mental Research Institute (MRI) in Palo Alto and its studies of schizophrenic communication. Through its studies, it – and others – sought to establish a general "nomothetic" theory of family functioning (Anderson, 2003). This was later challenged by postmodernist systemic family therapists who defined themselves by way of opposition to these earlier family systems theorists and researchers. Postmodernist systemic couple and family therapy (CFT) advocated an idiographic and largely atheoretical approach (i.e., White & Epston's, 1990 rejection of traditional family systems theory and normative theories of healthy vs. unhealthy patterns of interaction). This is supported by postmodernist therapists and social constructionists such as Anderson & Goolishian (1992) and De Shazer (1993), who believed we should concern ourselves not with the characteristics of the phenomena we face but with how we as therapists interpret and semantically construct these phenomena. In their view, client complaints should not be understood as a manifestation of an underlying condition but met openly and without preconception. We are aware that social constructionism is a broad and varied term for different positions on the relationship between constructions and reality (Burr, 2003; Flaskas, 2002; Smith, 2010), thus any general comment on constructionism risks misrepresenting more nuanced positions (Pocock, 2015). However, we are seeking mainly to counter strong social constructionism of the kind that has considerable influence in our field, such as that of Anderson (2016, 2019) and De Shazer (1993). It was espoused in its most extreme form by De Shazer (1993), who claimed that nothing outside of the therapy room can help us understand what happens in therapy. As a consequence, followers of these authors largely rejected or were indifferent to research-based knowledge regarding the phenomena we encounter in therapy, whether related to mental disorders, substance abuse, or abnormal development and behavioral difficulties suffered by children and adolescents. Their skepticism related particularly to knowledge obtained from research conducted at the group level (nomothetic knowledge), which, in their reasoning, was invalid and unhelpful when applied to individual clients (at the idiographic level).

Thus, at this point in the field's development, there is a conflict between family systems theorists, researchers, and practitioners who endorse and utilize nomothetic/general pattern theories and findings, and postmodernist systemic CFT that rejects nomothetic perspectives. While we acknowledge that postmodernist systemic CFT satisfies a need by addressing these unique characteristics, we also think that by cultivating such differences we risk becoming

just as orthodox as those against whom we originally objected. Failure to adopt an attitude of respect and humility toward our adjacent professional fields when cultivating our own preferred approach could result in an unproductive dichotomy. This might mean becoming too comfortable in our own camp, and at worst, believing in our own superiority. This would risk dismissing the knowledge of adjacent professional fields and/or knowledge obtained through research methods other than those with which we are familiar or prefer. We find that elements of the field of systemic CFT have ended up adopting such a narrow, purist perspective on what "systemic" means and how knowledge should be produced. This may potentially create a barrier between this field and adjacent professional fields of psychotherapy and thus constrain mutual professional exchange and discussion. We find this concerning. As a consequence, systemic CFT as a whole could potentially be perceived as an outlier not to be taken seriously (Tilden et al., 2022). An effect of systemic CFT as a distinct branch of psychotherapy being seen as an outlier is that it risks losing ground in several influential contexts (Bertrando, 2009; Lorås, 2016, 2021; Tilden et al., 2022). Our concern is not new. Others have previously articulated the need to move away from defining systemic CFT in terms of opposition to other modalities and instead to value inclusiveness, coherent integration, respect, and hospitality with regard to all models and therapy discourses (Larner, 2003; McNamee, 2005; Pinsof et al., 2018).

CONCERNING GAPS IN OUR FIELD

As presented, there are different and conflicting perceptions of how the systemic field should be defined. Some attempts have been made to define systemic therapy, such as those by Lorås et al. (2017) and Sydow et al. (2010). But, as Friedlander et al. (2021) write: "Simply put, there is no consensus about what is and what is not systemic therapy" (p. 540). Consequently, there may be gaps in terms of ontology and epistemology, as illustrated, for instance, in the mentioned nomothetic–idiographic debate (Fraenkel, 1995). This gap has a partial relationship to another decades-old gap between those performing clinical work and those conducting research, recognized in psychotherapy in general as well as in systemic CFT in particular (Drabick & Goldfried, 2000; Kazdin, 2009; Pinsof & Wynne, 2000; Teachman et al., 2012). Accordingly, in postmodern systemic CFT, we would argue that this gap has become more complex because segments of the field accommodate ideologies that limit recognition of specific types of research (Tilden et al., 2022). In fact, the position in these segments of the field is suspicious of nomothetic knowledge (Fraenkel, 1995). Such knowledge is viewed by some theorists and therapists as detrimental to individuals, confining them to generic descriptions that constrain creativity, subjugate pride, and disempower the individual in their attempts to solve problems (Fraenkel, 1995). This gap, created by those adhering to postmodern systemic CFT on one side and those taking more moderate approaches to systemic CFT on the other, is unfortunate, partly because the limited exchange between the divergent camps in our field suggests a lack of unity within systemic CFT and partly because it reduces contact and collaboration between clinicians and researchers. This lack of bilateral communication and interaction could, for instance, frustrate researchers when clinically relevant findings that may improve treatment are not implemented in therapy. Practitioners, on the other hand, maybe frustrated when they are not involved in the development of clinically relevant research questions that could influence research objectives and designs. For this reason, findings may not be perceived as clinically usable. Even when the aim of research is to create new knowledge that will improve treatment quality and benefit clients, this gap constrains the translation of clinically useful findings into everyday clinical practice. For instance, if nomothetic research convincingly concludes that a specific treatment approach should be recommended for a specific group of clients, these results need to be disseminated to clinicians, which should be followed

by the training and facilitation necessary to implement the relevant evidence-based treatment in the therapy unit (Tilden et al., 2022). Otherwise, clients will not benefit from the best available treatment approach, with the result of unnecessary individual suffering and greater public costs.

The gap between clinical practice and research is characterized by contextual, professional, and hierarchical distance: contextual because research rarely takes place within clinical units; professional because most clinicians are unfamiliar with the nature of research – particularly quantitative design – and may perceive it as invasive within a daily clinical work context; and hierarchical because the researcher and clinic leadership often make top-down decisions and initiate research within a clinical unit without a thorough staff-inclusive process, which runs the risk of clinical staff being neither anchored in the project nor committed to or enthusiastic about facilitating and supporting it (Håland & Tilden, 2017). One way to bridge this gap is by recruiting a researcher from the clinic who will provide a closer connection between knowledge of clinical practice and familiarity with the research project.

As already addressed by Fraenkel (1995), the field of postmodern systemic CFT contains elements that inhibit the bridging of this gap. For instance, systemic theorists who favor a strong social constructionist stance and/or collaborative dialogical practice have expressed skepticism over the application of nomothetic knowledge to clinical practice (Anderson, 2016, 2019; Anderson & Goolishian, 1992; Lock & Strong, 2014). As Anderson (2016) writes, "Authoritative discourses from this perspective give way to knowledge constructed on the local level that has practical relevance for the participants involved" (p. 185). In this way, she emphasizes the usefulness of ideographic knowledge that comes from the person's *internal* knowledge of their own lived experience, opinions, and interpretations. Such knowledge is considered to be linguistically generated and is obtained primarily by asking clients how useful they perceive the therapy to be. Consequently, qualitative research designs are preferred, and quantitative approaches are viewed as less useful for the discipline. The influence of social constructionism may therefore risk maintaining the gap between clinical practice and research, as clinicians and researchers have different views of what is useful, relevant knowledge, and how such knowledge is generated. Indeed, this also has the potential to create gaps *among* clinicians and researchers respectively due to divergent ideologies and philosophies of science, gaps that may be all the more concerning as they could create a split within the field of systemic CFT as a whole.

Although one may claim that research in the field of systemic CFT has grown from a different epistemological tradition than the majority of psychiatric and psychotherapy research (Lorås & Sundelin, 2018), this does not fully explain the current predicament. And with reference to Friedlander et al. (2021) stating that "systemic therapy" has not acquired a unifying definition, we advocate that it captures breadth. We find this logical due to our field of interest being complex and comprehensive. Accordingly, there is a need to embrace and make use of a variety of sophisticated and cutting-edge methodological approaches that are available. Therefore, the systemic CFT research of the future should encompass a multitude of research designs, welcoming all contributions and viewing these as valuable to the growing field of knowledge.

As research-based empirical evidence is usually included in a discipline's knowledge base in the same manner as practice (experience-based empirical evidence) and theory, the limited incorporation of research-based empirical evidence into the knowledge base of systemic CFT may appear odd (Tilden et al., 2022). However, the requirement for research-based work has grown in recent years and is likely to continue growing. Knowledge is now expected to be assessed, verified, and deemed suitable for the situation to which it is to be applied. The knowledge base will thereby help justify the practice of our profession. For this reason, the kind of knowledge on which our professional field is based is an essential, almost existential, concern.

Evidence-based practice as a tool for bridging professional gaps

As mentioned, our concerns address the scientist–clinician gap, as well as a split among groups of clinicians and scientists in systemic CFT. In our search for means to bridge these gaps, we address the keyword *integration*, which we find to be applicable on several levels. A key premise for integration can be found in the European Family Therapy Association's (EFTA, 2011) statement according to which scientific and clinical knowledge are considered crucial to professional development and the recognition of CFT as a field of psychotherapy:

> The goal of EFTA is to achieve recognition for family and systemic therapy as a distinct, scientifically based form of psychotherapy practice and to ensure rigorous standards of training and professional practice throughout Europe.
>
> (EFTA Training Standards, 2.1)

We find it particularly important that this EFTA statement integrates systemic therapy as a psychotherapeutic branch. Accordingly, systemic therapy cannot be considered as essentially different from other psychotherapeutic approaches. This should inspire consideration of its integration with rather than separation from other therapeutic approaches. Although systemic CFT was developed to be, and formed an identity as, different from other branches of psychotherapy, particularly those that apply a medical model, an integrative perspective means that we also need to learn from, and engage in exchange with, other areas of psychotherapy. What may remain unique to systemic therapy is that the body of research that clinicians should be familiar with goes beyond psychotherapy research. Examples include research in cognitive, social, developmental, neuroscience, and abnormal psychology, all of which are relevant for the practicing clinician (Priest, 2021).

Another central premise relevant to integration, given systemic therapy's definition as a psychotherapy branch, is how psychotherapy as a field has undertaken to bridge the scientist–clinician gap. Perhaps, the most concerted endeavor in this regard was the American Psychological Association's *Declaration on Evidence Based Practice* (EBP) (APA, 2006). EBP was developed in response to what was seen as missing from earlier paradigms of evidence-based treatment (EBT) and evidence-supported treatment (EST) (Duncan & Reese, 2013). According to the latter paradigms, randomized controlled trial (RCT) designs were considered to yield the most reliable and useful results for application in clinical work. For instance, these designs address the objective of recommending specific evidence-based treatment approaches for treating clients with specific disorders. But because these studies' findings were produced in contexts that differed considerably from natural clinical contexts, clinicians found it challenging to translate the results and apply them to natural clinical settings. In other words, they found it difficult to directly apply group-level findings (nomothetic knowledge) to individual clients (couples and families) in clinical practice (idiographic knowledge). If the clinicians were not trained in how to understand the precautions and reservations when applying group data results to clinical practice, they often found that the recommended evidence-based method did not fit all their clients, and accordingly, concluded that the results in question had little or no relevance for clinical practice. The EBT and EST paradigms were furthermore understood to prescribe the use of these approved therapy approaches by way of manuals, which provoked many therapists. They felt the manuals told them what to do without acknowledging the application of their professional judgment to adjust and tailor the treatment models for individual clients; thus the manuals were perceived as threatening their professional autonomy. As new studies comparing the efficacy of treatment models found almost no difference in the client outcomes of the models but greater difference among therapists *within* each model (Wampold & Imel, 2015), the basic assumptions underlying EBT and EST were challenged. Accordingly, the focus of psychotherapy research gradually shifted toward the study of common factors, therapist characteristics, and skills. In particular, the need to strengthen the client's voice was

emphasized, partly as an ethical obligation and partly because knowledge is needed from the client in order for the client to benefit from treatment (Tilden & Wampold, 2017). The principles of EBP thus effected a clear departure from the dominant paradigms of EBT and EST.

By definition, EBP integrates knowledge from the best available research with clinical expertise within the context of patient characteristics, culture, and preferences (Nordtvedt et al., 2012). *Integration* means that ideally all three types of knowledge should be applied in clinical work, free of any hierarchy suggesting that one type of knowledge is more important than another. To increase user involvement and thus improve treatment outcomes, the EBP declaration explicitly recommends making use of systematic feedback, such as routine outcome monitoring (ROM) (Tilden & Wampold, 2017). EBP principles thus offer a new way of considering the relationship between clinical practice and research, particularly in its enhanced focus on phenomena closer to daily clinical practice, which helps to bridge the scientist–practitioner gap. Accordingly, EBP principles suggest that psychotherapy is a collaborative enterprise between therapist and client. Not only is therapist–client collaboration an imperative in ethical and humanistic terms, there is also empirical support for the relationship between the client's active involvement in their treatment and the achievement of better outcomes (Wampold & Imel, 2015). Such user involvement is assumed to have a strong association with how the working alliance between therapist and client is established and maintained (Tilden & Wampold, 2017), that is, the agreement between client and therapist on goals and tasks along with a sufficient emotional bond (Bordin, 1979). And because there is strong evidence that such an alliance is associated with positive outcomes in psychotherapy in general (Norcross & Lambert, 2018) and systemic CFT in particular (Friedlander et al., 2018; Glebova et al., 2011; Knobloch-Fedders et al., 2007; Pinsof, 1994; Whittaker et al., 2022), it is hypothesized that there is an association between enhanced user involvement and outcomes. For instance, enhancing user involvement by addressing the process and progress via ROM feedback applied in real-time therapy would inform treatment on alliance topics (Tilden & Wampold, 2017). Thus, sharing and discussing such client feedback can enable the therapist and client to jointly evaluate and implement the adjustments to treatment needed to optimize its outcomes. This illustrates the potential impact that EBP principles can have on clinical practice.

The practical consequences of applying the EBP paradigm to bridge the scientist–practitioner gap can be grouped into the four categories discussed below:

Improved dialogue

Researchers need to engage clinicians in dialogue by asking them which clinically relevant areas they view as under-researched. Furthermore, clinicians should be involved in how future research aimed at addressing such an oversight could be carried out at their place of practice without impeding their clinical work. Consequently, clinicians should be actively involved in the planning, implementation, and conduct of research, thereby becoming co-researchers. Clients should also be considered to be involved as co-researchers; for instance, previous clients could be hired as experience consultants studies ate being designed and the potential impact of the research is being considered.

Incorporation of frequent client assessments

Clinical practice should employ ROM capable of addressing therapy-relevant topics, where the client provides frequent feedback to the therapist on the treatment process and progress. Such between-session feedback enables therapist and client to jointly assess, evaluate, and adjust therapy in real time. Hence, feedback has the potential to optimize outcomes by improving

client involvement and empowerment. Because EBP explicitly recommends that research be conducted to a larger extent in a natural clinical setting (i.e., practice-oriented research [POR]) (Castonguay & Muran, 2015), of which ROM is an integral part, collected ROM data could also serve research purposes. Thus, the intended improvement of treatment quality at both the individual and service levels and the conduct of research can be considered two sides of the same coin. As such, clinicians and researchers should enter into close collaboration and thus bridge the gap between clinical practice and research.

Inseparability of clinical work and research in student training

Teachers and instructors need to be familiar with the richness and variety of the entire field of CFT in which breadth of design has been applied. Students need to be helped to interpret the research and in its clinical application. Students should familiarize themselves with POR by incorporating ROM in their clinical training and hence become accustomed to participating in research projects. One way of teaching this to students is through exercises such as giving the students an assignment to conduct role plays on a variety of couple and family presenting problems (infidelity, a family in which a child is diagnosed with ADHD, a couple in which one partner is depressed, a first-generation immigrant family in which parents and teens are in conflict over the degree to which the teen can engage in behaviors typical of the country to which the family has immigrated, a stepfamily couple, etc.). The students read a research article or chapter relating to the specific role play/presenting problem, write up a short summary of the research and key points to remember when working with such a family or couple, then conduct the role play. This exercise trains students to always seek out research before beginning with a new couple or family in order to prepare for the clinical work. In essence, the aim is to generate understanding and experience among the students in terms of clinical work and research being mutually dependent on one another.

Optimizing the translation of research findings into clinical practice

Shifting the weight of research from efficacy to effectiveness suggests emphasizing process-outcome research and research on change mechanisms. Thus, research targets and results should gradually be perceived as more clinically relevant. A constraint to the clinician familiarizing themselves with research is the tribal language that characterizes published quantitative article literature in particular. This is not unique to the systemic practitioner, as translating and applying quantitative findings to clinical work is frustrating for most clinicians. But due to the aforementioned qualitative preference in certain camps of systemic CFT, our field may suffer from additional constraints: given that the systemic CFT clinician is familiar with Anderson's (2016) view of preferred research methodologies, the clinician's frustration may be attributable to an ideological and philosophical rationale according to which knowledge derived from quantitative research designs is considered irrelevant to and less useful in clinical practice, with the consequence that this clinician makes no effort to understand the challenging tribal language. Therefore, an important task for the researcher, who hopefully is capable of understanding this academic language, including the statistical terms and other jargon, is to translate what this research seeks to communicate into familiar clinical terms. For this reason, we strongly recommend the researcher to be a clinician, as such a translation could thus be conveyed in comprehensive language that is considered relevant to clinical practice. In addition, providing the clinician with better training in applying such research findings would both reduce frustration and acknowledge the value of research to clinical practice. For instance, all clinicians should be aware of the necessary precautions and reservations

when applying nomothetic knowledge in an ideographic clinical setting. Likewise, teaching evidence-based therapy models through the use of manuals should emphasize that they are to be considered guidelines within a theoretical framework suggesting how research findings can be applied in a tailored way according to the unique clinical context. How this is communicated is crucial, as the historical resistance of systemic family therapists to manuals has been significant (Sundelin, 2013), as manual recommendations have been perceived as "instructive interactions." Some of the criticism has been directed at the tendency for manuals to privilege aspects of therapy that are more easily specified and measured (Pote et al., 2003). However, more often than not, manuals emphasize flexibility, thus encouraging the clinician to make needed adjustments and tailor for the client's needs and goals and the unique treatment context (Sundelin, 2013). We consider the degree of "instructive interaction" to be of crucial relevance in terms of which central epistemological tenets of systemic CFT are maintained (Lorås, 2016, 2021).

Dichotomous research hierarchy as a constraint to bridging professional gaps

A significant impediment to bridging the aforementioned professional gaps comes from the perspective of the previously dominant hierarchy of research and knowledge that characterized the outdated EBT and EST paradigms. We find it interesting to note that as the field of systemic CFT has grown, it seems to have applied arguments similar to those of the American Psychology Association's task force, which established the principles of EBP (APA, 2006). Thus, we consider that systemic CFT and the principles of EBP share common objectives and find it puzzling that, to our knowledge, in Norway at least, few systemically oriented professionals today are aware of and acknowledge the principles of EBP. And, despite the aforementioned efforts to bridge the scientist–clinician gap via the principles of EBP, we find that this gap persists. One reason for this reluctance may be that some practitioners and researchers may perceive EBP as similar to EBT and EST, and accordingly, interpret EBP as advocating a positivistic view. The spread of such a perception is plausible due to the influence of powerful voices in parts of postmodern systemic CFT as a field of study advocating a preference for selected research designs and knowledge types (Tilden et al., 2022). Their preferences are inspired primarily by theories derived from ideologies and philosophies that oppose positivism. Accordingly, certain research designs (i.e., quantitative designs) and nomothetic knowledge are either dismissed or deemed to be less useful in clinical practice. For example, Anderson's collaborative–dialogic practice (2016, 2019) has become an important source of inspiration for several educational institutions in our field of study. Her stated priority of, and preference for, idiographic knowledge has influenced many systemic CFT students and clinicians and is responsible for their negative perception of much of the existing empirical knowledge produced through the application of quantitative methods. We understand systemic opposition as also implying a distancing of oneself from adjacent professional fields to establish one's own identity. In our view, Anderson's (2016, 2019) outspoken preference has had the detrimental consequence of abolishing valuable research knowledge – "the baby is thrown out with the bath water" – to the cost of systemic CFT and its beneficiaries. We therefore find it problematic that certain ideologies and philosophies of science form the rationale for approaches to research and knowledge that can in fact be considered contra-scientific. This is because they can limit awareness and acknowledgement of valuable knowledge among some systemic practitioners. In particular, if educational institutions communicate the value only of knowledge established by way of qualitative designs, then knowledge produced by way of other research designs is ignored and/or devalued. This contradicts a basic tenet of EBP regarding the application of a wide range of research designs and research results that the clinician finds useful for helping the client. Principles of EBP do not imply a preference for any research design or

type of knowledge; the rule of thumb is to apply the most appropriate research methodology to address the research question. Should the above-mentioned biased approach to knowledge dominate, students will not be aware of or familiar with the valuable research literature associated with other research designs and may potentially lack the vital competence connected with knowledge established at a group/nomothetic level that could make a difference to the client.

Furthermore, students will not be trained to participate in or conduct anything but qualitative research designs. This one-sided emphasis on knowledge would be viewed by other professions and stakeholders as strange and even unscientific. Systemic academic institutions and practitioners could thus end up being viewed as outsiders and not be taken seriously or even acknowledged by professional and scientific societies. Given these consequences, we see this as a major problem for our profession and our field of systemic CFT. Externally, this will constrain how clinicians and researchers from different traditions and adjacent professional fields can communicate and collaborate with each other. Given that this gap also exists within our own field of systemic CFT, a similar constraint may be relevant internally. As we find it natural and normal to prefer communication with those who share our beliefs in our own camp, we thereby lose out on the opportunity for exchange with others, and thus the gaps discussed will persist.

Unifying around principles of EBP may bridge gaps

We find that training in systemic CFT greatly emphasizes two of the three requirements of the principles of EBP: clinician professional experience and client local knowledge. The third of these requirements, research-based knowledge, may be the systemic field's Achilles' heel, one possible reason for which has been expressed by Glenn Larner:

> While family therapists acknowledge the need for clinical practice to be evidence-based, the difficulty is identifying any one methodology that does justice to the work.
>
> (2003, p. 20)

As Larner wrote this in 2004, one can speculate whether he would have put it differently after the principles of EBP had been publicized (APA, 2006). The first part of his statement refers to systemic practitioners actually acknowledging evidence-based approaches. As mentioned, our experience indicates that some systemic CFT professionals are very selective about what kind of evidence they consider valid and useful in clinical practice. For instance, when ROM systems were implemented at Norwegian CFT sites (Anker et al., 2009; Håland & Tilden, 2017; Tilden, 2017; Tilden et al., 2015), there was considerable skepticism among therapists. A national sample showed that 70% of CFT practitioners in statutory family counseling services reacted negatively to implementing ROM in their practice (Stokkebekk, 2013). In one study (Håland & Tilden, 2017; Tilden et al., 2015), therapists expressed considerable skepticism about the basis of *ideological reasons*, making statements such as "We don't believe in the value of quantitative questionnaires," "It is dehumanising to meet suffering people with questionnaires," "This brings therapy in the wrong direction towards technification and mathematical algorithms," and "If research is to be conducted, only qualitative designs offer valid and usable knowledge." When such attitudes were expressed, reference was made most frequently to Anderson (2016) with regard to skepticism toward general (nomothetic, general) knowledge and the preference for qualitative research for capturing the client's idiographic knowledge. We found that her position was interpreted as disqualifying the value of knowledge produced through quantitative research. This disqualification was justified by the argument that nomothetic knowledge has limited value for the postmodern systemic practitioner. Anderson (2016) also recommends restraint when sharing expert knowledge with the client but will share such knowledge if the client asks for it. On the basis of the above-mentioned knowledge

type preferences, this suggests that what can be shared will be selected from a delimited base of potential knowledge and will therefore be considered biased. Therefore, a basic question here is whose need comes first: the client's need to be informed on the basis of existing knowledge, or the therapist's need, which relates to their own theoretical and ideological preferences? We consider it unethical to dismiss the findings of research on ideological/theoretical grounds when such findings can be of direct use to families when delivered as psychoeducational interventions (by normalizing their struggles, helping them to realize they are not alone with those struggles, and providing interactional guidance on how to cope with their challenges) or when such findings are important for guiding the therapist's treatment.

As claimed by another social constructionist, Ekeland (2022), the word of evidence is used as a power instrument. He argues furthermore that manualization is an expression of monopolistic manipulation. Swedish researchers comment on this influence in the systemic field as follows: "Social constructionistic and language-oriented milieus have expressed hostility for research (…) that illustrates the gap between clinical practice and research in the development of CFT. In contrast with other fields, CFT has not been influenced by research" (Cederblad et al., 2022, p. 161).

In summary, it seems that the social constructionist influence on the systemic CFT milieu negatively affects efforts to bridge the researcher–practitioner gap. As such, one may ask whether social constructionists oppose the principles of EBP. One possibility, as previously discussed, is that concepts of EBP are misinterpreted as being similar to those of EBT/EST. Hopefully, we have clarified here that they are very different. Because the gaps persist despite the many efforts being made, we wonder whether we have failed to address another possible reason for the lack of unification in our field; we think it is necessary to realize that we as professionals relate to different *-isms* that are broader in scope than the gap between researchers and clinicians. For instance, if two professionals refer to different paradigms as discussed – the principles of EBP and social constructionist ideology – their references may represent fundamental and unbridgeable differences in terms of philosophy, theory of science, ideology, and paradigm. According to Gilje and Grimen (1993), in such cases, the professionals concerned are situated in two different paradigms, which causes major communication problems: "They no longer speak the same language. They are in two different worlds. Two paradigms are therefore not merely incompatible; they may also be *incommensurable*" (p. 92).

Our objective is therefore to address whether there may be such an *-ism* gap between the different camps in systemic CFT. If so, it is far more comprehensive than the researcher–practitioner gap alone. If we fail to deal with this assumption, our efforts to bridge the professional gap will be of limited value. If our hypothesis holds true, we must address some unspoken, unaddressed conflicts related to the basic assumptions and premises of our professional field. This brings us back to the second part of Larner's (2003) statement on the difficulty of identifying any one methodology that does justice to the work. Due to the complex and comprehensive nature of systemic CFT, we consider it natural and necessary that our field be characterized by various and diverse methodologies, both in clinical practice and in research. This may be one reason why there is no consensus on the definition of systemic therapy (Friedlander et al., 2021). On the basis of this realization, system-oriented clinicians and researchers are most likely to be varied and heterogeneous in range, as suggested by Tilden et al. (2022, p. 318), and include at least five types of systemic therapists (see Table 1).

Acknowledging such variety may facilitate greater tolerance of diversity and thus encourage curiosity about the prerequisites of our various respective positions.

We consider such variety fitting for the principles of EBP that constitute the overarching context of the chosen methodology/methodologies of systemic CFT clinicians and researchers. Applying these principles would encourage clinicians and researchers to explore one another's philosophies of science, theories of science, ontologies, ideologies, epistemologies, and paradigms, which are often unspoken but nevertheless influence our professional views and

TABLE 1 Characteristics of systemic practitioners.

No.	Primary emphasis on
1	Establishing a healing context by applying common factors
2	Applying specific models, e.g., narrative and solution-focused approaches
3	Applying manualised approaches, e.g., multi-systemic therapy (MST) or functional family therapy (FFT)
4	Applying approaches originally developed for individual therapy, e.g., emotion-focused and cognitive-behavioural therapy
5	Applying a meta-perspective and framework for the integrative use of a wide range of specific approaches tailored to the client's needs and goals, such as integrative systemic therapy (Pinsof et al., 2018)

choices. Our intention is therefore to highlight this as a phenomenon of concern that deserves greater exploration so as to determine whether it constrains the systemic field's development and legitimation as a science-based branch of psychotherapy.

CONCLUDING COMMENTS

On the basis of personal communication with social constructionists, we have the impression that quantitative research in the systemic field is perceived as a threat to their practice and the field of family therapy. This is understandable in view of the field's history of struggling for acknowledgement against the dominance of EBT/EST in psychotherapy research. However, on the basis of the principles of EBP, we do not consider quantitative research to be a threat to what has been achieved in qualitative systemic research. The APA's (2006) declaration on EBP is very explicit in its endorsement of multiple types of research evidence, such as clinical observation, qualitative research, systematic case studies, single-case experimental design, public health and ethnographic research, process-outcome studies, studies of interventions delivered in naturalistic settings (effectiveness research), randomized clinical trials (efficacy research), meta-analyses, and systematic reviews. From our point of view, no type of research design is omitted. As a matter of fact, we should not fixate on design issues; what really matters is the research question. The next step is choosing the design that best fits the question in order to answer it. We are convinced that when appropriate, it is beneficial to apply a blend of designs, such as a mixed design or merged methods, including sequential design applying both qualitative and quantitative methods in sequence throughout a research project. Perhaps, a central prerequisite for bridging the gaps referred to above is realizing that there is no dichotomy between different research designs. They should be considered complementary on a sliding scale. All designs are needed. That said, we must add that in this world where numbers often count for more than words among decision-makers and the funders of our professional activity, the magnitude of quantitative research serves to legitimize us all so that we can provide our service.

We believe both nomothetic and ideographic positions are valid and useful for systemic CFT and readily complement one another. Thus, we consider that the nomothetic–idiographic debate is too polarized and has led to the field being divided against itself. As suggested by Fraenkel (1995, p. 119), the enriching spiral between the search for commonalities among families facing similar problems and the careful, qualitative description of the unique aspects of each family's response to similar problems may offer systemic CFT the kind of diversity and complexity required for good theory and practice. The diversity of research can offer therapists enhanced understanding and knowledge of the family as a system and of external factors that affect the family system, such as what types of measures are effective for whom (Tilden

et al., 2022). Such knowledge may contribute to better justifying which types of interventions to implement and hence to more beneficial treatment of the individuals concerned. Therefore, it is necessary for the therapist to have access to research-based literature (where it exists) that describes which therapeutic methods are best suited for the individual problems and disorders we encounter in practice.

Acknowledging the *-ism* gap implies acknowledging and tolerating diverse beliefs, philosophies, and ideologies as the basis of our work. This is not restricted to the scientist–clinician gap but extends to communities of scientists and clinicians in general. We need, however, to be conscious of how this affects our production and application of knowledge. In particular, as this is an academic field, certain scientific requirements must be adhered to. For this reason, we need to consider whether the epistemology of certain philosophies should be questioned. For instance, an ideologically based preference for a narrow breadth of knowledge and research design could be considered unscientific. Similarly, a positivistic research approach has obvious limitations. However, we need freedom to choose, without prejudgement, whichever accessible design best addresses the research question. The philosophy of science is essential as a reference for our professional work, such as for our view of mankind, our values, and our roles as therapists and clients. However, when certain philosophies that contradict the common principles of science have an effect on research, we find it appropriate to regard this as constraining the entire field of systemic CFT. We therefore advocate application of the principles of EBP (APA, 2006) as the overarching guideline for systemic CFT research, as this would acknowledge all types of design and knowledge. Agreement on this premise may offer common ground for legitimizing our field, creating new knowledge for the benefit of best practice for our clients while enhancing the international reputation of systemic CFT.

ORCID

Lennart Lorås https://orcid.org/0000-0001-7247-588X
Kristoffer Whittaker https://orcid.org/0000-0001-6460-1516
Jan Stokkebekk https://orcid.org/0000-0002-9299-8108
Terje Tilden https://orcid.org/0000-0002-9164-8851

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