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Barbara Kreš
https://orcid.org/0009-0001-3218-1796

University of Ljubljana, Slovenia
https://ror.org/05njb9z20

# Effectiveness of the therapeutic process and categories of change in relational family therapy

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## Abstract

The effectiveness of a psychotherapeutic approach is often measured by the changes in various areas of the client's life that result from the therapeutic process. Research in this area shows that the common factors that promote change are elements that are present in all forms of therapy, such as therapeutic alliance, empathy, positive expectations, and corrective emotional experiences. In this study, we examined changes in psychotherapy, focusing on changes in the relational family therapy model. The study was conducted with 130 participants who were divided into an experimental group and a control group, one of which participated in relational family therapy and the other was not involved in psychotherapeutic treatment. The participants completed the Systemic Therapy Inventory of Change (STIC)[1] after the first therapy session and again after three months of therapy, with the same time period between the first and last test for the control group. The results of the study show that clients who participated in relational family therapy showed greater changes in various systems than those who did not receive psychotherapy. The results suggest that relational family therapy promotes positive changes in various areas of client functioning after three months of therapy.

## Keywords

psychotherapy, change in psychotherapy, therapeutic alliance, common factors in psychotherapy, relational family therapy

[1] W. M. Pinsof, J. L. Lebow, R. E. Zinbarg, L. M. Knobloch-Fedders, G. B. A. Friedman, B. Mann, S. Cytrynbaum, E. Durbin, E. Karam, J. Goldsmith, *Systemic Therapy Inventory of Change – STIC*, Evanston, IL 2005, The Family Institute at Northwestern University.

## 1. Introduction

The founder of person-centred psychotherapy, Carl Rogers,[2] understands change in psychotherapy as a change in the personality structure of an individual on a superficial, but also on a deeper level; as integration, less inner conflict and greater availability of energy for an efficient life. On the behavioural level, he observed the change from behaviours that we normally consider immature to more mature ones. One of the studies that examined therapeutic change[3] defined it as a process, in which insight and personal content of an individual emerge and new behaviours and empowerment of a person occur. The authors also cite definitions by other researchers who see the core of therapeutic change as a change in the client's subjective perspective. By this they mean subjective constructs and theories that represent a complex bundle of personal thoughts about oneself and the world, on the basis of which individuals behave and evaluate themselves. Based on these definitions, the clients change as they develop new interpretive models about themselves and the world around them. Changes in self-concept are linked to improved mental health and self-regulation, emphasising the importance of self-knowledge.[4] Score[5] points out that psychotherapy involves not only changes in the cognitions of a person's mental or brain structure, but more importantly, the changes in the affective embodied experience of one's own brain, mind and body. An important concept for psychotherapy is the non-verbal bodily affective dynamic that is expressed in the therapeutic alliance between the therapist and the client. Some authors use the term therapy outcome instead of the change in therapy,[6] with an explanation that we cannot

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2 C. R. Rogers, *The necessary and sufficient conditions of therapeutic personality change*, "Journal of Consulting & Clinical Psychology" 60 (1992) 6, pp. 827–832.

3 C. Altimir, M. Krause, G. De la Parra, P. Dagnino, A. Tomicic, N. Valdes, C. J. Perez, O. Echavarri, O. Vilches, *Clients', therapists', and observers' agreement on the amount, temporal location, and content of psychotherapeutic change and its relation to outcome*, "Psychotherapy Research" 20 (2010) 4, pp. 472–487.

4 M. Huflejt-Łukasik, W. Bąk, R. Styła, K. Klajs, *Changes in the self in the course of psychotherapy,* "Roczniki Psychologiczne" 18 (2015) 3, pp. 449–464.

5 A. N. Schore, *The science of the art of psychotherapy*, New York 2012, W. W. Norton & Company.

6 C. Altimir, M. Krause, G. De la Parra, P. Dagnino, A. Tomicic, N. Valdes, C. J. Perez, O. Echavarri, O. Vilches, *Clients', therapists', and observers' agreement on the amount, temporal location, and content of psychotherapeutic change and its relation to outcome*, pp. 472–487; C. J. Bryan, T. Blount, K. A. Kanzler, C. E. Morrow, K. A. Corso, M. A. Corso,

equate the results of the therapy with the client's satisfaction with the therapy. Indeed, the latter indicates how satisfied clients are with their experience of the therapeutic process and does not necessarily mean that they believe that therapy can help them solve their problems. The therapy outcome can therefore be seen as a change in the target complaints expressed by the client and is not necessarily a consequence of the therapy, but overlaps with the time of the therapeutic process.

Johansson and Høglend[7] argue that although we know that psychotherapy works, the processes and mechanisms underlying therapeutic change are still largely unknown, and they emphasise the importance of exploring the mediators and moderators of change in psychotherapy as a way to improve our understanding of the mechanisms at work in psychotherapy. Kazdin[8] defined mechanisms of change as events that are responsible for the changes that occur in psychotherapy, or the reasons for the changes and the ways in which the changes manifest in particular clients. These mechanisms are about the processes that explain how change actually occurs. The changes may have multiple outcomes with one mechanism or one outcome despite multiple mechanisms. The outcomes could be linear or non-linear to the mechanism. In his opinion, the mechanisms proposed for psychotherapeutic change must be plausible, temporally explicit, and empirically supported. Young[9] proposes six processes that could be involved in causal psychotherapy. These processes include the mechanism of activation-inhibition-coordination on the one hand and the executive function on the other. In between are the processes of co-regulation, analysis-synthesis, objectivity-subjectivity and psychological reserve. Each of these variables can vary from high to low, with the lower end being more problematic. He claims that psychotherapy can aim to bring the patient to an adaptive level.

*Reliability and normative data for the Behavioral Health Measure (BHM) in primary care behavioral health settings*, "Families, Systems & Health" 32 (2014) 1, pp. 89–100.

7 P. Johansson, P. Høglend, *Identifying mechanisms of change in psychotherapy: Mediators of treatment outcome*, "Clinical Psychology and Psychotherapy" 14 (2007) 1, pp. 1–9.

8 A. E. Kazdin, *Mediators and mechanisms of change in psychotherapy research*, "Annual Review of Clinical Psychology" 3 (2007), pp. 1–27.

9 G. Young, *Psychotherapeutic change mechanisms and causal psychotherapy: Applications to child abuse and trauma*, "Journal of Child and Adolescent Trauma" 15 (2022) 3, pp. 911–923.

The main limitations in psychotherapy research are the small samples and infrequent assessment.[10] In reviewing the literature on the mechanism or factors of change in psychotherapy, two paradigms are broadly distinguished: the older paradigm, which views psychotherapy as a process of applying psychological techniques to emotional or behavioural disorders, and the newer or alternative paradigm, which holds that therapeutic efficacy is primarily contained in the client's experience, and which places significant importance on the encouragement, empowerment and motivation of the client-therapist relationship. The newer paradigm views therapeutic procedures as important, but they become effective primarily when they contribute to the development and enhancement of the relationship with the therapist as experienced by the client.[11] Recent research emphasises that change is not merely a shift in internal states but an experiential learning process, where new sensory and emotional experiences play a crucial role.[12] Research into pathways of change in psychotherapy has attracted considerable attention in recent decades and is particularly relevant for therapists, as the results may indicate certain patterns of change that should trigger a clinical response. However, given the clinical relevance of these findings, researchers must consider the problem of limited generalizability.[13]

Relational family therapy[14] has been comprehensively described in numerous scientific articles.[15] As a therapeutic approach, it places the relationship

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[10] A. M. Hayes, L. A. Andrews, *A complex systems approach to the study of change in psychotherapy*, "BMC Medicine" 18 (2020) 1, pp. 1–13.

[11] S. Jerebic, D. Jerebic, *Consequences of childhood sexual abuse for intimate couple relationship according to relational family therapy*, "The Person and the Challenges" 8 (2018) 2, pp. 133–146; D. E. Orlinsky, *Foreword*, in: *The heart and soul of change: Delivering what works in therapy*, eds. B. L. Duncan, S. D. Miller, B. E. Wampold, M. A. Hubble, Washington, DC 2010, American psychological association, pp. xix–xxv.

[12] A. Banymandhub, *Le changement, un nouvel apprentissage*, "Le Journal Des Psychologues" N° Hors-série (2023) HS2, pp. 43–47.

[13] M. Bugatti, J. Owen, R. J. Reese, Z. Richardson, W. Rasmunsen, D. A. Newton, *The effectiveness of psychotherapy for depression in private practice: Benchmarking and trajectories of change*, "Professional Psychology: Research and Practice" 54 (2023) 5, pp. 327–335.

[14] C. Gostečnik, *Relacijska družinska terapija*, Ljubljana 2004, Brat Frančišek in Frančiškanski družinski inštitut

[15] C. Gostečnik, T. Repič Slavič, M. Cvetek, R. Cvetek, *The salvational process in relationships: A view from projective-introjective identification and repetition compulsion*, "Journal of Religion and Health" 48 (2009) 4, pp. 496–506; C. Gostečnik, T. Repič, T. Pate, R. Cvetek, *Body language in relational family therapy*, "Journal of Religion & Health" 57 (2018) 4, pp. 1538–1553; C. Gostečnik, T. Repič Slavič, T. Pate, R. Cvetek, *Repetition*

at the centre of therapeutic work, and it is within the relationship that the fundamental relationship structures are changed. Sensitisation to repressed content and the provision of missing early experiences is another important factor of this therapeutic approach.[16] The relational family model also places a high value on the hope for change and transformation. When a person actively participates in the therapeutic process, when the client takes full responsibility for their own psychological state, then with the help of a therapist, change is possible even in the worst traumas, because every pain and trauma also brings with it longing and hope for change, which can occur in a potential psychological space between therapist and individual, couple or family in the therapeutic process.[17]

## 2. Method

### 2.1. Participants

In this study, the reports of 130 participants, 74 women and 56 men, were analysed. The participants were divided into two groups, the experimental group and the control group, each consisting of 65 participants. The groups were equal in terms of gender, age and baseline range of individual, partnership and family problems. Both groups consisted of 28 men and 37 women. The experimental group consisted of participants who were actively involved in the relational

*compulsion revisited in relational family therapy: The discovery of old in order to develop something new*, "Journal of Religion and Health" 58 (2019) 2, pp. 612–627; B. Simonič, N. Rijavec Klobučar, *Attachment perspective on marital dissolution and relational family therapy*, "Journal of Divorce & Remarriage" 58 (2017) 3, pp. 161–174; K. Kompan Erzar, B. Simonič, *Marital infidelity: Relational family therapy perspective on adult detachment*, "Journal of Family Psychotherapy" 21 (2010) 2, pp. 105–116; T. Repič Slavič, C. Gostečnik, *Relational family therapy as an aid toward resolving the trauma of sexual abuse in childhood in the process of separation in the couple relationship*, "Journal of Marital & Family Therapy" 43 (2017) 3, pp. 422–434; S. Jerebic, D. Jerebic, *Consequences of childhood sexual abuse for intimate couple relationship according to relational family therapy*, pp. 133–146.

[16] T. Repič, *Nemi kriki spolne zlorabe in novo upanje*, Celje 2008, Društvo Mohorjeva družba, Celjska Mohorjeva družba.

[17] C. Gostečnik, T. Repič, R. Cvetek, *Potential curative space in relational family therapy*, "Journal of Family Psychotherapy" 20 (2009) 1, pp. 46–59.

family therapy process, while the control group consisted of participants who were not involved in any kind of psychotherapy. The average age of the participants in the experimental group was 35.4 years (SD = 4.7), and the average age of the control group was 34.41 years (SD = 6.56). The marital status of the participants in the experimental group was 61% married, 21.6% unmarried in a committed relationship, 10.8% divorced and the rest single (never married); in the control group 33.8% were married, 58.5% unmarried in a committed relationship and 7.7% single (never married).

### 2.2. Measuring tools

In the study, we used the Systemic Inventory of Change (STIC),[18] a measure to assess the state of individual problems and strengths, the relationship with the partner, the current family, the child's problems and the characteristics of the family of origin.[19] It is an inventory to assess change in the process of family, marital and individual therapy, considering the multisystemic and multidimensional perspective of psychotherapeutic change. The inventory is suitable for testing several hypotheses and consists of two forms:

1. Initial STIC: Participants complete the inventory at the beginning of the therapeutic process. The initial version of the questionnaire is longer because it also contains questions that capture demographic data and characteristics of the participant's family of origin.
2. Intersession STIC: is a shorter version of the questionnaire that is completed by participants during the therapeutic process (between sessions, optional) and at the end of the therapeutic process.

The Initial STIC includes five scales to assess the client's 5 systems: *Individual Problems and Strengths* (IPS), *Family of Origin Scale* (FOS), *Relationship with Partner* (RWP), *Family/Household* (FH) and *Child Problems and Strengths* (CPS).

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[18] W. M. Pinsof, J. L. Lebow, R. E. Zinbarg, L. M. Knobloch-Fedders, G. B. A. Friedman, B. Mann, S. Cytrynbaum, E. Durbin, E. Karam, J.Goldsmith, *Systemic Therapy Inventory of Change – STIC*.

[19] W. M. Pinsof, R. E. Zinbarg, J. L. Lebow, L. M. Knobloch-Fedders, E. Durbin, A. L. Chambers, T. Latta, E. Karam, J. Goldsmith, G. B. A. Friedman, B. Mann, *Laying the foundation for progress research in family, couple, and individual therapy: The development and psychometric features of the initial Systemic Therapy Inventory of Change*, "Psychotherapy Research" 19 (2009) 2, pp. 143–156.

The authors[20] selected these system areas because they believe they are the five most clinically relevant systems that can be consistently explored in family, marital, and individual therapy.

Each scale contains the most clinically relevant dimensions, based on the literature and the author's clinical experience. The Individual Problems and Strengths scale consists of 25 items divided into the following areas: *flexibility/ resilience* (3 items), *life functioning* (2 items), *open expression* (3 items), *self acceptance* (2 items), *disinhibition* (3 items), *negative affect* (8 items grouped into 3 subscales: *depression, anxiety, well-being*), *self-misunderstanding* (2 items), and *substance abuse* (2 items). The Family of origin scale consists of 22 items, which are divided into the following subscales: *mutuality of expectations (clear expectations)* (2 items), *positivity* (6 items), *abuse* (3 items), *intrusiveness* (2 items), *negativity* (5 items), and *substance use* (4 items). The Relationship with Partner scale consists of 24 items, divided into 7 subscales: *commitment* (2 items), *partner positivity* (9 items), *sexual satisfaction* (2 items), *trust* (3 items), *anger/inequity* (4 items), *physical abuse* (2 items) and *substance abuse* (2 items). The Family/Household scale consists of 28 items, which are divided into the following subscales: *boundary clarity* (2 items), *decision making* (2 items), *family pride* (2 items), *positivity* (9 items), *abuse* (3 items), *feeling misunderstood* (2 items) and *negativity* (8 items). The Child Problems and Strengths scale consists of 26 items, which are divided into 7 subscales: *parent/child alliance* (2 items), *prosocial* (3 items), *social/academic* (3 items), *antisocial* (6 items), *food/weight concerns* (2 items), *impulsivity* (4 items) and *negative affect* (6 items). The last scale, The Relationship with Child scale, consists of 6 items divided into 3 subscales: *efficacy* (2 items), *positivity* (2 items), and *negativity* (2 items).

The intersession STIC consists of only 4 measurement scales: *Individual Problems and Strengths scale*, *Relationship with Partner scale*, *Family/Household scale* and *Child Problems and Strengths scale*. All the scales of the Intersession STIC are similar to those of the Initial STIC in terms of content and methodology, but consist of fewer questions and are therefore shorter.

[20] W. M. Pinsof, R. E. Zinbarg, J. L. Lebow, L. M. Knobloch-Fedders, E. Durbin, A. L. Chambers, T. Latta, E. Karam, J. Goldsmith, G. B. A. Friedman, B. Mann, *Laying the foundation for progress research in family, couple, and individual therapy*, pp. 143–156.

### 2.3. Procedure

The participants in the survey were divided into two groups: the experimental group and the control group. The participants in the experimental group were clients in individual, marital or family therapy in various therapeutic centres in Slovenia, all of which practice relational family therapy. Their therapists asked them if they wanted to participate in the survey and instructed them to answer the Initial STIC after the first session and the Intersession STIC after at least 12 therapy sessions. The control group consisted of participants who were informed about the survey and randomly selected and who did not participate in any therapy. They were asked to complete the Initial STIC and after 3 months also the Intersession STIC. All participants (in both groups) were instructed to use the same personal code in the Initial STIC and the Intersession STIC so that their responses could be summarised and compared after the first and second measurement.

## 3. Results

### 3.1. STIC

#### 3.1.1. Individual Problems and Strengths

The difference in scores on the Individual Problems and Strengths scale between the initial and final test in the experimental group compared to the control group showed a statistically significant difference in favour of the experimental group. The change (measured as the difference in the arithmetic mean score between the initial and final measurement) was higher in the experimental group than in the control group in each subcategory. The difference was positive for the categories of well-being, life functioning, open expression, flexibility/resilience and self-acceptance. For the subscales measuring depression, anxiety, negative affect, disinhibition, self-misunderstanding, substance abuse, and individual problems combined, the difference was negative, meaning that these problematic behaviours improved.

The arithmetic means of the scores on the subscales of the Individual problems and strengths scale in the experimental and control groups after the initial and final measurements were then compared, using the T-test if the distribution of the results did not deviate from the normal distribution and the Wilcoxon's

test if the distribution of the results deviated from the normal distribution. The T-tests and Wilcoxon's tests showed that all differences between the experimental and control groups were statistically relevant at the 0.01 level, with the exception of life functioning, flexibility/resilience, substance abuse and self-misunderstanding.

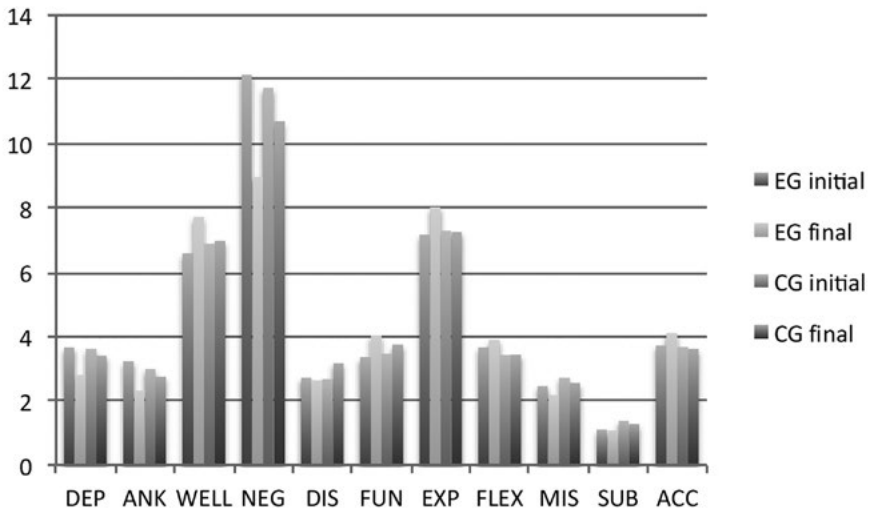


**Figure 1**: Individual problems and strengths in the experimental and control groups after initial and final measurements.

Subcategories: DEP – depression, ANX – anxiety, WELL – wellbeing, NEG – negative affect, DIS – disinhibition, FUN – life functioning, EXP – open expression, FLEX – flexibility/resilience, MIS – self misunderstanding, SUB – substance abuse, ACC – self-acceptance. EG – experimental group, CG – control group. All measures are given as the arithmetic mean for each subscale.

**Table 1**: Arithmetic means of the scores on the subscales of the Individual problems and strengths scale in the experimental and control groups after the initial and final measurements; means of the differences between the initial and final measurements in the experimental and control groups and statistical significance of the differences between the initial and final scores. The T-test was used if the distribution of the results did not deviate from the normal distribution, and the Wilcoxon's test was used if the distribution of the results deviated from the normal distribution.

| Subscales of Individual problems and strengths scale | | Experimental group | | | Control group | | |
|---|---|---|---|---|---|---|---|
| | | ***N*** | ***arithm.*** | ***st.dev.*** | ***N*** | ***arithm.*** | ***st.dev.*** |
| **Depression** | initial | 65 | 3,65 | 1,28 | 65 | 3,62 | 1,486 |
| | final | 65 | 2,8 | 1,078 | 65 | 3,4 | 1,183 |
| | diff. | 65 | **-0,85** | 1,265 | 65 | **-0,22** | 1,682 |
| | T-test | T=3,11 | | | | | |
| | p | **p=0,003**** | | | | | |
| **Anxiety** | initial | 65 | 3,22 | 0,838 | 65 | 2,98 | 0,96 |
| | final | 65 | 2,31 | 0,917 | 65 | 2,75 | 1,173 |
| | diff. | 65 | **-0,91** | 1,057 | 65 | **-0,23** | 1,17 |
| | T-test | T=3,46 | | | | | |
| | p | **p=0,001**** | | | | | |
| **Well-being** | initial | 65 | 6,58 | 1,802 | 65 | 6,88 | 1,505 |
| | final | 65 | 7,72 | 1,663 | 65 | 6,98 | 1,691 |
| | diff. | 65 | **1,14** | 1,952 | 65 | **0,11** | 2,07 |
| | T-test | T=-2,709 | | | | | |
| | | **p=0,009**** | | | | | |
| **Negative affect** | initial | 65 | 12,15 | 3,227 | 65 | 11,74 | 3,27 |
| | final | 65 | 8,97 | 3,419 | 65 | 10,69 | 3,548 |
| | diff. | 65 | **-3,18** | 3,344 | 65 | **-1,05** | 4,064 |
| | T-test | T=3,583 | | | | | |
| | | **p=0,001**** | | | | | |
| **Disinhibition** | initial | 65 | 2,71 | 0,805 | 65 | 2,68 | 0,97 |
| | final | 65 | 2,63 | 0,821 | 65 | 3,17 | 0,993 |
| | diff. | 65 | **-0,08** | 1,005 | 65 | **0,49** | 1,106 |
| | Wilcoxon's test | Z=-3,131b | | | | | |
| | p | **p=0,002**** | | | | | |
| **Life functioning** | initial | 65 | 3,35 | 0,779 | 65 | 3,46 | 0,812 |
| | final | 65 | 4,02 | 0,82 | 65 | 3,74 | 0,668 |
| | diff. | 65 | 0,66 | 0,973 | 65 | 0,28 | 0,944 |
| | Wilcoxon's test | Z=-1,946c | | | | | |
| | p | p=0,052 | | | | | |
| **Open expression** | initial | 65 | 7,17 | 1,587 | 65 | 7,29 | 1,588 |
| | final | 65 | 8,03 | 1,38 | 65 | 7,25 | 1,358 |
| | diff. | 65 | **0,86** | 1,56 | 65 | **-0,05** | 1,462 |
| | T-test | T=-3,406 | | | | | |
| | p | **p=0,001**** | | | | | |
| **Flexibility/resilience** | initial | 65 | 3,65 | 0,856 | 65 | 3,42 | 0,748 |
| | final | 65 | 3,89 | 0,753 | 65 | 3,43 | 0,749 |
| | diff. | 65 | 0,25 | 0,884 | 65 | 0,02 | 0,992 |
| | Wilcoxon's test | Z=-1,359C | | | | | |
| | | p=0,174 | | | | | |
| **Self-misunderstanding** | initial | 65 | 2,45 | 1 | 65 | 2,71 | 0,914 |
| | final | 65 | 2,18 | 0,917 | 65 | 2,55 | 0,83 |
| | diff. | 65 | -0,26 | 0,94 | 65 | -0,15 | 1,049 |
| | T-test | T=0,668 | | | | | |
| | p | p=0,507 | | | | | |

| Subscales of Individual problems and strengths scale | | Experimental group | | | Control group | | |
|---|---|---|---|---|---|---|---|
| | | *N* | *arithm.* | *st.dev.* | *N* | *arithm.* | *st.dev.* |
| Substance abuse | initial | 65 | 1,09 | 0,292 | 65 | 1,38 | 0,604 |
| | final | 65 | 1,08 | 0,322 | 65 | 1,28 | 0,573 |
| | diff. | 65 | -0,02 | 0,414 | 65 | -0,11 | 0,793 |
| | Wilcoxon's test | Z=-1,002c | | | | | |
| | p | p=0,317 | | | | | |
| Self-acceptance | initial | 65 | 3,72 | 0,875 | 65 | 3,68 | 0,886 |
| | final | 65 | 4,11 | 0,812 | 65 | 3,62 | 0,86 |
| | diff. | 65 | **0,38** | 0,842 | 65 | **-0,06** | 0,982 |
| | Wilcoxon's test | Z=-2,656c | | | | | |
| | p | **p=0,008**** | | | | | |
| Individual problems together | initial | 65 | 30,06 | 6,635 | 65 | 30,31 | 6,757 |
| | final | 65 | 24,25 | 7,802 | 65 | 28,97 | 7,163 |
| | diff. | 65 | **-5,82** | 6,605 | 65 | **-1,34** | 6,911 |
| | T-test | T=4,328 | | | | | |
| | p | **p=0,00**** | | | | | |

*Notes:* N – numerous, arithm. – arithmetic mean, st. dev. – standard deviation, diff. – difference, p – statistical significance, * p≤0.05; ** p≤0.01.

### 3.1.2. Relationship with the partner

Fifty eight participants in the experimental group and 63 participants in the control group participated in the analysis of the problems and strengths of the relationship with the partner.

The arithmetic mean values of the scores on the subscales of the Relationship with Partner scale in the experimental and control groups were compared after the first and last measurement using the T-test if the distribution of the results did not deviate from the normal distribution, and using the Wilcoxon's test if the distribution of the results deviated from the normal distribution. After the final measurement, the total scores on the Relationship with Partner scale showed a greater improvement in the experimental group than in the control group, with a significance level of less than 1%. For the various subscales of the Relationship with Partner scale, there were also statistically significant differences in the change from the initial to the final score, with the experimental group showing greater improvement in conversation between partners, mutual communication, mutual intimacy, positivity of the relationship and the value of the relationship in general. The study also showed a statistically significant decrease in mistrust/betrayal, inequity and anger/contempt between partners ($p < 0.01$). Another statistically significant result was the decrease in sexual dissatisfaction ($p < 0.05$).

The study found no statistically significant changes on the other subscales of partnership problems and strengths.

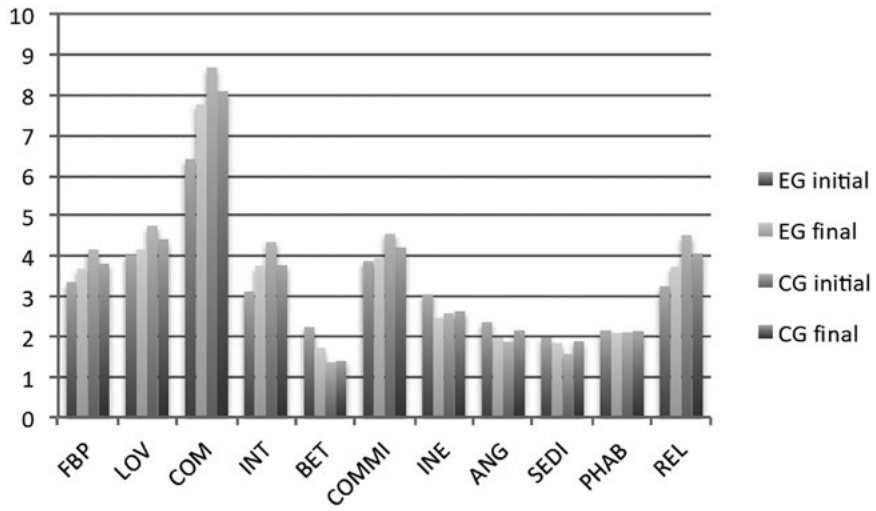


**Figure 2**: Relationship with partner scale scores in the experimental and control groups after the initial and final measurements.

*Note:* The subscales of the relationship with partner scale are: FBP – fun between partners, LOV – mutual love, COM – communication, INT – intimacy, BET – mistrust/ betrayal, COMMI – commitment, INE – inequity, ANG – anger/contempt, SEDI – sexual dissatisfaction, PHAB – physical abuse, REL – relationship in general. All the measures are shown as arithmetic mean for each subscale. EG – experimental group, CG – control group. All measures are given as the arithmetic mean for each subscale.

**Table 2**: Mean values of the subscales of the Relationship with Partner scale in the experimental and control groups according to the initial and final measurements; mean differences between the initial and final measurements in the experimental and control groups and statistical significance of the differences between the initial and final values. The T-test was used if the distribution of the results did not deviate from the normal distribution, and the Wilcoxon's test was used if the distribution of the results deviated from the normal distribution.

| Subscales of Relationship with partner scale | | Experimental group | | | Control group | | |
|---|---|---|---|---|---|---|---|
| | | ***N*** | ***arithm.*** | ***st.dev.*** | ***N*** | ***arithm.*** | ***st.dev.*** |
| **Fun between partners** | initial | 56 | 3,36 | 1,21 | 62 | 4,17 | 0,685 |
| | final | 56 | 3,69 | 1,245 | 62 | 3,81 | 1,09 |
| | diff. | 56 | **0,23** | 1,079 | 62 | **-0,29** | 0,876 |
| | Wilcoxon's test | Z=-2,804 | | | | | |
| | p | **p=0,005**** | | | | | |
| **Mutual love** | initial | 56 | 4,03 | 1,284 | 62 | 4,75 | 0,474 |
| | final | 56 | 4,16 | 1,197 | 62 | 4,41 | 1,057 |
| | diff. | 56 | 0,13 | 0,944 | 62 | -0,34 | 0,803 |
| | Wilcoxon's test | Z=-1,450c | | | | | |
| | p | p=0,147 | | | | | |
| **Mutual communication** | initial | 56 | 6,4 | 2,094 | 62 | 8,67 | 1,437 |
| | final | 56 | 7,76 | 2,011 | 62 | 8,08 | 2,058 |
| | diff. | 56 | **1,36** | 1,806 | 62 | **-0,59** | 1,852 |
| | T-test | T=-4,609 | | | | | |
| | p | **P=0,00**** | | | | | |
| **Mutual intimacy** | initial | 56 | 3,12 | 1,365 | 62 | 4,35 | 0,864 |
| | final | 56 | 3,76 | 1,218 | 62 | 3,78 | 1,142 |
| | diff. | 56 | **0,64** | 1,334 | 62 | **-0,57** | 0,919 |
| | Wilcoxon's test | Z=-4,048C | | | | | |
| | p | **p=0,00**** | | | | | |
| **Positivity** | initial | 56 | 17,02 | 4,919 | 62 | 21,94 | 2,533 |
| | final | 56 | 19,41 | 4,896 | 62 | 20,13 | 4,654 |
| | diff. | 56 | **2,21** | 4,33 | 62 | **-1,81** | 3,547 |
| | T-test | T=-4,378 | | | | | |
| | p | **P=0,00**** | | | | | |
| **Mistrust/Betrayal** | initial | 56 | 2,24 | 1,218 | 62 | 1,37 | 0,703 |
| | final | 56 | 1,72 | 1,056 | 62 | 1,41 | 0,835 |
| | diff. | 56 | **-0,52** | 0,968 | 62 | **0,04** | 1,029 |
| | Wilcoxon's test | Z=-3,002B | | | | | |
| | p | **p=0,003**** | | | | | |
| **Commitment** | initial | 56 | 3,88 | 1,415 | 62 | 4,56 | 0,616 |
| | final | 56 | 3,95 | 1,303 | 62 | 4,21 | 1,065 |
| | diff. | 56 | 0,07 | 1,062 | 62 | -0,35 | 0,813 |
| | T-test | T=-1,334c | | | | | |
| | p | p=0,182 | | | | | |
| **Inequity** | initial | 56 | 3,05 | 1,395 | 62 | 2,59 | 1,102 |
| | final | 56 | 2,47 | 1,203 | 62 | 2,63 | 1,067 |
| | diff. | 56 | **-0,58** | 1,299 | 62 | **0,04** | 1,073 |
| | T-test | T=3,173 | | | | | |
| | p | **p=0,002**** | | | | | |
| **Anger/Contempt** | initial | 56 | 2,36 | 1,21 | 62 | 1,87 | 0,813 |
| | final | 56 | 1,98 | 0.946 | 62 | 2,16 | 0,987 |
| | diff. | 56 | **-0,38** | 1,173 | 62 | **0,29** | 0,991 |
| | T-test | T=3,459 | | | | | |
| | p | **p=0,001**** | | | | | |

| Subscales of Relationship with partner scale | | Experimental group | | | Control group | | |
|---|---|---|---|---|---|---|---|
| | | ***N*** | ***arithm.*** | ***st.dev.*** | ***N*** | ***arithm.*** | ***st.dev.*** |
| **Sexual dissatisfaction** | initial | 56 | 1,98 | 1,263 | 61 | 1,57 | 0,856 |
| | final | 56 | 1,84 | 1,04 | 61 | 1,9 | 1,155 |
| | diff. | 56 | **-0,14** | 1,266 | 61 | **0,33** | 1,126 |
| | Wilcoxon's test | Z=-2,158b | | | | | |
| | p | **p=0,031**** | | | | | |
| **Physical abuse** | initial | 56 | 2,17 | 0,775 | 62 | 2,11 | 0,364 |
| | final | 56 | 2,09 | 0,629 | 62 | 2,14 | 0,82 |
| | diff. | 56 | -0,08 | 0,554 | 62 | 0,03 | 0,795 |
| | Wilcoxon's test | Z=-1,636b | | | | | |
| | p | p=0,102 | | | | | |
| **Relationship with partner (sum)** | initial | 56 | 43,71 | 10,922 | 61 | 52,98 | 4,379 |
| | final | 56 | 48,57 | 10,117 | 61 | 49,35 | 9,778 |
| | diff. | 56 | **-4,86** | 7,797 | 61 | **-3,36** | 6,567 |
| | T-test | T=-4,297 | | | | | |
| | p | **p=0,00**** | | | | | |
| **Relationship with partner (general)** | initial | 49 | 3,26 | 1,211 | 56 | 4,51 | 0,598 |
| | final | 49 | 3,75 | 1,159 | 56 | 4,07 | 1,032 |
| | diff. | 49 | **0,49** | 1,155 | 56 | **-0,44** | 0,781 |
| | Wilcoxon's test | Z=-3,362c | | | | | |
| | p | **p=0,001**** | | | | | |

*Notes: Notes:* N – numerus, arithm. – arithmetic mean, st. dev. – standard deviation, diff. – difference, p – statistical significance, * p≤0,05; ** p≤0,01.

### 3.1.3. Family (household); relationship with the child

Forty people in the experimental group and 35 in the control group participated in the analysis of the problems and strengths of the family/household.

The total score of the strengths and problems in the family/household after the final measurement showed a higher improvement in the experimental group than in the control group in the category "Feeling misunderstood", with a significance level of less than 5%. For the other subscales of the family/household scale, no statistically significant differences were found between the initial and final values in the study.

Thirty two people in the experimental group and 25 in the control group took part in the analysis of the relationship with the child scale. The study found no statistically significant difference in the mean values between the experimental and control groups.

## 4. Discussion

The results of the study show that there is a statistically significant difference in change between the experimental and control groups on the subscales of individual and relationship problems and strengths in favour of the experimental group. The comparison between the initial and final measurements confirmed that active participation in the therapeutic process of relational family therapy helps increase clients' strengths and decrease their problems. In 12 sessions, or after about 3 months, if there is continuous participation in the therapeutic process, the clients' condition improves significantly. Depression, anxiety and negative emotions decreased significantly, which was also found in other studies, e.g. in a study from 2022,[21] which found that the first four emotions most strongly experienced during the therapy process were happiness, relief, sadness and surprise in both therapists and clients

Both groups of participants were matched for the initial severity of problems, i.e., they consisted of participants with a similar intensity of initial problems. The study showed that participation in psychotherapy is useful and can be of great help in trying to improve conditions and eliminate problems. The greatest positive change was observed in partnership problems and strengths, followed by changes in individual problems and strengths and less improvement in family problems and strengths. This probably confirms an important fact inherent in the premise of relational family therapy,[22] that couples therapy usually offers clients the opportunity to have a corrective emotional experience with their partner as part of the therapy. Another important fact is that both partners have new experiences in partnership dynamics and communication, not just one. Shame and fear of the partner's reaction often prevent the disclosure of important issues (e.g., about sexual or physical abuse in the family of origin),[23] so new experiences with supportive responses can make a big difference in communication between partners. In the study, regardless of the type of therapy (individual, couple or family therapy), an improvement was observed on various subscales of the

[21] A. Çavdar, *Emotions and symptom change in psychodynamic psychotherapy: A longitudinal study*, "Turkish Journal of Psychology / Turk Psikoloji Dergisi" 37 (2022) 90, pp. 40–43.

[22] C. Gostečnik, *Relacijska zakonska terapija*, Ljubljana 2007, Brat Frančišek in Frančiškanski družinski inštitut.

[23] D. Jerebic, S. Jerebic, *Are childhood sexual abuse and intimate safety in adult intimate relationships correlated?*, "The Person and the Challenges" 9 (2019) 2, pp. 193–206.

couple relationship. From this, we can conclude that new insights in therapy can be the source for a different behaviour in the relationship with the partner and thus for new reactions to the partner. This could lead to a new, improved relationship dynamic.

The various psychotherapy models differ in terms of what they focus on emotions, cognitions or behaviour[24] etc. For relational family therapy, we can say that it focuses on the interconnectedness and interaction of all three, so that the results of therapy also appear on all sub-dimensions of a person's functioning.[25] The main effect of therapy is often the mitigation of current crises and the uplifting of the client's morale, but many therapists see personal growth as the most important outcome of psychotherapy. Personal growth involves developing a more accurate and realistic perception of self and others and better access to one's inner world and behaviour that is better aligned with achieving personal goals. Personal growth can also include better self-acceptance and emotional security, which can increase flexibility and spontaneity in relationships with others while improving the person's sense of well-being. For some people, psychotherapy also promotes the achievement of a more coherent and satisfying philosophy of life.[26] Another important outcome of therapy is a move towards a more realistic view of the family of origin, as many adults see their early relationships with parents as good,[27] but may not be aware of the less functional and potentially damaging side of family dynamics. An example of this is the adult children of alcoholics, for whom recognising the consequences of alcoholism in their family of origin is crucial to the quality of their adult lives.[28]

The reduction in negative affect, more specifically the scores on the depression and anxiety subscales, indicates an important positive effect of relational family therapy. According to Frank and Frank,[29] depression and anxiety are

[24] J. D. Frank, J. B. Frank, *Persuasion and healing: A comparative study of psychotherapy*, Baltimore 1993, The Johns Hopkins University Press.

[25] C. Gostečnik, *Relacijska paradigma in klinična praksa*, Ljubljana 2013, Brat Frančišek in Frančiškanski družinski inštitut.

[26] J. D. Frank, J. B. Frank, *Persuasion and healing: A comparative study of psychotherapy*.

[27] E. Osewska, *Memories of adults regarding relations with parents in childhood*, "The Person and the Challenges" 7 (2017) 1, pp. 149–158.

[28] B. Simonič, E. Osewska, *Emotional experience and consequences of growing up in a family with alcoholism in adult children of alcoholics*, "The Person and the Challenges" 13 (2023) 1, pp. 63–81.

[29] J. D. Frank, J. B. Frank, *Persuasion and healing: A comparative study of psychotherapy*.

directly related to demoralisation, which is the main characteristic of clients who come to therapy. People feel that they have not met their own expectations or the expectations of others, or that they have not been successful in overcoming a problem. They feel powerless to change a situation or themselves, and they feel that they are in a unique situation that no one has ever experienced before, so no one really understands them. In addition to anxiety and depression, they may feel other emotions such as anger and resentment. In our study, we examined the latter two emotions as subscales of the Relationship with Partner scale. The results of the study suggest that clients feel less anger and resentment after three months of therapy than at the beginning of therapy.

We asked participants to take part in the study at their first session with the therapist, so that they completed the initial STIC questionnaire after the first session and not before. We suspect that the differences would be even greater if they completed the questionnaire before the first session, because a lot can change even after the first session, even though they completed the questionnaire with answers that relate to the last month of their lives. People can be more optimistic after they have started the therapy process because they believe that they have started to solve their problems, they have confidence in the therapeutic process, etc. Patients and therapists also have psychotherapy-related expectations, such as their prediction of what processes will promote therapeutic change. The results of a study by Brugnera et al.[30] have shown that patients' expectations of the change process at the beginning of psychotherapy are related to therapy outcomes and lead to different effects in the early stages of therapy. These results suggest that patients' views of the therapeutic process could be a potential target for improving the effectiveness of therapy.

The participants completed the questionnaire via a web link, which could also mean that older or less educated people were not included, as they are generally less adept at using computers. They may also not have a computer or internet connection. Pinsof et al.[31] reported that they solved this problem in their study

[30] A. Brugnera, M. J. Constantino, A. Grossman-Giron, B. D., Tzviel, D. Tzur Bitan, *Patient and therapist change process expectations: Independent and dyadic associations with psychotherapy outcomes*, "Psychotherapy Research" march 2024 (ahead of print), pp. 1–10.

[31] W. M. Pinsof, R. E. Zinbarg, J. L. Lebow, L. M. Knobloch-Fedders, E. Durbin, A. L. Chambers, T. Latta, E. Karam, J. Goldsmith, G. B. A. Friedman, B. Mann, *Laying the foundation for progress research in family, couple, and individual therapy*, pp. 143–156.

by using computers or tablets that were available at the clinic so that participants could complete the questionnaires before each therapy session.

The study showed no statistically significant differences in some subscales (especially in relation to family and children), so the initial hypothesis of the study had to be rejected. Although the sample was large enough, there was only some participants with children, i.e., participants who were considered as the ones who have a family. It would be advisable to conduct the study with a sample consisting of more participants with children. The length of the STIC questionnaire could also be the reason for the lower number of responses on the subscales related to family, as the questions about children were at the end of the questionnaire, where there was a lower percentage of completed responses.

Due to the complexity of the family system and the changes within this system, it would be advisable to observe the changes over a longer period than three months, although some studies suggest that this may no longer give us statistically significant differences in the changes. The study examining the "good enough" model and the "dose-effect" model[32] found that the "good enough" model was a better fit to the data compared to "the dose-effect" model for all outcomes. Clients who attended fewer sessions showed faster improvement, suggesting that clients tend to discontinue psychotherapy when they feel that their symptoms, well-being, and life functioning have improved sufficiently.

The results of the present study are consistent with previous research results and theoretical foundations and provide new insights into the relationship between therapeutic treatment based on the relational family therapy model and changes in the area of individual and couple problems and strengths.

## References

Altimir C., Krause M., De la Parra G., Dagnino P., Tomicic A., Valdes N., Perez C. J., Echavarrri O., Vilches O., *Clients', therapists', and observers' agreement on the amount, temporal location, and content of psychotherapeutic change and its relation to outcome*, "Psychotherapy Research" 20 (2010) 4, pp. 472–487.

Banymandhub A., *Le changement, un nouvel apprentissage*, "Le Journal Des Psychologues" N° Hors-série (2023) HS2, pp. 43–47.

[32] J. J. Owen, J. Adelson, S. Budge, S. M. Kopta, R. J. Reese, *Good-enough level and dose-effect models: Variation among outcomes and therapists*, "Psychotherapy Research" 26 (2016) 1, pp. 22–30.

Brugnera A., Constantino M. J., Grossman-Giron A., Tzviel B. D., Tzur Bitan D., *Patient and therapist change process expectations: Independent and dyadic associations with psychotherapy outcomes*, "Psychotherapy Research" march 2024 (ahead of print), pp. 1–10.

Bugatti M., Owen J., Reese R. J., Richardson Z., Rasmunsen W., Newton D. A., *The effectiveness of psychotherapy for depression in private practice: Benchmarking and trajectories of change*, "Professional Psychology: Research and Practice" 54 (2023) 5, pp. 327–335.

Bryan C. J., Blount T., Kanzler K. A., Morrow C. E., Corso K. A., Corso M. A., *Reliability and normative data for the Behavioral Health Measure (BHM) in primary care behavioral health settings*, "Families, Systems & Health" 32 (2014) 1, pp. 89–100.

Çavdar A., *Emotions and symptom change in psychodynamic psychotherapy: A longitudinal study*, "Turkish Journal of Psychology / Turk Psikoloji Dergisi" 37 (2022) 90, pp. 40–43.

Frank J. D., Frank J. B., *Persuasion and healing: A comparative study of psychotherapy*, Baltimore 1993, The Johns Hopkins University Press.

Gostečnik C., *Relacijska družinska terapija*, Ljubljana 2004, Brat Frančišek in Frančiškanski družinski inštitut.

Gostečnik C., *Relacijska zakonska terapija*, Ljubljana 2007, Brat Frančišek in Frančiškanski družinski inštitut.

Gostečnik C., Repič Slavič T., Cvetek M., Cvetek R., *The salvational process in relationships: A view from projective-introjective identification and repetition compulsion*, "Journal of Religion and Health" 48 (2009) 4, pp. 496–506.

Gostečnik C., Repič T., Cvetek R., *Potential curative space in relational family therapy*, "Journal of Family Psychotherapy" 20 (2009) 1, pp. 46–59.

Gostečnik C., *Relacijska paradigma in klinična praksa*, Ljubljana 2013, Brat Frančišek in Frančiškanski družinski inštitut.

Gostečnik C., Repič T., Pate T., Cvetek R., *Body language in relational family therapy*, "Journal of Religion & Health" 57 (2018) 4, pp. 1538–1553.

Gostečnik C., Repič Slavič T., Pate T., Cvetek R., *Repetition compulsion revisited in relational family therapy: The discovery of old in order to develop something new*, "Journal of Religion and Health" 58 (2019) 2, pp. 612–627.

Hayes A. M., Andrews L. A., *A complex systems approach to the study of change in psychotherapy*, "BMC Medicine" 18 (2020) 1, pp. 1–13.

Huflejt-Łukasik M., Bąk W., Styła R., Klajs K., *Changes in the self in the course of psychotherapy*, "Roczniki Psychologiczne" 18 (2015) 3, pp. 449–464.

Jerebic S., Jerebic D., *Consequences of childhood sexual abuse for intimate couple relationship according to relational family therapy*, "The Person and the Challenges" 8 (2018) 2, pp. 133–146.

Jerebic D., Jerebic S., *Are childhood sexual abuse and intimate safety in adult intimate relationships correlated?*, "The Person and the Challenges" 9 (2019) 2, pp. 193–206.

Johansson P., Høglend P., *Identifying mechanisms of change in psychotherapy: Mediators of treatment outcome*, "Clinical Psychology and Psychotherapy" 14 (2007) 1, pp. 1–9.

Kazdin A. E., *Mediators and mechanisms of change in psychotherapy research*, "Annual Review of Clinical Psychology" 3 (2007), pp. 1–27.

Kompan Erzar K., Simonič B., *Marital infidelity: Relational family therapy perspective on adult detachment*, "Journal of Family Psychotherapy" 21 (2010) 2, pp. 105–116.

Orlinsky D. E., *Foreword*, in: *The heart and soul of change: Delivering what works in therapy*, eds. Duncan B. L., Miller S. D., Wampold B. E., Hubble M. A., Washington, DC 2010, American psychological association, pp. xix–xxv.

Osewska E., *Memories of adults regarding relations with parents in childhood*, "The Person and the Challenges" 7 (2017) 1, pp. 149–158.

Owen J. J., Adelson J., Budge S., Kopta S. M., Reese R. J., *Good-enough level and dose-effect models: Variation among outcomes and therapists*, "Psychotherapy Research" 26 (2016) 1, pp. 22–30.

Pinsof W. M., Lebow J. L., Zinbarg R. E., Knobloch-Fedders L. M., Friedman G. B. A., Mann B., Cytrynbaum S., Durbin E., Karam E. and Goldsmith J., *Systemic Therapy Inventory of Change – STIC*, Evanston, IL 2005, The Family Institute at Northwestern University.

Pinsof W. M., Zinbarg R. E., Lebow J. L., Knobloch-Fedders L. M., Durbin E., Chambers A. L., Latta T., Karam E., Goldsmith J., Friedman G. B. A., Mann B., *Laying the foundation for progress research in family, couple, and individual therapy: The development and psychometric features of the initial Systemic Therapy Inventory of Change*, "Psychotherapy Research" 19 (2009) 2, pp. 143–156.

Repič T., *Nemi kriki spolne zlorabe in novo upanje*, Celje 2008, Društvo Mohorjeva družba, Celjska Mohorjeva družba.

Repič Slavič T., Gostečnik C., *Relational family therapy as an aid toward resolving the trauma of sexual abuse in childhood in the process of separation in the couple relationship*, "Journal of Marital & Family Therapy" 43 (2017) 3, pp. 422–434.

Rogers C. R., *The necessary and sufficient conditions of therapeutic personality change*, "Journal of Consulting & Clinical Psychology" 60 (1992) 6, pp. 827–832.

Simonič B., Rijavec Klobučar N., *Attachment perspective on marital dissolution and relational family therapy*, "Journal of Divorce & Remarriage" 58 (2017) 3, pp. 161–174.

Simonič B., Osewska E., *Emotional experience and consequences of growing up in a family with alcoholism in adult children of alcoholics*, "The Person and the Challenges" 13 (2023) 1, pp. 63–81.

Schore A. N., *The science of the art of psychotherapy*, New York 2012, W. W. Norton & Company.

*The heart and soul of change: Delivering what works in therapy*, eds. B. L.Duncan, S. D. Miller, B. E. Wampold, M. A. Hubble, Washington, DC 2010, American psychological association.

Young G., *Psychotherapeutic change mechanisms and causal psychotherapy: Applications to child abuse and trauma*, "Journal of Child and Adolescent Trauma" 15 (2022) 3, pp. 911–923.