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Depression: The differing Narratives of Couples in Couple Therapy


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Abstract

How does the spouse of a person with depression take part in constructing narratives of depression in couple therapy? In this study we examined couples' ways of co-constructing narratives of depression in couple therapy. Three couple therapy processes were chosen for the study, one spouse in each couple having been referred to an outpatient clinic for treatment for his/her depression. Four sessions from each systemic couple therapy process (Jones & Asen, 2000) were analyzed using narrative analysis. According to our findings, couples co-constructed narratives of depression, each in their own way. It is crucial to focus not only on the patient's individual narrative of depression, but also on the depressed spouse's narrative as an interactive part of the non-depressed spouse's narrative, and a shared narrative created by the spouses about depression.

Keywords

Couple Therapy, Depression, Shared Narratives, and Narrative Analysis

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Depression: The Differing Narratives of Couples in Couple Therapy

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How does the spouse of a person with depression take part in constructing narratives of depression in couple therapy? In this study we examined couples' ways of co-constructing narratives of depression in couple therapy. Three couple therapy processes were chosen for the study, one spouse in each couple having been referred to an outpatient clinic for treatment for his/her depression. Four sessions from each systemic couple therapy process (Jones & Asen, 2000) were analyzed using narrative analysis. According to our findings, couples co-constructed narratives of depression, each in their own way. It is crucial to focus not only on the patient's individual narrative of depression, but also on the depressed spouse's narrative as an interactive part of the non-depressed spouse's narrative, and a shared narrative created by the spouses about depression. Key Words: Couple Therapy, Depression, Shared Narratives, and Narrative Analysis

Introduction

When a person becomes depressed, partnership can either be a source of strength, advancing recovery, or a source of further suffering, harming the health of both partners (Cordova & Gee, 2001). Also, depression in one spouse can create feelings of helplessness and hopelessness in both spouses (Cordova & Gee). These are some of the reasons why couple therapy has been used with persons diagnosed with depression and their spouses. Yet, according to Denton and Burwell's (2006) experience, which is similar to our own, the spouses of depressed patients often are not part of the treatment in psychiatric outpatient care, and hence feel unsupported, uninformed, isolated, confused, and frustrated.

When one of the spouses is depressed, a goal in using couple therapy as treatment for depression can be considered to be the development of a stronger sense of agency in both spouses (Holma & Aaltonen, 1998). According to White and Epston (1990), the objective of therapeutic work is to recruit an audience for a new and preferred self-narrative in the medium of the social world. In the couple therapy situation, one could regard both the therapist and the spouse as an audience for the depressed person's narrative. The spouse also can be regarded as a person who shares and who can co-construct the depressed partner's narrative. If the depressed person's spouse is present, the description of life can become more comprehensive and more complex, and in this way it can help the couple acquire a stronger sense of agency, find new ways of seeing their situation as well as new ways of behaving in it (White & Epston).

In recent decades, increasing attention has been paid to couple therapy in working with depressed persons (e.g., Beach, 2001; Beach, Finchman, & Katz, 1998;

Denton & Burwell, 2006; Gillian & Cottone, 2005; Gupta, Coyne, & Beach, 2003; Keitner & Miller, 1990; Mead, 2002). For example, Gupta et al. recommended that couple therapy should be used when the couple reports significant relationship discord. Researchers such as Cordova and Gee (2001) and Coyne and Benazon (2001) have recommended working with couples whose relationship is satisfactory. Involvement of the spouse in the treatment of a depressed person has been considered to be important (Denton & Burwell). Obstacles and difficulties in involving the spouses in the treatment have been reported (Gupta et al.). Couples may find it difficult or disagreeable if they sense that their relationship is to blame for depression. On the other hand, couples who seek therapy because they have problems in their relationship and who do not collaborate well, may find it senseless if collaboration is the means for addressing their problems. In addition, committing to conjoint sessions can be difficult for couples due to pressures of work and childcare responsibilities (Gupta et al.).

Studies dealing with couple therapy for depression have mostly dealt with treatment effectiveness. Beach and O'Leary (1992) studied cognitive-behavioral couple therapy; Emanuels-Zuurveen and Emmelkamp (1996) studied communication-focused couple therapy; Foley, Rounsaville, Weissman, Sholomskas, and Chevron (1989) studied interpersonal couple therapy; Teichman, Bar-el, Shor, Sirota, and Elizur (1995) studied cognitive-systemic couple therapy and Leff, Vearnals, Brewin, Wolff, Alexander, Asen, et al. (2000) studied systemic couple therapy. The authors of these reports have indicated that couple therapy approaches are as effective as individual therapy in helping depressed people, and that couple therapy also increases marital satisfaction. In addition to studying the effectiveness of couple therapy for depression, there is also a need to do more psychotherapy research that would utilize qualitative methods, with a view toward obtaining a more detailed picture of what actually happens in therapy sessions (Moon, Dillon, & Sprenkle, 1990). According to Pinsof and Wynne (2000), existing (largely quantitative) couple and family therapy research has had very little impact on the practice of most couple and family therapists.

This study was part of a larger project aimed at developing a treatment of depression used in a psychiatric outpatient clinic for the Department of Psychiatry at Kuopio University Hospital in Finland, by moving in a more family-therapeutic direction. Presently, the ways of working with depressed persons in this outpatient clinic have been mostly individually oriented. Taking into account the relational nature of depression and the ways in which depression affects the close relationships and in turn how close relationship can impact depression, family therapists working in the outpatient clinic wanted to develop systemic ways of working with depressed patients and their spousal partners.

The theoretical orientation for the couple therapy method utilized is based on a systemic couple therapy model developed by Jones and Asen (2000). In this model, depression is placed in the context of the individual's current and past relationships, and of social and cultural factors and discourses. The therapy aims to help both spouses get new perspectives on their problems, to attach different meanings to the depressive behaviors, or to experiment with new ways of relating to one another. The goal is to empower the couple to find their own solutions. Jones and Asen used this model in the London Depression Trial, a research project (Leff et al., 2000) in which couple therapy was used to help persons diagnosed with depression. In this context, couples were not asking for help with relational problems, rather the undiagnosed partner had agreed to accompany the depressed partner to therapy. According to Jones

and Asen the focus of therapy varied; in some cases the focus remained on the difficulties of one person, in other cases the focus shifted early on to difficulties within the couple's relationship.

In this study we examined couples' ways of co-constructing narratives of depression in the context of couple therapy. We hoped to produce information for couple and family therapists working in these settings in order for them to develop their work with couples experiencing depression. Our research question was: How does the spouse of a depressed person take part in constructing narratives of depression in couple therapy?

Method

The qualitative inquiry

The method of qualitative analysis used in this study was narrative analysis. Our approach was discovery-oriented. We used elements of *qualitative narrative analysis* (McLeod & Balamoutsou, 2001) and *meaning condensation* (Kvale, 1996). This method of analysis was chosen to describe couples' ways of jointly co-constructing narratives. The philosophical background of our analysis is social constructionism. Psychotherapy is seen as social action in which therapists and clients co-construct the stories of peoples' lives (Gergen, 2006). According to McLeod and Balamoutsou (2001) a goal for social constructionist research in psychotherapy is to describe and understand the ways in which therapy practices can be understood as forms of social action. The following questions can be explored: How and why do people tell stories in psychotherapy? What types of stories are told? How are stories co-constructed? We used Kvale's ideas of condensing the meanings by writing summary representations of the stories. McLeod's and Balamoutsou's (2001) ideas helped us to design the analysis as a whole. The emphasis in our approach is narrative, that is, the co-construction of narratives of depression on a larger scale, not minute-by-minute microanalysis of specific moments in therapy.

Setting and participants

The participants for the study were recruited from the first author's working context, a psychiatric outpatient clinic in Department of Psychiatry, Kuopio University Hospital, eastern Finland (catchment area of 90,000 inhabitants), where she worked as a clinical psychologist. In the outpatient clinic, there were around 30 employees including psychiatric nurses, psychologists, medical doctors, and a social worker. Approximately one third of the employees had family therapy training. As mentioned earlier, this study was part of a larger developing project. The aim of the larger project was to develop the treatment of depression in the outpatient clinic in a family therapeutic direction. This project aimed at finding ways to promote the new approach; the family therapists together studied couple therapy for working with depression; co-workers and colleagues were informed about this new way of treating patients, seminars were arranged and a booklet was written about couple therapy, to be given to new patients to inform them about the possibility of this treatment option. The current study was the research part of this project.

In the research project, family therapists invited the spouses of new, depressed patients referred from either primary health care or the psychiatric hospital to the clinic to take part in the treatment of their spouse's depression. (The word spouse will

be used to refer to both married and co-habiting partners.) The inclusion criteria of the patients in the study were that the patients were adults who suffered from moderate to major depressive disorder and were married or a co-habiting. The exclusion criteria were simultaneous substance-use disorders, cognitive impairment and psychosis. In this project, as in the London Depression Trial (Leff et al., 2000), inclusion criterion did not include that the couple had openly expressed marital problems in the referral; rather the aim was to include all the spouses and to work with them in a couple therapy format. The Joint Ethics Committee for Human Research at Kuopio University and Kuopio University Hospital granted permission for the material to be gathered and used in this study.

The therapists working with the couples had undergone three years of training in family therapy, validated by the National Authority for Medicolegal Affairs, and one of them was still in training. In all three cases, two family therapists worked as a team, participating jointly in all therapy sessions.

Procedures

The participants gave their informed consent to participate in the study. When a new patient who met the inclusion criteria for the study came for the first time to the outpatient clinic, he or she was told about the study and was asked if he or she and his or her spouse was interested in participating in the study. The patient was asked to talk with his or her spouse about the study. Patients were also informed that refusing to participate to the study would not have any consequences on their treatment in the clinic. It was also explained to couples that the focus of the study would be on the interaction in the therapy, not on them as persons. The first three couples referred to the clinic who gave consent were included in the study. Three cases were considered to be sufficient for the qualitative narrative analysis (McLeod & Balamoutsou, 2001), the method used in this study. In these three couples, two of the three depressed persons were diagnosed as having major depression, and the third as having recurrent depression and marital problems. The persons diagnosed with major depression were also on antidepressant medication.

Roles of the investigators

The first author of this paper is a clinical psychologist and an advanced specialized level family therapist. She has experience as a therapist working with couples experiencing depression in one or both partners. As a therapist she has been interested in dialogical (Seikkula & Trimble, 2005) and narrative ideas (White & Epston, 1990). This research project was a part of her specialization in psychotherapy and this paper is based on her licentiate thesis. Doing qualitative research in her own working context was a meaningful way of deepening her understanding of her clients' narratives.

The first author of the present study worked as one of two therapists in one of the three couple therapy processes. As a practitioner-researcher she wanted to have this double role of both therapist and researcher, since this arrangement gave her both the insider and outsider views of the data. After recording and transcribing the sessions it was possible for her to distance herself from the case she had worked with as a therapist and to study it in the similar way as the other cases. Studying transcripts distanced the researcher from the situation of the therapy sessions and the method of the analysis gave the structure that helped her to treat all the texts in a similar way.

Also, the analysis was made after some time had passed from the therapy sessions; this created temporal distance. Another reason for the double role was practical; since the first author was part of the staff in the outpatient clinic and the person to initiate the couple therapy project, she was one of the therapists working with the couples.

The second author is a psychiatrist, an advanced level specialized family therapist and psychoanalyst, interested especially in the developing family-centered work within the public health care systems. In this project he acted as an independent outsider relative to the clinical project and in that role was able to check possible biases stemming from the clinical researcher effect.

Data collection

All couples were asked to give permission to videotape all the sessions they had with the therapists. This was done in order to minimize the effect of recording; if only some sessions were recorded it would have had a greater impact on the participants. When all the sessions were recorded, the recording became a part of the setting; both therapists and clients got used to it and did not pay too much attention to it. Another reason for recording all the sessions was to have the freedom to decide later how many sessions would be chosen for closer studying.

All three couple therapies lasted more than 20 sessions. Four sessions from the beginning of the processes was considered to be enough for our analysis. In two of the cases (Case 2 and Case 3) the first four sessions were the ones to be studied. In Case 1, due to technical problems of videotaping, recording of sessions two and five had failed, so we used sessions one, three, four and six. From the point of view of the analysis this did not become a problem. It was still possible to follow the therapeutic process and to analyze the way the couple co-constructed narratives of depression. The authors of the paper decided to concentrate on sessions 1-6 because according to Jones and Asen (2000), in the context of psychiatric outpatient care, depression is usually talked about in the beginning of couple therapy. Since depression was the reason for therapy, the effects depression has on a couple's life, the symptoms of the person with depression, and both spouses' understanding of depression are talked about first. In this approach the therapeutic goal is to see depression in its context and that is why, when therapy continues, the couple's life in more general terms begins to be the topic of the conversations (Jones & Asen). We also had to narrow down the amount of data and that is why sessions 1-6 were chosen. The resulting 12 sessions, four sessions from each couple, were transcribed. These transcribed sessions formed our data. The analysis was carried out after the couple therapy treatments had ended.

Analysis

According to McLeod and Balamoutsou (2001), the first phase of qualitative narrative analysis is finding meaning and structure in the text as a whole. The first author read the transcribed 12 sessions several times in order to familiarize herself with the text and to develop initial ideas about the analysis. The texts were then divided into topic segments (McLeod & Balamoutsou, 2001). Topic segments were identified according to the content of the conversation. When the participants changed the topic, a new topic segment was created and who changed it was noted. The topic segments served as meaning units of the analysis. The meaning units varied in length from one client's utterance with therapists' reply to three pages of transcribed text of conversation between all four participants (the spouses and the two therapists). The

themes of the topic segments were named; each of them was given a title. According to McLeod and Balamoutsou (2001) identification of themes is a part of qualitative narrative analysis. Atlas-ti a registered trademark of Scientific Software Development, Berlin, which is a software package for analyzing qualitative data (Lewins & Silver, 2007), was used to organize the data and to write memos during the analysis.

In phase two, understanding of specific therapeutic events and processes is developed (McLeod & Balamoutsou, 2001). Since the co-construction of narratives of depression was the focus of this study, the meaning units where couples' talk with their therapists about depression and how it affected their lives and their relationships, were chosen for closer analysis. This was done by reading the meaning units and deciding if the main topic of the unit had to do with depression. According to McLeod and Balamoutsou (2001), common-sense understanding of what therapists and clients say can be used as a way to identify the area of content of the discourse. Forty-four units out of a total of 159 were chosen (19 from Case 1; 6 from Case 2; 19 from Case 3). The analysis was carried out one case at a time. Concentrating on one case at a time helped to form a picture of the co-construction process of the narratives in each case. Also, the stories told in psychotherapy many times refer to shared understandings between therapists and clients based on the earlier stories that had been told in the therapeutic process (McLeod & Balamoutsou, 1996, 2001), which makes studying one case at a time most useful.

Next, summaries of each meaning unit were written down using Kvale's (1996) recommendations. This was done using memos written about the text, and by going back to the original text. The summaries of the couples' co-constructions were written in the form of a narrative. The term *narrative* refers here to reconstructed representations of the stories of depression, written by the researcher. The narratives had the following structure: who initiated the topic shift, who was the main narrator in the discussion, what the story line was, and how the other participants responded to the main narrator's initiative. This form of condensing the text was chosen in order to describe the co-construction of stories; how did the spouses take part in creating narratives of depression? Riessman (1993) has also focused on the co-construction of narratives in her study concerning divorce. McLeod and Balamoutsou (2001) have used stanza form, adopted from Gee (1986, 1991) and identifying "voices" in the stories.

An example of a summarized narrative is shown below:

Narrative 12: It is possible to be alone

Therapists begin the topic by saying that it sounds like the wife has been able to enjoy herself lately.

Wife tells that she has felt nice, that she hasn't felt bad for a long time; she's able to also be alone and doesn't become anxious when husband leaves home, as she did earlier, but is able to for example do some homework during his absence.

Husband tells that wife has been alone at home a couple of hours at a time, rocking in her rocking chair. He also tells, laughing, that wife doesn't come to the forest, where he's working, to ask him come back home, since there are so many mosquitoes.

Therapists ask, if wife's anxiety has to do with husband's absence. They listen actively and note that the wife has not gone to look for her husband and that it seems that the wife's ability to be alone seems to be a sign for both of them that she feels better now.

Initiator of the topic shift: Therapists

Main narrator of the current story: Wife

The last phase of the analysis, according to McLeod and Balamoutsou (2001), is communicating what has been found. In the present study, a descriptive statement, also done in the form of a narrative, was written. In this narrative, the summarized narratives, which were written in the earlier phase of the analysis, were connected and a coherent narrative of depression was formed. These summary representations have the same structure as the narratives in the earlier phase of the analysis; the contents of the depression stories are first presented and then the co-construction of the stories is described. Extracts from the original text are included in the text to give the reader an idea of the original text.

Trustworthiness of the analysis

During the analysis, the first and the second author discussed every step in the analysis. The first author was the primary researcher and the second author acted as the supervisor. Each of the final narratives, the final form of the results, was negotiated with the therapists who had worked with the couples. The therapists read the final version of the results and commented. They found these narratives similar to their own experiences of the way they had co-constructed narratives of depression. After this the second author of the present study also read the narratives.

According to Lincoln and Guba (1985), there are four ways of evaluating the trustworthiness of qualitative research: credibility, confirmability, transferability, and dependability. The credibility of this analysis was evaluated by the therapists working with the couples. They read through the results of the study after the analysis was finished and commented on them. They found the description of the narratives of depression to be understandable and accurate. In order to improve the confirmability and dependability of the results, the second author audited every step of the analysis, the methodological and analytical decisions were discussed, and a consensus was reached. The reader of a study, according to Lincoln and Guba, evaluates the transferability of a study. To give the reader a possibility for this evaluation, a comprehensive and detailed description of the research procedure was presented in this article. In addition, direct extracts from the original text have been included into the article so that it is possible for the reader to follow the way the analysis was carried out.

Results

The results, the summarized narratives of how the couples co-construct narratives of depression in couple therapy, are presented one case at a time. First, the couples are introduced, then the content of the depression stories is presented and finally, the description of the way the couple co-constructed the stories, is presented. The analysis was done in Finnish and only the extracts presented here have been

translated into English. Pseudonyms were used to protect the identity and confidentiality of all the participants and the therapists. A notation system, where no clarifications or punctuation marks are added to the text is used to make sure that the text used in the study is accurate and complete (Frey, Botan, Friedman, & Kreps, 1992). See the Appendix for abbreviations and notation system used in analyzing the transcripts.

Case 1: Depression is Reinforced by Non-Diagnosed Spouse

The person diagnosed with depression in this couple was the wife, Anna. Her diagnosis was major depression. The couple therapy took place after two hospitalizations. She had received both electroconvulsive therapy and pharmacotherapy, and was still on medication. She was on sick leave from her job owing to the state of her physical health. Her husband, Otto, was retired due to his physical state of health. Both were in their late 50s.

Content of the depression stories

In the first two sessions, Anna mostly talked about the symptoms of her depression, how bad she felt, and how she was not able to tolerate being alone. She talked about depression as something that she now recognized as depression but had not recognized as depression when it had happened to her for the first time. The following extract is from the very beginning of the first session.

W: now I must say that my condition has gotten much worse

Th1: uhum

Th2: we were going to talk in the beginning about what the situation is like now and [how things] have been

W: [yeah]

Th2: it's good [that you have begun to talk about it]

W: [yeah now it's really this week] it began in the middle of the week well a lot of anxiety which I haven't had until now so I have been feeling really good and I have done many things at home and so now for a couple of days this awful anxiety and I haven't been able to do anything so if we hadn't had this appointment with you here I would have contacted you soon

Th2: uhum

W: well I don't know what might be the reason for this

H: and likewise she's had to use sleeping [pills]

W: [now] I've had really restless nights so I've had to take two sleeping pills even

Th1: uhum

Th2: uhum

H: the prescription should also [be renewed]

W: [it should be] renewed there aren't too many tablets left

Th1: okay

Th2: uhum

In this extract, discussion proceeds between the therapists and Anna. Anna talks about how worried she is about her situation and how she cannot understand what the reason for her anxiety might be. Otto adds some details to her problem-saturated story and in this way begins to reinforce it.

In the next extract, Otto's way of participating in the telling becomes visible again. Anna had told a story about how difficult it was for her to admit that she needed help. She talks about how she tried to refuse to go to hospital, even though she was feeling very bad. After a long conversation between the therapists and Anna, therapist invites Otto to talk about how he saw the situation. Otto comments by saying that in the health care center, where Anna was taken, she actually seemed to feel better for a while; but later, when she was sent to the psychiatric hospital the nurses and the doctor noticed her bad condition better. Otto doesn't talk about his own thoughts or feelings and mostly adds some details to Anna's story.

W: like also in the healthcare centre I did say that I have been brought here for nothing that he had brought me like I mean anyways I refused to admit that there was anything wrong

Th1: yeah

W: I said that this was not at all necessary that when I just get back home I will be just fine

Th1: aha... what did you Otto think about that this then

H: yes well she did in that moment actually become a bit better there when she

W: well I suppose I tried with my last strength to show that that there's nothing to be worried about yet like that I'm not going to stay in the hospital that when I only get back home

Th2: hmm

W: then everything is fine

Th1: hmm yes

H: but quite much like when they then sent her here (psychiatric hospital) they noticed this (her condition) much more clear

Th2: hmm... did you come voluntarily here to the hospital

W: no I didn't no I didn't no I was all the time against it like staying here in the hospital until the last moment -

H: - yes and coming here too

W: yes and coming here too like I didn't agree when he like he had to call the ambulance cause I didn't agree to come with him to see the doctor

Th2: hmm

Th1: yeah... aha

In session three, Anna began to tell stories that had to do with the lessening of her symptoms. She was more able to spend time alone, was not anxious and was able to meet other people. The therapists explored the ways in which Otto's behavior affected Anna's moods. Otto had tried to encourage her to do something, for example, to leave the house with him and go somewhere instead of lying down. Anna described the ways in which Otto was trying to help her. When the therapists asked Anna how talking to Otto affected her, her answer was that she did not have that much to say about it. She then continued to describe the ways in which Otto tried to cheer her up. Her narration remained on a very practical level, not exploring the meaning of her husband's behavior. In these stories depression was narrated as something that affected both spouses' daily lives, but also as something that did not seem to create or be created by conflicts between the spouses.

In session four the discussion moved from the symptoms of depression to the future-oriented theme of finding something meaningful to do. It included Anna's worry that if she did not find new things to do in her life she might become depressed again.

Th2: there have been these two things this sleeping and then the possibility to go to new places every now and then like.. go to some place like.. you have noticed clearly that these make you feel better.. have you two noticed other things that.. would affect in that way so that one would feel better (3) what helps (4)

H: well.. not now.. at least my mind has not been struck by such things

W: well one does cheer up but also becomes more tired too when our lot (son's family) comes to visit.. one doesn't have time then to think about one's own things.. you know when the children are there and everyone around so.. that kind of a thing makes you feel better.. but to be honest the autumn makes me worry like the lack of things to do like what will I be able to do like how could I find something to do

In the extract Anna begins to talk about the future, thinking about how to find things that she would be able to do, despite her depression. Anna also talked about the way she had become depressed in the first place, and how she did not understand then that she was depressed. Anna's narration moved from the present to the future and back to the past.

Co-construction of stories

In this case what was told was a narrative of depression as one spouse's problem, affecting the lives of both. The depressed wife was active in initiating the topic shifts in the discussions (as is the case in two out of the three extracts presented above). She was the main narrator in most of the stories concerning depression. Her narration was not strongly agentic. In her stories, depression seemed to be something over which she had no control. Moreover, the lessening of the symptoms seemed to happen to her; she did not have an effect on this change, or she could not understand it. Depression thus had an agentic role in these stories.

The husband, in his turn, reinforced his wife's narration by adding details or confirming, for example, dates, but he did not initiate any of the topic shifts. He usually agreed with his wife and did not bring new material to the conversation. Frequently, Anna would begin to talk and it was only after being asked by the therapists that Otto would join the conversation by answering the question. He was considered to be the main narrator in about one third of the stories.

Case 2: Challenging and Contradicting One Another

The depressed person in this couple was the husband Leo. He suffered from recurrent depression and also from marital problems. He worked professionally in a theater. He had not been hospitalized and was not on any medication for his depression. His wife Mia was working as a designer. The spouses were both around forty and they had two young children.

Content of the depression stories

This couple talked about their relationship from the very beginning of the therapy. Depression was not the main focus of their talk. The stories that had to do with depression centered mainly on the interactional problems the couple was experiencing. In the first session Mia said that Leo had accused her of making him feel bad. She found that unreasonable. She felt that there had to be other reasons for Leo's depression, for example too much work. She said she had previously believed that she was causing Leo's depression, but had then realized that it could not be her fault.

In the following extract Mia tells a story about the way Leo behaved when he had been very depressed some months previously. She had tried to talk with Leo about an appointment they had been invited to concerning their son, Mark, who had begun to have some behavioral problems. Mia was worried about Mark, and she connected his problems with the ones arising in the relationship with Leo.

Th2: what made you feel or think that... that you... you would cause...
Leo's like

W: if I asked for example that like I began a new teaching job I don't usually do teaching work I'm not good at teaching and... well (4) I hadn't spoken the whole morning I left home in that situation... then it was already time for an appointment because of Mark we had to go there to discuss things concerning Mark so in the evening the first word was at nine o'clock I had ret- then I said that... that like... that we'd got an invitation to this... clinic... CAN'T I HAVE ANY PEACE AT ALL GODDAMNIT.. I hadn't the whole day I had been teaching the whole day... I hadn't yet said anything the whole day the whole day I had been thinking at work... how am I going to say this in the evening at nine the first sentence so... Leo's reaction was that he can't be left alone at all goddamnit that you are all the time pressuring me with some things

(3)

In this extract Mia's mode of narrating becomes visible: she uses long turns in the discussion, her narrative is often fragmented and she states her point of view forcefully. In this story she describes herself as the victim of her husband's "unreasonable and angry behavior."

Leo described the situation when his depression was at its worst the previous fall. He was not able to work, even though he had a lot of work to do, and he also had a bad backache. He called this burnout, saying he did not feel depressed, but rather was anxious and nervous. Leo had already recovered from the most difficult part of his depression. Mia, in particular, wanted to talk about the ways in which they could prevent depression from coming back. She was wondering if depression was something that happened in her husband's head or in her head, or if it had some other kind of mechanism. In the next extract Leo talks about how he experienced Mia's behavior and how he reacted to her behavior.

Th1: do you remember Leo... this kind of... situation last autumn or or that you might somehow have had the idea that... that Mia... would then somehow cause then this... pressure and your feeling bad... is your idea similar or different

(5)

H: umm (19) well I do have that kind of... that kind of a memory about that that (2) that then we like (5) used to fight like a lot about chores at home and (6) and that (4) and about money (5) that in that way it felt like (6) like when you have a lot a lot of work and then there is like (2) that when... in a way like unreasonable unreasonable like... pressure that like... that you should not work (3) because the dishes are not washed

(2)

Th1: uhum... or did it include the pressure that you should be the one to wash the dishes

(4)

H: well there (3) or like in a way I feel that it was about the fights about washing the dishes that... that should we should we wash wash the dishes after every meal or once a day

(5)

Th2: but was it the case that it was difficult for you to talk about these things last autumn I was thinking that this question of guilt where did that idea come from... in a way

W: no we couldn't no we couldn't like talk

Th2: yes

W: it went like that...

Th2: uhum

W: it went like... it was so chaotic that whole autumn that... and the washing of the dishes and...

H: that that kind of experience I had like about last autumn that... that even though... or that there was of course this... stress stress because of the like... real work that was not done... and like then there was this like like (3) feeling that... that like Mia has all the time like... something to complain about (5) or I felt that way that about everything (5) and that (3) that I didn't have to energy to (4) like take it

(3)

Leo's mode of narrating is slow, with many long pauses. He repeats words and at times seems to be searching for the right words. According to his narrative he had had too much work to do and Mia was at the same time complaining about everything. In Leo's story he was the victim of Mia's unreasonable behavior.

Co-construction of stories

The depressed husband did not initiate any topic shifts that had to do with depression and did not talk as much as his wife did. He presented his ideas in a slow, contemplative way. In his stories, his feeling badly had connections with his wife's behavior and exhaustion at work.

The non-depressed wife talked about how her husband accused her of causing his depression, and in turn accused her husband of being unreasonable. She was the one to initiate the topic shifts and was also the main narrator in most of the stories concerning depression. She was active in talking about her experience and the ways in which she saw the situation and appeared to form a more active relationship with her husband's depression than her husband did.

In this case, two conflicting narratives were told: one by the wife and the other by the depressed husband. Both narratives included blame, disagreement, and experiencing the situation as difficult. In these narratives the husband's depression was related as something that affected and was affected by the interactional problems of the couple and this, in turn, was bound with the well-being of their son.

Case 3: Two Narratives Enriching One Another

The wife, Laura, was the depressed person in the third couple. She had twice been an in-patient for depression in a psychiatric hospital, was on antidepressant medication, and had been on sick leave from work due to depression. Her diagnosis was major depression. She worked as a secretary. Her husband, Eric, was working in a political organization. Both spouses were around 50. Their two children were young adults.

Content of the depression stories

The stories of depression were, in the early stages of the therapy, stories of the wife's symptoms. In these stories Laura talked about how restless she was, how she felt she did not have anything to do, and how she tried to sleep as much as possible, because sleeping was a relief from feeling bad. The following extract is from the beginning of the first session.

H: Laura's situation is wor- worse much more than actually now after midsummer the whole time day after day I- it has become worse so that it yesterday was quite a bad day and the whole day she mostly rested

Th2: uhum

H: was ve-very tired

W: well yes because I don't know what's wrong with me it... in the morning... like until one there is this terrible shaking... it's that kind of trembling and shaking that... that takes an awful lot of energy I don't know what's causing it then and it has not it just doesn't seem to go away

Th1: uhum

W: and yesterday was well the whole day was like that so that I had to go back to sleep and

Th2: yes yes

W: and rest like the whole day so that it is like... I can't connect it with what it... where it... where to... what's the reason for it but it just makes me shake... it has been going on for months now

Th2: uhum

Th1: have you been able to sleep

W: yes I think so I do sleep but I don't know then that... I sleep long periods but it just then... that trembling and shaking it comes it comes... it is then quite physical

This extract demonstrates the way the couple narrates things together. Eric begins and Laura continues the narration. Eric tells how Laura's condition has become worse and Laura begins to narrate how the trembling attacks her, having no way herself of understanding or controlling it. In this way depression has an active role in her problem-saturated stories.

In the first session Laura, however, began to narrate her way of understanding her depression. She felt that the apartment in which the couple had lived for the past year was the reason for her depression. Eric saw the situation differently. He thought the first symptoms of depression became visible in his wife's reactions to the new flat. He did not see the flat as the cause of her depression. In the first two sessions Laura also talked about the experience of being depressed. She described her feeling of her life having disappeared, of time having stopped, everything having vanished. She was not able to get hold of her life: "my brain doesn't say anything nice." Here, too, depression had an active role in the narration of both spouses. Both Laura and Eric wanted information about depression; for example they asked the therapists how long the depression was going to last. The therapists in turn asked how Laura's depression had changed over the course of time.

In the first session Eric went through events that had taken place during the previous fall and talked, without accusing Laura, about her strong feelings of jealousy that had preceded the depression. Laura had thought that Eric was having an affair with her best friend. This was an important theme, which was elaborated in the fourth session.

H: well yes this process went approximately like this that from October from September... the end of September until November we... all nights long we talked I mean she would jump (laughing) we went to bed at eleven or ten o'clock and so she stayed awake and sitting and well then suddenly I notice that my wife is sitting beside me and well then she began to question me and so we had this gestapo hearing for two months... she questioned me about this jealousy... she went about it for night- all nights long... all days too... always when we met... I mean that was the last autumn... but she had all the normal people's... like emotional scale now she says that she doesn't feel doesn't taste doesn't smell anything it is like... mild water that there is no taste in it but at that time she had all the scales... hatred and... hatred and well all the rest of it

W: yes and in other ways I then had a hold of my life but I don't have that any more

H: and like the cycle became worse so much that there was nothing else than this jealousy... everything went on around it this process was then

In addition to talking about Laura's jealousy, Eric made a point of Laura having all the emotions of a normal person during the time she was jealous. In that way, Eric said, jealousy was not as bad as depression, which had taken away Laura's emotions.

As the therapy proceeded, more interactional themes came into the discussion. In the third session the therapists began to work with the couple's genogram, and Laura's and Eric's families of origin were talked about. There was also discussion of the couple's relationship with their children and of the anticipated situation in which the couple would be living alone after their children had left home. Laura expressed her worry that she was too quiet at home, and that she did not come up with anything to say to Eric.

In session four, Eric talked about his experience of burnout some years previously. Laura described how at the time she had been worried because Eric was not able to enjoy anything, and how at that time her jealousy had begun. These stories brought together Eric's burnout, Laura's jealousy, and her depression. The stories Eric and Laura told began to enrich each other and to form a new, more understandable story of Laura's depression. The therapists also asked how Eric had coped with Laura's depression. Eric said that worrying made him anxious and less able to concentrate.

Co-construction of stories

In this process both the depressed wife and her husband were active in narrating their experiences concerning depression. Both spouses formed an active, reflective, and non-pathologizing relationship with the wife's depression, and in consequence the depression became elaborated.

The husband in this case initiated more topic shifts than his depressed wife did, and he was the main narrator in almost as many stories as his wife was. Particularly at the beginning of the therapy, he often acted as a spokesman, raising some issues and then letting his wife talk, or asking the therapist about things that his wife had been wondering about. He talked about his way of seeing the situation and added his own views to his wife's stories. He also talked about his own life and, for example, his burnout.

As their interaction continued, the depressed wife began to describe in a lively manner her ways of feeling and experiencing depression. She was also trying to understand why she had become depressed. At the beginning of the treatment process she seemed to be quite confused about her depression, feeling that she was not able to control her own situation. She also hoped that someone might be able to tell her when the depression would be over, and what she should do.

Discussion

This study was part of a regional project aiming at developing outpatient treatment for depression in a family therapeutic direction. The present study highlights the importance of inviting the spouses of depressed patients to take part in the treatment of depression. The aim of this study was to investigate the ways in which couples co-construct narratives of depression in the early stages of couple therapy processes, when the spouses of the depressed patients were invited to join the treatment. According to our results, spouses of depressed patients took part in constructing narratives of depression. In couple therapy for depression, it is thus

crucial to focus not only (a) on the patient's individual narrative of depression, but also (b) on the depressed spouse's narrative as an interactive part of the non-depressed spouse's narrative, and (c) on the shared narrative created by the spouses together.

Being seriously depressed is a major challenge, both to the depressed person and to those close to him or her (Beach & Gupta, 2003; Cordova & Gee, 2001). In the couple therapies we studied, the spouse's participation seemed, as Cordova and Gee pointed out, either to support or to contradict the depressed spouse's narrative. This is a challenge to the therapists; how to find a suitable way to help in constructing a new narrative with each couple. Based on this study, we can give some ideas for therapists to use in their work.

If the depressed person's narrative is merely reinforced by his or her spouse's narrative, the therapists might choose to focus mostly on the depressed person's narrative and depression. Nevertheless, the involvement of the other spouse may still be useful. Going to therapy as a couple can help the non-depressed spouse to cope with the stressful situation he or she is in; it can strengthen the relationship between the spouses, and it can help the therapist see the interactional ways in which depression affects the couple's life and vice versa (Jones & Asen, 2000). It may even help the non-depressed spouse to create a new, helping narrative (e.g., the third alternative in our results). This way of working could be described as spouse-aided therapy for depression (Emanuel-Zuurveen & Emmelkamp, 1997) or as the use of healthy relationships to treat depression (Cordova & Gee, 2001). In the same way, Gillian and Cottone (2005) have pointed out that it may be useful to use couple therapy ways of working in situations where the marital relationship is functioning well.

On the other hand, if the depressed person's narrative is challenged and contradicted by his or her spouse's narrative, couple therapy remains one recommended choice of treatment in such cases because of the connection between depression and marital problems (Beach et al., 1998; Beach & O'Leary, 1992). Couple therapy can both increase marital satisfaction and decrease depressive symptoms (Beach et al., 1998). This may sometimes be challenging, since one has to deal with both depression and marital problems at the same time, as pointed out by Gupta et al. (2003) and by Whisman and Uebelacker (2003).

If the spouses' narratives enrich one another, both spouses have an active relationship with depression in their stories. The involvement of the non-depressed partner can bring new material to bear in the therapy process. While listening to his or her spouse, the depressed spouse might find new perspectives to his or her pessimistic view. In therapy, it is possible to co-construct a narrative of depression and to elaborate it together with the couple, thus helping both spouses gain a stronger sense of agency in their difficult situation (Holma & Aaltonen, 1998; White & Epston, 1990). Encouraging mutual support between the partners is an important element in couple therapy for depression (Kung, 2000).

Strengths and Limitations of the Study

The first author's double role as therapist and researcher has both strengths and limitations. One source of limitation is a deep involvement of the researcher in the treatment process and in the research material. The involvement may make it difficult, especially within psychotherapy research, where the issues can be affect-laden even for the researcher. This can lead the researcher not to see the results clearly and there are risks of making biased observations and of drawing conclusions from

other sources than the data. To avoid or estimate this limitation is difficult, because there is no independent external measure. The methods used in this study to avoid or to limit the biases included checking the results with the therapists and with the second author not involved in the treatment process but experienced in the field of psychotherapy and research. The strength of this way of doing research is that this can be seen as one way to approach the therapist's in-therapy experiences important for "progress research" emphasized by Pinsof and Wynne (2000).

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Appendix

The following notation system is used in the transcripts:

- ... = Pause of less than 2 seconds,
- (3) = Pause longer than 2 seconds, the number indicating the duration of the pause in seconds
- [] = Simultaneous speech,

- CAPS = loud talking
- H = Husband or the male partner

- W = Wife or the female partner
- Th1 = Therapist 1
- Th2 = Therapist 2

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