APPLICATION OF THE ASSIMILATION MODEL IN THE CONTEXT OF COUPLE THERAPY FOR DEPRESSION: THE CASE OF RALPH AND ROSE

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ABSTRACT

This Master's Thesis is part of the Dialogical and Narrative Processes in Couple Therapy for Depression project (DINADEP). In this case study the aim was to investigate how the assimilation model, a theory of psychological change, can be applied in couple therapy for depression. To further study the process of assimilation, individual changes were traced across 21 sessions in a couple therapy process of Ralph and Rose, a couple who came to therapy due to Ralph's moderate depression and crisis in the relationship. The material of the research consisted of both qualitative and quantitative data: videotaped and transcribed couple therapy sessions and self-evaluation questionnaires. The Assimilation of Problematic Experiences Scale (APES) was utilized simultaneously with quantitative methods. It was found that assimilation model is a suitable method for a couple therapy setting. In addition, assimilation was tracked in four themes: one in Ralph's case (disgust at sex) and three in Rose's (feeling of responsibility, guilt, and fear of failure). Qualitative analysis of these themes suggested that Ralph reached assimilation level 5 (application and working-through) but ended up in lower levels at the end of therapy, thus his case was considered as an unsuccessful one. Rose progressed to the higher levels of assimilation and her case was considered as a successful one. The findings were analogous with previous studies in two ways: first, depressive symptoms improved in the successful case but not in the unsuccessful one, and second, assimilation analysis was amenable to be combined with qualitative and quantitative methods.

Keywords: couple therapy, depression, case study, assimilation analysis

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TIIVISTELMÄ

Tämä pro gradu –tutkielma on osa Dialogiset ja narratiiviset prosessit masennuksen pariterapiassa –projektia (DINADEP). Tämän tapaustutkimuksen tarkoituksena oli selvittää, voiko assimilaatiomallia soveltaa masennuksen pariterapiaprosessin tutkimiseen. Mallin avulla voidaan kuvata terapeuttista muutosta, ja mallin soveltuvuutta tutkittiin etsimällä yksilöllisiä muutoksia Ralphin ja Rosen 21 pariterapiaistunnosta. Asiakkaat hakeutuivat terapiaan Ralphin keskivaikean masennuksen ja heidän parisuhdekriisinsä vuoksi. Tutkimusaineisto koostui sekä nauhoitetuista ja litteroiduista terapiaistunnoista sekä itsearviointimittareista. Ongelmallisten kokemusten assimilaatio –asteikkoa (APES) hyödynnettiin yhtäaikaisesti määrällisten menetelmien kanssa. Tulosten mukaan assimilaatiomallin avulla pystytään jäljittämään myönteisiä muutoksia pariterapiassa. Assimiloitumista tapahtui Ralphilla yhdessä teemassa, vastenmielisyydessä seksiä kohtaan, ja Rosella kolmessa, vastuullisuudessa, syyllisyydessä ja epäonnistumisen pelossa. Laadullisen analyysin mukaan Ralph eteni ongelmassaan APES –tasolle 5 (työstäminen ja soveltaminen) mutta päätyi lopulta alemmille tasoille. Täten hänen hoitotuloksensa määriteltiin epäonnistuneeksi. Rose puolestaan saavutti kaikissa kolmessa ongelmassaan korkeimpia tasoja, joten hänen hoitotuloksensa määriteltiin onnistuneeksi. Löydökset ovat yhteneviä aikaisempien tutkimusten kanssa kahdella tapaa. Masennusoireet vähenivät onnistuneessa tapauksessa toisin kuin epäonnistuneessa. Lisäksi assimilaatioanalyysi todettiin soveltuvan käytettäväksi sekä laadullisten, että määrällisten menetelmien kanssa.

Avainsanat: pariterapia, masennus, tapaustutkimus, assimilaatio analyysi

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1 INTRODUCTION

When coming to therapy, clients usually bring a variety of problems that can be tracked, for instance, from their utterances and expressions (Stiles et al., 2006). The problems develop further in the therapist-client interaction and tend to follow a predictable path (Stiles et al., 1990). This Master's Thesis is a part of the Dialogical and Narrative Processes in Couple Therapy for Depression project (DINADEP) where couple therapy for depression was studied in a naturalistic setting in Finland (Seikkula, Aaltonen, Kalla, Saarinen, & Tolvanen, 2012). The thesis presents a case study of a couple where both partners were depressed, to show how positive changes may occur through couple therapy process in terms of the assimilation model, a theory of psychological change (Stiles et al., 1990). Stiles et al. (1990) introduced the assimilation analysis, an intense qualitative method that has been used to examine psychological change both in individual (e.g. Brinegar, Salvi, Stiles, & Greenberg, 2006; Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006; Honos-Webb & Stiles, 1998; Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Knobloch, Endres, Stiles, & Silberschatz, 2001; Leiman & Stiles, 2001; Stiles et al., 1991; Stiles, Meshot, Anderson, & Sloan, 1992; Stiles et al., 2006) and family therapy settings (e.g. Laitila & Aaltonen, 1998) but up to now, not in couple therapy. Thus, the aim of the research was to study, whether assimilation analysis can be applied in a couple therapy setting as well.

Treating depression is common in the practice of couple therapy and it has been suggested even for couples where both partners are depressed (Isakson et al., 2006). However, there is a lack of research concerning these cases, especially focusing on how couple therapy has helped partners individually. Based on the experience of many couple therapists, one of the most difficult situations occur when clients seek help with both relational and individual problems (i.e. emotional, behavioral, or health-related problems) (Snyder & Whisman, 2003). This study of psychotherapy change process offers an intensive focus not only on the depressed patient but also on the spouse's change process showing what kind of positive changes can be found in couple therapy for depression in terms of the assimilation model.

1.1 Couple therapy for depression

Depression can be a life-threatening disorder that is common in the community and in couple therapy (Denton & Burwell, 2006). It appears that a large amount of depressed people can benefit from couple therapy (Beach, 2003), possibly due to the new information that the spouse's

involvement brings into the therapy process (Rautiainen, 2003). Therefore, treating depression in couple therapy is becoming an empirically supported treatment (Gilliam & Cottone, 2005) aiming at emphasizing the supportive aspects of a relationship and modifying partners' negative communication (Barbato & D'Avanzo, 2009).

People suffering from depression are more likely to experience relationship discord and vice versa (Denton & Burwell, 2006). This may have increased the use of couple therapy for depression. Barbato and D'Avanzo (2008; 2009) performed meta-analyses of eight studies suggesting that couple and individual therapy as well as pharmacological therapy are equally effective in treating patients' depression. However, when both partners attend the therapy, the satisfaction in a relationship has also been found to improve (Barbato & D'Avanzo, 2009; Cohen, O'Leary, & Foran, 2010; Isakson et al., 2006; O'Leary & Beach, 1990). Nevertheless, Rautiainen et al. (2012) note that the spouse's attendance does not guarantee improved relational satisfaction, and that all the relevant problems need to be taken into discussion to enable this positive effect.

The use of couple therapy for depression has been recommended, for example, when the depressed person has not responded well to individual therapy (Gilliam & Cottone, 2005), when relationship discord is a major problem (Barbato & D'Avanzo, 2009; Rautiainen, Kuhlman, & Seikkula, 2012) or even when there are no relational problems (Rautiainen et al., 2012). Nevertheless, Beach (2003) emphasized that the use of couple therapy as a treatment for depression should be considered carefully when depression has occurred after the beginning of relationship discord. According to Beach and O'Leary (1990; 1992), improvement in relationship satisfaction is one of the most important goals in couple therapy, since the therapy seems to work as a mediator in the improvement of depression. However, research on the matter has been ambiguous as a number of studies have found no association between a decrease in depression and an improvement in relationship satisfaction (Barbato & D'Avanzo, 2009; Dessaulles, Johnson, & Denton, 2003). Additionally, a spouse's attendance has been found to be helpful (Rautiainen, 2007; Rautiainen et al., 2012; Rautiainen & Seikkula, 2009), but in some cases it has made talking more difficult for clients (Rautiainen & Seikkula, 2009).

Depression has an effect on a spouse in many ways. Rautiainen (2003) studied three couple therapy processes and found that spouses were afraid of being accused of causing partner's depression and the recurrence of depressive symptoms. In one study, depression was also associated with negative effects on both partners' health, such as increased negativity (Cohen et al., 2010). The previous studies have suggested that couple therapy is effective not only for the patient but also for the spouse by reducing his or her psychological distress and depression related burden (Cohen et al., 2010; Rautiainen, 2003). Furthermore, it has been suggested that non-depressed spouses can be in a situation of a great difficulty: they may have difficulties to understand their depressed partner and

be heavily burdened due to a greater responsibility in the family, as well as have a strong need to talk about the situation (Rautiainen, 2003, 2007; Rautiainen & Seikkula, 2009). Through couple therapy, a spouse may gain a better understanding of the situation (Cohen et al., 2010; Rautiainen, 2003; Rautiainen & Seikkula, 2009) as well as get a chance to talk for himself or herself (Rautiainen & Seikkula, 2009). All in all, couple therapy has been found to improve both partners' understanding and acceptance of depression (Cohen et al., 2010) and to help them to see how it affects their life (Rautiainen, 2003). Couple therapy may be the most effective treatment for relationship discord with coexisting depression (O'Leary & Beach, 1990).

1.2 When both partners are depressed

Several studies have shown that people living with depressed partners experience more depressive symptoms than the general population (Benazon & Coyne, 2000; Dudek et al., 2001; Griffith, Miller, & Johnson, 2005; Jeglic et al.,1987; Rautiainen et al., 2012). In one early study, Coyne et al. (1987) found that 40 per cent of spouses living with a depressed person were in need of psychological intervention for themselves due to distress. When summarizing the findings of the DINADEP project, Rautiainen et al. (2012) too emphasized the importance of focusing on the spouse's depressive symptoms and not only utilizing him or her as a support provider for the patient. According to Gupta and Beach (2005), there are no studies of couples where both of them suffer from depression, even though it is assumable that partners having depression simultaneously will become more common in the practice of couple therapists. However, Perko (2009) studied in her Master's Thesis depressed couples and found a significant relation between the spouse's depression and the outcome of the patient's depression treatment. Nevertheless, the suitability of couple therapy for depressed couples is unclear: On the one hand, having experienced depressive symptoms may facilitate the identification of the behavior of the depressed partner. On the other hand, being depressed may be a completely different experience for each individual, which renders the understanding of the partner challenging. Partners may also end up competing for the role of a patient since both of them are depressed (Gupta & Beach, 2005).

Isakson et al. (2006) investigated 25 couples where both partners were diagnosed with mood disorders, anxiety disorders or adjustment disorders. The authors compared 95 couples in four groups: neither distressed; both distressed; male distressed, female not distressed; female distressed, male not distressed. Their findings support the use of couple therapy when both partners are distressed, since improvement was found with couples when both suffered from the symptoms of depression and anxiety. Although the research did not focus particularly on depression, these results

may be applicable also for depressed couples, given that depression is one of the mood disorders. Accordingly, it is assumable that couple therapy for depression could be effective in decreasing both partners' symptoms of depression.

1.3 What makes change possible?

In couple therapy, two individuals participate in the same sessions and are treated by the same therapists. Still, partners may experience the therapy process in different ways since therapy does not always meet the unique needs of both individuals. *Therapeutic change* can be determined as useful and positive change in thoughts, behavior, emotions, and communication. This leads to increased or more effective life control as well as satisfaction in social and personal life (Hanna, 2009). The factors enabling changes in therapy have been studied, for instance, by tracing helpful factors in couple therapy (Rautiainen, 2007; Rautiainen & Seikkula, 2009) and applying the concept of the zone of proximal development (ZPD) in therapy (Leiman & Stiles, 2001). These will be further discussed later in this chapter.

Rautiainen et al. (2012) assert that therapeutic change begins as early as during the first sessions. The change has been studied by, for instance, interviewing clients of couple therapy at the end of the treatment (e.g. Christensen, Russell, Miller, & Peterson, 1998; Rautiainen, 2007; Rautiainen & Seikkula, 2009). Rautiainen (2007) interviewed two couples and their therapists drawn from the DINADEP project, and found the spouse's attendance and the atmosphere of safety to be important factors for the change. The importance of expressing oneself and being heard was emphasized, since the clients described conversations as being different from the ones at home. Convergent findings have since been made when Rautiainen and Seikkula (2009) gathered wider material from the DINADEP project by interviewing 25 couples in the presence of their therapists. According to the clients, helpful factors were a genuine, caring and interested therapist as well as easier and better conversations that tended to continue at home. Additionally, Christensen et al. (1998) interviewed 13 couples regarding their experiences of the process of change. The clients' answers suggested that the therapist ought to challenge the couple, interpret communication, and normalize the situation to facilitate the change process. Above all, both partners should feel being treated fairly.

In one study, the process of change emerged in three areas: affect, cognition, or communication (Christensen et al., 1998). Also Rautiainen (2007) noticed changes in cognition and communication but additionally in behavior and depressive symptoms. Christensen et al. (1998) and Rautiainen (2007) have both illustrated that the process of change happens gradually: beginning in

one area, progressing to the others to eventually be seen in all the areas. In psychotherapy, clients usually have several problems that initially are perceived as separate but that become more related in the course of the therapy. Clients may discover similarities between the problems, and so success in solving one problem may be carried onto the others. On the whole, problems may influence one another and often they cannot be resolved separately (Knobloch et al., 2001). Stiles et al. (2006) claim that even if problems have not been identified or formulated, clients may reveal them in patterns of interaction with the therapist. The change process has also been studied as a semantic change. Wahlström (1992) investigated the process of change in a family therapeutic setting and found that a semantic anomaly can be solved only when a change in sematic structures has successfully been adapted into the conversation.

The characteristic of a successful psychotherapy is that the therapist works in the therapeutic zone of proximal development by assisting the client in the therapy process (Leiman & Stiles, 2001). Originally the concept of ZPD was developed by Vygotsky (1978) who defined it as the distance between what a child has already mastered (the actual level of development) and what he or she can achieve with an adult's guidance (the potential level of development). Thus, ZPD is a concept describing learning process. Leiman and Stiles (2001) suggest that in psychotherapy ZPD can be understood as a region between the current APES level and the level the client can reach with the therapist's assistance. When a client and therapist work jointly, they may progress more than the client could without the therapist's guidance (Stiles, 2001). It is important that the therapist senses the client's tolerance and does not push his or her limits regarding the problematic experiences (Stiles et al., 2006). If the therapist works outside of the client's ZPD, therapy is premature and likely to be ineffective (Leiman & Stiles, 2001; Stiles, 2001). In resemblance to the idea of ZPD in therapeutic use, Andersen (1990) suggests that if the therapist tends to stay in client's usual comfort zone, desired changes are unlikely but if a therapist offers something new and discussion differs from usual, it might bring a change. Nevertheless, if the new material is too unusual or painful, the client may protect himself or herself and close up.

1.4 The assimilation model as a theory of psychological change

Assimilation of problematic experiences (APES) (Stiles et al., 1990; Stiles et al., 1991; Stiles et al., 1992; Stiles, 2001) is a model defining the process of change as a negotiation of understanding that occurs through the interactions of the client and therapist (Newman & Beail, 2002). The assimilation model draws on conceptual and empirical work by Piaget (1962) and Rogers (1959), and suggests that clients in successful psychotherapy assimilate their problematic and painful experiences finally into a *schema* (Stiles et al., 1990). According to the model, a schema (e.g. a

metaphor, narrative, theory, script) is a way of thinking or acting; the pattern of ideas. A schema contains prior beliefs which define what material will be integrated. A *problematic experience* (e.g. memory, feeling, idea, impulse, wish, attitude) causes psychological discomfort and feels threatening or emotionally disequilibrating to the client when brought to awareness. During *assimilation* a schema takes in new information by integrating, explaining, or incorporating it into its system of associations while *accommodation* refers to changes both within a schema and within an experience for it to become associated (Stiles et al., 1990).

TABLE 1. Assimilation of Problematic Experiences Scale (APES) (Stiles et al., 1992)

0. Warded off.
Content is unformed; client is unaware of the problem. An experience is considered warded off if there is evidence of actively avoiding emotionally disturbing topics (e.g., immediately changing subject raised by the therapist). Affect may be minimal at level 0, reflecting successful avoidance; vague negative affect (especially anxiety) is associated with levels 0.1 to 0.9.
1. Unwanted thoughts.
Content reflects emergence of thoughts associated with discomfort. Client prefers not to think about it; topics are raised by therapist or external circumstances. Affect is often more salient than the content and involves strong negative feelings-anxiety, fear, anger, sadness. Despite the feelings' intensity, they may be unfocused and their connection with the content may be unclear. Levels 1.1 to 1.9 reflect increasingly stronger affect and less successful avoidance.
2. Vague awareness.
Client acknowledges the existence of a problematic experience, and describes uncomfortable associated thoughts, but cannot formulate the problem clearly. Affect includes acute psychological pain or panic associated with the problematic thoughts and experiences. Levels 2.1 to 2.9 reflect increasing clarity of the experience's content and decreasing intensity and diffusion of affect.
3. Problem statement clarification.
Content includes a clear statement of a problem-something that could be worked on. Affect is negative but manageable, not panicky. Levels 3.1 to 3.9 reflect active, focused work toward understanding the problematic experience.
4. Understanding/insight.
The problematic experience is placed into a schema, formulated, understood, with clear connective links. Affect may be mixed, with some unpleasant recognitions, but with curiosity or even pleasant surprise of the "aha" sort. Levels 4.1 to 4.9 reflect progressively greater clarity or generality of the understanding, usually associated with increasingly positive (or decreasingly negative) affect.
5. Application/working-through.
The understanding is used to work on a problem; there is reference to specific problem-solving efforts, though without complete success. Client may describe considering alternatives or systematically selecting courses of action. Affective tone is positive, businesslike, optimistic. Levels 5.1 to 5.9 reflect tangible progress toward solutions of problems in daily living.
6. Problem solution.
Client achieves a successful solution for a specific problem. Affect is positive, satisfied, proud of accomplishment. Levels 6.1 to 6.9 reflect generalizing the solution to other problems and building the solutions into usual or habitual patterns of behavior. As the problem recedes, affect becomes more neutral.
7. Mastery.
Client successfully uses solutions in new situations; this generalizing is largely automatic, not salient. Affect is positive when the topic is raised, but otherwise neutral (i.e., this is no longer something to get excited about).

As a process, the assimilation of problematic experiences follows a certain predictable path: (0) warded off, (1) unwanted thoughts (2) vague awareness, (3) problem statement/clarification, (4) understanding/insight, (5) application/working-through, (6) problem solution, and (7) mastery (Table 1; Stiles et al., 1992). Across levels 0 to 2, the problematic experience emerges into awareness and negative feelings become more intense. At levels 3 and 4, the client gives a clear statement of the problem and understanding occurs. At the final levels, the client works through the problem and achieves a successful solution that will be used in new situations. At the end, the affect

is neutral (Figure 1) since the formerly problematic experience becomes a resource (Detert et al., 2006; Honos-Webb et al., 1998; Stiles et al., 1992). In the assimilation process, the feelings are assumed to become strongly negative as a problematic experience emerges into awareness but in the higher levels of assimilation the affect changes to positive after the problem has been actively processed (Figure 1; Stiles et al., 1991).

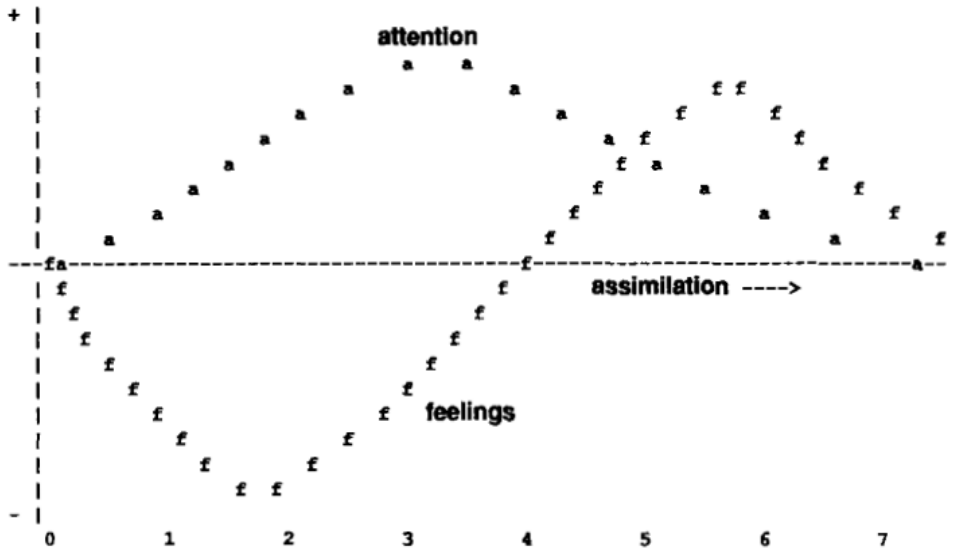

FIGURE 1. Feelings and attention in assimilation of problematic experiences. APES anchor points: 0 = Warded off; 1 = Unwanted thoughts; 2 = Vague awareness; 3 = Problem statement/clarification; 4 = Understanding/insight; 5 = Application/working through; 6 = Problem solution; 7 = Mastery (Stiles et al., 1991)

A new aspect to the assimilation model was presented by Honos-Webb and Stiles (1998). In this formulation, problematic experiences are active voices that have motives, feelings, and knowledge. Problematic voices are warded-off or outcast from the community and assimilation is defined as an integration of previously problematic voices and dominant community of voices. The therapist-client interaction is significant in both formulations: in the assimilation of a problematic experience to a schema (Stiles et al., 1991) or of a problematic voice into the community of voices (Honos-Webb & Stiles, 1998). The original model asserts that unassimilated problematic experiences cause psychological pain unless they are rejected or warded off (Stiles et al., 1991). Stiles et al. (1990) have demonstrated that assimilation and accommodation take place simultaneously during psychotherapy. In assimilation, a schema thus has to be accommodated in order for it to take in the problematic experiences and new information (Stiles et al., 1991). Also in the voices formulation, problematic voices need to accommodate to one another in the process of developing a meaning bridge that represents new understanding (Honos-Webb et al., 1999). According to the original model, even experiences of unpleasant matters can be accepted after being worked through and assimilated, since they are then a part of the schema (Stiles et al., 1990). Voices

formulation suggests that after the meaning bridge has been established, the dialogue between voices is smooth since they are now interlinked and are part of the community of voices (Honos-Webb et al., 1999).

1.5 Study design

The present study is assumed to be unique in two ways: First, there are limited studies concerning couple therapy for depression in the context of both partners being depressed. The study at hand focuses on a couple with both partners suffering from depression; namely, in addition to male patient's depression diagnosis, it became clear in the course of the therapy that the spouse too was showing depressive symptoms. Second, as mentioned before, the assimilation model has been applied previously in the context of individual and family therapy, but there is a lack of research concerning assimilation in couple therapy. In this case study, both partners' assimilation of problematic experiences was identified and tracked focusing on both of them separately in the context of couple therapy. The intent of the research was not to study progress in clients' relational problems, since the couple did not make significant progress concerning their relationship.

In this study, poor outcome couple therapy process was studied to test whether there were positive changes in terms of the assimilation model. Thus, this study aimed to answer to following questions:

1. How can the assimilation model be applied in couple therapy for depression in a naturalistic setting?
2. What kind of positive changes can be found in couple therapy for depression in terms of the assimilation model?

2 METHOD

This case was drawn from the DINADEP project, which was initiated in the University of Jyväskylä in 2005. The project has been conducted in co-operation with three mental health outpatient clinics in Finland: Northern Savo Health Care District in Kuopio, Western Lapland Health Care District in Tornio and Kemi, and Hospital of Jorvi regional psychiatric outpatient clinic in Espoo. The main aim of the project was to develop treatment for depression in the form of couple therapy. The second aim was to analyze the effectiveness of couple therapy for depression in a naturalistic setting. The patients were divided at random into a couple therapy group and a control group. The research group received couple therapy and any necessary forms of treatments that were considered

desirable as a part of the couple therapy process. The control group received Treatment As Usual (TAU) excluding only couple therapy setting. All the participants in this project were under 65 years of age and were living in a heterosexual couple relationship. They met the criteria for moderate depression (F32 or F33 in ICD-10), scored at least 14 on the Hamilton Depression Rating Scale (HDRS) (Hamilton, 1960), and had no clear psychotic symptoms, organic brain disorders or severe suicidal behavior. They had not been treated in family or couple therapy due to depression for at least two years before the index treatment. In all the research centers, qualified family therapists conducted couple therapy in teams of two therapists. The length of the therapy processes was a minimum of five sessions and the specific number of sessions was determined by the unique needs of each couple (Seikkula et al., 2012).

In the DINADEP project, the outcome of the couple therapy processes was determined based on the alleviation of the patient's depression. If the patient was considered as a poor outcome case, the entire couple therapy process was classified as poor, regardless of any improvement in the spouse's depression. The aim was to investigate couple therapy cases with poor outcomes in terms of the assimilation model, since good outcome cases tend to be overrepresented in the research literature. At the beginning, the purpose was to study two couple therapy cases, but after some consideration, it was decided to investigate only one of the couples to achieve deeper understanding of the change processes.

2.1 Clients and therapists

The case of Ralph and Rose. The clients were in their 30s and entered the project with Ralph's (a pseudonym) depression diagnosis (F32.1) and their concerns about the relationship as the cause of referral. At the beginning of the therapy, it was discovered that Rose (also a pseudonym) too was suffering from depressive symptoms. The clients had been together for 11 years. They were in a common-law relationship and did not have children. They had moved in together straight from their childhood homes and both of them had been raised by single parent mothers with whom they each still kept intense contact. Rose had two sisters and Ralph was the only child. Both clients' highest education was vocational examination and at that time, Rose was working full-time and Ralph was unemployed. He was on sick leave and had been on an anti-depressant medication for 18 months before applying for the treatment. The relationship was confronting a crisis concerning Ralph's infidelity and their sexual problems. Due to this Ralph was suffering from self-loath and shame while Rose acted bitterly. The situation was inflamed and the communication between the clients was poor. During late sessions Ralph and Rose settled upon ending their common-law relationship.

It is notable that based on the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) scores both clients suffered from moderate depression at the beginning of the treatment. Ralph's depressive symptoms did not improve but increased during therapy. His score on the Beck Depression Inventory went from a pre-treatment score of 29 to 32 at the end of the treatment, and he was considered as one of the poorest outcome cases in the DINADEP project. Over the same time course, Rose's scores declined from 22 to 9. Based on the BDI scores at the two-year follow-up assessment, Ralph still suffered from moderate depression (BDI = 30) while Rose was considered normal (BDI = 5). Even though the DINADEP project focused on the patient's outcome, in this case Ralph's, Rose's outcome too can reveal important information of the effects couple therapy may have on the patient's spouse and family. The duration of the couple therapy was 13 months including a total of 21 sessions: 17 joint sessions and two individual sessions per client. Each session lasted from 45 minutes to 90 minutes. Both clients gave their written consent to participate in the study.

Ralph and Rose's therapists were female family therapists with 7 to 10 years of clinical experience. They had no special therapy manual; rather, both of them had undergone a training program focusing on systemic family therapy, narrative therapies, and open dialogue in family setting. Thus, the therapy can be classified as systemic therapy, with a special focus on dialogues and narratives (Seikkula et al., 2012). In this approach, the couple and therapists form a system which aims to generate a dialogue in an attempt to increase understanding of the couple's situation and role of depression in their lives (Rautiainen & Seikkula, 2009).

2.2 Assimilation of problematic experiences scale (APES) as an analytical tool

The data were analyzed using assimilation analysis as it has been found to be an effective analyzing strategy pointing to specific elements in a therapy process (Detert et al., 2006; Honos-Webb & Stiles, 1998; Honos-Webb et al., 1998; Honos-Webb et al., 1999; Knobloch et al., 2001; Leiman & Stiles, 2001; Stiles et al., 1990; Stiles et al., 1991; Stiles et al., 1992; Stiles et al., 2006). This method identifies problematic experiences, extracts a variety of passages dealing with them, and examines how the experiences change across the treatment (Stiles, 2001). Every topic does not have to begin at level 0 or end up to level 7, instead clients' problems can represent any level when entering the therapy (Stiles et al., 1991). It has been found that psychotherapy clients do not always progress linearly and that drops to lower APES levels are possible (Detert et al., 2006). According to Stiles (2001) the assimilation model has been utilized in several cases that have confirmed as well as modified and elaborated it.

Even though several formulations of the assimilation model have been developed (Honos-Webb & Stiles, 1998; Williams, Stiles, & Shapiro, 1999), in this study the original formulation of it was used (Stiles et al., 1990). After considering different alternatives, the assimilation model of problematic experiences was selected for best fitting with the focus of this study and with the problems that the clients had. A tool to track sub-levels of therapeutic change was needed, since focusing on the entire change process at once is challenging. Already at the early stage of the analysis, it was known that Ralph's depression did not improve during the therapy, and that by the termination of the treatment the couple would end their relationship. Therefore, it was interesting to track whether there were any positive changes in the case of poor outcome couple therapy.

2.3 Analysis

This study combined multiple methods, since quantitative data was used as a facilitator of qualitative data. The material consisted of data obtained with the Outcome Rating Scale (ORS) (Miller, Duncan, Brown, Sparks, & Claud, 2000), Session Rating Scale (SRS) (Duncan, Miller, Sparks, Claud, Reynolds, Brown, & Johnson, 2003), BDI questionnaires, and video recordings of 21 sessions. However, only a total of 17 sessions were analyzed, since four sessions were unavailable. The recordings were watched several times and then all the sessions were transcribed as text files. Five of the sessions were pre-transcribed by previous investigators of the case. The transcript extracts used in this article were translated from Finnish to English, but analysis was carried out based on the Finnish material. To indicate when the passages have occurred, they have been labeled with session number and time. For example, (Session 2, 15:24) means that the passage occurred during the second session at time 15:24. Passages from session eight were exceptionally marked with page and paragraph number based on the printed transcripts made by the previous investigators. The passages drawn from the transcripts are highlighted; boldface text indicates material that can be considered highly significant for the assimilation while underlining is used for insights. The analysis was conducted according to Stiles' et al. (1991) procedure.

Step 1 was cataloguing (Stiles et al., 1992). The transcripts were read multiple times and a sequential catalogue of the topics the clients addressed was constructed. Some of the topics discussed during the sessions were disregarded. For example, Ralph's depression was not focused on since it was alleviated neither during the treatment nor at the follow-up. Depression itself includes a variety of symptoms, and tracking some specific changes was more relevant than trying to perceive the whole process of depression, which converges with the idea of the assimilation model (Stiles et al., 1990). The emphasis was predominantly on intrapersonal changes with

additional focus on interpersonal relationships.

Step 2 was finding insights (Stiles et al., 1992). For choosing problematic experiences for the study, the focus was on finding the insights achieved by Ralph and Rose during the therapy. Insights are emotionally charged and therefore easily found in the transcript (Stiles et al., 1992). The insights were searched for using the transcripts, catalogues and mind maps. In the case of Ralph, one problem, disgust at sex, underwent some change during the treatment, and the specific insight was found in session 13. For Rose, positive changes were found in regard to the feeling of responsibility, guilt, and fear of failure. The insights appeared in sessions 19, 19 and 11, respectively.

Step 3 was selecting passages (Stiles et al., 1992). The catalogue was searched for words and phrases that were relevant to each theme, and passages were listed based on the same attitudes or objects. The chosen passages illustrate the progress of both clients. This step of the analysis was carried out simultaneously with Steps 1 and 2 writing down the passages that represented emerged attitudes and emotions. The catalogues were examined repeatedly to develop an understanding of the themes. All the passages catalogued by the key emotions (i.e. guilt, feeling of responsibility, fear of failure, and disgust at sex) were re-read in the original context.

Step 4 was assigning assimilation ratings. Selected passages were classified according to the APES levels shown in Table 1. Stiles et al. (1992) have found that these classifications describe changes in the problematic experiences. After the initial analysis, certain ratings were readjusted as a greater understanding of the processes was gained.

2.4 Measurement

In addition to the qualitative approach, in this case assimilation analysis, also quantitative methods were used in this research. In the DINADEP project, the patients' outcomes were defined as good or poor based on the BDI scores. The spouses' BDI scores were recorded as well but not further defined. The BDI (Beck et al., 1961) is a 21-item self-report measure presenting several statements regarding depressive symptoms and attitudes. Numerical values from 0 to 3 reflect the degree of severity of each item. Studies have confirmed good reliability and validity of the BDI (Sprinkle et al., 2002; Storch, Roberti, & Roth, 2004).

In addition, two other quantitative measurements were utilized. The ORS is an ultra-brief outcome measure (Miller, Duncan, Brown, Sparks, & Claud, 2000) while the SRS is a simple alliance measure (Duncan et al., 2003). Duncan and Miller (2004) state that if the ORS scores begin to increase already at the beginning of the therapy process, it is a good predictor of the overall therapy outcome. High SRS scores do not guarantee a positive outcome, but remarkably low SRS

scores should be noticed and taken into discussion (Kuhlman, 2012). Both the ORS and SRS have been found to have good reliability and concurrent validity (Campbell & Hemsley, 2009). As part of the DINADEP project, the couples filled ORS questionnaires at the beginning of each session, while both the couple and the therapists filled SRS questionnaires at the end of each session. In the present study, the ORS -scores were utilized to convey further information of the client's affect and psychological stress, while the SRS -scores were used to describe the client's satisfaction for therapy sessions and alliance with the therapists. Clients' ORS and SRS scores will be presented later in the results.

3 RESULTS

3.1 Ralph (Unsuccessful case in terms of assimilation)

At the beginning of the therapy, Ralph described himself being depressed because of his mistakes and infidelity. Admitting failures was difficult for Ralph since he did not consider himself a person who could fail. In addition to depression, he complained about somatic symptoms and a lack of sexual desire. In his case, one problem was found where some positive changes occurred in terms of the assimilation model. This will be discussed in the following chapter. However, Ralph's assimilation process was considered unsuccessful because at the end of the therapy, his problematic experience was at an earlier stage of assimilation.

3.1.1 Disgust at sex

When entering the therapy, Ralph talked about the lack of their sex life due to his feeling of disgust at sex. He told that the disgust began after infidelity as part of his self-loath. His problem was both physical and mental since he could neither have sex nor allow any pleasure to himself. Intimacy between Ralph and Rose began to decrease after they moved in together seven years ago, and gradually ceased completely. At the beginning of the treatment, Ralph placed fault only on himself but later on began blame Rose as well. Across the treatment, Ralph moved from unwanted thoughts (APES rating = 1) to application and working-thorough (APES rating = 5) but gradually descended to vague awareness (APES rating = 2). During the process, he returned back to the lower APES level while skipping some of the levels on the way. This exemplifies flexible application of the assimilation model which has also been observed in previous case studies (e.g. Detert et al., 2006; Honos-Webb et al., 1999; Knobloch et al., 2001).

At the beginning of the treatment, Ralph preferred not to think about the problematic experience which is characteristic of unwanted thoughts (APES rating = 1). In the following passage the therapist brought up the theme of sex for the first time in session one:

> Therapist 2: *Have there been any changes in your sexual behavior?*
> Ralph: *Yeah. [Rose nodding]* ***It has been pretty dead already for a long time and it is my fault****. I don't feel like doing it.* ***After Rose's travelling, if it wasn't disgusting before that, now it is****.* ***I can't even think about it****...* (Session 1, 21:45)

Ralph responded by describing the situation and putting blame on himself. Consistent with APES level 1, his affective tone was strongly negative, involving disgust at intimacy.

Later in the same session, Ralph continued describing uncomfortable thoughts and the feelings appearing when thinking about sex. He reported pain and anxiety which is typical of APES level 2:

> *...I feel a lot of pressure to perform and it feels awfully bad. Because I still love Rose more than anything, and I would like to please her also sexually. But at the moment it's really difficult for me. I can't do it. When I see Rose suffering from it,* ***it causes me more and more pressure and that makes me feel bad and incapable****...*
> (Session 1, 22:36)

The passage above illustrates the ambivalent situation Ralph was facing regarding sex: on the one hand, he wanted to pleasure Rose but on the other hand knew that he was unable to do it. The continuous circle of the situation can also be seen in the passage above: all the pressure and pain Ralph had become even stronger when he saw how Rose was suffering from the situation. All this illustrates his awareness of the problem.

In the following passage, Ralph formulated the problem statement which is characteristic of APES level 3:

> *I would like to want but I just don't. Rose has done everything she could, maybe sometimes even too much.* ***That has made me feel disgusted at having sex*** *but I think something could be done for that.* (Session 2, 31:01)

Here, after stating the problem, Ralph's affective tone became more positive since he now saw the problem as something that could be worked on. His comment above illustrates a high level of self-blame but he also referred to Rose's role in the lack of intimacy. Later in the same session, Ralph elaborated that the disgust emerged not only when Rose initiated sex but also when the topic of intimacy was introduced into discussion. He continued *"...I would say that when I notice that Rose is turned on, it makes me feel more depressed. I know already beforehand that once again, this isn't going to work and I have to disappoint her."* (Session 2, 53:06). Ralph's description illustrates the

association between Rose's willingness to have sex and his depressive symptoms.

After the problem clarification, Ralph did not reach the understanding of the problem as is characteristic of the assimilation model. Instead, he continued the process suggesting attempts to solve the situation (APES rating = 5):

> Therapist 2: *Maybe she needs to wait a bit more?*
> Ralph: *Well, kind of.*
> Therapist 2: *Give you some time?*
> Ralph: ***Something should be done for this situation. Should I try some medication or what could help?*** (Session 2, 55:52)

In the passage above, Ralph clearly referenced to specific problem-solving efforts by suggesting medication, and for the first time he was hopeful regarding the sex issue. This is characteristic of application and working-through. Moving to APES level 5 happened by Ralph's initiation, but the therapist's offensive behavior may have led to recourse in the assimilation process. This was seen in the next passage:

> Ralph: … *I think I would want if I noticed that I'm capable but when I notice I can't.*
> Therapist 1: *What are you incapable of?*
> Ralph: *Erection.*
> Therapist 1: *Then there is Viagra.*
> Ralph: *Yeah.*
> Therapist 1: *Then you have to go to drug store to by Viagra [laughing]…But you haven't tried it yet?*
> Ralph: *No, no.*
> Therapist 1: *Try Viagra! [excited] Go to the drug store and buy Viagra.*
> Therapist 2: *…doctor.*
> Therapist 1: *I guess you can get it also without recipe or you can go to health care center or to private doctor…*
> Ralph: *Mmm.*
> Therapist 1: *And try it. Why suffer from something that can be fixed.*
> Ralph: *Mmm.* (Session 2, 59:08)

After the second session, Ralph and Rose continued the process by seeing a doctor and buying the recommended medicine. However, in spite of therapists and Rose's encouragement, Ralph did not try the medicine at all. The theme of sex was also minimally discussed until the session 13, when Ralph brought up his feeling of anxiety concerning intimacy. Consistent with APES level 3, he clarified the problem from a slightly different point of view as before:

> Ralph: *Of course I'm anxious. It makes me extremely anxious.*
> Therapist 1: *Are you talking about sex?*
> Ralph: *Yes, yes.* ***But somehow the anxiety feeds itself. Even when Rose is putting her hand on my knee, it gives me goose bumps right away.*** (Session 13, 01:02:14)

Later during session 13, Ralph gained an understanding of the roots of his disgust at sex (APES rating = 4):

> Therapist 1: *Do you see sex somehow dirty for you? Forbidden, dirty, disgusting?*
> Ralph: *No, I wouldn't say so but. At least at the moment, it brings unpleasant thoughts into my mind. It reminds me of what I have done and so on.*
> Therapist 1: *It is guilt.*
> Ralph: *Yeah. But it can't be just that, since we neither had sex before my infidelity. But now it brings me…*
> Therapist 1: *It brings disgust for you at the moment?*
> Ralph: *Yes, yes.* ***But it isn't the sex but that I hate myself.*** *I'm not disgusted at the thought of sex.* ***But it is more like me hating myself and that's why I don't want to allow any kind of pleasure for myself****.* (Session 13, 01:05:18)

The comment above illustrates an insight that should lead to higher mean levels of assimilation. However, Ralph did not follow the APES sequence strictly. Instead of reaching a higher level, he fell back to the lower APES levels. The following passages represent vague awareness (APES rating = 2). In session 14, the therapist suggested that Ralph should watch the television program "Sex Gurus", to which he responded with a high level of anxiety:

> Ralph: *The mere thought brings me such strong negative feelings.*
> Therapist 1: *You mean four-five years ago?*
> Ralph: *No, I mean at the moment.* ***I don't feel like watching Sex Gurus since that*** *(i.e. watching)* ***already makes me feel so bad****.* (Session 14, 47:15)

Slightly later Ralph continued describing his feelings of anxiety:

> *That's why I'm worried, I would like to but I do not want. Like really, from the bottom of my heart, I would like to want but I just don't want. I'm worried about myself. What can cause this? Why don't I want, even though I would like to want…* (Session 14, 01:00:04)

Even though Ralph did make progress on APES levels, at the end he returned to vague awareness feeling similar negative emotions as at the beginning of the therapy. Thus, the therapy was considered as unsuccessful for him. All in all, his progress followed an irregular pattern that will be further reviewed in the discussion later on.

3.2 Rose (Successful case in terms of assimilation)

Rose described herself as a thoughtful and caring person for whom studying and improving herself are important issues. Already at the beginning of the therapy, Rose acknowledged that she tended to put herself last in all of her relationships and to take on the majority of responsibilities in her current

relationship as well as in her family of origin. In her case, three problematic experiences were found where positive changes were evident and recognized. The problems can be described as *a feeling of responsibility, guilt*, and *fear of failure*. Rose showed significant improvement in all these problems and the therapy was considered as successful for her. Although each problem has been described separately, it was found out that the feeling of responsibility and guilt were related, since these problems tended to build on each other. This will be discussed further in the discussion.

3.2.1 Feeling of responsibility

The first problem concerned Rose's *feeling of responsibility* for Ralph and for her family of origin. Across the treatment, Rose understood how she had adopted the role of a caretaker in her childhood as well as at present. During the couple therapy, her experience of the problem moved from vague awareness (APES rating = 2) to problem solution (APES rating = 6). The first instance of Rose's feeling of responsibility was evident in session 2:

> *… somehow I just feel that in this situation when Ralph is depressed, I can't be.* ***I have to try to keep going****. I'm afraid that if I'm on a bad mood or feeling blue, it might make Ralph's depression even worse.* ***I'm trying to not to think about it****.* (Session 2, 15:24)

This passage represents vague awareness: Rose referred to the responsibility she had for Ralph by describing how she could not give up due to Ralph's depression. Before problem clarification, Rose's focus was on holding her resentment back. Slightly later during the same session, she used the word responsibility for the first time in therapy, which indicates acknowledgment of the problem (APES rating = 2):

> Therapist 1: *Do you feel yourself tired? Extremely tired and bored somehow?*
> Rose*: Yes.*
> Therapist 2: *Is there any other option than becoming unemployed? Would you need sick leave at the moment? It came to my mind.*
> Rose: *Well, I kind of have the feeling that I don't want a summer holiday. I don't want a sick leave. I want a holiday from life. If I could go to a psychiatric hospital for a year, I would be quite satisfied.* ***If I could get rid of all the obligations and problems and didn't need to deal with them. Being responsible and so on.*** *That way I feel I want to quit my job because I know that people would be terrified. How could I give up my wonderful career and so on. But maybe that's the reason, why I'm tired of being looked up to…* ***somehow I would just like to be myself****. And somehow I think that if both of us would be just sick at home, I don't know how. Maybe now in the summer when we could spend time on the beach but would we just increase each other's sadness. Is there any point? (Session 2, 26:20)*

During session 2, Rose experienced acute psychological pain which is characteristic of APES level 2. She hoped to be able to withdraw from all the responsibilities and to have time to focus on herself. Rose wanted to get into a psychiatric hospital, signifying a panic aspect of the situation. She tried to find a way out of the situation which shows an increasing assimilation of the problematic experience into an awareness range (APES rating = 2).

Even though Rose exhibited vague awareness of the problem already in session 2, the awareness grew much more intense in session 13, when Rose described how difficult it was to be the only one carrying responsibility:

> Rose: *I have a feeling that I am the only one accomplishing in our family and* ***I'm tired of being that person who has to accomplish.*** *Doing things, being responsible,* ***I'm sick of it****.*
> Therapist 2*: How would you like to be?*
> Rose: *I would like to have the freedom of just to study or freedom to quit my job. Somehow I just feel that Ralph will drop out of society if he is on sick leave for a long time. I do know he is sick. But somehow I feel that I don't want to be his only link to the society. Even though I may not be the only one, somehow I feel that it is only me who keeps him connected to the society. Because working is a part of society, being in this society. There are people who you connect with and… I'm tired of being the only one there.* (Session 13, 30:01)

This passage represents a problem clarification (APES rating = 3). Compared to her earlier vague awareness, Rose here felt that she was the only one having responsibility in their relationship and resisted her role as a caretaker. In session 14, Rose made an analogy between her caretaker role and her single parent mother who always took care of everything by herself. She acknowledged the problem and described her frustration with being the only responsible one. This kind of negative but manageable affect is characteristic of APES level 3. The following passage still represents APES level 3. Focusing on further clarification of the problem, the therapists and Rose discussed the possible break up:

> Therapist 2: *What do you think, why would it be good for you if you broke up? How could life become better?*
> Rose: *Maybe I wouldn't need to worry about his happiness, because somehow I feel that these two years when Ralph has been depressed and so on, I have been responsible for him, his happiness and his future.* ***And of course the thought of being able to think about just myself is relieving****.* (Session 16. 21:12)

Encouraged by the therapist's intervention, Rose described how future could be different. Due to the idea of decreased pressure of having to be responsible of Ralph's happiness, she expressed feelings of relief (APES rating = 3). APES level 3 continued to session 19 when Rose protested against her caretaker role by saying, *"I'm tired of worrying, I don't want to be his mother."* (Session 19, 16:45)

Even though Rose recognized her role as a caretaker she could still not associate it to her caretaker position in her family of origin.

Before session 19, Ralph and Rose settled upon ending their relationship, and Rose moved out. In the same session, Rose talked about her feelings regarding the break up and in the following passage the insight was found:

> *After all, everything is okay. So yeah, living alone does scare me and makes me feel nervous. How will I spend my evenings and so on. Nevertheless, somehow I feel that I will find the way. I see, in a way, I feel that Rose has been lost for a long time. I haven't had the possibility to live my own life. Somehow I needed to take care of the others in my childhood as well as nowadays... **I am relieved that all the responsibilities are gone**. I can just do what I want and that way I'm feeling good.* (Session 19, 39:22)

This passage was rated as APES level 4, insight, because for the first time Rose linked her caretaker role to a theory of causality, in this case involving her childhood family. This level is characterized by mixed affect and evidence of a greater psychological complexity (APES rating = 4). There was a new tone of relief added to the distress caused by the separation from Ralph. In addition to being "scared" and "nervous", Rose was having "a good feeling" about the new phase of her life. Rose described how she had always taken care of others, which had limited her possibilities to live her life as she had wanted.

The stage of application and working-through (APES rating = 5) did not appear in the course of the therapy. However, in the last session, Rose seemed to reach a successful solution for her feeling of responsibility (APES rating = 6) in saying: *"... **I'm not responsible for my sisters and my mother's happiness** and so on. I will do what I can..."* (Session 21, 18:01) Characteristic of APES level 6 is to build the solutions into usual patterns of behavior, which was also seen in Rose's plans on how she would act in future situations. Due to the changes in her behavior, the affect seemed to become satisfied and more neutral. Rose continued describing her positive feelings by saying: "*For the first time I had the possibility, at least I felt that way. Now that we have broken up, I can do what I want.**"*** (Session 21, 20:20)

Although Rose did not master her feeling of responsibility during the treatment, she made a progress in problem solution (APES rating = 6). In her last individual session, she returned to speak of her role as a caretaker:

> *On the other hand, I quite easily get into my old familiar role, **but now I'm planning to be everything else but responsible and decent**. More like enjoying my life and so on.* (Session 21, 46:56)

3.2.2 Guilt

Changes in Rose's feeling of responsibility were related to her second problem, *guilt*. At the beginning of therapy, Rose worried about not being able to make decisions in her life, and due to this she was disappointed in herself. In her case, there seemed to be a clear association between guilt and the feeling of responsibility. Midway to the therapy process, Rose began to express feelings of guilt about letting go of her responsibility for others. In the course of the therapy, her experience of guilt advanced from vague awareness (APES rating = 2) to mastery (APES rating = 7). The reduction of responsibility seemed to amplify the feeling of guilt. It is noteworthy that the discussion of responsibility began already in session 2 and continued throughout the whole process, whereas guilt was not introduced into discussion until session 8:

> *Well, I guess when the matter was brought up, it feels like, that it's me. I have pushed Ralph's infidelity out of my mind. So somehow I just felt hugely disappointed with myself, when I realized that two years ago when Ralph told me about infidelity. The first thought coming to my mind at that time. And I am still thinking about the same issues.* ***I feel disappointed with myself that two years later I am still stuck in the same situation****. Can't I do any decisions in my life, can't I progress with anything.* (Session 8, page 9, 190)

In this passage Rose expressed emotional pain without being able to clarify the problem, which is characteristic of vague awareness (APES rating = 2). She reported being disappointed and blamed herself for not proceeding with her decisions and for her and Ralph's relationship not improving. Rose continued describing the same uncomfortable experience later in same session: *"...time is passing by all the time. I said to Ralph that soon I will be sixty and I'm thinking that I haven't made any decisions in my life. Time is just passing by..."* (Session 8, page 11, 215) Rose described her uncomfortable associated thoughts, without yet being able to formulate the problem clearly (APES rating = 2).

Session 11 began with Rose's therapy homework: a letter for her late uncle. In this letter Rose used the word *guilt* for the first time in the therapy. The following passage illustrates a clarification of the problem, advancement toward APES level 3: *"I was always the one who should have made decision about the future, and that really made me feel guilty."* (Session 11, 00:56) At APES level 2, Rose only blamed herself for not progressing, whereas, at APES level 3 she understood that guilt had been inflicted in her by Ralph who too was unwilling to make any decisions concerning their relationship. By session 13, she was able to give a clear statement of the problem in words (APES rating = 3), *"I felt guilty. When at home with Ralph, I would feel extremely guilty for not being with my mother and sisters. And if I was with them, I felt guilty about not being with Ralph. And I can't take that anymore."* (Session 13, 32.21). She continued, *"So where ever I*

am, I'm always thinking that now it is Ralph's loss, now it is my mother's loss. ***In a way, nothing is for me.****"* (Session 13, 32:40) In evident in this passage, Rose saw the problem from a more objective perspective: whatever she did, it was not enough, and she felt her own needs not being met.

In session 16, Rose remained at APES level 3 in that she spoke more directly about her feelings of guilt in relation to Ralph: *"...if you ask Ralph, he would probably think I'm awfully selfish, because I have lectures, university studies, hobbies, and so on that keep me away from home.* ***Ralph's attitude towards those things of course always makes me feel guilty****."* and she continued: *"... I have been thinking about myself because I have gone and done those things. But then I'm having this uncomfortable feeling that Ralph is sad when I'm not at home.* ***So if I could get rid of that****. If I want to go to volunteer work every day, I can go.* ***Nobody would be telling me what to do****. That's not good." (Session 16, 36:27).* In this passage, *R*ose focused on working towards understanding the problematic experience. She realized how things could be less problematic, still without finding the means to change them.

In the same session, Rose talked about the fight she had had with Ralph concerning their mutual time. The following passage illustrates Rose's gradual work toward understanding the problem (APES rating = 4):

> *When me and Ralph were arguing, he said to me that he can't talk to me because I'm never home. And I said to him that in my opinion it was extremely hurting.* ***Because it is not right*** *that if I'm a couple of nights away from home and I have always been the one who started those conversations. I have never said that I'm not willing to talk, but he didn't want to say anything to that either… even though he always says that he doesn't think that way, that I shouldn't feel guilty about not being home. "Of course you can go." But if he still thinks that he cannot talk to me because I'm never home. Even though I'm home five evenings per week. Ralph's hidden attitude comes to daylight.* (Session 16, 37:20)

Rose expressed how Ralph's demanding behavior caused guilt in her while she simultaneously resisted feeling it. Her comment, "because it is totally wrong" implies a sense of something falling into place. She gained understanding that she is allowed to spend her spare time the way she wants and also expressed not being satisfied with the situation. Later in the same session, Rose was able to elaborate on how she saw the feeling of guilt developing:

> *But maybe partly Ralph got used to me being always at home, always being there just for him. I went to my sister's or mother's place when Ralph went out.* ***So maybe he just got used to being able to use me when needed,*** *and now that I have said that I'm away on Thursdays, it irritates him.* (Session 16, 38:20)

Rose felt there had been clear connective links between her being always available for Ralph and his demanding behavior (APES rating = 4). Still staying at APES level 4, Rose reflected a progressively greater clarity of understanding and the insight:

> *Well of course, [sigh] for sure **I worry a lot for Ralph and that's what has kept me in this relationship**. Ralph being sick and the guilt bothers me. I mean, can I leave him alone in that condition, now that Ralph's friend is also sick. Somehow I realized that I will find reasons like this for not leaving him for the rest of my life, even in a nursing home.* (Session 19, 40:29)

In session 19, Rose felt guilty for leaving Ralph, but she was now able to prioritize her own needs. Rose responded with relief as she realized that her feeling of guilt had kept her in a relationship with Ralph.

As Rose applied her new understanding, she began to consider working on the problem. Later in session 19, Rose achieved the APES level 5:

> *...I just have to listen to myself now that I don't have the energy to put effort into this relationship. That must say something. I don't want to be depressed and anxious all the time, and **I don't want to put my life on hold**. I do not think about new relationships or so on but somehow I have a feeling that we are in such different situations in our lives. That it just doesn't work.* (Session 19, 41:39)

This passage illustrates a turning point in Rose's behavior; for the first time she had the feeling of being in control of the problem. In the earlier sessions, she was waiting for the problem to be solved by itself, while by session 19 she openly took a more active role and began to work through the problematic experience. However, Rose evidently did not reach APES level 6 during the therapy sessions.

In the last session, Rose clarified the problem of guilt once more:

> *...Somehow in my childhood family, my mother and sisters, I always felt guilty if I wasn't with them. And while with them, I felt guilty for not being with Ralph. **Somehow I just got tired of always being the one giving and doing things**. I just wanted concretely something for me and only for myself.* (Session 21, 17:06)

The feeling of guilt remained after the break-up. However, Rose had gained ways to recognize and control it, accomplishing a mastery level (APES rating = 7). In the last session, the therapist raised the topic of guilt into the discussion:

> *Therapist 2: Mmm, how is the guilt doing?*
> *Rose: Well, I do feel it every once in a while but **I feel that this year, during this therapy process, I have realized so many things about myself** or at least the guilt has sort of... **If I feel it, I can straight away think that it is a totally***

> ***unnecessary feeling and I do not need to feel it****… So at least that way I can handle it.* (Session 21, 17:27)

The affect was positive, and Rose became more gentle towards herself. This can also be seen in her speculation: *"Maybe I blamed myself for more than was actually necessary."* (Session 21, 43:02) As an example, Rose continued to describe the solutions she had gained to manage the feeling of guilt: *"**Well at least I do recognize the feeling of guilt now much better than before**. In general, I feel that after traveling my values changed a bit. Maybe I turned into a bit more selfish person and somehow I think it's good."* (Session 21, 46:26) These passages represent how Rose used an achieved solution in new situations, which is characteristic of APES level 7. She saw the problem in more objective viewpoint since the guilt was expressed to her as an "unnecessary feeling." All in all, guided by more complex and differentiated self-understandings, Rose gained more viable options where to choose when acting in similar situations.

3.2.3 Fear of failure

Already in the first session, Rose talked about her failure concerning their relationship. During the therapy, this theme was specified as a *fear of failure*. For Rose, her parents' break-up represented failure which she did not want to face in her relationship. Over the course of the treatment, her statement of "I'm not a failure" changed into "I'm afraid of failing", and she understood that the fear of failure was preventing her from making decisions regarding their relationship. Rose's fear of failure moved from unwanted thoughts (APES rating = 1) to mastery (APES rating = 7).

Initially, Rose claimed that failure was impossible for her, which can be seen as an example of unwanted thoughts (APES rating = 1):

> *So it was more like, there were problems that we didn't want to admit because we were so perfect, or at least that's what we thought. In general, we were always hard workers. So I guess for me there was a kind of disbelief that I could fail in a relationship. My job is so great and I have a wonderful family and I'm healthy and so on.* ***It is simply impossible for me to fail****. It has to be someone else. That must have been one of the reasons why it was so easy to let Ralph go to the club. I didn't want to go with him. Instead I could just stay at home alone."* (Session 1, 14:56)

This passage reflects Rose's anxiety and disbelief caused by her strong denial. She described failing to be impossible for her, since all the other areas of her life seemed to be in control. It was not until session 2 that Rose could express sadness over their relational problems and admitted that she had failed:

> *I'm not sure if I can say that I'm depressed but I am extremely disappointed at our relationship and what has happened to us since things went like this.* ***And extremely***

> ***disappointed with myself for not being able to take care of this relationship***. ***I have failed***. *And on the other hand I'm also very sad for both of us since we have ended up to this kind of situation…* (Session 2, 14:04)

In session 2, Rose expressed disappointment with herself and their relationship. She described the crisis they have faced in their relationship with a high level of self-blame, placing the fault only on herself. Later in the same session, she verbalized the significance of the problem for her: *"...because I have failed in my life with such a big thing."* (Session 2, 31:02) and characteristically of APES level 1, Rose expressed rather not to think about it.

During session 8, Rose began to acknowledge the existence of her difficulty to make decisions (APES rating = 2). She mentioned the fear of unknown being the reason for that:

> *…because it is so difficult to even think about the other option, our relationship ending.* ***Because it is so hard to even think about it since the unknown is always scary****. So somehow I'm just stuck in so many things.* (Session 8, page 11, 207)

This passage is characterized by intense psychological pain. Rose was distressed and instead of showing attempts to clarify the problem, she tried to push it away by expressing unwillingness to think about the situation thoroughly. At that moment, Rose appeared to have no clear awareness of the association between her difficulty in make decisions and the fear of failure.

Movement from the APES level 2 to level 3 occurred later in the same session. Encouraged by the therapist's intervention, Rose gave a clearer explanation for the problem (APES rating = 3):

> Therapist 1*: There are pros and cons in your relationship, things bothering you. Could we then discuss it more? Even though of course the time between the sessions is also important but… What would help you to survive with the situation?*
>
> Rose: *Well, I do have thought about pros and cons quite a lot but I cannot say what would help.* ***For me it is really hard to make any decisions because all of them seem so definite****.* (Session 8, page 15, 263–264)

This passage clearly illustrates one of the many examples of the therapists' attempts to encourage Rose to explore the possible opportunities in their relationship. Later in session 8, Rose clearly described the difficulty of making decisions but had no understanding or theory of the causes of this problem.

However, by the 11th session, Rose articulated the new understanding of how and why the problem had initially begun. The following passage contains elements of the insight as Rose revealed the historical antecedents of her fear of failure (APES rating = 4): "...*I think that I don't want to fail. My own parents failed and so on. Somehow I decided to success whatever I will do."* (Session 11, 13:40) She later continued: *"I guess we thought that being in an unsatisfied relationship is better than being alone."* (Session 11, 16:07) For the first time, Rose addressed the

connection between her fear of failure and her parents' break-up that she saw as a failure. However, the therapists made virtually no attempt to utilize this new understanding that could have encouraged Rose to work on the problem. Thus, after achieving the insight, instead of referencing to specific problem-solving efforts, Rose continued with further clarification of the problem (APES rating =3):

> Therapist 1: *Are you unwilling to do something, something which would make the change?*
> Rose: *Mmm, maybe in some way.* ***I feel somehow insecure if any decision is right. And if I make a decision will I regret it afterwards****. (*Session 13, 13:09)

She continued later in session 13, giving a clear statement of the problem: *"I'm afraid to make any decisions"* (Session 13, 28:24). The previous two passages represent the recourse from APES level 4 back to APES level 3.

In session 15, the therapist returned to talk about Rose's difficulty in making decisions, and as a result, Rose started to work on the problem (APES rating = 5):

> Therapist 2: *I'm thinking about Ralph and what he is expecting. That you make a decision? And I think that the sooner you make it, the more it helps you both.*
> Rose: *But still, every time* ***I've tried to make decisions*** *or have suggested something, it's always Ralph saying "no, let the time pass by".* (Session 15, 18:04)

This passage illustrates decreased fear of failure since Rose mentioned the problem-solving efforts that she had suggested in their relationship. Regardless of her attempt to make decisions regarding their relationship, her success was not complete, which is characteristic of APES level 5. Notably, after session 15, Rose did not raise the topic of failure into discussion anymore.

By session 19, Rose had achieved a solution for the problem regarding the decisions of the relationship (APES rating = 6): *"Because there isn't a simple answer why we ended to break-up. It's a result of many things but* ***I'm more like relieved that the decision was made.****"* (Session 19, 15:16) By ending their relationship, she gained the courage to make decisions even though the possibility of failure still existed. Characteristically of APES level 6, the affect was positive and relieved.

In the last session, several passages illustrating mastery level (APES rating = 7) were found. All of them focused on Rose's feelings and thoughts after the break-up. For example, the following exchange occurred between Rose and the therapist at the beginning of session 21:

> Therapist 1: *What if you compare to the previous session, how do you think you're doing?*
> Rose: *Well at least in general I'm fine.*
> Therapist 1: *Is it better or worse than before?*
> Rose: *Better, I've got answers and made decisions so that way* ***I feel more relieved for not being on hold anymore****.* (Session 21, 01:13)

As another example, later in the same session Rose continued talking about her feelings encouraged by the therapist:

> Therapist 1: *Have you felt anxious?*
> Rose: *Well, sometimes. But **I haven't regretted**. That's something I haven't felt. But **I am disappointed since I couldn't make this relationship work**. However, I have felt anxiety quite a little so far. And all in all, I'm relieved. Or at least I think it was the right decision to end up our relationship.* (Session 21, 13:33)

Rose's feeling of relief was still present in session 21, when talking about decisions that she had made. Rose was proud of herself now that she had made progress in her life. The key passage illustrating the mastery level was found at the end of the therapy: "*But I do have a good feeling about the future. I would say that these couple of experiences I've had after the break-up, have made me certain of the fact that someone could still want me. And that I still have the possibility to have a relationship."* (Session 21, 54:05) By the end of the therapy, the fear of failure had been taken over by courage to make decisions. Rose had trust in the future and was not afraid of the unknown anymore. However, in the passage above, she did not see herself as a person who had the possibility to affect her future relationships. She still did not consider herself as the one who chooses but more like the one to be chosen or not.

3.3 Outcome Rating Scale and Session Rating Scale scores of Ralph and Rose

Figure 2 represents Ralph and Rose's ORS scores in the course of the couple therapy illustrating their overall situations. Ralph's ORS scores were irregular, undergoing twice a remarkable decrease. Rose's considerable distress at the beginning of the therapy was seen as the lowest scores in ORS questionnaire in session 2, but her scores increased significantly after the second session and stayed high through the entire therapy process.

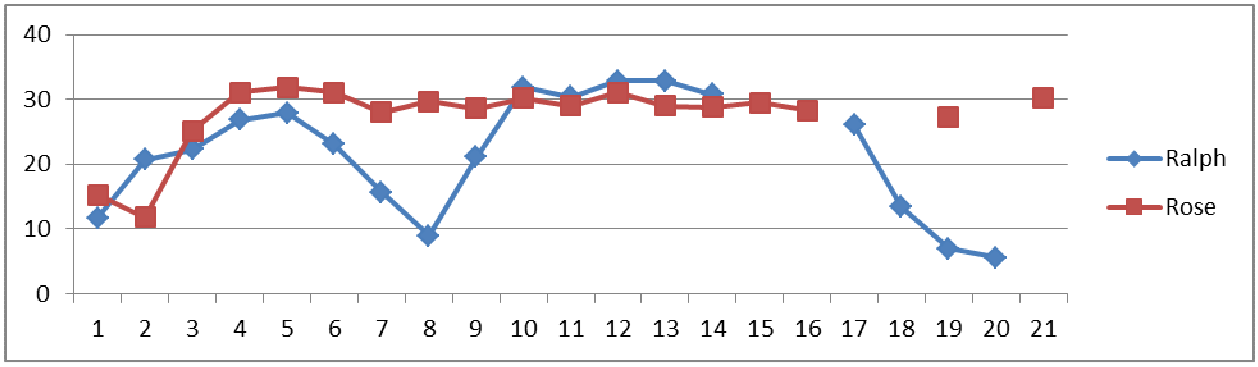

FIGURE 2. Outcome Rating Scale (ORS) scores during Ralph and Rose's couple therapy process (21 sessions)

Figure 3 represents Ralph and Rose's SRS scores in the course of the couple therapy and differences in their satisfaction with the sessions. Ralph's SRS scores decreased significantly twice indicating his dissatisfaction with the session. Rose's SRS scores were more stable illustrating her satisfaction with the entire therapy process.

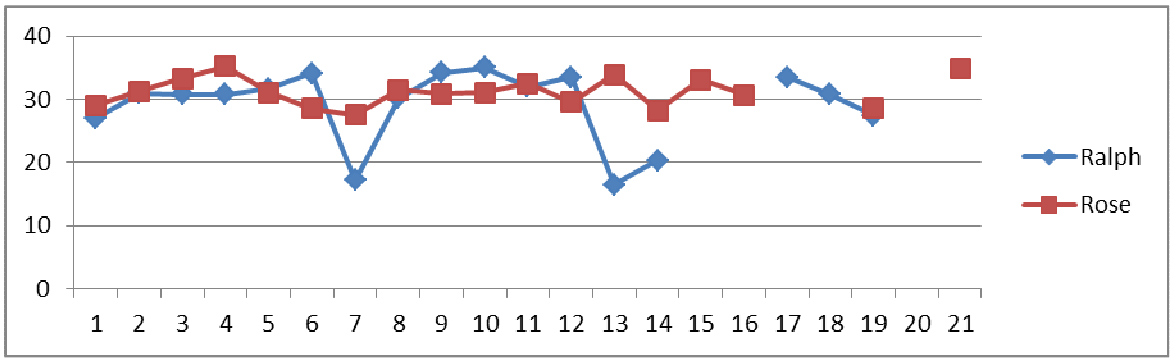

FIGURE 3. Session Rating Scale (SRS) scores during Ralph and Rose's couple therapy process (21 sessions)

4 DISCUSSION

The aim of this Master's Thesis was to study how the assimilation model can be applied in couple therapy for depression in a naturalistic setting. In addition, it was studied what kind of positive changes can be found in couple therapy for depression in terms of the assimilation model. First, the assimilation model (Stiles et al., 1990) was found to be a useful and applicable method in a couple therapy setting. Second, four positive change processes were tracked by using the assimilation model: one in Ralph's case and three in Rose's. In Ralph's case, progress was found in one problem called *disgust at sex*. In the case of Rose, three problems were detected and named *feeling of responsibility, guilt,* and *fear of failure*. These three problems were chosen because they represented the most developed processes in this couple therapy. As mentioned before, assimilation analysis has been applied only in individual and family therapy settings, however, these findings support the use of assimilation analysis also in the context of couple therapy.

Ralph's process regarding disgust at sex followed an irregular pattern. It was identified from unwanted thoughts (APES rating = 1) and showed characteristics of working through (APES rating = 5), but in the end returned to vague awareness (APES rating = 2). In turn, Rose's processes were more linear within the themes studied and she also achieved higher mean levels of assimilation than Ralph. The feeling of responsibility and guilt began as vague awareness (APES rating = 2) while the fear of failure appeared as unwanted thoughts (APES rating = 1) at the beginning of the therapy. In these two themes, guilt and fear of failure, Rose demonstrated mastery (APES rating = 7), whereas one theme, feeling of responsibility, progressed to problem solution (APES rating = 6).

4.1 The case of Ralph (Unsuccessful case)

Ralph's problem, *disgust at sex*, was considered simultaneously relationship –oriented as well as intimate and an individual psychological theme. The process showed rather poor progress over the course of the treatment. When entering the therapy, Ralph was already aware of the problem but the origins of it were not yet in the discussion. At the beginning he preferred not to think about the lack of intimacy he and Rose were facing, but during the treatment he showed improvement, achieving the level of working-thorough at best. As in the previous studies (e.g. Detert et al., 2006; Knobloch et al., 2001), the assimilation progress of Ralph's problem through the APES levels was not straightforward within the studied theme. After he achieved the APES level 5, some of his later passages were rated at APES levels 2 and 3. The irregularity of the process is also exemplified by some skipped APES levels, which may have caused the recourses back to lower levels.

Based on Knobloch et al. (2001), the interference of other problems may be one of the reasons why the process of a particular problem does not progress smoothly. Upon entering the therapy, Ralph was facing multiple problems that had induced his depressive symptoms. According to the therapists, the theme of infidelity played a significant role in Ralph's depression, but the theme could not be raised into a more specific analysis due to the identification issues. Even though the theme of sexuality ended up back to the lower APES levels, it showed most improvement in the process of assimilation, hence it was focused on. Importantly, Ralph's post-therapy BDI scores were still moderate, suggesting that the problems remained unresolved.

4.2 The case of Rose (Successful case)

In contrast to Ralph's assimilation process, Rose's problems progressed markedly. In the case of Rose, there was qualitative evidence that the assimilation tended to progress as this couple therapy advanced. It seemed like the therapy increased Rose's awareness of her problems, enabling her to achieve higher levels of assimilation in all of her processes. At the beginning of the therapy, Rose described herself as a responsible person and felt extremely exhausted with taking care of her depressed spouse, Ralph. Thus, one of her problems was named as a *feeling of responsibility.* Across the treatment, Rose understood she had adopted the caretaker role from her childhood. By the end of the therapy, Rose was able to successfully apply the new understanding she had gained. Accordingly, she did not need to be the only one with responsibilities anymore and to give her best while putting her own life on hold. Even though Rose achieved a solution for the problem, the level of working-through was not seen in the therapy sessions.

The theme of *guilt* was tracked to begin half-way through the therapy, but it was only later that Rose herself used the word guilt for the first time. Originally, guilt appeared to be caused by Rose's feeling of being stuck in her life and not being able to make decisions. Gradually the theme seemed to be related to carrying less responsibility for Ralph and to thinking more about her own benefit. Problem solution was not evident during the sessions, although Rose later mastered the guilt.

The assimilation analysis highlighted a complex relation between two themes studied concerning the case of Rose: the feeling of responsibility and the guilt. Problems usually tend to build on each other (Knobloch et al., 2001) and it seemed that guilt appeared in the therapy as Rose worked on the unnecessary feeling of responsibility and started to get her own needs met. Realizing it is not her duty to take care of others helped her gradually to let go of the feeling of guilt and move towards thinking about her own best. Inspired of the case of John Jones (Stiles et al., 1992) these

themes were initially found to be separate from each other but they showed gradual integration in the therapist-client interaction. Knobloch et al. (2001) assert that one problem may help with other problems' solution and that the problems cannot even be resolved separately. Thus, it is notable that insights of both problems were found in the same session. Across the therapy, the themes of responsibility and guilt converged as a one theme characterized of psychological differentiation, which for Rose involved separation from Ralph as well as her family of origin. By the end of the therapy, Rose reached a new level of differentiation which allowed her to put her own needs first without feeling guilty about it.

The third problem, *fear of failure*, advanced most in the mean levels of assimilation. In the first session, Rose described herself as a hard worker for whom failing is impossible, although later she was able to admit failure in their relationship. As progressing, she acknowledged her difficulty in making decisions that was caused by the fear of unknown. After achieving understanding, she returned to clarify the problem once more and finally accomplished mastery by describing the feeling of relief caused by the decisions made. Across the treatment, Rose thought over the reasons behind the fear of failure, and named her parents' divorce to be one of them – she did not want to make the same mistakes as her parents.

Rose showed marked improvement in the assimilation process over the course of the therapy. Importantly, all the themes that were focused on in Rose's case were fairly relationship-oriented, but psychological differentiation and separation that followed the progress were too much for the couple to cope with in their relationship. In a manner similar to the previous assimilation study (Honos-Webb et al., 1999), all the passages drawn from Rose's case did not strictly follow the APES sequence, and there were APES levels that were not seen in the therapy sessions regarding the feeling of responsibility and guilt. Stiles et al. (1992) remind that clients do not verbalize everything they think or feel and that all the meaningful moments do not take place during therapy sessions (Rautiainen, 2007). Because Rose was highly motivated with the therapy, it is assumable that she processed the problems also outside the therapy sessions. The last session was significant for the assimilation analysis since many passages demonstrating the highest levels of assimilation were extracted from this session. Rose told that she had maintained the new understanding and was applying it in her life.

4.3 Ambivalence of the treatment

In Rose's case, three successful assimilation processes were found, while Ralph's process was considered unsuccessful. As to why Rose progressed further than Ralph during the same therapy

sessions, four possible causes may be considered: the therapists failed to work in Ralph's zone of proximal development, the strength or weakness of therapeutic alliance, the applicability of the couple therapy, and the clients' own investment to the therapeutic process.

First, the ambivalence of the treatment can be understood as differences in the clients' zone of proximal development (Leiman & Stiles, 2001). Stiles et al. (2006) assert that a client's good progress suggests a fairly wide ZPD. As in the previous study by Stiles et al. (2006), it seemed that already at the beginning Rose and the therapists found an understanding. Thus, Rose was able to use the offered resources to achieve progress suggesting joint work between the client and the therapists in Rose's ZPD. Similarly to the previous case studies (e.g. Brinegar et al., 2006; Leiman & Stiles, 2001), it seemed that the therapists worked slightly ahead of Rose, which may have helped her to find a way out of the problematic situation and to achieve higher APES levels than would have been possible without guidance. In turn, the therapy did not meet Ralph's ZPD since the therapists tended to stay too ahead of him, exceeding his ZPD. Based on Stiles et al. (2006) it seemed that the therapists did not sense Ralph's tolerance but pushed his limits regarding the problematic experiences. This may have caused Ralph's feeling of pressure and being pushed and making him to avoid even more his own difficult material. In addition, the therapists' suggestions may have been too different from Ralph's own way of thinking. Andersen's (1990) work indicates that the therapist's pushing behavior may cause the client to close up to prevent damage to his or her personal integrity. For instance, when the therapists advised Ralph and Rose to end their relationship, Ralph reacted with anxiety and afterward accused the therapists of not acting fairly but aggressively and offensively.

Second, it seemed that the therapeutic alliance was also stronger in Rose's case than in Ralph's, which may have been another reason behind the different outcomes. The differences in Ralph and Rose's satisfaction of the sessions can be seen in SRS scores. Ralph's irregular SRS scores suggest that he may have lost his trust in the therapists in some of the sessions, whereas Rose seemed satisfied with the conversations in the therapy, since her scores stayed high through the entire process. She verbalized her satisfaction with the therapy at the end, assuring the therapists that she has gotten everything she needed. In addition, the therapists achieved deeper understanding of Rose's problems than Ralph's. This can be exemplified as therapists' future-oriented questions about the problems Rose was facing. The setting with two female therapists may have had an additional effect on why Ralph did not reach as good an understanding with the therapists as Rose did.

Next, Ralph was offered couple therapy in a situation where he already had the possibility to receive individual psychotherapy to treat his depression. He gave up the offered individual psychotherapy when entering the DINADEP project. It seemed that the couple therapy did not meet

the specific needs of Ralph in many terms. The therapists began to reconsider the suitability of joint sessions only when relational problems did not seem to progress and when noticing that Ralph could not express himself properly. When interviewing the clients of the DINADEP project, Rautiainen and Seikkula (2009) too found that the involvement of the spouse in the depressed person's treatment was one of the factors inhibiting clients from talking in couple therapy. In addition, some couples told that they would have preferred individual treatment instead. Half-way through the therapy, Ralph expressed his frustration with the therapy and criticized the therapists' way of working and said he was ready to quit the therapy. In contrast to Ralph, Rose seemed to benefit individually from joint sessions as well as individual sessions.

Finally, in order to progress through the levels of assimilation, a client needs to pay remarkable attention to a painful topic (Honos-Webb & Stiles, 1998). Rose was highly motivated with changing the problematic situation in their relationship. For instance, she put a lot of effort into her therapy homework. Additionally, she focused on difficult issues more than Ralph, who preferred not to talk about his most painful topic. Rose repeatedly expressed her willingness to continue discussions between the sessions, while Ralph was hesitant and did not maintain such a focus outside the sessions. To understand better the noncommittal behavior of Ralph, it is noteworthy that his problematic experience may have been more painful and more difficult to solve than Rose's problems.

This study confirms the suggestion of the previous study (Honos-Webb et al., 1999) that is, the assimilation analysis is amenable particularly to combine qualitative with quantitative methods. The present study is special due to the combination of multiple methods, as it is not usual of the assimilation model to be both supported by and tested with other approaches. Here the assimilation model was supported by quantitative methods, ORS and SRS, as well as qualitative background theories, for example the ZPD. The ambivalence of the treatment can be seen in divergent ORS scores (Figure 2). According to Kuhlman (2012), the clinical cut off score for the ORS is 25, and scores lower than this indicate psychological stress and motivation to change the situation. In the DINADEP project, the increase sufficient for the therapy to be considered effective in the patient's ORS was eight points, and six points for the spouse (Kuhlman, 2012). Notable is that Ralph's ORS scores were irregular, undergoing twice a decrease of more than eight scores and illustrating that his situation became worse. Rose's ORS scores increased more than six points after the second session and did not markedly decrease in the time period that her scores were followed. This increase is considered reliable change suggesting that therapy is effective and it should be continued the same way (Kuhlman, 2012).

The case of Ralph and Rose can be compared to a previous study comparing a successful and an unsuccessful therapy cases (Honos-Webb et al., 1998). Like Ralph, the client of the

unsuccessful therapy of the previous study too showed progress in assimilation. Nevertheless, by the termination of the treatment, the problematic experience was tracked at an earlier stage of assimilation and no alleviation was found in depressive symptoms. On the contrary to Ralph, Rose progressed through the higher stages of assimilation like the successful case in the previous study. Furthermore, in both of these successful cases, depressive symptoms improved by the end of the therapy and maintained at follow-up. Thus, the case of Ralph and Rose substantiates the results of previous case studies (e.g. Detert et al., 2006; Honos-Webb et al., 1998; Knobloch et al., 2001; Stiles et al., 1991) showing an association between reduction in depression and higher levels of assimilation. It appeared that couple therapy can be effective treatment for the spouse too, which converges with previous findings (Cohen et al., 2010; Rautiainen, 2003).

4.4 Strengths, limitations and future research

This Master's Thesis provides valuable information since presumably this is, up to now, the first study to apply assimilation analysis to a couple therapy setting. It offers an intensive focus on the change processes of two clients drawn from the same couple therapy sessions. One strength of this study is that the researchers investigated the entire therapy process and transcribed most of the sessions themselves, which Potter (2004) indicates may lead to the most revealing analytic realizations. Ideally, multiple researchers enrich the analysis with different perspectives (Brannen, 1992), and indeed investigator triangulation, the use of more than one researcher (Tindall, 1994), can be mentioned as one of the strengths of this study. In addition, this Master's Thesis was talked through and challenged by our supervisor and the colleagues in the same research group investigating the same couple. Tindall (1994) reminds that this kind of co-working facilitates understanding and illuminates blind spots. Methodological triangulation, the use of multiple methods both qualitative and quantitative, was used to construct comprehensive understanding of the clients' situations. Laitila and Aaltonen (1998) underline the importance of methodological triangulation because it enables the investigation of the material with different emphases. Using more than one method and assessing their convergence has been suggested to have a stronger validity than using only one (Stiles, 1993).

This study had several limitations. First, the missing sessions may be considered as the most significant one, since a remarkable increase in Ralph's ORS scores was measured during these missing sessions. Having those sessions might have offered further information about Ralph's process. For instance, some of the skipped APES levels might have been found in those sessions. Second, the research was limited by any potential distortions rising from researcher's personal

points of view. The possibility cannot be excluded that the results in part reflect the characteristics of the couple and the investigators. For instance, the passages were selected with careful consideration to offer readers direct grounding for the interpretation of the researchers, but they may reflect personal biases. Even though investigator triangulation was utilized, the authors did not adopt different roles and may not have adequately striven against consensus collusion. This kind of group thinking is not recommended (Tindall, 1994) and it can be considered as a third limitation. Collaborative working may have limited questioning the adequacy of the theory, which according to Tindall (1994) may affect the ability to explore alternatives.

The clients in this study received systemic therapy with a special focus on dialogues and narratives. Future work could examine if there are differences in assimilation in different theoretical orientations of couple therapy. The assimilation model has been used to help to understand the change processes in psychotherapy research (Stiles, 2001), but it could also be utilized further in the practice of couple therapy. According to Stiles et al. (1990), the model clarifies the change process and thus provides a way to understand the needs of different clients. In addition, in this case study, the assimilation model was utilized in couple therapy for depression determined as poor outcome. In the future, the model could be applied for instance in different outcome, other diagnosis or therapists with different gender to test the model further. Finally, more studies are needed focusing on couples where both partners suffer from depression.

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