DETECTING COUPLE THERAPY FOR DEPRESSION WITH A METHOD COUPLE THERAPY PROCESS Q-SET (CTQS): PROCESS-DESCRIPTIONS OF TWO GOOD, AND ONE POOR OUTCOME CASES

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ABSTRACT

This Master's Thesis is part of the Dialogical and Narrative Processes of Couple Therapy for Depression project (DINADEP), which aimed to investigate treatment and factors predicting the treatment outcome of couple therapy where another of the spouses suffered from either moderate or severe depression. In this study, one aim was to investigate three couple therapy for depression-treatment processes with a developing method Couple Therapy Process Q-set (CTQS). Another aim was to investigate the response of the therapists when the couple expressed emotions, and their possible causality towards the therapeutic outcome. CTQS is a scaling technique capturing different aspects of therapy process by analyzing a single couple therapy session. The material was analyzed from videotapes and by detecting self –evaluation questionnaires. The material for this thesis consisted of 11 sessions which were chosen from the beginning, middle and at the end of every treatment, to capture the variation of the process. It was found that the Couple Therapy Process Q-set is a suitable method in description of couple therapy processes, and with the CTQS, the description can also be precise. In addition, it was found that in succeeded treatments, therapists used a wider variation of strategies when facing the emotional expressions of the clients. This finding is analogous with previous studies. In the poor outcome case the therapists maintained using the same therapeutic tool, even though the clients did not seem to response on that. The CTQS requires further research, to make sure that all of its dimensions can be found and benefit from in the research of couple therapy.

Keywords: couple therapy, case study, couple therapy process q-set, CTQS,

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TIIVISTELMÄ

Tämä pro gradu – tutkielma on osa Dialogiset ja narratiiviset prosessit masennuksen pariterapiassa – projektia (DINADEP), jonka tarkoituksena oli tutkia masennuksen pariterapiaa ja mahdollisia tekijöitä, jotka voisivat vaikuttaa sen lopputulokseen. Tämän tutkimuksen tarkoituksena oli selvittää, miten pariterapiaprosessia kuvaavaa Q-set-menetelmää (PTQS) voidaan käyttää masennuksen pariterapiaprosessien kuvailuun tutkimalla kolmea tapausta, joista kaksi oli hyvin onnistuneita hoitoja ja yksi oli huonosti onnistunut hoito. PTQS arvioi yhtä terapiaistuntoa kerrallaan ja analysoitaessa useita istuntoja, saadaan tarkka kuva koko prosessista. Toinen tutkimuksen tavoite oli tutkia, kuinka terapeutit vastaavat prosessin aikana pariskunnan tunneilmaisuihin, ja niiden mahdollista vaikutusta terapian lopputulokseen. Tutkimusaineisto koostui sekä nauhoitetuista pariterapiaistunnoista, että itsearviointimittareista. Kokonaisuudessaan tutkimusaineisto koostui yhdestätoista pariterapiaistunnosta ja ne valittiin jokaisen tapauksen alusta, keskeltä ja lopusta, jotta saataisiin mahdollisimman tarkka kuvaus koko prosessista. Tulosten mukaan PTQS kuvailee tarkasti pariterapiaprosessin aikana tapahtuvia muutoksia. Lisäksi huomattiin että onnistuneissa tapauksissa terapeutit käyttävät erilaisia terapeuttisia työkaluja lähestyessään pariskunnan tunneilmaisuja ja ylipäätään koko terapiatilannetta. Tämä tulos tukee aiemmin tehtyä tutkimusta. Huonosti onnistuneessa tapauksessa terapeutit pitäytyivät pääsääntöisesti yhdessä strategiassa. PTQS tarvitsee vielä lisätutkimusta, jotta sen kaikki ulottuvuudet voidaan löytää ja hyödyntää pariterapiatutkimuksessa.

Avainsanat: pariterapia, tapaustutkimus, pariterapiaprosessin q-set, PTQS

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1. INTRODUCTION

This master's thesis is part of the Dialogical and Narrative Processes in Couple Therapy for Depression project (DINADEP), which aims to develop couple therapy as a treatment for depression (Seikkula, 2006). The aim of this thesis was to examine couple therapy processes and possible factors describing a succeeded and non-succeeded treatment. The material was analyzed with a developing qualitative method Couple Therapy Process Q-Set (CTQS; Peura 2013) and with questionnaires Outcome Rating Scale (ORS; Miller & Duncan, 2004) and Session Rating Scale (SRS; Miller & Duncan, 2004). Another aim of this thesis was to examine the CTQS as a method for couple therapy research. I will begin the Introduction by focusing on the background of the psychotherapy research, examining different aspects and interests from the 19th century till this day. By this, I will illuminate the background for this research and place it to the historical context. After that, I will present the CTQS and focus on the background of couple therapy for depression.

1.1. History of psychotherapy research

The interest to evaluate psychotherapy dates back to the 1930s, to the research made by Saul Rosenzweig. He indicated that all psychotherapies have equivalent outcomes regardless the therapeutic orientation and, that certain common factors would be responsible for the therapeutic outcome (Rosenzweig, 1936). He represented the famous "dodo bird verdict" –a conclusion of the Dodo bird describing a race in the book *Alice in Wonderland*: "Everybody has won and everyone must get a prize "(Carroll, 1865; Rosenzweig, 1936). This was the beginning of the psychotherapy research and the three main procedures within: research about the effectiveness, efficacy and the factors within the approaches.

About twenty years later, Eysenck came up with his meta-analysis concerning the efficacy of psychotherapy. His conclusion was that psychotherapy does not improve one's life: spontaneous recovery is as effective as psychotherapy (Eysenck, 1952). Eysenck's method was strongly criticized and it gave a starting point to the methodological conversation about the psychotherapy research. Finally in the 1980, Smith and Glass brought up a meta-analysis which proved that psychotherapy really was effective compared to non-treatment group (Smith & Glass, 1980). In the 1970's, Lester Luborsky and his colleagues found out that different psychotherapies had only small differences and the Rosenzweig's dodo-bird-verdict was getting support again (Luborsky & Singer,

1975). This led to the wave of studies: others for the dodo-bird-effect and others against it (i.e. Rachman & Hodgson, 1980; Gloaguen, Cottraux, Cucherat & Blackburn, 1998). The ones for it supported Rosenzweigh's idea of common factors appearing in the psychotherapy process and those factors being responsible for the outcome (i.e. Rosenzweig, 1936; Rogers, 1956; Imel & Wampold, 2008). Common factors are not factors stemming from the approach itself but they appear in every (or most) approach (Wampold, 2001). They can concern client's expectancies, therapist's qualities or for example an opportunity for catharsis (i.e. Jones, Cumming & Horowitz, 1988; Grencavage & Norcross, 1990). According to Wampold and Imel (2008), common factors are responsible for about 30 %-60 % of therapeutic outcome. Also a research published by American Psychological Association (APA) in 2002 reported that 30% of the effectiveness of the psychotherapy was result from the common factors while only 15% of the effectiveness was due to the approach itself (Norcross, 2002). This brings up a question whether the ingredients behind the common factors are available for capturing and what are the methods for that.

Many techniques have been introduced, for example Vanderbilt Psychotherapy Process Scale (VPPS; Gomes-Schwartz & Schwartz, 1978), which measures the therapeutic alliance with a Likert-like scale. California Psychotherapy Alliance Scales (CALPAS) also gather information about the therapeutic alliance (Gaston & Marmar, 1994). The Collaborative Study Psychotherapy Rating Scale (CSPRS; Hill, O'Grady & Elkin, 1992) detects therapists' adherence. It consists of 96 items describing the modality and non-modality of specific interventions. It was designed specifically for the Treatment of Depression Collaborative Study (TDCRP) and it lacks the aspect of universality.

The Q-sort-technique was built up back in the 1950's for investigation of individual psychotherapies (Stephenson, 1956). It was formed from the Q-methodology, which is a general scaling technique used in organizing data in terms of their existence or form (Stephenson, 1953). Jack Block from the University of California represented the observer-rating procedure for the Q-sort technique and developed the California Q-set (Block, 1961; Block & Haan, 1971). In the 1969, the California Child Q-set was published (Block & Block, 1980).

Jones, a psychoanalyst and psychotherapy researcher came up with the Manual for Psychotherapy Process Q-set (PQS; Jones, 1985). Jones was worried about the "*dodo bird verdict*'s"-impact on the psychotherapy research: He feared that it might lead researchers to make conclusions "prematurely or perhaps erroneously" about common factors and them being the only responsible active ingredients in the treatment process (Ablon, Levy & Smith-Hansen, 2011). He also suggested that specific techniques should be detected as a part of the analysis, and that is why he engineered the Q-set as a pantheoretical method (Ablon et al., 2011).

1.2. Psychotherapy Process Q-set

The aim of PQS lies in examining an adult psychotherapy process as a whole by finding the key factors describing each session (Ablon & Jones, 1999; Sirigatti, 2004). The method gathers information by "sorting" the data into nine dimensions within the normal distribution. After the division, the material is available for quantitative analysis if needed (Stephenson, 1956).

The PQS has proved to measure not just the process aspects relative to the therapeutic alliance but also the variety of elements widely descriptive, such as interactive aspects of the process, behavior of the client but also thoughts and feelings of the client (Ablon & Jones, 1998; Ablon & Jones, 1999). Through the PQS-evaluation, it has been demonstrated that the orientations presented by therapists are not so limited, and actually therapists move from an orientation to another depending on what suits the best for each session, or a patient (Jones, Cumming & Horowitz, 1988; Ablon et al., 1998).

Jones and Ablon have used the PQS successfully in analyzing single case designs but also large controlled randomized trials (Ablon & Jones, 1999; Ablon et al., 2011). In the project Treatment for Depression Collaborative Research Program (TDCRP, sponsored by the National Institute of Mental Health, NIMH), the process analysis was made by using the PQS (Ablon & Jones, 1999). The Psychotherapy Process Q-set has been utilized for analyzing the treatment of depression in psychodynamic therapy, cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), control-mastery therapy (CMT), rational-emotive therapy and gestalt therapy (Jones, Cumming & Pulos, 1993 & Ablon et al., 2011). The inter-rater reliability of the PQS has been consistent throughout the studies varying from .83 to .89 when 2 raters and from .89 to .92 when 3 to 10 raters (Jones, Hall & Parke, 1991).

In research made by Jones, Cumming and Pulos (1993), the Q-set was noticed as a renewable method according to the objectives of research. Since then, the Child Psychotherapy Q-set (CPQ; Schneider, 2003), the Adolescent Psychotherapy Q-set (APQ; Ablon, Bambery & Porcerelli, 2007) and the Adult Attachment Behavior Q-set (AABQ; Wampler, Riggs & Kimball, 2004) have been developed. In 1989, Wampler and his group introduced the Georgia Family Q-sort, which measured family functioning (Wampler, Halverson, Moore & Walters, 1989). Wampler and Halverson also introduced the Georgia Marriage Q-sort, which took the marital functioning under focus (Wampler et al., 1990). Over ten years later, Kogan and his research group introduced the Clinical Discourse Q-sets (CDQS; Kogan, 2002), which focused on capturing the linguistic aspects of the marital therapy session. The Couple Therapy Process Q-set (CTQS; Peura, 2013) is a method measuring the process of couple therapy by evaluating a single couple therapy session. One aim of this thesis was

to test if the CTQS could be applied in couple therapy settings by detecting three single couple therapy cases, where one of the spouses suffered from depression.

1.3. Depression in a relationship

It is said that the problems of an individual connect to the relationships surrounding the person (Minuchin, 1974). A couple sharing their lives together impact greatly on each other's thinking and ways of being. Also depression has been said to have an impact on the spouse's mental health and through this, to the marital satisfaction in general (e.g. Whisman, 2005; Lemmens, Heene, Eisler & Demyttenaere, 2007). At the same time, a spouse distressed can also be the source for depression (e.g. Beach & O'Leary., 1992; Mead, 2002; Beach, 2003; Coyne & Benazon, 2001; Whisman, 2001; Rautiainen, 2003).

This builds up a desirable need for treating depression with couple therapy: With the help of therapy, a couple can learn how to cope with depression and accept it as a part of their lives (Mead, 2002). Much research has been made and it has been noticed that couple therapy is a suitable method for the treatment of depression (e.g. Beach et al., 1992; Emanuels-Zurveen & Emmelkamp, 1997; Jones & Asen, 2000; van Wijngaarden & Koeter et al., 2009). When comparing couple therapy with anti-depressants, results show that couple therapy is more effective, especially when treated with Emotion-focused therapy (Dessaulles, Johnson & Denton, 2003). Couple therapy is also noticed as effective in the treatment of depression as cognitive-behavioral therapy (Beach & O'Leary, 1992). Finnish Käypä hoito-suositus (2009) recommends couple therapy as a treatment for depression when there is marital dissatisfaction involved. Barbato and D'Avanzo made a meta-analysis in 2008, and found out that couple therapy could not be indicated as a better treatment for depression but at least, it diminished the marital distress (Barbato & D'Avanzo, 2008).

1.2. Marital distress, depression and emotions

A person suffering from depression or marital distress is likely to experience a variety of emotions, and a part of them usually intertwine with anger (Riley, Treiber & Woods, 1989). Sorrow, lack of interest, guilty, hostility and shame are typical examples. (Lönnqvist, Heikkinen, Henrkisson & Marttunen, 2007; Gurman, 2007; Riley et al.1989).

Actually depression itself is said to be hate turned against a person himself (Freud, 1917). Hate and anger are basic emotions of a human being and evolutionary, ensuring living. In depression,

those emotions appear in a more excessive pressure and they are not suitable for the modern Western culture and are, for that reason, treated with psychotherapy (Shweder, Haidt, Norton & Joseph, 2007). Those emotions might enter into the therapeutic situations and it gives a challenge for the clinicians. The reaction of the therapist, when a person expresses emotions –is a crucial part when building a therapeutic alliance (Bordin, 1979). The quality of therapeutic alliance predicts the therapy outcome and is, for that reason, important to focus on (Duncan, Miller, Wampold & Hubble, 2010). Different therapeutic orientations have their own specific techniques to approach different situations –usually colored by emotions –in the therapy. Those techniques can be for example: confronting, neutralization, questioning, outsourcing or reflective discussion (a discussion between therapists in front of the couple: Andersen, 1991) or empathy stance.

This theme will also be taken under wider consideration in this thesis; as the Psychotherapy Process Q-set has a relatively large amount of items concerning the emotional expressions of the clients (n=25), but also the actions and reactions of the therapist (n=43), the processes of the possible repetitive patterns can be captured. As it can be assumed, comparing good and poor outcome therapies at the level of sessions, the changing processes, but also the factors enabling the changing processes can be noticed. In this thesis, in addition to the process-investigation, the actions and reactions of the therapist to the emotion-expressions of the clients are taken under focus. The results will be compared to the self-evaluations of the therapy sessions, but also to the therapeutic change-measurements, to have a more accurate picture.

Based on the previous formatting, following questions came up as the central line as a description of this research:

1. What kind of processes can be found from good and poor outcome couple therapy for depression -cases with the Couple Therapy Process Q-set (CTQS)?

2. When comparing good and poor outcome-cases, what was the therapists’ response to the emotional expressions of the couples?

3. When comparing self-evaluation-scales and the CTQS-evaluations, what were the effective and non-effective actions of the therapists in good and poor outcome-cases?

2. RESEARCH AND METHODS

2.1. DINADEP-project

Cases selected for this master's thesis are taken from the Dialogical and Narrative Processes in Couple therapy for Depressions project (DINADEP). Aim of the DINADEP was to explore the treatment and factors predicting the outcome of couple therapy where another of spouses suffered from either moderate or severe depression. The material was gathered in natural settings, to raise the inner validity of the research (Seikkula, 2013).

The DINADEP- project was carried out in Finnish outpatient clinics in northern Savo, western Lapland and Espoo. Clients seeking treatment for depression were informed about a possibility of taking part of the couple therapy intervention with their partners. After enough participants were recruited, they were randomized in couple therapy group (n=29) and in control group (n=22). Control group was treated as normally in a primary care; they were offered psychotherapy, medication or hospitalization but their partners did not take part in the sessions regularly or at least, not in a couple therapy setting. The couple therapy group was treated with their partners, with a therapists specialized in family or couple therapy. The average age of the therapists varied from 39 to 61 and their experience was 1 to 39 years (Seikkula, 2013; Rautiainen, 2010).

Symptoms of depression were investigated with BDI (Beck et al., 1961; self- reported depression) and HDRS, Hamilton depression rating scale (Hamilton, 1960; rater-evaluated depression). The Outcome Rating Scale (ORS; Miller & Duncan, 2004) measured the therapeutic change and the Session Rating Scale (SRS; Miller & Duncan, 2004) measured the therapeutic alliance. The outcome in the DINADEP was determined based on the alleviation of the depression symptoms of the patient (BDI and HDRS). The sessions of the couple therapy were either recorded or videotaped.

2.1.1. Cases selected for this research

Because this thesis is a part of the developmental process of the Couple Therapy Process Q-set, the reliability of the developing method needed testing. Two or three raters watched the same session and blindly, made the CTQS-evaluations. The CTQS-results included in this thesis were made by only one of the raters (the writer). Treatment processes differed from each other by the length of the treatment: Case 1 had five sessions, Case 2 had 26 sessions and Case 3 had 5 sessions.

The sessions watched and analyzed with the CTQS for the present thesis were:

-Case 1: Sessions 1, 2, 3 and 5

-Case 2: Sessions 2, 3, 14 and 26

-Case 3: Sessions 1, 2, and 5

Sessions were chosen from the beginning, middle and at the end of every case, to have more clear description of the process. Altogether 11 sessions were watched, and time used for watching and analyzing the sessions was approximately 34 hours. A single couple therapy session was approximately 1.5 hours long.

2.2. The Couple Therapy Process Q-set (CTQS)

The CTQS consists of 100 items which each have its own verbal description of the current therapy meeting (table 2). It characterizes the behavior of a therapist and clients and it organizes their existence in different classes depending on their existence in a single couple therapy session.

The arguments are divided so that one part of the descriptions is concentrating on the attitudes, behavior, and perceptible experiences of the clients (n=40), second part is concentrating on the actions and attitudes of the therapist (n=43), and third part focuses on the nature of the interaction, the environment and the atmosphere of the session (n=17) (Peura, 2013). The evaluation is made by raters who observe the therapeutic session and the behavioral and psychological aspects of it. Raters watch the session (either recorded, videotaped or a transcript version) and evaluates each of the 100 claims. The claims are printed separately on cards making it possible for easy arrangement or rearrangement. The evaluation is forced into the normal distribution, so that the claims are evaluated into piles from at least characteristic (category 1; 5 items) to the most characteristic (category 9; 5 items) (Table 1). Category 5 is for the neutral either unimportant items which appear irrelevant concerning the session and most of the items (n=18) are placed there. After a careful division of the items the results can be used in quantitative comparison and analysis

TABLE 1. Division of the Q-items.

Category	Number of items (n)	Label of category
9	5	extremely characteristic or salient

8	8	quite characteristic or salient
7	12	fairly characteristic or salient
6	16	somewhat characteristic or salient
5	18	relatively neutral or unimportant
4	16	somewhat uncharacteristic or negatively salient
3	12	fairly uncharacteristic or negatively salient
2	8	quite uncharacteristic or negatively salient
1	5	extremely uncharacteristic or negatively salient

Notes
a. Source: Jones, E.E. (1985) *Manual for Psychotherapy Process Q-set.* Unpublished manuscript, University of California, Berkeley.

TABLE 2. An example of the CTQS-item, Q-item number 1 (Peura, 2013)

1. Spouses express, verbally or non-verbally, negative feelings (e.g. criticism, hostility) toward therapist (vs. makes approving or admiring remarks)

Place toward *characteristic* end if couple expresses, verbally or non-verbally, feelings of criticism, dislike, envy, scorn, anger, or antagonism toward therapist. E.g. patient rebukes therapist for failing to provide enough direction in the therapy.

Place toward *uncharacteristic* end if couple expresses, verbally or non-verbally, positive or friendly feelings towards therapist, e.g. makes what appear to be complimentary remarks to therapist.

In Finnish:

1. Puolisot ilmaisevat negatiivisia tunteita (esim. kriittisyyttä,vihamielisyyttä) terapeuttia kohtaan (vs. tekevät hyväksyviä tai arvostavia huomautuksia)

Arvioi terapiaistunnolle *tunnusomaiseksi*, jos puolisot ilmaisevat joko verbaalisesti tai nonverbaalisesti kriittisyyden, inhon, kateuden, halveksunnan, kiukun tai vihamielisyyden tunteita terapeuttia kohtaan. Esimerkiksi he moittivat terapeuttia siitä, että tämä ei ymmärrä heitä tai ei ole tukenut heitä tarpeeksi terapian aikana.

Arvioi terapiaistunnolle *ei-tunnusomaiseksi*, jos puolisot ilmaisevat positiivisia tunteita terapeuttia kohtaan. Esimerkiksi he sanovat asioita, jotka osoittavat pitämistä, arvostusta tai kiitollisuutta tai heidän suhtautumistaan terapeuttiin muulla tavoin välittyy positiivinen tunnelataus.

2.3. Outcome Rating Scale (ORS)

The Outcome Rating Scale (ORS; Miller & Duncan 2004) is a brief method developed from the Outcome Questionnaire 45.2 (Lambert, Hansen et al., 1996). It measures therapeutic change and in the DINADEP, both the patient and the spouse filled the form. The ORS consists of four scales where the client estimates his/her last week and makes the evaluation depending on that. The scales

measure the individual well-being, the interpersonal relationships (family and other close relationships), the social life (work, school, friendships) and the general sense of well-being during the last week. The ORS is filled at the beginning of every therapy session, and the therapists mark the results to a specific form where the process of therapeutic change can be taken under detection.

In ORS, the clinical cutoff is 25 points and the points under that reflect psychological stress or unpleasant feelings towards current life situation. In the DINADEP-project, the clinical change was significant, if the points rose eight points from the beginning's under 25. The clinical change was significant for the spouses, if the points rose six points.

2.4. Session Rating Scale (SRS)

The Session Rating Scale (SRS; Miller & Duncan 2004) measures the quality of therapeutic alliance. It is a visual analogue instrument consisting of four scales; the bond of the relationship, the goals of therapy, the agreement about the approach used. The fourth dimension measures the client's view of the therapeutic session in general. (In the DINADEP-project, the therapists filled the SRS-scales also in addition to the patient and the spouse, but the fourth dimension for the therapists was modified so, that they evaluated the suitability of the approach for the couple.) The SRS was measured at the end of every session and it gave immediate results under discussion if needed.

The clinical cutoff for SRS is 36 points (Miller & Duncan, 2004). It has been suggested that people give more points for the therapists in the context where they are present at the evaluation (Orne, 1962). That is why the results over 36 are not construed. It is essential to notice the results under 36 because it might tell something about the treatment and the therapeutic alliance (Kuhlman, 2012).

In both scales the evaluation is carried out by putting a mark on the 10-cm-line where the left side illustrates the negative situation and the right side illustrates the positive situation. The patient measures each scale from the left side with a ruler and adds the centimeters together. Both metrics have a scale from 0 to 40.

2.5. Values available for this research

In this thesis, the ORS and SRS- measures were available in cases 1 and 2. According to those values, both cases can be considered successful (Figures 1 and 2). BDI and HDRS –values were

also detected and they are presented in the Table 3. The treatment success of the Case 3 was only evaluated by detecting the change of the BDI and HDSR-values at the beginning of the treatment and 6, 12 and 18 months after the treatment. According to those values, the treatment was not succeeded (Table 3).

TABLE 3. HDRS and BDI-values of depressed patients.

Measurement	Case 1	Case2	Case3
1. Measurement (at the beginning), HDRS	20	24	28
2. Measurement (6m from the beginning of the treatment), HDRS	13	7	25
3. Measurement (12m from the beginning of the treatment), HDRS	14	5	23
4. Measurement (18m from the beginning of the treatment), HDRS	6	2	21
1. Measurement (at the beginning), BDI	26	31	32
2. Measurement (6m from the beginning of the treatment), BDI	25	20	24
3. Measurement (12 m from the beginning of the treatment), BDI	14	14	16
4. Measurement (18m from the beginning of the treatment), BDI	8	7	14

Notes

a. HDRS=Hamilton Depression Rating Scale (Hamilton, 1960)

b. HDRS-scores: 10 – 13 (mild depression), 14 – 17 (mild or moderate depression), >17 (moderate or severe depression) (Hamilton, 1960).

c. BDI=Beck Depression inventory (Beck et al. 1961)

d. BDI-scores: 0 – 9 (no depression), 10 – 18 (mild depression), 19 – 29 (moderate depression), 30 – 63 (severe depression) (Raitasalo, 2007).

2.6. Process of the research

As mentioned before, evaluations for the reliability testing were made by three raters. One of the raters was Mr. Pekka Peura; a practical clinical psychologist and a family psychotherapist responsible of the development of the CTQS, and two graduate psychology students. Student raters

were trained by Peura for the application of the Q-technique with 6-hour training. After that, the student-raters watched videotapes of couple therapy sessions and made pilots of the sorting processes. The time used for the pilots was approximately 15 hours and it included 4 pilots. During that time and during the first five formal Q-sort-analysis, the students gave feedback about the CTQS to Peura for further development. Peura made corrections for the set and it was replaced with a new version after the first four pilots. In this thesis, 4 sessions out of 11 were rated with unmodified set, and 7 sessions with the modified one. The modified set differs from the old one in following items: item number 9's name was changed from "Therapists are distant and reserved" (Terapeutti on etäinen ja varautunut) to "Therapists are amenable and present at the emotional level" (Terapeutti on vastaanottavainen ja tunnetasolla läsnä). Item number 35's name was changed from "Therapist seeks exceptions for couples' trouble-illustrations" (Terapeutti etsii poikkeuksia pariskunnan ongelma-kuvauksille) to "There is discussion about clients' physical state" (Ruumiin toiminnoista, fyysisistä oireista tai terveydestä keskustellaan). Item number 54's name was changed from "Couples' expression is clear and structured" (Pariskunnan kommunikaatio on selkeää ja jäsentynyttä) to "Man's expression is clear and structured" (Miehen ilmaisu on selkää ja jäsentynyttä). Item number 66 was changed from "Therapist is openly calming" (Terapeutti on avoimen rauhoitteleva) to "Women's expression is clear and structured" (Naisen itseilmaisu on selkää ja jäsentynyttä). Due to a misunderstanding, the analysis of the first session of the Case 1, the two raters used the old set when the third rater used the modified one.

One pilot (rehearsal) of the CTQS-analysis was made from the fourth session of Case 3, when only the most and least characteristic values were detected. Although the analysis was not complete, the results from the extreme ends has been taken for this thesis because of their informative contents (Table 6).

2.7. Evaluating the reliability of the CTQS

Nine sessions altogether were taken under the reliability check. The inter-rater reliability rose from .32 to .60 when three sessions were evaluated. The first evaluations were made with three raters, and they can be considered as pilots. Also one pilot was evaluated with two raters and it gave .57 as agreement. The last five sessions were judged by two raters and they were analyzed with the modified set. The inter-rater reliability varied from .44 to .76, the average being .60.

3. RESULTS

The results will be presented case by case, describing the most descriptive features of the current process found with the CTQS. The results will be compared to the available ORS and SRS-values of the particular case. The names of the Q-items are expressed both in English and in Finnish for more clarity. Some passages are also made to clarify the category of the current Q-item. For more clarity, the passages are labeled with a session number and time. For example, (Session 1, 35:36) means that the passage occurred during the first session at time 35:36. The passages are transcribed and translated here from Finnish to English. In the quotations, the therapists appear in the text with abbreviations T1 (female therapist) and T2 (male therapist). The clients are pseudonamed as follows: In Case 1, the clients are Pam and Nolan (in passages: P and N), in Case 2, the clients are Emily and Jack (in passages, E and J) and in Case 3, the clients are Victoria and Conrad (in passages, V and C). The clients here were the couple, and in all cases, the depressed patient was the woman.

3.1. Description of the states of the analysis

After watching and sorting the sessions, the most salient processes in the current treatment were identified by the rater. The items identified were chosen for the moderately high ratings and items with little variability through time (Ablon et al., 2011), but also according to the interest of this research. Rater detected the processes of the chosen items throughout the couples therapy processes (Tables 2, 3 and 4). The ORS-values given by the clients were compared to their previous given SRS-values and it gave a standpoint for further analysis of the Q-items.

3.2. Case 1: Pam and Nolan

Pam and Nolan came for therapy because of the depression of Pam. At the first session, Nolan expressed that he had not understood Pam's state and what meant to be depressed. The session made him achieve new understanding (TABLE 4: Q-item 32, suom. Puolisot saavat uutta ymmärrystä tai oivalluksen) towards depression.

TABLE 4. Categories of the Q-sort-items during the therapy process of Pam and Nolan.

Q-item	Category (Session1)	(Session2)	(Session3)	(Session4)
Q-item 32: Couple achieves new understanding or insight (Suom. Puolisot saavat uutta ymmärrystä tai oivalluksen)	8	3	6	7
Q-item 94: Woman feels sad or depressed (Suom. Nainen on surullinen tai masentunut)	7	9	1	8
Q-item 99: Therapist questiones couple's view (vs. validates the patient's perceptions) (Suom. Terapeutti haastaa puolisoiden näkökulman (vs. validoi heidän havaintojaan))	8	2	3	5
Q-item 80: Therapist presents a specific experience or event in a different perspective (Suom. Terapeutti esittää tietyn kokemuksen tai tapahtuman toisesta näkökulmasta)	7	3	3	6
Q-item 65: Therapist restates or rephrases the patient's communication in order to clarify its meaning (Terapeutti selventää, ilmaisee toisin tai muotoilee uudelleen puolisoiden kommunikaatiota).	8	7	7	6
Q-item 48: Therapist uses outsourcing when talking about the problem (Suom. Terapeutti käyttää ulkoistamista ongelmien käsittelyssä).	3	8	6	5
Q-item 6: Therapist is sensitive to the couple's feelings, attuned to the couple; empathic (Suom. Terapeutti on sensitiivinen puolisoiden tunteille eli on empaattinen)	6	9	9	8
Q-item 95: Couple feels helped by therapy (Suom. Puolisot kokevat tulleensa autetuiksi)	9	6	8	9
Q-item 97: Couple is introspective, readily explores inner thoughts and feelings (Suom. Pariskunta havainnoi itseään ja tutkii mielellään sisimpiä ajatuksiaan ja tunteitaan tai keskinäistä vuorovaikutusta)	6	6	8	6
Q-item 92: Couple's feelings or perceptions are linked to situations or behavior of the past (Suom. Puolisoiden tunteet ja käsitykset yhdistyvät menneisyyden tapahtumiin)	7	7	7	4

Q-item 41: Attachement relationships, family background or family history is investigated (Suom. Kiintymyssuhteiden, perhetaustojen tai sukuhistorian vaikutusta pariskunnan elämään tutkitaan)	4	7	9	3
Q-item 22: Therapists use reflective discussion (Suom. Terapiaistunnossa käydään reflektiivistä keskustelua)	2	1	3	9
Q-item 17: Therapist is active in the interaction (Suom. Terapeutti on aktiivinen vuorovaikutuksessa)	6	4	5	5
Q-item 93: Therapist refrains from stating opinions or views of topics the patient discusses (Suom. Terapeutti on neutraali)	8	6	4	4

Notes
a. Placing to category nine signifies the item as extremely salient and characteristic when describing the session. Placing to category 1 signifies the item as extremely uncharacteristic or negatively salient. Category 5 means neutral or unimportant.

During the first two sessions, the couple expressed feelings of shame, guilt and depression (Q-item 71, suom. Puolisoilla on itsesyytöksiä; ilmaisevat häpeää tai syyllisyyttä, and Q-item 94, suom. Nainen tuntee itsensä surulliseksi ja masentuneeksi (vrt. hilpeäksi ja hyväntuuliseksi)). Pam seemed depressed and expressed also feelings of guilty. At the first session, therapists used confronting as a response to the couple’s thoughts and feelings about Pam’s depression (Q-item 99, suom. Terapeutti haastaa puolisoiden näkökulman (vs. validoi heidän havaintojaan)). The following passage represents an above-mentioned situation:

Session 1: 53:55

T1: You think that you are the only one studying health who suffers from mental problems?

P: ((laughs)) yeah

N: and drug problems

T1: Yeah. I understand what you are saying but really (1) no one is safe from these issues and they are part of life and (.) I thought that you haven’t made a choice of (2) being ill and these kind of problems entering into life are (2) issues that are not in your own hands (.) or under your own will (1) just like if you would be suffering from heartache or sore foot or (1) anything else so (2) no one would ask your right..

P: Yes (4) that is true

Therapists also used reframing in the descriptions of the current problems through the treatment, and they also reframed couple's thoughts which they brought up (Q-item 80, suom. Terapeutti esittää tietyn kokemuksen tai tapahtuman toisesta näkökulmasta and Q-item 65, suom. Terapeutti selventää, ilmaisee toisin tai muotoilee uudelleen puolisoiden kommunikaatiota).
Therapists' response to couples' thoughts towards depression was to use outsourcing on the second session (Q-item 48, suom. Terapeutti käyttää ulkoistamista ongelmien käsittelyssä). Depression was here taken from the context and it made it possible to detect it from outside:

Session 2: 33:06

T1: How clearly can you notice the landing of the "dark cloud"?
N: Well, you can notice it very clearly when you come home.

The ORS-values of Pam's rose between the first and second session from 23.9 to 30.6 and Nolan's from the 37.4 to 39.2, and they also expressed feelings of being helped throughout the treatment (Q-item 95, suom. Puolisot kokevat tulleensa autetuiksi). Couple was introspective throughout the process and willingly detected their inner thoughts (Q-item 97, suom. Puolisot havainnoivat itseään ja tutkivat mielellään sisimpiä ajatuksiaan ja tunteitaan keskinäisestä vuorovaikutuksesta).

One significant line of Pam's therapy was her state of depression. It varied considerably between the second and the fifth session (from category 9 to 1). Diminishing of the symptoms at the session three could have been due to the antidepressant medication Pam had started after the second session. The symptoms appeared again on the fifth session (category 8) -even though the ORS-values were high (35.9: Figure 1).

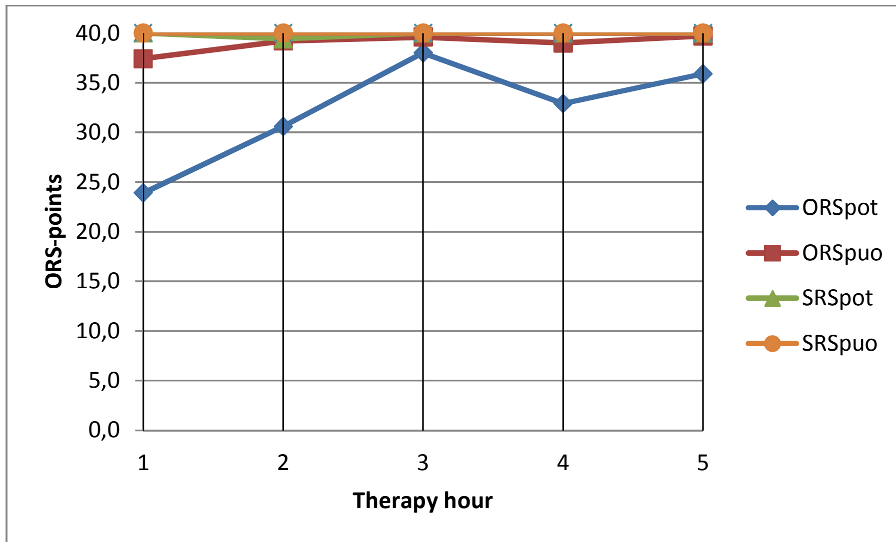

FIGURE1. Outcome Rating Scale and Session Rating Scale- scores of Pam and Nolan's couple therapy process (5 sessions).

Detecting the history of the couple and the impact of the early attachment relationships was one theme during the therapy (Q-items 92, suom. Puolisoiden tunteet ja käsitykset yhdistyvät menneisyyden tapahtumiin, and 41, suom. Kiintymyssuhteiden, perhetaustan tai sukuhistorian vaikutusta pariskunnan elämään tutkitaan).

On the fifth session, the therapists used reflective discussion (Q-item 22, suom. Terapiaistunnolla käydään reflektiivistä keskustelua) as a therapeutic tool. On the first session, the therapists were fairly active in the interaction (Q-item 17, suom. Terapeutti on aktiivinen vuorovaikutuksessa), but in general their activity was not a crucial part of this process. Therapists also expressed neutrality (Q-item 93, Suom.Terapeutti on neutraali) through the treatment, except on the third session, when it was placed in category 4 (somewhat characteristic or negatively salient).

One common ingredient in the therapy of Pam and Nolan was that the therapists were present at the emotional level, expressing friendliness and understanding (Q-item 6, Suom. Terapeutti on sensitiivinen puolisoiden tunteille eli on empaattinen. Q-item 9, suom. Terapeutti on vastaanottavainen ja tunnetasolla läsnä (vs. etäinen ja varautunut). The BDI-value of Emily was 26 at the beginning of the treatment but it had decreased to the value of 8 when measured 18 months after the beginning of the treatment (TABLE 3).

3.3. Case 2: Emily and Jack

The most common issue in Emily's and Jack's therapy was their experienced problems of communication. The sessions mostly focused on that specific theme (Q-item 23, suom. Dialogilla on tietty fokus). Emily felt that Jack did not talk to her in a way she expected and that Jack had not supported her in difficult situations, especially when she had had an abortion. Emily expressed anger and aggression (Q-item 84, suom. Puolisot ilmaisevat vihaisuuden ja aggression tunteita toisilleen) towards Jack during their treatment and he responded by withdrawing (Q-item 28, suom. Puolisoiden keskinäisessä vuorovaikutuksessa esiintyy toisen arvostelua, puolustelua, halveksuntaa tai keskustelusta vetäytymistä). Puolisoiden keskinäisessä vuorovaikutuksessa esiintyy toisen arvostelua, puolustelua, halveksuntaa tai keskustelusta vetäytymistä) and self-accusatory (Q-item 71, suom. Puolisoilla on itsesyytöksiä; ilmaisevat häpeää tai syyllisyyttä). Jack also seemed sad and depressed through the process (Q-item 20, suom. Mies vaikuttaa surulliselta ja masentuneelta), even though his ORS-values were high over the clinical cutoff (Figure 3).

Therapists were active in the interaction throughout the process (Q-item 17, suom. Terapeutti on aktiivinen vuorovaikutuksessa). At the beginning of the treatment, therapists questioned couple's thoughts concerning their problems but towards the ending, it was no longer a relevant ingredient. As the therapists used questioning on the third session (Q-item 99, suom.Terapeutti haastaa puolisoiden näkökulman (vs. validoi heidän havaintojaan), and the couple expressed resistance (Q-item 58, suom. Pariskunta vastustaa ongelmiin liittyvien ajatusten, reaktiotapojen tai motiivien tarkastelua).

One specific feature on the third session was also the therapists' own emotional conflicts with the current issue, and them intruding into the therapeutic relationship (Q-item 24, suom. Terapeutissa aktivoituvat omat asiat tai terapeuttiparin keskinäiset ristiriidat häiritsevät työskentelysuhdetta). Couple did not seem to get in touch with their problem and therapists expressed anger and frustration, which can be noticed on their reflective discussion (abbreviation below). Jack reacted to the expression of the therapists by withdrawing:

Session 3: 42:36

T1: and somehow I have this (2) towards Jack this some kind (2) of distress and that I feel like (.) how did Jack say (1) that (1) that in the level of thinking Jack has tried to do something so (.) something would change ((indicates to the relationship of Emily and Jack))

T1: That somehow I feel like (.) some kind of distress and some kind of (.) like <u>what is happening to our relationship</u> ((meaning Jack's and Emily's relationship))?

T2: Mmm (1) mmm

T1: [yes yes and he has no ways to approach Emily

T2: Exactly (1) exactly

T1: And it (1) and he still tries and tries with different ways and Jack must be a <u>master of trying</u> (3) <u>really</u>

T2: [yes and he should be given a medal, (1) mmm (.) mmm

T1: Yes it should and for real and really there are not many men [T2: yes (1) yes] or in general <u>no person</u> who can manage to try as much as Jack tries

T2: Yes, and is here a little bit like (1) a feeling like (1) another tries and tries a lot and the other waits for like when is it going to be (2) like in a certain way (1)[T1:but is it even possible to have that kind of trying which would be (2) for Emily] (4) yes (.) yes (2) exactly so is it even possible that there will be like someone that she is willing to accept

T1: Mmm mmm

T2: So this raises a question that how can this be faced (2) how can Emily meet Jack in this situation and give something like

T1: Emily also thinks that she wants this relationship to change and that they would have an opportunity (1) but what way will she give the opportunity (for change)

T2: Mmm mmm

T1: Because I think that Emily does not give any opportunities

T2: Now it seems like in a way it is one-sided that there comes suggestions but they are always rejected and (2) [T1: yes (1) yes] and how long] is he will be able to come up with these suggestions [T1: mmm mmmm] and (2) attempts for coming closer

T1: mmm (2) mmm (4)

J: ((Puts his hands in front of him)) But sometimes it feels unjustified in a way (2) that we talked (1) was it like after last time or time before that when we left (1) that there are a lot of things that that all of this is Emily's fault or (3)

T1: mmm mmm

J: or that Emily feels like she has been accused a lot from these things.

The SRS-value (Figure 2) of Emily decreased at the evaluation of the third session, but Jack's values increased. The SRS value of Emily at their third session was the second lowest during her treatment. The lowest was given by, when Jack did not come to their 18th session (24.5). That session was not analyzed for this thesis.

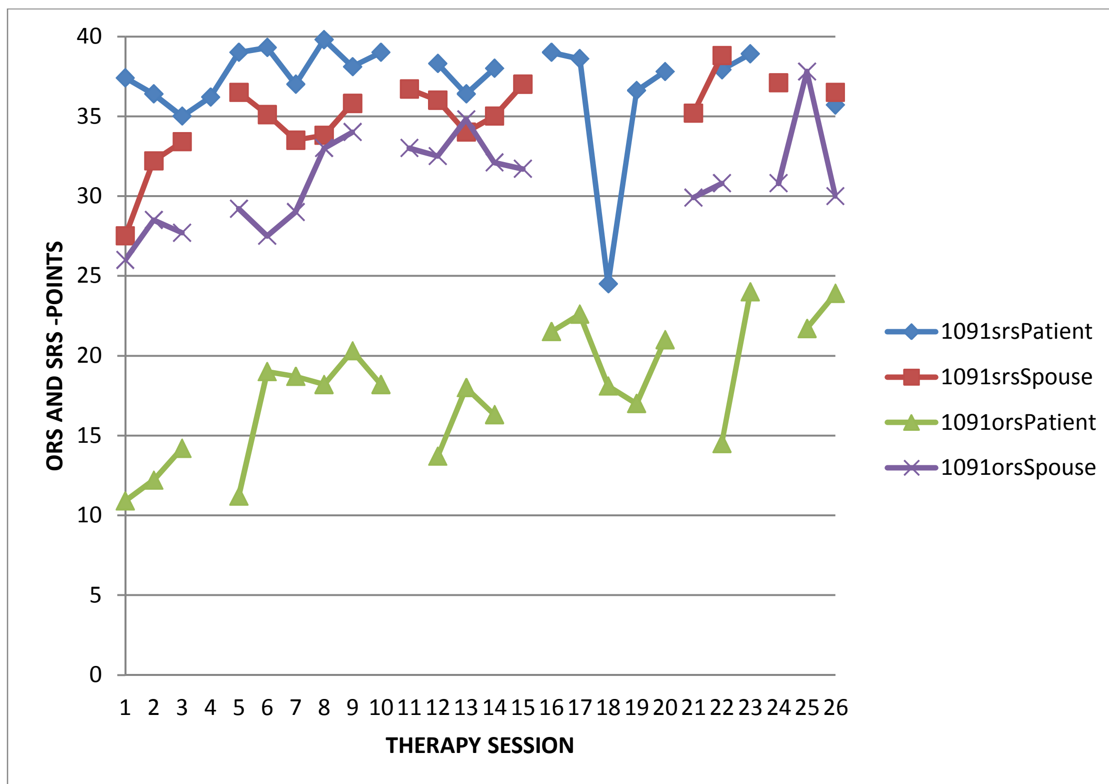

FIGURE 2. Outcome Rating Scale and Session Rating Scale scores of Emily and Jack's therapy process (26 sessions).

Therapists used reflective discussions through the treatment process (Q-item 22, suom. Terapiaistunnolla käydään reflektiivistä keskustelua). They encouraged the couple to try new ways of behaving with one another (Q-item 85, suom. Terapeutti rohkaisee pariskuntaa kokeilemaan uusia tapoja toimia toistensa tai muiden kanssa), but on the last session, it was no longer used. The couple seemed to have new understanding or insight at the beginning of their treatment (Q-item 32, suom. Pariskunta saa uutta ymmärrystä tai oivalluksen), but at their third session and from there on, it could not be noticed (Table 5). The couple was not interested in evaluating their inner thoughts, except on the first session (Q-item 58, suom. Pariskunta vastustaa ongelmiin liittyvien ajatusten, reaktiotapojen tai motiivien tarkastelua).The commitment towards therapy (Q-item 73, suom.

Pariskunta on sitoutunut terapiatyöskentelyyn) varied from session to session: On the second session, the commitment was placed to the category 8, on the third session it was placed on the category 4, on the 14th session to the category 8 and on the 26th session, it was placed to the category 4 again. The variation of commitment could be noticed from the SRS-scales also: Jack was not present in nine sessions and Emily missed five sessions.

At the first session, the couple expressed feelings of being helped (Q-item 95, suom. Puolisot kokevat tulleensa autetuiksi), but from there on, it could not be recognized.

Emily's ORS-value increased significantly (13.2 points) during the treatment even though the development was irregular (Figure 2). The ORS value was 23.9 at the end of the treatment, while her BDI-value was 7 points 18 months after the treatment had started.

TABLE 5. Categories of the Q-sort-items during the therapy process of Emily and Jack.

Q-item	Category			
	(Session2)	(Session3)	(Session14)	(Session26)
Q-item 23: Dialogue has a specific focus (Suom. Dialogilla on tietty focus)	7	9	8	8
Q-item 84: Couple express anger and aggressive emotions towards each other (Suom. Puolisot ilmaisevat vihaisuuden ja aggression tunteita toisilleen)	6	5	6	9
Q-item 28: There appears to be criticizing, defending, despise or withdrawal in the interaction of the couple (Suom. Puolisoiden keskinäisessä vuorovaikutuksessa esiintyy toisen arvostelua, puolustelua, halveksuntaa tai keskustelusta vetäytymistä)	6	5	6	8
Q-item 71: Couple is self-accusatory; express shame or guilt (Suom. Puolisoilla on itsesyytöksiä; ilmaisevat häpeää tai syyllisyyttä)	6	8	6	8
Q-item 20: Man seems sad or depressed (Suom. Mies vaikuttaa surulliselta tai masentuneelta)	6	7	6	6
Q-item 17: Therapist actively exerts control over the ineraction (e.g. structuring, introducing new topics) (Suom. Terapeutti on aktiivinen	8	7	6	6

vuorovaikutuksessa)				
Q-item 58: Couple does not examine inner thoughts, reactions or motivations related to their role in creating or perpetuating problems (Suom. Pariskunta vastustaa ongelmiin liittyvien ajatusten, reaktiotapojen tai motiivien tarkastelua)	2	8	7	7
Q-item 22: Therapists use reflective discussion (Suom. Terapiaistunnolla käydään reflektiivistä keskustelua)	9	7	7	6
Q-item 85: Therapist encourages couple to try new ways of behaving with others or with each other (Suom. Terapeutti rohkaisee pariskuntaa kokeilemaan uusia tapoja toimia toistensa tai muiden kanssa)	8	6	6	3
Q-item 32: Couple achieves new understanding or insight (Suom. Pariskunta saa uutta ymmärrystä tai oivalluksen)	7	4	3	3
Q-item 7: Man seems anxious or tense (Suom. Mies on ahdistunut tai jännittynyt)	3	7	4	8
Q-item 73: Couple is committed to the work of therapy (Suom. Pariskunta on sitoutunut terapiatyöskentelyyn)	8	4	8	4
Q-item 6: Therapist is sensitive to the couple's feelings, attuned to the couple; empathic (Suom. Terapeutti on sensitiivinen puolisoiden tunteille eli on empaattinen)	9	7	8	7
Q-item 99: Therapist questions couple's view (vs. validates the their's perceptions) (Suom. Terapeutti haastaa puolisoiden näkökulman (vs. validoi heidän havaintojaan))	7	8	1	6
Q-item 95: Couple feels helped by the therapy (Suom. Puolisot kokevat tulleensa autetuiksi)	7	1	4	3
Q-item 24: Therapist's own emotional conflicts inrude into the therapeutic relationship (Suom. Terapeutissa aktiviotuvat omat henkilökohtaiset asiat tai terapeuttiparin keskinäiset ristiriidat häiritsevät työskentely-suhdetta)	6	7	4	3

Notes
a. Placing to category 9 signifies the item as extremely salient and characteristic when describing the session. Placing to category 1 signifies the item as extremely uncharacteristic or negatively salient. Category 5 expresses neutral or unimportant in terms of the session.

3.4. Case 3: Victoria and Conrad

Victoria and Conrad came for therapy because of Victoria's depression. The discussion drifted quickly to the problems of their relationship, which appeared as a focus during their treatment process (Q-item 23, suom. Dialogilla on tietty fokus). Victoria felt that Conrad had not appreciated her at all during their 30-year marriage. One theme found from the process was that the couple's feelings were linked to the situations of the past (Q-item 92, suom. Puolisoiden tunteet ja käsitykset yhdistyvät menneisyyden tapahtumiin).

Victoria expressed a lot of anger and her behavior was aggressive towards Conrad during the treatment (Q-item 84, suom. Puolisot ilmaisevat vihaisuuden tai aggression tunteita toisilleen). Victoria expressed aggressive behavior towards the therapists at their fourth session (Q-item 1, Suom. Puolisot ilmaisevat negatiivisia tunteita (esim. kriittisyyttä, vihamielisyyttä) terapeuttia kohtaan). The next abbreviation is a part from the therapists' reflective discussion:

Session 4: 56:20

T2: Their situation might be that either one cannot listen to each other and and (.) Victoria has given (3) then is (2) the cork is open ((indicating to alcohol))

T1: [yes (1) yes (2) yeah

T2: so the cork is open and then

V: [<u>Tell me then how I'm I suppose to handle all this!</u>

T1: Well you do not have to

V: <u>I have to!</u> ((Pointing Conrad)) I have to

The therapists responded to the Victoria's aggressive behavior by having reflective discussion with each other (Q-item 22, suom. Terapiaistunnolla käydään reflektiivistä keskustelua). Although the interaction was difficult at times, the therapists did not comment on client's behavior during the sessions (Q-item 82, suom. Terapeutti kommentoi puolisoiden istunnonaikaista käyttäytymistä). Through the treatment, the couple did not seem to search for the approval of the therapists (Q-item 78, suom. Pariskunta etsii terapeutin hyväksyntää, kiintymystä tai sympatiaa).

Couple did not show respect or empathy towards each other (Q-item 40, suom. Puolisoiden välisestä suhteesta välittyy keskinäinen kunnioitus, kiintymys ja empatia), except on the first

session (Categoty 8). On the fourth session, the item was placed to category 1; their interaction was very distant and careless:

Session 4: 20:32

T1: Well what you said that you have become an alcoholic so what do you think that (2) what does it mean

V: Well it means that I drink too much sider (4) or too much and too much if I can say like when I think about (.) my friends and relatives they drink much more and they do not feel like being alcoholics but (.) the critique I receive (2) I feel like being some kind of a heavy drunk (3)

T1: Critique meaning Conrad (3)

V: Yes!

T1: So the critique comes from him?

V: And I feel so worried about you ((mimicking her husband)) (1) yeah right! (2) if a person is worried (.) if you see that the other one is in her breaking point and physically tired (2) usually then if you love the other (1) then you come and help her (2) so my point about love is very different than Conrad's (1)

T1: [:mmm

Victoria did not seem sad or depressed during the treatment (Q-item 94, suom. Nainen tuntee itsensä surulliseksi tai masentuneeksi (vs. hilpeäksi ja hyväntuuliseksi)), or at least it was not a crucial part of the process (categories 4 and 5). Her BDI values though did decrease during the treatment (Table 3). The couple resisted mildly processing the problems at the first and fifth session but on the second session, it was not that relevant (Q-item 58, suom. Pariskunta vastustaa ongelmaan liittyvien ajatusten, reaktiotapojen tai motiivien tarkastelua). At the first session, the couple seemed willingly detect their inner thoughts but after that, it was not that clearly noticed (Q-item 97, suom. Puolisot havainnoivat itseään ja tutkivat mielellään sisimpiä ajatuksiaan ja tunteitaan tai keskinäistä vuorovaikutustaan). One crucial theme was that the therapists used reflective discussion through the process (Table 6) as a therapeutic tool. They also expressed neutrality through the treatment (Q-item 93, suom. Terapeutti on neutraali).

TABLE 6. Categories of the Q-sort-items during the therapy process of Victoria and Conrad.

Q-item	Category (Session1)	(Session2)	(Session4)	(Session5)
Q-item 23: Dialogue has a specific focus (Suom. Dialogilla on tietty focus)	8	7	-	8
Q-item 92: Couple's feelings or perceptions are linked to situations or behavior of the past (Suom. Puolisoiden tunteet ja käsitykset yhdistyvät menneisyyden tapahtumiin)	7	8	-	8
Q-item 84: Couple express anger and aggressive emotions towards each other (Suom. Puolisot ilmaisevat vihaisuuden ja aggression tunteita toisilleen)	2	9	-	8
Q-item 1: Patient expresses verbally or non-verbally, negative feelings (e.g. critisicsm, hostility) toward therapist (vs. Makes approving or admiring remarks (Suom. Puolisot ilmaisevat negatiivisia tunteita (esim. kriittisyyttä, vihamielisyyttä) terapeuttia kohtaan (vs.tekevät hyväksyviä tai arvostavia huomautuksia))	3	5	9	5
Q-item 22: Therapists use reflective discussion (Suom. Terapiaistunnolla käydään reflektiivistä keskustelua)	9	8	-	9
Q-item 82: Couple's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously (Suom. Terapeutti kommentoi puolisoiden istunnonaikaista käyttäytymistä)	5	4	-	2
Q-item 78: Couple seeks therapist's approval, affection, or sympathy (Suom. Pariskunta etsii terapeutin hyväksyntää, kiintymystä tai sympatiaa)	3	3	1	3
Q-item 40: Respect, attachment and empathy can be noticed in the relationship of the couple (Suom. Puolisoiden välisestä suhteesta välittyy keskinäinen kunnioitus, kiintymys ja empatia)	8	3	1	4
Q-item 94: Woman feels sad or depressed (vs. joyous and cheerful) (Suom.Nainen on surullinen ja masentunut (vs. hilpeä ja hyväntuulinen)	4	5	-	4

Q-item 58: Couple does not examine inner thoughts, reactions or motivations related to their role in creating or perpetuating problems (Suom. Pariskunta vastustaa ongelmiin liittyvien ajatusten, reaktiotapojen tai motiivien tarkastelua)	6	4	-	6
Q-item 97: Couple is introspective, readily explores inner thoughts and feelings (Suom. Pariskunta havainnoi itseään ja tutkii mielellään sisimpiä ajatuksiaan ja tunteitaan tai keskinäistä vuorovaikutusta)	7	6	-	6
Q-item 93: Therapist refrains from stating opinions or views of topics the patient discusses (Suom. Terapeutti on neutraali)	8	6	-	8
Q-item 6: Therapist is sensitive to the couple's feelings, attuned to the couple; empathic (Suom. Terapeutti on sensitiivinen puolisoiden tunteille eli on empaattinen)	9	2	-	6
Q-item 20: Man seems sad or depressed (Suom. Mies vaikuttaa surulliselta tai masentuneelta)	4	6	9	7
Q-item 63: The couple deals with their conflicts from mild or positive point of view (Suom. Puolisot käsittelevät ristiriitojaan lempeästi ja myönteisesti)	9	3	1	6

Notes
a. Placing to category nine signifies the item as extremely salient and characteristic when describing the session. Placing to category 1 signifies the item as extremely uncharacteristic or negatively salient. Category 5 means neutral or unimportant.
b. Session 4 was a rehearsal made before the actual analysis for this thesis. Only the most and least characteristic ends (categories 1 and 9) were detected.

4. DISCUSSION

The aim of this Master's thesis was to describe the processes of two succeeded and one non-succeeded treatments of couple therapy for depression with a developing method Couple Therapy Process Q-set (CTQS; Peura, 2013). Another aim was to detect the actions of therapists towards the couples' emotional expressions through the process, and compare the results to the self-evaluations of the clients. It was assumed –when detecting both poor and good outcome-therapies –that there could be found factors which might tell, what works in therapy and what does not. The higher-level

ambition in this thesis was though, to explore the possible factors behind the succeeded and non-succeeded cases.

It was noticed that the Couple Therapy Process Q-set described profoundly the processes of couples who were treated for depression. The accuracy which can be achieved with the 100-item-system could capture the interaction of the naturalistic therapeutic situations in many dimensions, and that seems important when detecting the correlations between the treatment outcome and the process. Actually the correlation itself gets more dimensions when detected with the CTQS.

One factor found was that in the good outcome cases, the therapists used a variety of strategies, while facing the couples' emotional expressions. In the non-succeeded case, the therapists remained using a technique which did not seem to work. In the good outcome cases, the therapists varied the techniques depending on, what seemed to suit the best for each client. This supports the previously investigated fact (Ablon &Jones, 1999; Ablon & Jones, 2010). It was also noticed that in the case of succeeded therapy-processes, the therapists mostly reacted to the couples' emotional expressions by using a variety of techniques *at the beginning* of therapy processes, but towards the ending, only techniques that worked, remained. This seems reasonable: When the therapists learned to know the couple, they were able to adapt their techniques depending on their needs. One exception was in the case of Pam and Nolan, where the therapists used reflective discussion the most on their last session.

The most used strategies in these therapy-processes were reflective discussion, confronting, outsourcing, remaining neutrality, empathy stance and reframing. Strategies of the succeeded cases differed from each other by their theoretical background: They were not tied in one specific therapeutic orientation. This result verifies older research (Jones, Cumming & Horowitz, 1988; Ablon et al., 1998). As the family therapists in this research represented mainly on systemic therapeutic approach (with a special focus on dialogues and narratives: Seikkula, 2013), the use of previously mentioned techniques was expected. An interesting point still is what makes the usage of different strategies that effective? The resilience of the therapists seems to be at least one factor in the development of a therapeutic alliance, but also their therapeutic skills. The inflexibility of the therapists can be noticed from the case of Emily and Jack: on their third session, the therapist's own emotional conflicts disturbed the therapeutic relationship and the impact could be directly seen on the self-evaluations of the couple, but also on their behavior during the session. Still, in the case of Emily and Jack, but also in the case of Pam and Nolan –the therapists in general expressed empathic and friendly emotions during the sessions. This supports the fact that in succeeded therapies, the empathy is a common factor (Bryant, 1995; Lambert, 2001; Norcross, 2002).

The CTQS could capture, in addition f the therapists' actions –the characteristics, the motivation and the defensive structures of the clients. The effect of the clients' qualities to the therapeutic outcome should not be underestimated, and for example in the case of Victoria and Conrad, the behavior of the couple might have had an impact on the poor outcome of the therapy: Their interaction was mostly very distant and careless, and it seemed at times that the therapists did not have any options to break through it. They also did not seem to be motivated or willing to save their marriage and talk about the depression itself.

An interesting point in the cases of Emily, Jack, Victoria and Conrad was that the problems discussed on the sessions were mostly concerning marital distress, not the depression which was the ultimate reason for the therapy. This supports previous studies: The depression can be either a cause or a result from marital dysfunction (e.g. Mead, 2002; Rautiainen, 2003). In the case of Pam and Nolan, the themes on the sessions dealt mostly on Pam's depression and the possible causes of it, but the couple emphasized the knowledge what Nolan received about Pam's depression from the therapy: They felt that their relationship was feeling better when Nolan knew more about depression. This also highlights the importance of couple therapy, when treating depression.

4.1. Strengths, limitations and future research

This Master's Thesis offers valuable information because it is, presumably, one of the first researches made from couple therapy processes describing them with such a specific and detailed method. The CTQS can create a standpoint for detecting different components that appear in the couple therapy processes and in the long run, use the information when educating family therapists and other professionals dealing with marital problems. By detecting more cases of the poor and succeeded outcome cases, and searching for different causal actions (for example with the SRS and ORS), the results can be applied even in couple therapy-interventions. To get a more specific picture of the therapy processes, all sessions of the examinee therapy process should be watched and analyzed with the CTQS. One limitation for this thesis was though, the amount of watched sessions: For example in the case of Emily and Jack, the therapy process lasted 26 sessions from which only four were taken for this thesis. For more accurate and detailed description, all sessions should have been watched.

Another limitation concerns the difficulty of capturing the general atmosphere of the therapy sessions for the quotations: The atmosphere was only noticed when watching the sessions (for example Q-item number 23: Dialogue has a specific focus).

The evaluation itself takes approximately an hour and a half. The most reasonable time for making the evaluation is immediately after watching the session, to make sure that the content stays fresh in mind. That is why the CTQS is a time-consuming method, and it also demands a lot of concentration. The piles must obey the normal distribution and the items must be re-read many times during the evaluation.

The training for the CTQS was six hours long, and it was the first training for the developing method ever made. The first CTQS-evaluation was made together during the training day, but after that, students made the evaluations themselves, and the instructor (Peura) answered possible questions via e-mail or phone. Lack of supervised training might have had an influence on the low inter-rater reliability which did not quite reach the acceptable level ($r > .70$). Discussing about the meaning of each item, and making sure that everyone understood the items as it was supposed to, would have needed more time resources. Also more evaluations should have been made together as a team with the instructor, to make sure that the use of the set is understood profoundly. All this would have needed more resources.

One limiting factor in this research was my personal lack of experience about qualitative research. On the other hand, facing this method and exploring it as a “blank slate” has given me an expectation-free attitude. Another weakness was the lack of my therapy-education: Many of the items contained expressions and techniques that I have not yet studied, and absorbing them required resources that might have diminished the method-absorbing.

As it is said, the internal validity of the research raises when there is more than one researcher making the evaluations (Tindall, 1994). Even though the evaluations taken for this research were only rated by the writer, most of the sessions were watched with another researcher, and discussion about the seen sessions was made and the results were compared. If the results from all of the raters would have been taken here, if would have given a more precise and objective picture of the processes of the couples, but it would have also expanded this work to the limits not suitable.

Although this thesis was only a part of the developing process of the CTQS, it shows that the method is suitable in couple therapy settings. This supports the older research about Psychotherapy Process Q-set as being a renewable method (Jones et. al., 1993). Further research should though be made to explore all abilities of the CTQS. Although the results from this thesis are limited within the couple therapy for depression and they cannot be generalized, it has opened a path for the couple therapy research to achieve more valuable information about the correlations of the processes and the outcome.

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APPENDIX

Appendix 1

Symbols of the transcribes (Jokinen & Suoninen, 2000):

(.) Micro-break (under 1 second)

(2) The amount of time of the brake in seconds

[The beginning of the over spoken speech

] the end of the over spoken speech

<u>loudly</u> a part spoken loudly

(unsure) a part hard to hear from tape

((notice)) researcher's notion

Appendix 2

Quotations in Finnish

1. Pam and Nolan, Session 1, 53:55

T1: Sä oot maailman ainoo terveydenhuollon opiskelija jolla on mielenterveysongelmia?

P. ((nauraa)) niin

N: ja päihdetausta

T1: niin (.) joo ymmärrän kyllä ton sun pohdinnan mut et oikeesti ni (1) ni eihän kukaan oo suojassa näiltä asioilta sillä tavalla että elämäänhän ne kuuluu ja (.) mä aattelin että et kai sä oo niinku valintaa tehnyt siinä että no niin nyt niinku näin että (2) sairastaminen ja tämmösten asioiden elämään tulo on (2) semmosii juttuja jotka ei oo niinku tavallaan niinku omassa vallassa (.) eikä oman tahdon alla (1) ihan kun jos sulla ois sydän kipeenä tai jalka kipeenä tai (1) mikä muu paikka tahansa kipeenä ni (2) ei varmaan kukaan kyselis sun oikeutusta

P: niin (4) aivan

2. Pam and Nolan, Session 2, 33:06

T1: miten selkeästi sä huomaat kun se ”tumma pilvi”laskeutuu?

N: No kyllä se ihan selkeästi huomaa kun kottiin tulloo niin heti että

3. Emily and Jack, Session 3, 42:36

T1: ja jotenkin minulla niinku tulee tämmönen (2) Jackin puolelta semmonen hätä niinku että minusta niinku alkuun miten se Jack sano että (1) että tuota että (1) että niinku ajatustasolla Jack on yrittäny jotaki tehhä että (.) että niinku joku muuttus

T2: mmm (2) kyllä

T1: että niinku tulee vähän hätä ja niinku semmonen että mitä meidän parisuhteelle käy

T2: mmm (1) kyllä

T1: ja että hänellä ei oo keinoja enää enää lähestyä Emilyä

T2: aivan (1) aivan (1) kyllä

T1: Ja hän edelleen yrittää ja yrittää erilaisin että s Jackhän on varmaan yrittämisen mestari (3) ihan oikeesti!

T2:[kyllä] ja [siitä pitäis varmaan mitali antaa]mmm mmm

T1: kyllä pitäis ja ihan oikeesti antaa musta ihan oikeesti että harva mies tai yleensäkkään ihminen jaksaa noin paljon yrittää kun Jack yrittää

T2: joo, onko tässä pikkusen sit semmonen (1) semmonen maku kanssa että (1) toinen yrittää tai yrittää kauheesti ja toinen pikkasen oottaa niinku että millonka tulee sellasella (2) tietynlaisella (1) tavalla tarjottua [T1: mut et onko siinä mahollista tulla ees sitä semmosta yritystä et mikä niinku Emilylle niinku sitten (4) nii] nii (1) nii (1) joo (2) tätä juuri että onko se ylipäätään mahollista että tulee niin valmis semmonen minkä on ite valmis hyväksymään sit että tää on oikee juttu että tän mä hyväksyn

T1:mmm (1) mmm

T2: että herääkin kysymys että (1) millä tavalla tätä pystyis lähtee vastaan myös sitten (.) Emily tässä tilanteessa] ja että antaa sitä semmosta niinku (2) jotain

T1: [kyllä (2) kyllä (1) että missähän]

T1: Emilylläkin se ajatus on että hän toivois tähän suhteeseen muutosta tulisi ja että heillä ois vielä mahdollisuus (1) nii millä lailla Emily antaa sen mahdollisuuden

T2:mmm mmm kyllä

T1: koska minusta kuulostaa ettei Emily anna minkäänlaista mahdollisuutta

T2: nyt se kuulostaa aika lailla toispuoleiselta tää paino sillä lailla että siellä tulee ehdotuksia mutta kun ne tyrmätään ja (2) mutta nyt tuntuu myös että se (2) Jack on vähän epävarma että mitä tehä (1) että miten pitkään hän jaksaa heittää näitä ehdotuksia ja (2) lähestymisiä

T1: [niin (.) niin (1) mmm (.) mmm (.)mmm (4) mmm

J: ((laittaa kädet puuskaan)) mut tuntuu se vähän epäoikeudenmukaiselta tavallaan että (2) sekin me puhuttiin (1) oliks se nyt viime vai toissa kerralla kun lähettiin että niinku hirveesti tulee niinku semmosia asioita niinku että vika onkin Emilyssä tai (3)

4. Victoria and Conrad, Session 4, 56:20

T2: heidän tilanteensa lienee sellainen ettei kumpikaan pysty kuulemaan toinen toistaan ja

T1: [joo (1) joo]

T2: ja (.) ja tuota Victoria on antanut (3) sitten että (2) on korkki auki

T1: joo

T2: Siis korkki auki ja sitten tuota

V: <u>[Kertokaa mulle sitten miten mun pitää jaksaa]</u>

T1: no ei sinun ole pakko

V<u>: on pakko</u> (osoittaa Conradia) on pakko

5. Victoria and Conrad, Session 4, 20:32

T1: no mitä kun sää sanoit että sä olet alkoholisoitunut niin mitä tuota sä siitä aattelet että (2) mitä te tarkottaa sinun kohalla

V: no se tarkottaa minun kohalla sitä että mä otan siideriä liikaa (4) tai liikaa ja liikaa jos mä voin sanoa näin että mitä mä nyt seuraan sivulla (.) nii mun ystävistä ja tuttavista ja sukulaisista juo paljon enemmän ja ei koe olevansa alkoholisteja mutta tuota (.) kyllä se kritiikki mitä mä siitä saan niin (2) kyllähän mä koen olevani pahimmasta päästä oleva <u>juoppo</u> (3)

T1: kritiikki niin sä katot Conradia (3)

V: <u>niin!</u>

T1: sieltäkö se tullee se kritiikki

V: <u>ja kun minä olen niin huolissaan</u> <u>sinusta</u> (matkii miestään) (1) <u>just juu!</u> (2) jos ihminen on huolissaan niin (.) jos näkee että mä oon katkeamispisteessä ja fyysisesti väsyny (2) ni kyllä yleensä sillon jos toista ihmistä rakastaa (1) ni tulee auttaa (2) siis mun rakkauskäsitys on niin erilainen kuin Conradin (1) mmm

T1: [mmm]