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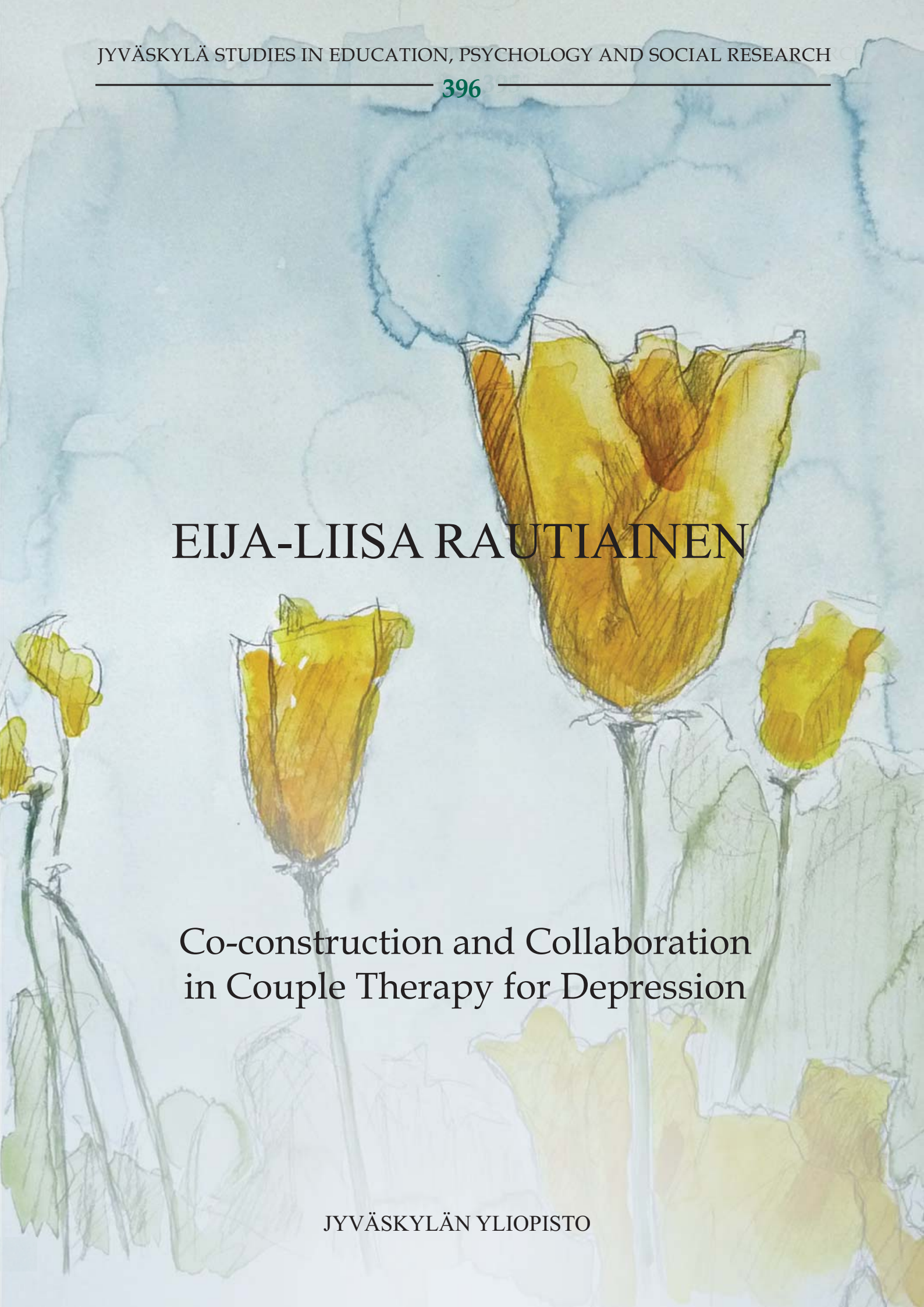

EIJA-LIISA RAUTIAINEN

Co-construction and Collaboration in Couple Therapy for Depression

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Eija-Liisa Rautiainen

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UNIVERSITY OF JYVÄSKYLÄ
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Co-construction and Collaboration in Couple Therapy for Depression

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ABSTRACT

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Finnish Summary
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This thesis aims at developing couple therapeutic work with depression in the context of mental health outpatient care. It reports on and draws conclusions from two studies. The data for the first study consisted of videotaped and transcribed couple therapy sessions, which were analyzed using narrative analysis. In this study the question was: How do couples in this context co-construct narratives of depression? In the second study the aim was to include both clients and therapists in a collaborative evaluation of the entire couple-therapeutic process. The data for this study consisted of videotaped and transcribed co-research interviews with both clients and therapists. The questions here were: What was helpful, what was not helpful, and what could have been done differently? The study applied Grounded Theory methodology. In the first study it was found that couples co-construct narratives of depression each in their own way. In the second study it was found that many clients experienced couple therapy for depression as helpful to them. Nevertheless, difficulties with the therapeutic work emerged, both for the clients and the therapists. Taken together, the studies suggest that it is important to negotiate with the couple regarding the focus of the therapeutic work: is it depression, is it the couple relationship, or is it both of these? It was also concluded that co-research interviews can be used in developing clinical work, in psychotherapy training courses, and in psychotherapy research.

Keywords: couples therapy, major depression, collaboration, narrative analysis, Grounded Theory

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CONTENTS

LIST OF ORIGINAL PUBLICATIONS

I Rautiainen, E-L., & Aaltonen, J. 2010. Depression: The differing narratives of couples in couple therapy. The Qualitative Report, 15, 156-175**.**

II Rautiainen, E.-L., & Seikkula, J. 2009. Clients as Co-researchers: How Do Couples Evaluate Couple Therapy for Depression? Journal of Systemic Therapies, 28, 41 – 60.

III Rautiainen, E.-L., & Seikkula, J. 2010 Focusing on therapists in co-research interviews: How do therapists see couple therapy? Accepted for publication in Journal of Systemic Therapies.

1 INTRODUCTION

This thesis deals with couple therapy for depressed persons and their spouses in the context of mental health outpatient care. Its general aim is to develop work of this nature. There are two parts in the thesis. The first part deals with a study of couple therapy sessions, which were examined in order to see how couples co-construct narratives of depression within such sessions. The second part deals with interviews in which couples and their therapists talked about their experience of couple therapy, after termination of the therapy. The interviews were studied in order to find out how both clients and therapists evaluated the therapeutic process they had undertaken together.

One of the goals for the thesis was to develop everyday clinical practice. It was important for me as a practitioner-researcher to arrive at appropriate research questions from the perspective of my clinical work with my colleagues. The hope was that such research could enrich our work in outpatient care, and I, personally, was keen to integrate my clinical experience with the research work. Another aim of this study was to bring psychotherapy research closer to the everyday work of therapists. Interviewing therapists while their clients were present and having them present while interviewing their clients, was a way to include them in the research process in a new way. This was the focus of the second part of this study.

This thesis is divided into two separate parts. I first began to study couple therapy sessions with couples facing depression and I became interested in the couples' ways of constructing narratives together. The first part of the study reported here thus emerged from a local project for developing the treatment of depression used in my working place (a psychiatric outpatient clinic of the Department of Psychiatry at Kuopio University Hospital, Finland) in a more family therapeutic direction. The ways of working with depressed persons in this outpatient clinic have up to now been mostly individually oriented. Taking into account the relational nature of depression and the ways in which depression affects the close relationships – and in turn how close relationships can impact on depression – I , together with the family therapists working in the outpatient clinic, wished to develop systemic ways of working with

depressed patients and their spousal partners. The project in question aimed at finding ways to promote such a new approach. Thus the family therapists, working collaboratively, studied couple therapy for working with depression; co-workers and colleagues were informed about this new way of treating patients, seminars were arranged, and a booklet was written on couple therapy. The booklet was to be given to new patients to inform them of the possibility of this treatment option. The first part of the present thesis is based on the research constituent of the project mentioned above.

The first project served as a pilot study for a larger project. Some years after the first project, a new research project called Dialogical and Narrative Processes in Couple Therapy for Depression was initiated. This project aims at both studying the outcome of couple therapy for depression and developing therapeutic work. The project involves collaboration between the Department of Psychology in the University of Jyväskylä, Finland, and three centers around Finland: Pohjois-Savon sairaanhoitopiiri (Hospital District of Northern Savo), Länsi-Pohjan sairaanhoitopiiri (Hospital District of Western Lapland) and Helsingin ja Uudenmaan sairaanhoitopiiri (Hospital District of Helsinki-Uusimaa). My responsibility in this project has been to conduct the evaluation interviews with clients and therapists. I took on this work because of my interest in both clients' and therapists' perspectives on what they find helpful in couple therapy for depression.

This study does not aim at studying the outcome of couple therapy. The emphasis is on the co-construction of an understanding of the therapeutic processes. Psychotherapy is seen as collaborative practice (e.g. Anderson, 2001, Seikkula & Trimble, 2005, Gergen, 2006). The overall aim has been to learn from the clients, bearing in mind that even though therapists are aware that they learn about therapy mostly from their clients, there has been surprisingly little research on this topic (Stahl, Hill, Jacobs, Kleinman, Isenberg & Stern, 2009).

In the second part of the study reported here, psychotherapy was studied as a whole. The participants in the therapeutic process were asked to reflect on and to evaluate their experience after the therapy had ended. Another approach to studying client experiences of therapy could be to study moment-to-moment in-session experiences (e.g. Henretty, Levitt & Matthews, 2008, Williams & Levitt, 2008). However, the approach to psychotherapy research adopted in this study could be seen as taking better into account the idea of psychotherapy in everyday life (Dreier, 2008). Psychotherapy is part of people's everyday life, and it cannot be useful unless clients can make it work outside the therapy room. Asking about experiences after the entire therapeutic process offers us a view of therapy as part of one's lived life. In addition, the novelty of co-research approach lies in the fact that not only the clients but also the therapists were invited to talk about their experience of the therapy, all within the same interview.

In this Introduction, the Finnish context of the treatment of depression will first of all be introduced. After that, there will be an account of couple

therapeutic approaches for depression. Finally, the collaborative approach to psychotherapy and to psychotherapy research will be presented.

1.1 The Finnish context of treatment for depression

Depression is a major challenge for the health care system. According to some authors the prevalence of depression has not increased in Finland (Gould et al., 2007, Lönnqvist, 2009). On the other hand, as Karlsson (2009) points out, there are methodological problems in studying this question. Up to now, no studies have been conducted using the same (accurate) measures to measure the prevalence of depression at two different times. Many indirect indications suggest that the problems caused by depression have increased. The use of antidepressant medication has increased rapidly (Voipio & Paakkari, 2007). In addition, there has been an increase in the number of medical visits to primary health care centers due to mental problems (Gould et al., 2007). At the same time, psychiatric disorders have become the most common reason for taking sick leave and for drawing disability pensions (Harjajärvi, Pirkola & Wahlbeck, 2006). In 2006 the number of persons retiring on a disability pension due to depression was 1.5 times that in the mid-1990s (Gould et al., 2007).

In Finland, mental health services have undergone major changes in recent decades, both administratively and structurally. Overall, the responsibility for organizing mental health services has been transferred from central government to the municipalities. In addition to this, there has been a shift towards emphasizing outpatient services as an alternative to inpatient services. The economic depression of the 1990s, which coincided with structural changes in health care provision, contributed to underdevelopment in the outpatient care system (Wahlbeck & Pirkola, 2008). A research project called Merttu, which aimed at examining the effectiveness of the mental health services provided for the working-age population in Finland, concluded that "despite the long-standing efforts to further develop outpatient care, the diversity of mental health services is still unsatisfactory in many municipalities" (Harjajärvi, Pirkola & Wahlbeck, 2006, p. 12.)

In the 1980s there was a national project which aimed at developing the treatment of psychotic patients; this was called the Schizophrenia project. Within this project it was recommended that family members should be included as part of the treatment from the very beginning. Starting from this project, ways to help psychotic people and their families have been developed, and good results have been achieved (Skitsofreniaprojekti, 1981-1987). The development of family therapeutic work at this time concentrated on aspects connected with psychosis, with no focus on treatment for depression. All of this has meant that there remains an urgent need to develop the outpatient treatment of depression.

Currently, there are both regional and national projects aiming at studying and developing treatment for depression. In the University of Kuopio there is a follow-up study of patients suffering from depression (e.g. Viinamäki et al., 2008). In addition to this, research focusing on the biological effects of individual psychotherapy for depression has been initiated at the University of Kuopio (Lehto et al. 2008). The Vantaa Depression Study (Vantaa Depression Study 2008) is a prospective, naturalistic cohort study of psychiatric out- and inpatients (secondary-level care) with a new episode of major depressive disorder. The Ostrobothnia Project (Ostrobothnia Project) is a broad regional mental health development project, implemented in the Ostrobothnia region by three Finnish hospital districts, i.e. Vaasa, South Ostrobothnia and Central Ostrobothnia. The objective is to develop mental health and substance-misuse work for the promotion of population mental well-being. The targets are the residents of the area, their life cycle, the service system around them, and their environment. One part of this project has focused on depression. At national level there is an ongoing project called Masto, conducted by the Ministry of Social Affairs and Health in the period 2008–11. It aims to reduce depression-related work disability in Finland. Another national project, of which the present study is a part, is the project Dialogical and Narrative Processes in Couple Therapy for Depression (DINADEP). It aims at developing couple therapy for depression.

1.2 An interpersonal view of depression

According to an interpersonal view of depression, depression not only has interpersonal features and consequences, but is also fundamentally interpersonal in nature. A good relationship can provide a buffer from depression, while difficult relationships can cause or maintain depression. The situation can be challenging, in the sense that one experiences a need for the very people one's depressive symptoms seem to alienate (Joiner, Coyne & Blalock, 1999). Relational problems are common among couples (e.g. Beach & Gupta, 2003) where one partner has been diagnosed as depressed. Taking into account the interpersonal mechanisms and consequences of depression, there is a risk of a vicious circle of couple distress and depression. The relationship between couple distress and depression is reciprocal: a partner's depression may be the source of interpersonal discord, while on the other hand, couple distress may initiate, maintain, or exacerbate depression (Beach & Gupta, 2003).

There has not been much research on the consequences of depression for families (van Wijngaarden et al., 2009). In one early study, Fadden, Bebbington and Kuipers (1987) found that the spouses of depressed patients did not know how to deal with the mood disturbance; they felt that they were unable to see things from the depressed person's point of view, and had not been given advice or support from professionals. Coyne et al. (1987) found out that a

depressed person's symptoms – such as a lack of interest in social life, fatigue, hopelessness and worrying – burdened their spouses. In their study, 40 % of the partners living with a depressed person were distressed themselves, to the extent that they themselves needed psychological intervention. The authors recommended developing therapeutic interventions for the partners. According to a recent study (van Wijngaarden et. al., 2009) the consequences of depression and schizophrenia for the caregiver are surprisingly similar. The authors conclude that families in which where there are depressed adults need more support and attention from health care systems.

Harris, Pistrang and Barker (2006) studied couples' experiences of depression and the spouses' ways of trying to help their depressed partners. The spouse was seen as the most important source of support during the episodes of depression. Nevertheless, it frequently happened that the spouses did not know what to do for, or how to support the depressed person. Sometimes what was wanted by the depressed person did not appear to be helpful, for example in the case of a desire not to take part in a daily routine. In addition, the needs of the depressed person changed over time; what could seem beneficial one day might be less welcome the next day. One spouse described the situation as "walking on eggshells". Communication was an important theme. The ability to talk was considered to be very important, yet at the same time there were times when the depressed person was almost unable to talk. A feeling of "working together" and managing one's feelings as a helper were seen as important by the spouses of depressed persons. Trust, acceptance, and open communication were regarded as important. The authors emphasize that close relationships in depression can be a key source of support during the course of the disorder, not merely a source of strain (which has been the emphasis in previous studies).

Sandberg, Miller and Harper (2002) interviewed 16 older couples without depression and 16 older couples in which one spouse had depressive symptoms. In this qualitative study the researchers focused on marital interaction as it relates to depression. Central themes in the grounded theory analysis applied were marital and family interaction (spouse help and problem solving, communication, and conflict and confrontation), the experience of depression (depression and family of origin, depression and marital interaction) and coping and recovery. The study found that depressed couples frequently mentioned marital conflict and confrontation, whereas nondepressed couples did not. Frequent themes in depressed couples' stories were isolation, hopelessness, and frustration. One of the most common coping mechanisms mentioned was a "get tough" attitude, meaning a "don't worry about what you can't change" perspective. This highlights the importance of a sense of personal control in dealing with depression in later life, as an alternative to feelings of hopelessness and helplessness. The results also emphasize the importance of social support: couples dealing with depression found social support very important for them. The authors recommend a holistic or systemic approach in helping couples with depression.

1.3 Couple therapy for depression

Several different couple therapy approaches to depression have been developed; these include interpersonal couple therapy (Foley, Rounsaville, Weissman, Sholomskas & Chevron, 1989), cognitive-behavioral couple therapy (Beach and O'Leary, 1992), cognitive-systemic couple therapy (Teichman, Bar-el, Shor, Sirota, & Elizur, 1995), communication-focused couple therapy (Emanuels-Zuurveen & Emmelkamp, 1996), systemic couple therapy (Jones & Asen, 2000), and emotion-focused therapy for couples (Dessaulles, Johnson & Denton, 2003).

Beckerman (2001) studied 23 couple therapists' ways of dealing with depression in the United States. According to her results, couples facing depression usually suffer from emotional distance and alienation, and nondepressed partners experience anger and frustration towards their depressed partners. The therapists found that the most important areas to assess were suicidal ideation, and how the couple's relationship could either contribute to or be used to mediate the depression. The therapists most frequently used Behavioral Marital Therapy or Emotionally Focused Therapy. Many of them integrated a wide variety of approaches in their work with the couples.

Denton, Golden and Walsh (2003) conducted a review of literature concerning marriage and depression and couple therapy for depression. They noted that research in this field had become duplicative, and that there had been few new scientific contributions in the past decade. Recent publications consisted of literature reviews and book chapters rather than data from well-designed studies. (Examples of the literature reviews are Kung, 2000; Mead, 2002; Gupta, Coyne and Beach, 2003 and book chapters by Beach & Gupta, 2003; Cordova & Gee, 2001.) Denton et al. summarize the situation as follows: "Couple therapy appears promising as a treatment of depression but couple interventions specially designed for the treatment of depression are needed, along with controlled trials examining the combination of couple therapy and pharmacotherapy versus monotherapy." (p. 29).

Barbato and D'Avanzo (2008) performed a meta-analysis of eight controlled trials (Foley et al., 1989, Jacobson et al., 1991, Beach & O'Leary, 1992, Teichman et al., 1995, Emanuels-Zurveen & Emmelkamp, 1996, Emanuels-Zurveen & Emmelkamp, 1997, Leff et al., 2000, Dessaulles et al., 2003) including 567 subjects. The reviewed studies had many limitations: small sample sizes, limited assessments at the end of treatment or short follow-up, unclear sample representativeness, and heterogeneity among studies. According to the analysis no difference could be found between couple therapy and individual therapy. The researchers found that the evidence for improvement in couple relationships may favor the choice of couple therapy when relationship distress is a major problem. The authors concluded that the evidence on the efficacy of couple therapy as a treatment for depression is still inconclusive, and they

called for more and higher-quality studies. In addition, Whisman and Uebelacker (1999), Kung (2000), Mead (2002), Gupta et al. (2003) and Gilliam and Cottane (2005) emphasize the need to further develop couple therapy for depression.

According to Snyder and Whisman (2003), couple therapists find that some of the most difficult situations in their clinical practice occur when they seek to help couples with both relational and "individual" problems (emotional, behavioral, or health-related). In their conclusions they suggest that in these challenging situations therapists need to use integrative ideas across diverse theoretical orientations, and to pay attention to differences in the urgency of individual and relationship issues and their progression during therapy. According to Gilliam and Cottone (2005) couple therapy could be a viable alternative to individual therapy when the depressed person has not responded well to individual therapy. They also suggest combining couple therapy with individual therapy, and incorporating within couple therapy some unique components directly addressing depression.

As was mentioned, couple therapy models for depression originate mostly from cognitive-behavioral, interpersonal and emotionally focused theories. The novelty of this study is to approach this work from social constructionist and collaborative direction.

1.4 Collaborative approaches to psychotherapy

The field of family therapy has undergone changes in recent decades. According to Dallos and Draper (2005) the third wave of development in family therapy has been based on social constructionist ideas. The focus has moved from models and techniques to meanings, language, and the uniqueness of every family. In several writings Gergen (e.g. 2000) has described this shift in the psychotherapy field. Instead of one truth there are multiple truths; the interest has shifted from individual to relational meanings, and from expertise to collaboration (Gergen, 2000).

Collaborative approaches to psychotherapy have their roots in social constructionist ideas. According to Burr (2003) social constructionism is a movement which has arisen from many disciplines and intellectual traditions. It is influenced by sociology, social psychology, the humanities, literary criticism, and philosophy. Its cultural backdrop is postmodernism. Postmodernism rejects the idea of grand theories or metanarratives by which we could achieve an understanding of the world. Instead, postmodern thinking emphasizes the co-existence of a multiplicity and variety of situation-dependent ways of life (Burr, 2003).

According to Gergen (2006), important arguments for social constructionism are the social origins of knowledge (knowledge of the world and of the self have their origins in human relationships), the centrality of

language (language as a pre-condition for thought and as a form of social action), and the politics of knowledge (concepts of truth and objectivity have been replaced by notions of practical outcomes). In a similar vein, following Gergen, Burr (2003) emphasizes the historical and cultural specificity of knowledge (seeing all forms of knowledge as historically and culturally specific) and thus focuses on interaction and social practices within a social constructionist orientation. Gergen (2006) points out that in a therapeutic orientation, social constructionist dialogues favor four major movements, namely movements toward flexibility, consciousness of construction, value-relevant practice, and a new range of practices. Concerning practices, Gergen (2006) lists five shifts: from mind to discourse, from self to relationship, from singularity to polyvocality, from problems to prospects, and from insight to action.

In the family therapy field, several authors and therapists have developed work along these lines. The approaches may be collaborative (Anderson 2001), reflective (Andersen, 1991), dialogical (Seikkula, 2008), or narrative (White & Epston, 1990; White, 2007); all have in common that they make use of social constructive ideas involving collaboration. As compared to the concept of an alliance, collaborative approaches emphasize the mutual nature of therapeutic relationships. Therapists are not seen merely as delivering interventions; they are part of a mutual process of change in collaboration with their clients (Seikkula & Trimble, 2005).

Anderson (2001) describes her collaborative approach to psychotherapy as aiming to invite, create, and facilitate a generative process, achieved through collaborative relationships and dialogical conversations. Transformation is inherent in this process; no importance is attached to the direction, content, or product of this transformation. Knowledge and language are relational, generative, and local. There are multiple realities and truths. The client and the therapist become conversational partners while engaging in dialogical conversations and collaborative relationships. In this approach, the concept of not-knowing has highlighted clients as experts. With the term being public Anderson refers to the therapist's way of talking about his or her ideas. Therapy is seen as a process of mutual transformation; both clients and therapists change during it. The focus of the therapy is everyday ordinary life. The uncertainty of life and of therapeutic processes has to be accepted and acknowledged (Anderson, 2001).

In the reflective approach to psychotherapy, Andersen (1991) sees it as important for the therapist to ask appropriately unusual questions, to listen to openings in the clients' talk, and to constantly reflect on the therapist's own contribution to the conversation. He sees the therapeutic conversation as a series of exchanges of ideas. Work of this nature began with developing the reflective teams and continued with the creation of possibilities for reflective positions and processes in more general ways. By separating the positions of listening and talking, therapists create space for inner and outer dialogues for both clients and therapists.

The dialogical approach (Seikkula, 2008; Seikkula et al., 2006; Seikkula & Olson, 2003) was first developed with families and social networks that were facing psychotic crises. It is both a way to organize mental health helping systems and a way to conceptualize therapeutic work. The approach has been used in various contexts in social and helping fields, both in Finland and in other countries. Central elements of the thinking here are the provision of immediate help, a social network perspective, flexibility and mobility, responsibility, psychological continuity, tolerance of uncertainty, and dialogism (Seikkula et al., 2006). In recent writings Seikkula (2008) has focused on the present moment of family and network therapy; how can the therapists be present and responsive to every utterance?

In the narrative approach to therapy Epston (1999) has conceptualized therapy as co-research. Within his project, clients together with their therapists jointly developed alternative ideas for families in which children and adolescents had life-threatening illnesses. The purpose of the process in this case was to help clients access their own knowledge, and to open space for the emergence of alternative life stories. Madsen (2009) has used Epston's ideas in developing family-centered services in the USA. He sees the co-research work in question as a partnership in which both clients' and clinicians' resourcefulness can be drawn on. Professional expertise consists of the ability to ask questions that help clients to envision and to develop their preferred directions in life. Nevertheless, clinicians also have wisdom that can be useful to their clients. Madsen sees it as important to first highlight the clients' wisdom, then ideas jointly developed in the meeting, and only then ideas based on professional experience.

1.5 Developing collaborative psychotherapy research

Taking into account the collaborative nature of psychotherapy, research on psychotherapy could also be done in a collaborative way. Nevertheless, this kind of approach to psychotherapy research is something that is only now emerging. Recently, more attention has been paid to clients' experiences of therapy. In addition, there have been calls for more research on therapists' views of therapy. There have not been many attempts to combine these two views.

Duncan and Miller (2000) have highlighted the importance of working in a client-directed and outcome-informed way. They have developed two scales, The Outcome Rating Scale and The Session Rating Scale (Miller & Duncan, 2004), which help the therapists to monitor the change that is taking place in the clients' situation, and the fit of the therapy with the clients' expectations concerning the relationship and the change. These scales were used in the DINADEP project.

In a review of qualitative studies of clients' experiences, Hodgetts and Wright (2007) found that relatively little research had been conducted on clients' experiences of therapy, despite recognition of the importance of this aspect. They reviewed studies concerning clients' general experiences in a mental health setting, clients' therapy-specific experiences, and experiences within different psychotherapies. They concluded that there is increasing interest in the views of users, and noted growing acknowledgement of the value of these views in providing an understanding of therapy. This tendency has also been referred to by McLeod et al. (2009). Working along similar lines, McKenna and Todd (1997), Kühnlein (1999), Messari and Hallman (2003), Lilliengrein and Werbart (2005), and Levitt, Butler and Hill (2006) have studied clients' views of psychotherapy in different contexts.

Timulak (2007) carried out a qualitative meta-synthesis of clients' experiences of the impacts of helpful significant therapy events. Nine core categories emerged, namely (1) awareness/insight/self-understanding, (2) behavioral change/problem solution, (3) empowerment, (4) relief, (5) exploring feelings/emotional experiencing, (6) feeling understood, (7) client involvement, (8) reassurance/support/safety, and (9) personal contact. According to Timulak, setting up mutually exclusive categories was difficult, since some primary categories would easily fit into more than one metacategory. He nevertheless saw the category list as a conceptual framework for client-identified helpful events in therapy.

Helmeke and Sprenkle (2000) studied clients' perceptions of pivotal moments in couple therapy and compared them to therapists' perceptions. They found that there was a lack of congruence between the spouses, and also between the therapist and the clients. In addition, the pivotal moments were more often connected to a change in the reporting spouse than to a change in the relationship. According to this research, this finding highlights the individualized nature of couple therapy; the spouses found different moments to be important to them, and they connected the change more to themselves than to the relationship. It also emerged that the therapist seldom identified the same moments as pivotal as did either of the spouses. The authors conclude with the observation that we as researchers can greatly deepen our understanding of couple therapy in the course of engaging our clients as partners in research.

So far, there have only been a few studies in which therapy processes have been analyzed using a reflective and collaborative approach. Edwards, Bermudez, Canady and Protinsky (2000) interviewed a therapist in the presence of a couple, and at the end of the interview posed questions to the couple. This was done during the actual therapeutic process, in the last part of the session. They suggest that clinicians can use this approach to (for example) decrease hierarchies, increase collaboration, and increase client ownership and energy. Similarly, Shilts, Ralbo and Hernandez (1997), Shilts, Filippino and Nau (1994), Joanides, Brigham and Joanning (1997), and Bischoff, McKeel, Moon and Sprenkle (1996) have utilized collaborative methods in investigating clients'

experiences of therapy. All these researchers used this information to improve ongoing therapies, finding it useful to include the clients in evaluating the therapeutic process. None of the authors used collaborative or reflective ideas in post-therapy evaluations.

In a recent paper, Stath et al. (2009) report interviews with therapists in training. The researchers asked what the trainees had learned from their clients. In addition to other aspects, one of the participants said: "I think it's sad that the clients don't know how much we learn from them… I think some clients need to think that we know everything. But to the clients who don't have that need, I think it would mean a lot to them… I wonder if there's some way to talk about it that is helpful… I think a lot of clients would like to know they had an impact on us." The co-research interviews reported in the second part of this thesis constitute a direct response to the wish expressed in this citation.

Co-research interviews were first developed by Andersen (1997) and by teams in Norway and Sweden. In these interviews, after termination of the therapy, therapists and clients evaluate with an outsider consultant the therapeutic process they have been involved in. The interview design aims at offering reflective processes by separating talking and listening: when the consultant interviews the therapists, the clients sit and listen, and when the clients are interviewed, the therapists listen, without participating in the conversation. At the end of the interview all the participants talk together, mostly to evaluate the experience of the interview. This interview represents a collaborative approach to psychotherapy; all the participants in the therapeutic process are present during the entire interview, and they hear what the others say.

Wächter (2006) has edited a book in which therapists who have taken part in development projects using co-research interviews talk about their experiences. In addition, a team in Sweden has described their experiences in a website (Knutsson, Norrsell, Johansson, Öhman & Ericson, 1998). There have so far been no reports on the systematic use of this interview method for the purposes of research.

1.6 The DINADEP project

As was mentioned above, this thesis is part of the DINADEP project, Dialogical and Narrative Processes in Couple Therapy for Depression. This project (which is still continuing) has involved studies on both the outcomes and the processes of couple therapy within mental health outpatient care (see 2.2.2 for a more detailed description of the participants). In the research group the patients were offered couple therapy together with their partners; in the control group patients were offered treatment as usual, without the involvement of family members. In the overall project, several ways of gathering information have been used. The Hamilton Depression Rating Scale (HDRS) (Hamilton, 1967).

and the Beck Depression Inventory (BDI) (Beck, Ward, Mendelssohn & Erbaugh, 1961)were used to evaluate depressive symptoms, and the Symptoms Check List- ratings scale (SCL) was used to evaluate psychological symptoms in a more general way. The assessment of couple satisfaction was conducted using the Dyadic Adjustment Scale (DAS) self-report rating scale, and the assessment of the psychological status of the patient was carried out by via a GAF rating. In addition to these, domestic violence, use of alcohol, and other psychosocial factors were analyzed. These assessments were conducted before initiation of the treatment, then at 6, 12, 18, and 24 months from the beginning of the treatment. In monitoring the therapeutic processes the researchers used an Outcome Ratings Scale among clients before each therapy session, and a Session Rating Scale (Miller & Duncan, 2004) among both clients and therapists after each session. These measures are not reported in this thesis. The data for the study reported here consists of the evaluation interviews that were conducted after termination of each couple therapy.

Some interesting initial results from the project are worth mentioning here, since they may, potentially, bear a relation to the data in the present study. According to Kouri (2008) persons who had depression and who also used alcohol benefited from couple therapy, even more than did persons with only a diagnosis of depression. Both the symptoms of depression and the use of alcohol were reduced in couple therapy group, whereas in the control group there was no reduction of the use of alcohol. According to Perko (2009) many of the spouses of the persons diagnosed as depressed were also depressed themselves. Furthermore, depressed persons with a depressed spouse recovered from their depression less well than did depressed persons with a nondepressed spouse. It also appeared that nondiagnosed but depressed persons did not get better during couple therapy. Koivula and Siivinen (2007) noticed that there was a difference in the narrative process between a good outcome and a poor outcome case. Somewhat surprisingly, in the good outcome case the narration was poor and in the poor outcome case it was rich.

1.7 Aims of the study

The study reported here aimed at developing couple therapy within outpatient mental health care. Couple therapies in this context have a special quality, in the sense that relationship issues are not usually the reason for the couples to seek help. In fact, many of the couples in the present study had not even sought couple therapy. Within the study, the non-depressed spouse was invited to join the treatment of the spouse diagnosed as depressed. As was mentioned earlier, when one spouse is depressed, relational problems are common (e.g. Mead, 2002). On the other hand, there are situations in which the relationship works quite well, despite the depression of one spouse (Cordova & Gee, 2001). This means that the therapeutic work with these couples can be couple-therapeutic,

or alternatively, it can be more focused on depression, in such a way that the partner is there to support the depressed person, and to get support him/herself.

This raises important questions: If the couple has not sought couple therapy, what is the position of the non-diagnosed spouse? And who is the client in these therapies? Is it the person diagnosed as depressed? Is it the couple relationship? Or both spouses individually? Or all of the above? How much does the focus of the therapy need to be on depression, and how much on the couple's relationship?

In the first part of this study the aim was to examine couples' ways of co-constructing narratives of depression in couple therapy sessions. The question here was: How do couples in this context co-construct narratives of depression? In the second part of the study the aim was to include both clients and therapists in a collaborative evaluation of the entire couple therapeutic process. The questions here were: What was helpful, what was not helpful, and what could have been done differently?

2 METHODS

This thesis is drawn from two main investigative areas. The first of these involves a study on couple therapy sessions and the ways in which couples co-construct narratives of depression in couple therapy. This study gave rise to one journal article. I shall refer to this study as Study 1. The second area involves an investigation focusing on collaborative interviews with (a) clients and (b) their therapists, after completion of couple therapy for depression. This research gave rise to two further journal articles. I shall refer to this second investigation as Study 2 (with reference also to sub-studies (a) and (b) where necessary). The two main studies will be introduced separately according to the methodology that was used.

In choosing a methodology for the studies in question the goal was to take into account the social constructionist approach, both within psychotherapy and psychotherapy research. According to McLeod and Balamoutsou (2001), adoption of a social constructionist view calls for a significantly different research agenda compared to most current psychotherapy research. In a social constructivist approach qualitative methods are usually used. A central goal for this kind of research is making sense of therapy as social action, and this is the frame for the studies reported in this thesis. Narrative analysis, concentrating especially on spouses' ways of co-constructing narratives, was chosen for Study 1. In Study 2, a collaborative interview method (Andersen, 1997) and a grounded theory methodology were chosen for analysis of the interviews. In addition, the methods chosen were appropriate for a practitioner-researcher, as Burck (2005) has pointed out. The close analysis of transcripts from couple therapy sessions, and interviews with clients along with their therapists, provided good opportunities to learn from clinical work, and to approach clinical work in a novel way.

2.1 Study 1: How couples co-construct narratives of depression in couple therapy?

In Study 1 the couple therapy sessions were studied using narrative analysis (McLeod & Balamoutsou, 2001). The notion of a narrative has been recognized as important in the social sciences and in psychotherapy research (Riesmann, 1993, Avdi & Georgaca, 2007). In Finland, Valkonen (2007) has used narrative analysis in studying psychotherapy. He studied persons seeking individual psychotherapy for their depression, focusing on their experiences of the effects of psychotherapy, their thoughts on changes in depression, and meanings related to the effects of therapy on their inner narratives.

In a review of narrative research in psychotherapy, Avdi and Georgaca (2007) group studies concerning narratives into the following groups: (1) thematic analyses of narrative content, (2) typologies of client narratives, (3) narrative as (self-) dialogue, (4) narrative processes, and (5) narratives as a whole. Avdi and Georgaca (2007) conclude that narrative research "provides a means for studying how meaning is co-constructed within the therapy encounter, which leads to reconceptualizing key therapeutic notions in linguistic and interactional terms" (p. 415). They call for more analysis that would take into account the interactional and wider sociocultural processes involved in narrative production and transformation. The approach to narrative analysis of the present thesis could best be classified within the group of narratives as a whole. The goal in the analysis was to study couples' different ways of co-constructing narratives of depression. The focus was on the co-construction process as a whole.

2.1.1 Data

The data used in this study comprised videotaped couple therapy sessions which were transcribed as text files. All the sessions from three different couple therapies were videotaped. The beginnings of the couple therapy processes were chosen for analysis, which meant that a total of 12 sessions (four sessions from each couple therapy) were analyzed. The sessions each lasted from one to one and a half hours. The couple therapies utilized in this study took place in the period 2001-2002.

2.1.2 Participants

The participants for the study were recruited from my working context, i.e. a psychiatric outpatient clinic in the Department of Psychiatry, Kuopio University Hospital, Finland, where I worked as a clinical psychologist. This study was part of a larger ongoing project. The aim of the larger project was to develop the treatment of depression in the outpatient clinic in a more family-

therapeutic direction. The study reported here constituted the research part of this project.

In the research project, family therapists invited the spouses of new, depressed patients (referred from either primary health care or the psychiatric hospital) to the clinic to take part in the treatment of their spouse's depression. The inclusion criteria for the patients in the study were that the patients should be adults who suffered from moderate to major depressive disorder and who were married or co-habiting. The exclusion criteria were simultaneous substance-use disorders, cognitive impairment, and psychosis. It should be noted that the inclusion criterion did not include the couple having openly expressed marital problems linked to the referral; rather, the aim was to include all the spouses and to work with them in a couple therapy format.

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

2.1.3 Analysis

The analysis was conducted in four phases (for a more detailed description, see Article 1). The first phase of qualitative narrative analysis is finding meaning and structure in the text as a whole. The transcribed 12 sessions were read several times in order to achieve familiarity with the text and to develop initial ideas about the analysis. The texts were then divided into topic segments (McLeod & Balamoutsou, 2001). Topic segments were identified according to the content of the conversation. The topic segments served as meaning units of the analysis. The themes of the topic segments were named, and each of them was given a title. Atlas-ti (a registered trademark of Scientific Software Development, Berlin) which is a software package for analyzing qualitative data (Lewins & Silver, 2007), was used to organize the data and to write memos during the analysis.

In the second phase, an understanding of specific therapeutic events and processes is developed (McLeod & Balamoutsou, 2001). Since the co-construction of narratives of depression was the focus of this study, the meaning units, in which couples' talk with their therapists about depression and how it affected their lives and their relationships, were chosen for closer analysis. This was done by reading the meaning units and deciding if the main topic of the unit had to do with depression. Forty-four units out of a total of 159 were chosen (19 from Case 1; 6 from Case 2; 19 from Case 3). The analysis was carried out one case at a time.

Next, summaries of each meaning unit were written following Kvale's (1996) recommendations. This was done using memos written about the text, and by going back to the original text. The summaries of the couples' co-constructions were written out in the form of a narrative. The term narrative refers here to reconstructed representations of the stories of depression, written by the researcher. The narratives had the following structure: who initiated the

topic shift, who was the main narrator in the discussion, what the story line was, and how the other participants responded to the main narrator's initiative.

The last phase of the analysis is, according to McLeod and Balamoutsou (2001), communicating what has been found. In the present study, a descriptive statement, also composed in the form of a narrative, was written out for each case. Within this latter (overall) narrative, the summarized narratives written in the earlier phase of the analysis were brought together, and a single coherent narrative of depression was formed. These summary representations had the same structure as the narratives in the earlier phase of the analysis, with the contents of the depression stories first being presented and the co-construction of the stories then being described.

In Study 1, I was the primary researcher, and Professor Jukka Aaltonen acted as the supervisor. Each of the final narratives (i.e. the final form of the results) was negotiated with the therapists who had worked with the couples. The therapists read the final version of the results and commented. They found these narratives similar to their own experiences of the way they had co-constructed narratives of depression. After this the supervisor of the study also read the narratives.

2.2 Study 2: Collaborative interviews with (a) clients and (b) their therapists

In this study (which included sub-studies a and b) grounded theory methodology was used (Glaser & Strauss, 1967, Strauss & Corbin, 1998). Grounded theory (GT) was developed in sociology in the 1960s, and it has been used also in psychology, in anthropology, and by researchers in practitioner fields such as education, social work, and nursing (Strauss and Corbin, 1998). In psychotherapy research, grounded theory has been used e.g. by Rennie (2001), Levitt (2001), Williams and Levitt (2008), Henretty, Levitt and Mathews (2008), Frankel and Levitt, (2009) and Rober, Elliot, Buysse, Loots and De Corte (2008). An example of the use of GT in studying marital therapy is the work of Odell, Butler and Dielman (2005).

A method that was strongly grounded in the data was chosen because of the novelty of the interview method. In fact, pre-existing information on this kind of interview was not available. The analysis can be regarded as a modified GT analysis. The structure of the interview directed the analysis more than would be typical in classical GT. The research questions were formulated according to the interview guide, and the answers given to each research question formed the categories. Since the interviews were semi-structured, answers to the research questions could appear in different parts of the interview. The interview data guided the analysis as much as possible; no pre-existing theoretical model was used in the analysis. The categorization was conducted using constant comparison and open coding. During the analysis,

memos were written in order to record ideas as they developed, and to keep track of the decisions that were made. An Atlas-ti program (registered trademark of Scientific Software Development, Berlin), software package for analyzing qualitative data (Lewins & Silver, 2007), was used to analyze the data and to write the notes.

2.2.1 Data

The data used in Study 2 consisted of 25 co-research interviews, which were videotaped and transcribed as text files. The interviews lasted around one and a half hours. In the interviews, a semi-structured interview guide was used (Andersen, 1997). The interview had three parts: the interviewer first talked with the therapists while the clients were listening, then talked with the clients while the therapists were listening; finally all the participants talked together. This study was part of the research project (mentioned earlier) called Dialogical and Narrative Processes in Couple Therapy for Depression. The interviews were conducted in the period 2007–2008.

2.2.2 Participants

The study described here was part of the wider study mentioned above, in which participants were recruited from outpatient clinics in the three research centers involved, and also from Pohjois-Savon sairaanhoitopiiri, Länsi-Pohjan sairaanhoitopiiri, and Helsingin ja Uudenmaan sairaanhoitopiiri (i.e. the hospital districts of Northern Savo, Western Lapland, and Helsinki-Uusimaa). Participants had been referred to mental health outpatient care because of depression. The diagnosis of depression was arrived at using the Structured Interview for DSM Disorders (SCID) instrument (Spitzer, Williams, Gibbon & First, 1992). The SCID diagnoses were 296.2 and 296.3 (DSM-IV). In addition, clients' depression was evaluated using the Beck Depression Inventory (BDI) (Beck, Ward, Mendelssohn & Erbaugh, 1961) and the Hamilton Depression Rating Scale (HDRS) (Hamilton, 1967). The inclusion criterion for the wider study was more than 13 points on HDRS. The exclusion criteria were psychosis, bipolar disorder, and serious violence between the spouses. Two patients were excluded from the study. One of them was diagnosed as having bipolar disorder in the structured interview, and one couple was excluded because of violence.

In the wider study participants were randomly assigned to a research group and a control group. The participants in the research group participated in couple therapy, meaning that their spouses were invited to participate in the therapy, whereas the participants in the control group were offered treatment on an individual basis, without the involvement of the spouse. Couple therapies lasted as long as was considered necessary. A minimum of five sessions was set, with no maximum number determined. The average number of sessions was 9, ranging from 5 to 33. Antidepressant medication was used, if it was considered necessary. The participants gave their informed consent to participation in the

study. The Ethics Committees for Human Research in all three hospital districts granted permission for the material to be gathered and used in the present study.

In the wider study, there were 32 participants in the research group and 28 in the control group. For Study 2 described here (including sub-studies a and b), a total of 25 interviews with participants from the research group were conducted using the co-research interview method, i.e. with the family therapists being interviewed along with the couple (Andersen 1997). The interviews involved a total of 44 persons who had attended couple therapy, and included 24 persons (15 men and 9 women) who had originally been diagnosed as depressed, together with their spouses when possible.

In all, 28 different family therapists took part in the interviews. They had always worked with the couples as a team of two therapists. All except one of the therapists had at least three years of training in family therapy, validated by the National Authority for Medicolegal Affairs. The therapists were recruited from the three centers that were involved in the study. The number of interviews per therapist ranged from one to five, according to the number of couples they had worked with in the project. Most of the therapists took part in one interview. Within the centers, one family therapist worked as a contact person. He or she recruited the family therapists in the centre. I acted as a contact person in one of the centers. As part of my daily duties I also worked as a therapist in two of the 25 cases.

2.2.3 Analysis

The first step in the analysis conducted for Study 2 was to identify meaning units in the text (i.e. the transcribed interviews). The meaning units were named using language that was as near as possible to the participants' own words. One meaning unit consisted of one single idea. When the meaning unit was identified, the person giving the answer was coded at the same time. The next step of the analysis was to group the meaning units according to their content by comparing them with each other. The research questions guided the formation of these clusters: most of the names of the clusters were in the form of a question to which the meaning units provided an answer. A new cluster was formed when the meaning unit did not fit into the existing clusters. The interviews were analyzed one by one, constantly comparing the meaning units to the previous ones. During the analysis some of the clusters were merged with existing ones. The answers in each cluster were then categorized and further sub-categorized. This was done using the Code families in the Atlas-ti program.

Credibility checking was conducted in three stages. First of all, at the end of each interview the participants were always questioned concerning their experiences and their thoughts about being interviewed. This was intended to give them the opportunity to reflect on and talk about things that the interviewer might not have asked. In general the participants had experienced

the interviews as interesting and good. None of the participants said that there had been problems in talking about their ideas during the interview.

Secondly, the results of the analysis were introduced to the therapists who took part in the research project in the course of seminars that were held on a regular basis during the research project. They found the results credible and interesting, and in accordance with their experiences. In two phases of the analyzing process the categories were presented to an outsider group of fellow PhD students, in the course of research workshops connected with a Doctoral program for psychotherapy research.

Thirdly, since I had conducted the analysis alone, my supervisor Jaakko Seikkula independently categorized eight randomly selected cases in sub-study 2(a) concerning the clients' answers, and five randomly selected cases in sub-study 2(b) concerning the therapists' answers. A consensus was arrived at concerning the analysis.

3 SUMMARIES OF THE ORIGINAL ARTICLES

Article 1

Rautiainen, E-L., & Aaltonen, J. (2010). Depression: The differing narratives of couples in couple therapy. The Qualitative Report, 15, 156-175.

How does the spouse of a person with depression take part in constructing narratives of depression in couple therapy? In this study we examined couples' ways of co-constructing narratives of depression in couple therapy. Three couple therapy processes were chosen for the study, one spouse in each couple having been referred to an outpatient clinic for treatment for his/her depression. Four sessions from each systemic couple therapy processes (Jones & Asen, 2000) were analyzed using narrative analysis.

Couples co-constructed narratives of depression, each in their own way. In the first case, the depressed spouse's narrative was reinforced by the nondepressed spouse's narrative. In the second case, two conflicting narratives were constructed, one by the nondepressed spouse and one by the depressed spouse. In the third case, the spouses co-constructed two narratives which enriched one another. It is thus crucial to focus not only on the patient's individual narrative of depression, but also on the depressed spouse's narrative as an interactive part of the nondepressed spouse's narrative and on the shared narrative created by the spouses. If the nondepressed spouse's narrative mostly reinforces the narrative of the depressed spouse, the focus of the therapy can be on depression. Therapists can still involve both spouses in the process, and coming together to the therapy can support both spouses. If the narratives are conflicting, attention needs to be paid to the couple relationship; the task for the therapists is to help the couple to find new ways to relate to one another. If the narratives of the spouses enrich one another, both spouses can be active participants in the therapeutic process; they can benefit both individually and as a couple.

Article 2

Rautiainen, E.-L., & Seikkula, J. (2009). Clients as Co-researchers: How Do Couples Evaluate Couple Therapy for Depression? Journal of Systemic Therapies, 28, 41 – 60.

How do persons diagnosed as depressed and their spouses evaluate couple therapy for depression? This study aimed at a collaborative evaluation of therapeutic processes with clients and therapists. Co-research interviews (Andersen, 1997) were conducted with 25 couples in the presence of their therapists, after termination of systemic couple therapy in which the focus had been on generating dialogues. The answers were analyzed using Grounded Theory methodology. In this paper, the clients' answers to the following questions are presented: What was helpful in couple therapy? What was not helpful? What could have been done differently?

According to the results the clients found the following helpful: (1) the therapist (the therapists' actions, their way of relating to the clients, and their general qualities); (2) talking in therapy; (3) participation of the spouse; (4) other helpful factors. The clients appreciated the therapists' way of listening, good questions, good collaboration between the two therapists, their active way of managing the conversation, and their way of clarifying what the other spouse had said. In the therapists' way of relating to them the clients saw the therapists' genuine interest and eagerness to help as important. Their respectful and caring attitude and their neutral way of listening to both spouses were mentioned. The existence of good chemistry between clients and therapists was seen as helpful. The clients also felt that they had been helped by therapists in their function as skilled professionals, through qualities such as calmness, informality, and warmth.

For the clients, it had been easy to talk in therapy. As outsiders, the therapists had helped the clients to talk. It was noticed that in therapy one listened one's spouse better than at home, and that talking continued at home after the sessions. The atmosphere of the sessions had been helpful: a safe, open, relaxed, and pleasant atmosphere had made it easy for to talk. The participation of the spouse had helped some clients. The spouse's presence made the situation feel safer, and made talking easier. In addition, it was seen as helpful that by participating in the therapy the nondepressed spouse understood the situation better, and got a chance to talk for him/herself. Some other helpful aspects were mentioned: getting information about depression, organization of the care, and (for some) medication.

Some non-helpful factors were mentioned: difficulties in talking in the therapy, problems in collaboration with the therapists, ineffectiveness of the therapy, and confusion concerning couple therapy. A lack of motivation – either one's own or the spouse's – was mentioned as a factor inhibiting talking during therapy. In addition, some clients had felt that the presence of the spouse made it difficult for them to talk. Problems in collaboration with therapists had to do

with problems of trusting and not getting along with the therapists. Some clients felt that couple therapy did not help the depression, and some would have liked more help with relational problems. Some clients had felt confused, since they had been offered couple therapy as treatment for depression, even when they did not have relational problems.

Some clients would have liked the therapists to work in a different way: they had hoped for a stronger focus on depression, tasks between sessions, more direct comments and suggestions, less uncertainty, more clearly agreed goals for therapy, and more concrete help. Some would have liked more frequent sessions, and some would have liked also to have individual sessions.

Overall, it emerged that the clients appreciated the therapists both as skilled professionals and as warm human beings. The action of talking in itself seemed to be important for the clients. The presence of the nondepressed spouse was seen as helpful in many ways, but sometimes it could also inhibit talking. The clients pointed out factors that were not helpful for them. These factors, especially confusion concerning couple therapy, should be taken into account in further developing couple therapy for depression in the context of outpatient mental health.

Article 3

Rautiainen, E.-L., & Seikkula, J. (2010). Focusing on therapists in co-research interviews: How do therapists see couple therapy? Accepted for publication in Journal of Systemic Therapies.

New ways of studying therapeutic work are needed, i.e. methods that take into account the collaborative nature of psychotherapy. This study aimed at a collaborative evaluation of the therapeutic processes, through interviews in which both therapists and clients were present. The co-research interviews (Andersen, 1997) were conducted with 28 therapists and their clients, after termination of systemic couple therapy in which the focus had been on generating dialogues. The clients had been diagnosed as depressed and their spouses had been invited to take part in psychiatric outpatient treatment. The research questions were: (1) What did the therapists wish the interviewers to ask their clients, in order to learn from them? (2) What did the therapists think their clients appreciated in their way of working? (3) Were there any notably difficult moments for the therapists? (4) What did the therapists learn from their clients? The answers were analyzed using a Grounded Theory methodology. A case example of the co-research interview was presented.

According to the results (1) the therapists raised several questions for the interviewer to ask their clients. They wanted to hear about the therapists' actions, the clients' experiences of the therapy, collaboration between the therapists and the clients, factors that were found useful, the suitability of the approach for the clients, and themes that had been talked about in the sessions.

(2) The therapists thought that the clients might have appreciated the following in their way of working: the therapists' actions, their way of relating to the clients, and how the space and time for speaking were arranged. They described their actions in the following way: they listened, spoke about the clients' everyday life, were active, spoke in a reflective way, were flexible, worked well as a team, listened to both spouses, and were able to continue conversations in difficult situations. The therapists described their way of relating to clients in terms of the atmosphere in the sessions being relaxed, informal, trusting, and safe. The therapists were present, were respectful, and wished to help the clients. Creating time and space for talking meant that the therapists gave space for both spouses to talk, were not in a hurry, and encouraged talking.

(3) As difficult moments during therapy the therapists mentioned the beginning of the therapy, difficult themes such as violence and alcohol, and feelings of uncertainty about how to proceed.

(4) The therapists felt that they had learned from their clients something about arranging family therapeutic help with clients with depression, a new understanding of couple therapeutic processes, and a new understanding concerning the clients. The therapists spoke about the importance of including the spouse within the depressed client's treatment, about the benefits of using couple therapy for depression, and about ideas concerning when to choose couple therapy and when perhaps to choose individual therapy. In relation to a new understanding of couple therapeutic processes, the therapists spoke about the importance of the beginning of the therapy: the significance of the first meetings with the clients, the importance of defining together what they were about to do with the couple, and the importance of listening to clients' own goals and hopes for therapy. In addition, the therapists spoke about taking care of the entire therapeutic process. Finally, the therapists had gained a new understanding concerning clients, and evaluated their collaboration with the clients.

To conclude, the therapists in the study orientated themselves in a collaborative way and had learned from their clients. The aspects found helpful were similar to those identified by the clients in their answers (see Article 2). Some therapists spoke about difficulties they had had during the therapy, introducing parts of their inner dialogues into the conversation. Overall, co-research interviews emerged as a good means of collaboratively evaluating therapeutic processes.

4 DISCUSSION

4.1 Main findings

The aim of this study was to develop couple therapy for depression in the context of mental health outpatient care. The main finding of the first study was that each couple had its own way of co-constructing narratives of depression. Three different ways of co-constructing narratives of depression were found. Thus, when a couple comes to therapy and one of the spouses has depression, there is no one way of helping them; rather, there is always a unique situation which calls for flexible ways of working. The focus of the therapeutic work can be one spouse's depression, the couple relationship, or both spouses' narratives. Furthermore, each couple therapy process is unique and the knowledge concerning it is local, as was demonstrated in the second study, within the co-research interviews. The therapists in this study had oriented themselves to the uniqueness of each therapeutic process. As things they had learned from their clients they mentioned a new understanding of couple therapeutic processes, and a new understanding of their clients.

According to the results of the second study, clients and therapists seemed to find fairly similar things helpful. Clients referred to the therapists' actions, the therapists' way of relating to them, and the therapists' general qualities. They mentioned as useful talking in therapy and the fact that their spouses had participated in the therapy. Therapists, for their part, thought that the clients had appreciated their actions, their way of relating to the clients, and the fact that they had arranged the space and the time for the client to talk. They also made comments on the usefulness of inviting the spouse of the depressed person to participate in the therapy. Good collaboration between the two therapists, their respectful way of relating to clients and willingness to help, plus a safe and informal atmosphere were mentioned, both by clients and by therapists. The therapists' way of listening and posing good questions was appreciated. For many clients, the nondepressed spouse's participation in the treatment of depression was useful; clients referred, for example, to the fact that

coming together to the therapy had helped them to talk, and to the fact that talking continued at home after the sessions.

Most clients had found couple therapy for depression to be helpful. What also became evident is that couple therapy, like psychotherapy in general, is challenging; not all the clients felt they got the help they needed. Some clients felt that some things were not helpful to them. They described difficulties in talking during the therapy and problems in collaborating with the therapists. They mentioned the ineffectiveness of the therapy, and confusion concerning couple therapy. For some clients, the spouse's participation had inhibited them from talking.

Clients had ideas about how to develop the work. Some clients would have liked to have individual sessions, either in addition to or instead of couple therapy. Some clients also reported a desire for a stronger focus on depression, tasks between sessions, more direct comments and suggestions, more clearly agreed goals for the therapy, and less uncertainty on the part of the therapist. For the therapists, there had been some difficult moments. Some therapists talked about difficulties regarding not knowing how to proceed; difficult moments could also involve themes such as violence and the use of alcohol.

The question of who is the client, or what is the focus of couple therapy as treatment for depression needs to be raised. In the first study it became apparent that the focus of the therapy with each couple needed to be different. Some clients' confusion concerning couple therapy in the interviews in the second study can be understood as an indication that the basic idea of using couple therapy for depression was not always clear to the clients. In addition, according to the therapists, the lesson they had learned from their clients was the importance of the beginning of therapy; it was important to negotiate the goals for the therapy and to listen more carefully to the clients' needs. The therapists also reported that they had learned more about family therapeutic work with depression: how important it is to include the spouse of the depressed person in the treatment. All this suggests that there is still work to be done in developing the treatment of depression in a more family-oriented direction.

According to the results, collaborative evaluation processes can be a useful way of learning from clients, and a way of further developing couple therapeutic work. It can be used in research, in everyday clinical practice when therapists want to learn from their clients, and in psychotherapy training courses, to help trainees to develop the skills needed in collaborative practices.

4.2 General discussion

I shall begin by discussing the results of the studies in relation to previous literature, and by offering some theoretical considerations. Since the goal of the studies was to develop couple therapy for depression in the mental health

context, I shall then move to discussing the results from the mental health point of view. Thereafter, I shall continue by evaluating the collaborative interview method used in Study 2. Finally I shall introduce some reflections on the research process, and ideas for future research.

According to the results of this study, the spouse's participation in the therapeutic process was frequently useful, and found to be a source of support – a point emphasized also by Harris, Pistrang and Barker (2006) and by Cordova and Gee (2001). By taking part in the therapy, the nondepressed spouse helped the depressed person to talk in therapy, and at same time had the chance him/herself to take part in conversation; all this led to a better understanding of the situation. In addition to this the couple could continue the talk at home. These results highlight the importance of including the spouse of the depressed person in the outpatient care of the depressed person, a point that has been suggested by many authors (Denton & Burwell, 2006; van Wijngaarden et. al., 2009; Sandberg, Miller and Harper, 2002).

This study emphasizes the importance, within the mental health context, of negotiating the question of who is actually the client in couple therapy. Usually one partner is referred to outpatient care and the other partner joins the therapy. For some partners, taking part in the therapy is entirely natural and easy to accept, but for other partners it can be confusing, implying that the relationship is being blamed for the depression (e.g. Gupta, Coyne & Beach, 2003). The idea of inviting the nondepressed spouse to join the treatment of the depressed spouse should be explained and re-explained during the therapy. A non-blaming stance is important. Significant others are not to be seen as the cause of problems; instead they can be part of the solutions (Coyne, 1999). Jones and Asen (2000), too, have noted the importance of this in their work with couples and with depression in the mental health context. According to their experience, some partners wanted to participate in the therapeutic process more actively, while others wanted to remain in a helping position in relation to the depressed spouse. This negotiation needs to be an ongoing process and not just something that occurs at the beginning of the therapy, since the positions can also change during the process. In this way the position of the nondepressed spouse can become clear to all the participants in the therapeutic collaboration.

Should the focus of couple therapy be on depression or on the couple relationship? Some authors recommend using couple therapy mostly with couples who have relational problems (Gupta, Coyne & Beach, 2003; Barbato & D'Avanzo, 2008), while others have suggested using couple therapy with couples in healthy relationships (Cordova & Gee, 2001). According to the results of this thesis, flexibility is needed. Some couples seemed to benefit from and hope for a focus on the relationship. For others, the main focus can be on working with the depression of one spouse, with the other spouse there more to give and receive support. Some couples need a combination of both relational work and help with depression, as recommended by Snyder and Whisman (2003). The important thing is for the therapists to keep this in mind and to

negotiate with the spouses; they have to find out the focus that the couple hope for and is ready for.

The clients appreciated the therapists' questions, their way of listening, and their way of relating to them. One could think that the clients saw the therapists both as skilful professionals and as human beings. The therapists emphasized similar aspects. The skills of listening and posing useful questions – or to borrow Andersen's (1991) words, "appropriately unusual questions" – can be seen as essential for the collaborative therapist; he or she is not an expert on the content but should have expertise on the process of talking (Anderson, 2001, Seikkula, 2008). The questions and the way of working should not be technical; it is equally important to meet the clients as living people (Rober, 2005a). According to the results of this study, therapists can achieve this by showing a caring attitude and a genuine willingness to help, by being interested in clients' everyday lives, and by being active participants in a dialogue with the clients.

What did the therapists learn from their clients in this project? The therapists had learned things to do with arranging couple therapy for depression; they had gained a new understanding of the therapeutic processes and also a new understanding of the clients' situation. Stahl et al. (2009) also asked therapists what they had learned from their clients (but without having the clients present in the interviews). In their study, the therapists had learned lessons about doing therapy, lessons about themselves, lessons about the clients, and lessons about the therapy relationship. The results were thus fairly similar to those reported in the present thesis, with two exceptions. In the present study, the therapists learned about arranging couple therapy for depression. Since this was the topic of the developing project, it is not surprising that this aspect gained prominence. In the research by Stahl et al. it was found that therapists learned something about themselves. This topic did not come to the fore in co-research interviews. It may be that the co-research interview situation and the fact that there had been two therapists working as a team with the couple did not direct the therapists to talk so much about this topic.

There has been continuing debate concerning common factors underlying change in psychotherapy. Some authors have emphasized that there are common factors of change in all effective psychotherapies (Lambert, 1992; Hubble, Duncan & Miller, 1999, Sprenkle & Blow, 2004 a & b). On the other hand, there are authors who argue that common factors, in their current articulation, are too simplistic to advance our understanding of the change process (Sexton & Ridley, 2004; Sexton, Ridley & Kleiner, 2004). Sprenkle and Blow (2004 a) and Davis and Piercy (2007 a & b) note that research concerning common factors in family therapy field is still in its infancy, and that in fact little is known about common factors of change unique to this field of psychotherapy – this despite the fact that in the wider field of psychotherapy this research has been going on years. The authors call for more hypotheses regarding what components should be considered common in family therapy.

According to Sprenkle and Blow (2004 a) there are three common factors unique to marital and family therapy. These are a relational conceptualization, an expanded direct treatment system, and an expanded therapeutic alliance. By a relational conceptualization they refer to keeping the whole system in mind when interacting with a part of the system, and to attempts to relate in a positive way to all parts of the system, regardless of who is in the treatment room. By an expanded treatment system they mean family therapists' attempt to involve more people than the identified patient directly in the treatment. Finally, by an expanded therapeutic alliance they mean that in family therapy the therapist forms an alliance not only with each member of the family individually, but also with subsystems of the family, and with the family as a whole.

I shall here discuss two ideas which rise from the results of the second study, in relation to common factors unique to family therapy. In this study the clients talked about the possibility of continuing the talk at home, which meant that the therapeutic work moved outside the therapy room and into people's own living context. This could be related to the second factor identified by Sprenkle and Blow (2004 a), i.e. having the spouse of the person diagnosed as depressed directly taking part in the therapy. The clients in this study also observed that in couple therapy they listened to their partner in a different way, and heard in a new way what he or she was saying. This could be understood as having he opportunity for a reflective position (Andersen, 1991). Having a chance to listen to other family members in therapy gives a possibility for new kind of understanding, and new ways of relating to him or her. The three concepts introduced by Sprenkle and Blow (2004 a) do not fully capture this phenomenon. Offering a possibility for reflective positions could be one more concept to explore further, when the common factors in marital and family therapy are developed.

The results of the second study pose a special challenge to dialogical (e.g. Seikkula, 2008) and collaborative (e.g. Anderson, 2001) approaches, namely dealing with uncertainty. Some clients would have liked the therapists to appear less unsure. They would have liked to receive more direct advice, with the goals for therapy being more clearly negotiated. As e.g. Guilfoyle (2006) has argued, even in collaborative therapies the therapist is expected to be an expert knower. The positions for therapists and clients are institutionalized positions, and they place participants in a power relation (Guilfoyle, 2003). The challenge for a collaborative therapist is on one hand to be able to negotiate and take into account the clients' needs without appearing too unsure, and on the other hand to take into account also the clients' wishes for an expert knower. Seikkula (2008) has emphasized the need always to respond to clients, in some way showing the clients that their every utterance has been heard. The collaborative and dialogical process might not have succeeded with these clients who desired more clear-cut advice, leaving them with unanswered hopes.

Rober (2005b) argues that the not-knowing position advocated by Anderson and Goolishian (1992), has two aspects, namely a receptive and a

reflective aspect. According to Rober, Anderson and her colleagues have emphasized the clients' expertise and the therapists' receptiveness, and this has left the therapists' reflections undeveloped. What does the therapist do with his or her own expertise? Using Bakhtin's and Volosinov's work, Rober puts forward the concept of a dialogical self, with the therapist's inner dialogue as a reflective space that bridges knowing and not-knowing. In co-research interviews, the therapists' inner dialogues can partly become a part of the outer dialogue, when, in the presence of their clients, therapists are interviewed about their thoughts concerning the therapy undertaken.

4.3 How can we develop couple-therapeutic work on depression within mental health outpatient care?

As became evident during this research project, the couple relationship is not always the focus of therapeutic work in couple therapy for depression in the outpatient mental health care context. In fact, the term "couple therapy" is too narrow, and should be re-thought. One alternative for the term could be family-oriented therapy for depression, which would also remind us of the importance of taking into account the children in the families concerned.

According to the experiences of both the clients and the therapists participating in Study 2, couple therapy for depression proved to be useful, and should be more widely used in Finnish mental outpatient care. Paying attention to the partner of the depressed person should be done in a flexible way. Sometimes one can offer couple therapy, sometimes one can combine individual and couple therapy; at a minimum, one should always invite family members for at least one session. As was mentioned earlier, there should be clear negotiation with the couple regarding the question of who or what is the client of the therapeutic work.

Some authors have recommended combining medication with couple therapy for depression (Whisman, Uebelacker, 1999; Beach, Finchman & Katz, 1998; Denton, Golden & Walsh, 2003). Within the Finnish mental health system, a combination of antidepressant medication with couple therapy is already widely used, and this was the case in many of the couple therapies discussed here. As was mentioned in the Introduction, the use of antidepressant medication has rapidly increased in Finland. According to the results reported in this thesis, in addition to medication, families struggling with depression need support and therapeutic help.

Following the collaborative approach used in the second study, spouses' goals and hopes, and also their fears and obstacles to talking in couple therapy should be openly asked and negotiated. Some couples appreciate open discussions on their situation, others might need to practice communication, some may hope to receive information on depression, and some may appreciate opportunities to have individual sessions in addition to couple sessions.

Sometimes it is the couple relationship that becomes better in couple therapy, sometimes it is the depressed partner who benefits from therapy individually, and sometimes it can be the nondepressed person who benefits. Many different therapeutic processes are possible, and these may indeed take place simultaneously. As Helmeke and Sprenkle (2000) discovered, it is often the case that the therapists do not know what is important for the clients. That is why collaborative negotiations are needed.

Some clients in the interviews would have liked a stronger focus on depression, while others would have wished to concentrate more on the relationship. If the couple has relational problems in addition to one spouse having depression, attention should be paid to sequencing and pacing the work, a point emphasized by Snyder and Whisman (2004). A deeply depressed person may not have the strength to make changes in the relationship before the symptoms of depression have become somewhat alleviated; hence the initial focus of the work may need to be on depression. On the other hand, if the relational problems move in a more positive direction, it may then be possible for the depressed person to begin to recover. Thus, in this situation too, it is necessary to tailor the work according to the particular couple's needs.

In the context of mental health outpatient care, when couple therapy is the treatment for the person who has been diagnosed as depressed, the perspective of the treatment for depression should not be overlooked: attention needs to be given to medication, sick leaves, support on occupational rehabilitation and so on. Taking a "need-adapted" approach to the treatment of depression can be useful. The term was developed in Finland during the Schizophrenia project (Alanen, 2004). The basic idea of this approach is to include within the treatment all the elements that are needed in each case: family-oriented work, work with the couple, individual work, vocational rehabilitation, medication, and so on.

When working with couples with depression it is also important to bear in mind that both spouses may be depressed, as noted by e.g. Coyne et al. (1987), and as was the situation with a proportion of the couples in the DINADEP project (Perko, 2009). If the initial results of the project are confirmed and it is found that persons diagnosed as depressed who have a depressed partner recover less well than depressed persons with nondepressed spouses, more attention should be paid to helping those families in which both spouses are depressed. This has also been emphasized by Whisman and Uebelacker (1999). As the DINADEP project continues it will produce more information and understanding of how to develop work with families and depression.

4.4 Collaborative evaluation of therapeutic processes

According to the results of the second study, collaborative interviews were a useful way of evaluating couple therapeutic processes. The fact that both clients

and therapists were interviewed in the presence of each other proved to be interesting and valuable. The interview method used in this study has not previously been used in psychotherapy research. It brings psychotherapy research closer to the everyday work of the therapists, and can be a useful tool in developing clinical work. It is also an intensive, inspiring and sometimes emotional experience for the interviewer. For a practitioner-researcher it is a good way to reach a deeper understanding of psychotherapeutic processes.

Psychologists (Havenkamp, 2005), systemic therapists (Burck, 2005), and psychotherapists in general (Knox and Burkard, 2009) are considered to be skilful in interviewing and can use this skill in conducting qualitative research. For me as a psychologist and as a family therapist it felt natural to choose an interview method that resembled family therapeutic work and I felt that it was very useful for me to have had more than fifteen years of experience with therapeutic work. On the other hand, for a therapist-researcher the challenge is to keep the researcher role clear in one's mind while interviewing. Research interviews are not therapy sessions, and this should be clear to all the participants (Burck, 2005; Haverkamp, 2005; Knox & Burkard, 2009). This is a challenge in co-research interviews, which can resemble family therapy sessions. In spite of this, the structure of the interviews helped in maintaining clearly the notion of a research interview. The role of the researcher was clarified at the beginning of the interview, and the focus of the interviews was the therapeutic process that the participants had undergone together, not the couple's problems. In addition, beginning the interview with the therapists positioned them as the clients of the interview. The therapists wanted to learn from the clients, and the clients were there to talk about their experiences, not to receive help themselves. As the interviewer I was always an outsider in relation to the therapeutic work; I had not met the clients previously as a therapist.

According to my experience, beginning the interview with the therapists proved to be very useful in many ways. By talking first, the therapists gave permission for the clients to talk, including talk involving difficult issues. Clients might have found it difficult to talk about difficult experiences they had had during the therapy while the therapists were present and listening. However, if the therapists began to talk about problems they had encountered as therapists, or if the therapists started to think aloud about topics that had perhaps been left unspoken, the clients felt freer to talk about similar things (as did indeed happen in the interviews).

Another reason for beginning with the therapists was to give the clients time and space to remember the therapeutic process. While listening to the therapists, the clients had the opportunity to think about and remember things connected to the therapy. After listening to their therapists talking, many clients commented that they had a lot of thoughts in their mind, and were eager to raise points themselves. The questions in this interview invited both therapists and clients to adopt a self-reflective position, and according to my experience were of a thought-provoking and inspiring nature. Clients had not been accustomed to listen to therapists being interviewed; usually they found the

experience very interesting, tending to strengthen the bond between themselves and the therapists.

It is important to bear in mind that some matters were not raised in the interview. I am sure that the therapists were not able to talk about everything they had thought and experienced with their clients, and the clients, too, must have had experiences they did not mention. Talking while both clients and therapists are present in the same situation is different from talking when only therapists or only clients are present. Since I see psychotherapy as collaborative action, both clients' and therapists' views are of interest; in the interview situation they enrich one another, making it possible to co-create a new understanding that did not exist before the interview.

4.5 Reflections on the research process

4.5.1 Strengths and limitations of the research

The goal of the research was to deepen understanding concerning couple therapy for depression, using methods that would fit well with the idea of psychotherapy as collaborative practice. Initially, the focus was on the spouses' co-construction of narratives in couple therapy sessions. Thereafter, collaborative interviews with both clients and therapists were conducted, with the aim of creating a new way of evaluating therapeutic processes.

The studies were conducted by a practitioner-researcher who knew the work from the inside, having had years of experience of this kind of work with depressed persons and their spouses. This was a strength of the research – that there was a researcher who was strongly connected to the research area, seeking novel ways of conducting psychotherapy research, and also – it was hoped – bringing research closer to clinicians' everyday work.

In this research, the participants were invited to participate in the research process in a new way, especially in the second study. In the co-research interviews, both clients and therapists were co-constructing an understanding of the therapeutic process, in the presence of each other, and with the interviewer also present. This meant two things: (1) that clients' experiences were regarded as an important source of understanding, and also (2) that clients had the opportunity to listen to the therapists' interviews, in the course of which they reflected on their thoughts concerning therapeutic work. This is something that has not usually been done in psychotherapy research. In addition to this, at the end of the interview they were asked to reflect on their experience of the interview, with care being taken to encourage them to communicate their thoughts concerning the research process.

After the analysis was conducted, the clients were not asked to comment on the results of the study, since they had been in such an active role. However, a group of therapists was interviewed after the co-research interviews within a

focus group; at this time they were asked to reflect as a group on their experiences of being interviewed in the presence of their clients. This step was taken because this kind of research is new and demanding for therapists. The results of this focus group interview will be reported later.

One limitation on the first study has to do with the fact that even though co-construction of narratives was the aim of the study, the analysis concentrated on the *couples'* way of co-constructing the narratives. The therapists' role in co-construction was not the focus of the study. Additional research on the therapists' contribution to the co-construction of narratives could enrich the picture of what happens in couple therapy sessions. The decision to concentrate on the clients' narratives was made in order to better describe the different ways in which the spouses together construct narratives of depression. Bearing in mind the context of the study (i.e. psychiatric outpatient care, in which depression is usually regarded as an individual problem) it was seen as important to embark on studying couples' ways of co-constructing narratives of depression.

In the second study, a Grounded Theory methodology was chosen and the clients' and the therapists' answers were analyzed separately. This was done in order to get an overview of all the interviews. It was hoped that in this way ideas for developing couple therapy as treatment for depression could be obtained. What was lost here was the collaborative nature of the interviews. Since clients and therapists were listening to one another, they shaped one another's answers, and each interview in this way forms a single entity. This leaves the door open for future research: the next step in the analysis will involve taking into account the collaborative nature of the interviews.

The analyses were carried out by a single researcher; there was not a research team involved in the analysis. In both studies the second author of the papers acted as an auditor for the analysis, remaining more distant from the raw material and offering valuable help. This is a typical situation for a practitioner- researcher; there are seldom the resources to employ, for example, an entire research team. According to Rennie and Frommer (2001), there are two points of view on this question. Many authors see using a research team, or at least having two persons equally involved in the analysis, as a definite criterion for good qualitative research. On the other hand, for example Giorgi (1988) has taken the view that in qualitative research, the primary investigator gradually becomes an expert on the phenomenon under study, and that it is not possible or necessary to have others taking part in this process.

Within this project I functioned both as a therapist and as a researcher. For the most part I was studying the work of other therapists, but I did also take part in both projects as a therapist, in one of the three cases in the first study, and in two of the twenty-five cases in the second study (In these two cases I took part to the interviews as a participant, not as an interviewer). This gave me both an insider and an outsider view on the data. In addition to this, I have had a great deal of clinical experience with both couples and individuals with depression. This posed a special challenge: how could I see the novelty of the

findings and not be blind to phenomena that are familiar to me? And also, how could I focus on the research findings and not arrive at conclusions from the clinician's point of view? The research methodology helped me in this, as did writing memos on my own thinking during the research process.

4.5.2 Ethical considerations

Haverkamp (2005) addresses the question of ethical perspectives on qualitative research in applied psychology. She raises many important questions, and I shall use them to discuss the ethical considerations relating to this study. The first theme is the question of asymmetries of power. Even when we do postmodern qualitative research, we cannot ignore the differences in power on the part of the researcher and the participants in a study. Conducting co-research interviews is an attempt to include both clients and therapists in co-creating a new way of understanding the therapeutic process. Clearly, it is good to remember the importance of the power relations in these interviews. I have discussed this theme in more detail in Article 3.

Informed consent is also a complicated question in qualitative research, since the basic idea in this kind of research is that the process cannot fully be planned beforehand; instead it is shaped during the research process. This means that when the participants give their informed consent at the beginning of the process they cannot fully know the kind of process they are about to participate in. For example, they cannot know which topics will be discussed in an interview and how the talking might affect them. Haverkamp (2005) recommends that informed consent should be seen as an ongoing process, rather than as a single event. This was the case in the present research. The clients had given their informed consent for participation in the whole research project, and they knew they would be interviewed after the end of their couple therapy. The therapists taking part in the interviews had been willing to participate in the research project, and they also knew that this kind of collaborative interview was part of the process. In addition to this, at the beginning of the interviews, the idea and the different phases of the interview were explained to the participants. Then, at the end of the interview the participants were always asked to give feedback on their experience of being interviewed, and to indicate whether there were important topics that had been left out of the interview.

Haverkamp (2005) discusses the notion of "research benefit". In traditional research this has been understood as research benefiting society at large. More recently, since qualitative research has transformed the relationship between researcher and participants, explicit benefits to participants – such as empowerment, access to knowledge, and community change – have been called for. In the present research, the aim was that by participating in the co-research interviews, the participants – both clients and therapists – would benefit from the experience; possible gains included elements of empowerment, access to a new understanding, and a change in the way depressed persons plus their spouses might be helped in the future.

4.5.3 Personal reflections: How has this research changed me?

For me as a practitioner-researcher this project has been very meaningful in many ways. During this project my understanding of couple therapy as a treatment of depression has become deeper. I still retain my enthusiasm for inviting the spouses of depressed persons into the treatment of depression. Like many of the therapists I interviewed, I also feel that this project has strengthened my belief in couple-therapeutic work. On the other hand, I have come to realize also the limitations and challenges surrounding this work. Couple therapy does not help all clients in all situations. There are times when it is better to find other ways of working, especially in situations where one of the spouses feels that it not possible for him or her to talk in the presence of the other spouse. (In these situations, however, I see a need to collaboratively negotiate and find ways to proceed. It might still be possible to find ways of working with the couple as a couple).

I believe working on this thesis has changed my way of working with my clients in an even more collaborative direction. To a greater extent, I negotiate with them and invite them to evaluate our collaboration throughout the time we work together. I have begun to create more possibilities for reflective processes for my clients; in couple therapy, especially at the start of the therapy, I frequently talk with one partner at a time, giving him or her the chance to express ideas, thoughts and feelings, and giving the other partner the opportunity to sit back and listen, and to really hear what the other spouse is saying. This seems to be very helpful for many couples.

This project has not merely changed my own way of working with my clients; it has also changed the work in my working place. Couple therapy has become an accepted way of treating depression, and the spouses of persons diagnosed as depressed are much more actively invited to take part in the treatment. In addition, new innovations have begun to evolve around couples and depression; there is currently a plan to start working with a group of families facing depression. In this group approach, a family therapeutic way of working will be combined with support received from other families in a similar life situation.

Doing the research has given me many opportunities to talk on this topic to different kinds of audiences. I have given presentations in both national and international congresses, and I have been teaching about it in seminars. A good deal of writing has come out of this theme – book chapters, papers in national journals, and so on. Learning how to write a scientific text has been demanding and challenging, but also rewarding. It has led me to express my ideas more clearly. I have also learned to evaluate research articles with both a critical view and with appreciation, recognizing the hard work that has gone into writing them.

4.6 Future research

There are several directions for future research. One possibility would be to continue to study the ways in which couples co-construct narratives of depression. Three different ways of co-constructing narratives were found, but how many other ways might there be? Furthermore, it would be interesting to look more closely at the ways in which the therapists take part in the co-construction. Another possibility could be to analyze the narratives in relation to the outcome of the therapies, as Koivula and Siivinen (2007) have done.

In relation to the second study, in order to capture the collaborative nature of the interviews, a case study approach could be used. This could combine information from symptom reduction, session-by-session ratings (ORS and SRS), and the interviews. Such an approach could offer a rich picture of couple therapeutic processes. In addition, the interviews in the present research concentrated on ways in which therapy had helped or not helped the clients. A broader view of what other factors had helped the clients could be adopted, bearing in mind the limitations of therapeutic work, and seeing therapy in the context of the everyday life of the clients. This would come close to the User-Constructed Outcome view advocated by McLeod and his colleagues (2009). Another direction would be to continue to study the therapists. As was mentioned earlier, a focus group interview was conducted after the co-research interviews; in it, seven therapists talked together about their experiences of being interviewed in the presence of their clients. This part of the study has not yet been analyzed and will be reported later.

Looking at the directions for future research in more general way, many possibilities open up. The co-research interviews can be used to study different contexts. The interview format is neither depression-specific nor mental health-specific. In my opinion it is a useful means for studying different kinds of clients in different settings, and different kinds of helping professionals in their work.

YHTEENVETO

Tässä tutkimuksessa tarkastellaan masennuksen pariterapeuttista hoitoa psykiatrisessa avohoidossa. Väitöstutkimus koostuu kolmesta alkuperäisartikkelista sekä näitä kokoavasta yhteenvetoartikkelista. Väitöstutkimus koostuu kahdesta osatutkimuksesta, joista ensimmäisen aineistona on ollut kolmen pariterapian neljä ensimmäistä istuntoa. Tämän tutkimuksen tutkimusmenetelmänä on käytetty narratiivista analyysiä ja sen tulokset on raportoitu ensimmäisessä tutkimusartikkelissa. Tämä aineisto kerättiin Kuopion yliopistollisen sairaalan psykiatrian klinikassa vuosina 2001 - 02. Toisen osatutkimuksen aineisto muodostuu 25 yhteistoiminnallisesta haastattelusta, jotka on tehty masennuksen pariterapiaprosessin päätyttyä. Tutkimusmenetelmänä on käytetty Grouded Theory-analyysiä. Tämän tutkimuksen tulokset on raportoitu toisessa ja kolmannessa tutkimusartikkelissa. Aineisto on kerätty Dialogiset ja narratiiviset prosessit masennuksen pari- ja perheterapiassa (DINADEP)-hankkeessa kolmessa keskuksessa (Pohjois-Savon, Länsi-Pohjan ja Helsingin ja Uudenmaan sairaanhoitopiirien alueella psykiatrissa avohoitoyksiköissä) vuosina 2007 - 08. Väitöstyö sijoittuu psykoterapiatutkimuksen kenttään, erityisenä tavoitteena on ollut tuoda tieteellinen tutkimus lähelle arkityön käytäntöjä.

Väitöskirjatyö kuuluu osana Dialogiset ja narratiiviset prosessit masennuksen pari- ja perheterapiassa – hankkeeseen (DINADEP). Väitöskirjatutkimuksen ensimmäinen osatutkimus toimi hankkeen pilottivaiheena. Toinen osatutkimus oli osa varsinaista hanketta. Hanke on Jyväskylän yliopiston psykologian laitoksen ja kolmen sairaanhoitopiirin (Pohjois-Savon, Länsi-Pohjan ja Helsingin ja Uudenmaan sairaanhoitopiirien) yhteistyötä. DINADEP-hankkeen tavoitteena on sekä masennuksen pariterapeuttisen hoidon tuloksellisuuden tutkiminen että pariterapiaprosessien tarkka analyysi. Tutkittavat olivat masennuksen vuoksi hoitoon lähetettyjä aikuisia, joilla oli parisuhde. Masennusdiagnoosi varmistettiin strukturoidulla haastattelumenetelmällä (SCID-haastattelu). Tutkittavat jaettiin satunnaisesti tutkimus- ja kontrolliryhmiin. Tutkimusryhmän potilaat saivat pariterapeuttista hoitoa, kontrolliryhmän potilaat puolestaan tavanomaista hoitoa. Molemmissa ryhmissä käytettiin lääkitystä tarpeen mukaan. Hankkeessa on kerätty monenlaista tietoa; seurantatietoa potilaiden masennusoireista BDI ja HDRS-mittareilla, parisuhdetyytyväisyydestä DAS-mittarilla ja alkoholinkäytöstä AUDIT-mittarilla. Lisäksi tutkimusryhmään kuuluneiden potilaiden kaikki pariterapiaistunnot on videoitu tai äänինauhoitettu ja jokaiselta istunnolta on kerätty ORS- ja SRS- mittareilla tietoa muutoksesta ja istuntojen arvioinneista. Pariterapiahoidon päättymisen jälkeen noin kolmen kuukauden kuluttua järjestettiin yhteisen tutkimisen haastattelu, jossa haastateltiin sekä pariskunta että heidän kanssaan työskennelleet terapeutit. Nämä haastattelut olivat toisen osatutkimuksen aineisto.

Ensimmäisessä tutkimusartikkelissa kuvataan sitä, miten pariskunnat kolmen eri pariterapiaprosessin alkupuolella yhdessä rakentavat tarinaa masennuksesta. Toinen puolisoista oli diagnosoitu masentuneeksi ja oli hakeutu-

nut hoitoon. Toinen puolisoista oli kutsuttu mukaan osallistumaan hoitoon. Tulosten mukaan kaikki pariskunnat rakensivat tarinaa masennuksesta omalla tavallaan. Ensimmäisessä tapauksessa mukaan kutsutun puolison tarina vahvisti masentuneen puolison tarinaa. Toisessa tapauksessa taas puolisot rakensivat kumpikin omaa tarinaansa. Nämä tarinat olivat keskenään ristiriidassa. Kolmannessa tapauksessa puolisot yhdessä rakensivat tarinaa masennuksesta rikastaen toinen toisensa tarinoita. Näin ollen on tärkeää, että masennuksen pariterapiassa ei keskitytä vain masentuneen puolison tarinaan masennuksesta vaan nähdään se osana ei-masentuneen puolison tarinaa ja keskitytään myös puolisoiden yhdessä rakentamaan tarinaan.

Toisessa tutkimusartikkelissa käsitellään asiakkaiden antamia vastauksia yhteisen tutkimisen haastatteluissa, joissa sekä asiakkaat että terapeutit kertovat kokemuksistaan masennuksen pariterapiasta terapian päättymisen jälkeen. Asiakkaat kokivat terapeuttien auttaneen heitä sekä ammattilaisina että ihmisinä. Mahdollisuus päästä puhumaan oli sinänsä koettu tärkeäksi. Puolison mukana olo masennuksen hoidossa oli koettu enimmäkseen auttavaksi, mutta joissakin tapauksissa se oli myös estänyt puhumista. Asiakkaat olivat olleet varsin tyytyväisiä saamaansa apuun mutta he toivat haastatteluissa esiin myös asioita, joihin he olivat tyytymättömiä tai joita he olisivat halunneet tehtävän toisin. Eräät asiakkaat olivat mm. kokeneet hämmentäväksi sen, että heille oli tarjottu pariterapiaa masennuksen hoitomuotona. Masennuksen pariterapian kehittämisen kannalta nämä asiakkaiden kokemukset on tärkeää jatkossa ottaa huomioon.

Kolmannessa tutkimusartikkelissa käydään läpi terapeuttien antamia vastauksia yhteisen tutkimisen haastatteluissa. Terapeutit toivoivat haastattelijan esittävän kysymyksiä asiakkailleen terapeuttien omasta toiminnasta, asiakkaiden kokemuksista terapian suhteen, yhteistyöstä asiakkaiden ja terapeuttien välillä, asiakkaiden hyödyllisiksi kokemista asioista, lähestymistavan sopivuudesta asiakkaille sekä terapiassa käydyistä keskusteluteemoista. Terapeutit arvelivat asiakkaiden arvostaneen terapiassa terapeuttien tapaa tehdä työtä, heidän tapaansa olla suhteessa asiakkaisiin sekä sitä, että terapeutit järjestivät ajan ja paikan puhumiselle. Hankalina hetkinä itselleen terapeutit olivat pitäneet tiettyjä hetkiä, kuten alkuvaihetta terapiassa, tiettyjä vaikeita teemoja kuten väkivaltaa ja alkoholinkäyttöä sekä epävarmuuden tunteita sen suhteen, miten edetä terapiassa. Terapeutit kokivat oppineensa asiakkailtaan siitä, miten järjestää pariterapeuttista apua masentuneille. Samoin he kokivat saaneensa uutta ymmärrystä pariterapiaprosesseista, erityisesti työskentelyn alun tärkeydestä. Kolmanneksi terapeutit kertoivat saaneensa uutta ymmärrystä kyseessä olleeseen pariskuntaan liittyen.

Kokonaisuudessa tutkimuksen tulokset nostavat esiin tarpeen ottaa masentuneen henkilön puoliso mukaan masennuksen hoitoon. Puolison mukanaolosta hoidossa oli monien pariskuntien mukaan hyötyä ja asiakkaiden kokemukset masennuksen pariterapiasta olivat myönteisiä. Tulosten mukaan, kun psykiatrisessa avohoidossa tarjotaan pariterapiaa masennuksen hoitomuotona, on tärkeää kiinnittää huomiota hoitojen alkuvaiheisiin ja yhdessä paris-

kunnan kanssa määritellä pariterapian asiakkuutta. Pariskunnilla on erilaisia tarpeita ja toiveita; masennuksen pariterapiassa on toisinaan tärkeää keskittyä parisuhteen asioihin, toisinaan masennukseen, toisinaan molempiin edellä mainituista. Yhteisen tutkimisen haastattelu osoittautui mielenkiintoiseksi ja antoisaksi tavaksi tehdä psykoterapiatutkimusta. Tutkimustyön lisäksi haastattelua voi käyttää käytännön työn kehittämisessä ja psykoterapeuttien kouluttamisessa.

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