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Ilpo Kuhlman

Accountability in Couple Therapy for Depression

A Mixed Methods Study in a Naturalistic Setting in Finland

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ABSTRACT

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Yhteenveto: Terapiamuutoksen todentaminen masennuksen pariterapeuttisessa hoidossa: Monimenetelmällinen tutkimus luonnollisissa hoito-olosuhteissa Suomessa

The aim of this research was to develop accountability in assessing the effectiveness of couple therapy for depression conducted in naturalistic multicenter settings. Participants seeking treatment for at least moderate depression were randomized to couple therapy or treatment-as-usual groups. The patients' depressive symptoms, general mental health, marital satisfaction, and alcohol use were assessed at baseline and at 6, 12, 18, and 24 months post-baseline. The spouses' depressive symptoms and marital satisfaction were assessed at the same time intervals. The couples in the couple therapy group assessed their subjective distress and the therapeutic alliance at every session. In addition, the therapists assessed the alliance at every session.

Study I (couple therapy group, n = 29; treatment-as-usual group, n = 22) indicated that the spouses had a significant role in the therapy process under both treatment conditions, and that in the couple therapy group, the spouses also benefited from the treatment. In the couple therapy group, the change in the patient's subjective distress predicted the patient's change in depressive symptoms and general mental health, and was associated with the patient's change in marital satisfaction.

Study II (couple therapy group, n = 29) indicated that subjective distress at the beginning of a session predicted the alliance at the end of the same session, and that the alliance at the end of the session predicted the subjective distress at the beginning of the next session. The therapy-system alliance was significantly associated with patients' depression outcomes, explaining 19.4% of the variance in the patients' depression change.

In Study III, a mixed methods Hermeneutic Single Case Efficacy Design (HSCED) was used to study one couple in the couple therapy group. Using both quantitative and qualitative data, it was concluded that the patient's symptoms had changed substantially during the treatment, and that the change was largely due to therapy. The mediating and moderating factors for the positive change were also identified.

The research as a whole emphasizes the importance of the spouse's involvement in treatment for depression, the provision of feedback on subjective distress and on the alliance, the need to take into account the association between subjective distress and the alliance during the treatment, and discussion of individual well-being and relational issues, in addition to the focus on depression.

Keywords: Couple therapy, depression, marital satisfaction, subjective distress, alliance, mixed methods, single-case study, naturalistic study

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Kuopio, August 2013

Ilpo Kuhlman

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APPENDICES

LIST OF ORIGINAL PUBLICATIONS

I Kuhlman, I., Tolvanen, A., & Seikkula, J. (2013). Couple therapy for depression within a naturalistic setting in Finland: Factors related to change of the patient and the spouse. *Contemporary Family Therapy*. Online first article.

II Kuhlman, I., Tolvanen, A., & Seikkula, J. (2013). The therapeutic alliance in couple therapy for depression: Predicting therapy progress and outcome from assessments of the alliance by the patient, the spouse, and the therapists. *Contemporary Family Therapy, 35,* 1–35.

III Kuhlman, I., Rautiainen, E-L., Laitila, A. & Seikkula, J. (2013). Couple therapy for depression in a naturalistic setting: A hermeneutic single-case efficacy design. Submitted manuscript.

CONTENTS

1 INTRODUCTION

The aim of this research was to develop accountability in assessing the effectiveness of couple therapy for depression, conducted within naturalistic multicenter settings. The initial stimulus for this research came during a two-day seminar in Helsinki, given by Dr. Scott D. Miller in May 2005. The subject of the seminar was accountability in psychotherapy, and in the course of the sessions the Outcome Rating Scale (ORS; Miller & Duncan, 2000) and the Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2002) were introduced. It has been noted by Fireman (2002) that accountability – considered from many points of view – is an essential issue in establishing the legitimacy of psychotherapy. Understanding the client's and the therapist's perceptions of the therapy and assessing symptom relief are clearly critical issues. Moreover, there's an idea of rigorous and open demonstration of the effectiveness of couple therapy in the face of public scrutiny. In this research, accountability was seen as constituted mainly by client feedback on the treatment progress, process, and outcome, obtained from multiple data sources. The therapists, too, took part in the assessment of the therapeutic process.

The idea of monitoring the treatment progress and process remained in my mind, and I included the ORS and SRS within my own work. An opportunity to begin research on this topic came via the research project called Dialogical and Narrative Processes in the Couple Therapy for Depression (DINADEP; Seikkula, Aaltonen, Kalla, Saarinen, & Tolvanen, 2012). The focus in the DINADEP project has been on developing couple therapy for depression in naturalistic settings. The aim has been to adapt treatments so that they are as similar as possible to those conducted in therapists' everyday work.

As a psychologist and family therapist it made sense to me to study accountability of the effectiveness and the change processes associated with couple therapy for depression, given that depression has become one of the most frequently diagnosed conditions among the adult population, and one that gives rise to severe employment disabilities (Richards, 2011). Moreover, the costs of health care are constantly rising, and customers are demanding better

and more effective treatments. These aspects embody challenges for mental health care in developing treatments with existing resources.

Over recent decades, various medical treatments and modalities in individual therapy have been introduced as treatments for depression. At the same time, research in the field of couple and family therapy has advanced, and new therapies have been developed for depression. According to research on psychotherapy, all the treatment modalities in question have shown themselves to be equally effective (Beach, 2002; Beach & Whisman, 2012; Carr, 2009; Goldfarb, Trudel, Boyer, & Préville, 2007; Wampold, 2001). Studies conducted on couple therapy have indeed produced promising results; nevertheless, the evidence on the efficacy of couple therapy for depression is not yet cogent, and more research is needed (Barbato & D'Avanzo, 2008; Stratton, 2010).

In aiming to enhance the effectiveness of couple therapy, researchers have become interested in the provision of feedback on treatment progress and on the therapeutic alliance. This interest derives from findings that an early change and a positive alliance are predictive of a good outcome (Friedlander, Escudero, Heatherington, & Diamond, 2011; Howard, Kopta, Krause, & Orlinsky, 1986; Lambert & Shimokawa, 2011; Miller & Duncan, 2004).

One rationale for the present research derived from findings in the DINADEP research project. Seikkula et al. (2012) found couple therapy for depression to be more effective than treatment-as-usual, and to entail fewer therapy sessions. Less is known about the particular factors that might generate differences between treatments for depression, in comparisons between couple therapy and treatment-as-usual groups. Moreover, several questions remain open regarding the process in couple therapy for depression, including the following: (i) What is the relationship between continuously monitored treatment progress and the outcome of the depressive symptoms? (ii) In what ways do treatment progress and the therapeutic alliance interact in the course of treatment? (iii) How is the alliance associated with treatment outcome? (iv) Is it possible to form causal process-outcome attributions, and to determine any mediating and moderating factors in relation to outcome? The research, which included three distinct but related studies, aimed to examine these questions. In all three studies, developing the accountability of couple therapy was of central interest. The study sample came from the DINADEP research project (Seikkula et al., 2012). Because the couple therapies were conducted in naturalistic settings, a mixed methods approach was used. Indeed, such an approach emerged as almost self-evident, as it allows the researcher to include multiple points of view, and to apply both qualitative and quantitative analytical methods (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005).

In Study I, the focus was on the factors that might explain the differences between the couple therapy and treatment-as-usual groups in the DINADEP study. In addition, there was interest in the predictive validity of measures obtained during the continuous monitoring of subjective distress, with regard to changes in depressive symptoms within the couple therapy group. In Study II, the focus was on the associations between subjective distress and the alliance

during the treatment, and between the alliance and the outcome within the couple therapy group. Finally, Study III investigated whether or not the therapy outcome was due to the treatment, and which specific processes might be responsible for the changes observed within a single case in the couple therapy group.

This introduction will consider depression as a burden on the individual and society, before addressing the association between marital satisfaction and depression. Thereafter, it will present some findings on couple therapy for depression. It will deal with means of developing the effectiveness research of couple therapy, starting with the common factors framework in psychotherapy, and presenting the associations between feedback provision and outcome, including feedback provision on subjective distress and the alliance, and closing with a discussion of the mixed methods study design in psychotherapy. It will also outline the broader DINADEP project to which the research belongs, and present the aims of the studies conducted within the research.

1.1 Depression as a burden on the individual and on society

Several studies have been conducted on the overall prevalence of depression (Hawthorne, Goldney & Taylor, 2008; Kessler et al., 2003; Patten, 2008), and on recovery rates (Spijker et al., 2002). The 12-month prevalence of major depression has been estimated at between 6.5% and 7.4% (Hawthorne et al., 2008; Kessler et al., 2003; Pirkola et al., 2005), while the lifetime prevalence has been estimated at approximately 16% (Kessler et al., 2003; Kessler et al., 2005). The estimates given in a review by Patten (2008) are even higher; thus Patten reports the lifetime prevalence for depression as approaching 20%, with the possibility that it may be as high as 50%. For women, the depression rate is about twice as high as that for men (Pirkola et al., 2005). Half of those persons who have a major depressive disorder recover in three months (Spijker et al., 2002), but 20% of depressive persons are at risk of chronicity 24 months later. In a study conducted in the United States (Kessler et al., 2005), depressive cases with comorbidity were as high as 40% at the 12-month follow-up, and the severity of illnesses was strongly related to comorbidity. Data from the Finnish ODIN sample indicate that every year about 3% of the working-age population experiences an episode of depressive disorder (Lehtinen et al., 2005).

Depression is connected to several forms of dissatisfaction in one's life. Thus it can involve, for example, physical assault, dissatisfaction with the control of one's finances, a low commitment to relationships, demand-withdraw transactions and a lack of constructive communication in relationships, dissatisfaction with one's decision making, and dissatisfaction with childcare task distribution (Beardslee et al., 1997; Burke, 2003; Byrne & Carr, 2000; Byrne, Carr, & Clark, 2004; Downey & Coyne, 1990; Mead, 2002; Richards, 2011; Simon, 2003; Sobocki, Jonsson, Angst, & Rehnberg, 2006;

Whisman & Bruce, 1999). There is a strong link between depression and increased mortality (Cuijpers & Smit, 2002).

There are mixed results concerning a possible increase in the prevalence of depression (Hawthorne et al, 2008; Gould, Grönlund, Korpiluoma, Nyman, & Tuominen, 2007; Karlsson, 2009; Lönnqvist, 2009); however, increases in disability benefits related to depression have important implications for the development of treatments and for rehabilitation practices (Gould et al., 2007).

1.2 Marital satisfaction and depression

The association between depression and concurrent marital distress has been well documented (Byrne, Carr, & Clark, 2004; Goldfarb et al., 2007; Heene, Buysse, & Van Oost, 2005; Hollist, Miller, Falceto, & Fernandes, 2007; Whisman & Bruce, 1999). Thus, Christensen, Atkins, Yi, Baucom, and George (2006) found that changes in individual well-being were strongly related to satisfaction in the relationship. Although the precise causal explanations for the connection between marital dissatisfaction and depression remain unclear, there is a tenfold risk for each member of the couple to become depressed if there is distress in the relationship (O'Leary, Christian, & Mendell, 1994). A good relationship can protect a person from depressive symptoms, while a complicated one can cause or maintain depression (Beach & Gupta, 2003; Joiner, Coyne, & Blalock, 1999). Hollist et al. (2007) reported marital dissatisfaction as having a strong connection with depression two years later, in addition to having a related simultaneous connection.

Research has been conducted on the association between patients' depression and marital satisfaction (i.e. involving actor effects). In addition, there appears to be a significant cross-spouse connection (i.e. involving partner effects) between marital satisfaction and depression, for both wives and husbands (Beach, Katz, Kim, & Brody, 2003; Whisman, Uebelacker, & Weinstock, 2004). The depression of one partner can cause relationship distress, and relationship distress can expose partners to depressive symptoms (Whisman et al., 2004). The depressed partner can consider the other partner to be a cause of negative relationship events, resulting in dissatisfaction within the relationship; conversely, marital distress may lead to accusations of the partner being the cause of negative events, and this may drive the partner to depression (Heene et al., 2005).

Related to this aspect, Coyne et al. (1987) found that 40% of the spouses living with a depressed person expressed distressed symptoms reaching the criterion for psychological treatment. These findings indicate that the family members of depressed persons should be assessed to determine whether they are in need of therapeutic intervention (Coyne et al., 1987; Heene et al., 2005).

1.3 Couple therapy for depression

Couple and family therapies have been found to be effective in the treatment of depression, and as effective as individual therapies or drug therapy (Beach, Fincham, & Katz, 1998; Blow & Sprenkle, 2001; Carr, 2009; Dessaulles, Johnson, & Denton, 2003; Isakson et al., 2006; Seikkula et al,. 2012; Shadish & Baldwin, 2003; Wampold, 2001; Waring, Chamberlaine, Carver, Stalker, & Schaefer, 1995). For example, in dealing with couples in which the female spouse was diagnosed as having a major depressive disorder, Dessaulles et al. (2003) compared Emotion-Focused Therapy (EFT) with pharmacotherapy. They found that females receiving EFT for couples benefited more than those receiving pharmacotherapy alone. The benefit of couple therapy as compared to individual therapies is that couple therapy increases both marital satisfaction and individual well-being (Beach et al., 1998; Beach & O'Leary, 1992; Jacobson, Schmaling, & Holtzworth-Munroe, 1987). In a more recent study, Lundblad and Hansson (2005) found that even relatively brief treatment with couple therapy reduced both overall individual symptoms and depression, both in females and males.

Seikkula et al. (2012) found that couple therapy for depression in a naturalistic setting produced better outcomes than treatment-as-usual in terms of interviewer-rated depressive symptoms, with fewer treatment sessions. Moreover, family therapies for marital distress and individual mood and anxiety disorders have been shown to be more cost-effective than individual or combined psychotherapies (Crane & Christenson, 2012; Crane & Payne, 2011). The effect sizes in couple and family therapies for depression have varied from medium to large (Klann, Hahlweg, Baucom, & Kroeger, 2011; Pinsof, Wynne, & Hambright, 1996). In a review, Wright, Sabourin, Mondor, McDuff, and Mamodhoussen (2007) found that in couple therapy studies for co-morbid relational and mental disorders, the effect sizes varied from d = .74 to d = 2.89, depending on the study.

Although studies on the role of couple and family therapy in reducing depression and marital dissatisfaction have given promising results, it is by no means clear that every depressed person will benefit from couple therapy. The extant literature suggests that couple therapy is beneficial for depression only if marital dissatisfaction is present (Beach et al., 1998; Gotlib & Hammen, 1992). The focus in the most effective couple therapy modalities has been on increasing the closeness and the communicational skills of the couple (Beach & O'Leary, 1992). Rautiainen and Aaltonen (2010) found that it is important to consider not only the depressed person's narrative of depression, but also the spouse's narrative in the co-construction of a new story. The researchers found the non-depressed spouse to be a resource in creating new narratives, and emphasized the importance of encouraging the spouses towards mutual support.

The long-term effectiveness of couple and family therapy has been examined in several studies (Christensen et al., 2006; Jacobson et al., 1987; Leff et al., 2000; Lundblad & Hansson, 2006; Shadish & Baldwin, 2003; Snyder, Wills, & Grady-Fletcher, 1991). For example, Christensen et al. (2006) found both traditional and integrative behavioral couple therapy to be effective in increasing satisfaction in the relationship in a two-year follow-up. Sixty-nine percent of integrative behavioral couple therapy clients and 60% of traditional behavioral couple therapy clients achieved a clinically significant degree of benefit from the treatment. In the same study, it was found that changes in individual well-being were strongly related to the level of satisfaction in the relationship. In the London depression trial reported by Leff et al. (2000), couple therapy and antidepressant drug treatment were compared among patients who were living with a critical spouse. The patients considered the couple therapy to be more acceptable than drugs, although both treatments were effective in the treatment of depression. The couple therapy appeared to be significantly beneficial at both the one-year and the two-year follow-up. Lundblad and Hansson (2006) found that at the two-year follow-up the outcomes remained the same as at the treatment termination and in some aspects they were improved for both women and men.

The spouse has an important role to play in couple therapy for depression (Gupta & Beach, 2005; Gupta, Coyne, & Beach, 2003; Isakson et al., 2006; Rautiainen & Seikkula, 2009), and the inclusion of family members clearly enhances the benefits obtained from the patient's treatment (Pinsof et al., 1996). If the spouse is not involved or does not support the depressed partner, other forms of treatment should be considered (Gupta & Beach, 2005; Isakson et al., 2006). Thus, in a study of 95 couples receiving couple therapy, the clinically disturbed females whose partners did not show similar levels of disturbance benefited from therapy less than those who received individual therapy. Those couples sharing the same level of disturbance at the beginning of the treatment showed similar good outcomes from couple therapy. Males with clinical disturbances benefited from both individual therapy and couple therapy, irrespective whether the partner was disturbed or not (Isakson et al., 2006). The challenge for individual therapies is to develop ways of lessening marital dissatisfaction (Gupta & Beach, 2005; Gupta et al., 2003).

1.4 Developing research on effectiveness in couple therapy

1.4.1 The common factors framework in psychotherapy

The "common factors" framework in psychotherapy includes the notion that certain core ingredients are common to *all* successful psychotherapies; hence, it does not identify separate specific factors for different therapies (Asay & Lambert, 1999; Blow & Sprenkle, 2001; Hubble, Duncan, & Miller, 1999; Rosenzweig, 1936; Sparks, Duncan, & Miller, 2007; Sprenkle, Davis, & Lebow,

2009; Wampold, 2001). The framework has been supported by empirical evidence over recent decades (Duncan, Miller, Wampold, & Hubble, 2010; Wampold, 2001).

During decades of research, there have been various proposals regarding the common factors that might underlie positive outcomes in psychotherapy (Asay & Lambert, 1999; Hubble et al., 1999; Norcross & Lambert, 2011; Rosenzweig, 1936; Sparks & Duncan, 2010; Sparks et al., 2007; Sprenkle et al., 2009; Wampold, 2001). These proposals organize the common factors, derived from empirical data, into the client/extra-therapeutic factors and treatment effects as major contributors to treatment outcome. The client/extra-therapeutic factors include such as the client's strengths, motivations, distress, life events, and social support in the living environment. The treatment effects consist of the factors such as the therapist effects, alliance effects, model and technique, and model and technique delivered (including the client's hope and expectancy for recovery and the therapist's allegiance for the therapy model). According to a major review conducted by Wampold (2001), the client/extratherapeutic factors accounted for 87% of the variance of change, whereas the treatment effects accounted for 13% of the variance. There has been also a proposal, based on the empirical findings of psychotherapy research, that client feedback on treatment progress and on the quality of the alliance should be seen as a common factor (Sparks & Duncan, 2010).

The common factors framework has been regarded as a useful concept in couple therapy (Blow & Sprenkle, 2001; Sparks & Duncan, 2010; Sprenkle et al., 2009). Nevertheless, though there is broad interest in the framework within couple therapy, it has also come in for criticism. On the basis of couple therapy research, Sexton, Ridley, and Kleiner (2004) have argued that the common factors framework is inadequate; they see it as deriving from individual therapy, and as problematic when applied to family therapy. The change process is more complex in couple and family therapy, and Sexton et al. (2004) see the common factors framework as simplifying the changes that may occur. In response to such criticisms, Sprenkle and Blow (2007) have emphasized the role of the therapist as a bridge between the common factors concept and successful therapy. The fit between the therapist's worldview and the therapy modality adopted can allow the therapist to work in the manner that is best suited to her/him. The models available are important, but the therapist serves as a vehicle when delivering effective therapy for the couple (Blow, Sprenkle, & Davis, 2007). Nevertheless, Sprenkle et al. (2009) admit that the research evidence for the individual components constituting common factors in couple therapy is in its infancy. They acknowledge that further evidence for such factors is needed in couple and family therapy.

At this point it should also be noted that in couple therapy, several common factors have been proposed as belonging to an "expert consensus"; these have been derived via a modified Delphi methodology (Blow & Sprenkle, 2001). The proposed common factors are not the same as those identified by Wampold (2001) and other researchers from decades of empirical research. In

fact, the "expert consensus" sets out four common factors unique to relationship therapy, as follows: (1) conceptualization of the difficulties in relational terms, (2) the disruption of dysfunctional relational patterns, (3) an expansion of the direct treatment system, and (4) an expansion of the therapeutic alliance (Sprenkle & Blow; 2004; Sprenkle et al., 2009). It is argued that in the absence of these common factors, relationship therapy may not be possible.

Conceptualization of the difficulties in relational terms means that the therapist keeps in mind the entire sociocultural environment to which the couple belongs, with special attention to the interactional cycles between the subsystems which form the larger systems, and which are related to the problem. The disruption of dysfunctional relational patterns refers to the therapist's use of cognitive, behavioral, and affective interventions with the couple to discontinue their negative ways of interacting. Expansion of the direct treatment system means that the therapist seeks to involve more people in the therapy than merely the identified patient. Finally, the expansion of the therapeutic alliance refers to the special importance of an alliance between the therapist and each individual and subsystem, involving the whole family and the larger social or treatment system, and also the subsystems within the family.

1.4.2 Outcome research in psychotherapy

In recent years, psychotherapy research has addressed the increasingly recognized need for clinicians to demonstrate satisfactory outcomes to clients, funding bodies, and other stakeholders. The demand for accountability in health care services is a challenge for both researchers and professional educators (Sparks, Kisler, Adams, & Blumen, 2011). There has thus been a tendency to apply evidence-based treatment approaches, with arguments in favor of randomized clinical trials in psychotherapy research. Meta-analyses of individual psychotherapy research have provided evidence that on average, treated patients show an 80% benefit as compared to untreated clients (Wampold, 2001). The success rates in psychotherapy have varied from 31% for the control group to 69% for the treatment group (Wampold, 2001). In a series of clinical trials 58% of the clients recovered and 67% benefited from the treatment, with a mean of 12.7 sessions (Hansen, Lambert, & Forman, 2002; Slade, Lambert, Harmon, Smart, & Bailey, 2008). In these studies, under treatment-as-usual groups, only 14% of the clients recovered, while 20.9% benefited with a mean of 4.3 sessions. Other findings from psychotherapy research suggest that there are few or no differences in effectiveness between treatment models (Blow & Sprenkle, 2001; Wampold, 2001).

Looking at the matter positively, it could be said that a proportion of the patients do indeed seem to recover due to treatment; from a negative point of view, however, a proportion of patients show no improvement, while 5–10% may actually deteriorate (Lambert & Shimokawa, 2011; Slade et al., 2008). In a study by Harmon et al. (2007) it was found that as many as 23% of the clients were at risk of being predicted as deteriorators (i.e. they were at risk of a poor

outcome on therapy). In addition, it has been estimated that eighty percent of the customers in health care use 20% percent of the resources, and conversely, twenty percent of the customers use 80% of the resources (Ryynänen, Kinnunen, Myllykangas, Lammintakanen, & Kuusi, 2004). Moreover, dropout rates manifest a significant problem in psychotherapy. In a review of 125 studies, Wierzbicki and Pekarik (1993) observed that about 47% of the patients interrupted their treatment prematurely. This problem is familiar in all the therapy models adopted. Masi, Miller, and Olson (2003) found no differences in dropout rates among individual, couple, and family therapies.

One problem in this field is that psychotherapists do not recognize those patients that are at risk of a poor outcome or deterioration; indeed, psychotherapists tend to be over-optimistic in their evaluations concerning the recovery of their patients (Slade et al., 2008). Hannan et al. (2005) investigated how well therapists were able to identify the recovery or non-recovery of their patients during the treatment. It was found that the therapists recognized only one out of the 40 patients who got worse. Moreover, therapists tend to continue in the same way as before with clients who are at risk of a poor outcome (Kendall, Kipnis, & Otto-Salaj, 1992). Brown, Dreis, and Nace (1999) found that if clients got worse during the first three therapy visits, the risk of interruption to the course of therapy was doubled in comparison with those who were showing progress in the therapy. Given that therapists are poor at identifying possible deteriorators, it would appear that other means of obtaining the relevant information are needed.

Another problem is that the results achieved in clinical studies are not necessarily transferable to naturalistic settings in which practitioners have a heavy case load (Carr, 2009). The efficacy of couple therapy has been studied in randomized clinical trials. The emphasis in randomized clinical trials is on internal validity; the mean group data for a specific treatment are studied under the assumption that the causality between the independent and dependent variables is controlled (Bohart, Tallman, Byock, & Mackrill, 2011). The merits of these randomized clinical trials should not be underestimated; nevertheless, there are problems in transferring the results to clinical applications, since as much as 20% of the efficacy of manualized therapies can be lost when they are applied in everyday clinical practice (Shadish, Ragsdale, Glaser, & Montgomery, 1995; Sprenkle et al., 2009). There is thus a need for more clinically representative studies in naturalistic settings (Shadish & Baldwin, 2005).

1.4.3 Feedback provision and outcome

Recently, individual and family therapy researchers have emphasized the importance of monitoring client feedback during therapy (Friedlander et al., 2011; Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, & Tutle, 2004; Lambert & Shimokawa, 2011; Pinsof & Wynne, 2000; Slade et al., 2008; Sparks & Duncan, 2010; Sparks et al., 2011). The provision of client feedback fits logically with the common factors framework mentioned above. Clinicians cannot know

in advance what will work for a given client; thus, there is a need to monitor treatment as it progresses. Moreover, collecting client feedback routinely can be tied to the growing interest in outcome, since clinicians can use this system on an everyday basis to track their outcomes (Sparks et al., 2011).

A challenge for previous psychotherapy research models emerged with the development of a new research paradigm called *patient focused research* (Howard, Moras, Brill, Martinovich, & Lutz, 1996; Lutz, 2003). Basic questions concerning the effectiveness and efficacy of psychotherapy were formulated, namely (i) whether it works under special conditions, (ii) whether it works in clinical practice, and (iii) whether it works for a given patient. Using these questions as a framework, studies were carried out, indicating that if positive changes in treatment do not occur early, there is an increased risk that no benefit will occur (Beach, Sandeen, & O'Leary, 1990; Brown et al., 1999).

There has been an increasing focus on several concepts that have been seen as associated with the treatment outcome. These include early symptom change, progress feedback, the therapeutic alliance, therapeutic techniques, and the role of the therapist and the patient (Barber, 2009; Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Beach et al., 1990; Howard et al., 1986; Howard et al., 1996, Thomas, Werner-Wilson, & Murphy, 2005; Werner-Wilson, Michaels, Thomas, & Thiesen, 2003; Whipple et al., 2003). Studies on individual and couple therapies have indicated that if the therapists receive ongoing feedback (from every session) on the patients' progress and alliance, their patients benefit more from therapy, and that if the patients are at risk of a negative outcome, feedback provision doubles the success rates (Anker, Duncan, & Sparks, 2009; Friedlander et al., 2011; Hannan et al., 2005; Hawkins et al., 2004; Lambert et al., 2001; Lambert et al., 2002; Lambert & Shimokawa, 2011; Pinsof & Wynne, 2000; Slade et al., 2008; Whipple et al., 2003). In line with this, Hannan et al. (2005) found that systematic feedback provision correctly identified all the patients (N = 36) who were at risk of a poor outcome. This method identified 86% percent of the at-risk patients as early as the third session. In a review, Lambert (2010) found that out of patients at risk of a poor outcome, 45% recovered to a clinically significant degree (Jacobson & Truax, 1991), if feedback provision was applied. In the treatment-as-usual group, the recovery rate was only 22%. In the feedback group, both the patients and the therapists received the feedback information, and the therapists used Clinical Support Tools to assist them in enhancing the alliance and the patient's motivation, and to evaluate and reinforce social support for the patient. In addition, with clients at risk of a poor outcome, more sessions could be provided if feedback was available. Overall, research has demonstrated the value of routinely monitoring clients' feedback on treatments, while emphasizing also the point that therapists need assistance with clients who are at risk of a poor outcome (Slade et al., 2008).

The research designs commonly used include an analysis of progress measures at intake, at treatment termination, and at follow-up. However, the change is not always a gradual or linear continuum: fluctuations can appear in

the progress made, and various patterns of change during treatment have been identified (Hayes et al., 2007; Stulz, Lutz, Leach, Lucock, & Barkham, 2007). Multiple measurement points are recommended for use in the study designs and data analyses, the aim being to gain more precise information on progress, and on those patients who are at risk of a poor outcome (Lambert, 2010; Laurenceau et al., 2007; Pinsof & Wynne, 2000; Sparks & Duncan, 2010).

Studies have also been conducted on how the frequency of feedback provision may affect the treatment outcome. In couple and family therapies this question is of added importance, given that obtaining feedback from several persons (within a couple or family unit) may be a complex task. Ogles et al. (2006) reported that in a study on feedback in wraparound services for young people and families, feedback at four intervals did not improve the young people's outcomes or family functioning as compared to a no-feedback group (the 48-item Ohio Scale was used; Ogles, Melendez, Davis, & Lunnen, 2001). In contrast, Anker et al. (2009) studied feedback on subjective distress in couple therapy for marital distress within a naturalistic setting, monitoring the feedback at each session. They found that the couples in a feedback group achieved almost four times more clinically significant changes than those under treatment-as-usual, and the results were maintained at the six-month follow-up. There was also a significantly lower rate of separation or divorce in the feedback group. Reese, Toland, Slone, & Norsworthy (2010) replicated the study procedure on couple therapy and obtained broadly similar results.

Multiple methods and measures have been developed for obtaining feedback (Barkham et al., 2001; Horvath & Greenberg, 1989; Howard et al., 1996; Kordy, Hannöver, & Richard, 2001; Lambert et al., 1996; Miller & Duncan, 2004; Pinsoff et al., 2009). For example, Lambert and his colleagues (1996) developed Outcome Questionnaire – 45 (OQ-45) to measure the progress during treatment, and Horvath and Greenberg (1989) introduced the Working Alliance Inventory (WAI) to measure the experience of the alliance.

The scales used to measure the patient's progress and alliance, have been found to be time-consuming (Miller & Duncan, 2004). In fact, therapists are unlikely to use a measure that takes more than five minutes to complete, score, and interpret (Brown et al., 1999). As a solution to this problem, the *Partners for Change Outcome Management System* (PCOMS) was developed, the aim being to obtain continuous client feedback and thus improve outcomes (Duncan, 2012; Duncan, Miller, & Sparks, 2004; Miller, Duncan, Sorrell, & Brown, 2005). PCOMS serves as a brief alternative to Lambert et al.'s (1996) feedback model which uses the OQ-45 measure. PCOMS involves the Outcome Rating Scale (ORS; Miller & Duncan, 2000) for measurement of subjective distress, and the Session Rating Scale (SRS; Miller et al., 2002) for measurement of the alliance. Both scales are ultra-brief measures: completing, scoring, and interpreting the responses takes only few minutes with paper versions, and less than a minute with computerized versions (Duncan et al., 2004; Miller et al., 2005). Due to the brevity of the measures, the system is feasible for everyday use by clinicians in naturalistic settings, even under a heavy case load.

PCOMS differs from Lambert et al.'s (1996) assessment model in two ways; firstly, PCOMS involves an open discussion with the client on the feedback of progress at every session; secondly, the therapeutic alliance is measured at every session, and once again there is discussion with the client regarding the feedback. Having these features, PCOMS functions as a collaborative instrument for the therapist and client to assess the treatment progress and process (Duncan, 2012). Moreover, ORS is not a measure of symptoms or problems, assessed by the clients or others. Instead, it is a measure for assessing the client's global subjective distress, and it expresses the client's need for help (Campbell & Hemsley, 2009; Duncan, 2012; Miller, Duncan, Brown, Sparks, & Claud, 2003).

1.4.4 Subjective distress and outcome

The research reported in this dissertation investigated whether the patients' and the spouses' experience of subjective distress (measured via ORS) during couple therapy predicted changes in depressive symptoms, general mental health, and marital satisfaction at the six-month post-baseline assessment. The basis of the interest in studying the relationship between subjective distress and therapy outcome lies in studies previously conducted on psychotherapy efficacy (Frank & Frank, 1991; Howard et al., 1986; Howard, Lueger, Maling, & Martinovich, 1993; Howard et al., 1996; Lutz, 2003). Thus, Howard et al. (1993) developed a phase model of psychotherapy on the basis of Jerome D. Frank's (Frank & Frank, 1991) work on the concepts of *demoralization* and *remoralization*. According to the phase model, change occurs in three different phases, with the movement to a later phase requiring development in an earlier phase.

Patients seek treatment after they have tried to solve their psychic problems by various means; these efforts have failed, causing them to experience subjective incompetence, which involves a sense of powerlessness and hopelessness. Moreover, the patients have become distressed due to their negative emotional feelings. Subjective incompetence together with distress can be regarded as *demoralization* (de Figueiredo, 2007; de Figueiredo & Frank, 1982). The first change phase, *remoralization*, involves both an increase in the patient's subjective well-being (i.e. reduction of subjective distress) and resolution of the subjective incompetence. The essential elements of the recovery process in this phase include the patient's feelings of hoping for help, the patient's confidence in the therapists, the patient's ability to define problems as internal rather than external, and the alliance between the patient and the therapist early in the treatment (Howard et al., 1993).

The second change phase manifests itself as a decrease in the patient's symptoms (e.g. depression) and/or a solution to life problems (*remediation*). During this phase, the therapy involves a mobilization of the patient's coping skills and the finding of new and more effective coping skills. In the third phase, the patient's life-functioning improves (*rehabilitation*). During this phase, the treatment involves the unlearning of longstanding dysfunctional and

maladaptive patterns, and the establishment of new patterns of life-functioning (Howard et al., 1993).

Many studies have been conducted on the association between subjective distress and the symptoms and the symptom change. Howard et al. (1993) reported that clients' increased well-being (i.e. reduction of subjective distress) preceded and was probably essential for symptom relief, and this result was supported by Callahan, Swift, and Hynan (2006). In a review, Hammen (2005) found that there was a clear association between subjective distress and depression. Symptom-specific subjective distress has been found to predict a search for treatment for depression (Angst et al., 2010). Anderson and Lambert (2001) found that subjective distress at the outset was a strong predictor of patients' experience of change. Moreover, in a study examining deterioration in a training clinic context, it was found that increased symptoms reliably preceded both decreased functioning and decreased well-being (Swift, Callahan, Heath, Herbert, & Levine, 2010). Finally, general mental health has been found to present a global distress factor, and there is an association with depressive symptoms (Holi, 2003; Ivarsson, Lindström, Malm, & Norlander, 2011; Kennedy Morris, Pedley, & Schwab, 2001).

An association has also been observed between subjective distress and marital satisfaction (Diener, Gohm, Suh, & Oishi, 2000; Lincoln & Chae, 2010; Williams, 2003). Subjective distress is related to an increase in counterproductive interactions in close relationships, to the development of marital discords, and the emergent risk of divorce (Bodenmann, Ledermann, & Bradbury, 2007; Randall & Bodenmann, 2009). Mastekaasa (1995) found a relationship between a period of subjective distress (lasting four years) and subsequent marital separation.

1.4.5 The alliance and the outcome

Another interest in the research reported here concerned the relationship between the therapeutic alliance (measured via SRS) and the therapy outcome. According to Bordin (1979), the basic elements of the therapeutic alliance are agreement on goals, agreement on tasks, and a relational bond. In couple and family therapy, it has been suggested that there could be a fourth element, namely the interpersonal dimension of the alliance (Johnson & Wright, 2002; Pinsof, Zinbarg, & Knobloch-Fedders, 2008).

The patient's and the therapist's agreement on the topics related to change has been found to play a significant role in the formation of the alliance (Hubble et al., 1999). Both the patient and the therapist have a "theory" about the origins of and the solution to the problem; a fit between these theories creates a basis for mutual agreement on the goals of the treatment, and makes possible the formation of a functional alliance. In addition, family-of-origin distress and social support in current social relationships have been found to be connected to the creation of the alliance, and in couple therapy, the couple's former relationship, higher marital distress, and relational power differences emerge as factors associated with the forming of an alliance with the therapist (Garfield,

2004; Knobloch-Fedders, Pinsof, & Mann, 2004; Mallinckrodt, 1991; Symonds & Horvath, 2004).

The start of therapy is important for creating a beneficial therapeutic interaction (Laitila, Aaltonen, Wahlström, & Angus, 2001). Right from the first therapy session the challenge for the therapist is to contribute to an atmosphere that will facilitate new kinds of discussion, differing from the discussions occurring in the couple's home (Thomas et al., 2005). The therapist's characteristics contribute to whether the patient's feeling of hope increases, and to whether the patient has a feeling of being heard in relation to his/her need (Baldwin, Wampold, & Imel, 2007). In later phases of therapy, there are challenges for therapists in maintaining a positive alliance and in repairing ruptures in order to continue the therapy process successfully (Horvath & Luborsky, 1993; Rait, 2000; Safran, Muran, & Eubanks-Carter, 2011; Sprenkle et al., 2009).

The alliance has been found to predict outcome in couple and family therapy across treatment modalities and orientations (Anderson & Johnson, 2010; Anker, Duncan, Owen, & Sparks, 2010; Bourgeois, Sabourin, & Wright, 1990; Friedlander et al., 2011; Johnson & Talitman, 1997; Knobloch-Fedders, Pinsof, & Mann, 2007; Pinsof et al., 2008; Quinn, Dotson, & Jordan, 1997; Sparks & Duncan, 2010; Symonds & Horvath, 2004). In a meta-analysis, Friedlander et al. (2011) found a moderate association between the alliance and treatment outcome in couple and family therapies (r =.26).

In line with these trends, within a group marital skills training program the therapeutic alliance explained the outcome on relational distress at a level of 5% for women and 7% for men (Bourgeois et al., 1990). Using a systemic model of psychotherapy called integrative problem-centered therapy, Knobloch-Fedders et al. (2007) found that the alliance predicted the outcome at a level of 5% for men and 17% for women. In EFT for couples, the alliance accounted for 22% of the variance in post-treatment dyadic satisfaction, and 29% of the variance at follow-up (Johnson & Talitman, 1997).

In research on individual, couple, and family therapies, there has been mixed findings concerning which person's evaluation of the alliance is the best predictor of treatment outcome. Horvath and Symonds (1991) found that the patient's rating of the alliance is a better predictor of the outcome than the therapist's assessment. On the other hand, Martin, Garske, and Davis (2000) found that patients', therapists', and observers' ratings of the alliance were all adequately reliable. In addition, Symonds and Horvath (2004) found that in couple therapy the therapists' ratings of the alliance constituted better predictors of the outcome than the couples' ratings. A meta-analysis by Friedlander et al. (2011) found that in couple therapy the observers' perceptions of the alliance were more accurate than the couples' self-reported assessments of the alliance. Friedlander et al. (2011) emphasized the significance of the entire experience of the alliance at the therapy-system level: co-operation between the family and the therapists (involving commitment, connectedness with the therapists, and feelings of safety) may be necessary at the beginning of the

treatment when the alliance is forming. In later phases of the treatment, co-operation between family members may take on added importance. In previous studies, both the family members and the therapists have assessed the clients' experience of the alliance. In the present study, an important aspect was that both the couple and the therapists assessed their own perception of the alliance.

The results are mixed as to whether measurement of the alliance at an early point, at mid-therapy, or at the end of treatment is the best predictor of the outcome (Anker et al., 2010; Bourgeois et al., 1990; Knobloch-Fedders et al., 2007; Symonds & Horvath, 2004). There are also mixed findings concerning the extent to which the alliance is stable, or else varies in the course of the treatment (Knobloch-Fedders et al., 2007; Sprenkle et al., 2009). Anker et al. (2010) found three different alliance patterns (high linear, moderate linear, and low linear) in their investigation of alliance development and couple outcomes. To better understand whether the therapeutic alliance remains stable over the course of couple treatment or whether it varies over time, and whether this stability/variability is associated with the outcome of the treatment, it is recommended that there should be analyses of measurements from every treatment session, during the course of the treatment (Watson, Schein, & McMullen, 2010). In view of these findings, couple therapy studies recommend routine evaluation of the alliance in order to enhance the benefits of treatment, and to identify those patients who are in at risk of a poor outcome; in this way one may seek alternative actions with those patients who manifest the risk of an alliance rupture (Friedlander et al., 2011; Pinsof & Wynne, 2000; Sprenkle et al., 2009).

Previous research on couple therapy has supported opposing positions, indicating on the one hand that individual symptom distress has no effect on the formation of the alliance (Knobloch-Fedders et al., 2004; Mamodhoussen, Wright, Tremblay, & Poitras-Wright, 2005), and on the other hand that male symptom distress has an effect on alliance formation in couple therapy (Nishida, 2007). Overall, the research shows mixed results on the association between the therapeutic alliance and individual functioning in couple therapy for relational distress. Anker et al. (2010) found that alliances were predictive of individual outcomes in treatment for marital distress in natural settings. Anderson and Johnson (2010) found that female partners' individual psychological distress was affected by their own between-system alliances and by their male partners' alliances (both within-system and between-system) in couple therapy for relational distress. Knobloch-Fedders et al. (2007) found that for women and men alliances did not predict progress in individual functioning.

It should be noted here that patients seldom verbalize their dissatisfaction before they decide to terminate treatment (Bachelor & Horvath, 1999); hence it is important for therapists to get feedback on their clients' ratings of the alliance during the treatment. With feedback from the session, the therapist can adjust the treatment in order to make it more relevant to the client's needs, in cases

where the client shows no improvement or is at risk of terminating the treatment.

1.4.6 The mixed methods study design

As mentioned above, randomized clinical trials have been challenged as an appropriate method in psychotherapy research (Bohart et al., 2011; Elliott, 2002). The results of randomized clinical trials indicate only what works on average; thus the broader context is ignored, the therapist's and the patient's experiences are disregarded, and there is no description of the process leading to treatment outcome (Elliott, 2002; McLeod, 2010). There is also a gap between researchers and clinicians, in the sense that the results obtained in research are not easily transferrable to naturalistic settings (Dattilio, 2006). Because of these defects, mixed methods study designs and systematic case studies have been proposed as an alternative source of information in psychotherapy research (Dattilio, 2006; Dattilio, Edwards, & Fishman, 2010; Elliott, 2002; Hanson et al., 2005; McLeod, 2010). The fact that any research method has strengths and weaknesses argues for a synthesis of results derived from various methods, one that will encompass group and case studies, using multiple quantitative and qualitative sources of data, and analytical methods (Dattilio et al., 2010).

A mixed methods study design will thus involve multiple data collection methods including both quantitative and qualitative data sources. By this means the procedure known as *triangulation* is followed (Hanson et al., 2005), in order to verify, enrich, and deepen knowledge of the phenomenon under study. The research reported in this dissertation used concurrent triangulation, which combines quantitative and qualitative research methods; thus a given research subject gave rise to both quantitative and qualitative data, with the two types of data being collected and analyzed at the same time (Hanson et al., 2005).

Single-case studies have been proposed as a means to bridge the gap between researchers and clinicians (Barlow, 1981; Dattilio, 2006). Via systematic single-case studies, there are better opportunities to obtain information on the unique characteristics of the case (Elliot, 2002; McLeod, 2010), including practical knowledge of the case (Ruddin, 2006).

Elliot (2002) introduced the Hermeneutic Single Case Efficacy Design (HSCED) as a method for systematically evaluating the efficacy of treatment in single cases. HSCED is a mixed methods study design; the conclusions are established through multiple data sources, utilizing both quantitative and qualitative data. The first two questions that the HSCED must evaluate are (i) whether a change has occurred, and (ii) whether the change is a causal effect of the therapy. A third question then arising, in the event of change, is which specific processes (i.e. moderators and mediators) caused the change. Note also that HSCED aims not only to obtain evidence for the efficacy of the therapy, if such evidence exists, but also to discover alternative explanations for any change.

Elliot et al. (2009) presented an adjudicated form of the HSCED method, aimed at strengthening the causal validity of the process-outcome attribution in

single case studies. The first step in the adjudicated HSCED method is to compose a *rich case record*, describing the patient's change process and outcomes before, during, and after treatment. Thereafter, *affirmative and skeptic briefs* are created, each making the best case possible, the purpose here being to highlight both therapy-driven and non-therapy driven explanations for the change. Each of the views expresses a rebuttal of the contrary case, and in addition, provides a narrative summary of the case, seeking to convince the reader of the explanation argued for. In the procedure outlined by Elliot et al. (2009), three judges formed independent judgments on the research questions, based on the process and outcome data. The final conclusions were based on these adjudications.

In this research, an adapted HSCED method was used in order to study whether the therapy process caused the outcome of one depressed patient and her spouse in couple therapy for depression, within a naturalistic setting. The quantitative measures and the qualitative sources were different from those in Elliot's adjudicated HSCED version; nevertheless, the research procedure was substantially consistent with the original method.

1.5 The DINADEP project

This research was located within the broader research project called Dialogical and Narrative Processes in Couple Therapy for Depression (DINADEP; Seikkula et al., 2012). The DINADEP project was conducted to develop therapy for depression and to investigate the effectiveness of couple therapy in naturalistic clinical settings. The participants were recruited via the usual routes from the adult population of the hospital districts of Northern Savo, Western Lapland, and Helsinki-Uusimaa.

DINADEP aimed at high external validity and focused on both the processes and the outcomes of treatments. The participants were randomized into couple therapy and treatment-as-usual groups. The patients underwent baseline and 6, 12, 18 and 24-month post-baseline individual assessments using a battery which included assessments of depressive symptoms, general mental health, marital satisfaction, and use of alcohol. The baseline and the post-baseline assessments were conducted in the research sites by persons other than the therapists. The spouses rated their depressive symptoms and marital satisfaction independently, and the assessments were collected about the same time as the patients' assessments. Precise descriptions of the participant flow, background information, and the study methods are presented in the Methods section.

Within DINADEP research project, in order to increase the external validity of the investigations, the therapists were advised that as far as possible they should conduct the therapies in the normal manner for their work. The additional work required of the therapists in the couple therapy group involved obtaining feedback on subjective distress and on the alliance from each session.

Moreover, the therapists, too, were required to complete an alliance measure at the end of every session.

The main findings of the DINADEP research project were that in the couple therapy group there were significantly fewer therapy sessions; also that from baseline to the six-month outcome, the patients in the couple therapy group demonstrated significantly better gains in interviewer-rated depressive symptoms, in self-rated general mental health, and in decreases in alcohol consumption, as compared to those in the treatment-as-usual group. These differences were maintained throughout the entire two-year research period (Seikkula et al., 2012).

An interesting qualitative research on DINADEP research project was conducted by Rautiainen (2010), who used a Grounded Theory methodology to examine the quality of couples' experiences of couple therapy for depression. At three months from therapy termination, the couples and also the therapists took part in co-research interviews (Andersen, 1997), which were conducted by an outside interviewer (mostly Rautiainen herself). These co-research interviews were video- or audio taped and thereafter transcribed. Rautiainen found that many couples assessed couple therapy for depression as having been helpful to them, and that both the couples and the therapists considered the spouse's participation in the treatment to be beneficial. In addition, the couples appreciated the therapists' actions, including their way of relating to the patients and the spouses. Finally, it appeared that negotiation of the focus of the work was important; Rautiainen speculated whether the focus should be on relational issues or on depression.

My participation in the DINADEP research project began when I joined the research group in January, 2006 – at the same time as the inclusion period for the study participants began. Hence, I was not involved in the planning phase of the study. My participation in the data collection involved conducting the baseline assessment and the 6, 12, 18 and 24-month post-baseline assessments for five patients (two patients in the couple therapy group and three patients in the treatment-as-usual group). In addition, I was a co-research interviewer in two cases in the couple therapy group. I did not actually take part in the couple therapies as a therapist. Otherwise, my attendance in the project was mainly in the capacity of a "well-intentioned" researcher from outside, helping in whatever way I could as a trained family therapist.

1.6 Aims of the research

The current research aimed to develop accountability in assessing the effectiveness of couple therapy for depression, conducted in naturalistic multicenter settings. Accountability involved (i) the quantitative and qualitative understanding of a client's and a therapist's perception of the therapy practice that occurred, and (ii) the assessment of symptom relief. Accountability in the effectiveness of treatment for depression has become a crucial issue in times

when the costs of health care are increasing, and when consumers and stakeholders increasingly demand evidence of treatment effectiveness. These factors make the development of effective psychological treatments a challenge for those working in the field. In responding to this challenge, research on both individual and family psychotherapies has emphasized the connection between client feedback and the outcome of the treatment, and the usefulness of client feedback provision during the treatment (Lambert & Shimokawa, 2011; Sparks et al., 2011). However, there was still a lack of knowledge concerning how continuous monitoring of the patient's and spouse's progress and of the alliance may be related to the outcome in couple therapy for depression, and concerning the kinds of mediating and moderating factors that may be related to change.

An overall goal of these studies was to develop accountability in couple therapy for depression in real-world practices, by exploring whether there might be feasible methods for practitioners to monitor the treatment progress and process on a session-by-session basis. The specific aims and hypotheses of the research were:

1) To examine possible explanations for differences in changes in depressive symptoms between couple therapy and treatment-as-usual groups, over the first six months of therapy (Seikkula et al., 2012). Changes in marital satisfaction are also of interest. It is hypothesized that the spouse's participation in therapy benefits the patient's treatment for depression, and that the spouse also benefits from it (Coyne et al., 1987; Gupta & Beach, 2005; Gupta et al., 2003; Heene et al., 2005; Pinsof et al., 1996). Study I.
2) To examine within the couple therapy group whether the feedback provided by patients and/or spouses regarding subjective distress show a relationship with changes in depressive symptoms, general mental health, and marital satisfaction. It is hypothesized that the changes in subjective distress is associated with the treatment outcome (Anker et al., 2009; Duncan, 2012; Lambert & Shimokawa, 2011; Sparks & Duncan, 2010). Study I.
3) To explore within the couple therapy group the association between subjective distress and the therapeutic alliance during the therapy. It is hypothesized that there is an association between subjective distress and the therapeutic alliance during the therapy (Anderson & Johnson, 2010; Anker et al., 2010; Nishida, 2007). Study II.
4) To determine within the couple therapy group whether the quality of the alliance is associated with the patient's depression outcome. It is hypothesized that the therapeutic alliance is associated with the treatment outcome (Anker et al., 2010; Duncan, 2012; Friedlander et al., 2011; Sparks & Duncan, 2010). Study II.
5) To determine within a single case whether the patient changes during couple therapy for depression. Study III.
6) To determine within a single case whether the observed changes are due to the couple therapy for depression. Study III.

7) To determine within a single case which specific moderators or mediators are involved in the changes observed in the couple therapy for depression. It is hypothesized that both the client/extra-therapeutic factors and therapy effects are identifiable as the cause of the outcome of one depressed patient and her spouse in couple therapy for depression (Beach et al., 1998; Carr, 2009; Elliot, 2002; Elliot et al., 2009; Klann et al., 2011; Shadish & Baldwin, 2003; Sparks & Duncan, 2010; Sparks et al., 2007; Sprenkle et al., 2009, Wampold, 2001). Study III.

2 METHODS

2.1 Study design

As mentioned above, this research was part of the DINADEP research project (Seikkula et al., 2012). The participants were seeking treatment for depression from outpatient mental health services either on their own initiative or via a referral. The inclusion criterion was a rating at least 14 (Rush et al., 2008) on the Hamilton Depression Rating Scale (HDRS; Hamilton, 1960). Unipolar depression (296.2 and 296.3) was diagnosed by the Structured Clinical Interview for DSM disorders (SCID; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). The other inclusion criteria were that the client should be under 65 years of age and living in a heterosexual relationship. The exclusion criteria were as follows: clear psychotic symptoms; organic brain disorder; bipolar disorder; serious violence between the spouses; severe suicidal behavior that would prevent participation in therapy discussions; previous family or couple therapy due to depression during the two years prior to treatment for the current episode. Both the patient and the spouse were given information on the research and were asked for their written consent to voluntary participation in the research. The Ethics Committees of the hospital districts of Northern Savo, Western Lapland, and Helsinki-Uusimaa approved the study. The inclusion period started in January 2006 and ended in August 2007.

A total of 132 patients (females 46%) were given the opportunity to participate in the study. Out of these, 50% refused to participate (n = 66). The most common reasons for non-participation were: unwillingness to involve the spouse in the therapy (51%), unwillingness to take part in the study at all (21%), and unwillingness to be video or audio recorded (15%). Those refusing participation were more likely to be women, to have a better employment status, and to have had a shorter period of depressive symptoms. Overall, it appeared that the participants had a more difficult life situation and a background of more severe symptoms than depressed patients in general (Seikkula et al., 2012).

The participating patients (n = 66) were randomized into a couple therapy group (n = 35) and a control "treatment-as-usual" group (n = 31). Fifteen participants (23%) were lost over the 6, 12, 18, and 24-month post-baseline assessments and were thus excluded from the final analysis (Seikkula et al., 2012). Hence, the final sample in this study consisted of 51 participants (couple therapy group n = 29 and treatment-as-usual group n = 22). The formation of the sample is shown in Figure 1. The background information on the couple therapy and treatment-as-usual groups is shown in Tables 1 and 2.

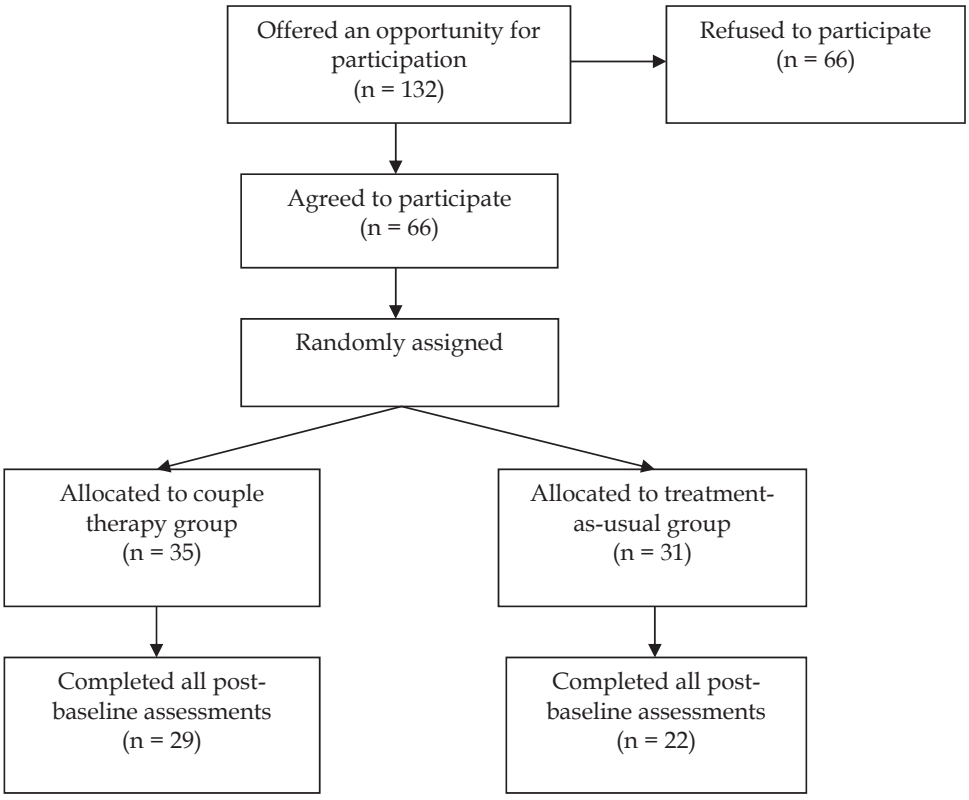

FIGURE 1 Formation of the sample.

TABLE 1 Background information at baseline; *t*-tests for couple therapy and treatment-as-usual groups.

	CT (*n* = 29)	TAU (*n* = 22)			
	M (SD)	*M (SD)*	*t*	*df*	*p*
Patient's age	41.2[a] (11.0)	43.5[a] (11.2)	-.540	48	.592
Spouse's age	40.9[a] (12.3)	43.5[a] (11.7)	-.734	45	.467
Duration of unemployment	3.6[b] (7.5)	0.9[b] (2.0)	1.766	30.80	.087
Duration of depressive symptoms	38.0[b] (56.3)	45.0[b] (63.7)	-1.097	26.89	.282
Children under school age	0.3[c] (0.53)	.09[c] (.43)	1.384	48.77	.173
Test for alcohol-related disorders (AUDIT)	10.5 (8.0)	6.2 (4.8)	2.429	46.59	.019
Use of antidepressants at baseline	26.5[d] (71.8)	29.1[d] (71.7)	-.128	49	.899
Number of patients using antidepressants at baseline	14	11	-	-	-

Note: CT = Couple therapy group; TAU = Treatment-as-usual group; AUDIT = Alcohol User Disorders Identification Test; [a] = years; [b] = months; [c] = number; [d] = weeks.

TABLE 2 Means, standard deviations, and effect sizes for BDI, HDRS, SCL-90, DAS.

	CT (*n* = 29)				TAU (*n* = 22)			
	Patient		Spouse		Patient		Spouse	
	M (SD)	*d*	*M (SD)*	*d*	*M (SD)*	*d*	*M (SD)*	*d*
BDI								
Baseline	24.2 (5.38)		9.3 (8.59)		24.1 (5.51)		4.7 (4.65)	
6-month outcome	14.6 (9.33)	1.78	6.3 (5.73)	0.35	18.3 (11.22)	1.05	3.4 (3.57)	0.28
HDRS								
Baseline	20.2 (4.40)		-		19.6 (4.25)		-	
6-month outcome	11.2 (7.64)	2.05	-		13.2 (7.75)	1.51	-	
SCL-90								
Baseline	2.57 (.40)		-		2.51 (.52)		-	
6-month outcome	1.95 (.51)	1.55	-		2.28 (.78)	0.44	-	
DAS								
Baseline	103.3 (12.52)		104 (12.48)		105.1 (13.06)		111.4 (9.80)	
6-month outcome	105.8 (13.81)	0.2	106 (14.81)	0.13	106.1 (14.92)	0.07	110.7 (9.36)	0.07

Notes: CT = Couple therapy group; TAU = Treatment-as-usual group; BDI = Beck Depression Inventory; HDRS = Hamilton Depression Rating Scale; SCL-90 = Symptom Checklist 90; DAS = Dyadic Adjustment Scale.

2.2 Participants

2.2.1 Study I

The sample comprised 51 participants, split into 29 patients (plus their spouses) in the couple therapy group and 22 patients in the treatment-as-usual group. The mean age of the study population was 42 for both the patients and the spouses. The patients' gender distribution in the total final sample was 24 women and 27 men, with the couple therapy group containing more men than women (18 men vs. 11 women) and the treatment-as-usual group more women than men (13 women vs. 9 men). The differences were not significant. In the couple therapy group, the patients consumed more alcohol than in the treatment-as-usual group (Table 1). In the couple therapy group, the spouses had more depressive symptoms (t = 2.38, df = 44.73, p = .022) and lower marital satisfaction (t = -.2.23, df = 47, p = .031) than in the treatment-as-usual group (Table 2). The groups did not differ in respect of the patients' depressive symptoms, general mental health, or marital satisfaction. In these respects the groups resembled each other, and can thus be seen as comparable.

2.2.2 Study II

The study was conducted on all 29 couples from the couple therapy group; eleven of the patients were female. The mean age was 41.2 years for the patients, and 40.9 years for the spouses. Note that there was no treatment-as-usual comparison in this study.

2.2.3 Study III

The case for this single-case study was selected from the couple therapy group as fulfilling two main criteria: (i) from an initial examination the change appeared to be positive for the patient; nevertheless (ii) the change could have been attributed either to the therapy or to changed psychobiological and/or life situations. The members of the couple selected were given the names of Marja and Pauli for the purposes of this study. Marja was aged 53 and Pauli aged 55 when therapy was undertaken. The couple had been together for 21 years.

2.3 Therapies

The sessions in the couple therapy group (Studies I – III) were conducted by case-specific co-therapy teams of two family therapists (30 therapists were recruited; 20 females, 10 males), each with at least a three-year training in systemic family therapy. The mean age of the therapists was 51 years (range 39–61; all Caucasian). The therapists' experience in couple and family therapy

ranged from one to 30 years, with a mean of ten years. The number of couples treated by each therapist in Studies I and II varied from one to five. The therapists in Study III were named as Liisa and Jarmo for the purposes of this study. They were trained as clinical psychologists and as family therapists at specialist level. Liisa was also trained as a psychodynamic psychotherapist at specialist level. Liisa had sixteen years and Jarmo seven years of post-training experience of family therapy before therapy started.

There was no specific manual for the therapy, and the therapists were advised to conduct the treatments as they usually did in their work. Within their work the therapists integrated systemic family therapy (Jones & Asen, 2000), a collaborative approach (Anderson, 2001), reflective processes (Andersen, 1991), narratives (Carr, 1998; White & Epston, 1990), and dialogues generated in the treatments (Seikkula & Trimble, 2005).

The treatments were expected to last for as long as required, depending on the patient's need. Within the couple therapy group a minimum of five sessions was set as a study criterion, with the aim of ensuring that a couple-therapeutic process truly occurred. The patient could have individual psychotherapy sessions if this was needed as part of the couple therapy process. In addition to this, patients could be given all the forms of treatment seen as necessary, for example psychiatric consultation, medication, and hospitalization.

The treatment-as-usual group (Study I) included individual treatment with possible individual or group psychotherapy sessions, along with other forms of usual treatment (e.g. psychiatric consultation, medication, and hospitalization). When necessary for the patient's treatment, the patient and his/her spouse could have family or couple sessions; however, the couple were given information only on depression and on the form of treatment. If there was a non-urgent need for couple therapy intervention, the couple were asked to wait nine months for it to begin. However, if the need for couple intervention was urgent, the sessions were started immediately, and the patient was excluded from the study.

2.4 Data collection

At baseline, the participants were questioned about their background status (both the patient's and the spouse's age, duration of unemployment, duration of depressive symptoms, number of children under school age, and use of antidepressants; see Table 1, page 33). The patients underwent baseline and 6, 12, 18 and 24-month post-baseline individual assessments using a battery which included assessments of depressive symptoms, general mental health, marital satisfaction, and use of alcohol. The spouses rated their depressive symptoms and marital satisfaction independently, and the assessments were collected about the same time as the patients' assessments.

2.4.1 Quantitative data

2.4.1.1 Assessment of depressive symptoms

The Hamilton Depression Rating Scale (HDRS; Hamilton, 1960) is an interviewer-based measure of depressive symptoms (Studies I and III). The patients filled the measure in Study I at baseline and at the 6-month post-baseline assessment, and in Study III at baseline (before session 1), mid-therapy (after session 5), post-therapy (three months after session 8), and follow-up (nine and fifteen months following the end of therapy). The measure contains 21 items summed into a single score varying from 0 to 65. A rating of at least 14 has been regarded as a criterion for depressive symptoms (Rush et al., 2008). The internal consistency for the HDRS was .32 at the baseline assessment and .80 at the six-month post-baseline assessment. The inter-rater reliability of the HDRS scale applied to the video-recorded interviews was r =.78 (p <.001).

The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is a widely used measure in assessing depressive symptoms (Studies I–III). Both the patients and spouses filled the measure in Study I at baseline and at 6-month post-baseline assessment, in Study II at baseline and again at 6, 12, 18, and 24-month post-baseline assessments, and in Study III at baseline (before session 1), mid-therapy (after session 5), post-therapy (three months after session 8), and follow-up (nine and fifteen months following the end of therapy). The measure contains 21 self-rating items and it assesses the cognitive, affective, behavioral, and somatic areas of depression, summed into a single score varying from 0 to 63. A score of at least 10 is generally accepted as a cut-off point indicating possible depression. In the total sample used for this research (n = 51), the internal consistency (Cronbach's alpha) for the BDI at baseline was .59 for the patients and .92 for the spouses. In the post-baseline assessments the internal consistency of the scale ranged from .85 to .94.

2.4.1.2 Assessment of general mental health

In Study I, the general mental health of the patients was assessed via Symptom Checklist 90 (SCL-90; Derogatis, 1983), at baseline and at the six-month post-baseline assessment. Patients rated each of 90 items on a five point scale (0 = none; 4 = extreme). The mean value of all the items is summed into a Global Severity Index (GSI). The internal consistency was .95 at the baseline assessment and .92 at the six-month post-baseline assessment.

2.4.1.3 Assessment of marital satisfaction

The marital satisfaction of both the patients and the spouses was assessed with the self-rated Dyadic Adjustment Scale (DAS; Spanier, 1976) in Study I at baseline and at the six-month post-baseline assessment, and in Study III at baseline (before session 1), mid-therapy (after session 5), post-therapy (three months after session 8), and follow-up (nine and fifteen months following the

end of therapy). The Finnish version (24 items) of the original DAS was used, and the totaled raw scores from the DAS (range 24–141) were used for the analyses. The scale contains four areas of dyadic adjustment: *dyadic consensus* (fifteen items), *dyadic satisfaction* (four items), *dyadic cohesion* (four items), and *affective expression* (one item). A rating above 95 was taken to indicate marital dissatisfaction. The internal consistency was .88 for the patients and .89 for the spouses at baseline. The values ranged from .81 to .93 at the post-baseline assessments.

2.4.1.4 Assessment of use of alcohol

In Study III, a self-rated measure called the Alcohol User Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001) was used to assess the use of alcohol for patients, at baseline (before session 1), mid-therapy (after session 5), post-therapy (three months after session 8), and follow-up (nine and fifteen months following the end of therapy). The measure contains ten self-rated items summed into a single score ranging from 0 to 40. A score of 8 or more is associated with harmful drinking. The internal consistency for the scale was .87 at baseline and ranged from .81 to .84 at the post-baseline assessments.

2.4.1.5 Assessment of subjective distress

In Studies I – III, the subjective distress of both the patient and the spouse in the couple therapy group was assessed using PCOMS (Duncan, 2012; Miller et al., 2005). The patients and the spouses scored a paper version of the Outcome Rating Scale (ORS; Miller & Duncan, 2000; Appendix 1) in the therapy room at the start of each session. The development of PCOMS is based on research indicating that the client's subjective experience of change early in the treatment is a strong predictor of outcome (Howard et al., 1993; Lambert & Shimokawa, 2011; Miller & Duncan, 2000; Whipple et al., 2003). The ORS is a self-reported visual analogue scale; it contains four areas of individual functioning, categorized as *individual* (personal well-being), *interpersonal* (family, close relationships), *social* (work, school, friendships), and *overall* (general sense of well-being).

After participants had scored each 10 cm line using a centimeter ruler, they counted up a total score ranging from 0 to 40. The total score for each partner was then plotted onto a single graph by the therapists (Appendix 2). The cut-off point of the measure is 25. Scores below that indicate an individual's stronger distress and a need for change, whereas scores above that indicate better well-being (Miller & Duncan, 2004).

In the current study, the internal consistency (investigated for the first five sessions) for the ORS (n = 29) ranged from .77 to .89 among patients, and from .87 to .96 among spouses.

Before the start of the study, the therapists were given brief written instructions (in Finnish; based on The Outcome and Session Rating Scales:

Administration and scoring manual, Miller & Duncan, 2004) on how to administer and score the ORS in the session; otherwise no special training was offered. The instructions included the same procedure as in the original manual, except that the therapists were not absolutely expected to discuss with the couple about the information obtained from the measures during the session. However, in the research procedure for the present study, there was no control over this aspect; hence no information is available on the therapists' responses to patients' and spouses' feedback.

2.4.1.6 Assessment of the alliance

In Studies II and III, the alliance, too, was measured using PCOMS (Duncan, 2012; Miller et al., 2005). The patient, the spouse, and the therapists filled out a paper version of the Session Rating Scale (SRS; Miller et al., 2002; Appendix 1) at the end of each session. The SRS is a brief self-reported visual analogue scale, and it covers three areas of the therapeutic alliance: the therapeutic relationship, agreement on goals and topics, and agreement on the approach or method. There is a fourth scale measuring a general sense of alliance.

Following the procedures of dialogical therapy, the assessments were completed in the presence of the other participants at the end of the session. Both partners gave ratings independently without discussing them during the assessment. They put a hash mark at the preferred spot on the line to represent their experience of the alliance in the session. After scoring each 10 cm line using a centimeter ruler, the participants calculated a total score ranging from 0 to 40. Thereafter, total scores were plotted onto a graph by the therapists (Appendix 2). The cut-off point of the measure is 36, and scores below that indicate the risk of a negative outcome (Miller & Duncan, 2004).

In this study, the therapists, too, scored the SRS therapist version at every session. Each of the therapists completed the alliance measure individually, with no discussion of the evaluations during the scoring. The therapists' version is virtually identical to the client-rated version, except that the item Approach or Method is reworded, changing *me* to *the family*. The therapist marks his/her response on a line extending from ''the therapist's approach is not a good fit for the family'' to ''the therapist's approach is a good fit for the family.'' In this way the entire measure is seen from the therapist's own perception of the alliance.

In the current study, the internal consistency (Cronbach's alpha; investigated for the first five sessions) for the SRS ranged from .79 to .91 among the patients, from .88 to .99 among the spouses, and from .72 to .91 among the therapists.

Before the start of the study, the therapists were given brief written instructions (in Finnish; based on The Outcome and Session Rating Scales: Administration and scoring manual, Miller & Duncan, 2004) on how to administer and score the SRS in the session; otherwise no special training was offered. The instructions included the same procedure as in the original manual, except that the therapists were not absolutely expected to discuss with the couple about the information obtained from the measures during the session.

However, in the research procedure for the present study, there was no control over this aspect; hence no information is available on the therapists' responses to the feedback of the alliance.

2.4.2 Qualitative outcome data

In Study III, all eight couple therapy sessions were videotaped. The data thus obtained comprised the source of qualitative information on the therapy conversations for the HSCED.

In Study III, three months after treatment termination, a semi-structured co-research interview (Andersen, 1997) was conducted. The data thus obtained comprised the source of qualitative information on the follow-up conversation for the HSCED. This interview between the patient, the spouse, the therapists, and the co-research interviewer lasted about one and a half hours. The entire interview was transcribed. The co-research interview procedure had three parts: first of all, the interviewer talked with the therapists while the clients listened; then she talked with the clients while the therapists listened; finally all the participants discussed how it was to talk together in this way (Andersen, 1997; Rautiainen & Seikkula, 2009).

2.5 Analyses

2.5.1 Quantitative analyses

The data analyses for the means, standard deviations, correlations (Spearman's rho), and effect sizes were conducted using the PASW statistics 18 for Windows program. The correlations between background, baseline, and treatment variables in relation to the mean changes (= six-month outcome minus baseline assessment) in outcome variables were calculated separately for the couple therapy and treatment-as-usual groups, and the equality of the correlations was tested in order to determine significant differences between the groups (McNemar, 1969; Study I).

In Studies I and II, two-level modeling analyses (Bryk & Raudenbush, 1992; Hox, 2002) were executed using the Mplus statistical program (version 6, Muthén & Muthén 1998–2010). Two-level modeling is ideal for analyzing longitudinal data for couples, as it allows the variances and covariances to be decomposed into two components, namely between individuals and within individuals. Two-level modeling also allows variability in the timing, in the missing cases, and in the number of assessments.

In Study I, for the analyses of factors that predicted the changes in the couple therapy group, a two-level random coefficient regression analysis was used; this provided an estimation method involving full information maximum likelihood with robust standard errors (MLR), assuming the few missing values to be random in their occurrence (MAR). At level 1 the variation *within*

individuals was modeled, and at level 2 the variation *between* individuals was modeled.

In Study II, the data were analyzed using two-level modeling with repeated measures nested within individuals. It was decided that the deviations from individuals' average measurements (i.e. deviations at any given session) would be used as the units of analysis, since these deviations indicate both the ruptures and the successes in the alliance, and both the deteriorations and the improvements in the progress. A random coefficient multilevel regression model was estimated for the purposes of predicting the deviations from the average alliance rating and subjective distress. Thereafter, a linear growth model was used to analyze the changes in the alliance quality, and a nonlinear growth model was used to analyze the patients' depression outcomes. The purpose in using these models was to analyze the association between the alliance ratings and the patients' depression outcomes. The formation of the latent factors for the couple members, for the therapists, and for the therapy-system is presented in the Results section.

All the analyses were estimated using the MLR estimator, applying the MonteCarlo integration method. The program produces estimates, standard errors, and correspondence *p*-values; these are presented in the Results section.

The psychotherapy outcomes were assessed by observing the number of patients who achieved clinically significant or reliable change (Jacobson & Truax, 1991; Studies I and III). *Reliable change* refers to an increase or decrease (deterioration) exceeding the random effect of measurement error in the assessment of patients on the outcome measure. Unless the difference in the assessments made by the patient exceeds the measurement error, the patient is classified within the *no change* category. C*linically significant change* requires the reliable change and also the patient's outcome score to shift from the clinical range to the nonclinical range, based on the cut-off score separating the clinical and the normative population.

2.5.2 Qualitative analyses

I watched the videotaped therapy sessions two times (Study III). On the second watching I made notes on the conversations. I then wrote a narrative for each session, including the themes of the conversations and a description of the therapists' actions during the session. Thereafter, the second and third authors of Study III read the session narratives. The final version of the session narratives was created once mutual confirmation of the content of the descriptions was agreed on.

The semi-structured co-research interview was transcribed. The first step in the analysis was to identify those phrases which could help to answer the research questions. I reviewed the co-research interview data several times with the research questions in mind, highlighting the sections in which there were aspects relevant to the research questions. Thereafter, the results of the analysis were introduced to the second and the third authors of Study III, who also

reviewed the transcription. The final version of the highlighted sections was established when mutual agreement was reached.

2.5.3 The mixed methods analysis

The research used the mixed methods analysis involving concurrent triangulation, which combines quantitative and qualitative research methods; thus a given research subject gave rise to both quantitative and qualitative data, with the two types of data being collected and analyzed at the same time (Hanson et al., 2005). In Studies I and II, the study method was quantitative, while in Study III the method involved both quantitative and qualitative data sources. The quantitative data analyses and the interpretation of the results in Studies I – II were first arrived at independently for each study. In Study III, the quantitative and qualitative data were first analyzed separately, and were then integrated into the HSCED analysis. The integration of the results of all three studies is presented in the Results section of this dissertation, and the interpretations of the results are presented in the Discussion section.

The quantitative analysis methods for Studies I - III are presented in section 2.5.1 and the qualitative analysis methods for Study III are presented in section 2.5.2.

In Study III, an adjudicated form of the Hermeneutic Single Case Efficacy Design (HSCED; Elliot, 2002; Elliot et al., 2009) was used to systemically evaluate the efficacy of the couple therapy for a single case. The HSCED is a mixed methods analysis method involving both the quantitative and qualitative sources of data. As Elliot et al. (2009) have pointed out, it is a method that is still under development. The adapted HSCED method was used to study whether the therapy process caused the outcome of one depressed patient and her spouse in couple therapy for depression, within a naturalistic setting. In the present research, the quantitative measures (see 2.4.1) and the qualitative sources (see 2.4.2) were different from those in Elliot's adjudicated version; nevertheless, the research procedure was substantially consistent with the original method.

As recommended by Elliot et al. (2009), I as a single researcher drew up an *affirmative* and a *skeptic case* including *briefs, rebuttals,* and *summaries*. As an extension of the original method, after the composition of the each brief, the researcher who had conducted the research interviews with the couple at baseline, mid-therapy, post-therapy, and follow-ups assisted me in composing the affirmative case, and the researcher who was unfamiliar with the case assisted me in composing the skeptic case. This procedure was used in order to make the research procedure less burdensome and further, to avoid imprecision in the narratives.

I first composed a *rich case record*, which included an integration of the quantitative and the qualitative evidence of the patient's change process and outcome before, during, and after treatment. Thereafter, the affirmative and skeptic cases (including briefs, rebuttals, and summary narratives) were created. The analyses for the quantitative and qualitative data were first conducted

separately, and the results were then compared and contrasted within the briefs, rebuttals, and summary narratives.

The purpose of the affirmative case was to make a convincing case for the view that (1) the couple had benefited from the treatment and (2) the benefit was essentially inherent to the treatment. The affirmative case was divided into three parts: (i) a brief, presenting the main contents of the argument; (ii) a rebuttal, challenging the arguments of the opposing brief; and (iii) a succinct summary narrative (Stephen, Elliot & Macleod, 2011).

The purpose of the skeptic case was to create alternative explanations for the notion (i) that there were significant positive changes within the couple's therapy, and (ii) that the changes were due to the therapy. The skeptic case contains the same three-part structure as in the affirmative case: a brief, a rebuttal, and a summary narrative. In all these sequences, the skeptic case attempted to offer alternative explanations for the interpretations of the rich case record.

All the briefs attempted to make the best case possible. To further this aim, the following note was attached to each brief (Elliott et al., 2009): *Note from the authors: Not all of the arguments in this presentation are the views of the authors. They are included in order to support the analysis of the change, providing opposing points of view.*

All these data were delivered to three judges, who formed their independent judgments on the research questions, based on the process and outcome data. The three judges were experienced professionals in clinical psychology and in couple and family therapy. They volunteered to participate in the adjudication process, having an interest in taking part in a single case study. Judge A is a professor in clinical psychology and psychotherapy. He is trained in family therapy at advanced specialist level and he has had over twenty years of experience as a systemic clinician and trainer, both in clinical settings and with organizations. Judge B is a lecturer in the Department of Psychology. He has had several years of experience of family therapy at advanced specialist level. Judge C is a Licentiate in Psychology, with twenty years of experience of couple and family therapy. I as the principal HSCED researcher communicated with all three judges via email while the adjudication process was taking place. Each of the judges worked independently.

In the first question, the judges were asked to indicate the extent to which they felt that change had emerged in Marja's and Pauli's couple therapy for depression. They were then asked how certain they were of this. The judges were also asked to indicate the evidence that had done most to convince them in the affirmative and skeptic briefs, and how they had utilized this evidence. In the second question, the judges were asked to evaluate whether the change was due to the therapy, and how certain they were about this. In the first and second questions, the scales for the answers were: *no change* (0%), *slightly* (20%), *moderately* (40%), *considerably* (60%), *substantially* (80%), *completely* (100%). In the third and fourth questions, the judges were asked to evaluate the mediating and moderating factors that had affected the therapy process. The final conclusions were based on these adjudications.

3 SUMMARY OF RESULTS

3.1 Descriptive statistics

Table 2 (page 33) shows that the patients and spouses under both treatment conditions attained significant change on multiple measures. The effect sizes (ESs) were at a medium and large level (Cohen, 1992). On the DAS, both the patients' and the spouses' ES was small in the couple therapy group; indeed, the spouses' DAS scores in the treatment-as-usual group diminished slightly. Table 3 shows the mean numbers of couple therapy sessions, other psychotherapy sessions, and other treatment events during the treatment course from baseline to the six-month post-baseline assessment. The groups differed in the number of couple therapy sessions and in the number of other psychotherapy sessions, but not on other treatment events.

TABLE 3 Number of couple therapy sessions, other psychotherapy sessions, and other treatment events in the couple therapy and treatment-as-usual groups; from baseline to the six-month post-baseline assessment.

	CT	TAU			
	M (SD)	*M (SD)*	*t*	*df*	*p*
Couple therapy	6.92 (2.4)	0.33 (0.9)	13.02	32.50	.000
Other psychotherapy	.29 (0.8)	11.1 (6.7)	-6.941	18.44	.000
Other treatment events[a]	2.7 (3.2)	3.25 (3.3)	-.561	41	.578

Note: CT = Couple therapy group; TAU = Treatment-as-usual group; [a] = psychiatrist consultation, occupational therapies, group meetings, etc.

3.2 Study I

3.2.1 Clinically significant change

The outcomes for the patients and the spouses were classified as *deteriorated, no change, reliable change,* or *clinically significant change* (Jacobson & Truax, 1991). On the BDI, 37.9% of the patients and 24.1% of the spouses reached the level of reliable or clinically significant change in the couple therapy group. In the treatment-as-usual group the proportions were 35.3% (patients) and 9% (spouses). On the DAS, the proportions were 10.3% (patients) and 20.7% (spouses) in the couple therapy group, and 13.6% (patients) and 0% (spouses) in the treatment-as-usual group. On the HDRS, 44.8% of the patients were classified as reaching the level of reliable or clinically significant change in the couple therapy group. The corresponding proportion in the treatment-as-usual group was 27.3%. On SCL-90, 65.5% of the patients were classified as reaching the level of reliable or clinically significant change in the couple therapy group. The corresponding proportion in the treatment-as-usual group was 50.0%. On the ORS (couple therapy group only), 44.8% of the patients and 24.1% of the spouses reached the level of reliable or clinically significant change.

3.2.2 Group differences between couple therapy and treatment-as-usual

Correlation analyses were conducted for background, baseline, and treatment variables in relation to the difference scores in outcome variables (difference scores were calculated by subtracting the baseline score from the six-month post-baseline score). Table 4 shows the correlations and the probability levels for the equality of the correlations (McNemar, 1969).

The male spouses in the couple therapy group showed a greater change in depressive symptoms than the female spouses. A comparison of spouses under the couple therapy and treatment-as-usual conditions showed a group difference. In the treatment-as-usual group, high depressive symptoms among spouses at baseline were associated with a greater change in patients' interviewer-rated depressive symptoms, and there was a group difference favoring the treatment-as-usual group. Spouses with high baseline depressive symptoms in the couple therapy group achieved a greater change than the corresponding spouses in the treatment-as-usual group. In the couple therapy group, spouses' high depressive symptoms at baseline were associated with a smaller change in marital satisfaction, among both patients and spouses. Under the treatment-as-usual group the associations were reversed, and there was a difference between the couple therapy and the treatment-as-usual groups. In the couple therapy group, spouses achieved a greater change in marital satisfaction, with fewer therapy sessions, as compared to the treatment-as-usual group.

TABLE 4 Factors explaining different individual changes from baseline to the six-month post-baseline assessment in the couple therapy and treatment-as-usual groups.

	CT			TAU			Group diff
Variable	*n*	*r*	*p*	*n*	*r*	*p*	*p*
Sex							
Spouse BDI change[a]	25	-.522	.007	18	.399	.101	.001
Spouse baseline BDI							
Patient HDRS change	29	-.030	.878	19	-.589	.008	.021
Spouse BDI change	25	-.815	.000	18	-.453	.059	.026
Patient DAS change	26	-.430	.029	19	.119	.627	.038
Spouse DAS change	23	-.475	.022	18	.181	.473	.020
Therapy sessions[b]							
Spouse DAS change	22	-.559	.007	17	.083	.752	.021

Notes: CT = Couple therapy group; TAU = Treatment-as-usual group; BDI = Beck Depression Inventory; DAS = Dyadic Adjustment Scale; HDRS = Hamilton Depression Rating Scale; group diff = significant group difference calculated by McNemar test (McNemar, 1969); [a] = negative correlation represents males; [b] = for the couple therapy group, the "therapy sessions" were taken to be couple therapy sessions, while for the treatment-as-usual group, the "therapy sessions" were taken to be other psychotherapy sessions.

3.2.3 Changes in subjective distress

In the couple therapy group, first-session subjective distress was stronger for patients than for spouses (Patients: M = 21.4, p < .001, SD = 5.87, p < .001; Spouses: M = 27.7, p < .001, SD = 5.68, p < .001; Wald test: χ^2 (1) = 28.31, p < .001). There was individual variation in both the patients' and the spouses' first-session subjective distress, and the extent of the variation did not differ between patients and spouses. There was an equal positive change in the subjective distress of both patients and spouses (Patients: M = 6.9, p < .001, SD = 5.83, p < .05; Spouses: M = 5.5, p < .001, SD = 5.42). Once again, the extent of the variation in the patients' and spouses' change in subjective distress was equal. The effect sizes on the changes in subjective distress for both the patients and the spouses were at a large level (d = 1.18 vs. d = .97, respectively; Cohen, 1992). Correlations were found between the patients' first-session subjective distress and the spouses' first-session subjective distress (r = .68, p = .000), and between the patients' first-session subjective distress and the spouses' change in subjective distress (r = -.71, p = .000). The correlations indicate that when either the patient or the spouse or both were distressed at the start of the therapy, this distress was associated with the spouse's benefit from the treatment, but was not associated with an improvement in the patient. The change among patients was not explained by higher or lower subjective distress at the beginning of the treatment; by contrast, the change among spouses was explained largely by subjective distress at the outset (r = .69, p = .000).

3.2.4 Subjective distress and depression

The patients' change on the BDI was not explained by the baseline score. By contrast, the spouses' change on the BDI was explained largely by the baseline score (55.3%). For the patients, the first-session subjective distress explained 12.6% of the change on the BDI, while the change in subjective distress explained 45 % of the change on the BDI. The patients' change on the HDRS was not explained by the baseline score. The patients' change in subjective distress explained 47.2% of the patients' change on the HDRS. The patients' change on the SCL-90 was not explained by the baseline score. For the patients, the first-session subjective distress explained 15.6% of the change on the SCL-90, while the change in subjective distress explained 38.3% of the change on the SCL-90.

3.2.5 Subjective distress and marital satisfaction

The change in subjective distress was associated with a change in marital satisfaction among patients (r = .59, p =.002), but not among spouses (r = -.54, p = .139). The patients' change in subjective distress was not associated with the spouses' change in marital satisfaction (r = .49, p = .079), and the spouses' change in subjective distress was not associated with the patients' change in marital satisfaction (r = -.30, p = .314).

3.3 Study II

3.3.1 Subjective distress and the alliance

Both the patients' (β = .29, p = .000; SD = .20, p = .021) and the spouses' (β = .27, p = .008; SD = .23, p = .181) positive deviations in subjective distress *at the beginning of any given session* predicted positive deviations in the alliance *at the end of the session*, while negative deviations in subjective distress predicted negative deviations in the alliance. The deviations in the individual's subjective distress rating predicted the deviations in the individual's own alliance rating equally for patients and spouses. The prediction level for both couple partners was at the medium effect size. Cohen (1992) estimates the effect sizes for d as 0.2 *small*, 0.5 *medium*, and 0.8 *large*.

Both the patients' (β =.16, p = .018; SD = .03, p = 1.000) and the spouses' (β = .15, p = .035; SD = .11, p = .456) positive deviations in the alliance *at the end of any given session* predicted positive deviations in subjective distress *at the beginning of the next session*, while negative deviations in the alliance predicted negative deviations in subjective distress. For patients and spouses, there was an almost equal association between the individual's alliance rating and the same individual's subjective distress at the beginning of the next session. The

level of the prediction for both couple partners was at the small-effect size (Cohen, 1992).

3.3.2 The alliance and depression

The analysis went on to examine the associations between the patients', spouses', and therapists' assessments of the alliance (mean levels for each) with the patients' depression outcome. First of all, the patients' and spouses' assessments of the alliance were used as predictors of the patient's depression outcome. Secondly, it was calculated that the mean level of the alliance ratings correlated between patients and spouses (r = .72, p < .001), between patients and therapists (r = .53, p < .001), between spouses and therapists (r = .47, p < .001), and between therapist 1 and therapist 2 (r = .53, p = .001). Because of the high correlations in the alliance assessments between patients, spouses, and therapists, latent factors were created for the therapists and for the couple members (fixing the factor loading as equal), and also for the therapy-system level. It was also conducted a separate analysis predicting patients' nonlinear change in depression outcomes via the mean level of the alliance for patients, spouses, couples, therapists, and the therapy-system; here, a random multilevel regression model was used.

Among patients, the mean levels of the alliance predicted 12.3% of the variance in the patients' depression outcomes for the entire two-year research period. Among the couples (patients and spouses) it predicted 14.4% of the variance. Among the therapists it predicted 53.3% of the variance, and at the therapy-system alliance level it predicted 19.4% of the variance.

The associations between the mean for the therapy-system alliance and the mean level for the patients' depression outcomes (from the baseline assessment to the 6-, 12-, 18-, and 24-month post-baseline assessments) are shown in Figure 2. Three curves are depicted: (i) for when the therapy-system alliance is at the mean level, (ii) for when it is one standard deviation *below* the mean level, and (iii) for when it is one standard deviation *above* the mean level. At the mean level for the therapy-system alliance, the mean patient BDI was 23.8 at the outset, and 10.4 at the 24-month post-baseline assessment. When the mean level for the therapy-system alliance was one standard deviation above the mean, the predicted BDI score was 3.7 for the 24-month post-baseline assessment, and when it was one standard deviation below the mean level of the alliance, the predicted BDI score was 17.1.

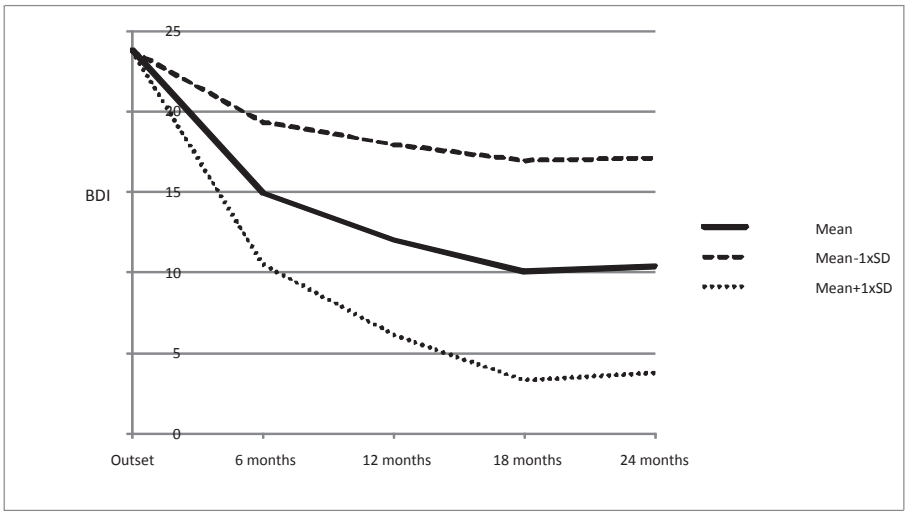

FIGURE 2. The association between the therapy-system alliance and the changes in patients' depression outcomes.

3.4 Study III

3.4.1 Process-outcome causality in couple therapy for depression

3.4.1.1 The rich case record

The rich case record was composed by the authors of Study III. The rich case record contains a broad description of the therapy with the couple, including key information on the couple's demographics and current afflictions, along with information on the therapy process and outcome, taken from several data sources. Here the quantitative and qualitative data are presented.

Quantitative outcome and process data. Marja's and Pauli's quantitative outcome and process scores are presented in Table 5 and Table 6. Marja's scores on all measures except DAS were within the clinical range at baseline (Jacobson & Truax, 1991). At the mid-therapy point, Marja showed a reliable change on BDI and a clinically significant change on ORS, HDRS, and AUDIT-3 (the first three items assessing current use of alcohol). At post-therapy and follow-ups she showed a clinically significant change on ORS, SRS, BDI, HDRS, and AUDIT-3. On the full AUDIT questionnaire, Marja demonstrated a clinically significant change at the 9-month and 15-month follow-up assessments. Pauli's scores on the ORS, SRS, and BDI measures were within the non-clinical range at each assessment. On the DAS, Pauli's score was within the clinical range at baseline; in this regard he showed a clinically significant change at mid-therapy and at later assessments.

TABLE 5 Marja's and Pauli's baseline and outcome data.

Instruments	Cut-off	RCI min	Baseline	Mid-5	Post-3	Fup-9	Fup-15
Marja							
BDI	< 16	9.6 (↓)	32	11 (+)	3 (++)	2 (++)	3 (++)
HDRS	< 14	10.1 (↓)	25	12 (++)	2 (++)	6 (++)	0 (++)
DAS	< 95	12.0 (↑)	120	116 ( )	108 ( )	116 ( )	117 ( )
AUDIT	< 6	7.0 (↓)	21	20	21	0 (++)	0 (++)
AUDIT-3	< 4	4.4 (↓)	8	0 (++)	0 (++)	0 (++)	0 (++)
Pauli							
BDI	< 8	6.7 (↓)	1	-[a]	0 ( )	0 ( )	0 ( )
DAS	< 95	11.5 (↑)	86	110 (++)	115 (++)	-[a]	115 (++)

Note. Mid-5 = Mid-therapy at five months; Post-3 = Follow-up at three months post-therapy; Fup-9 = Follow-up at 9 months post-therapy; Fup-15 = Follow-up at 15 months post-therapy; (↑) = Increased score indicates a positive change; (↓) = Decreased score indicates a positive change; (++) = Clinically significant change in relation to baseline; (+) = Reliable positive change in relation to baseline; ( ) = No change in relation to baseline; [a] = Missing value; RCI = Reliable Change Index; BDI = Beck Depression Inventory; HDRS = Hamilton Rating Scale for Depression; DAS = Dyadic Adjustment Scale; AUDIT = Alcohol User Disorders Identification Test; AUDIT-3 = Alcohol User Disorders Identification Test (the first three items assessing current use).

TABLE 6 Marja's and Pauli's process data for ORS and SRS, sessions 1–8.

Instruments	Cut-off	RCI min	1.	2.	3.[a]	4.	5.	6.	7.	8.
Marja										
ORS	< 25	7.8 (↑)	12.5	23	-	33.5	33	26.5	30.5	37.5(++)
SRS	< 36	5.3 (↑)	34.5	36	-	38.5	40	40	40	40(++)
Pauli										
ORS	< 25	5.7 (↑)	31.4	38.3	-	39.7	39.8	39.6	39.7	39.7(+)
SRS	< 36	4.2 (↑)	40	40	-	40	40	40	40	40
Therapist 1 SRS	< 36	5.9 (↑)	39	38.8	-	36.9	36.5	38.8	32	35.2
Therapist 2 SRS	< 36	4.9 (↑)	36.4	38.2	-	39	38	39.4	38.7	39.3

Note. (↑) = Increased score indicates positive change; (++) = Clinically significant positive change in relation to first session; (+) = Reliable positive change in relation to first session; [a] = Missing value; RCI = Reliable Change Index; ORS = Outcome Rating Scale; SRS = Session Rating Scale.

Qualitative outcome data. In their co-research interview three months from treatment termination, Marja, Pauli, and their therapists, Liisa and Jarmo, were asked to evaluate the treatment and how they had experienced it. The transcribed co-research interview contained a considerable amount of information; references to the relevant details are summarized in the briefs, rebuttals, and summary narratives in the original article. Table 7 presents the

qualitative treatment outcomes which Marja identified as resulting from the therapy.

TABLE 7 Process and Qualitative Outcome Matching.

Qualitative outcome	Sessions in which the process occurred	Examples of the process
Marja recovered from her depressive symptoms.	1,2,3,4,5,6,7,8	Session 4: Marja saw the value of life after a serious surgical operation. Session 8: Marja realized that she did not always have to have a good feeling; she did not need to reward herself to feel better.
Marja became sober.	1,2,3,4,5,6,7,8	Session 1: Marja realized that annoyance increased her use of alcohol. Session 3: Marja had stopped taking alcohol, because she no longer wanted to feel "numb."
The conflicts in Marja's working life became easier to deal with.	1,2,3,4,5,6,7,8	Session 6: Marja felt that she had received support for her opinions regarding conflicts with her employer.
Marja became more sociable.	1,2,3,4,5,7,8	Session 4: Marja realized that alcohol caused her fears; the couple considered that with more sobriety they could lead a more sociable life in future.
Marja became relaxed.	4,5,6,8	Session 4: Marja was becoming more aware of the value of life, and this relaxed her.
Marja found her strengths.	3,4,5,6,7,8	Session 6: Marja felt stronger, and felt that her points of view were being validated. Sessions 6 and 8: Realizing that she did not always have to feel good made Marja better able to face facts without alcohol or drugs.
Marja's relationship with her parents improved.	2,3,6,8	Session 6: Marja recognized a change in herself – she could let her mother come closer to her.
Marja's and Pauli's relationship improved.	1,2,4,5,8	Session 2: Marja and Pauli agreed that Marja's depression and use of alcohol had troubled their sex life. Session 4: Marja and Pauli were hopeful that when Marja become sober, their relationship would improve. Session 8: Marja and Pauli had learned to have faith that they could deal with problems together.

3.4.1.2 The affirmative brief

The purpose of the affirmative brief was to argue that a positive change had indeed occurred in the couple therapy for depression attended by Marja and Pauli, and that the change had been a result of the treatment. In this brief, four types of direct evidence for the connection between change and process were expressed: (1) an early change in long-lasting problems detected on multiple sources; (2) retrospective attribution (i.e. Marja and Pauli attributed the changes to the therapy process); (3) process-outcome matching (i.e. congruence between the alliance and outcome measures); (4) event-shift sequences (i.e. the positive

change in Marja's outcome scores appeared to have generated a positive change in her satisfaction with the therapeutic alliance). This brief argued (i) that Marja and Pauli had benefited from the couple therapy for depression, and (ii) that the change in long-lasting problems was due to the therapy. This presentation implied a connection between the outcome and the therapy process, and a connection between the therapy process and significant events during the therapy.

3.4.1.3 The skeptic brief

The purpose of the skeptic brief was to challenge the conception that a substantial change had emerged during Marja's and Pauli's couple therapy for depression, and/or to argue against the notion of any change being associated with the therapy. This brief offered the rich case record, the briefs, the rebuttals, and the summary narratives as cogent evidence for an alternative explanation for the points made in the affirmative brief. The skeptic brief claimed that (i) there had only been trivial changes; (ii) statistical errors could explain the change; (iii) Marja and Pauli might have felt a willingness to please the therapists and the researcher; (iv) Marja's and Pauli's experience of changes might have been influenced by their own expectations; (v) self-help and spontaneous recovery explained the changes; (vi) events in Marja's and Pauli's life made changes possible; (vii) psychobiological causes could not be ruled out; and (viii) the participation in the research project influenced Marja's and Pauli's evaluations of the changes (Elliot, 2002). The skeptic brief had argued that the changes were trivial and were more connected to events in the life of the couple than to the actual couple therapy for depression. In this view, the role of the treatment was more to observe the changes in life events and to stabilize them, rather than to initiate the change process.

3.4.1.4 The affirmative rebuttal

The purpose of the affirmative rebuttal was to challenge the skeptic brief's assertions that the changes in Marja's and Pauli's couple therapy for depression were only trivial, and/or that the changes were due to extra-therapy events. The points made in the rebuttal were that (i) Marja and Pauli attributed the changes to the therapy; (ii) Marja and Pauli believed that the treatment was terminated at an appropriate time; (iii) positive changes occurred on several measures; (iv) the stability of the changes was supported by the congruence of the quantitative and the qualitative data, and by (v) the long-term follow-up data. The crucial aspect was that Marja recovered from her depression and stopped drinking (1) *at that point of time,* (2) *by participating along with her spouse Pauli,* (3) *in couple therapy for depression.*

3.4.1.5 The skeptic rebuttal

The skeptic rebuttal argued that the positive changes were a result of the recovery process from a psychological crisis, and were independent of the therapy. Marja's impulsive behavior had continued, and contained a potential risk of relapses in subsequent stressful life circumstances. The positive attributions had been emphasized in the co-research interview because of the satisfactory relationship with the therapists.

3.4.1.6 Adjudication

The three judges adjudicated the rich case record, briefs, and rebuttals, and they made their evaluations of the change process belonging to Marja's and Pauli's couple therapy for depression. The conclusion of the adjudication was that the change was substantial (80%), with a substantial level of confidence (all the judges rated the probability at 80%). The results also indicated that the change was due to therapy, assessed at the "considerable" level (mean 66.7%; judges' ratings 60%, 60%, and 80%), and with a considerable level of certainty (mean 73.3%; judges' ratings 80%, 60%, and 80%).

3.4.2 Mediating factors in couple therapy for depression

The results indicated that the positive alliance with the therapists had been an essential mediating factor in the therapy process. The important factors identified were: the therapists' "outsiderness"; the therapists' listening and appreciative stance; the therapists' willingness to give their impressions and opinions on the themes of the discussions; Marja's cessation of drinking quite early in the treatment; and the way in which Marja and Pauli remained the subjects of their own life in their relationship with the therapists (i.e. Marja and Pauli decided matters on their own).

3.4.3 Moderating factors in couple therapy for depression

The results made it possible to identify several personal resources and characteristics of Marja and Pauli which might have been moderating factors in the change. These were as follows: Marja's readiness for change; her ability to create a trustful relationship with therapists; her ability to self-observe; her ability to connect her problems to her life narrative; Marja's recognition of the need to change her own attitude and behavior. Furthermore, both spouses were willing to openly discuss and share their problems with the therapists; both spouses were ready to listen to each other and to the therapists' opinions; the couple were motivated to obtain help, and they had recognized and mutually agreed on their problems; the couple had shown the willingness, ability, and commitment to work in the therapeutic relationship. Finally, the couple's long-lasting relationship was seen as a resource to which each of the spouses was committed.

The overall conclusion, based on the results, was that a change in depressive symptoms had occurred for the selected patient in the selected couple during couple therapy for depression.

4 DISCUSSION

4.1 Main findings of the research

The aim of this research was to develop accountability in assessing the effectiveness of couple therapy for depression, conducted within naturalistic multicenter settings. The main finding of Study I was that in the couple therapy group, the change in the patient's subjective distress significantly predicted the patient's change in depressive symptoms and general mental health, and was significantly associated with the patient's marital satisfaction at the six-month post-baseline assessment. The patients' changes in subjective distress were not explained by higher or lower first-session scores. When either the patient or the spouse or both were distressed at the outset, this was related to the spouse's benefit from the treatment. The results indicated also that the spouse's gender, the spouse's depressive symptoms, and the number of therapy sessions were significantly related to differing degrees of change in the couple therapy and treatment-as-usual groups. Moreover, the spouses in the couple therapy group demonstrated a significantly higher treatment response than those in the treatment-as-usual group. Among both patients and spouses, under each of the treatment conditions, positive changes in depressive symptoms emerged during the treatment. The treatment gains favored the couple therapy group. For patients, the general mental health increased in both groups, but the change was greater in the couple therapy group. As regards marital satisfaction, the changes were on average at a low level in both groups.

In Study II, the mean value of the ratings for the therapy-system alliance was associated with the patients' depression outcome, explaining 19% of the variance in the patients' change in depressive symptoms. The patients' and spouses' alliances evolved from the beginning of the treatment, and the changes were significant. The deviations from individuals' average subjective distress at the beginning of a session predicted their own deviations from their average alliance ratings (i.e. at the end of the same session). The patients' and spouses'

deviations from their (individual) average alliance ratings predicted their own deviations from their average subjective distress in the next session.

In Study III, it was concluded that there had been a change in the depressive symptoms of the selected patient in the selected couple. The three judges adjudicated the rich case record, constructed in such a way as to contain arguments for and against the success of the treatment. It was concluded that the patient had changed substantially during the treatment, and that the change was largely due to therapy. The important mediating factors in the therapy process appeared to be the positive alliance with the therapists, the therapists' "outsiderness," the therapists' listening and appreciative stance, the willingness of the therapists to give their impressions and opinions on the themes of the discussions, Marja's cessation of drinking quite early in the treatment, and the fact that Marja and Pauli remained the subjects of their own lives in their relationship with the therapists (i.e. Marja and Pauli decided matters on their own).

Several personal resources and characteristics of Marja and Pauli emerged as possible moderating factors in the change, namely Marja's readiness for change, her ability to create a trustful relationship with therapists, her ability to self-observe, her ability to connect her problems to the context of her life narrative, and her recognition of the need to change her own attitude and behavior. Moderating factors were further identified, in that both spouses were willing to openly discuss and share their problems with the therapists, both spouses were ready to listen to each other and to the therapists' opinions, the couple were motivated to obtain help, and they had recognized and mutually agreed on their problems. In addition, the couple had shown a willingness, ability, and commitment to work in the therapeutic relationship. Finally, the couple's long-lasting relationship was seen as a resource to which each of the spouses was committed.

On the basis of these results, couple therapy emerged as a viable and valuable treatment for depression, capable of bringing benefit not only to patients but also to the spouses of the patients. The provision of feedback on subjective distress and on the alliance was found to be a useful method of obtaining information on the progress and process of couple therapy for depression, and one that could be implemented in everyday outpatient clinical settings.

4.2 General discussion

4.2.1 Feedback provision on subjective distress and the alliance

Previous research on outcome studies has indicated that subjective distress at the outset is a strong predictor of the patient's experienced change, and that an early change in subjective distress is related to treatment outcome (Anderson & Lambert, 2001; Beach et al., 1990; Callahan et al., 2006; Howard et al., 1993;

Lambert & Shimokawa, 2011). The research reported in this dissertation indicated that even at an early stage (within the first six months) in the couple therapy group, positive changes in the patient's subjective distress predicted changes in the patient's depressive symptoms and general mental health. The important notion here is that among patients, the changes in subjective distress during the treatment had a stronger association with the changes in depression and with general mental health than the baseline levels of the subjective distress, depressive symptoms, or general mental health. The research also gave some support to the notion that when the patient and/or spouse had more subjective distress at the outset of the treatment, the spouse showed a greater increase in well-being during the treatment. Moreover, there was an association between the change in the patient's subjective distress and his or her experienced change in marital satisfaction.

The alliance also had a clear connection with the treatment outcome. The patient's, the couple's, and the therapists' ratings of the alliance were associated with the change in the patient's depressive symptoms, while the spouse's ratings were not. However, it was concluded that within this sample it would be unreasonable to speculate on whose perception of the alliance was most associated with the patients' depression outcome, bearing in mind the substantial standard errors in the evaluations. In any case, the research indicated that the therapy-system alliance was a significant predictor of the patient's recovery from depression. This research also suggests that there is a need for therapists to balance the relationship between all the persons in the entire therapeutic system (patient, spouse, and therapists), given that the subjective distress at the start of the session predicted the alliance at the end of the same session, and that the alliance at the end of the session predicted the subjective distress at the start of the next session. These findings support a previous study, to the effect that there is a need to balance the pre-existing relationship between the partners (i.e. an allegiance) with the alliance between the couple and therapists (Symonds & Horvath, 2004). The findings also support Pinsof and Catherall's (1986) hypothesis concerning the impact on the treatment outcome of an "intact alliance" between the couple partners.

An important aspect in this research was that the therapists, too, evaluated the alliance. This procedure made possible not merely the patient's and the spouse's perspectives on the process and the outcome; it also revealed the therapists' viewpoints on how the treatment was proceeding. Research on individual and family therapies has obtained mixed results on whether the patient's or the therapist's evaluation of the alliance is the best predictor of the outcome (Friedlander et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000; Symonds & Horvath, 2004). The present research could not reach a firm conclusion on who is the best evaluator of the alliance, but it supported the view that it would be beneficial for both the couple and the therapists to evaluate the alliance.

In relating these results to clinical settings, one can suggest that it is important for therapists to consider regular monitoring of the progress made

and of the alliance. Routine evaluation of subjective distress and of the alliance conveys data on how the therapy is proceeding and on the "atmosphere" of the process. By this means, the therapists have access to information on which of their patients are at risk of having a poor outcome or even deteriorating (Anker et al., 2009; Lambert & Shimokawa, 2011). The benefit of the feedback on a session-by-session basis is that there is an opportunity for personal information on the case during the treatment process. When therapists conduct the treatment in this way, they are not dependent only on the mean group data for a specific form of therapy: they have the possibility to obtain case-specific information on how the treatment modality is proceeding at a particular moment of time with any couple experiencing the problem in question (for example depression). Therapists have access to real-time data on the treatment progress and process – a dynamic that may include both impasses and success. Hence, therapists can adjust their therapeutic actions according to the couple's need. For example, identifying and resolving ruptures in the therapeutic alliance may be important for recovery and outcome (Rait, 2000; Safran et al., 2011). One could regard this as a matter of evidence-based practice turning to practice-based evidence (Barkham et al., 2001; Duncan, 2012; Miller, Duncan, Brown, Sorrell, & Chalk, 2006)

One must bear in mind that when using feedback on the progress made and on the alliance, it is crucial that the couples and the therapists should have an affirmative attitude in assessing the treatment process. The couples need to be brave enough to express how they really evaluate their progress and the alliance with their therapists, and the therapists need to be self-confident concerning their work when evaluated by their clients.

4.2.2 Spouses' involvement in couple therapy for depression

In this research, the spouses had a significant role in the therapy process under both treatment conditions. The results support earlier studies that have emphasized the spouse's participation in couple therapy for depression (Gupta & Beach, 2005; Gupta et al., 2003; Isakson et al., 2006; Rautiainen, 2010). In the present research, the spouses had an influence on the processes of change among patients, both in terms of depression and marital satisfaction, in addition to possibly benefiting themselves, especially in the couple therapy group. This underlines the fact that depressive symptoms are not merely a problem for the patients. In a study by Coyne et al. (1987), 40% of the spouses living with a depressed person expressed distressed symptoms reaching the criterion for psychological treatment. In the present research, at baseline, 38% of the spouses in the couple therapy group expressed depressive symptoms that would indicate at least a mild level of depression. Furthermore, the spouses' baseline depressive symptoms were associated with relatively small changes in both the patients' and the spouses' changes in marital satisfaction. These findings indicate that the spouses of depressed persons should be assessed to determine whether they are in need of therapeutic intervention (Whisman et al., 2004; Heene et al., 2005), and that they should be included in the treatment

given to depressed persons. An important notion here is that it is essential to create a balance between discussing subjective distress, depression and the couple's relationship: if there is inadequate consideration of the couple's need, the patient and the spouse may have an unsatisfactory experience of not being heard (Goldfarb et al., 2007). By participating in couple therapy for depression, the spouses may receive help and support for themselves, and through that change they may be able to help the depressed partner. Moreover, the spouse's involvement in the couple therapy makes it possible to focus on potential marital problems.

4.2.3 Research on effectiveness in couple therapy for depression

Randomized clinical trials have become a "gold standard" in psychotherapy efficacy research (Bohart et al., 2011). The emphasis in randomized clinical trials is on internal validity: mean group data (involving a control group) are obtained for a specific form of therapy, conducted with precise adherence to a manual. The idea is that such manualized treatment can be readily transferred to another context. However, randomized clinical trials have been challenged as an appropriate method in psychotherapy research, the problem being that the conclusions drawn from experimental group comparisons are difficult to apply in naturalistic clinical settings (Bohart et al., 2011; Elliott, 2002; Kazdin, 2006; Pinsof et al., 1996). It has been observed that as much as 20% of the efficacy of manualized treatments may be lost in the transfer to a natural clinical setting (Shadish et al., 1995, Sprenkle et al., 2009).

It is worth noting that in the present research the outcomes seemed to be at the same level as in randomized clinical trials. The findings based on multiple measures of medium and large effect sizes, and those concerning the proportions of reliable or clinically significant change, are comparable with previous studies on couple therapy (Anker et al., 2009; Pinsof et al., 1996; Shadish & Baldwin, 2005). The reason for the better outcomes in the present research may be that all aspects of the treatment were integrated in such a way as to work in the same direction for positive change. The emphasis was on achieving maximum external validity. This was implemented by adhering as closely as possible to the treatment procedures used in the various research sites: the patients were referred to the clinics via the usual routes considered appropriate in their community, and the frequency and the length of the sessions were left open to the couple and therapist through negotiation within the treatment. There was no manual for the therapies, and the therapies were conducted by trained family therapists; hence the treatments were comparable to the couple therapy treatments usually offered in Finland. These aspects all support the possibility of generalizing the results concerning the effectiveness of the treatments to other naturalistic contexts.

4.2.4 The common factors framework in couple therapy for depression

Empirical data from decades of research supports a view of the common factors in therapy as including the following major contributors to treatment outcome: the client/extra-therapeutic factors; the therapist's characteristics; the therapeutic alliance; model/technique effects; model and technique delivered (including the client's hope and expectancy for recovery and the therapist's allegiance for the therapy model (Asay & Lambert, 1999; Hubble et al., 1999; Norcross & Lambert, 2011; Rosenzweig, 1936; Sparks & Duncan, 2010; Sparks et al., 2007; Sprenkle et al., 2009). There has been also a proposal, based on the empirical findings of psychotherapy research, that client feedback on treatment progress and on the quality of the alliance should be seen as a common factor (Sparks & Duncan, 2010). An expert consensus regarding the common factors in couple therapy (Sprenkle & Blow, 2004; Sprenkle et al., 2009) proposes four unique elements applying to relationship therapies, namely (1) conceptualizing difficulties in relational terms, (2) disrupting dysfunctional relational patterns, (3) expanding the direct treatment system, and (4) expanding the therapeutic alliance.

In the present research, several elements of the common factors mentioned above can be identified from the findings. Firstly, the change in the patient's subjective distress significantly predicted the patient's change in depressive symptoms and general mental health, and was significantly associated with the patient's marital satisfaction at the six-month post-baseline assessment. Secondly, a strong therapeutic alliance between the therapists and the couples seemed to constitute an important element for successful change. This notion was supported by both the quantitative and the qualitative data. As observed in Study II, higher ratings for the therapy-system alliance were significantly associated with a stronger improvement in the patient's depressive symptoms. In addition, in Study III, the alliance between the therapists and the couple was clearly confirmed as an important element contributing to the experience of successful therapy. One can ask how the feedback on subjective distress and the alliance should be characterized according to the common factors framework (Sparks & Duncan, 2010). From the results obtained in the present research, one can speculate that feedback of an early change in subjective distress and the positive alliance may be factors in an effective outcome. In fact, the change in subjective distress was found to be a robust predictor of the patient's change in depressive symptoms and in general mental health. After all, as noted previously, subjective distress constitutes feelings concerning one's personal well-being and one's close and extended relationships.

Thirdly, other major contributors to the therapy outcome in Study III appeared to involve extra-therapeutic factors, the patient's characteristics, and the therapist's characteristics. According to Study III, the identification of problems, plus the existence of opportunities to talk about them in the co-research interview, favored the affirmative case. This aspect highlights the

significance of reflective processes in couple therapy for depression (Andersen, 1991). As Rautiainen (2010) has noted, the common factors unique to couple therapy, as presented by Sprenkle et al. (2009), do not appear to capture adequately the phenomenon of reflective processes within couple therapy.

All in all, it appears that in couple therapy for depression, the focus of the conversations constitutes a complex task that therapists need to negotiate with the couples. In co-operation with the couple, therapists need to balance the discussions carefully between relational issues, depressive symptoms, and subjective distress.

4.3 Strengths and limitations of the research

The research aimed to investigate couple therapy for depression in naturalistic settings. Hence, it was seen as having a number of strengths built into its basic design. In particular, it was regarded as appropriate for the work of the therapists, who would be able to work in their usual manner, and for the needs of the couples, who would be able to concentrate on their therapy, with goals negotiated according to their need. These aspects were bound up with the desire to maximize the external validity of the research, and the methodology appeared to work satisfactorily in this regard.

Taken as a whole, the mixed methods design appeared to work well for myself as researcher, since I was able to test my research hypotheses on the sample and to deepen my general understanding of couple therapy for depression (Hanson et al., 2005). An additional strength was that the design was capable of obtaining highly accurate information on the treatment processes. Overall, the range of the studies was considerable. The research obtained both quantitative and qualitative data; it included a randomized group comparison (Study I), a single-group study (Study II), and a single-case study (Study III). Moreover, the data encompassed high levels of detail: all the sessions were video- or audio taped, both the patient and the spouse evaluated their progress at every session, and each of the participants (patient, spouse, and therapists) within the therapy system evaluated the alliance at every session.

A further strength in Study III is that the HSCED analysis constituted a new method in couple therapy research. Hence, this study can be seen as a pioneering work in the field. At the same time, it must be recognized that obtaining such mixed-methods data is not a self-evident procedure when one is seeking to determine process-outcome causality. The HSCED method is undoubtedly a systematic analytical method, and one that can obtain explicit information on the case. However, the various stages, which involve composing a rich case record, creating affirmative and skeptic briefs and rebuttals, and adjudication by outsider judges, do constitute a challenging task within a scientific discipline.

As the researcher conducting these studies, it could be considered as an advantage that I had gained fifteen years of experience on couple therapy. My longstanding interest has been in the formation of the therapeutic alliance, how it develops, and how it relates to the treatment outcome. My experience also involves working with individuals, couples, and families with severe psychiatric disorders such as psychoses and major depressive disorders. I believed that my awareness of the research area was an advantage, as was my understanding of the challenges involved in conducting research within everyday practice. This was a necessity in understanding the extremely important relationship between scientific research and therapists. The paramount issue here is how one can conduct a study that will produce meaningful information – information which is understandable and interesting to therapists who work in real-world settings (Fireman, 2002).

I felt it to be an advantage on a personal level that I was able to deepen further my expertise in a field in which I was already experienced, and to which I was committed. The research provided me with a learning process concerning the diversity of social perspectives in relation to the etiology of depression, and it broadened my perspectives on the recovery processes undergone in couple therapy for depression. The research confirmed my perception of couple therapy as a co-operative, socially constructed process, in which no single point of view is paramount for understanding the phenomena related to the topic, and in which the outcome is a sum of multiple factors influenced by the individual, the couple, the therapy system, and the external social environment (Sprenkle et al., 2009).

Further strengths of the research include the fact that the continuous measures of progress (i.e. the ORS) and of the alliance (i.e. the SRS) provided real-time information for the therapists on how the therapy had proceeded. The results obtained here are important, underlining the usefulness of brief outcome and alliance measures in couple therapy for depression in a naturalistic setting. In addition, the present study incorporated also the therapists' continuous quantitative evaluations of the therapeutic alliance within each therapy session. This procedure made possible not merely the patient's and the spouse's perspectives on the alliance; it also highlighted the therapists' viewpoints on how the treatment was proceeding.

Furthermore, the procedure of having the co-research interview at a point three months from therapy termination demonstrated its worth: it enabled both the couple and the therapists to hear mutual experiences of the psychotherapy process (Study III). In general, the co-research interview can be seen as a collaborative, reflective, and dialogical interactive situation in which the clients have an opportunity to be involved in the system-level evaluation of the treatment. The clients also have access to the therapists' standpoints regarding the therapists' own concerns when they listen to the discussion between the therapists and the interviewer (Rautiainen & Seikkula, 2009). For the therapists, the co-research interview can be an opportunity to learn about how to best conduct couple therapy with depressed patients (Rautiainen & Seikkula, 2010).

In all these aspects, the research pursued well-established lines, and functioned as envisaged.

Despite these major strengths, there are some limitations in this research. First of all, in Study I, the inability to analyze the therapist-effect on outcomes is a major limitation. This was due to the fact that there were several co-therapy teams who treated only one couple; it would thus not have made sense to conduct an analysis of outcomes between couples seen by the same co-therapy team.

A second limitation is the large attrition rate among the participants. It should be noted that the sample reflects those who were perhaps more amenable to couple therapy, representing a potential bias in the sample. Moreover, it is reasonable to assume that the participating patients were in a more difficult life situation and had more a severe symptomatic background than depressed patients in general (Seikkula et al., 2012). The question is whether the results would have been different if the study population had been more representative.

Thirdly, one characteristic of the present naturalistic study design was that the frequency of the sessions fluctuated, as did the length of the treatments, with differences also in the number of sessions and the time intervals. These aspects involved challenges for the selection of appropriate statistical methods. Because of the small sample size in this study, the capacity to detect small or even medium effects was limited. In the event, however, statistical analyses could be undertaken, giving rise to statistically significant findings. In this sense, the choice of methods can be regarded as successful. A point to note in connection with the naturalistic design I used is that there was no control group against which I could analyze the data on subjective distress and the alliance. This could be seen as a limitation in the research. If one were able to conduct a study incorporating a control group in a natural clinical setting, this could produce more useful information, and might help to ensure treatment fidelity. Another issue in the naturalistic design is that it allows multiple treatments to be conducted within each research group. Although this is inevitable in a naturalistic setting, it is a factor that could limit the strength of the findings at some points. These limitations might raise some questions concerning the generalizability of the results. However, the main focus of this research was on the progress and the process as experienced by each partner within the couple, and furthermore, on the therapists' experience of the process in couple therapy for depression in a naturalistic setting. Hence, the lack of a control group and the use of a range of treatments were not seen as obviating worthwhile – and to some extent generalizable – results.

Fourthly, one may wish to raise the question of the generalizability of results obtained from a single-case study (Study III). Here it should be noted that the problems with randomized clinical trials (mentioned above) have given rise to an interest in systematic single-case studies, as being better able to provide detailed information on the characteristics (unique or otherwise) of the case (Elliot, 2002, McLeod, 2010; Ruddin, 2006). Via single-case studies there is

an opportunity to obtain accurate information on the broader context of the case, including both the couple's and the therapists' experiences of the therapy, and the processes leading to the treatment outcome. In the present research, the single-case study made possible a deepened understanding of the phenomenon of couple therapy for depression; at the same time, it tended to verify the notion that couple therapy brought about a considerable improvement in depressive symptoms for the selected patient in the selected couple, and increased the marital satisfaction of the spouse. Nevertheless, there were two key limitations concerning the single-case method used. In the first place, I was the only individual who viewed the videotapes of the sessions and who wrote the session narratives. The second and third authors of study III only reviewed the narratives. An extension would have involved the narratives being produced by more than one person, on the basis of the tapes. This would have strengthened the data and the analysis. A second limitation was that although much of the qualitative data included the words of the couple participants and the therapists in the co-research interview, there was no "member check" (Lincoln & Guba, 1985; Schwandt, Lincoln & Guba, 2007), referring to a return to the participants for their input at this point. This represents a weakness in the triangulation of the data, and consequently, less "trustworthiness" in the conclusions. However, the rich case record was compiled three years after the last follow-up interview and any "member check" would thus have been difficult to obtain.

Fifthly, the use of PCOMS in the couple therapy group might have played a role in the findings, as there is evidence that continuous feedback on treatment progress and on the alliance enhances therapy outcomes (Anker at al., 2009; Sparks & Duncan, 2010). Moreover, questions arise concerning the reliability of the brief self-rating measure used for subjective distress and the alliance. A brief measure may not be as valid and reliable as a longer measure, but there is evidence that the validity and the reliability of both the ORS and the SRS are at an acceptable level (Campbell & Hemsley, 2009). The main benefit of the brief measures is their feasibility, which allows them to be used on a session-by-session basis; hence therapists can monitor the progress and process throughout the treatment, and fit the therapeutic approach or style to the needs of the clients. One limitation in the use of the SRS was that the modified therapist version of the measure was not validated. In relation to this, the authors of the SRS were consulted in the planning phase of the study design before the rewording of the SRS for use by the therapist. However, they did not audit the final version. This being so, a violation of the copyright and licensing agreement occurred, for which I apologize.

Sixthly, there is an issue concerning the assessments of the treatment, and also the qualitative co-research interview, related to demand characteristics (Orne, 1962). Demand characteristics are related to the tendency of the interviewee to respond in a socially desirable way in situations where the interviewer has access to the feedback given in the interview. It might indeed be

the case that demand characteristics influenced some of the findings of the present research, and this can be regarded as a limitation.

Finally, a limitation, deriving from familiarity with couple therapy on my part and that of the judges of Study III, is that we might have been biased in analyzing the data, bearing in mind that the researcher's allegiance to the treatment modality has been shown to affect the outcomes (Luborsky et al., 2006). This could have been a particular concern when I was analyzing the group comparison data between the couple therapy and treatment-as-usual groups, and when I was constructing the affirmative and skeptic cases in the HSCED study. Here, an important point arises: the finding that client and extra-therapeutic factors were *secondary* to treatment factors in Study III contradicts common factors studies that have found these factors to be significantly *more* influential for the overall outcome than the actual treatment (a result obtained from several empirical studies; Wampold, 2001). This finding from Study III might be the result of an unconscious bias on the part of myself and the judges of the study, leading us towards conclusions based on our own "lenses."

4.4 Ethical considerations

Ethical considerations enter into every stage of a mixed methods research design (Creswell, 2009; Haverkamp, 2005). It is important that the researcher should deal with ethical aspects in selecting the research problem and questions, collecting and analyzing the data, interpreting and writing the study report, and disseminating the research (Creswell, 2009). The ethical practices of this research involved, for example, the protection of the participants, confidential co-operation with research sites, and taking into account potential readers (Creswell, 2009). I shall discuss each of these aspects below.

In the present case, the ethical grounds for conducting research on depression were based on the extant literature, and have been presented in the introduction to this dissertation. In connection with depression, several sensitive subjects were investigated, including subjective distress and marital satisfaction. The Ethics Committees of all the participating hospital districts approved the study. Patients seeking treatment for moderate or major level of depression were invited but not required to participate in the study. Both the patient and the spouse were asked for their written informed consent to voluntary participation in the research, and also for their permission to use the research data in study reports.

It will be recalled that the participants were randomized to either a couple therapy or a treatment-as-usual group. In the couple therapy group, the patient could have individual psychotherapy sessions if this was considered desirable as part of the couple therapy process. In addition to this, patients could be given all the forms of treatment seen as necessary, for example psychiatric consultation, medication, and hospitalization. In the treatment-as-usual group, if there was a non-urgent need or desire for couple therapy intervention, the

couple were asked to wait nine months for it to begin. If the need for couple intervention was urgent, it was envisaged that the sessions would be started immediately, and that the patient would be excluded from the study. However, the possibility that some patients might not have received the type of treatment they desired could be seen as a potential ethical consideration, acting also as a potential confounding factor in the findings.

All the research data were carefully stored according to the standards set by Jyväskylä University and the three participating hospital districts. Before the final analyses, all identification data were removed from the research material in order to guarantee the anonymity of the participants. In Study III, the names of the couple selected and of the therapists were changed; this was done also for the background information and for several other variables in the case, to make identification of the participants impossible.

An important aspect of research is the aim that both the participants and the researcher should benefit from it (Creswell, 2009). In this research, the principle was that the patients were offered treatments according to the best practice available, and that if the participant wished to withdraw from the study, this would have no effect on the treatment offered. In Study III the co-research interviews served as an invitation for the participants and the therapists to act as co-researchers in evaluating the therapeutic process, and thus, each of them could receive feedback of the therapy process.

As mentioned above, this research provided a precious learning opportunity for me on a personal level. In interpreting and reporting the findings of this research, I tried throughout to be honest, and also respectful towards the patients, spouses, and therapists. My intention was to write a comprehensive research report on important issues, and to make it as understandable and interesting as possible for readers.

4.5 Future research

Future research should aim to concretize and to further explore the associations between the continuous monitoring of subjective distress, the alliance, and the outcome in couple therapy for depression. For this purpose, studies should be conducted in naturalistic clinical settings – as in the present research – but with the inclusion of a control group, participating in the same treatment modality, and differing only in the absence of the variable under study. The benefit of such research would be that treatment integrity could be better evaluated, and it would also be possible to evaluate the influence of feedback on treatment outcomes.

One area for the future research would pertain to long-term effectiveness in the outcomes of couple therapy for depression. Only a few studies have examined this aspect, and much remains to be discovered concerning the benefits of couple therapy over the longer term.

An important research task for the future would be an analysis of the therapist-effect on treatment outcomes. It would be interesting to obtain information on whether the therapists differ in their work when they conduct similar therapies in feedback groups and treatment-as-usual groups. In addition, questions pertaining to the therapist's personal characteristics would be of interest: new research information on these aspects could assist in developing training in couple and family therapy, and also supervision in the field.

Finally, this research introduced the HSCED mixed methods study design in the context of couple therapy for depression. There is now a need for further research on HSCED, since this method may point to avenues for quantitative exploration that will allow a more accurate assessment of the effectiveness of couple therapy for depression in naturalistic settings; this will also make it possible to evaluate the representativeness of the case study reported here.

4.6 Clinical implications

This research supports couple therapy for depression as an effective treatment for the symptoms of depression. The research also provides further evidence of the important role of both patients and spouses in the recovery processes within couple therapy for depression. Furthermore, the study identified several mediating factors (e.g. a positive alliance with the therapists) and moderating factors (e.g. the patient's readiness for change) in the change. A further point to emerge was that the monitoring of subjective distress and of the therapeutic alliance is a useful way to obtain information on the treatment process during couple therapy. The benefit of feedback on a session-by-session basis is that there is an opportunity for personal information on the case to be transmitted during the actual treatment process. The therapists are not dependent merely on mean group data for a specific treatment: they have the possibility to obtain case-specific information on how the treatment modality is proceeding at a particular moment of time, with any couple experiencing the problem in question (for example depression).

When therapists have access to real-time data on the treatment process they may become aware that the process includes both impasses and success. Whichever of these predominate, the therapists will have the possibility of adjusting their therapeutic actions according to the couple's need. There is, however, a caveat that necessarily applies in such cases: when using feedback on the progress made and on the alliance, it is crucial that the couples and the therapists should have an affirmative attitude in assessing the treatment process.

The present research leads to the recommendation that spouses should be included in the treatment for patients suffering depressive symptoms. It also recommends that couple therapists should obtain continuous feedback on the treatment progress and alliance at each session. The therapists should discuss with the couple the information they have obtained, and adapt the treatment

according to the couple's needs. It is important to discuss the characteristics and personal resources of each patient and spouse, and the therapeutic processes that may have an effect on the treatment outcome. By doing this, therapists become accountable to their clients in everyday clinical practice. Finally, this research demonstrates the importance of having conversations on subjective distress and relational issues during treatment for depression, over and above conversations on the depressive symptoms.

YHTEENVETO (SUMMARY)

Terapiamuutoksen todentaminen masennuksen pariterapeuttisessa hoidossa: Monimenetelmällinen tutkimus luonnollisissa hoito-olosuhteissa Suomessa

Tämän tutkimuksen tarkoituksena oli kehittää menetelmiä masennuksen pariterapeuttisessa hoidossa tapahtuvan terapiamuutoksen todentamiseksi. Tutkimus toteutettiin luonnollisissa hoito-olosuhteissa, ja sen raportointi koostui kolmesta osatutkimuksesta ja kokoomateoksesta. Tutkimuksessa selvitettiin pariterapeuttisen hoidon vaikuttavuutta potilaan masennusoireiluun, joten se kuului psykoterapian vaikuttavuustutkimuksen kenttään.

Tutkimuksessa haluttiin selvittää, mitkä tekijät selittävät Seikkulan ym. (2012) löytämiä eroja masennuksen pariterapeuttisen ja tavanomaisen hoidon välillä. Seikkulan ym. (2012) tutkimuksessa pariterapiaryhmän potilaat hyötyivät hoidosta tavanomaisen hoidon ryhmän potilaita enemmän ja vähemmällä käyntimäärällä puolen vuoden seurantahaastattelussa ja ero säilyi koko kahden vuoden seuranta-ajan. Tutkimuksessa haluttiin selvittää lisäksi pariterapiaryhmän osalta, miten yksilöiden jokaisella istunnolla arvioima henkilökohtainen stressi oli yhteydessä masennusoireilun muutokseen puolen vuoden aikana (osatutkimus I). Tutkimuksen seuraavassa vaiheessa mielenkiinnon kohteena oli pariterapiaryhmän osalta, miten istuntokohtaiset koettu yksilöllinen stressi ja terapeuttinen yhteistyösuhde ovat vuorovaikutuksessa keskenään terapiaprosessin aikana. Lisäksi haluttiin selvittää, missä määrin terapeuttinen yhteistyösuhde ja siinä tapahtuvat muutokset ovat yhteydessä potilaan masennuksesta toipumiseen (osatutkimus II). Tutkimuksen kolmannessa vaiheessa haluttiin selvittää syvemmin masennuksen pariterapiaprosessissa hoidon tulokseen vaikuttavia tekijöitä tapaustutkimuksen avulla (osatutkimus III).

Tutkimus tehtiin ns. mixed methods -asetelmalla, jossa tutkimusaineisto koostuu sekä määrällisestä että laadullisesta aineistosta. Osatutkimuksissa I ja II tutkimusaineisto oli luonteeltaan määrällistä, ja osatutkimuksessa III käytettiin sekä määrällistä että laadullista aineistoa. Lisäksi tutkimuksessa toteutettiin ryhmävertailua (osastutkimus I), yhden tutkimusryhmän prosessin analysointia (osatutkimukset I ja II) ja tapaustutkimusta käyttäen hermeneuttista tapaustutkimusasetelmaa (Hermeneutic single case efficacy design; HSCED; Elliot, 2002; osatutkimus III).

Tutkimus oli osa laajempaa Dialogiset ja narratiiviset prosessit masennuksen pariterapiassa (DINADEP) – tutkimushanketta (Seikkula ym., 2012). Tutkimushankkeeseen osallistuivat Pohjois-Savon, Helsinki-Uusimaan ja Länsipohjan sairaanhoitopiirit. Kaikkia tammikuun 2006 – heinäkuun 2007 välisenä aikana vähintään keskivaikean masennuksen vuoksi hoitoon tulevia potilaita pyydettiin osallistumaan tutkimukseen. Yhteydessä oltiin kaikkiaan 132 potilaaseen, joista 66 (50 %) halusi olla mukana. Potilaat osallistuivat alkuhaastatteluun, jossa kerättiin taustatietoja ja arvioitiin heidän masennusoireiluaan (Beck Depression Inventory; BDI; Beck ym., 1961; ja Hamilton Depression Rating Scale; HDRS; Hamilton, 1960), yleistä mielenterveyttään (Symptom Checklist 90;

SCL-90; Derogatis, 1983), parisuhdetyytyväisyyttään (Dyadic Adjustment Scale; DAS; Spanier, 1976) ja alkoholinkäyttöään (Alcohol User Disorders Identification Test; AUDIT; Babor ym., 2001). Tämän jälkeen potilaat satunnaistettiin pariterapeuttisen ja tavanomaisen hoidon ryhmiin. Potilaat osallistuivat 6, 12, 18 ja 24 kuukauden kuluttua seurantahaastatteluihin. Potilaiden puolisot molemmista ryhmistä osallistuivat masennusoireilun (BDI) ja parisuhdetyytyväisyyden (DAS) arviointiin samoina ajankohtina potilaiden seurantahaastatteluiden kanssa. Kaikista pariterapiaryhmän istunnoista tehtiin joko video- tai audiotallenne. Pariterapiaryhmässä potilaat ja puolisot arvioivat jokaisen istunnon alussa kokemaansa henkilökohtaista stressiään Muutosarviointiasteikolla (The Outcome Rating Scale; ORS; Miller & Duncan, 2000). Potilaat, puolisot ja myös terapeutit arvioivat jokaisen istunnon lopussa terapeuttista yhteistyösuhdetta Terapiaistunnon arviointiasteikolla (The Session Rating Scale; SRS; Miller ym., 2002).

Kahden vuoden seurannan aikana 15 potilasta jäi pois tutkimuksesta, joten ryhmien kooksi jäi 29 potilasta pariterapiaryhmään ja 22 potilasta tavanomaisen hoidon ryhmään. Pariterapiaryhmässä potilaat ja heidän puolisonsa kävivät vähintään erityistason perheterapiakoulutuksen saaneiden perheterapeuttien hoidossa. Perheterapeutit tekivät työtään tavanomaiseen tapaansa; mitään erityisiä manuaaleja ei ollut käytössä. Vastaanottokäyntien tiheys ja hoidon pituus määriteltiin yhteisessä keskustelussa potilaan ja hänen puolisonsa hoidollisten tarpeiden mukaan. Potilailla saattoi olla yksilöhoitokäyntejä, mikäli se oli tarpeenmukaista pariterapiaprosessin kannalta. Lisäksi potilailla oli käytössään kaikki tarpeelliset hoitomuodot, kuten psykiatrin vastaanottokäynnit, lääkehoito ja sairaalahoito.

Tavanomaisen hoidon ryhmässä hoito sisälsi yksilö- tai ryhmäterapiakäyntejä. Potilailla oli lisäksi käytössään kaikki muu tavanomainen hoito: esimerkiksi psykiatrin vastaanottokäynnit, lääkehoito ja sairaalahoito. Mikäli tavanomaisen hoidon ryhmässä oli tarvetta parikäynteihin, sellaisia voitiin toteuttaa, jos sisältönä oli pelkästään depressioon liittyvän tiedon antaminen. Jos pariskunnalla oli tarvetta pariterapeuttiseen prosessiin, heitä pyydettiin odottamaan yhdeksän kuukautta. Mikäli tarve oli kiireellinen, potilas suljettiin tutkimuksesta ja pariterapia aloitettiin heti.

Molemmissa tutkimusryhmissä tapahtui masennusoireilun vähenemistä ensimmäisen puolen vuoden seurantajakson aikana sekä potilailla että puolisoilla – muutokset olivat voimakkaampia pariterapiaryhmässä. Potilailla tapahtui myönteistä muutosta yleisen mielenterveyden osalta molemmissa ryhmissä, mutta muutokset olivat suurempia pariterapiaryhmässä. Parisuhdetyytyväisyyden osalta muutokset olivat keskimäärin vähäisiä molemmissa ryhmissä. Puolisoilla oli merkittävä rooli potilaiden masennusoireilusta toipumisen prosessissa molemmissa hoitomuodoissa ja erityisesti pariterapiaryhmässä, jossa myös puolisot itse hyötyivät pariterapeuttisesta hoidosta siten, että heidän henkilökohtaisesti kokemansa stressin määrä väheni merkittävästi, mikäli toinen tai molemmat puolisoista olivat stressaantuneita hoidon alussa. Pariterapiaryhmässä miespuolisilla puolisoilla tapahtui suurempi masennusoireilun

muutos kuin naisilla. Hoitoryhmien välillä oli tässä eroa. Puolison alkutilanteen masennusoireilu oli yhteydessä ryhmien välisiin eroihin sekä potilaan että puolison toipumisessa masennusoireilusta ja muutoksessa parisuhdetyytyväisyydessä. Puolisoilla tapahtui suurempi parisuhdetyytyväisyyden muutos vähäisemmillä terapiaistunnoilla kuin tavanomaisen hoidon ryhmässä.

Pariterapiaryhmän osalta tehtiin havainto, että muutokset potilaan istuntokohtaisesti arvioidussa hyvinvoinnissa (henkilökohtaisesti koetussa stressissä) ennustivat potilaan masennusoireilun vaihtelua puolen vuoden seurantahaastattelussa. Potilaan ja puolison kokema yhteistyösuhteen laatu koheni terapian kuluessa. Sekä potilailla että puolisoilla istuntokohtaiset poikkeamat keskimääräisestä koetusta stressistä istunnon alussa ennustivat istuntokohtaisia poikkeamia keskimääräisestä koetusta terapeuttisesta yhteistyösuhteesta saman istunnon lopussa. Samoin sekä potilaan että puolison istuntokohtaiset poikkeamat keskimääräisestä koetusta terapeuttisesta yhteistyösuhteesta ennustivat istuntokohtaisia poikkeamia keskimääräisestä hyvinvoinnista seuraavalla istunnolla.

Koko hoitosysteemin (potilaan, puolison ja terapeuttien) arvioima hoidonaikainen keskimääräinen terapeuttinen yhteistyösuhteen taso selitti 19 % potilaan masennusoireilun vaihtelusta tutkimuksen kahden vuoden seurantaaikana. Hoitosysteemin terapeuttisen yhteistyösuhteen ollessa keskimääräisellä tasolla masennusoireilu oli seurantajakson alussa 23,8 BDI-asteikolla mitattuna. Kahden vuoden seurantajakson lopussa BDI-pistemäärä oli 10,4. Mikäli hoitosysteemin terapeuttinen yhteistyösuhde oli yhden keskihajonnan verran keskimääräisen tason yläpuolella, BDI-pistemäärä oli seurantajakson lopussa 3,7. Hoitosysteemin terapeuttisen yhteistyösuhteen ollessa yhden keskihajonnan verran keskimääräisen tason alapuolella BDI-pistemäärä oli seurantajakson lopussa 17,1.

Tutkimuksen kolmannessa osassa tutkittiin tapaustutkimuksen avulla pariterapian vaikuttavuutta potilaan masennusoireilusta toipumiseen. Tulosten perusteella hoidossa ollut pariskunta hyötyi suuresti saamastaan hoidosta ja hoidon tulos oli merkittävästi yhteydessä masennuksen pariterapeuttiseen hoitoon. Hoitoprosessin hoitotulokseen vaikuttavina välittävinä tekijöinä (mediaattoreina) nousivat esille myönteinen terapeuttinen yhteistyösuhde, terapeuttien ”ulkopuolisuus” suhteessa pariskuntaan ja heidän asioihinsa, terapeuttien kuunteleva asenne ja tapa kertoa omia mielipiteitään sekä terapeuttien luottava suhde pariskunnan itsemääräämisoikeuteen omien elämänasioidensa osalta. Hoidossa olleen pariskunnan hoidon tulokseen vaikuttaneina luonteenpiirteinä tai henkilökohtaisina ominaisuuksina (moderaattoreina) nousivat esille valmius muutokseen ja motivaatio saada apua; halu, kyky ja sitoutuneisuus luoda luottavainen suhde terapeuttien kanssa; halu keskustella avoimesti olemassa olevista ongelmista terapeuttien kanssa sekä halu kuunnella toinen toisensa ja terapeuttien mielipiteitä; kyky itsehavainnointiin liitettynä siihen, että ongelmat voitiin nähdä osana omaa elämäntarinaa; tarve muuttaa omaa asennetta ja käyttäytymistä.

Tutkimuksen johtopäätöksinä voidaan todeta, että puolison mukanaolo masennuksen hoidossa on tärkeää ja myös puolisot itse hyötyvät hoidosta. Jatkuva istuntokohtainen palaute tuo tietoa potilaan ja puolison kokemuksesta henkilökohtaisesta hyvinvoinnista ja terapeuttisesta yhteistyösuhteesta. Tämän avulla terapeutit ovat tietoisia siitä, miten prosessi etenee, ja he voivat sovittaa hoidolliset interventiot potilaan ja puolison tarpeita vastaaviksi. Palautteen avulla voidaan ennustaa myös hoidon tulosta. Terapiamuutoksen ja -prosessin istuntokohtainen arviointi voi tuoda esille keskusteluun myös sellaista, mitä olisi ollut muuten hankalaa tavoittaa.

Vaikka saatuihin tuloksiin seurantamenetelmän hyödyn yleistettävyydestä masennuksen pariterapiassa liittyy rajoituksia, niin systemaattisella potilaan ja puolison henkilökohtaisen stressin ja terapeuttisen yhteistyön seurannalla on se etu, että siinä saadaan tapauskohtaista tietoa muutoksen ja prosessin etenemisestä. Tämä tuo sen mahdollisuuden, että terapeutit eivät ole hoidon vaikuttavuuden osalta pelkästään eri hoitomenetelmien vaikuttavuutta eri potilasryhmiin selvittävien keskiarvotutkimusten varassa, vaan sen lisäksi heillä on mahdollista saada tietoa siitä, kuinka tietyn asian (esim. masennuksen tai parisuhdeongelman) hoito etenee tietyllä hetkellä ja kyseisellä menetelmällä juuri tietyllä pariskunnalla. Hoidon seurantamenetelmiä käytettäessä on tärkeää, että sekä terapeuteilla että hoitoon osallistuvilla pariskunnilla on terapiaprosessin yhteiseen arvioimiseen liittyvä hyväksyvä suhtautuminen – arviointia tekevät pariskunnat tarvitsevat rohkeutta ilmaistakseen sen, mitä he todella ajattelevat, ja terapeutit puolestaan tarvitsevat uskallusta ottaa vastaan asiakkaidensa taholta tulevaa oman työn arviointia.

Tutkimuksen perusteella masennuksen pariterapeuttisessa hoidossa on tärkeää keskustella masennusoireilun lisäksi sekä potilaan että puolison henkilökohtaisesta hyvinvoinnista hoidon aikana ja parisuhteeseen liittyvistä aiheista.

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APPENDIX 1: ORS & SRS SAMPLES

MUUTOSARVIOINTIASTEIKKO (ORS)

Nimi:_____ **Pvm:**_____**No:**_____
Auta meitä ymmärtämään, miten olet voinut kuluneen viikon aikana, mukaan lukien tämän päivän. Mieti alla olevia elämänalueita ja merkitse rasti sille kohdalle, millä tunnet olevasi. Janan vasen reuna merkitsee alempaa ja oikea reuna korkeampaa tasoa.

Yleisesti:
(Yleinen elämäntilanne)
|----------|

Yksilöllisesti:
(Henkilökohtainen hyvinvointi)
|----------|

Läheisten ihmissuhteiden osalta:
(Perhe ja muut läheiset ihmissuhteet)
|----------|

Sosiaalisesti:
(Työ, koulu, ystävyyssuhteet)
|----------|

TERAPIAISTUNNON ARVIOINTIASTEIKKO (SRS V.3.0)

Nimi:_____**Pvm:**_____
No:_____
Terapeutit:_____

Arvioisitko tämänkertaisen keskustelumme seuraavien asteikkojen osalta. Aseta merkki sille kohdalle, joka parhaiten kuvaa Sinun kokemustasi

En kokenut tulevani kuulluksi	**Terapiasuhde:** |----------|	Tulin kuulluksi, minua ymmärrettiin ja kunnioitettiin
Me emme työskennelleet ja keskustelleet niistä aiheista, joista olisin halunnut	**Päämäärä ja keskustelun aiheet:** |----------|	Me työskentelimme ja keskustelimme toivomistani aiheista
Terapeuttien työtapa ei sopinut minulle	**Työskentelytapa ja menetelmä:** |----------|	Terapeuttien työtapa sopi minulle hyvin
Keskustelusta puuttui jotain	**Yleisesti:** |----------|	Yleisesti ottaen päivän istunto oli hyvä

APPENDIX 2: ORS & SRS GRAPH

ORS- ja SRS- Taulukko

Nimi:_____ **Pvm:**_____ **No:**_____