ACCOUNTABILITY IN COUPLE THERAPY FOR DEPRESSION: A MIXED METHODS STUDY IN A NATURALISTIC SETTING IN FINLAND

Ilpo Kuhlman
Kuopio Mental Health Services, Kuopio Psychiatric Center
ilpo.kuhlman@kuopio.fi

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Accountability

- Understanding the client’s and the therapist’s perceptions of the therapy and assessing symptom relief during therapy.

- An idea of rigorous and open demonstration of the effectiveness of couple therapy in the face of public scrutiny.

- Outcomes are available to clients, therapists, funding bodies and other stakeholders.
The costs of health care are increasing and the poor economic situation in society; a challenge in maintaining health services.

Need for developing more cost-effective psychological treatments.

80% of the customers in health care use 20% of the resources, and conversely, 20% of the customers use 80% of the resources.
Psychotherapists do not recognize those patients that are at risk of a poor outcome or deterioration.

Tend to be over-optimistic in their evaluations concerning the recovery of their patients.

Tend to continue in the same way as before with clients who are at risk of a poor outcome.
Why to follow therapy change?

- Early change in therapy process is a good predictor of good outcome
- Client’s subjective experience of meaningful change is a good predictor of good outcome
- The longer the treatment continues without remarkable improvement the more likely is a risk of poor outcome or to drop out of therapy
Why to follow therapy change?

- 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 (Brown, Dreis, & Nace, 1999)

- Systematic feedback provision of progress can identify a large amount of patients at risk of a poor outcome early in the treatment
Why to follow therapy change?

- Feedback at four intervals
  - did not improve the young people’s outcomes or
  - family functioning as compared to a no-feedback group (Ogles, 2006)

- Feedback from every session
  - couples in a feedback group achieved almost four times more clinically significant changes than those under treatment-as-usual
  - The results were maintained at the six-month follow-up.
  - There was also a significantly lower rate (46%) of separation or divorce in the feedback group (Anker, Duncan and Sparks, 2009)

- Time intervals may have an effect on the benefit of feedback provision?
Outcome

↓

Process
Why to follow therapy process?

- What matters in creating good working alliance?
  - At least:
    - Clients’ family-of-origin distress
    - Clients’ social support in current social relationships
    - Couple’s former relationship
    - Couple’s higher marital distress, and relational power differences
    - The therapists’ co-operation
Why to follow therapy process?

- The start of therapy is important for creating a beneficial therapeutic interaction
  - Therapy starts immediately

- Therapists need to be connected to clients first at individual level
  - A challenge in group situation
Why to follow therapy process?

- No correlation between the length of the process and the strength of the alliance
- Clients seldom verbalize their dissatisfaction before they decide to terminate treatment

→ Therapists need ongoing feedback of clients’ assessments of working alliance (every session)
Why to follow therapy process?

- With feedback from the session therapist can adjust the treatment relevant to clients needs in the case client shows no improvement or is at risk terminating the treatment.

- Client-therapist agreement on theory of problem and change is remarkable on building a strong alliance.
Why to follow therapy process?

Client’s theory of problem and change

FIT

Therapist’s theory of problem and change
Background for this research

- Part of the Dialogical and Narrative Processes in Couple Therapy for Depression (DINADEP; Seikkula et al., 2012) – research project

- The DINADEP project was conducted to develop therapy for depression and to investigate the effectiveness of couple therapy in naturalistic clinical settings.
1) What is the relationship between continuously monitored treatment progress and the outcome of the depressive symptoms?

2) In what ways do treatment progress and the therapeutic alliance interact in the course of treatment?

3) How is the alliance associated with treatment outcome?

4) Is it possible to form causal process-outcome attributions, and to determine any mediating and moderating factors in relation to outcome?
The participants were recruited via the usual routes from the adult population of the hospital districts of Northern Savo, Western Lapland, and Helsinki-Uusimaa.

132 patients were contacted of whom 66 volunteered to the research.

Randomized to Couple therapy (CT) and Treatment-as-usual (TAU) groups.
Participants

- For patients baseline assessment and post-baseline assessments at 6, 12, 18, and 24 months
  - Depression (BDI, HDRS)
  - General mental health (SCL-90)
  - Marital satisfaction (DAS)
  - Use of Alcohol (AUDIT)

- For spouses baseline assessment and post-baseline assessments at 6, 12, 18, and 24 months
  - Depression (BDI)
  - Marital satisfaction (DAS)
Fifteen participants (23%) were lost over post-baseline assessments and were thus excluded from the final analysis.

The final sample consisted of 51 participants
- Couple therapy group $n = 29$
- Treatment-as-usual group $n = 22$
The sessions in the couple therapy group were conducted by case-specific co-therapy teams of two family therapists.

There was no specific manual for the therapy, and the therapists were advised to conduct the treatments as they usually did in their work.

The treatments were expected to last for as long as required, depending on the patient’s need.

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.
Couple therapies

- All couple therapy sessions were audio- or videotaped.

- In couple therapy group patients and spouses scored their subjective distress using The Outcome Rating Scale (ORS; Miller & Duncan, 2000) at the start of each session.

- The patient, the spouse, and the therapists scored their alliance ratings using The Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2002) at the end of each session.
Outcome Rating Scale (ORS)

- Developed as a brief alternative to the Outcome Questionnaire-45 (OQ-45; Lambert et al., 1996)

- Four areas of client functioning
  1) Individually (personal well-being)
  2) Interpersonal relationships (family, close relationships)
  3) Social role performance (work, school, friendships)
  4) Overall (general sense of well-being)
Outcome Rating Scale (ORS)

![Graph showing Treatment length over 25 weeks]

Treatment length 25 weeks
Outcome Rating Scale (ORS)

Treatment length 103 weeks
Developed from the Johnson’s (1995) 10 item Session Rating Scale

Four areas of working alliance
1) Therapeutic relationship
2) Agreement on goals and topics
3) Agreement on approach or method
4) Overall (general sense of alliance)
ORS, SRS

Couple therapy length 25 weeks
Couple therapy length 103 weeks
Results

- Correlations were found between the patients’ first-session subjective distress and the spouses’ first-session subjective distress, and between the patients’ first-session subjective distress and the spouses’ change in subjective distress.

- 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.

- 38% of spouses had depressive symptoms at baseline.

- 20% of the spouses had depressive symptoms at the end of treatment.
Results

- The patients’ change in subjective distress explained 38% - 47% of the patients’ changes on depressive symptoms and general mental health at six month post-baseline assessment.

- The patients’ change in subjective distress associated with a patients’ change in marital satisfaction at six month post-baseline assessment.
Results

- 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.
Results

- The patients’, spouses’ and therapists’ ratings of alliance were highly correlated.

- Therapy\textsubscript{System} –factor was created to predict the patients’ recovery from depression.
Results

The association between the Therapy Alliance and the changes in patients’ depression outcomes.
Process–outcome causality in couple therapy for depression

- Hermeneutic Single Case Efficacy Design
  (HSCED; Elliott, 2002; Elliott et al., 2009)

- Attempt to answer:
  - Whether the patient changed?
  - Whether the observed changes were due to the treatment?
  - Which specific mediators (therapy processes) were involved in the changes observed?
  - Which specific moderators (personal resources and characteristics of couple) were involved in the changes observed?
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
A. Rich case record
B. Affirmative brief
C. Sceptic brief
D. Affirmative rebuttal
E. Sceptic rebuttal
F. Affirmative summary narrative
G. Sceptic summary narrative
H. Adjudication
Background information for patient and spouse

- Marja was 53 and Pauli 55 years old
- The couple had been together for 21 years
- Marja was diagnosed at least moderately depressed
- Marja’s depressive symptoms had been lasted about a year before therapy start
- Eight therapy sessions were conducted

Quantitative process data

- The Outcome Rating Scale
- The Session Rating Scale
### Marja’s and Pauli’s process data for ORS and SRS, sessions 1–8.

<table>
<thead>
<tr>
<th>Instruments</th>
<th>Cut-off</th>
<th>RCI min</th>
<th>1.</th>
<th>2.</th>
<th>3.(^a)</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
<th>8.</th>
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<tr>
<td><strong>Marja</strong></td>
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<tr>
<td>ORS</td>
<td>&lt; 25</td>
<td>7.8 (↑)</td>
<td>12.5</td>
<td>23</td>
<td>-</td>
<td>33.5</td>
<td>33</td>
<td>26.5</td>
<td>30.5</td>
<td>37.5 (++)</td>
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<td>34.5</td>
<td>36</td>
<td>-</td>
<td>38.5</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40 (++)</td>
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<td><strong>Pauli</strong></td>
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<tr>
<td>ORS</td>
<td>&lt; 25</td>
<td>5.7 (↑)</td>
<td>31.4</td>
<td>38.3</td>
<td>-</td>
<td>39.7</td>
<td>39.8</td>
<td>39.6</td>
<td>39.7</td>
<td>39.7 (+)</td>
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<td>4.2 (↑)</td>
<td>40</td>
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<td>-</td>
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<tr>
<td>Therapist2 SRS</td>
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<td>4.9 (↑)</td>
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<td>38</td>
<td>39.4</td>
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*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 (Jacobson & Truax, 1991); ORS = Outcome Rating Scale; SRS = Session Rating Scale*
A. Rich case record

- Quantitative outcome data
  - Baseline; after 5. session; 3, 9 and 15 months after treatment termination
  - Hamilton Rating Scale for Depression (HRSD)
  - Beck Depression Inventory (BDI)
  - Dyadic Adjustment Scale (DAS)
  - Alcohol User Disorders Identification Test (AUDIT)
### Marja’s and Pauli’s baseline and outcome data.

<table>
<thead>
<tr>
<th>Instruments</th>
<th>Cut-off</th>
<th>RCI min</th>
<th>Baseline</th>
<th>Mid-5</th>
<th>Post-3</th>
<th>Fup-9</th>
<th>Fup-15</th>
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<td>32</td>
<td>11 (+)</td>
<td>3 (++)</td>
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<td>6 (++)</td>
<td>0 (++)</td>
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<td>116 ( )</td>
<td>108 ( )</td>
<td>116 ( )</td>
<td>117 ( )</td>
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<td>20</td>
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<td>0 (++)</td>
<td>0 (++)</td>
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<td>AUDIT-3</td>
<td>&lt; 4</td>
<td>4.4 (↓)</td>
<td>8</td>
<td>0 (++)</td>
<td>0 (++)</td>
<td>0 (++)</td>
<td>0 (++)</td>
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<tr>
<td>Pauli</td>
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<td>-a</td>
<td>0 ( )</td>
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<tr>
<td>DAS</td>
<td>&lt; 95</td>
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<td>86</td>
<td>110 (++)</td>
<td>115 (++)</td>
<td>-a</td>
<td>115 (++)</td>
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</table>

Note. Mid-5 = Mid-therapy at five months; Post-3 = Follow-up at three months post-therapy; Fup-9 = Follow-up at nine months post-therapy; Fup-15 = Follow-up at fifteen 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)
A. Rich case record

Qualitative process data

- Sessions were videotaped
- Narrative for each session
  - themes of the conversations
  - description of the therapists’ actions during the session
  - Marja’s and Pauli’s comments about session
- ‘Member check’
A. Rich case record

Qualitative process data (continued)

- Co-research interview
  - Patient, spouse and therapists
  - Three months after treatment termination
  - Semistructured
  - To obtain from participants their experiences of the changes, including the helpful and impeding processes in the therapy
  - First, interviewer talked with the therapists while the clients listened
  - Next, interviewer talked with the clients while the therapists listened
  - Finally, participants discussed how was it to talk together in this way
  - Whole interview was transcribed
  - Sections in which there were aspects relevant to the research questions were bolded
  - Interviewer’s questions which were related to co-research interview procedure are bolded and underlined
B. Affirmative brief

- Early change in long-lasting problems
- Retrospective attribution
  - Both Marja and Pauli attributed the occurred changes to the therapy process
- Process-outcome matching
  - The changes after the treatment termination were related to the specific events, perspectives or processes during the therapy
- Event-shift sequences
  - The significant therapeutic events were followed by the positive changes on the patient’s problems
In the co-research interview Marja and Pauli indicated that the timing of the treatment was suitable for them

- Marja: “...it really was a good thing, that I had begun that therapy earlier that, that those, th- all the things were figured out like at the same time then”
- Pauli: “And it happened to be in a good time…that beginning of the therapy…”. (Page 23)
C. Skeptic brief

- Trivial change in long lasting problems
- Statistical artifacts
- Relational artifacts
- Expectancy artifacts
- Self-correction processes: self-help and a self-generated return to baseline functioning
- Extratherapy events
- Psychobiological causes
- Reactive effects of research
The agreement to terminate the therapy followed soon after the acute crisis had been relieved. Like the Therapist 1 (Liisa) noticed:

- “…that it was kind of a crisis, therapy, crisis therapy sessions on these few sessions…”. (Page 18).

And Marja confirmed:

- “But after that it surely turned to be a kind of, like crisis treatment or help then, those couple of sessions here, that…“. (Page 24).
- “…so I thought that it was, like kind of a limit maybe, like, we made it ourselves, that limit, into that, which were those, like, the most difficult matters”. (Page 29).
D. Affirmative rebuttal

- Patient and spouse attributed the changes to the therapy
- Marja and Pauli believed that the treatment was terminated at an appropriate time
- Positive changes occurred on several measures
- The congruence of the quantitative and the qualitative data
- Long-term follow-up data supported the stability of the changes
E. Skeptic rebuttal

- The process of recovery from the crisis was independent of the therapy

- Impulsive behavior had continued in major life activities

- The emphasis on positive attributions in the co-research interview
The crucial point was that Marja had recovered from depression and stopped drinking

(1) at that point of time

(2) by participating with her spouse, Pauli, in

(3) couple therapy for depression.
There was a potential risk for impulsive behavior in subsequent stressful life circumstances, and this might cause relapses in Marja’s anxiety and that might have an influence on Marja’s depressive symptoms and Pauli’s marital satisfaction.

Marja and Pauli would have needed a longer period of couple therapy for depression or individual therapy if Marja was to find solutions for her impulsive behavior.
Data was delivered to judges

- Three experienced professionals in family therapy
- Judges got familiar with the data and answered to questions
H. Adjudication

How to adjudicate
Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer, and change to bold type or a different colour). In answering the remaining questions, please use as much space as you need in order to provide a full response.

1. To what extent did Marja and Pauli change over the course of couple therapy?
   No Change   Slightly   Moderately   Considerably   Substantially   Completely
   0%          20%        40%         60%           80%            100%

1a. How certain are you?

   100%  80%  60%  40%  20%  0%

1b. What evidence presented in the affirmative and sceptical cases mattered most to you in reaching this conclusion? How did you use this evidence in reaching your conclusion?

2. To what extent was this change due to the therapy?
   No Change   Slightly   Moderately   Considerably   Substantially   Completely
   0%          20%        40%         60%           80%            100%

2a. How certain are you?

   100%  80%  60%  40%  20%  0%

3. Which therapy processes (mediating factors) do you feel were helpful to Marja and Pauli?

4. Which characteristics and/or personal resources of the client (moderating factors) do you feel enabled Marja and Pauli to make the best use of their therapy?
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%)

What mattered?:
- Parallel results between quantitative and qualitative data
- Identification of the problems and the opportunity to speak about them
- Long follow-up time
H. Adjudication

- Change was due to therapy
  - Judges assessed at the “considerable” level (mean 66.7%; judges’ ratings 60%, 60%, and 80%)
  - With a “considerable” level of certainty (mean 73.3%; judges’ ratings 80%, 60%, and 80%).
Mediating factors

- Positive alliance with the therapists
- Therapists’ “outsiderness”
- Therapists’ listening and appreciative stance
- Therapists’ willingness to give their impressions and opinions on the themes of the discussions
- 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)
- Marja’s cessation of drinking quite early in the treatment
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
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
The couple’s longlasting relationship was seen as a resource to which each of the spouses was committed.
Change in depressive symptoms had occurred for the selected patient in the selected couple during couple therapy for depression.

Change was largely due to therapy:
- The finding that client and extratherapeutic factors were secondary to treatment factors contradicts common factors studies that have found these factors to be significantly more influential for the overall outcome than the actual treatment.
HSCED – Conclusions

- Capability of obtaining highly accurate information on the treatment processes
- Process and outcome data is available for both clinical and scientific use
Overall conclusions

- Important role of both patients and spouses in the recovery processes within couple therapy for depression

- Monitoring of subjective distress and of the therapeutic alliance is a useful way to obtain information on the treatment process during couple therapy
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)
Spouses should be included in the treatment for patients suffering depressive symptoms

Couple therapists should obtain continuous feedback on the treatment progress and alliance at each session

Therapists should discuss with the couple the information they have obtained, and adapt the treatment according to the couple’s needs

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
Future research

- Studies in naturalistic clinical settings
  - control group
  - same treatment modality
  - differing only in the absence of the variable under study

- Long-term effectiveness in the outcomes of couple therapy for depression

- Therapist-effect on treatment outcomes

- Further research on HSCED
  - Evaluating the representativeness of the case study reported here
Recommendations for couple and family therapy training

- Use of feedback provision should be included in training programs

- HSCED is a useful method as a trainee to learn one’s way of working with clients during training period

- Teaching an attitude of being accountable should be included in training programs

Thank you!