Experiences of working-age adults with depression of psychodynamic couple therapy: a thematic analysis using a phenomenological approach

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Abstract

Background: Depression is a complex condition that affects over 320 million people worldwide and entails risks of relapse and suicide. As a result of the increasing number of adults experiencing symptoms of depression and anxiety in the United Kingdom, Improving Access to Psychological Therapies (IAPT) services have been established to assist individuals with these difficulties. The National Institute for Health and Care Excellence (NICE) guidelines have recommended behavioural couple therapy for the treatment of depression, but public provision is limited. Despite the wide range of literature that explains the link between couple wellbeing and mental health outcomes for adults and children, there is an evidence gap around the experiences of psychodynamic couple therapy.

Method: Five participants completed a semi-structured interview, following at least six months of couple therapy for the treatment of severe distress and depression. They were recruited from an internationally renowned couple therapy provider in London, using a purposive sampling technique. Data was analysed using a phenomenological approach to thematic analysis.

Results: Participants described the therapist as a "third person" who became a referee, and mediated the communication within the couple and provided a different perspective, which enabled a safe environment for reciprocal listening. A crucial aspect of couple therapy was the process of making links with the past, which enabled participants to understand their current behaviour as individual and dysfunctional areas as a couple. The process of creating connections with the past was meaningful for all participants, and some perceived fostering self-reflective skills as a practical tool, but others wanted to receive direct guidance. Three main active ingredients facilitated the therapeutic process: the therapist's ability to understand the couple as individuals rather than as a unified entity; the therapist neutrality and capacity to empathise and connect with the couple. At the end of therapy, most participants reflected that their overall therapy experience has been helpful and highlighted a positive impact in terms of their depression, perspectives and connecting with emotions, not only for the couple involved but also in the wider system.

Conclusions: This study highlighted the intertwined dynamic between relationship difficulties and depression. Participants were not able to make a clear distinction between these two

experiences and this microcosm may reflect the difficulties that clients face in public services, which have historically held an individualistic perspective of distress.

Introduction

Chapter overview

This chapter will include two parts: a general introduction and a systematic review of the current literature. In the first part of the chapter, prevalence rates and economic costs will be discussed. This will lead to a discussion around the different epistemological positions on depression, including: medical naturalism, social constructionism, biopsychosocial, behavioural and psychodynamic models. Following the critical analysis of these theories, there will be a discussion on how depression is diagnosed, and a working definition of emotional distress will be offered. This part will also provide a general overview of the couple therapy models used for depression, with an emphasis on theories and techniques of psychodynamic couple therapy.

In the second part of the chapter, a systematic review of the current evidence on couple therapy for depression will be outlined in order to provide further indications on the initial results and challenges of the current literature.

Part 1 – General overview

Prevalence of depression and related costs

Depression is among the most common mental health problems and is related to considerable difficulties of psychological and physical quality of life (Saarni et al., 2007). The World Health Organisation (WHO, 2020) stated that depression affects more than 264 million people and is on the rise globally. In the United Kingdom (UK), over 19% of adults experienced symptoms of depression, and there was a significant increase of 1.5% in only one year, between 2013 to 2014 (Office for National Statistics, ONS, 2016). Individuals may experience depression at any age and often around their twenties or thirties, with a peak in older adulthood, with a prevalence of 7.5% among women and 5.5% among men aged 55-74 (WHO, 2017). Despite depression being seen as a time-limited mental health problem, which lasts an average of four to six months, a WHO study found that at least 50% of individuals suffer symptoms of

depression after one year, and for 10% it becomes a chronic condition (Simon et al., 2002). The level of chronicity of depression may lead to a burden on the individual and their family in terms of emotional, psychological, social and financial problems (Loukissa, 1995).

According to the WHO (2017), depression is the main cause of disability and contributor to suicide, affecting over 800,000 per year and the second cause of death among 15-29 year-olds worldwide. At a global level, depression is ranked as the single largest contributor to non-fatal health loss. Twice as many individuals, compared to the general population, are unable to attend work because of their experiences of depression. In England, in 2000, the financial burden of depression was estimated to be £9 billion, which is a figure that is continuously rising (Thomas & Morris, 2003). Overall, mental health problems cost the UK economy 70 billion every year, which amounts to 4.5% of the GDP due to healthcare costs, benefit payments and productivity issues at work (Organisation for Economic Cooperation and Development, 2014).

Consistently, a study conducted in the United States found that the financial burden also seems to be due to 'presenteeism', which was described as being able to attend work but not in a fully functional capacity (Greenberg et al., 2015). Due to this considerable necessity for appropriate interventions to tackle depression, a transformation of services occurred in the National Health Service (NHS) in 2008, with the establishment of the Improving Access to Psychological Therapies (IAPT) programme. IAPT implements the NICE guidelines for individuals with depression and anxiety, with the primary aim to assist them in returning to social and occupational functioning (Department of Health, 2007).

Depression understood according to different perspectives

This section will describe and critically assess three positions that have been influential in the debates around depression: medical naturalism, social constructionism and the biopsychosocial model (Pilgrim & Bentall, 1999). Following this, the theoretical understanding of depression according to behavioural and psychodynamic literature will be described and evaluated.

Medical naturalism

According to the medical naturalism perspective, which Kraeplin initially theorised, mental health problems stem from organic origins. The proponents of medical naturalism postulated that there is a connection of pathogenesis and the manifestation of psychiatric disorders. Emil Kraeplin, who lived at the same time as Sigmund Freud, expressed a lifetime interest in experimental psychology. According to Elbert and Bär (2010), the position of the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases (WHO – ICD-10) are based on Kraepelin's concepts.

According to DSM-5 (2013), the diagnosis of a major depression episode requires five or more symptoms to be present within a two-week period. One of the symptoms should, at least, be either a depressed mood or anhedonia. The secondary symptoms are: appetite or weight changes, sleep difficulties, psychomotor agitation or retardation, fatigue or loss of energy, diminished ability to think or concentrate, feelings of worthlessness or excessive guilt, and suicidality. This symptom-based and biomedical model of depression undertakes that depression is a "biologically-based brain disease" caused by biological abnormalities located in the brain. Consequently, psychotropic medications were seen as the treatment for depression (Andreasen, 1985).

According to Wilson (1993), in the 19th century, depression, along with other mental health difficulties, were medicalised and subjugated by Kraepelinian psychiatry. From the end of the Second World War until the mid-1970s, American psychiatry understood mental health difficulties from a biopsychosocial model (BPS), which integrated perspectives from psychoanalysis, sociology and biology. However, the BPS model could not delineate a framework where individuals were seen as "mentally well" or "mentally ill". As a result, this led to a crisis of legitimacy of the discipline of psychiatry, which responded with the publication of the DSM-III in the 1980s. During this legitimisation process of psychiatry, there was a shift in the focus of psychiatric knowledge from a clinically-based BPS model to a research-based medical model.

McPherson and Armstrong (2009) summarised that the biopsychosocial understanding of mental health problems represented the process of "demedicalisation", which was followed by a period of "re-medicalisation" in the 1970s when the use of psychotropic medications started

widening. As Healy (2000) pointed out, the word "antidepressant" only started emerging in dictionaries in the 1980s. This change in the discourse of depression becoming a "disease" was very likely initiated by pharmaceutical companies that developed competencies for collecting and publishing evidence.

Currently, the Royal College of Psychiatrists recognises the value of antidepressants and Lovett, the dean, stated: "there is evidence that for people who have recurrent episodes of depression the longer use of antidepressants reduces the incidence of relapse and in certain situations this will be clinically appropriate" (Campbell, 2017). Moreover, Pariante, the spokesperson of the Royal College of Psychiatrists, with reference to the study by Cipriani et al. (2018), stated: "these drugs do work in lifting mood and helping most people with depression" (Boseley, 2018). This discourse was also evidenced in the increase in prescriptions of antidepressants. The NHS incurred £267 million of the prescription costs for antidepressants in 2017, representing an increase of 108.5% compared to 31 million in 2006 (Campbell, 2017).

This disease-centred model led a shift towards a discourse of 'fixing the brain's chemical imbalance', which has been widely criticised. Firstly, this position has been viewed as problematic because it failed to demonstrate the causes of depression being attributed to solely biological pathology, such as biochemical deficiency of serotonin (Kirsch, 2010). Secondly, there is no current evidence that a chemical imbalance exists in depression; therefore, "correcting" it with medication might not be seen as meaningful nor effective (Moncrieff, 2008). Thirdly, current literature does not demonstrate how specific antidepressant medications may elevate the mood in the short and long term (Moncrieff & Cohen, 2006). Finally, several studies proved that subgroups of participants, between 6-13%, developed treatment-emergent suicidal ideation (TESI) around the beginning of pharmacological treatment, when there was a change of dosage or the medication was withdrawn (Healy et al., 2014).

Accordingly, the results from the largest meta-analysis to date, which found that antidepressants were more efficacious than placebo in adults with major depressive disorder (Cipriani et al., 2018), was deemed to have several limitations. Firstly, Mulkholm et al. (2019) indicated that the reported effect of antidepressants over placebo evaluated on depression rating scales was small and overestimated by numerous and serious methodological limitations in the trials including: blinding of participants, personnel and outcome assessment; placebo run-in and inclusion of already treated patients; and antidepressants' actual harms not being assessed.

Secondly, Jakobsen et al. (2020) provided a critique of the study by Cipriani et al. (2018). They expressed their concerns that antidepressants seem to have statistically significant effects on depression, but the size of the effects has debatable importance to most patients. In fact, antidepressants offer a marginal positive impact on depressive symptoms and intensify the risk of serious and non-serious adverse events. This was echoed by Hengartner and Plöderl (2018), who explained that recent meta-analytic evidence demonstrates that antidepressants do not work for most service users. The ratio is one in nine people benefit from medications, and the remaining eight might be put at risk of adverse drug effect. Moreover, Hengartner et al. (2021), in a recent meta-analysis of 27 articles, found that the use of new-generation antidepressants is associated with higher suicide risk in routine-care adults with depression and other difficulties.

However, despite the methodological critiques on RCTs for antidepressants being presented by Irving Kirsch at the 36th Maudsley debate "The drugs don't work" at the Institute of Psychiatry (King's College, London), these ideas were met with "strategic ignorance". This debate led McGoey (2010) to conclude that: "RCTs have tended to command greater regulatory and popular legitimacy the more that people point out their failures" (p. 74). Moreover, Mulkholm et al. (2019) were also concerned about selective outcome reporting of the study by Cipriani et al. (2018) and concluded:

> Erroneous conclusions that antidepressants are efficacious for depression have the effect that they may prevent people suffering from depression from seeking other solutions to alleviate their condition, such as psychotherapy and dealing with psychosocial stressors, and they may stall funding and research of such treatment modalities. (p. 9)

Accordingly, medical naturalism was also criticised for holding a reductionist position and minimising the impact of psychosocial and environmental issues in developing distress (Lilienfeld, 2007). As described by McPherson and Armstrong (2009): "Depression has been widely described as a medicalised condition in that an everyday emotion, albeit often severe, is given a disease label" (p. 1141). Accordingly, the model seems to have led to a "medicalisation of misery", where social and contextual factors that may lead to sadness and unhappiness are not taken sufficiently into account (Pilgrim & Bentall, 1999).

Social constructionism

Foucault (1975) and other proponents of social constructionism, criticised the medicalisation process because it paved its way to considerable sociopolitical consequences such as the construction of the "psychiatric patient" as "disciplined bodies". This criticism echoes the social constructionism view that power and knowledge are vital in understanding the process in which individuals are "made subjects" and how "psychiatric identities" are produced (Foucault, 1991). As Foucault (1975) stated:

> The great asylum physician, whether it is Charcot or Kraepelin, is both the one who can tell the truth of the disease through the knowledge [savoir] he has of it and the one who can produce the disease in its truth and subdue it in its reality, through the power that his will exerts on the patient himself. (p. 43)

Accordingly, Thomas Szasz (1960) repudiated psychiatry's misappropriation of discourses such as "illness" and described this as an "harmful myth". Szasz (1960) has drawn from Cartesian dualism to challenge the complexity of psychiatric taxonomy by questioning: how is "mental illness defined and by whom?" (Kelly et al., 2010). This view resonates with the study by Parker et al. (1995), who highlighted that some individuals are categorised as "different", as "the other" and how their "mental illness" is a social construct designed by mental health professionals.

Social constructivists view the notion of context, in which psychological problems such as depression emerge, as a key lens to understand these constructs. Foucault attempted to "historicise" the construct of mental illness by demonstrating that it arose at a particular time in history, culture and society; on the other hand, he "politicised" the construct by indicating that it developed within a period of political concerns, norms and values (Roberts, 2005). Further evidence of the problematic nature of diagnosis is derived from cross-cultural studies. For example, Marsella (1981) found that in many non-Western cultures, there was not an equivalent word for the construct of depression. Accordingly, Russell (1991), in a large review of ethnographic studies, concluded that most cultures utilise idiosyncratic descriptions for emotional states, which are culturally specific, and collectivist societies have been found to differ from their individualist counterparts.

Biopsychosocial model (BPS)

According to Pilgrim and Bentall (1999), these two contrasting epistemological positions of medical naturalism and social constructionism do not seem to deliver concrete answers to approaches around depression. The authors referred to the work by Bhaskar (1990) and recommended the middle position of critical realism:

> It ensures a proper caution about historical and cultural relativism, without degenerating into the unending relativism and nihilism attending social constructionism (…) This position respects empirical findings about the reality of misery and its multiple determinants but does not collapse into the naive realism of medical naturalism. (p. 271)

Accordingly, depression is viewed as clinically and etiologically heterogeneous. Genetic, biochemical, psychosocial and environmental factors are deemed to predispose individuals to depression, and its severity is determined by the intensity and number of symptoms (Hasler, 2010).

For the past 40 years the BPS model, proposed by Dr George Engel, has been widely seen as an integrative answer to the complexity of mental health difficulties and "established as psychiatric orthodoxy" (Pilgrim & Bentall, 1999). This model holds that several explicatory perspectives can inform our understanding of a multifaceted experience such as depression. Engel (1977) evoked Szarz's postulation of the myth of mental illness and invited "the removal of the functions now performed by psychiatry from the conceptual and professional jurisdiction of medicine" (p. 130). Engel envisaged that the BPS model would integrate the "objective imperatives" related to the disease-centred model of illness and the "subjective imperatives" associated with a person-centred approach of care (Benning, 2015).

Borrell-Carrio' et al. (2004) critiqued the BPS model because it was envisaged to be dynamic and interactional, but instead it continued to perpetuate a dualistic view of the human experience centred on the mutual influence of the mind and the body. The epistemological understanding of the duality of the body and the mind is seen as problematic as this knowledge is socially constructed, along with the similarity with Cartesian dichotomies cherished by positivism. Hence, Borrell-Carrio et al. (2004) critiqued BPS as being reductionist, and invited

clinicians to move beyond this multifactorial linear thinking for an adequate model, including participation in care.

Despite the BPS model being included in mental health professionals' thinking, the medical approach of diagnosing and treating depression is yet predominant. Accordingly, the BPS model has failed to create an interdisciplinary and pluralistic epistemological understanding of mental health difficulties in psychiatry, which is more imbalanced than ever for its bias in favour of biomedical explanatory paradigms (Benning, 2015).

Psychodynamic perspective

Psychodynamic theory was the leading school of thought within the discipline of psychology in the first part of the 20th century, when Freud proposed a different understanding of depression compared to Kraepelin, his contemporary. Sigmund Freud was the first neurologist and psychotherapist to coin the term "mourning" in his seminal paper "Mourning and Melancholia" (1917). Sigmund Freud portrayed both mourning and melancholy, or depression, as an involuntary withdrawal of object cathexis, which is the process of allocating mental, emotional or sexual energy to a person, object or idea.

Freud described mourning as the individual reactions to a loss of an external object, such as a loved one or an abstract subject, including an ideal, freedom, or a country, etc. According to Freud (1917), some individuals go through a mourning phase and, following this, they might experience melancholy, which would be defined as depression in modern terms. In depression, due to the withdrawal of object cathexis being forced, it becomes a painful experience as the ego protests and searches for a substitute object. However, because the ego may not find a substitute in the outside world to displace its object cathexis and refuses to admit that the object is gone, the ego draws within itself. The process may lead to an "*identification* of the ego with the abandoned object" (p. 60).

This process of identification in melancholia may create inner conflict due to a potential sense of ambivalence towards the lost object, including the process of "love and hate" (Freud, 1905). This subsequent sense of guilt, which exists in the melancholic process, may be due to the individual being aware that they attacked the lost object in their fantasy or reality; or unconsciously wanted their death due to the object's inadequate availability and affection.

The individual with depression may experience this process as further introspection and less attention to the outside world (Carhart-Harris et al., 2008). Freud (1917) made the following distinction: “In mourning it is the world which has become poor and empty; in melancholia it is the ego itself. The patient represents his ego to us as worthless, incapable of any achievement and morally despicable” (p. 62).

The symptoms of depression, according to Freud (1917), are:

> A profoundly painful dejection, cessation of interest in the outside world, loss of capacity to love, inhibition of all activity, and lowering of the self-regarding feelings to the degree that finds utterance in self-reproaches and self-reviling and culminates in delusional expectations of punishment. (p. 65)

Ribeiro et al. (2017) noted that these symptoms resemble the current DSM criteria of depression.

Karl Abraham (1924) offered other causes for depression that were grounded in his clinical work. Abraham (1924) explained that four factors were needed to develop depression. Firstly, the patient with depression was not able to go through the five stages of psychosexual development and was fixated on the oral stage. In contrast, Abraham theorised that oral satisfaction might lead to self-assurance. Secondly, the patient may have suffered initial and frequent childhood disappointments in love and affection, which led to a profound wound to childhood narcissism (Van Schoonheten, 2018). Notably, the first of these disappointments may have happened before his oedipal wishes, which entailed desiring the parent of the opposite gender, have been resolved. Finally, the melancholic patient may have experienced a repetition of this primary disappointment in love in different stages of their lives.

Similar to Freud, Abraham thought that the depressive state stemmed from repressed adverse feelings towards the object of love, due to constant attempts to gain possession of it. As a result, this sense of torment leads the melancholic patient to sadistic self-punishment and a sense of self-destruction demonstrated in suicidal thoughts. This is due to the identification with the object and subsequent introjection, and the feeling of being a reason for suffering to the love-object (Abraham, 1924). According to Van Schoohenten (2018), these were ground-breaking

ideas as prominence was given to the mother and baby relationship and the impact of early abandonment on depression in adulthood.

Similar findings were theorised by Melanie Klein, who provided a remarkable contribution to the understanding of depression. “In Kleinian thesis the depressive illness arises as a result of an inability to face, or adequately deal with, the conflict aroused in the depressive position” (Rosenbluth, 1965, p. 20). Klein (1945) postulated that the depressive position stems from the fundamental conflict that a child needs to deal with once they have become conscious of the distinction between them and the outside world. In the first year of life, the baby who has reached the depressive position becomes conscious of feelings of love and hate towards the mother and can integrate them. This position follows the paranoid-schizoid position where the baby felt that the love object, prototypically the mother, were two separate objects and was consequentially splitting them: one ideal and loved, through the process of idealisation, and the other persecutory and hated, through projective identification. This was due to the baby’s primary anxiety being the survival of the self (Spillius et al., 2011; Steiner, 1992).

As Ribeiro et al. (2017) emphasised:

> Thus, in melancholy, there is a regression to an earlier failure to integrate good and bad partial objects into whole objects in the inner world. The depressive individual believes himself omnipotently responsible for the loss, due to his inherent destructiveness, which has not been integrated with loving feelings. Klein argues that pining, mourning, guilt, reparation, possibly delusional thinking, omnipotence, denial, and idealisation characterise depression. (p. 105)

Luyten and Blatt (2012), in their review of the key theoretical psychodynamic assumptions on depression, specifically commented that they are “still clinically relevant…but too broad to be empirically tested” (p. 44). Accordingly, Luyten and Fonagy (2016) moved towards an understanding of depression as the consequence of impairments in the process of social cognition or mentalising, which are involved in reflecting on the self and others.

According to Paris (2017), psychodynamic theory was widely critiqued because it did not operationalise its hypotheses, and did not test them with empirical methods to gain scientific support. Psychodynamic theory utilises a hermeneutic methodology that emphasises the

meaningful interpretation of a phenomenon, rather than empirical testing of hypotheses. Since the case studies of Sigmund Freud, psychodynamic literature has been critiqued for offering theories supported by clinical case studies, which Paris (2017) compared to "illustrations" and a methodology similar to literary theory.

In 2009, the British Journal of Psychiatry debated whether the journal would consent to receive psychoanalytic case reports. Lewis Wolpert claimed that they should be rejected because they are not scientific. On this occasion, Peter Fonagy defended psychoanalytic research and explained that research is starting to be conducted. Paris (2017) concluded that psychodynamic theory is going through a "lingering decline" and it would only endure if it is ready to "dismantle its structure" as a distinct field and to return to academia and scientific thinking. Among all these critiques, psychodynamic theory leaves a vital legacy to psychiatrists and has taught them how to thoughtfully pay attention to service users by listening and valuing their life stories (Paris, 2017).

Moreover, Fonagy et al. (2015) provided evidence that long-term psychoanalytical psychotherapy (LTPP) is beneficial for the treatment of long-standing major depression, which is based on the theories elucidated above. Fonagy et al. (2015) recruited 129 patients for a RCT to test the effectiveness of LTPP as an adjunct to treatment-as-usual (TAU) with service users with treatment-resistant depression. In the LTPP arm, there were declines in observer-based and self-reported measures for depression and improvements in social adjustment, and at 24 months and 42 months the treatment benefits were superior to the control group. This research indicated that LTPP is beneficial and the importance of post-treatment follow-ups in RCTs to assess the potential development of delayed therapeutic benefits in individuals with chronic depression.

Issues around diagnosis and recognition of emotional distress

Despite the different perspectives on depression described above, general practitioners (GPs) are the service users' first point of contact. The medicalised discourse of depression seems to be privileged from the outset. Accordingly, over 90% of service users experiencing depression in the UK are managed within primary care settings managed by GPs who are expected to provide a diagnosis and refer to IAPT (NICE, 2018).

However, the detection of depression in primary care remains a complex issue for several reasons. Primarily, the difficulty is to distinguish between *normal* emotional distress and psychiatric disorder, which would depend on how depression is conceptualised (Garathy et al., 2015). Despite the general understanding of following an integrative model such as the BPS, the dominant conceptualisation of depression is based on the diagnostic criteria of the DSM-5 and the ICD-11 around symptoms, duration and functioning. Accordingly, screening tools such as the PHQ-9, are widely used for their validity, reliability and brevity and are based on the DSM criteria (Ferenchick, 2019).

In a diagnostic meta-analysis (Gilbody et al., 2005), 14 studies comprising 5.026 participants, validated the PHQ-9 for major depressive disorder in terms of: sensitivity = 0.80 (95% CI 0.71-0.87); specificity = 0.92 (95% CI 0.88-0.95); positive likelihood ratio = 10.12 (95% CI 6.52-15.67); negative likelihood ratio = 0.22 (0.15 to 0.32). However, the UK National Screening Committee (UKNSC) does not advocate screening the population seen within primary care clinics, and the NICE guidelines recommend screening individuals with a history of depression or considerable physical difficulties. These recommendations by the UKNSC highlight the lack of evidence of benefit and emphasise the preoccupation of potential harm to service users, such as over-diagnosis and overtreatment (Thombs et al., 2017).

Accordingly, the DSM-5 emphasises that:

> An expectable or culturally approved response to a common stressor or loss such as the death of a loved one is not a mental disorder (…) this requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss. (DSM-5, in Geraghty et al., 2019, p. 2)

Therefore, GPs are expected to make a clear distinction between depression and emotional distress, which would lead to the decision on starting to prescribe psychotropic medications or referring to IAPT. Geraghty et al. (2019) conducted a qualitative study and found that GPs understood depressive disorder based on biological symptoms such as loss of appetite and sleep disturbances. In contrast, they saw emotional distress as a lack of physical symptoms within a triggering context, including difficult life events such as family or employment stress-related

circumstances or bereavements. This led several researchers to conclude that emotional distress is not a medical problem and should not be treated as such (Kokanovic et al., 2008).

On the one hand, individuals consulting GPs due to low mood might struggle to discuss psychosocial difficulties as they might deem that it is not an appropriate topic for medical consultations (Pollack, 2009). On the other hand, it was demonstrated that service users with chronic depression who did not respond to antidepressants were unable to discuss social and emotional problems due to the "question and answer format" of GP consultations' time-limited setting (McPherson et al., 2014). For example, in one of the 12 audio-recorded routine consultations qualitatively analysed, the GP welcomed psychosocial explanations expressed by service users that just corresponded to the "detect and treat model", which led to a different prescription. The GP did not co-construct a psychological formulation that included emotional concerns, including "loneliness" and a breakdown in the social network.

Accordingly, some of the dilemmas discussed in qualitative accounts by GPs are feelings of powerless and uncertainty on the causes of distress being social, and therefore beyond the management and treatment within the medical arena (Barley et al., 2010). A qualitative study conducted by Thomas-MacLean and Stoppard (2004) evidenced that GPs seem to experience a tension between the biomedical discourse, due to their training, and the acknowledgement of the impact of the social context on the service user's experience of emotional distress. The authors concluded: "while physicians perpetuate a medicalised discourse of depression, this discursive construction also constrains their practice" (p. 288). Accordingly, GPs may be hesitant to investigate the psychosocial problems that service users experience due to the considerable pressure of other duties and the resultant emotional burden (Rogers et al., 2001).

Chew-Graham et al. (2002) conducted interviews with GPs practising in inner-city and semi-rural areas of the north-west of England, who were treating service users that belonged to different socioeconomic backgrounds. The authors concluded that GPs understood depression as a reaction to changes of circumstances or a "normal response to life events" for the whole spectrum of socioeconomic deprivation or economic affluence. However, the authors also established that GPs might utilise a "palliative approach" by providing service users with care for major depressive disorder if they believed that stressful life events and situations were unlikely to be resolved. As noted in the study by Garaghty et al. (2019), for the most part, GPs

that were interviewed perceived their responsibility in managing distress by listening, providing a diagnosis and indicating appropriate services.

Service users who attended a consultation due to their emotional distress might not expect to be diagnosed with depression, and several articles highlighted the resistance to be prescribed antidepressants (Grime & Pollock, 2003; Pollock, 2009). This evidence has also been supported by a qualitative study with individuals diagnosed with depression in Australia (Kokanovic et al., 2013). The authors found that participants have initially consulted their GP for non-medical problems, due to the lack of other forms of assistance, and were ambivalent around the use of antidepressants. They felt the need to embrace the medicalised discourse by "feeling that there was something wrong with them", taking the prescribed medications and "incorporating a diagnosis of depression into their life story" (p. 385). Moreover, McPherson and Armstrong (2009) found in their qualitative study that the interviewed GPs experienced difficulties to categorise a group of service users who did not respond to antidepressants. Subsequently, the GPs constructed a category of people described with defiant features such as manipulative predispositions, hostile personalities and engrained social difficulties in relation to others.

Due to the issues around the diagnosis of depression and the theoretical underpinning of this thesis project, the writer and the partner organisation's preferred working definition will be *emotional distress*, which will be used interchangeably with the words *depression* and *low mood*.

Depression is linked to the couple relationship

There is considerable evidence that proves the association between depression and relational distress. This might be because couples experiencing depression describe more negative communication, such as blaming and complaints, further difficulties resolving conflict and less communication of love than couples that are not depressed (Coyne et al., 2002). Beach et al. (1990) found that marital difficulties and discord may intensify the risk of low mood and depression due to increasing conflict and reduced social support. Whistman and Bruce (1999) utilised a community sample of 904 married participants, who did not meet the criteria for major depressive episode (MDE) at baseline. Following a 12-month period, the results revealed

that marital dissatisfaction was associated with an increased incidence of MDE, with an attributable risk of almost 30 per cent.

This idea has been taken a step forward as more recent evidence found a considerable interdependency between adult couple relationship and mental health outcomes. A longitudinal population-based survey of households in England, which included 1896 middle-aged and older couples, found a bidirectional association between marital discord and depressive symptoms (Whisman & Uebelacker, 2009). In another longitudinal study with over 296 couples, Kouros et al. (2008) found a reciprocal relation between marital satisfaction and depressive symptoms where the relationship length and marital conflicts were significant moderators. Therefore, the longer the relationship, in the context of marital problems, the more vulnerable individuals were to develop depressive symptoms. Accordingly, as Priestley et al. (2017) highlighted in their qualitative study, depression may be described as a "couple disease", due to the important role that partners play. The authors concluded that involving partners in the therapeutic process may lead to significant consequences, such as avoiding relationship breakdown.

This evidence around the interpersonal context of depression may be explained by the contagion effect theorised by Coyne (1976). Individuals experiencing depression interacting with others may provoke negative moods and cause themselves to be rejected. A meta-analysis supported this theory with 4952 participants across 36 studies, which found that depressive symptoms and mood are contagious (Joiner & Katz, 1999). The authors outlined different perspectives to attempt to explain this phenomenon. Firstly, a cognitive approach (Beck et al., 1979), focuses on the hopelessness theory of depression, where individuals perceive the world in a pessimistic fashion and consequently hold negative attributions around their partner's distress. Secondly, a behavioural approach, where a modelling explanation may be applied in the transmission of depressive symptoms and negative mood, may lead to less positive reinforcement from the partner. Thirdly, interpersonal factors, where the individual experiencing depression may experience low self-esteem and may feel that they depend on others for their sense of worth, which may lead to excessive reassurance seeking.

Finally, relationship difficulties before and after the birth of a child may lead to less positive interaction between parents and babies and in turn, less attachment security (Yu et al., 2012). This intense couple conflict may lead children under five to act out, cry or become withdrawn;

when they are older, the distress may cause internalising problems such as long-term anxiety, depression, worse academic performance and antisocial behaviour (Harold & Sellers, 2018).

Treatments for depression

The NICE guidelines recommendations for the treatment of mild to moderate depression within the adult population is antidepressant medications or individual low-intensity psychotherapy, including: guided self-help or computerised cognitive behavioural therapy (CBT), behavioural activation, and structured group physical activities (NICE, 2018). For individuals who have not benefitted from low-intensity psychological interventions, they may be offered high intensity interventions including: CBT, interpersonal psychotherapy (IPT) and behavioural couple therapy.

However, for individuals with moderate to severe depression, the NICE guidelines (2018) recommend a combination of antidepressants and high-intensity psychological intervention, but solely CBT or IPT, and not behavioural couple therapy. The following sections will describe behavioural and psychodynamic couple therapy.

Couple therapy for depression

Couple therapy for depression was included in the NICE guidelines for the treatment of mild to moderate depression when there is distressed relationship dynamics that may cause or perpetuate the depressive symptoms in one partner (NICE, 2018). Couple therapy for depression is defined as an integrative, behaviourally based, and short-term intervention of up to 20 sessions. It is a relationship-problem-orientated intervention, which focuses on important areas in the relationship that may decrease stress and improve support, including: communication, problem-solving skills and acceptance within the couple (Hewison, 2015).

GPs can refer service users to IAPT services, where behavioural couple therapy is offered to individuals with mild to moderate depression. Couple therapy's recovery rate for depression, 58.8%, is significantly higher than all therapy modes offered by IAPT, including CBT (NHS England, 2016). Despite these encouraging results, the percentage of couple therapy for depression sessions delivered in IAPT services amounted to just 0.62% of the total provision and no more recent figures were found (Tavistock Relationships, 2015). Moreover, in terms of

the High Intensity IAPT workforce composition, only 2% of staff delivered behavioural couple therapy, compared to 61% that offered CBT (NHS England, 2015).

The NICE recommendation of including couple therapy was mainly derived from one randomised control trial (RCT), the London Depression Trial (Leff et al., 2010), which intended to compare three treatments for depression: antidepressants, couple therapy and cognitive therapy. The couple therapy intervention was a brief version of systemic therapy, 12 to 20 sessions, which conceptualises depressive symptoms in the context of problematic ways of interacting. The couple therapy techniques included: observation and enactment of couple issues, awareness of difficult cycles of behaviour in order to change negative attributions, and setting tasks to develop less distressing ways of interacting (Jones & Asen, 1999).

The results of the RCT indicated that systemic couple therapy is a better treatment than antidepressants for the maintenance phase of severe depression. The trial's CBT arm had to be discontinued due to non-compliance of participants assigned to this treatment condition, where 8 out of 11 dropped out. Moreover, more than half the participants dropped out of pharmacotherapy treatment (57%), compared with 15% of those having couple therapy. Leff et al. (2018) reported that from initial assessment to the one-year follow-up, the mean Beck Depression Inventory (BDI) score in the couple therapy group fell between 1.62 and 11.54 points lower than the corresponding mean in the pharmacotherapy group, which was maintained at the 2nd year follow-up.

The NICE guidelines deemed this study to be of low quality due to the high attrition rate in the CBT and pharmacotherapy conditions. Consequently, couple therapy has been reduced to a therapeutic option for mild to moderate depression rather than a first-line treatment for moderate to severe difficulties, which is reflected in the IAPT provision of services.

According to the NICE guidelines manual of reviewing evidence (2012), RCTs are seen as better suited for estimating the effects of interventions than non-randomised studies. Therefore, other studies have been obscured from providing evidence on the effectiveness of couple therapy. In fact, other quantitative studies have found that behavioural couple therapy is as effective as individual therapy or medications in alleviating depression. Couple therapy is specifically effective with individuals who experience relational distress, and is even more effective in improving relationship distress (Gupta et al., 2003). Shandish and Baldwin (2005),

in a meta-analysis, recapitulated the results from 30 randomised experiments comparing behavioural couple therapy with no-treatment control. They found that couple therapy is significantly more effective than no treatment (*d*= .585). Couple therapy for mood difficulties and marital distress is also more cost-effective than individual or combined therapy (Crane & Christenson, 2012). As Hewison (2017) noted:

> Treating only the individual means that the depression-aggravating relationship setting does not change, rendering individuals more likely to have a subsequent relapse including those who have already been successfully treated for depression, whether by individual psychotherapy or psychopharmacological treatment. (p. 405)

Psychodynamic couple therapy

Psychodynamic couple therapy has not been included in the NICE guidelines, unlike short-term psychodynamic therapy that may be offered for people with mild to moderate depression who decline an antidepressant, CBT, IPT, behavioural activation and behavioural couple therapy. According to McPherson et al. (2020) patient preference may have an influence on commitment and sense of fulfilment with cognitive and behavioural models. One criterion for the preference of one therapeutic model over the other might be the interest in a manualised and short-term approach focusing on present issues and problem-solving, which would lead to choosing behavioural couple therapy. Instead, psychodynamic couple therapy is a longer term and open-ended approach where there is an in-depth exploration of personal meanings and a focus of "making a short story long" (Nielsen, 2017). Accordingly, the psychodynamic model would help individuals with depression that might have experienced considerable past difficulties, including attachment problems, to "repair a fragmented or broken self-narrative" (Valkonen et al., 2011, p. 239). A psychodynamic couple therapist listens to the couple and attends unconscious dynamics between the couple, based on each partner's individual and family of origin's experiences (Hewison et al., 2016).

Psychodynamic couple therapy stems from psychoanalytical thinking around object relation and the use of transference and counter-transference as key guiding tools. The theories described in this section are the foundations of the techniques that are used in couple therapy including: attitude of impartiality; holding and containment; object relations history and

attachment style assessment; interpretation of defence patterns and projective identificatory system; working with the unconscious, dreams and phantasies (Scharff & Savege Scharff, 2014). Scharff and Savege Scharff (2014) explained that psychodynamic couple therapists:

> They join the couple at the level of resonating unconscious processes to provide emotional holding and containment. From inside the shared experience, the object relations couple therapist interprets anxiety that has previously overwhelmed the couple, and so unblocks partners' capacity for generative coupling. (p. 3)

In the UK, the movement towards couple therapy started in the 1950s, when object relation theory applied at an individual level was flourishing and the Tavistock Institute of Marital Studies, nowadays Tavistock Relationships, was established. The landmark publication by Dicks (1967), integrating Fairbairn's theory of endopsychic structure and Klein's concept of projective identification, gave a boost to the flourishing couple therapy.

Fairbairn emphasised the human need for relationships throughout life. The infant needs a relationship with the primary caregiver, prototypically the mother, but feels disappointed at times due to her inability to meet their needs constantly. When the disappointment takes places, the infant can place into their mind the image of an unsatisfying object, described as the process of introjection. Due to the intolerable unsatisfying aspects of the image they have created, they split these off and repress them because they are too distressing to be placed into consciousness. This creates a three-part structure of the ego: a central one; a rejecting internal object relationship in the ego, connected to feelings of sadness and resentment; and the exciting object linking to longing and craving.

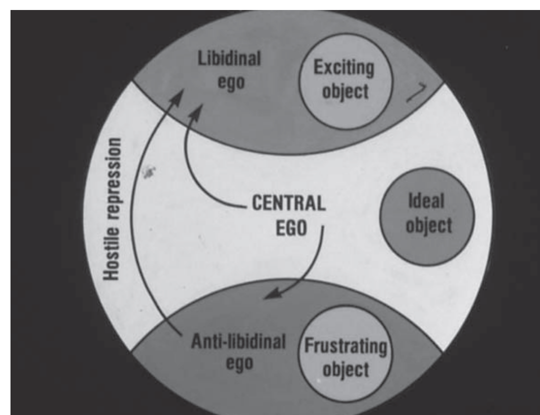

Figure 1. Fairnbairn's model of psychic organisation
(Copyright of David E. Scharff, 2014)

Accordingly, Klein (1945) postulated that all infant-parent relationships and the ones that follow are distinguished by the unconscious process of projection. Though the process of projective identification, individuals relate unconsciously by placing sides of themselves that they feel are threatening into the other. The individual who receives the projective identification may endorse features of the other through introjective identification. For example, a wife who feels emotionally weak may desire but also be distressed by strength, and may decide to marry a tyrannical man. She may see his power with a combination of dread and admiration (Scharff & Savege Scharff, 2014). Klein, and her followers, suggested that intimate relationships offered the prospect of being in contact with parts of the self that have vanished, which were split off (Balfour & Morgan, 2018).

Within the depressive position, which was defined as the ability to achieve emotional stability, the child is able to admit the reality of the parental couple, bear not to be included, and still feel loved. The feelings of rivalry may become less damaging for the child, and the oedipal situation may be resolved by gradually decreasing the phantasy of sole control of the preferred parent (Britton, 1989; Klein, 1945)

Bion (1962) illustrated the consequences for infants when the parent is unable to provide appropriate containment. Bion (1962) described the devastating and envious aspects of the psyche, that may impede their ability to establish positive relationships with others. However, if the parent cannot contain the infant's upsetting fears, the child might perceive it as a destructive deed by the parent, and might use the process of splitting to regain the concept of a good maternal object (Britton, 1989; Nyberg, 2018). The process of containment was described as the parent receiving unstructured anxieties of the infant that unconsciously resonate with them (projective identification); when the parent responds with more structured and organised understanding that helps structure the child's mind (introjective identification). Scharff and Savege Scharff (2014) offered a parallel between the primary bond with caregivers and adult relationships, where in the ladder, there is a constant feedback through cycles of projective and introjective identification as dynamic for unconscious communication.

As discussed, Dicks (1967) integrated parts of the theories of Fairbairn and Klein. In his book based on clinical cases of *disturbed marriages*, Dicks (1967) found that in long-term couples there are constant dynamics of mutual projective identification and an unconscious match between the internal object relations sets of each partner.

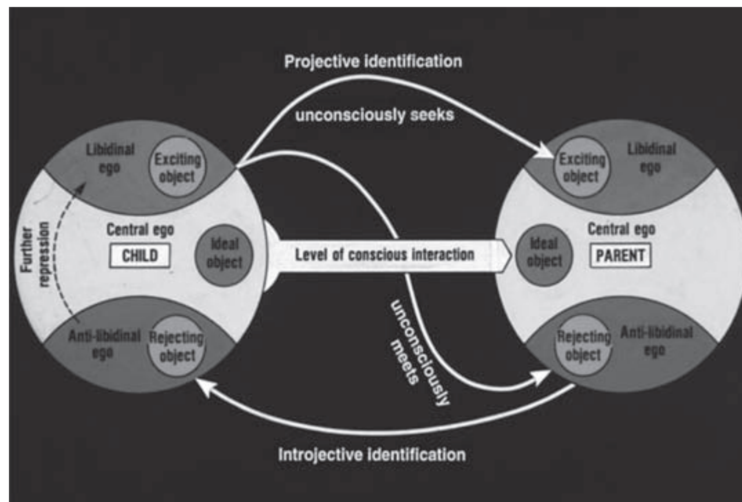

Figure 2. Projective and introjective
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Fairnbairn's idea, that human motivation is driven by relationships, inspired Bowlby's ethological approach. Bowlby appraised studies of different animal species and learned that all primate infants display instinctual behaviour around emotional connectedness and protection. If these needs for proximity were not addressed, this lead to pathology, which became the foundations of attachment theory. These observations were taken forward by Ainsworth, who studied the reactions of infants when being united with their mother following brief periods of separateness in the Strange Situation test. Infants' attachment style at a year can be classified into four groups: secure, anxious-insecure, avoidant-insecure, and disorganised. According to Fonagy, patterns of attachment become an important feature of how we develop relationships with others throughout our lifetime (Scharff & Savege Scharff, 2014). In 1980s, attachment theory started being utilised to understand relational processes during adulthood and the term "romantic attachment" was coined. Hazan and Shaver (1987) investigated the attachment behavioural system in the context of couple relationship and postulated that "romantic love is an attachment process" (p. 511). Hazan and Shaver (1987) explained that individuals internalise attachment styles, as Bowlby described as "inner working models", and the bond between infants and caregivers translates to the relationship between adult romantic partners. Consequently, Bartholomew (1997) examined the impact of differences in individual attachment styles on adults' relationships, including the ones at risk of violence.

Another important characteristic of individuals that are part of a relationship, is the idea of an "internal parental couple" or "unconscious phanthasy couple", that is informed by their

experience of their own parents' relationship. The internal parental couple is an emotional entity that might guide the unconscious beliefs and hopes that the couple have for their relationship. Partners who have internalised a parental couple that can work collaboratively around difficulties, may feel a sense of psychic containment, which they may convey into their adult romantic relationships (Nyberg, 2018).

In line with the theories above, when the early childhood context and environment are safe and encourage growth, an adult patient may perceive the therapist as a good understanding parent within the transference dynamics. However, if the childhood context is hostile, the patient might perceive the therapist as a malign parental object, which in turn would have an impact on the therapist's countertransference. In couple therapy, contextual transference stems from the couple's holding of each other, which is their shared environmental holding, and from the couple's mutual projective identification, which is their centred holding. The couple projects a feature of their individual and shared unconscious world to the therapist, who receives them as countertransference (Scharff & Savege Scharff, 2014).

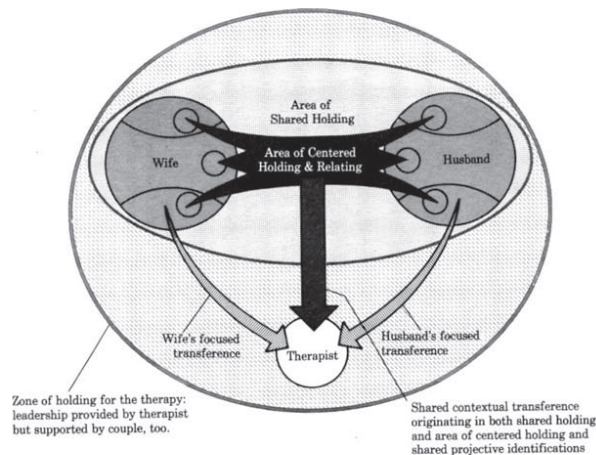

Figure 3. Transference and countertransference
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This triangular setting of couple therapy, where the therapist is outside the couple, may encourage the couple to reflect on their relationship. Accordingly, Balfour and Morgan (2018) described the following process:

> Over time, each partner might begin to extend a curiosity and openness to thinking about the experience of the other – to move towards thinking about the meaning of their

> relationship dynamics and how each contributes to them, internalising what has been termed a *couple state of mind*…which allows the emergence of their relationship as a *third entity*. (p. 45)

The "third entity" or "position", which was theorised by Britton (1989) in the context of the oedipal situation in childhood, translates to the individual being able to observe oneself and be oneself, whereas in the couple state of mind, each individual is able to observe oneself in the relationship and be oneself in it. Following the difficulties that life presents, the trust in the relationship as a container, allows each partner to develop more successfully and the couple can collaboratively work together in ways that they may not have done independently (Colman, 1993).

Part 2: Systematic review

A recent systematic review of controlled studies has been conducted by Barbato et al. (2018), where they considered studies of couple therapy delivered in outpatient settings. In these studies, the partner had a clinical diagnosis of depressive disorder, which derived from standardised and validated diagnostic criteria.

Barbato et al. (2018) reviewed RCTs and quasi-randomised controlled trials and excluded observational studies. The main comparison was individual psychotherapy, and the secondary comparisons were antidepressant medication with no/minimal treatment. Fourteen studies with 651 participants were reviewed, but there were not any studies that examined psychodynamic couple therapy. The review suggested that: "couple therapy is as effective as individual psychotherapy in improving depressive symptoms and more effective in improving relations in distressed couples" (p. 1). However, the low quality of evidence reduced the likelihood of drawing firm conclusions. Barbato et al. (2018) referred to the following issues: small number of cases, performance bias, assessment bias due to the non-blinding outcome assessment, incomplete outcome reporting and the allegiance bias of investigators.

Aims of the current review

The current review aims to expand from the results found by Barbato et al. (2018) by including and analysing uncontrolled study designs with the working definition of depression and psychological distress.

Method

Design

The review followed the reporting guidance by the Centre for Reviews and Dissemination (University of York). The guidance for conducting systematic reviews has been designed explicitly for evaluations of the impact of healthcare interventions. It has been used internationally and is deemed a good practice tool by the Health Research Health Technology Assessment (NIHR HTA) programme and by NICE.

Search strategy

An electronic search was completed on 16th October 2019 using the following four databases: PsychINFO, PsychARTICLES, MEDLINE, and CINAHL. Articles published in peer-reviewed journals between 1960 and 2018 were identified. The search terms included couple therapy and depression. The keywords were as follows:

1) therapy search terms: couple therapy OR couple counseling OR counselling OR marriage counseling OR marriage counselling OR marriage therapy
2) Mental health problem: depress*
3) Outcomes: outcome* OR effectiveness.ab OR efficacy OR effect

Following the database searches, the selected articles' reference lists, prior reviews and relevant book chapters were also consulted. The process of hand-searching relevant journals of family therapy and affective disorders was also performed.

Inclusion and exclusion criteria

Population

Participants that took part in the selected studies were working-age adults (18-65). Any gender and nationality were considered. This review addressed depression as the main presenting problem and widened the working definition to low mood or emotional distress in either one individual or both members of the couple. Adults met the criteria of major depressive disorder according to the DSM-5 (American Psychiatric Association, 2013) or the ICD-10 (WHO, 2014). However, studies where participants experienced symptoms of depression and did not receive a medical diagnosis, were also included. According to the UK Adult Psychiatric Morbidity Survey (NHS England, 2016), it is a common phenomenon not to receive a professional diagnosis for depression. Moreover, some psychotherapeutic approaches do not endorse the medical construct of diagnosis of mental disorders.

Studies were also excluded if depression was not the primary presenting problem or focused on post-natal depression. Studies were excluded if the participants had a diagnosis of bipolar disorder or experienced symptoms of psychosis.

Setting

The studies included in this review were based in community settings, such as primary care or specialist services.

Intervention

This interview included any form of conjoint couple therapy where partners are in a committed relationship. The working definition of couple therapy is: a structured intervention that aims at reducing distress, based on a human interaction with a trained therapist and constructed around psychological models. Therefore, the studies were included if they were based on talking therapies. Couple therapy based on any religious belief was excluded as the evidence from this systematic review should be utilised for recommendations for the general population. Moreover, studies that were based on family therapy, which involved children, were excluded.

Outcome measures

The studies that were considered eligible for this review evaluated the effectiveness of therapy outcomes, where psychological distress was assessed before and after the intervention. Hence, all the studies have utilised psychometric measures before the beginning of the therapeutic intervention and at post-treatment/follow up. The participants were the informants of the emotional distress changes through self-report measurement tools and/or therapist.

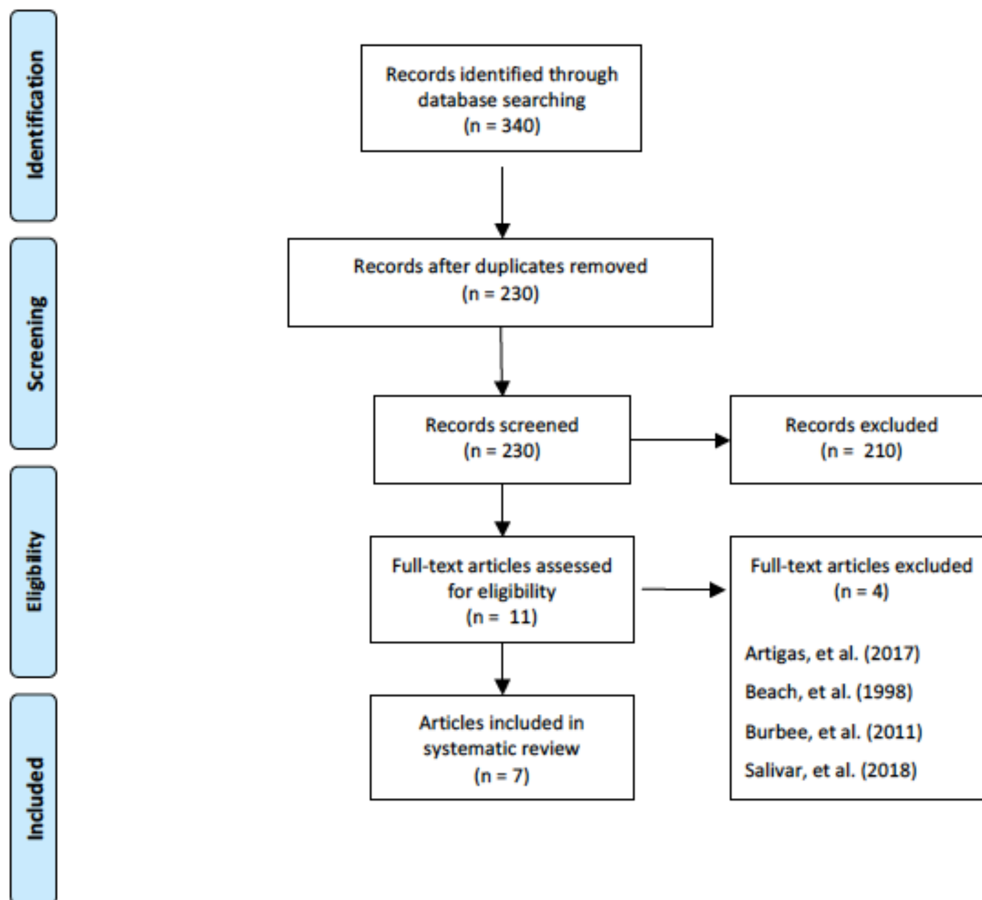
Study design

Peer-reviewed articles of quantitative research published in English, Italian, French, Spanish and Portuguese were included in this review. The selected studies were conducted in any setting and utilised a pre-post and/or between-group assessment design to examine treatment effects. Studies were included if they did or did not have a control group. However, RCTs were not included as a recent review by Barbato et al. (2018) has already been conducted. Grey literature, including dissertation and theses, was not included due to potentially lower methodological quality compared to peer-reviewed studies.

Study selection and data extraction

The flow chart showing the number of studies at each stage of the study selection followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines for systematic reviews (Moher et al., 2009). The initial search strategy of all the databases found 340 articles. As demonstrated in figure 1, after the duplicates were removed, 230 articles' titles were scrutinised. The abstract and full text of 11 studies was examined. Four articles were excluded from the review due to: evaluating the therapeutic alliance rather than the impact on psychological distress (Artigas et al., 2017); a review of the literature on couple therapy for depression (Beach et al., 1998); a programme based on evangelical Protestant Christian theology (Burbee et al., 2011); a brief web-based programme based on CBT (Salivar et al., 2018). The data was extracted from each study by one reviewer and was checked by the second reviewer. The final review included seven studies.

Fig 1: Adapted PRISMA diagram



Quality appraisal methods

Mayo-Wilson and Montgomery (2007) in a Cochrane protocol recommended a priory assessment of quality criteria should be performed in order to prevent systematic errors or bias. Therefore, the quality of the studies included in the systematic review was assessed using a quality appraisal method tool, the EPHPP, which was developed by the Effective Public Health Practice Project. This tool was selected because it evaluates several intervention studies including: RCTs, observational, and pre and post studies.

The tool was deemed to have construct and conduct validity (Thomas, 2004). Moreover, in a study by Armijo-Olivo et al. (2010) assessing the methodological quality of 20 RCTs using the EPHPP tool, the inter-rater reliability of the individual domains was 0.60, which was deemed a fair agreement among raters. The inter-rater reliability of the final mark that was given to each study by this tool was ICC = 0.77 (95% CI 0.51–0.90), which was deemed an excellent agreement.

The tool assesses six domains: selection bias; study design; confounders; blinding; data collection method; and withdrawals/ dropouts. According to the total score, studies are allocated a quality rating of weak, moderate, or strong.

Results

Characteristics of the studies

Following the selection procedure, seven studies met the criteria of the study requirement (Figure 1). The studies designs were heterogeneous and included: three multiple baseline across participants' design (pre-post test), a randomised pilot study (pre-post-test and follow up), two control group design (pre-post-test and follow up) and a single case study (pre-post and follow up). The studies by Denton et al. (2012) and Dessaulles et al. (2003) appear also in the review by Barbato et al. (2018) as they were both pilot studies rather than RCTs.

A comprehensive summary overview of the included studies is incorporated in table 1. It should be noted that specific psychometric measures were also utilised in the studies to address other outcomes that were relevant to the subject of couple therapy, which included relational

distress, marital adjustment and satisfaction. In most of the studies the changes in mental health were associated with the couple's marital satisfaction, interpersonal wellbeing and vice versa.

Effect of couple therapy on depression

As highlighted in Table 1, all studies have evaluated the impact of couple therapy on depression. Balfour and Lanman (2012) examined the changes from beginning to end of 40-weeks' psychodynamic couple therapy on depression, as self-rated on CORE, and the effect size was d=0.64, which was considered medium according to Cohen's criteria (Cohen, 1998). Hewison et al. (2016) examined 23-weeks psychodynamic couple therapy using the CORE, and the effect size was large, d = -1.04,

Baucom et al. (2018) evaluated 10-weeks behavioural couple therapy using the PHQ-9 and the effect size was large, d=2.23. Similar results were found by Kuhlman et al. (2013) that examined a seven-weeks systemic couple therapy, using the BDI, and the effect size was large, d=1.78.

Dessaulles et al. (2003) used the IDD outcome measure to assess the impact of 15-sessions of Emotion Focused Therapy (EFT) and found large treatment effects, d = 1.56. Similarly, Denton et al. (2012) found that the levels of depression decreased more in the medication augmented with EFT condition compared with medication alone arm, from pre-treatment M(SD)=40.0 (10.2) to post-treatment, 12th month, M(SD)=17.8(13.2). Peterson et al. (2009) evaluated the impact of 12 sessions of ACT with two couples and found that there was a consistent decrease in overall psychological distress.

Table 1 - Summary overview of included articles

Study	Research design	Sample size and characteristics	Definition of emotional distress, therapy, duration and therapist characteristics	Outcome measures	Therapy key findings
Balfour & Lanman (2012)	Multiple baseline across participants' design (pre, consultation, mid- post-test)	18 couples (M age = 38)	• 27 participants had moderate to severe levels of anxiety and or depression according to the Clinical Outcome in Routine Evaluation (CORE, Evens et al., 2000) • 40 weekly sessions of psychodynamic couple therapy • Delivered by 5 therapists trained for 4 years at Tavistock Relationships	• Couple: CORE • Therapist: (PRP) • Observer: Rating the videotape sessions	CORE: • Time (Consult to End): F (2,34) = 6.882, p <.005 • ES (Effect size) Consult to Mid-therapy: d=0.53 • ES Consult to End Therapy: d= 0.64 PRP: • Therapist: DP Scale (Consult to End): F(2,34) = 32.279, p <001; ES Consult to mid: d=0.62; Mid to End, d = 0.84; Consult to End, d=1.7 • Observer: DP Scale (Consult to End): F(2,34) = 8.769; p <.001, d = 0.92
Baucom et al. (2018)	Multiple baseline across participants' design (pre-post test)	63 couples	• One partner scored 10 or greater on the Patient Health Questionnaire (PHQ-9) • 10 weekly sessions of Behavioural Couple Based Treatment for Depression (CBT-D) • Delivered by 23 IAPT Therapists trained in during a one week intensive course with previous postgraduate training in CBT	Couple: PHQ-9	PHQ-9 • Clients: Pre-mean (SD) = 16.17 (4.65), post-mean (SD) = 7.75 (6.03), ES: d = 2.23 Reliable and clinical significant change (RCI) = 58.7% • Partners: pre-mean (SD)= 7.54 (4.84), post-mean (SD)= 4.54 (4.38), ES: d = .79 RCI = 14.3%
Denton et al. (2012)	Randomised pilot study (pre-post-test and follow up)	12 couples were randomly assigned to medication alone (MM), M age=34,0, or to MM augmented with EFT couple therapy, M age =31.7	• Female partner met the criteria for major depressive disorder using the Structured Clinical Interview for the DSM-IV (SCHID; First et al., 1997). She scored 24 or more on Inventory of Depressive Symptomatology (IDS-C, Rush et al., 1996)	Female partner: • SCHID • IDS-C	• MM: levels of depression decreased from pre treatment, M(SD)=40.3 (9.6) to 6th month, M(SD)=16.9 (17.0), to 9th month M(SD)=17.1 (20.2) to post-treatment, 12th month, M(SD) = 27.0 (20.0) • MM + EFT: levels of depression decreased from pre treatment, M(SD)=40.0 (10.2) to 6th month, M(SD)=3.5 (1.9), to 9th month M(SD)=10.3

			15 conjoint sessions of Emotion Focused Therapy (EFT) - Delivered by 2 doctoral trainees and 2 Master level students who attended a week long course in EFT and received weekly supervision.		(11.9) to post-treatment, 12th month, M(SD) = 17.8 (13.2)
Dessaulles et al. (2003)	Control group design (pre-post-test and follow up)	12 couples were randomly assigned: 7 to EFT and 5 to MM (M age = 37)	- Female partner met criteria for a major depressive episode on Diagnostic Interview Schedule (CDIS; Blouin et al., 1986). She had to endorse depressive symptomatology of at least moderate intensity by scoring 25 or greater on the Inventory to Diagnose Depression (IDD; Zimmerman et al., 1986) 14 conjoint sessions of EFT and one individual session for each partner - Delivered by 6 doctoral trainees in clinical psychology with a minimum of one year of supervised training in EFT	Female partner: IDD	- Repeated measures ANOVA revealed that the main effect for treatment of IDD scores was not significant. - MM: significant reduction in depression from pre to post, $F(1,32) = 4.23$, $p < .05$, $r = .34$. 6-months follow up did not differ significantly from the treatment phase, $F(1.32) = 2.58$, $p > .05$ - EFT: levels of depression decreased from pre to post treatment, $F(1,32) = 7.82$, $p <.05$, $r = .44$. From post-treatment to 6-months follow up, $F(1,32) = 9.42$, $p < .05$. ES =1.56
Hewison et al. (2016)	Multiple baseline across participants' design (pre-	N = 877 (508 females and 369 males) M age = 35	- All participants were individually distressed according to the CORE, M (SD) = 16.35 (4.50) 23 conjoint sessions of psychodynamic couple therapy	Couple: CORE	- Clients reported significant decrease in individual psychological distress over course of therapy (B = -4.99, SE = .31, z = -16.25, p < .001 - ES: d = -1.04 - RCI = 36.6%

	post test study)		• Delivered by qualified couple therapists (42.20%) and couple therapist in training (54.80%)		
Peterson et al. (2009)	Single case study (pre-post and follow up)	2 couples (M age =30.7)	• Both couples were in the distressed psychological range (scores > 62) on Interpersonal Relationship Functioning and Psychological Distress Outcome Questionnaire (OQ-45.2, Lambert et al., 1996) at pre-therapy. Both couples were not in the depressed range (scores >14) as measured by the Beck Inventory-II (BDI-II, Beck, et al. 1996) • 12 sessions of Acceptance and Commitment Therapy (ACT) for couples • Delivered by the first author, a PhD level licensed marriage and family therapist trained in ACT	Couple: • OQ-54.2 • BDI-II	The two couples began treatment in the distressed range (couple 1 score = 62, couple 2 score = > 63) and showed a consistent decrease in overall psychological distress (OQ 45.2) over the course of therapy and were in the non-distressed range at 6-month follow up (29 and 38 respectively).
Kuhlman et al. (2013)	Control group design (pre-post-test and follow up)	51 couples were randomly assigned: 29 to couple therapy (CT) and 22 to TAU, M age = 42	• One partner scored at least 14 on the Hamilton Depression Rating Scale (HDRS, Hamilton, 1960) • CT sessions: M (SD) = 6.92 (2.4). TAU: individual or group psychotherapy sessions): M (SD) = 11.1 (6.7)	Couple: • HDRS • BDI • Symptom Check-List-90 (SLC-90, Derogatis, 1983)	CT - patients • HDRS: Pre-treatment - M (SD) = 20.2 (4.40), 6 months – M (SD) = 11.2 (7.64). ES, d = 2.05 • BDI: Pre-treatment - M (SD) = 24.2 (5.38), 6 months – M (SD) = 14.6 (9.33). ES, d = 1.78 • SLC-90: Pre-treatment - M (SD) = 2.57 (.40), 6 months – M (SD) = 1.95 (.51). ES, d = 1.55 • ORS: ES, d= 1.18

			• Delivered by 30 systemic family therapists	• Outcome rating scale (ORS, Miller & Duncan, 2004)	TAU – patients • HDRS: Pre-treatment - M (SD) = 19.6 (4.25), 6 months – M (SD) = 13.2 (7.75). ES, d = 1.51 • BDI: Pre-treatment - M (SD) = 24.1 (5.51), 6 months – M (SD) = 18.3 (11.22). ES, d = 1.05 • SLC-90: Pre-treatment - M (SD) = 2.51(.52), 6 months – M (SD) = 2.28 (.78). ES, d = 0.44

Discussion

Quality of the studies

Table 2 highlights the rating for each paper according to the eight criteria of the EPHPP. The EPHPP criteria were not always considered relevant due to the study designs' heterogeneity and several strengths and limitations were found. The studies' quality was moderate in five of the studies, one was considered to have strong quality (Balfour & Lanman, 2012) and two were deemed to have weak quality (Dessaulles et al., 2003; Paterson et al., 2009).

Across the studies, there were consistent strengths where all the studies reported details regarding the validity and the reliability of the data collection tools and presented good descriptions of the statistical methods and results. However, there were several methodological limitations in most studies around: selection biases, study design, confounders, blinding, data collection, attrition and intervention integrity. Due to the methodological limitations in the studies, the outcomes should be treated with caution.

Selection biases. There were issues around selection biases in all studies. The samples of the studies seemed to be representative of the clinical population. However, all the studies were based in Europe and North America, with participants with similar demographic characteristics, such as being White and educated. Moreover, some studies reported that all couples that participated were heterosexual, and in two studies the index service users were all females (Denton et al., 2018; Dessaulles et al., 2003). These biases might reduce the generalisability of the results to other socioeconomic, cultural, gender, and sexual orientation backgrounds.

Only three studies reported the percentage of selected individuals that agreed to participate (Denton et al., 2012; Dessaulles et al., 2003; Kuhlman et al., 2013). Moreover, apart from the article by Hewison et al. (2016), most studies utilised a small sample, which may have a negative impact on the external validity and generalisability of the results. As a result, because the sample size may affect the statistical power, it may not be possible to identify differences between groups. The small sample size and potentially low power may impact the likelihood that a true effect is found even though a nominally statistically significant finding was detected (Button et al., 2013).

Study design. In two studies, the couples were randomly assigned to couple therapy (or augmented with medication) or pharmacotherapy (Denton et al., 2018; Dessaulles et al., 2003). One study was based in a naturalistic setting and the participants were assigned to couple therapy or TAU in accordance to their needs (Kuhlman et al., 2013). The rest of the studies used a multiple baseline across participant's design, which included a single case study (Paterson et al., 2009). Accordingly, the lack of both comparison condition and/random assignment denotes a potential limitation of the current literature. This lack of external validity may impede to draw conclusions on whether the improvement in the participants' mental state was caused by the couple therapy interventions alone. RCTs are deemed as having strong internal validity as there is the opportunity of controlling confounding variables. Whilst in the studies included in this review, there may be the chance that the experimenter biases may have hindered the objectivity of the causal effects of these studies.

However, it is proposed that naturalistic studies of couple therapy delivered in clinical settings, including at IAPT services and Tavistock Relationships, may be seen as a different but equal source of knowledge as RCTs (Balfour & Lanman, 2011; Baucom et al., 2017; Hewison et al., 2018; Kuhlman et al., 2013). Despite naturalistic studies being placed below the RCTs in the pyramid of evidence, these two methodological modalities test distinctive forms of interventions (Leichsenring, 2004).

RCTs are based on work undertaken in a laboratory and test efficacy, whilst naturalistic studies are based on field therapy that test effectiveness. Accordingly, the evidence from RCTs may not be transferred to the psychotherapeutic practice in the field. The therapeutic models utilised in these studies, such as psychodynamic and systemic therapies, do not render to the precise adherence to a manualised treatment, and therefore the results may not be transferred to another context. As Kuhlman et al. (2013) noted: "The generalisability of the results of the naturalistic studies can add trustworthiness of the results by increasing the external validity in the way that it follows accurately the treatment procedures used in the real-world settings" (p. 668). In fact, according to the EPHPP criteria and the medicalised construct of the gold standards of RCTs, the studies that did not utilise an RCT methodology such as naturalistic studies, may have received a poor rating even though they were undertaken in a clinical setting.

Confounders. According to the EPHPP criteria, only three studies (Denton et al., 2018; Dessaulles et al., 2003; Kuhlman et al., 2013) met the criteria where relevant confounders were

described but not controlled. In the rest of the studies, participants may have been taking psychotropic medications for the symptoms of depression. Therefore, the effectiveness of couple therapy may also been confounded by the dosage and frequency of medication use. Moreover, most studies have not reported whether the participants experienced other co-morbid diagnoses, hence it was not possible to isolate the treatment effects due to the confounding variables not being controlled.

Finally, in one study (Kuhulman et al., 2013) alcohol consumption was included as a difference between the couple therapy and TAU group, which may have affected the results in the other studies. As reported by Peterson et al. (2009):

> We cannot unequivocally attribute the change in each couple to the treatment interventions because we could not control for factors like coincidental events that occurred during the treatment the process of maturation which may mimic change, and repeated completion of the assessment measures. (p. 441)

Blinding. Blinding was involved in two studies (Denton et al., 2018; Dessaulles et al., 2003), however a description of randomisation was only available in Denton et al. (2018). The researchers described how the randomisation schedule was prepared prior to the start of study enrolment, where pieces of paper indicating the group assignment were sealed in envelopes and participants were advised not to reveal their treatment group to the interviewers. It is a common feature of psychotherapeutic outcomes research that blinding of participants and clinicians may prove to be considerably difficult, compared to investigations around psychotropic medications. However, combining the awareness of the treatment condition, self-report or unblinded expert measures may lead to a high risk of biases.

Data collection. As discussed, all the studies in this review utilised psychometric tools that were shown to be reliable and valid. However, apart from Balfour and Lanman (2012), in the remaining six studies the informants were solely the participants of the intervention. This study's authors highlighted that they were confident of the convergent evidence of therapist ratings, observer and participant's self-reports. They reported that they had emphasised the importance of independent raters not being aware of the sequence couple's ratings so that the discrepancy in rating between the beginning and end of therapy was not subject to their

expectations.

Therefore, for the rest of the studies, it may be concerning to rely solely on self-report data to evaluate the intervention's effectiveness. Self-reporting measures might create potential biases including: selective memory and overemphasis around symptoms (Cassady, 2001). Due to potential social desirability, participants may also incur in acquiescence response biases, where they may have had a general tendency to provide affirmative answers to items of a measure (Hinz et al., 2007).

Moreover, in two studies all the index participants were women (Denton et al., 2018; Dessaulles et al., 2003), who may experience depression differently than men. Hewison et al. (2018) highlighted in their research and in other effectiveness studies, that women tended to be more distressed than men, which may lead to the hypothesis that gender may play a part in the presentation of distress in heterosexual couples. Accordingly, Chuick et al. (2009) described how male study participants encountered difficulties expressing their feelings of depression and seeking help due to social norms around masculinity and socialisation around gender roles being deeply internalised.

Withdrawals and drop-outs. Attrition rates were a cause of concern in four studies. In the study by Hewison et al. (2016), the end of therapy data was available for 48% of the individuals (N=425) of the total sample described in the paper (N=877). They explained that in naturalistic studies it is not always possible to monitor outcomes. Accordingly, in a similar study, a service evaluation study by Baucom et al. (2018), they used 63 couples who met caseness for depression to calculate the recovery rates. In the study by Denton et al. (2018), the attrition rates and reasons were outlined but only six participants (50%) completed all the couple therapy sessions. Finally, in the study by Dessaulles et al. (2012), one-third of the couples (6 couples out of 18) dropped out following the randomisation, and two did not complete the follow-up assessment.

Treatment fidelity. In most of the articles the intervention integrity was deemed as moderate when considering the consistency of the interventions was not measured in all the studies, and participants may have received an unintended intervention, which may have influenced the results. The treatment length varied considerably, where some participants received ten

sessions of CBT-D (Baucom et al., 2018) and others had 40 weekly sessions of psychodynamic therapy (Balfour & Lanman, 2012).

Accordingly, the studies were heterogeneous and also differed significantly in the level of qualification of the therapists that delivered the interventions. In some studies, the therapists were fully qualified with vast previous experience, but in others they were trainees or doctoral students. Accordingly, there was a considerable disproportion of training length when considering that in two of the articles the therapists had a one-week intensive course based on CBT or EFT (Baucom et al., 2018; Dessaulles et al., 2003) and in another study the therapists received a high level training for the duration of four-years at Tavistock Relationships, alongside personal psychotherapy three times per week (Balfour & Lanman, 2012). Therefore, there may be concerns around whether the therapeutic interventions were of high quality or not.

In one study, 42% of the interventions were delivered by qualified couple therapists and 55% by couple therapists in training. The authors explained that the fidelity adherence to psychodynamic therapy was not strictly controlled, even though regular supervision was available to trainees (Hewison et al., 2016). Appropriately, Denton et al. (2012) highlighted that the therapists received weekly supervision with experts in EFT and monitoring of video recording of therapy sessions, which may have increased the adherence to the model. However, Denton et al. (2012) felt that it was necessary to assess fidelity systematically with a valid and reliable instrument. Baucom et al. (2018) noted that most of the therapists had no experience working with couples and were specialised in the individual CBT model of depression and the trainers highlighted that they were required to broaden their perspective to include an interpersonal lens. The authors also wondered if, following the training in the theory and clinical applications of CBT-D and supervision, the treatment effects would have continued.

Peterson et al. (2009) noted in the limitations of their study that the ACT therapy sessions were not videotaped to ensure treatment fidelity. Moreover, the therapy was delivered by one therapist. It could be argued that the therapist's interpersonal skills might have led to the changes rather than the intervention. This issue was highlighted by Kuhlman et al. (2013), who explained that they were not able to analyse the therapist-effect on the outcomes because there were several co-therapy teams that treated only one couple.

Table 2. Ratings of the quality of the studies

	Selection bias	Study design	Confounders	Blinding	Data collection methods	Withdrawals and drop-outs	Intervention integrity	Analyses	Quality category
Balfour et al. (2012)	Moderate	Moderate	N/A	N/A	Strong	Moderate	Moderate	Strong	Strong
Baucom et al. (2018)	Moderate	Moderate	N/A	N/A	Strong	Weak	Moderate	Strong	Moderate
Denton et al. (2018)	Good	Moderate	Moderate	Good	Moderate	Weak	Moderate	Strong	Moderate
Dessaulles et al. (2003)	N/A	Moderate	N/A	Weak	Moderate	Weak	Moderate	Strong	Weak
Hewison et al. (2016)	Moderate	Moderate	Moderate	N/A	Moderate	Weak	Moderate	Strong	Moderate
Peterson et al. (2009)	Weak	Weak	N/A	N/A	Moderate	Moderate	Moderate	Moderate	Weak
Kuhlman et al. (2013)	Moderate	Strong	Moderate	N/A	Weak	Moderate	Moderate	Strong	Moderate

Further quality concerns

The eight criteria of the EPHPP were not deemed exhaustive in addressing the quality of the studies and there are two main further concerns that need to be highlighted.

Researcher allegiance. A source of concern may have been the researcher allegiance due to the researcher's potential involvement in the treatment condition, which may increase apprehension around conflict of interest. Apart from the articles where they have utilised retrospective data (Baucom et al., 2016; Hewison et al., 2016), in most studies there was no clarity around the researchers' involvement in the treatment conditions, which may have led to biased treatment outcomes. Paterson et al. (2009) clearly explained that the first author conducted the therapeutic interventions, a PhD educated family therapist.

Follow-up. In three studies, data was available on whether the outcomes of the therapeutic interventions for depression were maintained at six-months follow-up (Denton et al., 2012; Dessaulles et al., 2003; Peterson et al., 2009). Assessing the effectiveness of therapeutic interventions for depression at a follow-up period is crucial for the evaluation of treatment outcomes. Depression is considered a complex, chronic, long-term mental health condition where further episodes of relapse are common. Therefore, long-term trial data would be crucial evidence (McPherson & Hengartner, 2019).

Strengths and limitations of the review

This review's strength is that it utilised uncontrolled studies, which were not all included in the recent Cochrane review. All the articles utilised different methodologies and psychometric measures, hence it was not possible to conduct a meta-analysis as the differences in effects may have been obscured (Green & Higgins, 2008). Another strength of this review was that the search criteria aimed at articles written in five languages because the exclusion of non-English language literature may bias the understanding of treatment effects (Balshem et al., 2013). However, following a detailed examination, seven studies in English language were selected.

This lack of available literature on couple therapy for the treatment of depression poses significant limitations, and the outcomes of this review should be taken with carefulness. Alongside the limitations described above, it was concerning that most of the studies' sample sizes were small. The combination of including studies that were not statistically powered and non randomised, may not have allowed external validity. Moreover, as all the studies were based in Europe and North America with predominantly White participants, this may have also reduced the generalisability of the results to other cultures and ethnic backgrounds. Potential co-morbidities such as anxiety and excessive alcohol consumption, which may be present alongside depression, were not addressed in most studies. Therefore, it was not possible to isolate the treatment effects.

Justification for the present study

The current literature highlights some promising results around the impact of couple therapy for depression and relational difficulties. However, as discussed, the current paucity of uncontrolled quantitative literature is not free from methodological shortfalls. This evidence is

consistent with the recent systematic review by Barbato et al. (2018). They found that most studies had small sample sizes, unclear sample representiveness, only six-month follow-ups, high attrition rates and investigators' allegiance bias.

Quantitative research attempts to establish a relationship between cause and effect around treatment effectiveness but not all therapeutic modalities are best understood using this approach. Accordingly, other research methodologies are required to examine the effectiveness of ideographic therapeutic modalities, emphasising the importance of the distinctive personal human experience (Shean, 2014). Therefore, it is proposed to utilise a qualitative methodology, which may be more adept in examining the experiences of couple therapy interventions within a clinical environment and can help understand how and why some people might find therapy useful and others might not.

According to Balfour and Lanman (2012), psychodynamic couple therapy has been investigated and evaluated to a lesser extent than any other modality. In the systematic review of the literature, the naturalistic studies of psychodynamic couple therapy demonstrated a medium effect size (d=0.64) from the beginning to the end of 40-weeks' interventions with individuals with depression (Balfour & Lanman, 2012), whilst a large effect size (d= -1.04) was found following 23-weeks therapy (Hewison et al., 2016). In the review by Barbato et al. (2018), there were not any RCTs that examined psychodynamic couple therapy.

Exploring the experiences of psychodynamic couple therapy might give additional evidence to sit alongside quantitative evidence, due to the lack of psychometric measures that address the specificity of the couple dynamics and sensitivity to change that might impact the couple's functioning. This idiographic therapy's goal includes the exploration of memories, expression of emotions and patterns of difficult experiences.

Psychodynamic approaches are intended to help couples understand how difficulties have developed in the relationship, and what may impede shifting away from them by exploring conscious and unconscious factors. The potential impact of therapy on a profound appreciation of the sense of meaning of the human existence and lack of connectedness with another, which may be seen as characteristics of the depressed state, may not be quantified in advanced statistical analysis. Therefore, qualitative analysis combined with careful methodological considerations to avoid researcher's biases will allow a further understanding of the processes

of psychodynamic psychotherapy and outcomes from the service users' perspectives.

Research aims and questions

This study aims to explore the experiences of adults with depression who received psychodynamic couple therapy. This study also has the secondary objective to answer the following questions around adults' experiences of psychodynamic couple therapy:

1. How do adults with depression experience potential changes in mood and emotional distress?
2. How do adults with depression experience their relationship with their partner?
3. How do adults with depression experience their children's behaviour or wellbeing?
4. How do adults with depression experience their relationship with the therapist?

Methodology

This chapter will describe the methodology that was utilised to address the aims of the study. The first section will describe the theoretical underpinnings, including the rationale for using a qualitative design and the research paradigm around epistemological stance.

A detailed account of the study's participants will be elucidated, including the sampling method, sample size and the inclusion and exclusion criteria. The study procedure will be described, including the recruitment of the participants and data collection. A clear account and rationale of the use of thematic analysis with a phenomenological approach will be illustrated, along with the methods used to maintain high standards of rigour and trustworthiness.

The crucial components of the researcher's reflexivity and positionality will be elucidated in order to consider the potential impact of her persona in analysing the results, including which procedures were put in place to avoid this from occurring. The ethical consideration, including the risk of harm to the participants and the researcher, will be highlighted in the final section.

Research paradigm

Rationale for qualitative design

Research around the effectiveness of different therapeutic approaches has seen a longstanding tradition of use of quantitative approaches, which lie in the positivist principles of objectivity, causality, replicability and generalisability. Within this realm, RCTs have been seen as the "golden standard of research" and the most respected method of evaluating interventions for the past half-century (Jones & Podolsky, 2015). RCTs have been positioned at the top of the pyramid of the "hierarchy of evidence" along with the uncontested credibility given by the Cochrane Collaboration and guidelines including NICE and the Scottish Intercollegiate Guideline Network (Midgley et al., 2014). RCTs are mostly used for evaluating medical approaches where a causal relationship is sought across participants (Shean, 2014).

Healy (1999) argued that RCTs were utilised in psychiatry to evaluate and promote

pharmacotherapy, and the psychotherapy disciplines were compelled to align with the same investigation method. According to McPherson (2018), RCTs endorse symptom-focused and diagnostic criteria that might favour short-term and manualised therapy approaches, such as CBT. Consequently, non-manualised and non-brief therapies, including psychodynamic, were placed in a disadvantaged position. Moreover, most RCTs do not evaluate the effectiveness of a therapy at a follow-up period longer than six-months. A longer follow-up period is particularly important for assessing treatment outcomes of a multifaceted and long-term mental health problem such as depression, where further episodes of relapse are common. Finally, another pitfall is that several RCTs utilise treatment/no treatment randomisation to examine the response rates of therapeutic interventions (Fogany, 2010).

Shedler (2015) offered further critiques to the methodology of RCTs in evaluating therapeutic models. Echoing Fogany (2010), Shedler (2015) highlighted that the control groups in RCTs could be pseudo-treatments. The study by Gilboa-Schechtman et al. (2010) was cited where the control group was offered a psychodynamic treatment for Post Traumatic Stress Disorder (PTSD) by graduate students from a research laboratory. Moreover, two-thirds of participants are excluded from RCTs because they might meet the DSM criteria for more than one diagnosis, which is a common feature of depression where individuals present with other mental health difficulties. As Healy and Mangin (2019) postulated in their critique of RCTs:

> Science advances knowledge by generating data as we avail ourselves of new techniques, such as a method of evaluation, to throw up new observations. The mission of science, however, is not to replace judgment by technique. Patients constitute the core clinical dataset and are present in the flesh to be cross-examined. (p. 20)

Differing from a positivist epistemological viewpoint, which privileges neutrality, in the qualitative research tradition it was argued that by devaluing experiential knowledge from service users, we might lose a crucial source of knowledge. Advocates of qualitative research questioned the “unbiased value-free” position maintained in the positivist tradition, where service users might be seen as “close to the problem” (Beresford, 2020).

Qualitative research aims to generate a more in-depth understanding based on contextual and comprehensive data (Mason, 1996). Hence, the epistemological underpinning is that reality is not objective but instead it should be understood in the context where it emerged. Accordingly,

qualitative methods provide the "contextual knowledge" and emphasis on understanding the meaning and value of a therapeutic approach from service users' perspectives (McLeod, 2011). Moreover, Beresford (2020) highlighted the centrality of experiential knowledge that service users provide in shaping services, based on subjective and lived experiences, rather than on research and experiments.

Therefore, advocates of qualitative research reject the notion that objective reality can be assessed whilst holding an interpretivist philosophical position where the social world is understood and interpreted according to a flexible methodology. A central question is why and how a phenomenon occurs rather than addressing the frequency and manipulations of variables in quantitative research. Within the context of therapeutic research, where emotional distress is characterised by its multi-layered nature and notable individual differences, narrative accounts are crucial. "Good narratives typically approach the complexities and contradictions of real life. Such narratives may be difficult or impossible to summarise into neat scientific formulae and general propositions" (Flyvberg, 2005, p. 240).

The aim of this research is to evaluate the experiences of working-age adults with depression of psychodynamic couple therapy. Accordingly, a qualitative method approach has been selected because it would offer a "thick description" and a rich insight in understanding the therapeutic dynamics and the impact on individual lives. Psychotherapy is inherently an intersubjective dialogue rather than an objective truth, where numerous understandings of the phenomena may be revealed by a thorough analysis of different accounts (Levitt, 2015). As such, a qualitative approach might be better at describing the multi-layered nature of psychotherapy dynamics, including the process of transference, and giving a voice to the idiosyncrasies of the human experience.

Qualitative methodologies may "allow people to speak in their own voice, rather than conforming to categories and terms imposed on them by others" (Sofaer, 1999, p. 1105). Accordingly, this approach was selected because it would provide an avenue for the voices of underrepresented groups to be heard. These voices do not seem to be equally valued in quantitative research, as they are reduced to an *average* experience and included within a dominant discourse. The structural disadvantage in mental health is replicated through forms of research that are not service user led or controlled. Hence, there is an increasing pressure for "epistemic justice" by ensuring that the perspectives from different social groups are finally

heard, following centuries of being marginalised from the creation of knowledge (Beresford, 2020)

Within the richness that a diverse society brings, such as in London where the couple therapy provider is based, it seemed necessary to identify the therapeutic needs of service users from a variety of backgrounds and the dynamics that may develop between them and the therapists (Dos Santos & Dallos, 2012; Mulvaney-Day et al., 2011).

In the meta-synthesis conducted by the researcher before this study, there was not any published publication on the experiences of couple therapy for depression. In this light, with the considerations noted in the section above, the qualitative analysis proposed for this study would provide an avenue of clinical utility for this area of research that has not been explored before.

Research paradigm

Assumptions around the nature of reality and knowledge are intrinsic within the researcher's *weltanschauung*, view of the world. This research paradigm addresses these belief systems, which would lead to a further understanding of the methodology that was utilised in this study. The ontological reflections on how the researcher might understand reality and knowledge are the foundations of a research project (Grix, 2004). Is reality: "A singular, verifiable reality and truth (or) …. socially constructed multiple realities"? (Patton, 2002, p. 134). These ontological questions led the researcher to specific epistemological assumptions around the nature of knowledge and how it is acquired.

A positivist approach to research claims that objective truth exists, and their ontological position is realism. Positivists rigorously apply the scientific method to reveal an objective reality and utilise techniques to study the natural world in social contexts by hypothesising potential cause-effect relationships (Giddens, 1995). The epistemological position is objectivism, which emphasises objective detachment and techniques to improve the reliability and validity of the studies. Positivism is founded on empiricism, where inductive methods, such as observations of patterns in experiments and statistical analysis, are used to understand the world.

Interpretativism rejects the idea of verifiable reality. An ontologically relativist position is held where reality is socially constructed by language, discourse, and different perspectives of individuals. Hence, there is not one truth but multiple realities that are socially constructed by the meaning attached to them by individuals who may come from different social backgrounds, culture, gender, etc. The interpretativism epistemological position to knowledge is to comprehend the interpretations of a phenomenon from the participant's viewpoint within their context rather than from the researcher's perspective. They collect qualitative data from participants, mostly in the format of ethnographies and case studies.

In between these different views of positivism and interpretativism sits the critical realism position, which seeks to overcome this dualism. Bhaskar (1999) focused on the interplay between an observed social phenomena and how it is conceptualised through the perception of individuals. Critical realism argues that the existence of a phenomenon can be understood as a result of a scientific methodology. As a result, the knowledge and meaning attached to it, through the use of the interpretative or hermeneutic element of research is subjective, dependent on a discourse, and an incessantly changing social construction (Sayer, 2000). Bhaskar (1999) refers to this process of epistemic relativity in light that: "there is no way of knowing the world except under particular, more or less historically transient descriptions" (p. 99). Thus, critical realism shares with interpretativism the idea that phenomena are dependent on concepts and discourses but it does not exclude the positivist concept of causal explanation. This led critical realism to become a synergy of epistemological relativism and ontological realism.

Accordingly, the critical realist approach was deemed suitable for this research to understand the experiences of individuals of psychodynamic couple therapy for depression. A critical realist approach would recognise that a phenomenon, such as a therapeutic intervention, is seen as meaningful to service users in different ways. However, it would also acknowledge the process of the causal relationship between therapy and potential outcomes. Another layer of this understanding may be around how the wider contexts, including social, cultural and gender norms, might shape the expectations and meanings that individuals may hold of psychodynamic couple therapy (Clark et al., 2003).

A phenomenological epistemological approach

A phenomenological approach was selected because it provides a profound analysis of the lived experiences of participants. Moreover, contemporary psychodynamic therapies have absorbed the phenomenological approach because there is a common epistemological question of "what" the other experiences rather than "why" (D'Agostino et al., 2019).

Lived experience is understood from a *lebenswelt*, lifeworld approach, which postulates that the world is populated by conscious beings that experience life. Critical realism and phenomenology share the refusal of the phenomenalist reduction to a sense of experience. Accordingly, phenomenological analysis is unattainable unless the totality of lifeworld is examined, objectively and subjectively (Budd, 2012).

Hussel, one of the main theorists of phenomenology, was concerned with what we are perceiving rather than how we are perceiving it. Consequently, a sense of meaning is formed through embodied perception (Sokolowski, 2000). On the other hand, Heidegger (1927) focused on what it means to exist among others, which each individual may experience in different fashions, rather than concentrating on "how we know what we know". Therefore, according to this phenomenological understanding, individuals are shaped by lived experience, which may be revealed by the lifeworld, our physical being in the world, and how we relate with others.

Participants

Sampling method and size

In qualitative research a crucial principle is trustworthiness which includes the four aspects of: credibility, transferability, dependability, and confirmability (Guba, 1981). This is a different position compared to quantitative research, which aims to generalise the results through probability sampling.

Accordingly, purposeful sampling is extensively utilised to select "information rich cases" which are knowledgeable or have experienced a phenomenon (Creswell & Plano Clark, 2011;

Patton, 2002). As Spradley (1979) highlighted, participants should demonstrate their capability to communicate experiences in a clear, coherent and reflective manner. Accordingly, the sample should be appropriate and consisting in participants who allow a deeper insight of the topic in question (Morse et al., 2002).

The considerations above influenced the decision on the sample size. The sample size should be *large enough* "to allow a new and richly textured understanding of experience" but also *small enough* "for deep, case oriented analysis" (Sandelowski, 1995, pp. 183). The idiographic aim of the current study required the sample to be sufficiently small for the participants to have a *voice* and for an exhaustive analysis of each interview to be conducted (Robinson, 2015). Data saturation from the interviews was another element that was addressed when considering the sample size (Hennink et al., 2017)

Braun and Clark (2013) recommended between six to ten participants for small scale projects. In line with the realistic time limitation of this thesis and recruitment difficulties caused by the COVID-19 pandemic, a sample of five working-age adults was recruited for this study.

Inclusion and exclusion criteria

The sample consisted of five working-age adults (age 18-65) who have been attending the couple therapy provider for six months since the assessment consultation and who had completed the treatment. Participants who stayed together as well as those who separated were considered eligible. Participants were individuals who scored above the clinical caseness score on the CORE-OM at the start of therapy. Following this, the CORE-OM score was mapped onto the BDI using a validated approach in order to describe levels of depression in the sample.

The following inclusion and exclusion criteria were decided in discussion with the couple therapy provider on the above sampling strategy in order to uphold the homogeneity of the sample:

- Individuals who attended psychodynamic couple therapy and experienced clinical levels of psychological distress (based on the scores of the psychometric measure – CORE–OM or by describing themselves as depressed)

- Individuals of any gender, sexual orientation, socioeconomic and marital status and nationality were included
- Participants spoke fluent English and did not require a translator
- Individuals with specific learning, psychotic or substance use, significant risk of self-harm and severe medical conditions were excluded. This was identified according to the individual responses in the CORE-OM and by asking therapists to confirm whether there is any known issue in these areas

Research procedure

Recruitment

Recruitment was conducted through a couple therapy provider, which is a charity based in the UK providing counselling and psychotherapy services to couples. Potential participants were identified from the client database by the research lead. The initial recruitment sought to identify potential participants from a diverse background (cultural, ethnical and sexual) to represent the broad range of clients that attend couple therapy at this service.

The therapist who saw the clients identified as eligible to participate in the study was contacted to check whether there were any clinical contra-indications to contacting the couple. The therapists were all female qualified psychodynamic couple therapists. One of these therapist was also qualified in individual psychoanalytical psychotherapy.

If there were no contra-indications, an administrator from the couple therapy service sent an initial brief invitation letter by email to these former clients. The rationale behind not having the therapist as the point of contact, along with recruiting only former service users, was that this might have had an impact on the transference relationship and patient outcomes. Due to the nature of psychodynamic therapy, where the transference is an important indicator of how the service user might feel towards the therapist, an interview might have been considered as an intrusion in these processes and dynamics.

Where both individuals within a couple presented with clinical caseness described above, both were invited as individuals. Letters included brief information about the study (Appendix B) and asked the former clients whether they would provide their consent to be contacted further

by the researcher. The participants that were interested in taking part in the study, were contacted by the researcher in order to provide further information. Following this, the participants who agreed to take part were contacted by the researcher to arrange a suitable time for the interview. The signed and scanned consent form (Appendix C) was also collected by e-mail prior to conducting the interview.

Difficulties with recruitment

The recruitment of participants started in November 2019. The research department at the couple therapy service has thoroughly selected the participants according to the inclusion criteria, which was drafted in collaboration with the University of Essex. The five participants of this study were recruited in January 2020, prior to the COVID-19 pandemic.

Due to this limited number of participants, between July and September 2020, the researcher made three significant amendments to the original Ethics Application: recruitment from charitable and private organisations, including private clinics, and the use the snowballing technique. Sadly, none of these organisations wished to be involved in this project, and there is a limited number that offers psychodynamic couple therapy. Upon reflection, there were no other foreseeable ways to have addressed the issue of a small sample. The researcher started recruiting the participants over a year and a half before the submission and contacted the couple therapy provider and the other organisations on numerous occasions.

Data collection

The data collection took place between October 2019 and February 2020, and the opportunity for recruitment was open until January 2021. The interviews consisted of open-ended questions in a conversational style, which lasted approximately 45 to 90 minutes and were digitally tape-recorded. The semi-structured topic guide was formulated by the researcher, her academic supervisor and the lead researcher at the couple therapy service. The questions were around the relationship with the therapist; the experiences and the impact of psychodynamic couple therapy, including changes in mood, relationship with the partner and wider system (Appendix G). The researcher tried to be flexible and responsive to the participant's answers, rather than having a set of question to be asked in a certain order. The researcher avoided utilising summarising techniques. The following data collection strategies were used.

Telephone interviews. The interviews were conducted solely over the telephone. The rationale behind not using face-to-face contact within the couple therapy service headquarters was that this procedure might have opened an avenue for potential intra-psychic dynamics that were supposed to have been addressed during the therapeutic intervention. Moreover, the service's Executive Board deemed that the telephone interview would not expose the participants to a great extent. Accordingly, studies have highlighted the methodological strengths of conducting interviews by telephone with individuals from different socioeconomic status, including: perceived anonymity, increased privacy, and reduced distraction (Stephens, 2007; Sweet, 2002).

Individual interviews. Participants were interviewed individually, not as a couple. I was informed that two participants were a couple but I used the data to extrapolate their individual experience rather than as a couple. With reference to the systematic review in the first part of this thesis, the participants' pre and post scores were assessed on an individual basis.

Moreover, the process of interviewing participants individually allowed them to express their individual opinions on the therapeutic process. Correspondingly, during joint interviews, the responses to sensitive questions may have been influenced by the presence of the partner even though their experiences may have been considerably different (Aquilino, 1993). Accordingly, in joint interviews, participants may have represented themselves as a couple by negotiating and co-constructing their narrative and "making sense of the world from within it, not detached from it" (Taylor & de Vocht, 2011).

Therefore, in line with an Heideggerian phenomenological approach, it was crucial for the participants to be fully able to express their experience of therapy and not be influenced by their partner (Valentine, 1999). The choice between individual and joint interviews echoes the difference in the epistemological approaches that stress the sense of meaning for each participant, phenomenology, or the sense of meaning being constructed dialogically, constructionism (Brikmann, 2013).

Finally, in line with the ethical principle of not causing harm to participants, it was crucial to secure their wellbeing and ensure that the interviews would not have a damaging impact on the relationship, including any potential disruption (Farrimond, 2012).

Analysis

Thematic analysis

Following the rationale from a critical realist perspective, this study utilised a thematic analysis with a phenomenological approach. Clark and Braun (2006) described thematic analysis as: "a method for identifying, analysing, and reporting patterns (themes) within data. (…) Thematic analysis can be a method which works both to reflect reality and to unpick or unravel the surface of reality" (pp. 79-81).

Thematic analysis was selected due to its flexibility and the possibility of being applied across several theoretical and epistemological approaches, in contrast to other approaches which are closely linked to a specific model such as Interpretative Phenomenological Analysis (IPA), aligned with hermeneutic phenomenology (King, 2004). There are considerable similarities between IPA and thematic analysis with a phenomenological approach. The ladder was selected because of the flexibility in considering participants' lived experiences but at the same time not excluding the positivist approach of causal explanation, which is related to the research paradigm of critical realism. Therefore, this study sought to explore the conditions that might have triggered certain experiences during past events, relational and family dynamics, sociocultural domains, etc. Moreover, a critique of IPA is that this methodology does not give a satisfactory recognition to the role of language, context, discourses and narratives (Tuffour, 2017).

Through careful examination of the individual experiences of couple therapy, an attempt was made to describe the meaning for each participant. Hence, the *truth* of the experience of couple therapy, may be considered as an abstract entity, as individuals subjectively represent it in different ways depending on who is asking and what is the context. Accordingly, the analysis began with a search for meaning and how the different meanings relate to each other. Subsequently, the meanings are organised into patterns, where themes begin to emerge (Sundlel et al., 2018).

Thematic analysis using a phenomenological approach stresses the role of the researcher's reflective attitude and questioning their pre-understanding. As Sundlel et al. (2018) argued:

"questioning involves attempting to set aside one's experiences and assumptions as much as possible and means maintaining a critical stance and rend reflecting on the understanding of the data and the phenomenon" (p. 735). Accordingly, researchers become the "instrument of the analysis" by assessing the data, coding and theming (Starks & Trinidad, 2007). It is crucial for researchers to demonstrate how the analysis has been carried out, through recording and systematising with sufficient detail in order for the reader to establish whether the method was considered credible (Nowell et al., 2017). Given the significant responsibility of the researcher to ensure the rigour and trustworthiness of the analysis, several strategies have been put in place, which will be described in this section.

Accordingly, thematic analysis is methodologically sound, due to the rigorous definition of the ontological and epistemological account utilised, and the transparency around the decisions that have been made to analyse the data. The following six phases described by Braun and Clarke (2006) were utilised to analyse the data:

1. The interviews were transcribed by the researcher in order to familiarise themselves with the available data. A transcript excerpt has been included in Appendix H. Following this, the transcriptions were read repeatedly in order to actively find meanings and patterns.
2. The second phase involved the production of initial codes that describe the main ideas stemming from the data. Coding has been described as a way of organising and classifying the data into meaningful groups (Tuckett, 2005, in Braun & Clarke, 2006).
3. The collated codes were then combined to create candidate themes. The use of a mind-map using different post-it notes with codes facilitated the process.
4. A set of candidate themes was carefully reviewed when the researcher read all the extracts from each theme to establish whether there was a coherent pattern or not. The themes that were problematic were either re-worked or discarded from the analysis. A candidate thematic map, which was reviewed on several occasions, facilitated the process of the revision of the themes.
5. This phase entailed identifying the 'story' around each theme by conducting and writing a comprehensive analysis. Themes were subsequently arranged into different levels, including overarching and sub-themes.

6. The final step involved the final analysis and write-up into a consistent narrative, which illustrated the data by going beyond a general description and instead formulated a compelling argument to answer the research question.

Rigour and trustworthiness

Differing from quantitative research, where validity and reliability are the paramount of the methodology, in qualitative research rigour and trustworthiness have been defined as the cornerstone (Lietz et al., 2006). Trustworthiness is determined when findings reflect the meanings as described by the participants as closely as possible (Lincoln & Guba, 1985). Therefore, in order to manage the reactivity and biases that might have incurred within and between the researcher and participants, the following strategies have been implemented.

Audit trail. The researcher noted all her research decisions and activities throughout the study, including theoretical, methodological and analytic choices. The researcher kept a log of all the research activities in a research journal and memos. She also documented all the data collection and decisions around the analysis, including the themes and sub-themes that would be used (Creswell & Millar, 2000). This process improved not only the credibility of the study but also its potential replicability. As Sandelowski (1986) highlighted:

> Findings are auditable when another researcher can clearly follow the decision trail used by the investigator in the study. In addition, another researcher could arrive at the same or comparable but not contradictory conclusions given the researcher's data, perspective and situation. (p. 28)

Triangulation through multiple analysts. In case the data might have been interpreted and reported using the previous assumptions towards psychodynamic therapy, all the interviews were recorded and transcribed. The candidate themes were indicated by the author and reviewed by the supervisors in order to minimise biases. The goal was not to find a consensus but to highlight the multiple ways to understand the data from a variety of perspectives (Patton, 2002). This process facilitated a decision on the results of the qualitative analysis to be more transparent (Sandelowski, 1993).

Participants' quotes. Verbatim quotes from participants were used to support the findings

section and improve the study's overall trustworthiness (Smith & Noble, 2014). Moreover, it was hoped that using verbatim quotations would illustrate the phenomena and offer a greater depth of understanding of the participants' feelings. This may also provide participants with a voice to express their views of their individual experience of therapy (Corden & Sainsbury, 2006).

Reflective memos. The researcher utilised reflective and descriptive memos to record her thoughts and reflections during the data collection. The memos were written prior to and straight after the interview. The memos were used to test the researcher's previous assumptions, which might have led to bias in interpreting the data. The process of "bracketing" was considered crucial in improving the trustworthiness of the research and was seen as paramount when utilising a phenomenological approach. As Starks and Trinidad (2007) highlighted:

> The researcher must be honest and vigilant about her own perspective, pre-existing thoughts and beliefs, and developing hypotheses (…) engage in the self-reflective process of "bracketing", whereby they recognise and set aside (but do not abandon) their a priori knowledge and assumptions, with the analytic goal of attending to the participants' accounts with an open mind. (p. 1376)

However, this process of "bracketing" based on Hussel's philosophical ideas has been criticised because putting aside previous knowledge and assumptions might be impossible. As Gadamer (2004) noted, assumptions are part of our understanding and researchers are invited to question what is the meaning behind the participants' accounts. At the same time, it is important to recognise personal beliefs and assumptions that may restrict the researcher's openness and curiosity towards the phenomena. Openness entails being observant and sensitive to the expression of the experience by maintaining an attitude of "not knowing" and "wanting to understand" (Dahlberg & Dahlberg, 2003).

Researcher's reflexivity and positionality

The process of reflexivity is an essential procedure in qualitative research to acknowledge and deal with the risks of bias. Moreover, this process acknowledges how the researcher's positionality, beliefs, identity personal, social, and cultural contexts may play a part in how we

understand the world (Etherington, 2004). Accordingly, the process of reflexivity entails deconstructing who we are and the ways in which this may influence the observation, analysis, and process of co-constructing meanings with the participants (Guillemin & Gillam, 2004; MacBeth, 2001). As Etherington (2016) noted:

> As therapist and/or researcher, we are part of those relationships, each party influencing, informing and shaping the ways knowledge is co-created and stories are told. It therefore seems disingenuous if we do not include ourselves when we engage in either of these activities. (p. 19)

It is important to note that the researcher is currently a trainee clinical psychologist, which might have had an impact on how the participants perceived her as a junior professional. Her positionality statement below provides an account of her background, which might have had an impact on the analysis of the results, and the procedures that were put in place to prevent it are described above.

Positionality

I am originally from Italy, where the psychodynamic approach is a widely used therapeutic model and has influenced writers and filmmakers, which are two of my main interests. I started reading Freud's work at the age of 16, which was part of the curriculum at Grammar School, along with ancient Greek and Latin. Since teenage-hood, I was a fond reader of the Greek tragedies and reading Freud helped me to accompany this passion for humanities with a profound understanding of the human experience. I have been reading psychodynamic authors for twenty years, which has shaped my thinking as an individual and clinician.

I have a considerable amount of training and supervised practice in CBT and behavioural parenting programmes. However, in the current socioeconomic climate that favours short-term therapeutic approaches, I felt protective towards the psychodynamic understanding of human suffering. I was keen to keep the legacy of this approach. I am currently attending my specialist placement at the Adult Complex Needs Psychoanalytical Service at the Tavistock and Portman NHS Foundation Trust. Accordingly, I might have favourable bias towards psychodynamic therapy, which were minimised by using the strategies described above to improve rigour and trustworthiness.

Ethical considerations

Ethical approval was sought from the organisation that provided couple therapy and the University of Essex Ethics board, prior to the data collection process (Appendix A). Three ethical approval amendments were sought and approved due to recruitment difficulties during the COVID-19 pandemic. Firstly, a proposal was made to widen recruitment to any charity or third sector organisation that provides couples therapy within the UK (Appendix D). Secondly, another proposal was sent to add additional recruitment sites, including private sector organisations (Appendix E). Thirdly, following a discussion with the supervisor and the director of clinical services at couple therapy provider, another proposal was made to use the snowballing technique (Appendix F). Regrettably, despite the widening of recruitment sites, no participant was recruited following the aftermath of the COVID-19 pandemic.

Ethical issues

Informed consent. Participants were informed about the aim of the research via an invitation letter, which their treating therapist sent. The invitation letter included an information sheet explaining the following: expected duration of the telephone interviews and procedures; the rights to decline their participation; the right to withdraw from the research at any time where the data provided to that point would be destroyed accordingly without any consequences on their liaison with the organisation providing therapy; reasonably anticipated risks and benefits in their participation; and how anonymity and confidentiality would be kept. Participants were also encouraged to contact the researcher or her supervisor about any questions around the study.

Once consent was obtained, the researcher contacted the participants in order to provide further information. Following this, the participants who agreed to take part were contacted by the researcher to arrange a suitable time for the telephone interview. The researcher collected the written consent forms (Appendix C) prior to conducting the interviews.

Confidentiality and anonymity. The participants' confidentiality and anonymity were ensured through the following procedures. Firstly, the research lead identified the participants from the client database and subsequently informed the treating therapist. The participants were informed around the limits of confidentiality and anonymity in the information sheet, through

informal contact with the researcher prior to providing consent, and on the day of the interview. Secondly, due to the therapeutic approach being couple therapy, participants were informed that if their partner also experienced low mood and psychological distress prior to beginning therapy, they were invited to take part in a separate invitation. It was their decision whether or not they would discuss their participation with their partner.

The participants were informed that following the interview, all the data was anonymised and kept confidential according to the Data Protection Act (1998). The audio recording digital data was saved onto an encrypted memory stick and was safely deposited in a locked cupboard. The transcribed interviews' data and all the consent forms were anonymised and saved onto an encrypted drive. The paper data was deposited in a locked cupboard, scanned onto an encrypted memory stick and destroyed at the earliest opportunity.

The participants were also advised that solely the researcher and her supervisor would be able to access the transcript during the data analysis, and the anonymised extracts from the interviews may be used in the results section of the thesis or future publication. All the data was not identifiable, and their partner was not informed of their participation or responses in the study.

Risk of harm

Participants. Prior to signing a consent sheet, participants were informed about the interview's content and potential impact due to its emotional content. It was anticipated that the study might have triggered memories of difficulties encountered prior to, during or after the therapeutic intervention. On the day of the interview, the researcher explained that they had the right to refuse to answer any question that they did not find comfortable. Moreover, participants were advised that, in the eventuality of issues around the risk of harm to themselves/others or social protection were raised, the researcher would have to inform their treating health professional (e.g. GP). Following the interview, all participants were provided with the opportunity to debrief and reflect on their experience. The debrief session allowed a space to answer any questions raised by the participants and ensure that they left in a similar emotional state as before the interview (Harris, 1988). In the event of psychological distress, further support was provided through signposting via therapeutic input and helplines.

Researcher. Interviews were solely conducted within public premises or over the telephone in order to avoid any risk to the researcher. Due to the potential risk of the interviews, evoking difficult feelings for the researcher, the risk management plan was to discuss potential difficulties with their personal tutor and in personal psychodynamic therapy.

Compensation. Following the interview, all participants were given a £10 voucher to thank them for their participation.

Dissemination

This study will be disseminated through different avenues. The abstract for this study was selected for "9th World Congress of Psychotherapy" in Moscow (Russia). Regrettably, the Congress is not going to take place anymore in 2021. Therefore, the abstract was selected to be presented at "15th Annual International Conference on Psychology", which will take place on 24th-27th May 2021 at Athens Institute for Education and Research (Greece). A copy of the finalised abstract was included in Appendix I.

Findings will be finalised for peer-review publications, including: International Journal of Applied Psychoanalytic Studies, European Journal of Psychotherapy and Counselling, Journal of Couple and Relationship Therapy, Journal of Marital and Family Therapy, Psychotherapy Research, and Journal of Affective Disorders. During future NICE guideline revisions, the study will be submitted for calls for evidence.

Results

Chapter overview

This chapter presents an analysis of the data. Firstly, demographic information about the participants is described. Secondly, an analysis of the data will be presented, using a phenomenological approach to thematic analysis where the themes and sub-themes are elucidated.

Demographic information

Five participants have taken part in this study, and the table below provides their demographic details. Pseudonyms have been used to ensure anonymity.

Table 3. Information about participants: demographic data and treatment history

Participant pseudonym (gender)	Age	Partner's gender	Ethnicity	Length of therapy
Zoe (F)	48	Male	White	Nine months
Sandra (F)	32	Female	White	Six months
Daniel (M)	48	Female	White	Nine months
Emma (F)	42	Male	White	24 months
Paul (M)	58	Female	White (Other)	12 months

Characteristics of the sample

Five participants received psychodynamic therapy for depression for six to 24 months at the couple therapy service. The age of the participants, at the time of their interviews, ranged between 32 and 58 years old. A majority of participants defined themselves as White British, with the exception of Paul, who is from a country in the European Union. Participants partners

were of the opposite gender, apart from Sandra who explained that she was in a same-sex relationship.

Thematic analysis

The methodology elucidated by Braun and Clarke (2006, 2020) has been used to individuate the themes and subordinate themes of the analysis. The phenomenological position of understanding "subjective viewpoints" has been utilised (Flick, 2014, p. 423). An emphasis has been placed on participants' view and sense-making of their lived experiences of couple therapy. The themes follow the journey of participants' experiences of mood and relationship difficulties, the therapeutic process, the end of therapy and the impact on their lives. How participants experienced the dynamic of having "the third person in the room" varied, and these different accounts brought a richness to the analysis.

Qualitative findings

This study presents the following seven themes and subordinate themes, which will be discussed in detail in the section below.

1. **Prior individual experiences brought into the room**
   1.1. The intertwined dynamic between relationship difficulties and depression
   1.2. Expectations of couple therapy
   1.3. Learning to share the therapeutic space

2. **Sharing the space with a third person in the room allowed the process of listening to one another**
   2.1. The therapist providing a third eye perspective
   2.2. Sharing the therapeutic space enables reciprocal listening

3. **Fostering connections between the couple and the therapist**
   3.1. Understanding each of us
   3.2. Therapist empathy helps to foster connection with the couple
   3.3. Therapist neutrality enables the process of bringing us to the present moment

4. **Couple dynamics played out and re-enacted in the room enabled repair in the therapist-client relationship**

5. **Exploring the past enabled new perspectives and communication**
    5.1. Making links with the past enabled the process of understanding the couple
    5.2. Process of acquiring new perspectives and improving communication
    5.3. Practical tools and help to build on current and future behaviour

6. Endings: facing the future without a safe space
    6.1. Sadness about the loss of a safe space to have difficult conversations
    6.2. We are ready to face our relationship and depression just between the two of us

7. Holding onto the learning from therapy and moving forward as a couple
    7.1. Looking back at the overall experience of couple therapy
    7.2. Individual changes in mood, perspectives and connecting with emotions

Theme 1: Prior individual experiences brought into the room

This theme examines previous individual and relational experiences that contributed to the participants' overall insights of couple therapy. The first sub-theme describes the intertwined experiences of depression and relationship difficulties, which provide a context for understanding the therapeutic process for the couple. This sub-theme is followed by the participants' expectations of couple therapy. Most participants spontaneously discussed and compared their experiences of individual therapy attended prior to and during couple therapy. There are descriptions of the couple's perceptions of being joined by a therapist in the room, where the therapeutic space was used in a different way than in individual therapy.

The intertwined dynamic between relationship difficulties and depression

This sub-theme highlights how relationship issues and depression were seen as intertwined. Participants recognised that depression went hand in hand with noticing difficulties in the relationship. Some participants described their own experience of depression, including Sandra and Daniel.

> Sandra: “Before (therapy) I've been very reluctant to talk about feelings or I struggled to understand how to express my feelings (…) There was like stillness in my life, it became stagnant (…). I did have low mood and a lot of down spells. And it was my partner who was really keen on going. I think I'd got to the point where I was open to trying new things and learning to be comfortable with who I was as a person. Therapy seemed to be the next option to try”.

The mood and relationship difficulties presented in the participants’ narratives were seen as inter-related inclusive and not evidently differentiated. Moreover, Sandra, Zoe, Daniel and Paul utilised the word “we” to describe their experience of these difficulties as a couple.

> Paul: “We started in a moment where I think both of us were quite depressed with very low mood. We needed this therapy (…) We opened this because we talked with a couple of friends and they had an experience in that place. We started because of the lack of communication, which at some point was unbearable”.

Other participants described vividly the emotional processes that occurred as a couple in relation to low mood. They also provided examples of how they responded individually to their partner’s difficulties. The account below illustrates the intertwined nature between relationship difficulties and depression.

> Zoe: “I think we both did (experience depression) and for my husband it was significant (…) We entered into therapy because he had a real crisis in his life about life itself, the future, and everything. He was also drinking a lot. There was a lot going on for him, a lot of things he was unhappy with and he just entered into his own therapy and then couple counselling came after. Yes, he'd already been in individual therapy for quite some time (…) I think we always felt that the two of us have something very special and that somehow we were sabotaging it, kind of being our own saboteurs or whatever, and we couldn't understand why it was happening or my husband was in a lot of pain and upset at the time. I felt for all sorts of reasons that I wasn't reaching out to him enough and helping him. I was experiencing unhappiness as well because of the loss, because of him. I wasn't able to ask for help or say how unhappy I felt. We just weren't comforting each other”.

Expectations of couple therapy

This sub-theme emphasises participants' expectations of therapy that were related to addressing current individual and relationship concerns. Therapy was revealed to be in depth and more far reaching than expected. Paul expressed his expectations of therapy to "fix" difficulties with his partner and described it as a "process of growth".

> Paul: "I have never been in therapy before and my expectation was to understand better who we were as a couple (…) I think my partner had deleted all the good moments. I thought this was a mechanism to get rid of the relationship as quick as possible and I expected that therapy would have fixed this. But what I got was that I understood that we have very different points of view of life. Through therapy, I learned that I maybe was a bit naïve and it was a process of growth".

Sandra and Daniel expected therapy to be an opportunity to "understand myself" and to "learn more about our individual and joint behaviour". They explained that therapy had "exceeded their expectations".

> Sandra: "I actually wasn't sure what to expect. I went in with a good, positive, clear mind and I hoped that I would be able to be a better person for myself, to learn more about myself and understand why I was making these choices, why I was being the way that I was, and how that was contributing to my relationship. Actually, they completely surpassed what I went in there with and it was so much better".

> Daniel: "It was very important to learn more about our individual and joint behaviour and why we got ourselves into quite a bad place. As far as that, you know, that exceeded my expectations because I didn't really know that we would go back that far (…) Whereas actually being aware of negative bad behaviour, you know, that exceeded my expectation".

Emma explained that she wanted to have a better relationship with her partner but also was hoping for her partner "to go for himself and to see us more clearly".

> Emma: "I felt like I was taking Oscar to therapy because I've been in therapy for about ten years, so I was quite familiar with myself. I really wanted him to go for himself and to see us more clearly (…) I wanted us to have a better relationship".

Learning to share the therapeutic space

Previous experiences of individual therapy enabled participants to recognise the differences with couple therapy and to discuss their feelings when learning to share the therapeutic space. Most participants indicated that they attended individual therapy before starting couple therapy and they initiated a comparison. In the setup of therapy, a powerful element transpired by the nature of bringing a couple into a room with a third person, the therapist.

Zoe explained the difference with personal therapy, which was described as a place where she was able to express all her thoughts and feelings and it was defined as “your space and your time”. In comparison, participants highlighted the experience in couple therapy of “sharing the space”, which implied the difficulty, at times, to express whatever was going on in their mind. Therefore, having a therapist in the room enabled the couple to use the therapeutic space in a different way than in individual therapy.

> Zoe: “I'm just very aware of such a big difference between having your own therapy, where you can say whatever you want and you can use that hour to talk and talk or to do what you want, it is your space and your time. I think with a couple, you are very much aware, just as you are in your relationship, of having to listen to the other person, as well as talking, sharing the space and sharing time equally. Maybe sometimes you want to say something that you fear. If you say something that the other person might not like, you're having to look after yourself and you have to look after and be responsible for your other half as well”.

The idea of participants taking their partner and relationship into consideration during therapy was also highlighted in Sandra’s account.

> Sandra: “Facing facts and facing yourself in a solo therapy is hard enough. I think it's doubly difficult in couple therapy, because you have to face two aspects, yourself and another person and then how you work in a third aspect, your relationship”.

Emma explained that elements of individual therapy became apparent during the couple therapy. This difference led her to reflect on the space that she was sharing with her partner and considering herself as “you kind of are someone else in a way”.

> Emma: “Well, it's quite complicated because I haven't had couple therapy before, but I have had individual therapy and it's quite different. I found it quite challenging, I suppose, because it brought out different things from my individual therapy, right, because if you're with someone else, you kind of are someone else in a way, or a different element of you comes out”.

The narrative above echoes Daniel’s experience at the beginning of therapy, where he used the metaphor of him and his wife meeting the therapist at a “dinner party”. It emerges the idea of having to share a “side of the personality that wasn’t quite true” in order to “impress” the therapist.

> Daniel: “Well, I'd already had individual therapy before. Whereas this was obviously coupled and it was difficult to begin with because I kind of felt like we were meeting somebody at a dinner party or something, where I had to sort of impress and sort of perhaps bring across the side of my personality that wasn't quite true. I didn't allow myself to, you know, make the most of therapy”.

Theme 2: Sharing the space with a third person in the room allowed the process of listening to one another

This theme illustrates the participants’ experiences of the presence of “third person” delivering therapy, which is a distinct feature of couple therapy. All participants indicated that having “a third eye view” changed the relational dynamic within the couple during the course of therapy. The first sub-theme discusses “the therapist as a third eye”, and examines the process of the couple being joined by a third person in the room, which varied among participants at the beginning of therapy.

However, upon further reflection, all participants agreed that the presence of the therapist facilitated the expression of thoughts and feelings for the couple. Participants noted that the equal use of time in the therapeutic setting led to the second sub-theme “sharing the therapeutic space enables reciprocal listening”.

The therapist providing a third eye perspective

This sub-theme explores the experiences of having a "third eye perspective" or "third person" in the room, which was perceived differently by participants. There seemed to be different steps and processes that occurred in couple therapy. Firstly, the therapist became a "referee" who would observe the dynamic within the couple, mediate and become a safety net for discussions. The next step further comprised the role of the therapist becoming internalised in the partners' minds and enabling them to see the relationship from a "third eye view", which would lead to not needing the therapist in the room.

Moreover, this sub-theme discusses two distinct ontological understandings of the nature of the therapist being in the room. Most participants attended therapy with the assumption that the therapist would enable the couple to find better ways of communicating with each other, where the "neutral third eye" was the objective that they wanted to attain for themselves in the long term. Controversially, other participants addressed the dynamic of the therapist experiencing "their own stuff" and "the couple having their own agenda".

Paul and Sandra seemed to have had a positive experience from the beginning of experiencing this process and setting. Paul described the therapist as a "referee" that the couple had in front of them who facilitated the expression of "more objective meanings" rather than words that seemed emotionally "charged" within the home environment.

> Paul: "I remember the first feelings for me was like having kind of a referee in front of us because she was there, and we were able to talk about things that if we tried to discuss at home… words were filled up with many subjective meanings. Every word felt charged and so it was difficult… because at least with her in front of us, words had to be kept in more objective meaning".

Sandra discussed how the therapist was able to demonstrate a "third eye perspective" on her relationship and she felt "safe". The couple were able to be honest with one another in the room. Interestingly, Sandra explained that she was able to "incorporate a third eye view" in the decisions that she makes on the relationship.

Sandra: “She connected with both of us in the way that we needed and then was able to actually put the third eye perspective into our relationship and make us connect with that third eye (…) I absolutely felt heard in the therapy room, and my partner did as well (…) Once we connected with our therapist we felt comfortable and safe. It became really easy to talk to her, really easy. We were able to be honest with each other about our own feelings (…) It was a third eye view, and I was making sure that decisions that I make incorporate a third eye view and this impacted our relationship”.

Emma, Zoe and Daniel took some time to adjust to the process of the third person in the room. Emma explained that she spoke to her partner differently and it took her a “long time to feel comfortable enough” to be able to open up in therapy. Emma also referred to “different things flying around” and “different agendas” that partners would bring into therapy. Emma also seemed to imply that the therapist would have “her own stuff” when meeting with the couple.

Emma: “It's very complicated because having three people there...I mean, it's a different way of talking to your partner, so you are not as you really are at home. I think that probably takes quite a long time to unpick and feel comfortable enough. There's just so much different things flying around (…) It is really complicated because you have your own stuff and two other people that have got two different agendas usually because otherwise why would they be in therapy? (…) It takes longer and there are two of you and hear each person and to really work out what's going on. It's not so obvious or direct as when it's just one person with the therapist”.

Daniel also explained that this process was “difficult at first”, but then the “calm voice” of the third person would “add structure” and was also able to “mediate”.

Daniel: “I think (the third person in the room) was very difficult at first, but then it became very helpful in that there was someone to add some structure. It was good that somebody was overseeing the conversation. Sometimes if it got heated, then she would be the calm voice. She would be calm and also sort of mediate”.

Zoe noted that the dynamic between three people is different from two, and the couple found this “tricky” at times. Zoe highlighted that once the couple felt “safe” with the therapist, they used the space as a “safety net” because they could address their difficulties during the week

and experience a sense of "vulnerability" in the room and continue with the conversation following the session.

> Zoe: "The dynamic is very different between three people and between two people. I sometimes struggled as much as I found the therapy really beneficial (…) We sometimes thought that the dynamic of three was a little bit tricky (…) We became very aware that it was safe... I know my husband feared that it had become a bit of a safety net…that third person we could go to and say: 'This is what happened (…) We ended up shouting at each other and then we ended up getting upset. And feel that we've taken five steps back'. But we always knew that we had her at the end of the week to take these things to".

Sharing the therapeutic space enables reciprocal listening

This sub-theme explores how the therapeutic setting and the presence of the therapist observing acted as a catalyst for change in the couple. All participants agreed that this process enabled the possibility of sharing time and reciprocally listening to their partners. Following the initial "tricky" feelings of being three individuals in the therapy room, Zoe highlighted that she wanted to "listen to her husband" and the therapist presence allowed the process of being "vulnerable" with him. Both Zoe and Paul described that feelings of anger would have "exploded" outside of the therapy room, whilst during the sessions they felt that they were able to listen to their partners in a "respectful" way.

> Zoe: "We were very respectful to each other…I wanted to listen to my husband. There were a lot of tears, honesty and a lot of things said that maybe if it was just the two of us, the temper would have frayed and anger would have been different but somehow with the three of us, this vulnerability was OK to be with".

> Paul: "There was a difference between talking about an issue at home and there (during the sessions). We tried to listen more respectfully, but I think it was because the therapist was there. At home anything could lead to an explosion or an uncomfortable conversation. In order to avoid that, we didn't continue because it was a kind of conversation that didn't lead to anything. When we wanted to talk about something, we discussed it in therapy".

Following the three-person dynamic in the room being managed, all participants reflected that therapy was an important place to communicate with their partners. Emma, Paul and Sandra utilised the same expression “therapy was a place where we could talk”. Moreover, all participants highlighted that they were able to share the therapeutic space equally with their partner, which seemed to have been an issue previously in their relationships.

> Zoe: “I think sharing the space with another person, not wanting to take over, giving them their space to talk sometimes…maybe the sessions went more towards him or more weighted towards me”.

> Daniel: “I think the fact that the therapist was there meant that we both had our fair share of time within the hour that we were with her. We pretty much always felt that we had equal time to talk (…) I don't think without a therapist, the time would have been shared as well”.

This sense of “equal time” that each partner could use to express their feelings, seemed to have brought a space where partners could listen to one another. Zoe reflected that she struggled initially with the third person because she had to “learn to listen and not jump in all the time”. Daniel also re-evaluated the aspect of having the therapist in the room, which he described as “difficult at first” or “alien to us at first”, but then led the couple to be aware that “somebody was observing”, “mediating” and “understanding perspective of the other”.

> Zoe: “It was a space where my husband felt safe to talk without being interrupted, without me shouting, without me losing my temper and things like that, which I think he felt I did normally. Within the therapy space, I think he really valued that ‘third person' being there to listen to him and encourage me to listen without interrupting. I think I struggled with the dynamic of three a little bit more because maybe I had to learn to listen and not jump in all the time”.

> Daniel: “For years of being together we've never had anyone sort of mediating during one of our discussions (...) They have witnessed it but never done anything to calm it or anything. It was very alien to us at first to have that third person. But it worked out well because we became aware that somebody was observing. It allowed us to understand each other's point of view from their perspective”.

Theme 3: Fostering connections between the couple and the therapist

Through the relationships formed with the therapist, there were three distinct active ingredients that fostered a sense of connection with the couple. Firstly, emphasis was placed on the therapist's ability to recognise their individual needs and personalities. Secondly, empathy was seen as an important therapeutic feature in connecting with the couple. Thirdly, therapist neutrality and impartiality was perceived as a crucial feature of couple therapy. Moreover, participants deemed important the discussion of the relational dynamics by "reflecting what happened outside of the room within the room", when the couple was encouraged to return to the present moment.

Understanding each of us

The first active ingredient of connecting with the couple, was the therapist's ability to appreciate them as individuals rather than as an entity. Accordingly, all participants highlighted that the therapist capacity to "understand each of us" was an important therapeutic process.

Participants differ in their views on the length of the process of being seen as an individual, where individual factors and personalities might have contributed towards the sense of connection with the therapist. Daniel noted that "gaining his trust" was an emotional process that took place before he could perceive some positive results in connecting with the therapist and his emotions. After a couple of sessions, Sandra was already looking forward to the sessions where she felt that the therapist was "understanding each of us and how we work as separate people". Zoe also emphasised in her narrative that the therapist was "quite receptive" and understood her and her husband's needs.

> Daniel: "I started to see some positive results once the therapist started to gain my trust (…) I think she handled things very professionally".

> Sandra: "I feel like she actually bothered to learn who we were as people to help improve our relationship (…) The therapist was incredible in understanding each of us and how we work as separate people. She understood how to try and communicate with us in order for

us to communicate better in our relationship. After a couple of sessions, I actually enjoyed going and was looking forward to it".

> Zoe: "I found the therapist quite receptive. I thought she brought up issues over our time together...I think our relationship definitely grew and grew. I think she started to understand what my husband's needs and mine were, what we were lacking, where it was going wrong".

Emma had a different experience and explained that the process of understanding the couple took a "really long time". This alludes to how Emma experienced the therapist as struggling to understand the individuals in the couple as separate beings. Emma added that they were "sort of functioning" as a couple, which might have hindered the process of the third person from getting to know the individual as a separate entity.

> Emma: "I felt for the therapist because she was really well-intentioned and she really wanted to understand. But it just took her a really long time (…) It took a very long time to realise that because as a couple we were sort of functioning, but there were aspects of us that weren't operating at all and have been before… I think it just took a long time for her to understand that perhaps".

Therapist empathy helps to foster connection with the couple

This sub-theme explores the importance of empathy in encouraging a sense of connection with the couple. Paul explained that he experienced the therapist as empathic also through the "expression of the face or even the body language". The therapist was able to formulate "small questions" that made him feel comfortable to discuss his difficulties.

> Paul: "Therapy helped us because I remember at the beginning the good thing I felt was having a therapist like X, because we started with our first interview to evaluate the needs and she was really quick in understanding and connecting with us (…) It is a feeling of having someone in front of you that feels the empathy and the therapist was sometimes asking small questions…. She saw how we were feeling sometimes physically in the expression of the face or even the body language...A kind of empathy that makes you feel comfortable to talk about the most important thing in that moment".

Sandra also experienced the therapist as "calm, understanding and sympathetic" and highlighted that she understood how to connect with the couple "using a colloquial language to get you to respond better".

> Sandra: "I feel that because she was so cool, calm, understanding and sympathetic, she actually really got to know each of us individually during the sessions. So, by week four, she knew exactly how to talk to us not in a friend's capacity, but you know how your best friends are able to…they use your nicknames or they use a colloquial language to get you to respond better. My partner and I are very different in that aspect (…) I feel like she invested in us".

Therapist neutrality enables the process of bringing us to the present moment

Neutrality was a crucial feature of establishing a connection with the therapist and addressing difficulties in the couple's relationship. The therapist was described as neutral, because they did not disclose any personal information, and the couple was unable to ascertain if they were identifying more with one or the other. Accordingly, Zoe appreciated the therapist's neutrality and felt she was "not taking sides" or "pointing out faults".

> Zoe: "The therapist was incredibly calm and... There was no taking sides. There was no pointing out faults in me or pointing out faults in my husband. She was always very neutral (…) I quite like that distance, I didn't want to know anything about my therapist, I didn't want to know whether she was married or single or had children, I love the neutrality, that relationship. I think sometimes my husband was more curious about what sort of person she was. I quite like her being completely neutral and you know nothing about her".

Emma explained in her account the process of the therapist "drawing the couple back to the room". Similar to Zoe's account, Emma explained that the therapist was not encouraging the couple to point out each other's faults but tried to "slow things down" to facilitate understanding of the couple's dynamics by "reflecting what happened outside of the room within the room".

> Emma: "I think that the therapist often drew us back to the room. She didn't like us saying 'Oh, this is wrong with you'. She would be much more interested or at least try to get us to be more interested in the dynamic of what was happening now so she would try to slow us

down a little bit and say: 'I noticed that when you said that this happened to Oscar, this happened to Emma', and she responded like this. She was trying to reflect on what happened outside of the room, within the room, and comment on it. Yeah, not so much about blaming each other or getting into the sort of situations that we usually do which don't get anywhere. It was really about seeing it, stopping it and then reflecting on it. I can see why that would be a valid method, if you're analysing and slowing down how your dynamics work".

Emma expanded her narrative regarding the process of bringing the couple back to the present moment. The following account describes the mechanism of 'projection', which is a distinctive feature of psychodynamic couple therapy.

> Emma: "The therapist listens, watches and then reflects back and maybe picks up on one word or something as a metaphor for what happened. The therapist would try to make us think about how our responses have triggered something which was maybe quite familiar to the other person and maybe might have responded much more to their inner world. I guess she was trying to get us to see what we projected to each other and to withdraw the projection, sort of to make us recognise that that's how we operate".

Theme 4: Couple dynamics played out and re-enacted in the room enabled repair in the therapist-client relationship

Given the triangular setting of couple therapy, where the couples were joined by a therapist, couple dynamics were played out or re-enacted in therapy. Zoe and Emma explained that on one or several occasions, the couple's dynamics were "played out" in the therapy room. For both Zoe and Emma, it was a positive aspect that the therapist was able to "see the dynamic for herself". In Zoe's case, the couple continued an argument that started prior to the session.

> Zoe: "Looking back, most of our sessions were very calm, almost polite. There was sometimes a worry when I was in couple therapy that we were both being too polite. I don't know whether our therapist had that thought herself, I don't know, but then there was one session where we had a row on the way there, and then that row carried on in the therapy room. So, there was one session that was very different to the rest. I think there was certainly on my husband's side a real sense of shame that there was somebody else to witness our row, or his anger or my anger, I think he is very private and didn't like it. It was a little

element of that going on with me as well. But I think it was a good thing. It was a good thing that the row actually happened in the session so the therapist would have seen the dynamic for herself".

Due to the triadic nature of couple therapy, a participant struggled to make her voice heard due to a previous traumatic experience where she would allow others to lead conversations. Emma explained that during the therapy sessions, she felt "quite dominated by her partner", due to her family history where there were "strong personalities". Emma explained that she would not be able to "stand up for herself" and these difficulties were "played out in therapy".

> Emma: I felt quite dominated by my partner at times, and he could be quite aggressive and loses his temper a lot. I had a mum who was really strong-willed and shouted a lot (…) I had a grandmother who was quite famous and both were really strong personalities and my dad was as well (…) So that dynamic was going on. Then within the therapy, he (partner) was also really articulate and lovely and could sell himself in a very normal way. Typical, which is quite different from how he is when living with him, you know, how he is internally because he has a lot of violent thoughts which he kept to himself when he was younger (…) I suppose in a larger group, I tend to withdraw in that way and sort of let other people go with it (…). I found a way to kind of get through it by not standing up for myself with that kind of thing. So that dynamic played out in therapy".

Emma described that at the beginning, the therapist was not able to "see these aggressive things" that were occurring within the couple dynamics. This left Emma feeling that the therapist was quite "aligned to him", where at times she did not feel that "she was taken care of". However, once her partner Oscar started "acting out" because Emma was able to "stand up for herself", it seems that there was a repair process that occurred between the therapist and Emma. It seemed important to Emma that the therapist could "realise how difficult it had been for her" and that "she could see her experience more clearly", in order for this repair process to take place.

> Emma: "At the beginning, (those issues) didn't come out and I kept saying all these really aggressive things, and the therapist kept saying: 'I don't really see it!'. Once I just went a bit crazy and actually just stood up for myself (…) Oscar got very cross and there were times where he walked out of therapy and shouted loudly. It was just odd because I felt that

she was quite aligned to him in a way (…). I think right at the end, she really realised how difficult it had been for me and how he really wasn't there emotionally for me, because he is so articulate and can talk about emotions (…) He started to be much more animated, and it was when she experienced how it is for me at home in the room with her, that she could see it (…) She could definitely see my experience more clearly once he started acting out, because I became more expressive, I got much more confident and much more assertive, I suppose, and then he became much more volatile because I wasn't like... It was always about me being silent, passive-aggressive and oh, this is what you do".

In both scenarios, the couple dynamic played out in a continuation of an argument or in the re-enactment of feeling dominated by stronger voices followed by a rebellion within the therapy room. This led to the therapist witnessing the difficulties the couple was encountering. As a consequence, these situations enabled an improvement in the relationship between the therapist and both partners.

Theme 5: Exploring the past enabled new perspectives and communication

All participants noted that throughout couple therapy, there have been conversations on their upbringing, family dynamics and attachment. The first sub-theme illustrates the individual experiences of understanding the couple dynamics in relation to individual past experiences. For most participants the therapeutic process of revisiting the experiences of their parents' relationship and being parented enabled the "process of acquiring new perspectives and improving communication", which is illustrated in the second sub-theme. However, creating connections with the past in order to understand current emotions and couple dynamics was not entirely satisfactory for all participants. Two participants explained that they would have preferred some practical skills or guidance on how to tackle couple difficulties, whilst two other participants were satisfied with the resources that they had received and were able to reflect on them during therapy. These narratives are described in the third sub-theme "quest for practical help and tools to build on future behaviour".

Making links with the past enabled the process of understanding the couple

This sub-theme emphasises the importance of understanding the couple's current dynamics by creating links with past individual experiences. All participants highlighted that understanding

of the past enabled them to understand their current behaviour as an individual and dysfunctional areas as a couple. Daniel explained this process in his account:

> Daniel: "I think it made us look at our behaviour and where that comes from. Sort of learned behaviour perhaps from how our parents behaved or what we want from a relationship (…) It was our upbringing and our parents and various aspects like that. But also, the things that happened, such as how we dealt with bereavement, how we dealt with tough situations, how there's always been some sort of blame game or a way of working through together. It was sort of looking at the distant past and further back".

Zoe explained that therapy brought up "dysfunctional areas of a relationship" where she reflected that the repetition of unproductive habits would remind her how her "mother might have reacted".

> Zoe: "There were issues that were brought up for both of us, a slightly dysfunctional area of a relationship or the marriage where one person or couple keeps falling into the habit of doing certain things. For me certainly brought aspects that I thought: 'Oh, no! This is everything that I didn't want the marriage to be about or this is what my mother was like and I don't want to be like my mother'. So, there was a lot of issues that were brought up for me repeating certain things like how my mother might have reacted or how my mother would have been".

Sandra explained that she became aware of how all previous experiences had an impact on her current life, which was a novelty for her.

> Sandra: "We talked about different things, you know, past experiences that had affected us, parental relationships, family relationships, work relationships and how they were impacting our lives. All past experiences were affecting the way that we were and to actually realise that…"

Paul explained that he found the process of understanding his past very important as he learned about the family experiences of war, which allowed him to develop some "references"

> Paul: "There were plenty of conversations on the members in our respective families that experienced the war. It was very interesting to talk about these things because I was also making connections with my own family and understanding behaviours, inherited or learned. What I learned is that we grow with a limited quantity of references and I found this process very interesting".

Emma explained that she felt that her partner benefitted from making the links with the past, which shed light on difficulties during his upbringing. Emma noted that even though they have spoken about this before, "hearing it from that outsider was really important and stimulating for him". Emma felt that this process "empowered him".

> Emma: "My partner definitely found it really helpful in a lot of ways because he hasn't been in therapy before. There were quite a lot of things that we noticed about my behaviour related to his parents and that kind of thing. It also brought up about how his upbringing and the difficulties which he had really thought about before because we had talked about it. But hearing it from an outsider was really important and stimulating for him. So, from that point of view, it was really good. He says that it was really helpful to empower him and that kind of thing and recognise stuff (…)".

Daniel and Sandra explained that in the therapeutic process of "drawing that back to past behaviour" helped understand their current behaviour and at times the sessions seemed to focus on "one aspect", which provided them with a place to reflect on their difficulties.

> Daniel: "If we had finished a particular subject the previous week, she would start the new week with the floor sort of being open, and asking us about our week. Sometimes we used to feel that would backfire because then we would spend a lot of the session talking about just one aspect as opposed to the bigger picture that was the entire relationship….But, you know, it was just about one aspect or one particular disagreement during the week, then, she would often find a way of drawing that back to past behaviour and sort of putting a mirror up to current behaviour and seeing the patterns".

Sandra also explained that, even though the couple would attend the session with one topic in mind, "another issue would come up", which would provide them with insights of how current psychological difficulties were connected to others.

Sandra: “My partner didn't come in exactly the same way, but it definitely did make her realise certain things and opened her eyes to different aspects of us. I went in every week thinking: ‘Oh, I'll discuss this, like this is our week, I'll discuss this’. And that other issue would come up. I felt a bit blindsided. ‘Oh, I didn't realise actually we needed to talk about that. I didn't realise that that was actually connected to this. This is how and why I've been feeling this way”.

The link with the past was an important feature of therapy for Emma and her partner Oscar but then “it got lost in my family stuff”. The dynamic was occurring at home because Emma felt “unavailable to Oscar because I was looking after the kids and grieving”. The same process was played out in therapy, which was “consumed” by Emma’s experiences of trauma rather than spending time understanding what was “underneath” the difficulties in the relationship.

Emma: “I think it was really important for him to reflect on how I am, how his parents are and his distant things (…) I don't think it got quiet but it got lost in all my family stuff. I think it reflected what had been going on. So, it was like, 'acting out' because that is what happened and then that played out in the therapy. All the trauma consumed the therapy and Oscar, rather than kind of getting to what was underneath it. What was underneath me and Oscar before all that happened, which was fragile as well”.

Process of acquiring new perspectives and improving communication

Creating links with the past has been a beneficial experience for all participants and offered them new perspectives and enabled the process of improving communication. Paul explained how the exploration and understanding of attachment difficulties experienced by the couple’s families during the war opened up new perspectives and made him aware of the importance of taking these into account in his relationship with his daughter.

Paul: “The therapist told me that it takes three generations to overcome war issues. I realised about this even with my father, because (during the war) he did not belong to the ‘right side’ that didn't have an easy way to overcome this and to live in this society (…) They were living as refugees abroad and this was all his youth (…) So when I was asking him, did you talk about it with your friends? How could you have avoided that? He said that: ‘We just

avoided it'. So they never talked and I never felt a sense of anger from him towards the people who won the war and who ruled the country for many years. This therapy, let me also see this much bigger picture (…) But even in my ex-partner, the war in [city in Europe] where her mother comes from, the following behaviour was that they were able to overcome the attachment that was created with her grandmother, with her mother and with her mum. I want to say that is all related. And then what? It is inherited at the end. I'm sure a lot of these kind of unsolved conflicts or behaviours are transmitted somehow. I try to be conscious of it. As a father, I do my best in using my understanding on these attachment patterns".

Zoe explained the process of revisiting her past and her early experiences of being "mothered" made her realise that she wanted to be different for her husband and her children.

> Zoe: "The way that I was parented and I was mothered was a part of couple counselling. A lot of the focus was also on how we operated as a family. So sometimes, you know, the way we were parented as children and then responded as a mother and father was also very relevant in our couples counselling. Obviously, that also brought up issues with the way my mother mothered me (…) So there were difficult times where I realised that I didn't want to be that mother or I didn't want to be that type of wife".

Sandra felt that the connections that were created with the past allowed her to have a more "positive outlook" rather than feeling that "everything has been pre-programmed". This process allowed her to make some steps in improving her relationship with her partner, work, family and friends.

> Sandra: "Through the connections that I made, I realised that I could try to move on to a more positive outlook and actually taking a step back and being introspective about why I am the way I am and how I am the way I am and everything that's been so pre-programmed (…) And if I'm doing that in my relationship, how also can I impact my job, my family, outside of that my friends".

Daniel seems to have a similar perspective in his reflections on how his individual responses in his relationships was characterised by previous memories about how his parents might have behaved.

> Daniel: “I think it made us look at our behaviour and where that comes from. You know, sort of learned behaviour perhaps from how our parents behaved or what we want from a relationship (…). I think perhaps how individually we learn to deal with situations, arguments or tense moments or stress. You know, my wife did it in a certain way she had learned and I did it in a way that I'd learned”.

For Sandra, hearing the different past experiences of her partner made her appreciate “where she was coming from” and allowed her to “take a massive step back” to understand her partner better, which enabled the process of gaining new perspectives.

For Zoe, Sandra and Daniel, the therapeutic process in couple therapy of hearing the other person’s perspective, improved their communication. In Zoe’s case, this also led her and her husband to find time for one another:

> Zoe: “Definitely there was a shift (in communication) as soon as we started couples counselling because some time ago, we would have a row in the week. Instead of it escalating, one of us would be able to say that: ‘Let's continue this on the Friday with the therapist’ (…) I think one thing that came up to me and my husband is that we regularly kept that day free for ourselves so we could go out and talk outside of the house, because I think we both realised that talking in the house is different to actually going out (…) It got us thinking that going for a coffee together, just sitting there, really talking is something so important because we've always prided ourselves on our communication and then we realised that communication was actually letting us down”.

Practical tools and help to build on current and future behaviour

This sub-theme emphasises that the process of creating links with the past was meaningful and that practical tools were required. Participants seemed to have different opinions on this issue as some perceived fostering self-reflective skills as a practical tool, and others wanted to receive guidance. Some participants, including Sandra, explained that the therapist has provided them with material that they have utilised during therapy and fostered their self-reflective skills.

> Sandra: "We were always given advice or a book to read or a study that was recommended. Just because of the sort of learner that I am, we would go back and look at things. We would talk about things that came up, how to correctly identify issues in our relationship and then communicate those issues (…) The time between sessions gave me time to relax for a little while and then to reboot myself through the week, because then I could judge myself week to week: 'Have I listened? Have I learned? Have I been a better person? Have I been more open? Have I been more honest? Have I tried harder? Have I listened to what's been going on? Have I listened to what's being put in front of me?".

Other participants noted that therapy had not provided them with sufficient tools that would enable future change in the couple's dynamics. Daniel and Emma highlighted that understanding patterns in the past was a helpful experience but the lack of "guidance" and "practical measures" seemed to have led to a disappointment. Daniel explained that following the exploration of the past, the couple experienced a sense of "how can we go forward?".

> Daniel: "There was sometimes a feeling between my wife and I that she (the therapist) didn't really look for a lot of solutions, sort of plans of how to move forward, it was more exploring the past (…) To have that made quite clear to us, you know, was very beneficial, and that was the positive aspect to that. I suppose it's just we were sort of also looking to say: "OK, well, we've learned that now. What can we do going forward? Putting the tools in place to actually build on future behaviour as opposed to just having an understanding of past behaviour (…)".

Emma highlighted that if the therapist noticed some relational patterns within the couple, they would have found it beneficial to receive some "guidance" and "instructions" on practical skills to facilitate communication.

> Emma: "There wasn't much practical stuff about how we should be together, so I found it...I would have liked that more than in my own individual therapy. I would have found it easier if we had a little bit of guidance somehow on how...Just a little bit, because if she (therapist) could see patterns then I think it would have been quite helpful, especially for Oscar. I think he would have responded if he'd been given a little bit of instruction on how we might say,

> listen, if one person does something and then they have this automatic response, which she (the therapist) sees in the therapy to think about that …”

Theme 6: Endings: facing the future without a safe space

This theme examines the sense of loss and the fear of the future along with feelings of courage to go forward together at the end of therapy. Paul and Emma expressed feelings of sadness about the end of therapy because it was a place where difficult conversations have taken place, which is described in the first sub-theme: “sadness about the loss of a safe space to have difficult conversations”. The second sub-theme illustrates the feelings of separating and departing from the therapist when participants felt that they could work on their relationship and the difficulty arising “just between the two of us”.

Sadness about the loss of a safe space to have difficult conversations

This sub-theme explores the couple’s sadness over losing a space for them to discuss their difficulties, which also reflects the sense of mourning for the breakdown of the relationship. Paul described his feelings of sadness about the therapy ending because it was a ‘safe space to have conversations’.

> Paul: “I found the end of therapy a bit sad. It was so comfortable for me, so positive that I would have liked to continue. I think if I was still living in London, I probably would have liked to continue (…) I think my partner and I are still so different, we still are not able to talk properly, as I would like to. The therapy space was a safe space for these conversations”.

Emma explained that she has been advised by the therapist to continue attending further sessions. Emma and her partner were separating at the time of interview and Emma felt that it would have been important for Oscar to experience certain feelings in therapy “to move on properly”.

> Emma: “The reason why the therapist wanted us to have more sessions was that she wanted Oscar to see or to feel some sadness and regret…because in order to move on properly, for us to have any relationship that is going to function even if we're separated, he had to have

those feelings and he never actually got to that stage. He was just talking about how he felt guilty for the kids, how he was really relieved and also, he was definitely very angry. He didn't really acknowledge that, but he said he didn't feel sad and he didn't feel all the things that I would have liked him to feel, for whatever reason he didn't. The end session was a bit disappointing from the therapist's point of view and Oscar, I don't think even noticed. Just the last look of the therapist's face when I left the room was…I feel she just really felt for me…"

We are ready to face our relationship and depression just between the two of us

The process of separation from the therapist was an important step where from a triadic relationship, the couple was back to their usual sense of intimacy. Daniel and Zoe noticed that the therapist was hoping to continue with therapy with them. They highlighted that they felt ready to end therapy, whilst the therapist did not seem to be of the same opinion.

> Daniel: "We found the therapy ending a little bit difficult because my wife and I really wanted it to lead to a sort of a closure. We felt that we had gained a lot and we were ready to put into practice what we learned (…) We had to work out together what we needed to do and the behaviours that we needed to avoid. So, we were quite keen to do that, but we felt that we weren't being sort of led to that endpoint and we were made to feel that we weren't ready yet to finish when we felt we were. Yeah, slightly awkward. It created a slight atmosphere of 'us vs. 'her'."

> Zoe: "I think definitely she was very disappointed when we finished. When we said: 'Right, that's enough', she advised us not to. I think she thought it was too premature. …we felt that, and I think my husband felt that made sense, and we were ready to just sort face our relationship, the world together, and deal with problems that came just the two of us".

Both Zoe and Sandra expressed their feelings of being welcomed back by the therapist where there would not be a "sense of shame or failure" and "the door was open". Sandra explained that the response from the therapist was 'warm' and 'reassuring'. These responses seemed to have encouraged Sandra to use her 'renewed energy' for her wellbeing and for the relationship with her partner.

Zoe: "We kinda thought, if we get into difficulties again, we knew there would be no sense of shame or failure if we had contacted our therapist and said: 'Oh, we're back. We really need some more help"

Sandra: "We actually left quite abruptly because financially it became not viable for us. I found a new job that was less money, it was less days per week, so much less stress. Actually, leaving therapy and knowing, from the therapist, that we could go back if we need it. It was there and that door was open still. It was really reassuring; is the way I'd put it".

Theme 7: Holding onto the learning from therapy and moving forward as a couple

This theme discusses the impact of therapy for the participants. The first sub-theme discusses the overall experiences of therapy. The second sub-theme concentrates on the individual outcomes in terms of depression, perspectives and connecting with emotions. Finally, the third sub-theme illustrates the impact of therapy, not only for the couple involved but also in the wider system and networks.

Looking back at the overall experience of couple therapy

Therapy has been an important experience individually and as a couple. Zoe described that the couple can still feel "the benefit of therapy"; Sandra highlighted that this experience allowed her to "look at my whole life a lot differently"; and Paul was pleased to have received "many inputs".

Zoe: It was a good experience overall (…) There have not really been many wobbles since, nothing major, certainly not where we were before. And yes, I think we still feel the benefits from therapy really".

Sandra: "Being in therapy helped me realise how to communicate my feelings better, to express my wants and needs emotionally much easier. It actually made not just an impact in my relationship but it made me look at my whole life a lot differently".

The same participants reported that the emotional changes that they have made through the course of therapy were noticed by others, including relatives.

> Zoe: "Yes, definitely others have noticed the changes. I would have said my sister in law, who I was very close to and probably knew all the reasons why we ended up in couples counselling, definitely noticed and felt really pleased that there were big changes".

> Daniel: "My wife noticed the changes (…) The children might have, but they didn't mention anything. Um, I think without realising they were probably relieved that there was less tension in the house. You know, we're quite private in that respect, but I think we've certainly noticed it amongst ourselves and that's the most important thing".

In contrast, Emma explained that the experience of couple therapy has not been "containing or helpful" but acknowledged that her partner might have provided a "completely different side".

> Emma: "I didn't feel that it was a containing or helpful experience actually. But Oscar does so it might be worth talking to him about it, because I'm sure you would get a completely different side".

Individual changes in mood, perspectives and connecting with emotions

Couple therapy has helped individuals considerably, not only in terms of mood difficulties but has also helped them in widening their life perspectives and choices. Due to the nature of low mood, when individuals may become closed off from others, couple therapy has led to improvements in emotional expression. Most participants explained that therapy has been crucial in helping with mood difficulties where their life became stagnant. Sandra highlighted that "therapy changed everything" and "it was showing in every aspect of my life". Sandra explained that considerable life changes have taken place including changing her job and physical appearance.

> Sandra: "My mood was different and I had a more positive outlook instead of just... It wasn't a negative outlook but there was no passion in my life. It was showing in every aspect of my life (…) All the small things, everybody started to notice the difference in me and was saying that I looked healthier and happier. I just was seen more joyful in my life by others

(…) Therapy changed everything. I changed my job because I realised, I was in a really unhappy and unhealthy environment. I needed to change the way I looked because I was unhappy in the inside and so I was presenting this to the outside. Actually, I started to do that and dress and have my hair the way I wanted to".

Paul explained that therapy has helped him feel more positive, and personality features that were not showing when he felt depressed were returning back to the surface. Paul has moved back to his country of origin and despite having to start his professional life back from scratch, he is "trying to open new doors" and he "has grown".

Paul: "I am much more positive to make new changes because I'm starting from zero and it seems that something could happen. I realised that my writing is much nicer now. I used to have a very good sense of humour and I thought for these years that I was becoming a boring person. I think I am getting back that sense of humour (…) It is not all about luck, you make that happen. I'm starting from scratch and I felt a very different mood and I always try to open a new door in my conversations in business and I think I've got these positive results so far (..) I feel that I have grown and I always feel that there is a link to this process of insight (through therapy)".

Therapy has also helped participants in changing their perspectives, connecting with emotions and expressing them to others. Sandra explained that therapy has helped her to realise that there were other "options and choices" available to her.

Sandra: "I felt my life was stagnant and that was sort of highlighted to me. Any anger or frustration I was having in my life, I realised that there were other options and choices I could make (…) It made me able to stand back and look at everything from a brand new perspective and actually go: 'You know what, I am going to make that change that I wanted to. I'm going to do this. I'm really unhappy in my job. I love my work colleagues, but I really dislike my job. So, I'm going to find a new job and put all my energy into that'. Without the therapy, I don't think I would have got there".

Sandra and Paul have also explained that therapy has helped them to connect with their emotions and to express their feelings to others and empathise with them.

Sandra: "I am not an emotional person. I'm learning and have been growing over the past couple of years to connect with my emotions better and to appreciate emotions in myself and other people and to respect them. This actually helped me find a place in myself where I could deal with everything that was being brought to me emotionally from outside of my relationship, but also inside my relationship and for myself (…) I used to think a while ago that: being open, being emotional, sharing your feelings with other people, didn't get you anywhere and was a sign of weakness. But I started to realise that actually reaching out to people for help was a sign of strength".

Paul: "I have changed because of these insights (from therapy). Before therapy, I didn't open myself so easily to anyone. I had very good friends, but a small quantity. It is not that now I have more friends, but I decided that it is a relief to talk about emotions (…) I make links with therapy and new insights and I focus a lot on these aspects. This is me, it's more from the perspective of someone looking from outside of me...But, I always felt that I was the kind of person who can empathise with people, but therapy brought this interior growth, I think I empathise in a deeper way".

Changes in communication and emotional expression with the partner and wider family and social dynamics

Therapy has been an important experience in terms of improving communication and emotional expression in the relationship and with others. Most participants highlighted that not only did communication become smoother with their partner and other members of their network, but they were also able to mentalise rather than project their fears towards others. Zoe explained that therapy has helped her to feel "more vulnerable and ask for help" and to be able to "listen more" to her partner.

Zoe: We went through a huge personal transformation and we did as a couple as well (…) I think the big thing that came up for me was needing to allow myself to be vulnerable and ask for help. It felt difficult to be vulnerable sometimes. I also really started to feel the need to listen more, not just angry, shouting and not listening. So listening was a big thing for me. (…) We spent a lot of time together and talked to each other. What we realised is that the talking wasn't necessarily always quality, which sometimes we were very aware of. Not always being honest enough with each other and talking about things that really mattered or

made us feel vulnerable or made us feel that we need to say: 'I need a bit of help here. I'm feeling very scared at the moment and I am feeling frightened or alone' or all those things that you should do. Maybe we realised that we were holding back a bit".

Daniel also explained that in the past the couple would "blame each other for not being supportive" or the "guilty one". Daniel explained that therapy has helped the couple to have a "continual form of communication" and allowing the emotional expression of the partner.

Daniel: "I think when I started, I certainly had a lot of anger and then that sort of subsided and eventually, we found calm and happiness. So, therapy was very successful in all. (…) And you know, the ability to discuss things that I had felt unable to discuss in a sort of adult fashion in the past (…) I think that we'd both been through quite a bereavement in the past seven years. I've got to the point where we were sort of almost blaming each other for not being supportive. We were looking to each other to be the guilty one, whereas now we sort of work through that, we can work together by communicating better (…) I think there was a lot of bottling things up and whereas now it's a continual form of communication and allowing each other to be, you know, allowing each other to be upset or down or angry and not taking it personally (…). Well, it is liberating really that it was ok to be upset".

Building on this dynamic within the relationship that Daniel described it to be "ok to be upset", Zoe explained that her husband was able to understand the feelings of anxiety and insecurity underneath the expressed anger.

Zoe: "I think then when a row started, seeing the other person as the enemy, somebody who has pushed your button and made you cry, I'm certain that my husband started looking at me and thinking: 'I hate my wife when she's shouting at me. I hate my wife when she's angry'. I think he was able to see that my anger was just a self-defence mechanism because I was frightened or scared, or suddenly felt terribly insecure in my relationship, and that was the way I handled it".

Zoe explained that improved communication with her partner had a positive impact on the rest of the family dynamics, including the relationship between father and son.

Zoe: “The awful rows that were happening at the beginning, which led us towards couple counselling, started to subside and that was a marked improvement when we were able to put our hands up and say: "There's something wrong, we need to address this". We both started to be more positive and feel gentler, kinder and more vulnerable towards each other. I think that fed into the family dynamic as well. I think our children definitely have benefited from it. When we were in couple therapy, my daughter was having a few of friendship issues at the time as well, and now she doesn't have any of those issues at all. She's now in a very positive place. I think my son is also in a very strong place, and I think he's definitely got a stronger relationship with the father because I think his father is in a much better, happier and in a more positive place. That certainly might have had an impact on my husband and his son”.

Sandra explained that therapy has been helpful not only in her relationship with her partners but also with others in her wider network. Sandra explained that the process of “taking a step back” and asking herself questions such as “What is going on with that person?” enabled her to feel more compassionate towards others, which indicates her ability to mentalise with others. She also highlighted that therapy helped her to communicate better with the rest of her extended family and that consequently “fostered more communication among other people as well”.

Similarly, Paul explained that therapy “unlocked the communication” and enabled the couple to understand their “new reality”.

Paul: “Therapy was a positive experience because it unlocked communication, we would go deeply in the conversation, we discovered and we confirmed through therapy that we were very different people in terms of aims and ways to look at life. I think through therapy we understood this concept of a new reality. It was a matter of time, conversations or words said, but absolutely it was therapy that unlocked this”.

Discussion

This chapter will provide an overview of the findings in relation to the study aims and the literature presented in the introduction. The critique of the methodology, including the study's strengths and limitations will also be presented, along with the clinical and research implications. Finally, this chapter will conclude with the researcher's self-reflexivity in relation to her learning.

Overview of the findings

This study aimed to explore the experiences of adults with psychological distress who received psychodynamic couple therapy. The four research questions sought to explore:

1. How do adults with depression experience potential changes in mood and emotional distress?
2. How do adults with depression experience their relationship with their partner?
3. How do adults with depression experience their children's behaviour or wellbeing?
4. How do adults with depression experience their relationship with the therapist?

A thematic analysis method from a phenomenological position was used and seven themes were identified that followed the participants' journey before, during, and after psychodynamic couple therapy. The experiences that characterised the participants' journey highlighted the intertwined dynamic between relationship difficulties and depression, where all participants did not specifically distinguish between one experience and the other. Participants expected therapy to address their individual and relationship concerns and found that it was more far-reaching than expected, particularly when they were able to internalise the therapist's third eye perspective. In comparison with individual therapy, a powerful element transpired by the method of situating the couple in a room with a third person, the therapist.

The third person became a referee who would mediate the communication within the couple and provide a different perspective, which enabled a safe environment for reciprocal listening. At times there were complex personal and couple dynamics that played out or were re-enacted in therapy, which enabled a repairing process in the relationship with the therapist when they were addressed.

A crucial aspect of couple therapy was the process of making links with the past, which enabled participants to understand their current behaviour as individual and dysfunctional areas as a couple. The process of creating connections with the past was meaningful for all participants, and some perceived fostering self-reflective skills as a practical tool, but others wanted to receive direct guidance.

Three main active ingredients facilitated the therapeutic process. Firstly, the therapist's ability to understand the couple as individuals rather than as a unified entity. Secondly, the therapist's capacity to empathise and connect with the couple. Thirdly, the therapist's neutrality, impartiality and ability to reflect on the couple's dynamics from outside, but within the clinic space by focusing on the present moment.

Towards the end of therapy, there were different feelings elicited in participants, including a sense of loss, fear for the future and feelings of courage to go forward together as a couple. At the end of therapy, most participants reflected that their overall therapy experience has been helpful and highlighted a positive impact in terms of their depression, perspectives and connecting with emotions, not only for the couple involved but also in the wider system.

Study findings in relation to literature and theories

Following the systematic review in the introduction chapter, this study found consistent positive and promising results on couple therapy's beneficial experiences for depression and relational difficulties. The systematic review was based on a quantitative research methodology that examined the effectiveness of different ideographic therapeutic modalities, whilst this study analysed and discussed the lived experiences of psychodynamic couple therapy. The themes that were indicated in the results chapter will be examined in relation to the literature and theories discussed in the introduction chapter.

Prior individual experiences brought into the room

Participants described how their experiences of depression were related to relationship difficulties, which led to an understanding of the intertwined nature of both experiences. These results are consistent with the existing literature, where two longitudinal studies found an

association between marital discord and depressive symptoms (Kouros et al., 2008; Whisman & Uebelacker, 2009). This is echoed in the study by Priestley et al. (2017), where 19 participants in a long-term relationship with a person with chronic depression described their experiences. The participants illustrated the overwhelming impact that depression poses on both partners, and the "couple disease" construct was coined. There was a considerable shift in the couple's dynamics that affected the participants' wellbeing, which led them to establish strategies to care for themselves and their partner, along with considerable frustrations and resentment.

This evidence leads to another result from this study when participants discussed their previous experiences of individual therapy spontaneously, which might have led to initial difficulties in engaging in the couple therapy approach. In the participants' accounts, their concerns transpired around sharing the space with their partner. This led to difficulties in expressing entirely their feelings, because they felt a sense of responsibility towards their partners who were experiencing depression. Other intra-psychic factors could have contributed to these initial concerns about starting couple therapy compared to individual therapy. Couple therapy theorists valued Carl Jung's work who stressed the importance of understanding individuals for their idiosyncratic nature. Carl Jung highlighted the importance of the process of individuation, which is seen as an important feature of the self, and is defined as:

> A unique combination, or gradual differentiation, of functions and faculties that in themselves are universal. Individuation is the expression of the collective by a unique individual (…) The aim of individuation is nothing less than to divest the self of the false wrappings of the persona on the one hand and of the suggestive power of primordial images on the other. (in Colman, 1993, p. 107)

Therefore, as discussed by participants, there might have been some resistance by showing a "persona", which was not their real self in front of the couple therapist. Participants felt that "they were someone else" in order to impress the therapist, which they might not have encountered in individual therapy. This persona, which derives from the Latin persona and its etymological meaning "theatrical mask", is in a conflictual and compensatory relationship with the "shadow". When individuals experience depression, there might be a tension between who they are and who they wish to be (Sharp, 1998).

According to Jung, due to the need for individuation, each person is considered to be in a "search for wholeness", leading to self-acceptance (Lyons & Mattieson, 1993). This process occurs when the individual is able to recognise and assimilate their shadow, which is "the thing a person has no wish to be", and if it is not owned, it may create an impoverishment of the personality and deprive the person of the ego strength to connect with others (Jung, 1959, p. 102). Therefore, the lack of acknowledgement of the shadow may lead individuals to project unwanted feelings to others. When feelings are contrary to the ego ideal, they are repressed so that the individual does not feel that they belong to them, and they are "split off" or projected to the partner (Balfour & Morgan, 2018; Klein, 1952; Scharff & Savege Scharff, 2014).

Similarly, in the study, participants explained that they were having arguments, blaming and not reaching out towards each other, and were stuck in their own unhappiness. Lyons and Mattieson (1993) explained how partners are in the greatest difficulty when they desperately need to feel contained by the other and do not acquire the ability to recognise the other's needs, which might leave them with the conundrum of "who is the baby?".

Barfour and Morgan (2018), who are couple therapists, proposed that, in a similar predicament, the couple struggles to understand that they are creating a relationship rather than seeing the partner "doing something to them". They described the importance of understanding the split part of the self, and that the process of "taking it back" into the personality may lead to the individual becoming more "whole" through the opportunity provided by the relationship.

This echoes Jung's definition of marriage or a committed romantic relationship as a "container". This dynamic parallels with Bion's idea of containment in the primary bond with caregivers, where unconscious communication is revealed in cycles of projective and introjective communication (Bion, 1962; Scharff & Savege Scharff, 2014). The raw feelings and impulses in the couple dynamics may re-evoke early years' feelings of love and hate towards the primary caregivers (Rosenthall, 2007). There is a considerable concern when both partners are lost in a maze of projections, where there is a threat of survival for the couple and individual, which Morgan (1995) refers to as a "projective gridlock".

As the child needs to be contained by being provided with a safe or "breathing" space, another parallel was made in the couple relationship where each partner can explore the world and return to the "emotional container" (Lyons & Mattieson, 1993). Jung (1934) explained that marriage may be used as an instrument of maturation and the development of a personal sense of wholeness. This is because each partner is in intimate contact with themselves and the other. Jung (1934) stated:

> Individuation has two principal aspects: in the first place it is an internal and subjective process of integration. In the second it is an equally indispensable process of objective relationship. Neither can exist without the other, although sometimes the one, and sometimes the other predominates. (p. 183).

Due to the intertwined dynamic between depression and relational difficulties, partners might have encountered difficulties in seeing their relationship as an "emotional container". Moreover, the object relations theories highlighted above are developmental and by definition relational, which conceptually lends them to a triadic approach to depression where the participants may make use of the figure of the therapist *holding* the couple.

From the participants' accounts, there seemed to be a quest to reciprocally feel separate from their partners, a sense of separateness, because of their intra-psychic need for a sense of individuation. This is consistent with the results from the study where participants expected couple therapy to be an experience where they would understand themselves and learn about their individual and joint inner world.

In the participants' accounts, there seemed to be an initial resistance towards couple therapy and a *phantasy* that they would be able to express themselves with individual therapy. Participants seemed concerned about the couple therapy approach, instead they wanted to impress the therapist and show a side of the personality, which was not "true". The Jungian perspective highlighted the importance of the persona, but there are two other theoretical viewpoints to be considered.

Firstly, this quest for authenticity may be due to participants wanting to show their "true self" in therapy, which might have been suppressed by the need for compliance, initially with the parent's demands, then later by partner and society. According to Winnicot (1960), therapists

can help untangle the false self from the true self when patients feel safe to be authentic through the process of regression.

Secondly, Irvin Goffman (1959) described the social rather than intra-psychic dynamics that occur for individuals using dramaturgical language in his book "The presentation of the self in everyday life". Goffman started the book by discussing the use of masks and theorised that individuals "perform" a part to impress others by playing different roles during social encounters. There are similarities with the theory proposed by Winnicot (1960), as Goffman explained that we all perform at the "front stage" and we hide parts of ourselves in the "backstage".

Sharing the space with a third person in the room allowed the process of listening to one another

All participants illustrated their feelings of experiencing the presence of the "third person" delivering therapy. Participants expressed their initial difficulties adjusting to the dynamics of having a third person in the room. These reflections are consistent with the psychodynamic literature on the triangular frame of couple therapy. The setting of couple therapy between three people is similar to the "oedipal setting" between the couple and the psychotherapist (Nyberg, 2018). Fisher (1993) explained that couples might experience "the anxieties of the triangle" where each individual is capable of being a separate entity in a relationship with the other. The anxieties are around being excluded from the couple or being a part of the couple who excludes the third person. The process of mastering these anxieties allows for psychological space to think about difficulties.

Accordingly, Balfour and Morgan (2018) explained that this triangular setting allows the process of witnessing the relationship difficulties being enacted by the couple and the therapist. The couple would experience the combinations of "being in" and "being out" at different points of therapy. This element of tolerating a triangular setting is crucial for couples who experience difficulties sharing a "psychic space". Moreover, witnessing the therapist tolerating this position can be vital for the couple because it can support their ability to observe oneself and reflect on the relationship. This echoes the seminal chapter by Britton (1989) on the setting of the "oedipal situation":

> It creates what I call a 'triangular space'—i.e.: a space bounded by the three persons of the oedipal situation and all their potential relationships. It includes, therefore, the possibility of being a participant in a relationship and observed by a third person as well as being an observer of a relationship between two people (…) The capacity to envisage a benign parental relationship influences the development of a space outside the self capable of being observed and thought about, which provides the basis for a belief in a secure and stable world. (p. 86)

In this study, the therapist *joining* the couple led to the participant experiencing "a third eye view" or a "referee" who facilitated the process of listening to one another. This dynamic is also consistent with previous psychodynamic literature. Balfour and Morgan (2018) explained that witnessing the therapist containing the triangular setting may lead each partner to become more interested in the other's experience and about the meaning of the relationship's dynamics. This process may lead to a "third position" where partners can observe and make sense of their experiences from different standpoints (Nyberg, 2018). Britton (1989) theorised this therapeutic process:

> A third position then comes into existence from which object relationships can be observed. Given this, we can also envisage being observed. This provides us with a capacity for seeing ourselves in interaction with others and for entertaining another point of view whilst retaining our own, for reflecting on ourselves whilst being ourselves. This is a capacity we hope to find in ourselves and in our patients in analysis. (p. 87).

Consequently, the study's participants highlighted the importance of the therapist facilitating a safe place where the couple's difficulties can be addressed. Participants experienced feelings of anger outside the therapy room but were able to start listening to one another with the therapist's presence. This process resonates with the writing by Colman (1993), who explained that couple therapists offer a "therapeutic container" for the safe expression of emotions, including love and hatred. Colman (1993) describes the therapist's role as one who facilitates the process of the couple being able to internalise the therapeutic containment into their relationship, in a similar way to how the infant internalises the mother's containing function. In this scenario, the relationship becomes both a container and contained.

Fostering connections between the couple and the therapist

Participants described different therapeutic ingredients that fostered a connection with the therapist. Firstly, participants emphasised the importance of the therapist's ability to recognise their individual needs and personalities. This is consistent with the literature proposed above on the need for individuation (Jung, 1938). Moreover, Joanna Rosenthall, a couple psychoanalyst, reflected on her clinical experience that couples attend therapy because they need support with their relationship dynamics and their "shared defences". However, service users express their need to develop separately as "an individual in their own right", which they might not have experienced in the past (Rosenthall, 2007). This dynamic echoes what Bion described as the need for service users "being known" in therapy. Bion (1962) and Fraiberg et al. (1975) referred to the process that initially occurs between infants and primary caregivers of being contained, and linked this with the psychoanalytical relationship between therapist and service user. According to Bion (1962), one member of the relationship is engaged in getting to know the other and the other to be known. However, the therapist-client dynamics can encounter a destructive process of "not understanding". Corresponding to what occurs when the mother is unable to *take in* the infant fears and metabolise them, which leaves the infant with a "nameless dread".

Secondly, participants explained that the therapist's neutrality and impartiality were perceived as a crucial feature of couple therapy. This is consistent with psychodynamic literature on the therapeutic setting. Temperley (1984) explained that neutrality is a vital feature of psychodynamic approaches because it facilitates an analysis of the patients' inner lives and their relationships with other people.

> We believe that the therapist will cloud and obscure the transference if he shares with the patient personal information or needs of his own. Questions about your family may arise from oedipal anxieties (…) The objective of the psychotherapeutic encounter is to identify the unconscious phantasies and object relations that characterise the patient's inner life and his relationships with other people. We attempt to identify and interpret these phantasies and object relations as they manifest themselves in the patient's way of relating to us in the transference. (p. 101)

The therapeutic skill of neutrality emerges from the metaphor proposed by Freud (1912) of the surgeon who needs to put aside his feelings in order to concentrate on the patient's mind. This view has been widely critiqued in the past two decades, within psychodynamic literature too, for being impossible to achieve and even detrimental to service users (Orenstein & Onerstein, 2003; Renik, 1996). A caricature of neutrality depicts the therapist as distant and even cold (Greenson, 1967). However, Gelso and Kanninen (2017) postulated that neutrality is an active ingredient in contact with the patient and does not imply that the therapist is indifferent or cold. They highlighted that neutrality allows the therapist to take an observer position and implies not taking sides with service users' inner or outer difficulties, which in turn encourages them to experience feelings at their pace rather than "gratifying" the therapist's needs.

Thirdly, participants described empathy as a crucial therapeutic feature in connecting with the couple. The active ingredient of empathy is consistent within the literature and has attained a prominent position in the psychodynamic processes (Orenstein & Onerstein, 2003). Empathy allows therapists to access the patients' inner world, and to some extent experience it, without getting lost in a panacea but instead by preserving their separate identity (Gelso & Kanninen, 2017). Kohut (1971) explained that it would be impossible for therapists to access another human being's complex inner world, without the ability to understand this "via vicarious introspection".

Nonetheless, empathy is also an important and beneficial quality used in other therapeutic models. Different meta-analyses comparing specific therapies found common factors that focus on processes, including empathy, in the client-therapist relationship (Brown, 2015). Accordingly, other notable common factors with other therapeutic models place importance on the therapeutic alliance between therapist and service users. Wampold (2015) cited a meta-analysis by Horvath et al. (2011), who examined nearly 200 studies involving over 14,000 patients. The researchers found that the aggregate correlation between therapeutic alliance and outcome was the equivalent to a Cohen's d of 0.57, exceeding the threshold for a medium sized effect (Horvath et al., 2011). Wampold (2001) analysed more than 200 articles of bona fide therapies in a meta-analysis and found that the difference in the treatments' effectiveness was minimal. It was concluded that psychotherapies are equally effective and a metaphorical parallel was created with the "Dodo bird verdict" from the book Alice in the Wonderland where "Everybody has won, and all must have prizes".

Couple dynamics played out and re-enacted in the room enabled repair in the therapist-client relationship

Participants explained that the couple's dynamics were "played out" in the therapy room on different occasions. The "triangular space" of couple therapy might cause anxieties if the individual had difficulties internalising the oedipal situation in childhood in a manageable manner. This would include the different possibilities of being a participant in the relationship, for example, with the father, observed by the mother, as well as being the observers of the relationship between the two other parties (Nyberg, 2018).

Sigmund Freud (1914), in the seminal article "Remembering, repeating and working through", spoke about the concept of "repetition compulsion". Freud explained that patients might not remember what they had repressed and forgotten, but they would "act it out" without being aware in therapy, which would become transference material for the therapist. Accordingly, Balfour and Morgan (2018) explained that it is common for service users in couple therapy to "enact" unconscious feelings on the relationship rather than discussing them. These *enactments* are positioned in a prominent place of analysis because they provide the therapist with material to understand how the couple functions at their deeper unconscious levels. Therefore, when the therapist witnesses and observes the couple's enactments with him/her and within the couple, they may make use of the feelings evoked through the transference to make sense of the relationship between the partners. This approach may help the couple shift the relationship from being dominated by the enactments of mental states to carefully thinking about them. Consequently, with the therapist's help, the couple may attain a different perspective where they can observe their dynamics and communicate about their difficulties, which may lead to internalising a couple state of mind.

Participants also felt that these complex dynamics were also re-enacted with the partners and the couple therapist. A participant of the study felt that she could not stand up for herself in therapy due to her experience in childhood of strong personalities. Accordingly, McDougall (1986), in her book "The theatres of the mind", echoes similar ideas to the ones of Goffman (1959), and cited the famous Shakespeare's quote "All the world is a stage", where each individual is conceptualised as living through roles, which are repetitive. McDougall (1986) used the theatre as a metaphor for service users' psychic realities and explained that "the analytic stage" entails both the childhood and adult selves to become familiarised. She

explained that individuals might externalise their inner conflicts or unresolved mental pain by choosing others to enact parts and decide to play other parts themselves in what she portrayed as a “transitional theatre”. Behind this considerable intra-psychic endeavour, there might be an attempt to: "try and make sense of what the small child of the past, who is still writing the scripts, found too confusing to understand" (McDougall, 1986, p. 65).

Correspondingly, Rosenthall (2012) explained that “partners in a couple unconsciously nudge and pressurise each other into re-enactments of their unconscious internal couple and as-yet unresolved oedipal dramas” (p. 157). Similarly, the couple therapist might be drawn into a re-enactment of a situation that belonged to one of the partner’s inner world, carried from childhood, where the oedipal situations were not resolved (Feldman, 1999).

In his article about enactments, Frayn (1996) explained that all psychotherapeutic models depend on the personality of the therapist, who may facilitate a therapeutic alliance with the service users. Frayn cited Alexander and French’s phrase that therapists may offer “corrective emotional experiences” where incidences, such as the ones described by the participants of this study, may lead to non-destructive enactments that can be worked through and thought about in therapy.

Exploring the past enabled new perspectives and communication

Throughout couple therapy, the participants explained that they discussed their individual family history and attachment style in relation to their current couple dynamics. Participants explained that they were concerned that their relationships’ dynamics were similar to their parents, where they would blame each other. These accounts are consistent with the couple therapy literature where Rosenthall (2012) explained that her patients would rebel to these unconscious repetitions and say: “I didn’t want to be like my parents, but that is exactly the way we are!” (p. 160). Rosenthall (2012) elucidated that there are two important elements of this scenario. On the one hand, service users encounter difficulties to describe circumstances, and on the other hand, they blame each other and cannot acknowledge that they might have contributed to the difficulties.

These reflections stemmed from the theory of Melanie Klein (1928), who revealed that individuals do not internalise their parents but projections and introjections influence the

representation of them in their inner world. The couple's relationship is unconsciously determined by their parents' representations and re-enacted in their internal and external object relationship (Ruszczynki, 1993). Nyberg (2018) refers to this process as the "internal parental couple" or "unconscious phantasy couple" that guides unconscious beliefs on the couple dynamics and an entity. These beliefs and this shared unconscious may be projected to the therapist in the transference (Sharff & Savage Scharff, 2014). In turn, the therapist focuses on the transference and assesses the couple's attachment style to construct a relational narrative with the couple (Rosenthall, 2012; Sharff & Savage Scharff, 2014).

The focus on attachment styles, which originates from psychodynamic tradition with Bowlby and Ainsworth's studies, inspired several therapeutic models, including systemic therapy (Johnson & Lebow, 2000). An assessment of attachment styles informs the therapist of the key processes that delineate the nature of intimate relationships. This process would lead the couple to a shared understanding of the origins of their difficulties, patterns and provide new perspectives.

Participants explained that the ability to understand where their individual difficulties stemmed from and hearing their partners' past experiences, enabled the couple to improve their communication within the couple dynamics. This echoes Hertzmann and Nyberg's (2018) reflections on the ability of partners to mentalise, which is characterised as the "curiosity of others' mental states, to 'read' one's own and others' psychic processes" (p. 133). When partners are able to mentalise, they can appreciate that the other is separate and different from them, which in turn would lead to the couple having healthier ways of relating. When the couple does not feel contained and is unable to mentalise, this would lead to paranoid-schizoid position of functioning, which Klein (1952) theorised when she spoke about the processes of projections and introjections when partners solely blame each other. Correspondingly, the ability to mentalise is a socio-cognitive skill that is first developed in the parent-child attachment relationship. An ample body of psychological literature supports the importance of mentalising, the ability to recognise thoughts and emotions in oneself and others, in relation to communication, the attainment of affect regulation skills and romantic attachment (Fonagy et al., 2002).

Consequently, some participants were pleased that couple therapy fostered their self-reflective skills, which they used to evaluate their learning and ability to communicate with their partner.

Other participants instead were hoping to receive guidance and practical skills to improve their communication with their partner. This is consistent with a qualitative study by Valkonen et al. (2012) that compared psychodynamic and solution-focused therapy experiences for depression. The authors concluded that individuals with a "life historical inner narrative" preferred long-term psychodynamic therapy, whilst the short-term solution focused therapy counterpart supported the progress of a "situational inner narrative". Accordingly, couple therapy for depression, a behavioural counterpart model, includes problem-solving and exercises, during the sessions and as homework, along with communication exercises (Thompson, 2018).

Endings: facing the future without a safe space

Some participants expressed a sense of loss and sadness about the end of therapy because it was where the couple's difficult conversations took place. This echoes the process of mourning, which Freud (1917) referred to as an involuntary withdrawal of object cathexis. The mourning process is defined as a concentration of "psychic energy", which makes the subjective introjection of the loss possible. On the one hand, participants might be experiencing mourning the loss of the analytic setting as a safe container where their inner world confines (Gray, 1994). On the other hand, there is a loss of the committed romantic relationship as a container (Jung, 1934). Shmueli (2018) provided the metaphor of the resilient eggshell that symbolises the couple relationship as a container that had fractured. Scharff and Savege Scharff (2014) explained that couple therapy aims for the loss of the relationship to be accepted and mourned.

Other participants expressed that the process of separation from the therapist was an important step when the couple returned to their usual sense of intimacy, by leaving a triadic relationship. Two important processes were occurring for participants. On the one hand, participants felt ready to end therapy, but the therapist did not agree with this decision. This echoes Scharff and Savege Scharff (2014), who explained that therapists work with the process of separation for the final parting when specific goals have been successfully achieved including: the therapeutic space has been internalised with a secure quality extended beyond the couple dynamics to the wider family; unconscious projective identifications have been accepted; the ability to work as life partners have been re-established; intimacy becomes mutually gratifying; and the needs of each partner are acknowledged to be separate and different. Therefore, it seems that the

therapists did not feel that the goals had been met fully, which might have led them to refrain from ending the treatment.

On the other hand, some participants felt that they were able to internalise a “couple state of mind” (Balfour & Morgan, 2018). Colman (1993) explained that therapist work with couples to internalise the therapeutic containment into their relationship in the same way that the child internalises the parental containing function. This process would lead each member of the couple to be both a container and contained.

Holding onto the learning from therapy and moving forward as a couple

Participants described the impact of couple therapy in relation to depression, changes in perspectives and connecting with emotions. This is consistent with a significant body of literature that found that if conflicts characterise the couple’s relationship, this in turn can cause and maintain depression in one or both partners (Whisman & Bruce, 1999). Whisman (2000) conducted a meta-analysis and found that marital dissatisfaction is associated with depression, with a high correlation of .66. Accordingly, Teo et al. (2013), in a ten-year follow-up from a nationally representative study including a cohort of 4.642 American working-age adults, found that the poor quality of relationship with a partner increased the risk of depression.

Participants explained that improved communication with their partner positively impacted the rest of the family dynamics. This is consistent with the literature that evidenced that parents that are satisfied in their relationship tend to relate to their children with warmth, and are likely to establish positive co-parenting relationships (Casey et al., 2017). Clulow (2018) explained that children suffer when they are exposed to arguments between parents. Inter-parental conflict affects children because they might be drawn to taking sides and trying to compensate for the difficulties in the relationship or being scapegoated in order to hold the parents together. Children might act in roles that are different from their needs and sense of self because they might feel responsible for the inter-parental conflict. These dynamics may pose serious intergenerational implications in terms of children’s emotional and attachment security.

Accordingly, Harold and Leve (2012) claimed that targeting the inter-parental relationship can offer “substantial dividends”, due its importance in the family system, where spill-overs into the mother-child and father-child relationship may occur. This proposition is based on a vast

body of literature that found strong associations between the couple relationship and different facets of family functioning (Casey et al., 2017; Fincham & Beach, 2010).

Strengths and limitations of the study

Strengths of the study

This was the first qualitative study that examined the experience of psychodynamic couple therapy for depression. The opportunity to access participants' experiences enriched the currently limited research literature on this topic. One of the foremost aims of this research was to use rigour and trustworthiness to ensure the findings reflected as closely as possible the participants' meanings. The rigorous method enabled a sense of openness and grounding for the participants' accounts during the analysis, described in detail in the methodology chapter. Moreover, from a gender perspective, this study offered insights from almost an equal number of male and female participants. There is an extensive body of literature that demonstrates that social conditions tied to women's lesser power and status in society compared to men contribute to the higher rates of depression in women (Nolen-Hoeksema & Puryear, 2003).

This study included a small homogenous sample of participants. This homogeneity is a strength in terms of validity, as this study highlighted process and dynamics occurring in a specific socioeconomic and cultural group (Jager et al., 2017). Studies with few participants are prototypical within psychodynamic theory, research and practice (Desmet et al., 2013). Moreover, using a phenomenological approach with a small number of participants adhered to the nature of the methodology employed. Echoing Sandelowski (1995), the study's sample size seemed adequate in being large enough to allow the unfolding of new understanding and small enough to provide a deep and case-oriented analysis of psychodynamic couple therapy. The analysis of the interviews demonstrated code saturation. There are existing questions on meaning saturation, as there might be further dimensions or insights of issues that might have been identified with more interviews (Hennink et al., 2017). Finally, the analysis of the data enabled the reframing and generation of theories on psychodynamic couple therapy.

Limitations of the study

This study has three major limitations. Firstly, the small sample size might limit the

transferability of the findings. Secondly, as participants provided retrospective recall of therapy, this might lead to distorted memory issues. Thirdly, it is a qualitative study that implied issues around reflexiveness.

The small sample size might lead to the risk of the sample not being representative of the wider population, which could lead to a difficulty to draw inferences from the sample to other populations and cultures (Vasileiou et al., 2018). All participants in this study described their ethnicity as White British, apart from one who was from a white background from the European Union. All participants were also employed in white-collar jobs, and the majority were educated at a university level. Apart from one participant, who described herself as being in a same-sex relationship, the majority seemed to be in a heterosexual couple. These considerations lead to a shortfall related to the participants belonging to a group that falls under Western, Educated, Industrialised, Rich, and Democratic (WEIRD), as described by Henrich et al. (2010). As Sue (1999) proposed in his critique of the lack of psychological research on ethnic minority populations: “When theories and models applied to different populations are examined, important ethnic and cultural differences are often found” (p. 1074).

Additionally, another shortfall of this study might be that as the participants were invited at the end of therapy, their retrospective recall of therapy might distort their memory. This criterion was negotiated with the couple therapy service due to important therapeutic issues, including transference and counter-transference dynamics between the therapist and the couple. However, according to current literature, individuals who suffer from depression tend to retrospectively underestimate positive effect, reflecting the inability to recall positive experiences and up-regulate positive emotions (Colombo et al., 2020).

Finally, as this is a qualitative study, it is important to address study reflexiveness. There are potential sources of bias related to the researcher’s background and expectations about the topic and about the study findings. As described in the methodology section, the researcher attempted to address these biases by going through a bracketing interview with her supervisor, which took place in November 2019, and to write a positionality statement.

Issues with the COVID-19 pandemic and webcam-based psychodynamic couple therapy

In March 2020, the current COVID-19 pandemic and subsequent restrictions led the couple therapy provider to transfer all their caseload to webcam-based therapy. The research department explained that some couples who had a planned ending might have decided to continue with webcam-based therapy, whereas many ended at the point of transfer to online therapy within a couple of weeks due to other systemic issues including: small children and lack of privacy at home. In this instance, the therapists may not have felt comfortable about the ending as it was not a therapeutically led ending. Some couples from the face to face cohort still preferred to wait for face to face work. The therapists were the gatekeepers of initial contact with the participants, as their clinical judgment was considered essential in this project as the experience of therapy was evaluated. The therapist selected two potential webcam-based therapy cases, but they both declined to proceed. As a result, the director of clinical services at the couple therapy provider explained that "the bond is not the same between therapists and clients".

The recruitment issues elucidated above are consistent with the literature on the delivery of psychotherapy approaches. Accordingly, participants of a qualitative research study guided by an internet-based cognitive-behavioural treatment for depression felt that authentic interaction was a crucial missing ingredient and it was not viable to "establish a meaningful therapeutic relationship online" (Bendelin et al., 2011). Therefore, the lack of therapist support was felt to reduce the impact of therapy (McPherson et al., 2020).

Russell (2015) drew from psychoanalytic experience and neuroscience to examine the use of technology in treatment. In intimate relationships, such as between therapist and client, there are significant non-verbal elements that carry equal or more weight than verbal components. The use of the *presence* of the therapist may be undermined under these conditions, as the embodied perception and interaction with others are important for the perception of the self.

Lemma (2017) explained that affect-based and relational therapies, such as psychodynamic therapy, may not lend themselves to a webcam-based setting, especially for individuals with complex needs. This challenge seems to be because the shared embodied experience that occurs face-to-face may not be replicated in a virtual space. The consulting room's bounded experience and the analytic setting are seen as an indispensable background that offers

containment to continue unfolding the service users' transference. The analytic setting is seen as a safe container where the patient's internal world confines and is a core part of the analytic technique (Gray, 1994).

Lemma (2014) highlighted that the therapist's physical appearance and body language create important sensory features of the setting. These experiences contribute to the therapist's containment and become embodied by the patients. The therapist's nods and glances may act as important stimuli in the patient's internal world and manifest in their unconscious phantasies, internal objects, enactments and associations. Moreover, the consulting room decorations may awaken in service users a sense of warmth and the phantasies of being taken care of, whilst an unadorned environment may raise the phantasies of being deprived of care.

Research implications

This is the first study that examined the experiences of psychodynamic couple therapy but the limitations discussed would suggest the following research implications. Participants were interviewed separately, partially due to the time constraints of the clinical psychology doctoral experience. This is a methodology that has been critiqued for privileging the "dominance of individualism" (Sayer & Klute, 2005). A suggestion for future research might be for the research question to be asked at a dyadic-level with each partner separately. At a second stage, the data can be aggregated to report the couple's perspective (Eiskovits & Koren, 2010; Sayer & Klute, 2005). Another suggestion refers to Heaphy and Einarsdottir (2012) and Blake et al. (2021) who utilised a Multi-Level Interview Design, where they initially interviewed the partners together, and then interviewed separately each partner. Both these methodologies, may bridge between the epistemological underpinning of phenomenology and constructivism.

Moreover, the sample size should be more extensive and widened to different groups including: diverse and cultural, age, socioeconomic and sexual orientation. Future studies could widen their representations of diverse and cultural groups, including Black and ethnic minorities. According to Mirecki and Chou (2013), ideas around family systems and attachment that are based on Western assumptions do not always apply to other migrant cultures living in the United States of America. The Western discourse places the relationship within the couple dyad at the epicentre rather than focusing the responsibilities towards the extended family and wider network of kinship, as indicated in Black American populations (Zaker & Boostanipoor,

2016). Diverse cultural perspectives and cosmologies around the sets of beliefs of couple relationships might influence the experiences of psychodynamic couple therapy. Therefore, it would be important to ascertain if there are considerable differences of experiences from the sample of this study, especially given that 11% of the residents in England and Wales define themselves as belonging to South-Asian and Black ethnic groups (ONS, 2015). Moreover, evidence derived from diverse cultural groups on experiences of psychotherapies for depression is still limited, and it would be crucial to inform guideline development (McPherson et al., 2020).

Secondly, this study focused on working-age adults and thus, the participants' age ranged between 32 and 58 years-old. Future research could include other age groups, including older adults. Several studies indicated that the prevalence of depression increases with age and is a prominent mental health concern among the older adult population (Singh & Misra, 2009). In 2016 in the UK, 18% of people were aged 65 and over, and this figure is continuing to rise. Therefore, it would be useful to have further studies that would inform the planning of psychological care provisions (ONS, 2017). The current NICE guidelines for recognising and managing depression do not differentiate between working-age and older adults, and it would be interesting to place emphasis on this age group (NICE, 2009). This approach would be in line with the depression guidelines from the American Psychological Association (2019), which recommends specific interventions for the treatment of adults and older adults.

Thirdly, the participants from this study accessed private clinical services at the couple therapy provider and were all highly educated. Future studies could aim to include participants from other socioeconomic backgrounds. This recommendation's rationale is that socioeconomic difficulties pose challenges in relationships, including communication problems and risks of marital instability (Williamson et al., 2013). Therefore, it would be crucial for future research projects to understand if there are considerable differences in experiences of therapy compared to the participants in this study, where the stress levels might be higher due to lack of access to opportunities and socioeconomic deprivation.

Finally, the majority of the participants defined themselves as heterosexual, apart from one participant. Future studies could aim to recruit participants from lesbians, gay men, bisexuals and transgender populations (LGBT). Perceived stigma and discrimination create a hostile and stressful environment that can cause mental health problems in the LGBT populations (Meyer,

2003). Newbigin (2015), who is the chair of the Advisory Group on Sexual Diversity for the British Psychoanalytical Council, explained that this task group has attempted to challenge the idea that members of the psychoanalytical community belong to an "exclusive club" reflected by dominant values and assumptions. She added that the consequences of this exclusivity have led to a lack of inquisitiveness on the impact of social differences in the therapeutic setting.

As Beresford (2020) critiqued, there seem to be research issues with the sources of knowledge located in academia, which is perceived as "elitist" and an "exclusionary world". This criticism comprises the failure in academia to engage minority groups and narrow the creation of knowledge to a Eurocentric weltanschauung, by excluding viewpoints from other cultures and life experiences. Beresford (2020) expressed the importance of including survivors' experiences, to challenge the bio-medical thinking about distress. *Mad Studies* is a term that was coined in Canada, aiming to include activism and intellectual endeavours to represent groups of individuals that see themselves as: mad, mentally ill, psychiatric survivors, consumers, service users, patients, neurodiverse, and disabled (Castrodale, 2015). Beresford (2020) cited the research conducted by survivor researchers that explored how survivors with mental health difficulties understood their world and how they felt society responded. The researchers concluded that the biomedical model dominated societal and professional thinking and that this stigmatises.

Rose (2018) highlighted that there should be a shift of where "knowledge production" is located, from "dominant sites" such as universities, to widening the arena of new thinking by creating novel spaces for service-users led research. Therefore, it seems imperative for future research to include marginalised groups and develop an alternative social model where lived experience is highly valued. A further proposition is for research to be led by service users or in collaboration with organisations' consultants to provide marginalised groups with a voice of the services they receive.

Policy and clinical implications

The findings from this study indicate wider clinical and policy implications. A crucial finding is an intertwined dynamic between relationship difficulties and depression for both partners, which leads to the following recommendations.

Firstly, GPs are service users' first point of contact and are expected to diagnose and refer to IAPT (NICE, 2018). On the NHS website under "diagnosis of clinical depression" the following is written: "If you experience symptoms of depression for most of the day, every day for more than two weeks, you should seek help from a GP" (NHS, 2021). As demonstrated in a recent article on the British Medical Journal (BMJ), England, Nash and Hawthorne (2017) called for an urgent reform of GP training in mental health at a national level. The authors stressed that GP training has been the same for over 30 years and has fallen behind in understanding complex mental health difficulties. The authors highlighted that 90% of people with mental health difficulties are supported in primary care but despite this, under half received training in this field.

According to England et al. (2017), GPs had to become "experts" in areas outside of healthcare including: relationship, family and employment. Therefore, a policy implication within the wider NHS system is for GPs to have comprehensive training in mental health in order to take into account relational and psychosocial dynamics that may pose considerable challenges not only for the individual who experiences depression, but also for the couple. This strategy might offer physicians the opportunity to move away from the discourse around the medicalisation of depression, where biological factors are privileged. In turn, the prescription of antidepressants is seen as a *cure* (Geraghty et al., 2019; McPherson & Armstrong, 2009). The involvement of Experts by Experience (EBEs) is becoming more prevalent in psychological professions core training programmes, which might be helpful in further training GPs and other mental health professionals.

Secondly, the intertwined dynamic process between depression and relational difficulties, rather than an individual problem, indicates that the provision of services should be tailored according to service users' needs. On the NHS website under "condition of depression" it is highlighted that: "If you're having relationship or marriage difficulties, it might help to contact a relationship counsellor who can talk things through with you and your partner" (NHS, 2021). Accordingly, in this advice to the public there is an acknowledgement of the vast literature that demonstrated the interdependency between couple relationship and depression, and the impact on the wider system (Joiner & Katz, 1999; Kouros et al., 2008; Priestley et al., 2017; Whistman & Bruce, 1999).

Interestingly, the advice states to contact a "relationship counsellor", which leads to the idea

that they should be contacted privately, rather than being employed in community clinics, such as IAPT services. This is evidenced in the IAPT services, where only 0.62% of the entire provision is dedicated to behavioural couple therapy for depression (Tavistock Relationships, 2015). Therefore, a policy recommendation is to train more clinicians in couple therapy within IAPT services. Recent figures revealed that only 2% of the High Intensity IAPT workforce delivers couple therapy, compared to 61% that offered CBT (NHS England, 2015). Moreover, IAPT services are currently experiencing high non-engagement and drop-out rates (Davies et al., 2020).

This recommendation leads to another important finding of this study around the importance of service users in creating links with the past. Psychodynamic couple therapy offers a detailed exploration of past experiences and relationships with a therapist, whilst the behavioural counterpart focuses on improving communication difficulties within the couple (Hewison, 2015; Scharff & Savege Scharff, 2014). Therefore, it seems imperative to offer services that consider individual differences and service users' choices. Accordingly, the Department of Health (2012) stated the importance of involving service users in their care by being patient-centred and providing different psychological therapies.

The argument against the "one size fits all approach" is relevant for two reasons. Firstly, as discussed in the 2016 European Psychiatric Association guidelines, individual preferences for a specific therapeutic approach for depression might be guided by the service user's personal history, including attachment style, traumatic experiences, etc. (McPherson, 2018). Secondly, it is improbable that one therapeutic model would be appropriate for every person in every situation. Therefore, privileging individual preferences for a specific therapeutic model may strengthen a sense of control, which would lead to positive outcomes and less incidences of leaving therapy (Cooper & McLeod, 2007).

Therefore, the NICE guidelines (2018) acknowledged that service users should make informed choices and be at the centre of their care. In a recent study with 28 people with lived experience of depression across three focus groups, it was found that few people experienced having any choice in the psychological therapy they could access through the NHS, and individuals from BAME backgrounds (Black, Asian and mixed heritage) struggled to find therapists who were able to discuss issues around experiences of racism (Faulkner, 2020). These consultations with

experts by experience raised the importance of creating a Patient Decision Aid tool, to empower service users to make choices about their treatment. This tool might be a drop in the ocean as there are not many therapies modalities available in the NHS, but it would be a move in the right direction.

The issue around the choice of treatment leads to another important finding related to changes in communication with the broader family system. This finding may hold important clinical implications. As discussed, relationship difficulties may lead to problems in children's attachment to their parents and, in turn, for children under five, to acting out and becoming withdrawn, whilst when they become teenagers, to internalising issues including long-term anxiety and depression (Harold & Sellers, 2018; Yu et al., 2012). Parental mental health and positive outcomes in the couple's relationship may lead to supportive co-parenting, which is the most important contributor to children's social and cognitive development (Cheng et al., 2009).

Therefore, clinical psychologists and other mental health professionals should increase their awareness in considering the couple relationship when working with children and teenagers. Similar to adult depression, the NICE guidelines advice for children experiencing emotional distress between the age of 5 to 18 is to use CBT based therapies and group IPT. If these options do not meet children needs or circumstances, the NICE guidelines mention attachment-based family therapy. As a result, addressing individual child difficulties rather than considering systemic factors, such as the parental relationship, seems to be the favoured approach. In conclusion, children and families should be involved in how they can choose between treatment options, especially considering the impact of difficulties in the relationship.

Personal reflections

I found this research rewarding for different reasons. I experienced one year of individual psychodynamic therapy in the past. I have benefitted from it for several years due to a sense of containment within the therapeutic relationship that led to this secure base being internalised into my inner world.

During 2016, I attended an NHS funded PG(Dip) Child Psychology at the University of Edinburgh. I trained in CBT and behavioural parenting programmes, evidence-based practices according to the dominant NICE guidelines discourse. I was critical of how this model did not sufficiently consider existential issues around depression, socioeconomic and cultural factors. I reflected on my academic background in Humanities, Philosophy and Political Sciences, and I felt the importance of delivering and receiving a therapeutic approach that adhered to my values and interests. Consequently, I found it frustrating that there are hardly any psychodynamic therapies available in the current NHS provision, unless individuals are severely depressed and may pose risks to themselves and others.

When Professor McPherson and I discussed this research topic, I became enthusiastic about working with her and contributing towards the existing meagre literature on applied research on psychodynamic therapy. I found this research rewarding and challenging at the same time. The research was emotionally challenging because I got married in the summer of 2018, a couple of months before the research started. Therefore, analysing and discussing issues around couple discord and separation was difficult at times.

During the interview process, my dual role of being a clinician and a researcher became complex. Because the interviews were about the participants' experience of therapy, I noticed that they might have perceived me as a clinician and expressed their feelings towards their partners on several occasions. To the best of my abilities, I tried to re-direct the participants' attention back to the experience of therapy and it was a difficult endeavour. At times, I found that the material was emotionally charged, as participants also discussed retrospective experiences of complex trauma, severe attachment difficulties and emotional abuse.

I experienced feelings of counter-transference during one interview with a male participant from a country in the European Union. His previous partner was from Italy, and he repeated on several occasions: "X was from Italy like you". I felt powerful projections that were directed towards me. Paul explained that he moved to the UK and struggled to learn the language and was occasionally unemployed during his tenure in the country, whilst back home he had his own professional studio, which was closed down because of the recession. Amidst the Brexit discourse, I felt deeply moved by his account and a strong sense of empathy towards him, and I felt an urge to try to help by providing him with some comfort or reassurance. I resisted and kept the conversation at a professional research level.

Due to the COVID-19 pandemic, I experienced significant recruitment issues as service users did not feel that the bond they had created with the therapist was as strong with web-cam based therapy. As a result, I contacted over ten organisations that deliver couple therapy and none was keen to participate in my study. I felt deflated at times as I was eager to demonstrate the meaningful experiences of this therapeutic model and contribute towards the current literature on an alternative approach than the ones described by the NICE guidelines.

However, there was a turning point during this journey. During my third-year placement at the Adult Complex Needs Psychoanalytical Service at the Tavistock and Portman NHS Foundation Trust, I read numerous journal articles that described applied research to single clinical cases. The depth of the participants' emotional experiences described in these articles was outstanding, and I utilised the researchers' reflections to inform my clinical work. Therefore, these embodied experiences provided me with the determination to conduct and embed the research in the current literature where the depth of the participants' accounts was carefully analysed. I found this process rewarding as I created theory and practice links on a therapeutic model that I personally find effective, and could pave its way back to being offered more widely.

Conclusion

The aim of this research was to explain the experiences of service users of psychodynamic couple therapy. The theoretical model proposed describes how participants sought to be *seen* as individuals throughout therapy, and how they experienced the therapist's third eye perspective, who became a referee and mediated the communication within the couple. Participants were able to internalise the figure of the therapist providing containment leading to "a couple state of mind". The original contribution of this qualitative study is not only around being the first to examine psychodynamic couple therapy for depression, but also because it highlighted the intertwined dynamic between relationship difficulties and depression. Participants were not able to make a clear distinction between these two experiences, and this microcosm may reflect the difficulties that service users are confronted with in an individualised provision of services. This process may atomise and reduce individuals to a diagnostic label requiring a "treatment" for profound wounds and existential difficulties, whereas in-depth work with the distressed couple may become a precursor of wellbeing for all

the system around them. Therefore, it seems imperative to offer services that consider individual differences and service users' choices.

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Appendix A: Ethical approval letter

17/09/2019

Miss Ilaria Tercelli

Health and Social Care

University of Essex

Dear Ilaria,

Ethics Committee Decision

I am writing to advise you that your research proposal entitled "Title of project: Experiences of working age adults with psychological distress of psychodynamic couple therapy: a qualitative study" has been reviewed by COMMITTEE.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Frances Blumenfeld

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Wivenhoe Park
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Appendix B: Participant information sheet

Participant information sheet

My name is Ilaria Tercelli and I am a Trainee Clinical Psychologist. I am conducting this research as part of my thesis project, which has been approved by the Ethics Committee at the University of Essex.

About the study
This study aims to explore the experiences of psychodynamic couple therapy for people who may have been experiencing low mood and/or psychological distress at the time they started couples therapy. I am interested in examining individual and socio-cultural factors prior to the therapy intervention and the dynamics between you and your therapist. I would also like to investigate the impact of couple therapy on your emotional responses and on the relationship quality.

Procedure and data protection
If you wish to participate, we will agree on a convenient time to talk over the telephone. The interview will entail questions about your experience of psychodynamic couple therapy, which will last for approximately one hour. If your partner also experienced low mood and psychological distress prior to beginning therapy, they will also be invited to take part but this would come as a separate invitation and it is up to you whether or not you discuss your participation with your partner.

Following the interview, all the data will be anonymized and kept confidential. The audio recording digital data will be saved onto an encrypted memory stick and will be safely deposited in a locked cupboard. The paper data will be deposited in a locked cupboard, scanned onto an encrypted memory stick and destroyed as soon as possible. Your data will not be identifiable and your partner will not be informed of your participation or your responses in this study.

Participants' rights Your participation in this research is voluntary. You may wish to decide to stop the interview at any time and any data provided to that point will be withdrawn and destroyed accordingly. Choosing not to be involved or withdraw from the research will not have an impact on your liaison with X. You are most welcome to ask me any questions about the research and your rights.

Risks and benefits
This project may evoke difficult feelings due to the emotional content of the interviews. A space will be offered, if you wish, to discuss any difficult feelings. Your contribution will provide further evidence on couple therapy for the treatment for depression, which will be submitted to a peer-reviewed academic journal.

Compensation
To thank you for your time, you will be given a voucher for the value of £10.

Further information about the study
If you have any questions about the study, please contact me or my academic supervisor:

Ms. Ilaria Tercelli, Clinical Psychology, School of Health and Social Care (University of Essex)
E-mail: it18033@essex.ac.uk

Dr. Susan McPherson, Clinical Psychology, School of Health and Social Care (University of Essex)
E-mail: smcpher@essex.ac.uk

Resources in the event of distress

In the event of distress, you may contact the following organisations:

Mind – www.mind.org.uk – 0300 123 3393
Samaritans – www.samaritans.org - 116 123

Appendix C: Participant consent form

Participant consent form

Title of research: Experiences of working age adults with psychological distress of psychodynamic couple therapy: a qualitative study

Researcher: Ilaria Tercelli

By signing below, you agree with the following statements:

- I am participating in this research study voluntarily
- I have read and understood the information sheet. Following this, I have asked questions about my participation in the research that have been answered adequately
- I was informed about the potential risks and procedures
- The interview will be anonymised and data governance procedure will be followed according to the Data Protection Act (1998)
- My participation in this research is voluntary and I may withdraw at any time.

Name ____

Signed ____

Date ____

Appendix D: First ethic amendment approval letter

13/07/2020

Miss Ilaria Tercelli

Health and Social Care

University of Essex

Dear Ilaria,

Ethics Committee Decision

I am writing to advise you that your research proposal entitled "Title of project: Experiences of working age adults with psychological distress of psychodynamic couple therapy: a qualitative study" has been reviewed by the Science and Health Ethics Sub Committee.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Dr Camille Cronin

Appendix E: Second ethic amendment approval letter

12/08/2020

Miss Ilaria Tercelli

Health and Social Care

University of Essex

Dear Ilaria,

Ethics Committee Decision

I am writing to advise you that your research proposal entitled "Title of project: Experiences of working age adults with psychological distress of psychodynamic couple therapy: a qualitative study" has been reviewed by the Science and Health Ethics Sub Committee.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Dr Camille Cronin

Appendix F: Third ethic amendment approval letter

04/10/2020

Miss Ilaria Tercelli

Health and Social Care

University of Essex

Dear Ilaria,

Ethics Committee Decision

I am writing to advise you that your research proposal entitled "Title of project: Experiences of working age adults with psychological distress of psychodynamic couple therapy: a qualitative study" has been reviewed by the Ethics Sub Committee 1.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Dr Camille Cronin

Appendix G: Interview topic guide

In the introduction I will explain the following:

- Aim of the study
- Length of the interview and importance to be open about their experience of therapy
- The session will be recorded and there will be firm confidentiality measures in place

<u>Interview topics</u>

Experiences of psychodynamic couple therapy

- Experiences of starting therapy
    - anything difficult, helpful, surprising etc
- Comparison to hopes and expectations of therapy
- Thoughts about the therapist
    - connection, empathy, technique etc
- Experiences of continuing with therapy
    - progress, key moments, continuity, challenges etc
- Experiences of ending therapy

Impact of therapy

- Changes in mood and emotional distress
    - Noticed by participant
    - Noticed by friends/family
    - Connection between therapy and changes noticed
- Changes in relationship with partner
    - Noticed by participant
    - Noticed by friends/family
    - Connection between therapy and changes noticed
- Changes in childrens' behaviour or wellbeing
    - Noticed by participant
    - Noticed by friends/family
    - Connection between therapy and changes noticed

Closing

- Anything else to mention?
- Debrief – sources of further support if required

Appendix H: Transcript excerpt

Ilaria: Can you tell me the experiences of starting therapy, what was it like?

Daniel: Well, I'd already had individual therapy before. Whereas this was obviously coupled and it was difficult to begin with because I kind of felt like we were meeting somebody at a dinner party or something, where I had to sort of impress and sort of perhaps bring across the side of my personality that wasn't quite true. I didn't allow myself to, you know, make the most of therapy.

Ilaria: OK. So you felt that you had to try to impress the therapist at the beginning?

Daniel: Yes.

Ilaria: Ok. And did you see any changes afterwards?

Daniel: Oh yeah. Yeah, absolutely. I started to see some positive results once the therapist started to gain my trust.

Ilaria: Ok, so it was a matter of trust. Trust in the therapist or in the process, do you think?

Daniel: Probably a bit of both.

Ilaria: I was wondering if you have noticed any changes in yourself since therapy started in terms of your mood or emotional distress?

Daniel: Yeah, I did. I think when I started, I was certainly experiencing a lot of anger. And then that sort of subsided, eventually, you know, we found calm. And, you know, happiness. So it was very successful in all.

Ilaria: So do you think that the anger was a side where therapy helped?

Daniel: Yes

Ilaria: Were there other things that have changed in terms of low mood?

Daniel: Well, the relationship, obviously. And you know, the ability to discuss things that I had felt unable to discuss in a sort of adult fashion in the past.

Appendix I: Abstract submitted to conferences

Experiences of working-age adults with depression of psychodynamic couple therapy: a thematic analysis using a phenomenological approach

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Background: Depression is a complex condition that affects over 320 million people worldwide and entails risks of relapse and suicide. As a result of the increasing number of adults experiencing symptoms of depression and anxiety in the United Kingdom, Improving Access to Psychological Therapies (IAPT) services have been established to assist individuals with these difficulties. The National Institute for Health and Care Excellence (NICE) guidelines have recommended behavioural couple therapy for the treatment of depression, but public provision is limited. Despite the wide range of literature that explains the link between couple wellbeing and mental health outcomes for adults and children, there is an evidence gap around the experiences of psychodynamic couple therapy.

Aim: This is the first study exploring the experiences of individuals with depression who have received psychodynamic couple therapy.

Method: Five participants completed a semi-structured interview, following at least six months of couple therapy for the treatment of severe distress and depression. They were recruited from the internationally renowned X clinic in London using a purposive sampling technique. Data was analysed using a phenomenological approach to thematic analysis.

Results: Participants expected therapy to address their individual and relationship concerns and found that it was more far- reaching than expected, particularly when they were able to internalise the therapist's third eye perspective. The "third person" became a referee who would mediate the communication within the couple and provide a different perspective, which enabled a safe environment for reciprocal listening. There were complex personal and couple dynamics re-enacted in therapy, which enabled a repairing process in the relationship with the therapist when they were addressed. A crucial aspect of couple therapy was the process of making links with the past, which enabled participants to understand their current behaviour as individual and dysfunctional areas as a couple. The process of creating connections with the past was meaningful for all participants, and some perceived fostering self-reflective skills as a practical tool, but others wanted to receive direct guidance. Three main active ingredients facilitated the therapeutic process: the therapist's ability to understand the couple as individuals rather than as a unified entity; the therapist neutrality and capacity to empathise and connect with the couple. At the end of therapy, most participants reflected that their overall therapy experience has been helpful and highlighted a positive impact in terms of their depression, perspectives and connecting with emotions, not only for the couple involved but also in the wider system.

Conclusions: This qualitative study's original contribution is that it highlighted the intertwined dynamic between relationship difficulties and depression. Participants were not able to make a clear distinction between these two experiences and this microcosm may reflect the difficulties that clients face in public services, which have historically held a more individualistic perspective of distress.

Keywords - Couple therapy; psychodynamic; depression; qualitative

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