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TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - 'Luisa'

© 2016 Enrico Benelli, Desiree Boschetti, Cristina Piccirillo, Laura Quagliotti, Vincenzo Calvo, Arianna Palmieri, Marco Sambin & Mark Widdowson

Abstract

This study is the third of a series of three, and represents an Italian systematic replication of previous UK findings (Widdowson 2012a, 2012b, 2012c, 2013) that investigated the effectiveness of a recently manualised transactional analysis treatment for depression with British clients, using Hermeneutic Single-Case Efficacy Design (HSCED). The various stages of HSCED as a systematic case study research method are described, as a quasi-judicial method to sift case evidence in which researchers construct opposing arguments around quantitative and qualitative multiple source evidences and judges evaluate these for and against propositions to conclude whether the client changed substantially over the course of therapy and that the outcome was attributable to the therapy. The therapist in this case was a white Italian woman with 10 years clinical experience and the client, Luisa, was a 65-year old white Italian woman who attended sixteen sessions of TA therapy. Luisa satisfied DSM-5 criteria for severe adjustment disorder, with moderate depression and mixed deflected humour and anxiety, for which she had been taking medications and homeopathic treatments for over a year. The conclusion of the judges was that this was a good-outcome case: the client improved over the course of the therapy, reported a positive experience of therapy and maintained this improvement at the end of the follow-up.

Key words

Systematic Case Study Research; Hermeneutic Single-Case Efficacy Design; Transactional Analysis Psychotherapy; Major Depressive Disorder; Persistent Depressive Disorder (Dysthymia); Phase of life problem

Editor's Note

Those who read all three papers in this issue will see that some parts of the introduction, ethical considerations, method, and similar material, is repeated here for completeness of each paper.

Introduction

This article is the third of a series of three and represents an Italian systematic replication of a previous UK based case series (Widdowson 2012a, 2012b, 2012c, 2013). This present study is focused on investigating the effectiveness of transactional analysis (TA) treatment of depression, under the auspices of the project 'Toward a transactional analysis psychotherapy recognised as empirically supported treatment: an Italian replication series design', funded by the European Association of Transactional Analysis (EATA).

This present case study analyses process and outcome of brief treatment of 'Luisa', a 65-year-old Italian woman who showed symptoms matching DSM-5 criteria for moderate Major Depressive Disorder, Persistent Depressive Disorder (Dysthymia) and a severe level of anxiety. The psychotherapy was conducted according to the recently manualized TA treatments of depression (Widdowson, 2015) integrated with the recommendations of (Boschetti & Revello, 2013).

The aim of the study was to investigate the effectiveness of short-term TA treatment of depression in a naturalistic setting.

TA is a widely practiced form of psychotherapy that is still under-recognised within the worldwide scientific community of psychotherapy. Although its clinical efficacy is experienced in the consulting room by thousands of Transactional Analysts every day, research supporting such achievement with empirical evidence was scant and of poor quality until recent years (Khalil, Callaghan & James, 2007). Ohlsson (2010) provided a valuable reference list of TA research studies but a search of that yields no single case efficacy studies.

In order to define TA psychotherapy as an efficacious Empirically Supported Treatment (EST), its efficacy must have been established in at least one Randomized

Clinical Trials (RCT) replicated by two independent research groups, or alternatively in at least three Single Case Efficacy Design studies (SCED), replicated by at least three independent research groups (Chambless & Hollon, 1998). Recently, a wide community of researchers proposed that treatment efficacy in psychotherapy is a complex object that cannot be adequately evaluated with the experimental approach of RCT (Norcross, 2002; Westen, Novotny & Thomson-Brenner, 2004) and SCED (McLeod, 2010). Systematic case study research has been proposed as a viable alternative to RCT and SCED (Iwakabe & Gazzola, 2009), and Hermeneutic Single Case Efficacy Design (HSCED) (Elliott, 2002; Elliott et al., 2009) is nowadays considered the most comprehensive set of methodological procedures for systematic case study research in psychotherapy (McLeod, 2010). Recently, a systematic review of all HSCED studies published within English language peer reviewed journals highlighted methodological issues related to different levels of stringency, offering solid alternatives according to the availability of resources for research (Benelli, De Carlo, Biffi & McLeod, 2015).

Systematic case study research has already been applied to investigate TA effectiveness with people with long term health conditions (McLeod, 2013a; 2013b) and HSCED methodology has already been successfully applied to TA and widely described in this Journal by Widdowson (2012a). Recently, several HSCEDs supporting TA treatment for depression (Widdowson, 2012a, 2012b, 2012c, 2013) have been published, as was an additional adjudicated study which demonstrated effectiveness of TA for mixed depression and anxiety (Widdowson, 2014), and additionally a related study was published on TA for emetophobia (Kerr, 2013) The case series by Widdowson has shown that TA can be an effective therapy for depression when delivered in routine clinical practice, in private practice settings, with clients who actively sought out TA therapy and with white British therapist and client dyads.

Ethical Considerations

The research protocol follows the indications of the ethical code for Research in Psychotherapy of the Italian Association of Psychology and the American Psychological Association norms on rights and confidentiality of research participants. Before entering the treatment, the client received an information pack, including the detailed description of the research protocol, and gave an informed consent and a written permission to insert part of disguised transcripts of sessions or interviews within scientific articles and/or to be presented at conferences. The client was informed that she would have received the therapy even if she decided not to participate in the research and that she was able to withdraw at any moment without any impact on her therapy.

All aspects of the case material were disguised, so that neither the client nor third parties are identifiable. All changes are made in such a way that do not lead the reader to draw false conclusions related to the described phenomena. The final version of the article, in Italian, was presented to the client, who gave written consent for its publication.

Method

Inclusion and exclusion criteria

Participating psychotherapists were invited to include in the study the first new client with a diagnosis of depression who accepted to be involved in the research. Other current psychotherapy, active psychosis, domestic violence, bipolar disorder, antidepressant medication, alcohol or drug abuse were considered as exclusion criteria. As the overall aim of this project was to study the effectiveness of TA therapy in routine clinical practice, both inclusion and exclusion criteria were evaluated case by case.

Client

Luisa is a 65 year-old white Italian woman who lives in a small rural community in Northern Italy. She was the eldest of two sisters. Her parents were described as concrete persons, hard workers, not very close, and who lived a life of sacrifice. She began work when she was very young, stopping her education early. She was married and has 2 sons, who are now 41 and 42 years old. At the time of starting therapy, she had been divorced for 14 years. After her divorce, she had no romantic relationships for a period of 7 years. Although officially in retirement, Luisa still works most of her time in the family business, together with her older son. Her job appears to be an important part of her identity; a family value passed on through generations. Seven years ago she started a relationship with a new partner. In the last few years, the relationship entered a critical phase, since her partner expressed his desire to spend more time together for enjoying their retirement, whereas Luisa continued to work and take care of her son and her elderly mother.

Luisa described that in the last two years she felt increasingly tired, with low self-esteem and feelings of hopelessness. A year ago her general practitioner prescribed her an antidepressant, which had no noticeable benefit on her depressive symptoms. In the last few months prior to therapy she had noticed a worsening of her symptoms. Recently her partner ended their relationship and she had a sharp deterioration of her depressive symptoms: she had little appetite, insomnia, substantial weight loss, felt a continual sense of sadness, isolation, despair and fatigue. Most concerning to Luisa was that for the first time ever, she lost all enthusiasm for her job. Due to this, she decided to seek therapy, asking a friend to recommend a therapist. She had no history of previous engagement with psychotherapy.

Although she reported having a great number of acquaintances due to her job, she presented herself as being fairly socially isolated, only seeing friends infrequently over the last months. She reported that she tends to satisfy everyone else's desires and to appease others in conflicts, and has a tendency to shift her own needs and desires to the background. She defines herself as someone for whom "everything is fine", showing a tendency to over-adapt to others. She also often feels guilt and a sense of responsibility for others. This relationship style appears to be evident also in her relationship with her ex-partner, where she constantly adjusted to please his desires, which would then occasionally break by exploding in a sudden burst of anger. At the same time, she described herself as a "sulking person". Some of Luisa's ambivalence appeared within sessions: Luisa immediately agreed to take part in the research, but did not want to be recorded for the first session, and also sometimes complained about needing to complete the outcome questionnaires.

Therapist

The psychotherapist is a 38 year-old, white, Italian woman with 10 years of clinical experience and a certification as Provisional Teaching and Supervising Transactional Analyst (Psychotherapy) (PTSTA-P). For this case, she received weekly supervision by another PTSTA-P of the same level of experience.

Intake sessions

Luisa attended three pre-treatment sessions (0A, 0B, 0C), which were focused on conducting a diagnostic interview evaluation according to DSM 5 criteria (American Psychiatric Association, 2013), developing a case formulation, creating a definition of the problems she was seeking help for in therapy, and collection of self report outcome measure data relating to depression, anxiety and general distress. The therapist proposed the research protocol to the client, who immediately agreed. Despite this, the client initially withheld permission to record the sessions and expressed some concerns about the confidentiality of session recordings. Due to this, the intake sessions and the first two sessions of therapy were not recorded. After this, Luisa felt more comfortable in therapy and consented to sessions being recorded.

Throughout the duration of the therapy, Luisa was on medication. She had been prescribed an antidepressant and anxiolytic by her general practitioner for over one year. She was also taking homeopathic remedies for insomnia. Despite the use of drugs or homeopathic remedies generally being considered within the research protocol as exclusion criteria, the researchers noted that the client had been taking her antidepressant for more than one year, and that the situation was worsening, suggesting that the effect of the pharmacotherapy would be absent or slight, and that it would be unlikely that Luisa would experience any sudden improvements in mood due to the medication after taking them for so long. For this reason, the authors decided to include this case in the study. This is also in line with the main aim of this research, which is to depict a realistic picture of real clients in daily clinical practice.

DSM 5 Diagnosis

During the intake session, the therapist noticed that Luisa's depressed mood was present for more than two years, supporting the diagnosis of Persistent Depressive Disorder, late onset, with intermittent Major Depressive Episode, with current episode. Luisa's depression appeared to be due also to her retirement, since her identity relied heavily on work, suggesting a focus of clinical attention on her difficulty in adjusting to this life-cycle transition and supporting also a DSM diagnosis of Phase of Life Problem.

Knowing the level of an individual's personality functioning and pathological personality traits provides the therapist with fundamental information for treatment planning. Therefore, a diagnosis of personality was also conducted, using the alternative dimensional model developed for DSM 5 Section III. This diagnosis allows: assessment of the level of impairment in personality functioning (1) and an evaluation of personality traits (2). A moderate level of impairment in personality functioning is required for the diagnosis of a personality disorder, in at least two of the following areas: Identity, Self-direction, Empathy and Intimacy. The patient showed little impairment in these areas, and did not resemble the prototypical description of the moderate level. She had however been diagnosed with some personality traits in the domains of Negative Affectivity (Anxiousness, Submissiveness, Hostility) and Detachment (Anhedonia, Depressivity); however these personality traits did not reach the pathological level. Both the level of personality functioning and the traits have been considered in drawing up the treatment plan.

TA Diagnosis and Case formulation

Luisa's depression was conceptualized as connected to a severe self-critical internal dialogue between ego states (Berne, 1964; Widdowson, 2015), internalized during early childhood and adolescence, and which feeds her feelings of guilt. She presents Please Others and Be Strong drivers (Kahler, 1975) and the injunctions (Goulding & Goulding, 1976) Don't be you, Don't be important, Don't be a child and Don't enjoy. Luisa's Racket System (Erskine & Zalcman, 1979) shows beliefs such as "People are annoyed by my needs", "I must adapts to others' needs" and repressed emotions of anger and pride. Interpersonally, Luisa tends to alternate roles (Karpman, 1968) of Victim, (when backing down without expressing her feelings), and Persecutor (during outbursts of hostility).

Treatment

The therapy followed the manualised therapy protocol of Widdowson (2015) and the treatment recommendations of Boschetti and Revello (2013). The treatment plan primarily focused on creating a therapeutic alliance, primarily providing Permission (Crossman, 1966) congruent with the patient's injunctions, namely; *be yourself, be important, enjoy*. The therapist offered Luisa

empathic listening, supporting Luisa to feel and express her emotions, needs and wishes. During these early sessions, the therapist also explained the ego state model to Luisa, in order to give her some theoretical knowledge that might help her to better understand the emotional states she experiences and her behaviours. Then, the therapist focused on reinforcing self-esteem, supporting Luisa's recognition of the importance of her job in maintaining her identity and self-esteem, differentiating between her own point of view on her job, and her partner's point of view. From Session 4, the focus was more on Luisa's drivers, injunctions and related script beliefs. The therapist explored behavioural patterns related to her Please Others driver, supporting several redecisions about the beliefs which formed part of her racket system which had previously led her to satisfy everyone else's needs but not her own. The final sessions were focused on reviewing the process of therapy and supporting changes in Luisa's life.

Analysis Team

The HSCED main investigator and first author of this paper is a Certified Transactional Analyst with 5 years of post-specialisation experience, with a strong allegiance to TA. Following the indication of Bohart (2000), the analysis was carried out by a team of 8 'reasonable persons', not yet overly committed to any theoretical approach or professional role. They were postgraduate students who were taught the principles of hermeneutic analysis in a course on case study research at the University of Padua, by Professor John McLeod. The students were split into two groups, the affirmative case and the sceptic case, with each group independently preparing their responses to the case. The main investigator supervised the briefs and rebuttals from both analysis teams.

Judges

The judges were two researchers in psychotherapy at the University of Padua and co-authors of this paper: Vincenzo Calvo, a psychologist and counsellor with expertise in attachment theory, and Arianna Palmieri, a neuropsychologist and psychotherapist with a training in dynamic psychotherapy. Both judges had some basic knowledge of TA but had not engaged in any official TA training.

Transparency statement

The research was conducted entirely independently of the previous case series (see Widdowson 2012a, 2012b, 2012c). The last author, Mark Widdowson, was involved in checking that the research protocol and data analysis process was adhered to, in order to make the claim that this case series represents a valid replication of the initial study, (with minor changes) and was involved in the final preparations of this article.

Quantitative Outcome Measures

Three standardized self-report outcome measures were selected to measure target symptoms: the Patient Health Questionnaire 9-item for depression (PHQ-9) (Spitzer, Kroenke & Williams, 1999), the Generalized Anxiety Disorder 7-item (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006) for anxiety and the Clinical Outcome for Routine Evaluation - Outcome Measure (CORE-OM) (Evans, Connell, Barkham, Margison, Mellor-Clark, McGrath, & Audin, 2002) for global distress. These measures were evaluated according to clinical significance (CS) and Reliable Change Index (RCI) (Jacobson & Truax, 1991). CS indicates that the client moved from a clinical to a non-clinical range score. RCI indicates that the observed change is reliable and not due to measure error. See the notes accompanying Table 2 for CS and RCI values for each measure.

All these measures were administered prior the start of each session to measure the on-going process and to facilitate the identification of events in therapy that produced significant change.

Before each session, the client also rated the simplified Personal Questionnaire (PQ) (Elliott, Shapiro, & Mack, 1999), a client-generated measure in which clients specify the problems they would like to address in their therapy and rate their problems according to how distressing they are finding each problem.

All of the measures were administered also during the assessment phase to obtain a stable baseline, and during the three follow-up intervals.

Qualitative Outcome Measurement

The client was interviewed using the Change Interview protocol (CI) (Elliott, Slatick & Urman, 2001) about one month after the conclusion of the therapy. The CI is a semi-structured qualitative change measure which asks clients how they feel they have changed during the therapy and since the therapy's initiation, how they think these changes came about, what they felt was helpful or hindering in the therapy, and what changes they feel they still need to make. Clients are asked to identify key changes they made and to indicate on a five point scale: 1) if they expected to change (1=expected; 5=surprising); 2) how likely these changes would have been without therapy (1=unlikely; 5=likely), and 3) how important they feel these changes to be (1=slightly; 5=extremely).

The client also completed the Helpful Aspects of Therapy form (HAT) (Llewelyn, 1988) at the end of each session. The HAT allows the client to describe hindering or useful aspects of the therapy and to rate them on a nine-point scale (1=extremely hindering, 9=extremely useful).

Therapist Notes

A 'structured session notes form' (Widdowson, 2012a, Appendix 6, p. 50-52) was completed by the therapist at the end of each session. In this form the therapist provides a brief description of the session in which are identified the therapy process, the theories and interventions used, and an indication of how helpful the therapist felt the session was for the client.

Adherence

The therapist, the supervisor and the main researcher were all Transactional Analysts and they each independently evaluated the therapist's adherence to TA treatment of depression using the 'operationalized adherence checklist' proposed by Widdowson (2012a, Appendix 7, p. 53-55). The conclusion of the three evaluators was that the treatment had been conducted coherently according to TA theory and to a good/excellent level of application.

HSCED Analysis Procedure

Affirmative Case

The affirmative position according to Elliott (2002) should locate evidence in the rich case record supporting the claim that the client has changed, and that the change is causally due to the therapy. A clear argument supporting the link between change and treatment must be established on the basis of at least two of the following five sources of evidence:

1. Changes in stable problems: client experiences changes in long-standing problems. The change should be replicated in quantitative and qualitative measures. Change should be Clinically Significant (scores fall into the healthy range), Reliable (corrected for measure error) and Global (Reliable Change is replicated in at least two out of three measures);
2. Retrospective attribution: according to the client the changes are due to the therapy;
3. Outcome to process mapping: refers to the content of the post-therapy qualitative or quantitative changes that plausibly match specific events, aspects, or processes within therapy;
4. Event-shift sequences: links between 'client reliable gains' in the PQ scores and 'significant within therapy' events;
5. Within therapy process-outcome correlation, the correlation between the application of therapy principles (e.g., a measure of the adherence) and the variation in quantitative weekly measures of client's problem (e.g. PQ score).

Sceptic Case

A sceptic position requires a good-faith effort to find non-therapeutic processes that could account for an observed or reported client change. Elliott (2002) identified eight alternative explanations that the sceptic position may consider: four non-change explanations and four non- therapy explanations.

The four non-change explanations assume that change is really not present, and should consider:

1. Trivial or negative change which verifies the absence of a clear statement of change within qualitative outcome data (e.g. CI), and the absence of clinical significance and/or reliable change index (Jacobson & Truax, 1991) in quantitative outcome measures (e.g. PHQ9);
2. Statistical artefacts that analyse whether change is due to statistical error, such as measurement error, regression to the mean or experiment-wise error;
3. Relational artefacts that analyse whether change reflects attempts to please the therapist or the researcher;
4. Expectancy artefacts, analysing whether change reflects stereotyped expectations of therapy.

The four non-therapy explanations assume that the change is present, but is not due to the therapy, and should consider:

5. Self-correction which analyses whether change is due to self-help and/or self-limiting easing of a temporary problem or a return to baseline functioning;
6. Extra-therapy events that verify influences on change due to new relationship, work, financial conditions;
7. Psychobiological causes which verify whether change is due to medication, herbal remedies, recovery from medical illness;
8. Reactive effects of research, analysing the effect of change due to participating in research, such as generosity or good will towards the therapist.

The formulation of affirmative and sceptic interpretations of the case consists of a dialectical process, in which 'affirmative' rebuttals to the sceptic position are constructed, along with 'sceptic' rebuttals of the affirmative position.

Adjudication Procedure

Each judge received the rich case record (session transcriptions, therapist and supervisor adherence forms and session notes, quantitative and qualitative data and also a transcript of the Change Interview) as well as the affirmative and sceptic cases and rebuttals, by email, together with instructions. The judges were asked to examine the evidence and provide their verdict. They were required to establish:

- If the case were a clearly good outcome case, a mixed outcome case, or a poor outcome case;
- If the client had changed;
- To what extent these changes had been due to the therapy;
- Which aspects of the affirmative and sceptic arguments had informed their position.

Furthermore, the judges had to observe which mediator factors in the therapy they considered to have been helpful and which characteristics about the client did they think had contributed to the changes as moderator factors.

Results

In earlier published HSCED the rich case records, along with hermeneutic analysis and judges' opinions were often provided as online appendices (Benelli et al., 2015). Since all the material is in Italian language, we adopted here the solution of providing a summary of the main points, as proposed in MacLeod and Elliott (2012). The complete material (session transcriptions, Change Interview, affirmative and sceptic briefs and rebuttal, judge opinions and comments) is available from the first author on request.

Quantitative Outcome Data

Luisa's quantitative outcome data is presented in Table 1. Luisa's initial scores were over the clinical cut-off range in every measure: the CORE-OM score was 15.6, indicating a moderate level of global distress and functional impairment; the PHQ-9 score was 15, indicating moderate level of depression; The GAD-7 score was 17, indicating a severe level of anxiety. The PQ mean score was 5.6, indicating that Luisa's problems were identified as considerably to very considerably bothering. At Session 8, (mid-therapy), there is an improvement in all measures, that is reliable for GAD-7 and PQ. At Session 9 the GAD-7 and the PHQ-9 reached the clinical significant and reliable change level, that was reached by the CORE and the PQ at Session 11, indicating an early symptomatological improvement. By the end of the therapy, Luisa achieved both clinically significant and reliable change in all measures, and this was maintained in the 1-, 3-, and 6-month Follow Ups. It is noteworthy that Luisa interrupted all her medications (apart from her homeopathic remedy for insomnia) between Sessions 12 and 13. Table 2 showsthe main problems that the patient identified in her PQ at the beginning of the therapy and their duration. All the problems were scored as standing from less than one year. Figures 1 and 2 show respectively the CORE-OM and the PQ weekly scores.

Qualitative Data

Luisa compiled the HAT form at the end of every session (Table 4), reporting only positive/helpful events. All positive events were rated 8 (greatly helpful) or 9 (extremely).

Luisa participated in a Change Interview 1-month after the conclusion of the therapy. In this interview she identified her main and significant changes (Table 5). Luisa described her therapy as "helpful, I felt better just coming out from the study" (CI, Patient line 9), "I felt I feel more relieved, more serene" (P 10). She " would not have ever thought to talk about those things with a stranger... but it was very easy... there was feeling, lets say" (P16). She was surprised "at 65 years... to be still able... I mean, I now enjoy being with people, I enjoy talking" (P 26). Luisa felt that her problem was the end of the relationship with her partner, and "Now I have really changed my behaviour towards him... we talk a lot... I spoke about things that... before I held inside me... and also he changed towards me" (P38). Luisa summarised two main areas of change. First, an improvement in her way of communicating with others. Luisa identified this change as unexpected (rated 5, surprising), unlikely without therapy (1) and extremely important (5). She recognised that she is "more diplomatic in her communication with everybody" (P 62-3). The second change she identified was an improvement in her health condition, since she describes all the symptoms she had at the beginning of the therapy. She said that she expected such a result, because she went in therapy for that (rated 1, expected), and that the change would have been neither more nor less probable without therapy, because she was also under medication with her general practitioner that was particularly taking care of her (P 59). Luisa was also invited to comment on the mechanism of changes and to what she attributed them. Luisa said that it was "a melting pot of things... the therapy helped me a lot... and also my three best friends... they were very close to me... always inviting me when organising something... and my family too... my son, my daughter-in-law... my nephews... in general, my relationships" (P 64-5). Luisa thought that the therapy helped her "in the sense that alone I would not have been able to get out of this situation.. I managed to open up and it made me realise where I was wrong... Also some topics came out that I did not expect... also about my past... for me it was very important" (P 66). Luisa in her CI did not report any negative, obstructive or unpleasant aspect of therapy. On the contrary, she felt that "from the first session I felt more relieved, even if it was unpleasant to think about my father's death, my partner and the bad things he said to me" (P 70) and "we touched on all the topics in an easy way... it was a complete thing, we spoke of everything" (P 72).

HSCED Analysis

Affirmative Case

The affirmative team identified four lines of evidence supporting the claim that Luisa had changed and that the therapy had a causal role in this change.

Change in stable problems - In Table 1 we observe a significant improvement in the measures of global suffering (CORE-OM), depression (PHQ9), anxiety (GAD7) and severity of personal problems (PQ). At the end of the therapy and in the follow ups all measures show clinically significant and reliable change, indicating that there is a stable Global Change. In the PQ (Table 2), Luisa identified 5 main problems at the beginning of the therapy, which she was trying to solve. All the problems were related to depressive symptoms: her sensation (tired, depressed), feeling (guilty, not enjoying) or emotional behaviour (not smiling). All the PQ problems (apart from the 4th, I do not smile anymore) reached

	Clinical Cut-Off	Case Cut-Off	Reliable Change Index	Pre-Therapy	Session 8 (middle)	Session 16 (end)	1 month FU	3 months FU	6 months FU
PHQ-9	10	15	5.1	**15.6**	**15,2**	1,2(+)(*)	0,6(+)(*)	2,4(+)(*)	1,2(+)(*)
CORE	10	15	6	**15**	**10**	1 (+)(*)	2(+)(*)	4(+)(*)	2(+)(*)
GAD-7	8	10	4	**17**	**8 (*)**	0(+)(*)	3(+)(*)	1(+)(*)	1(+)(*)
PQ	3	3.5	1	**5.6**	**4 (*)**	1,2(+)(*)	1,8(+)(*)	1(+)(*)	1,6(+)(*)

Table 1: Luisa's Quantitative Outcome Data

*Note. Values in **bold** are within clinical range; + indicates clinically significant change (CS). * indicates reliable change (RCI). CORE = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2000). PHQ-9 Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999) GAD-7 = Generalized Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006). PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). HAM-D = Hamilton Depression Rating Scale (Hamilton, 1960). FU = follow-up.*

	PQ items	Duration	Pre-Therapy	Session 8 (middle)	Session 16 (end)	1 month FU	3 months FU	6 months FU
1	I feel down (tired)	1-5 m	**6**	**4**	1	1	1	1
2	I feel depressed	1-5 m	**5**	**5**	1	1	1	1
3	I feel guilty	6-11 m	**6**	**4**	1	2	1	1
4	I don't smile anymore	6-11 m	**6**	**3**	2	**4**	1	**4**
5	Overall suffering: I don't enjoy anything	1-5 m	**5**	**4**	1	1	1	1
	Total		28	20	6	9	5	8
	Mean		**5,6**	**5**	1,2	1,8	1	1,6

Table 2: Luisa's Personal Questionnaire items

***Note:** Values in **bold** are within clinical range; the rating is on a scale from 1 to 7 and indicate how much each problem has bothered the client during the previous week: 1 = not at all; 9 = completely. FU = Follow Up. m = month. y = years.*

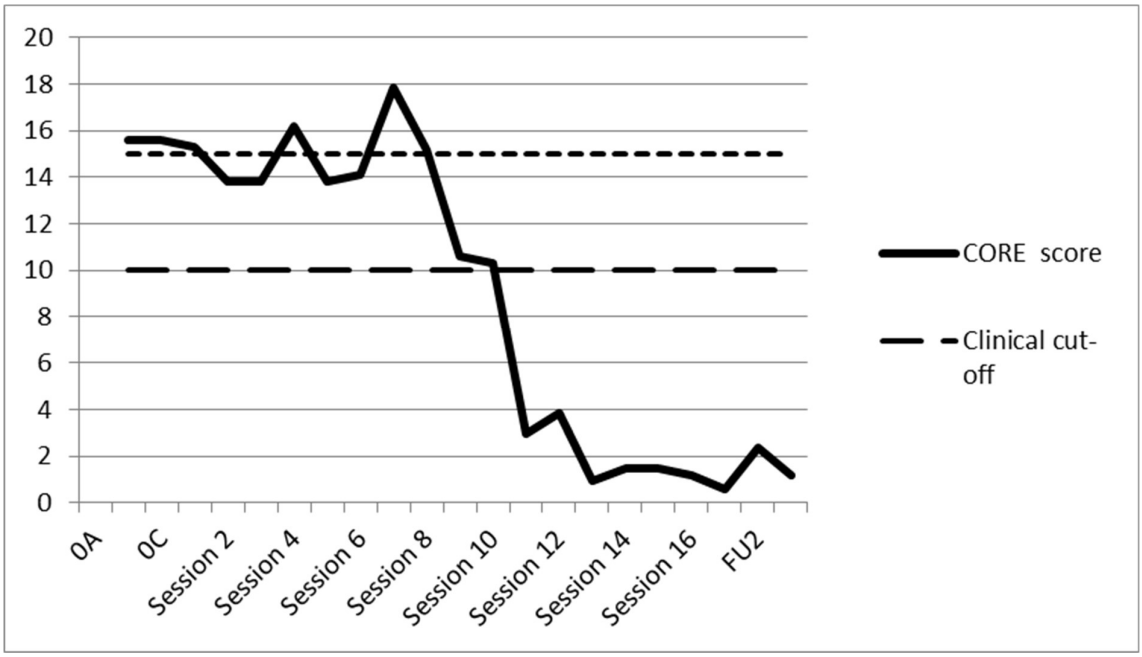

Figure 1: Luisa's weekly CORE-OM score

Note. 0A, 0B and OC = assessment sessions. CORE = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2000). FU = follow-up.

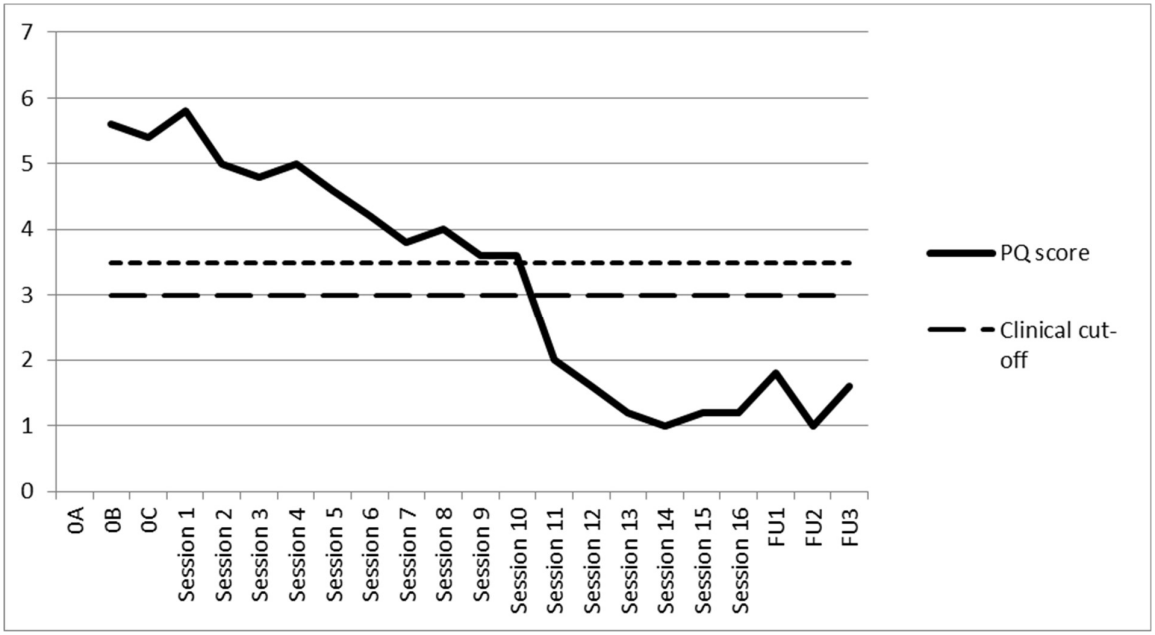

Figure 2: Luisa's weekly PQ score

Note. 0A, 0B and OC = assessment sessions. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). FU = follow-up.

Session	Rating	Events
1	8 (greatly)	Understand that my son was critical about my ex partner / Get in touch with my feelings
2	9 extremely 8 greatly	Express my sadness / I can't express with anybody else To understand that my work caused our rupture but that it is important for me
3	8 greatly	Understand my need for clarity in relationship / when I feel angry there has been no clarity
4	9 extremely	to obtain my son's approval about therapy
5	9 extremely	To realize that working is important for me and it is different for my ex partner / we have different ideas
6	9 extremely	Hospitality - I feel instinctively more hospitable. It's emerged that I feel only half considered by my ex partner, not entirely.
7	9 extremely	I realised that I must avoid him and don't look for him anymore/ for me this awareness is important
8	-	Missing
9	9 extremely	It has been useful to talk about my meeting with him with more serenity than the previous times.
10	9 extremely	To have received a validation of my need to clear things up with my son/ Helped to clarify a doubt
11	9 extremely	Today it has been important for me to talk about the clarification I had with him. I received confirmation that I didn't' do anything wrong by going back with him.
12	9 extremely	The reconfirmation in regard to the changes obtained in the relationship with him. To talk about it with a great serenity.
13	9 extremely	To reflect on what I should say to my son. The confirmation of my consideration for him.
14	9 extremely	The confirmation of a recovered well-being in the relationship.
15	9 extremely	I confirm my change. I didn't think I could change.
16	9 extremely	Sharing the reading of E.'s note with the therapist. The confirmation of how the content of the note changed his value for me over time.

Table 4: Luisa's helpful aspect of therapy (HAT forms)

Note. The rating is on a scale from 1 to 9; 1 = extremely hindering, 9 = extremely helpful. HAT = Helpful Aspect of Therapy (Llewelyn, 1988)

CI ITems	How much was change expected [1]	How likely change would have been without therapy [2]	Importance of change [3]
To have a better communication with others	5 (surprising)	1 (unlikely)	5 (extremely)
To overcome my health problems (weight loss, insomnia, gastritis, shingles)	1 (expected)	3 (neither)	5 (extremely)

Table 5: Luisa's Changes identified In the Change Interview (Elliott et al. 2001).
[1]The rating is on a scale from 1 to 5; 1= expected, 3= neither, 5= surprising. [2] The rating is on a scale from 1 to 5; 1=unlikely, 3=neither, 5=likely. [3] The rating is on a scale from 1 to 5; 1=slightly, 3 = moderately, 5=extremely.

clinical significance and reliable change by the end of the therapy and were maintained throughout follow ups. The only exception was the item "I don't smile anymore", which she hypothesised wasn't a real problem to solve, but an aspect of her personality. In fact, she states that she has always been like that (CI, P 80), in line with her depressive personality traits and Dysthymia. As for problem durations, we note that all the problems were scored with a maximum duration of 11 months. However, within transcriptions we find several descriptions of these problems as long standing problems. She refers to having always been someone who seldom smiles, (CI, P 80), always feels guilty (Session 4, P 148-9) and always unhappy (Session 16, P 77-78). Thus, we claim that Luisa obtained a stable change in long standing problems.

Qualitative data seems to support this conclusion: in fact, Luisa reports as a main achievement in therapy her change in relationship with others, a long standing problem ("I was used to keeping things buried, for the sake of a quiet life"; (CI, P 39), a problem that was not identified in the first sessions

Retrospective attribution - Luisa recognised in her Change Interview two important changes in different aspects of her life which she attributes to therapy (Table 5). Both the improvement in her communication with others and in her health condition are considered extremely important, the first unexpected and unlikely without therapy, and the second expected and neither likely nor unlikely without therapy. She recognised that the therapy allowed her to change different aspects of her relationships with others. The first change was not identified by Luisa in the PQ at the beginning of therapy, but emerged in the end as fundamental issues that Luisa addressed and changed during therapy. The client asserts that the therapy was very useful to her, in particular for the kind of relationship established, that she describes as very warm and hospitable. She also affirms that there were no negative aspects, obstacles or unhelpful aspects to her therapy.

Association between outcome and process (outcome to process mapping) - The HAT completed at the end of each session provides us with regular and immediate reports of what Luisa found helpful in each session. All reported events are considered greatly or extremely useful and are connected to the therapist's interventions during the session or to specific therapy processes. In particular, it is important to notice the therapeutic focus on hostility in Session 3 and submissiveness in Session 6. In Session 3, Luisa realised that her hostility is a consequence of a lack of clarity (Table 4, HAT 3). In Session 6, Luisa realised that her submissiveness was a protection against her fear of abandonment, and was followed by a change in her interpersonal relationships (Table 4, HAT 11, 12, 13). This focus on personality traits led to a deep and stable change. For example, before therapy she used to listen to her partner's criticism without answering but, instead, ruminating, sulking and avoiding discussion (Session 11, P 97-98). At the end, she changed this attitude: she started to face discussion and began to express her emotions and thoughts (C 38-39-40). In Session 7, the therapist focused on the end of the relationship with her partner and her need to take care of herself, which led to increased awareness that in turn brought a symptomatological improvement in subsequent sessions (Table 1, Figure 1 and 2).

Event-shift sequences - Self-report data shows a substantial change starting from Session 9. For example, Luisa's CORE score at the beginning of therapy was 15.6, which dropped to 2.9 at session 11 and to 1.2 by the end of therapy. In particular, in Session 7 the problem of the separation from her partner was explicitly addressed, and the client was confronted about her fantasies about the possible meanings of the ex-partner's words "I don't want you anymore". Here, the therapist helped Luisa come to terms with the actual end of their

relationship, focusing on her needs to take care of herself and to enjoy life. Luisa seemed to acquire a new awareness of herself and to make meaning from her experience of this loss. In Session 9, Luisa reported feeling a sense of relief immediately after the last sessions, which had lasted for the following days, thanks to her remaining aware of her situation. She reported also having been able to finally notice an improvement in her sleep and she had regained her appetite. Luisa also expressed a feeling of gratitude towards her therapist, who she saw as the only person she could really trust. Furthermore, from this session on there appears to have been a general improvement in her relationships: Luisa seems to have taken on a more active role and to have been able to directly express her thoughts and wishes. Looking at the transcripts of the sessions, it is clear that Luisa's improvement began prior to her getting back together with her partner (between Sessions 10 and 11).

Within therapy process-outcome Correlation - As for the fifth source of evidence, no correlation between within-therapy processes measures, the adherence form and quantitative outcome measures has been found, suggesting global rather than intermittent change.

Affirmative Conclusion - In conclusion, it appears that the depression of Luisa was triggered by her retirement, which enhanced a conflict of identity (hard-worker versus retired woman) leading to rising dysthymic symptoms. Her conflicts and symptoms had an adverse impact on her relationship, since her partner wanted to spend time with Luisa, enjoying retirement together. The relationship deteriorated, which deepened her depression. The therapist focused on Luisa's self-critical ego state internal dialogue, self-esteem, sense of identity, as well as Luisa's personality traits of submissiveness and hostility, which led to a change in her overall internal and interpersonal attitude. This in turn had an impact on depression and resulted in Luisa and her partner reconciling their conflict.

Sceptic Case

1. The apparent changes are negative (i.e. involved deterioration) or irrelevant (i.e. involve unimportant or trivial variables) - Although standardised quantitative measures shows Global Reliable Change, we observed that the Personal Questionnaire items appear to describe variables which are all similar in content, largely reflect depressive symptoms and mood, and do not cover all the five areas suggested for the item generation (symptoms, mood, specific performances or activity, relationships, self-esteem). Moreover, items appear to reflect general and vague problems, which are not adequately specified.

2. The apparent changes are due to statistical artifacts or random errors, including measurement error, experiment wise error from using multiple change measures, or regression to the mean - On several occasions Luisa voiced some ambivalence about completing the outcome questionnaires. Some of her measures contained mistakes (e.g. forgot to fill in the last item of the GAD-7 (that is very close to the score line) suggesting inattentiveness, are uncompleted or missing because she refused to fill them in (as the HAT in Session 8). Starting from Session 13, every test is filled in almost identically, assigning the lowest score possible. There is some evidence that in the final sessions she filled in the CORE (with a line of 0 scores), somewhat mechanically, thus wrongly scoring 4 in the inverted items and then correcting them. This negative attitude towards the questionnaires cast doubts on the overall accuracy of her self-reported scores and answers, which the sceptic team feels more accurately suggests global unreliable change.

3. The apparent changes reflect relational artifacts such as global 'hello-goodbye' effects on the part of a client expressing his or her liking for the therapist, wanting to make the therapist feel good, or trying to justify his or her ending therapy - In her CI, Luisa reported only positive comments about the therapy and the therapist, and in her HAT forms she reported only positive/helpful events. Despite this, there is some evidence in the therapist notes of dissatisfaction about recording sessions and filling in questionnaires. This incoherence suggests that CI and HAT may be biased by Luisa's tendency to Please Others and a desire to present a good image of her therapist to the researcher, in line with her personality traits. Also, the massive and rapid change in self-report measures from Session 11 may reflect the willingness to appear healthy in order to end the therapy, as expressed from Session 12 (P 202) and in Session 14 (P 146).

4. The apparent changes are due to cultural or personal expectancy artifacts; that is, expectations or 'scripts' for change in therapy - The sceptic team were not able to find any evidence within the rich case record which would support a claim that Luisa's changes were associated with expectancy effects.

5. There is credible improvement, but involves a temporary initial state of distress or dysfunction reverting to normal baseline via corrective or self-limiting processes unrelated to therapy - At the beginning of the therapy Luisa presented with severe global distress due to the end of the relationship with her partner. She also described in her PQ form that the problems she was seeking to address in therapy were not long-lasting problems, all of which she indicated had been problems for a period of between 6 to 11 months. The diagnosis of Major Depressive Disorder appears to be inappropriate and symptoms are likely to be an understandable and appropriate response to a significant loss. Thus, the observed reliable global change appears to be a spontaneous remission. This is supported also by the general, almost simultaneous improvement in all self-reported measures after five months. It appears quite unlikely that therapy has such a sudden effect, supporting the conclusion that the symptoms were caused by a temporary state of distress and that the change is not due to therapy.

6. There is credible improvement, but it is due to extra-therapy life events, such as changes in relationships or

work - Luisa and her ex-partner met and resumed their relationship between the 9th and 10th session of therapy. In fact, in Session 10 she reports feeling better thanks to the re-starting of the relationship. We observe a steep improvement from Session nine to Session eleven in all measures. Moreover, a few sessions after she had resumed her therapy, Luisa indicated that she did not feel it necessary to continue in therapy because she felt better. Following this, she indirectly asked several times to end the therapy. We believe it is important to note that Luisa had regular therapeutic massages since Session 7, and stated in her CI that she had found these to be useful. Furthermore, in her overall change reported in her CI, she states that she renegotiated her spare time with her partner, but this may be related also to the close death of three friends, reported in Session 16. These tragic events may have changed Luisa's awareness about her retirement and influenced her choices.

7. There is credible improvement, but it is due to unidirectional psychobiological processes, such as psychopharmacological mediations, herbal remedies, or recovery of hormonal balance following biological insult - Luisa has been included in this research despite the fact that she was taking antidepressant medication. We affirm that it is not possible to differentiate between the effects of psychotherapy or medication in either the outcome or process measures.

There is credible improvement, but it is due to the reactive effects of being in research - There is no evidence of Luisa's changes being connected to the reactive effects of participating in the research; on the contrary, she appears slightly oppositional towards recording and sometimes felt annoyed by filling in the questionnaires.

Sceptic conclusion - According to the sceptic team, Luisa's depression was due to a transient adjustment to her retirement that led to a deterioration in her relationship with her partner, which caused her depression. When the relationship was resumed, Luisa's depression recovered and she asked to end the treatment.

Affirmative Rebuttal

1. It appears evident in session transcripts, and the CI and HAT data, that Luisa had a better verbal fluency than reading or writing ability, congruent with her education. She appeared to be fatigued by reading and succinct in writing, sometimes asking the therapist for help in writing her HAT. Furthermore, in line with her personality traits, Luisa presents difficulty in naming and connecting her sensations, feelings and emotions to words. During the PQ item generation and defining her problems, at times she appeared to be upset by the procedure.

2. Luisa's minimal education may account for some of the errors and incongruences in filling in tests. The tendency to repeat the same minimal scores when she felt better in the last part of the therapy may reflect a lack of subtle differentiation between similar levels; for example she may have struggled with differentiating between 'not at all' or 'only occasionally' (CORE) or from 'very little' and 'little' (PQ).

3. Despite the evidence of a Please Others driver and Luisa's expressed desire to end the therapy, we note variation in scoring that would not be present if the patient was trying to appear completely healthy. Also, the symptomatic remission was what she was seeking help for at the beginning of the therapy so it would appear quite normal for her to end therapy when she felt she had recovered.

5. As for remission to previous baseline, in session transcripts it appears evident that Luisa had met the diagnostic criteria for Persistent Depressive Disorder for more than two years. Above all, the symptoms of Major Depressive Disorder were present prior to her breaking up with her partner and were noted by friends, which Luisa also referred to. Her depression appears more tied to a conflict of identity than to loss, with symptoms which were present before separation and were probably related to Luisa's internal conflict between her old identity of 'hard worker' and her new identity of 'retired woman'. Furthermore, Luisa affirmed that she experienced therapy as very helpful.

6. As for extra-therapeutic events, it is probable that resuming her relationship had an effect on Luisa's mood; however we note that her moods were improving from Session 8, whereas the relationship reconciliation did not take place until between Sessions 9 and 10. After Session 7, Luisa claimed that she felt better, having slept better and regained her appetite. The improvement appeared tied to the therapeutic interventions which happened in Session 7 (See HAT, Table 4), which were focused on challenging Luisa's fantasies of still being together despite clear denials. Luisa mentioned in the following session several additional positive changes. Also social contact and her therapeutic massages may have had an effect on Luisa's mood, but in her CI she refers to them as "other factors beside therapy", attributing a primary role to the therapy.

7. As for medication, it is important to note that Luisa in her CI claimed to have stopped taking her antidepressants (although occasionally would take a homeopathic sleeping pill) since Session 12, thus excluding a direct effect of medication on the outcome of the therapy and suggesting that the changes were due to the therapy.

Sceptic Rebuttal

Within transcripts of the therapy is always possible to find evidence supporting virtually any affirmation. In several occasions Luisa contradicted herself, for example by affirming, at the end of the therapy, that she was able to express her needs and thoughts, and that she was still avoiding discussion and conflicts. Luisa appears to be not yet able to differentiate between her needs and her partner's wishes. If it is true that at the end of the therapy

she was able to keep in touch with her emotions, it is also true that she was not yet able to express them appropriately.

Adjudication

Each judge examined the rich case and hermeneutic analysis and independently prepared their opinions and ratings of the case (Table 6). Both judges concluded that this is a clearly good outcome case, the client made consderable changes, and that the changes are considerarably to substantially due to the therapy.

Opinions about the treatment outcome (good, mixed, poor)

Judge A. 'This case appears to be a clearly good outcome (60% certainty) or a mixed outcome (40%) There is no doubt that the Major Depressive Disorder is substantially diminished at the end of the therapy, both in quantitative and qualitative measures. There is a Global Reliable Index improvement and the client's behaviour is coherent with these results (organising trips with friends, holidays, parties and so on). There is no reason to believe that quantitative scores are biased from a Please Others driver or wish to end therapy, and surprising scores appear to reflect a real change in her experienced suffering.

Judge B. 'This is a clearly good outcome (80% certainty) or a mixed outcome (20%) There is great convergence between quantitative and qualitative data at the end of the therapy: the patient had no symptoms, her life showed evidence of deep change (e.g. having more time for her partner) and there is evidence of improvement in all her relationships.

Opinions about the degree of change

Judge A. 'Luisa changed moderately (40%, with 80% of certainty) both her symptoms and long standing relational patterns. There is strong evidence that she is now able to express herself in a way that she was not able to prior to therapy. This change appears stable in the follow up, even if it is not completely pervasive. I was also impressed by the improvement in the patient's ability to perceive and voice her emotions. The patient had limited goals at the beginning of the therapy, most of which were related to symptoms and she was not interested in a deeper change; for such reasons her change may not be considered more than moderate.'

Judge B. 'The patient changed substantially (80%, with 80% of certainty). When entering therapy, the patient reported depressed symptoms which had had a duration of between 6 and 11 months, but in her transcripts it appears that her depression was of a longer standing nature. At the end of the therapy, her symptoms are no longer present (do not meet criteria for Major Depressive Disorder), but above all she appears aware of the reason for her long-standing unhappiness (Persistent Depressive Disorder), and changed her behaviour and attitude in order to adjust to retirement. The change appears above all tied to her new ability to express herself, her emotions and thoughts, but also to a new perception of herself as a woman that can stop work and enjoy retirement.'

Opinions about the causal role of the therapy in bringing the change

Judge A 'The therapy appears to have contributed considerably to the changes (60% with 80% certainty). CI and HAT reports contain several examples of such changes. Despite this, the change is probably not due only to the therapy, since the reconciliation with her partner may have played an important role in her recovery, together with Luisa experiencing the death of three friends in the space of one week.'

Judge B 'The therapy has contributed substantially (80%) to Luisa's change, with a certainty of 80%. There is clear evidence within sessions that Luisa changed her internal experience and her relational patterns. It appears improbable that such a change could be strongly tied to external factors such as resuming her relationship.'

	Judge A	Judge B	Mean
How would you categorize this case?	Clearly good outcome	Clearly good outcome	Clearly good outcome
How certain are you?	60%	80%	70%
To what extent did the client change over the course of therapy?	40% Moderately	80% Substantially	60% Considerably
How certain are you?	80%	80%	80%
To what extent is this change due to therapy?	60% Considerably	80% Substantially	70% Considerably to Substantially
How certain are you?	80%	80%	80%

Table 6: Adjudication results

Mediator Factors

Judge A 'The therapist has considerable experience and appears to have a high adherence to TA principles and techniques. She appears focused on exploring emotion, feelings, sensations, and on helping the client to create connections between bodily experiences and words. The therapist also focused on reinforcing the client's identity, with a careful recognition of her transgenerational values, helping her to differentiate between her own and others' points of view. At the beginning of the therapy, the therapist used a psycho-educational approach, explaining the ego states model and so on, which appeared to have greatly helped the client to understand her own inner process.'

Judge B 'The therapist appears to be solid, gently challenging and active in the process, leaving room for the emergence of the client's narrative but never losing a clear direction and maintained clear session contracts throughout. The therapist focused on relational patterns, often challenging the client's tendency to not communicate her emotions or thoughts, expressing hostility and submissiveness, and exploring different ways to change such behaviours.'

Moderator Factors

Judge A. 'The patient has a network of relationships related to her job that may have had a supportive effect in contrasting her depressive tendencies with closeness.'

Judge B 'The patient appears hospitable and open to relationships, probably due to her long work experience, where she is always in contact with clients. She had no difficulty in describing her life and was open to speak about any topic during sessions. Her level of education may have been a subtle hindering factor, by not facilitating a deeper exploration.'

Discussion

This case demonstrates the effectiveness of TA treatment with a person with a DSM 5 diagnosis of persistent depressive disorder with a current episode of major depression (double depression), with comorbidity with severe anxiety and Phase of life problems (retirement). The client had a mild level of non-pathological impairment in personality functioning and personality traits of submissiveness and hostility. The judges believe that this is a clearly good outcome case, with clear and convincing evidence of clinical remission of symptomatology in all diagnoses, which was sustained at the follow up.

The effectiveness of TA psychotherapy in this case appears to be tied to the focus on permissions coherent with the client's injunctions, gentle challenge and redecision processes. The therapeutic alliance appears to have been built on a non-directive style and modelling permissions corresponding to the patient's Injunctions. The therapist allowed the client to create an affective bond with an exchange of positive strokes. Specific TA techniques were: the explanation of the ego state model and internal dialogue, drivers, redecisions and racket system analysis, all of which allowed the patient to rapidly get in touch with her relational behaviours and mental processes. We note that the therapy did not use regressive techniques, remaining focused most on here-and-now. This appears coherent with the client's request of a change focused on symptoms remission rather than in deep script analysis. Furthermore, the therapy appears to be consistent with the manualised therapy described by Widdowson (2015), and suggests that the treatment described in that manual can be effective for the psychotherapy of depression.

Limitations

The first author has a strong allegiance to TA, is a university teacher of the members of the hermeneutic groups and a colleague of the two judges. The author was also funded for this research by TA institutions (see Funding below). Despite the reflective attitude adopted in this work, these factors may have influenced in subtle ways both the hermeneutic analysis and the judges' evaluations.

The baseline consisted of only two measurement intervals whereas international standards require at least three measurement intervals to make claims of a stable baseline.

The adjudication procedure has been conducted by two judges and would be have been enhanced by inviting a third judge to offer their perspective on the case.

Conclusion

This case represents the third Italian systematic replication of the case series by Widdowson (2012a, 2012b, 2012c, 2013) which had been conducted with British patients. This case suggests that there is cultural transferability of findings and that TA psychotherapy can be effective in other European settings. The judges concluded that this was a good outcome case of TA treatment of depression. Although this single case cannot be used as evidence of the TA efficacy and effectiveness for the treatment of depression, it provides evidence that TA therapy has been effective with an Italian woman with dysthymia, moderate depression and severe anxiety; as such it adds to the growing evidence base for the effectiveness of TA for depression and supports claims about the effectiveness of a manualised approach to TA therapy for depression (Widdowson, 2015).

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Enrico Benelli PhD, Certified Transactional Analyst (Psychotherapy), Vice-President of the Center of Dynamic Psychology of Padua (Italy), Adjunct Professor, University of Padua can be contacted at: enrico.benelli@unipd.it

Desiree Boschetti, Provisional Teaching & Supervising Transactional Analyst (Psychotherapy)

Cristina Piccirillo, Certified Transactional Analyst (Psychotherapy)

Laura Quagliotti, Teaching & Supervising Transactional Analyst (Psychotherapy)

Vincenzo Calvo, Assistant Professor, University of Padua

Arianna Palmieri, Assistant Professor, University of Padua

Marco Sambin, Certified Transactional Analyst (Psychotherapy), Full Professor, University of Padua

Mark Widdowson PhD, Teaching & Supervising Transactional Analyst (Psychotherapy)

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