

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

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Abstract

This study is the first 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, Sara, was a 62-year old white Italian woman with moderate depression and three recent bereavements, who attended sixteen sessions of transactional analysis therapy. The diagnosis is based on the new DSM-5 criteria that allow differentiation between Depression and Bereavement. The conclusion of the judges was that this was a good-outcome case: the client improved early over the course of the therapy, reported positive experience of therapy and maintained the improvement at the end of the follow-up.

Key words

Systematic Case Study Research; Hermeneutic Single-Case Efficacy Design; Transactional Analysis Psychotherapy; Depression; Bereavement

Introduction

This article is the first of a series of three and represents an Italian systematic replication of previous findings in the UK (Widdowson 2012a, 2012b, 2012c, 2013) supporting 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 'Sara', a 62-year old Italian woman presenting with depression and bereavement. The psychotherapy was conducted according to manualised TA treatments of depression (Widdowson, 2015; 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. Finally, 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.

Client

Sara is a 62 year-old white Italian divorced woman. She lives alone and has a 30 year-old son, born within her ended marriage. Sara works as a teacher in middle school and is due to retire within the next few years. At the beginning of the therapy she reported several somatic symptoms, in different parts of her body, but mainly at the gastrointestinal tract. She reported that for several years now, she had not “felt well”, she always felt “guilty” and viewed herself as “rubbish”, she devalued herself and she had lost interest in all of the things that previously she had enjoyed. She had started to think that all the activities that she used to love were only a burden and a duty. However, she was afraid of being alone and therefore always tried to keep herself busy with work, friends and various activities, even though she found this coping strategy wearisome.

In the last year her situation seemed to have become increasingly grave, due to the death of her mother, her aunt (whom she experienced as a second mother) and her partner. Sara had started her relationship with her partner 3 years earlier and he died 2 months before she started the therapy. She appeared to have been deeply touched by the death of her lover; he used to make her feel protected, accepted and “appeased”, in a total and complete relationship. This last bereavement worsened her already depressed mood, leaving her in a heartbreaking state of suffering, loneliness and emptiness. She felt that the situation was progressively worsening. She used to feel that nothing could have helped her to enjoy her life again. Moreover, she had started to think that if she were to be aware that she was going to die, she would not mind at all, even if she was surrounded by friends and people who loved her. Sara referred to having always been a person who leaned to others, and who likes to talk and chat with friends, but also feels guilty of her tendency towards “pouring out her problems onto others”.

Sara described her mother as a cold woman, who never showed her love towards Sara and who was emotionally closed and had a bad temper. When her mother used to quarrel with Sara or with Sara’s father, she would not speak to them for several days. The only times in which her mother really showed love to her were when Sara was sick. Sara cared for her mother during all her illness and until her death, but often felt guilty and mean for

sometimes being angry with her mother. Sara described her father as ironic and adorable. She stated that he taught her a passion for life and for dancing, singing, painting and the theatre. He died when Sara was 30 years old.

Her husband was a rich man; with him she lived an easy life, frequenting high social classes: however, during their marriage they experienced a severe economic crisis. After their divorce she still used to lend him money or be his guarantor for loans. Sara reported she had always had difficulties in her relationship with men. She was a beautiful woman, always elegant and she used to feel appreciated by her husband because at her side he always stood out. However, she always had the impression that she was wearing a mask.

In contrast to this, in the relationship with her recently deceased partner, she felt accepted for who she really was and discovered the simplicity of being truly herself. He gave to Sara reassurance, tenderness, love, physical contact and sharing. Now, without him, her fears came back. In relationships with others she reported that she often felt betrayed or surprised by them. Sometimes she completely trusted in people who in the end disappointed her. On such occasions she felt stupid and fragile, thinking that she was unable to understand people. Sara usually felt inadequate.

Sara had previous experience of therapy, which she had engaged with at several times in her life when dealing with difficult life situations or to manage life transitions. She thought that her therapy has been really useful; she had great esteem for the therapist, appreciating their capacity for dialogue. Despite this, she chose not to return to her previous therapist for the therapy described in this paper. Sara stated that she did not want to use any kind of medication, and preferred talking therapy to help her deal with her problems. Sara had several strengths: high education, high culture, intelligent and articulate, with many interests and creativity. She had a wide social network and participated in theatrical, choral and dance activities.

Therapist

The psychotherapist is a 40 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

Sara attended two pre-treatment sessions 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 also proposed the research

protocol and obtained informed consent from Sara for her participation in this research.

DSM 5 Diagnosis

From the diagnostic interview, it was determined that Sara met DSM 5 diagnostic criteria of Major Depressive Disorder. Sara feels sad and experiences depressed mood nearly every day (criterion 1), has a markedly diminished interest and pleasure in almost all her activities (2), fatigue and loss of energy nearly every day (6), feeling of worthlessness and inappropriate guilt nearly every day (7), diminished ability to think and concentrate nearly every day (8) and recurrent thoughts of death. Such symptoms may be considered appropriate considering the series of significant bereavements, the last of which is the partner death two months before. Despite this, a differential diagnosis according to the DSM 5 variable proposed for clinical judgment (Table 1), suggested that Sara's depressed mood was more related to a Major Depressive Episode rather than Grief.

Knowing the level of an individual's personality functioning and pathological 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 client showed some impairment in these areas, which did not resemble the prototypical description of the moderate level, leading to a diagnosis of high level of personality functioning. She had also been diagnosed with some personality traits in the domains of Negative Affectivity (Withdrawal, Intimacy avoidance, Anhedonia and Depressivity) and Detachment (Anxiousness, Separation insecurity and Submissiveness): however these did not reach the pathological level. Both the level of personality functioning and the traits were considered in drawing up the treatment plan.

TA Diagnosis and Case formulation

Sara's depression was conceptualized as a consequence of self-critical ego states dialogue (Berne, 1964), internalized during early childhood and adolescence. She presented several injunctions (Goulding & Goulding, 1976) tied to depressive symptoms and personality traits: Don't be you, Don't be angry, Don't enjoy, Don't be close, as well as Please Others and Be Strong drivers (Kahler, 1975). During her childhood in the relationship with her mother she implicitly learned to hide her anger and to replace it with guilt, fixing a script decision (Berne, 1972) and related racket system (Erskine & Zalcman, 1979). This pattern was reinforced in subsequent years within the majority of her interpersonal relationships, leading to her present suffering.

Variables	Grief	Major Depressive Episode
Predominant affect	Feeling of emptiness and loss	Persistent depressed mood and inability to anticipate happiness or pleasure
Course of dysphoria	Decrease over days to week and occurs in waves (pangs of grief)	More persistent
Content of dysphoria	Waves are associated with thoughts or reminders of the deceased	Not tied to specific thought or preoccupation
Positive emotions and humour	May be present	Uncharacteristic
Content of thoughts	Preoccupation with memories of the deceased	Self-critical, pessimistic ruminations
Self-esteem	Generally preserved	Feeling of worthlessness and self-loathing
Self derogatory ideation	If present, typically involves perceived failings with the deceased	Common and generalized
Death and dying thoughts	Generally focused on the deceased and about "joining" the deceased	Focused on ending life because of feeling worthless, undeserving of life, unable to cope with the pain of depression

Table 1. DSM-5 variables proposed for differentiating Grief and Major Depressive Episode

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 the empathic attunement of Sara's experience. Sara initially sought help in order to deal with her bereavement, feeling alone and extremely sad. In the first sessions, the therapist offered Sara an empathic listening, allowing Sara to express her emotions relating to the death of her partner. During these early sessions, the therapist also explained the ego state model, the drivers and the internal dialogue. The therapeutic alliance formed in the early sessions created an atmosphere of permission (Crossman, 1966) to enable Sara to move out of personality patterns relating to her injunctions. Particularly, the focus was on the injunctions; Don't be close, Don't be you, Don't be angry, and Don't enjoy. The therapy also explored archaic episodes regarding Sara's relationship with her mother and significant relational episodes relating to others. In discussing these relational episodes, Sara's internal dialogue, interpersonal options and racket analysis were explored when appropriate, to explore how Sara inhibited thoughts, emotions and physical sensations. In subsequent sessions, Sara made redecisions (Goulding & Goulding, 1979) relating to her Please Others and Be Strong drivers and the injunction Don't be angry. The final part of the therapy was focused on exploring permission to be herself and to enjoy life rather than be worried and adapt to the needs of the others.

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 suffering. 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) 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

Sara's quantitative outcome data is presented in Table 2. Sara's initial scores were over the clinical cut-off range in every measure: the PHQ-9 score was 15, indicating moderate depression; the CORE-OM score was 20.9, indicating a moderate to severe level of global distress and functional impairment; the GAD-7 score was 8, indicating mild anxiety; the PQ mean score was 5.4, indicating that Sara's identified problems bothered her considerably to very considerably. By session 8 (mid-therapy), the PHQ-9 and GAD-7 scores had fallen below the clinical cut off, indicating an early symptomatological improvement. Also PQ and CORE showed a reliable improvement, but not clinically significant change. By the end of the therapy, Sara achieved clinically significant change in all her measures, and reliable change in all measures except GAD-7. At the first Follow Up there is deterioration in all measures, which is followed by an improvement in both the second and third Follow Ups. At the third Follow Up, all her quantitative measures show a clinically significant change, as well as a reliable change in all measures with the exception of the GAD-7. In Table 3 the main problems that the client identified at the beginning of the therapy and for which she sought therapy are listed. Figures 1 and 2 show respectively the CORE-OM and the PQ weekly scores.

Qualitative Data

Sara compiled the HAT form at the end of every session (Table 4), reporting only positive/helpful events within sessions, all of which she rated at either 8 (very useful) or 9 (extremely useful). The HAT form of the fourth session was not completed.

Sara participated in a Change Interview one month after the conclusion of the therapy. In this interview she identified her main and significant changes, which she felt happened due to therapy (Table 5). The first reflects a change in her emotions, the second reflects a change

	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	6	15	8(+)(*)	5(+)(*)	12	4(+)(*)	5(+)(*)
CORE	10	15	5.1	20.9	12,1(*)	8,8(+)(*)	16,8	10,6(*)	9,1(+)(*)
GAD-7	8	10	4	8	5(+)	5(+)	12	5(+)	6(+)
PQ	3	3.5	1	5,3	3,4(*)	2,1(+)(*)	4(*)	2(+)(*)	1,9(+)(*)

Table 2: Sara'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 cannot get out of mourning	1-5 m	7	4	2	3	2	2
2	I feel guilty for my anger toward my mother	>10 y	3	3	2	5	2	1
3	I have always had difficulty in my relationship with men	6-10 y	3	4	3	4	3	3
4	I feel afraid and anxious for the future	1-2 y	7	5	3	4	3	3
5	I feel lonely	1-5 m	6	5	2	3	1	1
6	I cannot share my suffering without feeling guilty	1-5 m	5	3	2	4	2	2
7	I feel death upon me	1-5 m	7	2	1	5	1	1
8	I cannot express my anger	> 10 y	4	2	1	4	1	1
9	I'm not capable of understanding people or solving my problem with them	> 10 y	6	3	3	4	3	3
	Total		48	31	19	36	18	17
	Mean		5.3	3.4	2.1	4	2	1,9

Table 3: Sara'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.

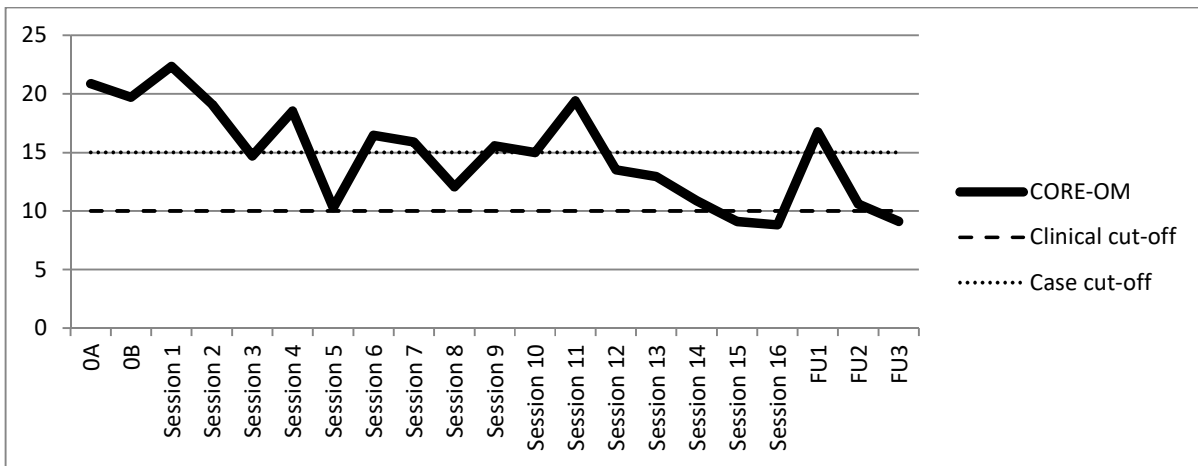


Figure 1: Sara's weekly CORE-OM score

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

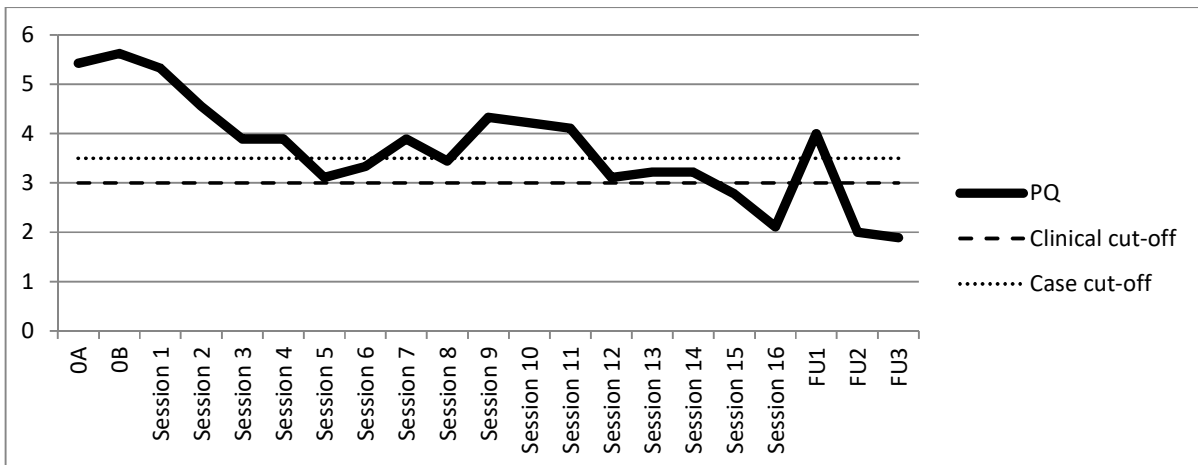


Figure 2: Sara's weekly PQ score

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

in self-perception, whereas the others reflect interpersonal changes. Moreover the researcher invited the client to talk about her mechanism of change and to what she attributes it. Sara reported that she was surprised (in the transcript, line C 21) because the therapist spoke very little, and that she was used to the other analyst who was more active. She felt gratified, welcomed, accompanied in a route, she recognised that the therapist was able to lead her in her own way into a deep transformation (C 22). She was able to put herself at the centre of her life, rather than taking care of the wishes of others at her own expense (C 42). She changed her sense of guilt towards her mother and affirmed that the therapist assisted with this. She realized that she often had a role - not being herself (C 46). She also changed the communication style with her son by starting to share emotions and problems (C 50). She realised how much others like to share emotions with her (C 51), and that previously she did not share because of

her concerns that her feelings would be too heavy for others to bear. She felt that the therapy caused most of her change, together with her good predisposition towards the therapy process (C 61). In her CI, Sara identified also some extra-therapy factors that may have influenced her therapy, such as an improvement in the relationship with her son and with her friends.

Sara in her CI did not report any negative or obstructive aspects of therapy. She only reported that she thought it was difficult and painful to talk about her past, but at the same time useful and inevitable. Moreover Sara reported she wanted to continue her therapy after the end of the research project, asking the therapist to resume the psychotherapy after the last Follow Up. By the third Follow Up, Sara had the opportunity to anticipate her retirement and accepted, and described the pleasure to have more time for herself. Furthermore, she described her happiness at becoming a grandmother.

Session	Rating	Events
1	9	The therapist thanked me for sharing my emotions
2	9	To talk about the passive anger of my mother
3	8	The therapist made me feel appreciated, thanking me for the vividness of my narrative descriptions of my life and of my lessons with my students
4	missing	-
5	8	To understand my driver "please others"
	8	To understand that grieving is only one of my problems
6	9	A new comprehension of the relationship with my mother and her conditioning in my life
	8	Understand my real nature and accept my tiredness
7	9	To understand my uneasiness about my chatting with an ex
8	8	I felt valued by the comments of the therapist
9	8	I felt reassured about my loneliness and I understood the difference between to be alone and to miss
10	9	To understand that my problems are related to childhood, when I confused my mother's expectations with my own.
11	8	To differentiate between the expectations of others and my own
12	9	My ability to put a boundary in place with my ex-husband
13	8	I was able to discover the ridiculous aspect of a situation and to tell it with humour- a new perspective on the problem
14	8	I realized that people around me have positive attitudes toward me
15	9	I felt well when my ex cancelled an appointment for a coffee. I realised that I want to be authentic and overcome past drives
16	8	I realised how much I changed in my relationship with my dead partner about my authenticity.

Table 4: Sara'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 ¹	Importance of change ³
The end of the sense of guilt toward my mother	5 (surprising)	1 (unlikely)	5 (extremely)
To think about myself and my needs before pleasing others	4 (almost surprising)	2 (quite unlikely)	5 (extremely)
Being able to create an intimate relationship with my son and to be able to share our emotions	4 (almost surprising)	1 (unlikely)	4 (very)
Being able to share emotions with others without annoying them	4 (almost surprising)	2 (quite unlikely)	4 (very)
Being authentic without hiding myself behind a role	4 (almost surprising)	2 (quite unlikely)	5 (extremely)

Table 5: Sara's Changes identified In the Change Interview (Elliott et al. 2001).

¹The 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.

HSCED Analysis

Affirmative Case

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

The first line of evidence referred to change in stable problems. In Table 1 we observe a clinically significant improvement since the middle of the therapy in the measures of depression (PHQ9) and anxiety (GAD7). At the end of the therapy and at the third follow-up all measures show clinically significant change, indicating that the change is stable and maintained after the end of the therapy. The quantitative change is also valid according the Reliable Change Index of Jacobson and Truax (1991) in 3 out of 4 measures, supporting the claim for a Global Reliable Change. The PQ shows a reliable improvement in 8 of the 9 problems that the client asked to work on at the beginning of the therapy. Furthermore, qualitative data from HAT and CI support this conclusion. In the HAT forms and in the transcriptions of the sessions there is strong evidence that the client experienced several changes in her relationships. Also in the CI the client affirmed that she made several unexpected changes. This data supports the claim that there has been a positive change.

The second line of evidence is the retrospective attribution of change to the therapy. The affirmative team noted that throughout her CI, Sara clearly attributed her changes to the therapy, affirming for example that regarding her anger towards her mother, the change had been surely due to the therapy, and that her overall changes are mostly due to the therapy. She felt that although the therapist spoke less frequently than she had expected would be the case, she had observed clear changes in her life, feeling accompanied by her therapist in finding her own solutions. This provides evidence that supports the claim that the client considers the change due to the therapy, as opposed to chance or solely due to her own efforts.

The third line of evidence is related to the process-outcome mapping. Sara states in her HAT forms from sessions 2, 6 and 10 to have felt that it was extremely helpful to work on themes related to her mother, and this appears to be coherent with the easing of her sense of guilt regarding her mother as reported in the CI. In the HAT from sessions 5, 11 and 15 Sara states that it was very or extremely helpful to work on her tendency to please others and not be authentic, and that this is related to an increasing ability to think about her own needs before pleasing others. It appears in the HAT from

Sessions 1, 3 and 8 that the therapist was able to give appreciation to the client, modelling within sessions the ability to share emotion, which Sara started to do with her son and with her associates; both of which are changes reported by the client in the CI. These links between in-session events and client changes support the claim that change is due to the therapy.

The fourth line of evidence is related to event-shift sequences. We observe in Figures 1 and 2 that after session 2 both the CORE and the PQ show a sharp improvement, which follows the work on emotions related to the client's mother, also reported in the HAT. Another sharp improvement in both measures is observed after session 4, in which the client worked on her fear of burdening her therapist with her emotions, and after session 11, in which the client worked on the emotional intrusiveness of others and her pattern of response. These sessions appear very important also in the session notes of the therapist, who described them as particularly important sessions. In session 4, the therapist reported that the session focused on working on Sara's critical internal dialogue and changing this to a nurturing internal dialogue, as well as the analysis of Sara's script decisions which were associated with her critical internal dialogue. In session 11, the therapist explored the inner dialogue and the inner payoff. This data supports the claim that specific interventions are related to the observed improvements.

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

Sceptic Case

In relation to non-change explanations, the sceptic team pointed to the score of the first Follow Up, which demonstrated a large deterioration in all measures, to suggest that Sara's changes are not stable and that any claim of efficacy should be verified in a further follow up. There is also a baseline of only two measurement intervals before therapy, despite international standards for single case experimental design requiring at least three measurement intervals to make claims of a stable baseline.

Also, it is noteworthy that the client did not refer to hindering or negative aspects of the therapy in either her HAT, or in CI, suggesting that her tendency to please others is present also towards the therapy, her therapist and the researcher and is reflected in both quantitative scores and qualitative data.

The client knew her therapist before engaging with the therapy because they worked in the same institute and she had a positive feeling toward the therapist, suggesting that the quantitative score may reflect an expectancy and relational artefact. Sara's change seems then to be due to her relationship with the therapist, which would possibly explain her deterioration in scores at the first Follow Up.

As for the non-therapy explanations, the sceptic team argued that the client had three bereavements during the last year, and that the depressive symptomatology is more likely to be related to the grieving process of the death of her last partner. Thus, the diagnosis of depression is an error, and a more appropriate diagnosis would be that of bereavement symptoms. So, the observed change is due to a temporary problem and represents a return to baseline functioning.

Also, there is an effect due to extra-therapy events. Sara's changes could be due to an improvement in her relationships with her son and friends, widely reported during sessions, HAT and CI. This could have led to an improvement in her qualitative measures. There is also a new relationship with an ex-partner, which appeared at session 13.

Furthermore, the absence of negative aspects in the CI may reflect a general tendency to be overly positive in her depiction of her therapist in front of the research team.

Affirmative Rebuttal

Despite the deterioration of Sara's scores during the first follow up period, the scores of the PHQ-9, PQ and CORE are improved compared to the beginning of therapy. Furthermore, first Follow Up quantitative data, which indicates a significant deterioration, are contradicted by Sara's Change Interview, which depicts a more positive situation. Since the client appears unhappy to have ended the therapy, we think that she may have enhanced her complaint in order to present herself as suffering and support her request to continue the therapy and that this 'spike' in the data could be considered as an aggressive reaction to the end of the therapy, which Sara felt as an abandonment. Possibly Sara wanted to show an exaggerated suffering in order to continue her therapy, instead of waiting until the conclusion of the full follow-up to resume therapy. As for stable baseline, it is usual to consider the quantitative data gathered before the first session of therapy as a part of the baseline, as there may not yet be an effect of the treatment. Thus, we can consider a stable (Table 2) or even deteriorating (Table 1) baseline.

Even if there is not a clear baseline supported by quantitative data, Sara reported her long history of suffering, stating that it dates back to her teenage years. This is the reason why Sara affirmed in her CI that her bereavement is 'on another level' and that she did not fully face it within therapy; the HAT form from session 10 also confirms this. Indeed, during her therapy she focused on her long-standing problems and she used the relationship with the therapist as an instrument to this end. This relationship appeared warm and intimate, and should not be confused as a pleasing or gratifying attitude. It is true that Sara knew her therapist before having started the therapy because they worked in the same institute, but they had different roles (teacher and psychologist) and their relationship was only on a professional level, and not at a personal level; therefore,

it is unlikely that change is due to relational artefacts. As for diagnostic error, this depends on the diagnostic system adopted. In the DSM 5 the diagnosis of Major Depression is now clearly differentiated from the one of Complicated Bereavement. The therapist used the DSM 5 criteria for the differential diagnosis between grief and depression. Moreover, the client reported that she did not face the bereavement in therapy, focusing on her long-standing problem of depression, belonging to her childhood and due to the conflicting relationship with her mother. The effect of extra-therapy factors considered by sceptic team appear to us an effect, rather than a cause, of the therapy. In fact, the relational improvement follows the sessions in which the therapist focused on internal dialog and relational patterns.

Moreover, the relationship with the ex-partner appears more conflictual and ambivalent than supportive, and it seems improbable that the change might be due to such an event. Finally, there is convincing evidence in the session transcripts about a change in self-description, which appears to relate to a change in self-representation. This in turn leads to the change observed in relationship with her son and friends. This appears to be an effect of the intimacy experienced within the treatment and the work on sharing emotions with the therapist.

Sceptic Rebuttal

Despite the new diagnostic criteria supporting the distinction between depression and bereavement, the reality is often less clear-cut and it is not possible to accurately make a differential diagnosis. So, probably the change is related to her return to normal functioning. Also, there is evidence in the transcripts that although the client can reflect on and describe her change, she is still not able to put relational boundaries in place in different situations, such as those described in session 15, when she accepted a pressing invitation without considering her own feelings and needs. The changes described appear incompletely and inconsistently applied to her

everyday life. The relational climate within the session often appears to be very gratifying for the client, as stated in her HAT forms and CI. This may lead to idealisation and dependency, and to a change due to the transference, as opposed to a deep resolution of her problems. Furthermore, in the third Follow Up the client says she is retiring and becoming a grandmother, both of which are external factors that are likely to have a strong influence on her measures in follow up. Finally, at the third Follow Up the client stated that she is going to re-start the therapy with the same therapist, and this may have had a hello-goodbye effect on the outcome measures.

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 obtained a substantial change, and that the change is due substantially due to the therapy.

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

Judge A. 'This case appears to be a clinically good outcome (80% certainty). The client shows a clinically significant change in the self-reported standardised quantitative measures (PHQ-9, CORE, GAD-7), both at the end of the therapy and at the six month follow-up. All measures (apart from GAD-7) also show reliable change. The PQ shows a clinically significant change in six out of nine problems, and in all nine problems shows a Reliable Change both at the end of therapy and at the six month follow-up. According to the quantitative data, this is a clearly good outcome. Qualitative data also supports this conclusion, since the client states in her CI that she has changed long-standing problems. Despite all of this converging evidence, I still have some doubt about the efficacy of this intervention, because it is difficult to differentiate between depressive symptoms and recent bereavement.'

	Judge A	Judge B	Mean
How would you categorize this case?	Clearly good outcome	Clearly good outcome	Clearly good outcome
How certain are you?	80%	80%	80%
To what extent did the client change over the course of therapy?	60% Considerably	80% Substantially	70% Considerably to Substantially
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%	100%	90%

Table 6: Adjudication results

Judge B. 'This is clearly a clinically good outcome (80% certainty). There is great convergence between different evidence supporting the claim that the client made positive changes. This appears to be a clearly good outcome since there is an evident improvement in all quantitative measures, with clinical (Clinical Significance), reliable (Reliable Change Index) and global (Global Reliable Change) improvement. Six out of nine problems reported in the PQ show a clinical and reliable change, of which two were long standing problems with a duration of over ten years. The improvement appears to be maintained also at the six-month Follow Up. The qualitative data is also consistent with this conclusion.'

Opinions about the degree of change

Judge A. 'The client shows and refers to having experienced considerable change (60%) with an 80% of certainty. Along with the affirmative rebuttal, within the transcripts of the sessions the client reported changes in self-representation and description, which are coupled with evidence of change in her behaviour and relationships. Eight out of nine problems in the PQ show a reliable change at the third follow-up, and six of them are clinically significant. Furthermore, in her CI the client states that she feels free of her depressive symptoms, and noticed unexpected themes, identifying change also in areas which were not initially considered in the PQ. These different types of evidence support the claim that the client's changes have been wide ranging. Despite this, the certainty is mitigated by the above mentioned consideration about bereavement: the change may reflect a grieving process.'

Judge B. 'In my view, the client changed substantially (80%), with 80% of certainty. The changes appear to be clear and correspond to the assertions of the client in her CI, which are expressed in a convincing way, and with balanced discussion of the positive and negative aspects of the therapy. The quantitative measures reveal a significant change. The sceptic claim that the simple passing of time allowed the resolution of the grief is not credible, since the change involves problems that are not related to the bereavement. The client clearly states that she feels as if she is finally living without a mask, in relation to the new skills in expressing and sharing her emotions with others. Her narratives reported in sessions show that several changes occurred in her life, bringing change in her daily life at the behavioural, relational, cognitive and emotional levels. These changes are considerable and involve her relational ability, such as sharing her suffering with friends, getting angry with her intrusive ex-husband and expressing her willingness to be open, even when this means coming into conflict with others. The therapy has touched several areas, addressing long-standing problems that need more time to be solved, such as the client's general relationship with men, to understand and solve problems with people in general, and her fear of the future. These themes appear to be more related to personality factors rather than

depressive symptoms. These kind of problems are unlikely to be overcome with a limited and short therapy and require longer interventions.'

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. In the CI, the client affirms that the therapy determined 80% of her change. From observing her HAT forms, I notice that the client experienced several helpful within-session events. There is a clear link between many interventions described in therapist notes (e.g. working through emotions associated with expressing her rage to the mother), the client's perception reported in the HAT (e.g. "to talk about the passive anger of my mother"), and subsequent changes in her behaviour (e.g. express anger with ex-husband) and a decrease in PQ score (e.g. item 8, "I cannot express my anger"). It is unlikely that a change in this kind of long-standing problem would happen without therapy. Despite this evidence, some doubt remains about the extent of the influence of the previous therapy. Indeed, the client appeared to be involved in the therapeutic process since the beginning, and this may be due to her previous therapy that may have enhanced the process of change. The grieving process may have also enhanced the outcome'.

Judge B. 'The therapy has contributed substantially (80%) to Sara's change, with a certainty of 100%. The client makes good use of what happens within sessions, generalising it to her daily life. In several sessions the client reports having thought about what the therapist said, and reports relational episodes in which the change is widely described. This appears to be clear in session transcripts and includes the client's discussion of long standing problems reported in the PQ. For example, the thoughts of guilt associated with her rage towards her mother, the ability to express anger to others, the process of understanding her own deep need for and fear of men. Anyway, it is not possible to differentiate how much of this change was due to this therapy, and how much is an effect of the previous one. Probably, the previous therapy has created a readiness to obtain the best-possible results from this therapy. In particular I think what has been especially useful in the current therapy is the analysis of Sara's relationship with her mother and the contact with her authentic and archaic anger, covered by a racket emotion of guilt. Thanks to the therapist's ability to reduce Sara's guilt, the client's symptomatology has almost disappeared completely. Moreover, this process has been quickly generalised to all the other emotions and feelings, leading the client to feel, recognise and express her sadness, her fatigue and her anger. Thanks to this, her scores in relationship, self-esteem and perception of herself as more authentic have quickly improved. It is not possible to easily differentiate the effects of the therapy from the effects of the grieving process; however I think that Sara's depression was not due to her multiple bereavements. Indeed, the client

affirms in her HAT that the grief was only one of her problems, and throughout her therapy she focused on older and long-standing problems'.

Mediator Factors

Judge A. 'The therapist has long experience and adherence to TA principles according to the point of view of both supervisor and researcher. She appears warm, emphatic, attuned and to offer positive gratification, creating a good therapeutic relationship. The client responds to this positively, feeling appreciated and consequently deeply exploring her past relationships. This was also facilitated by the client's previous experience of therapy. The therapist appeared to be focused on accepting all emotions presented by the client, and encouraging their expression. The therapist's style appears to be non-directive, but also able to focus the attention of the client on internal processes when it is useful to do so. During the therapy, the therapist explained several theoretical concepts when relevant, such as ego states and drivers.'

Judge B 'Upon reading session transcripts, it appears that the therapist is very empathic and is able to provide a climate for assisting the client in exploring her emotions and making her feel valued and appreciated. Moreover, the therapist's empathic listening, non-directive, mainly non-educative approach favoured the subjective exploration of Sara's experiences. During the session the client has been supported in exploring alternative patterns of thinking and behaviour. The therapist guided the client within actual and past relational episodes, re-experiencing emotion and allowing the client to develop a new attribution of meaning. The relationship aspect seems to have facilitated Sara's improvement, promoting her (relational) procedural and behavioural change. Sara suggested she was surprised that the therapist spoke so little in contrast to her previous therapist, who she described as driving her a lot during their dialogues, talking frequently and often giving her suggestions and advice.'

Moderator Factors

There are several client characteristics that could have influenced and moderated the effect of therapy: The high level of her personality functioning; high level of culture, curiosity and intelligence; great social network and several creative activities (dancing, theatre, singing); and her previous long dynamic psychotherapy. Moreover, the client knew the therapist before having started the therapy and they had a good professional relationship, based on reciprocal respect and esteem. Sara reports that she began the therapy because she felt already deeply understood by the therapist.

Discussion

This case presents a person with depressive symptoms after the recent loss of her partner, which may lead to a misleading diagnosis of bereavement. The diagnostic criteria of DSM 5 appear to differentiate between normal reactions to a loss and a Major Depressive Episode and

therefore help the therapist create an appropriate treatment plan. According to the judges, this case represents a clearly good outcome, with early remission of depressive symptoms. The process of therapy that emerges from the HAT forms depict a pattern of recovery whereby the client feels accepted, explores past experiences, understands her interpersonal and intrapsychic processes such as drivers, racket and internal dialogue, realises that her grief is only a part of her problem and begins to focus on early relationships. In doing so, she learns to understand the influences of her mother and differentiates self from other, gets in touch with her real nature, body sensations, emotions, and changes her interpersonal behaviour. This includes a greater use of humour and she becomes more aware of the positive attitudes that others have towards her, which reinforces her decision to be more authentic in relationships. The main aspects tied to the change appear to be the good therapeutic relationship together with specific use of TA techniques.

The therapeutic alliance appears to have been built on a non-directive style and modelling permissions corresponding to the client'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 and racket system analysis, which allowed the client to rapidly get in touch with her relational behaviours and mental processes. The main aspects related to change appear to be the racket system analysis of an archaic episode between the client and her mother, in which the client became aware of her buried emotions of anger covered by guilt. The client recognised that this therapy allowed her to change long-standing problems, and was surprised by her therapist's style: warm, non-directive and with few interventions, unlike the previous therapy.

It is noteworthy that the client asked at the first Follow Up to continue the therapy after the conclusion of the research. This is a request that many therapists in private practice come across, since often clients after a symptomatic remission ask for deeper work on their script, or personality. This raises a question about the extent to which Randomised Clinical Trials, which focus generally only on symptoms and short-term interventions, accurately reflect the experience of therapists in routine practice.

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 researchers that acted as 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 have been enhanced by inviting a third judge to offer their perspective on the case.

Conclusion

The judges concluded that this is a good outcome case of TA treatment of depression, even if the therapy may have been influenced by the client's natural grieving process. It is possible that there are some aspects of the depression that are unresolved and which are related to personality traits, such as the tendency to please others, to put the desires of others first, to avoid expression of anger and sadness, and to live according to a role. These kind of depressive traits may need a longer treatment to be addressed. In line with research on common factors, mediator factors are the strength of the therapeutic relationship, based on permissions corresponding to the client's injunctions. Also the use of TA key techniques, such as racket analysis, at a good to excellent level of application, is considered a mediator factor. As moderator factors there are the personal strengths of the client and her previous experience of therapy.

This case represents the first Italian systematic replication of the case series by Widdowson (2012a, 2012b, 2012c, 2013) conducted solely with British clients. 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 moderate depression and recent bereavement and adds to the evidence base for the effectiveness of TA for depression.

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