

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

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### Abstract

*This study is the second of a series of seven, and belongs to the second Italian systematic replication of findings from two previous series (Widdowson 2012a, 2012b, 2012c, 2013; Benelli, 2016a, 2016b, 2016c) that investigated the effectiveness of a manualised transactional analysis treatment for depression through Hermeneutic Single-Case Efficacy Design. The therapist was a white Italian woman with 10 years of clinical experience and the client, Caterina, was a 28-year old white Italian woman who attended 16 sessions of transactional analysis psychotherapy. Caterina satisfied DSM-5 criteria for major depressive disorder with generalized anxiety disorder. The conclusion of the judges was that this was an outstanding good-outcome case: the depressive symptoms showed an early clinical and reliable improvement, maintained till the 6 months follow-up, accompanied by reductions in anxiety symptoms, global distress and severity of personal problems. Adherence to the manualised treatment for depression appears good to excellent. In this case study, transactional analysis treatment for depression has proven its efficacy in treating major depressive disorder in comorbidity with anxiety disorder.*

### Key words

Systematic Case Study Research; Hermeneutic Single-Case Efficacy Design; Transactional Analysis Psychotherapy; Major Depressive Disorder; Generalized Anxiety Disorder; Dependent traits; Histrionic traits.

### Editor's Note

*This is the 2<sup>nd</sup> paper in this issue of the Journal; certain content is repeated from the 1<sup>st</sup> paper in order to ensure this paper is complete if/when it is consulted separately in the future.*

### Introduction

This study is the second of a series of seven, and belongs to the second Italian systematic replication of findings from two previous case series (Widdowson 2012a, 2012b, 2012c, 2013; Benelli, 2016a, 2016b,

2016c) and was conducted under the auspices of the European Association for Transactional Analysis (EATA) and the University of Padua.

Transactional analysis (TA) is a widely-practiced form of psychotherapy, supported with a vast literature (for a review see Ohlsson, 2010), but still it is under-recognised within the worldwide scientific community of psychotherapy. In order to define TA psychotherapy as an efficacious Empirically Supported Treatment (EST), its efficacy must have been established in at least one Randomised Clinical Trial (RCT) replicated by two independent research groups, or alternatively in at least three Single Case Experimental Design studies (SCED), replicated by at least two independent research groups, with each group conducting a case series of a minimum of three cases, without conflicting evidence (Chambless & Hollon, 1998). Recently, a wide community of researchers proposed that efficacy and effectiveness in psychotherapy are a complex object that cannot be adequately evaluated with either the experimental approach of RCT (Norcross, 2002; Westen, Novotny & Thomson-Brenner, 2004) or classical SCED (reverse or multiple baseline design) (McLeod, 2010). Systematic case study research has been proposed as a viable alternative to RCT and SCED (Iwakabe & Gazzola, 2009). Considering that approaches without evidence from RCTs tend to be under-recognised, Stiles, Hill and Elliott (2015) proposed collecting a series of mixed methods systematic single case studies as the first step toward recognition of marginalised and emerging models of psychotherapy.

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, and is a viable alternative to RCT and SCED in psychotherapy (McLeod, 2010). HSCED is gaining momentum with enhanced versions proposed by different research groups, to validate new psychotherapeutic approaches or extensions of previously validated psychotherapies for

investigation into their effectiveness with other disorders (e.g. Wall, Kwee, Hu & McDonald, 2016). Recently, a systematic review of all published HSCED studies found within English language peer-reviewed journals (Benelli, De Carlo, Biffi & McLeod, 2015) highlighted methodological issues related to different levels of stringency, offering solid alternatives to conducting sound research according to the available resources within practitioner research networks.

Systematic case study research has already been applied to investigate the effectiveness of TA for people with long term health conditions (McLeod, 2013a; 2013b) and HSCED methodology has been successfully applied to TA and widely described in this Journal by Widdowson (2012a). Recently, several HSCEDs supporting the effectiveness of TA treatment for depression (Widdowson, 2012a, 2012b, 2012c, 2013; Benelli, 2016a, 2016b, 2016c) have been published, as was an additional adjudicated study which demonstrated effectiveness of TA for mixed depression and anxiety (Widdowson, 2014). Furthermore, a related study was published on TA for emetophobia (Kerr, 2013). The case series by Widdowson and Benelli have shown that TA can be an effective therapy for major depressive disorder when delivered in routine clinical practice, in private practice settings, with clients with mild to moderate impairment in functioning who actively sought out TA therapy and with white British and Italian therapist and client dyads.

The present study analysed the treatment of 'Caterina', a 28-year-old Italian woman who had been suffering from depressive symptoms for more than ten years, worsening in the last year.

The aim of this study was to investigate the effectiveness of the manualised TA treatment of depression (Widdowson, 2016) applied to a major depressive disorder in comorbidity with general anxiety disorder. The primary target was the depressive symptomatology, with the secondary target symptoms of anxiety, global distress and severity of personality problems. Qualitative data was also collected from therapist and client on helpful aspects of the therapy and following change.

## Ethical Considerations

The research protocol follows the requirements of the ethical code for Research in Psychotherapy of the Italian Association of Psychology (AIP, 2015), and the American Psychological Association guidelines on the "rights and confidentiality of research participants" (APA, 2010, p. 16). The research protocol has been approved by the Ethical Committee of the University of Padua. Before entering the treatment, the client received an information pack, including a detailed description of the research protocol, and gave an informed consent and written permission to include segments of disguised transcripts of sessions or interviews within scientific articles or for these 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 could withdraw from the study at any moment without

any negative 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 as to not lead the reader to draw false conclusions related to the described phenomena. The final article, in Italian language, was presented to the client, who confirmed that it was a true and accurate record of the therapy and gave her final written consent for its publication.

## Method

### Inclusion and exclusion criteria

Psychotherapists participating in this case series were invited to include in their studies the first new client, with a disorder within the depressive spectrum as described in DSM-5 (Major, Persistent or Other Depressive Disorder), who agreed to participate 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 is to study the effectiveness of TA psychotherapy in routine clinical practice, comorbidity is normally accepted and both inclusion and exclusion criteria are evaluated case by case.

### Client

Caterina is a 28-year-old white Italian woman who lives with her mother and her younger sister in a metropolis in Italy. She works in a big company but she does not like her job. Her parents are divorced: her mother has dependent traits, whereas her father is a narcissistic ladies' man. She reports her parents as having being unable to put boundaries and protect her. Her younger sister is in therapy too. She feels frustrated and has many feelings of guilt both in her work and in relationships. She devaluates herself, feeling like she is not important for other, but especially for herself. When she was a little girl, if she expressed an opinion or taste that did not align with her mother's, she was frequently mocked by her. At the time of therapy, she did not have any kind of relationship. Two years earlier she had ended a four-year therapy, reporting no significant improvement. She decided to seek therapy again when she spoke to her sister's 'doctor', who recommended a therapist.

### Therapist

The psychotherapist is a 43-year-old, white, Italian woman with 10 years of clinical experience and international certification as Provisional Teaching and Supervising Transactional Analyst (PTSTA-P). For this case, she received weekly supervision by a PTSTA-P with 15 years of experience.

### Intake sessions

The client paid a normal fee for the therapy. She attended four pre-treatment sessions (0A, 0B, 0C, 0D), which were focused on explaining the research project, obtaining consensus, conducting a diagnostic evaluation according to DSM-5 criteria, developing a case formulation and a treatment plan, defining the problems

she was seeking help for in therapy, as well as their duration and their severity (i.e. preparing the personal questionnaire, see later), and collecting a stable baseline of self-reported measures for primary (depression) and secondary (anxiety, global distress, personal problems) symptoms.

### DSM-5 Diagnosis

During the diagnostic phase, Caterina was assessed as meeting DSM-5 diagnostic criteria of moderate major depressive disorder: she experienced depressed mood in daily activities for more than one year, most of the day, nearly every day (criterion A1), decreased pleasure in most activities (A2), hypersomnia (A4), feelings of worthlessness and inappropriate guilt (A7), diminished ability to think or concentrate (A8). She also met DSM-5 diagnostic criteria for generalized anxiety disorder: she experienced excessive anxiety and worry for more than one year (criterion A), she found it difficult to control the worry (B), she was easily fatigued (C2), she had difficulties in concentrating (C3) and she suffered sleep disturbance (C6). Knowing the level of an individual's personality functioning and personality traits provides the therapist with fundamental information for treatment planning. Therefore, a personality diagnosis was also conducted using the alternative dimensional model developed for DSM-5 Section III. This diagnosis allows assessment of: 1) the level of impairment in personality functioning, and 2) personality traits. Caterina showed impairment ranging from some to moderate in the level of organisation, and personality traits of depressivity, anxiousness, submissiveness, distractibility, emotional lability. The therapist also rated the computerised Shedler-Westen Assessment Procedure (SWAP-200; Shedler & Westen, 1999) that supported the diagnosis of moderate level of functioning, with traits of depressive, dependent and histrionic personality.

### TA Diagnosis and Case formulation

Caterina presented evidence of Please Me and Be Perfect drivers (Kahler, 1975) and the injunctions (Goulding & Goulding, 1976) Don't be important, Don't feel, Don't be close, and Don't be yourself. Caterina's racket system (Erskine & Zalcman, 1979) showed beliefs such as Compliance to obtain love. Her script (Steiner, 1966) analysis involved substitute feelings (English, 1971) of sadness. Interpersonally, Caterina tended to alternate dramatic roles (Karpman, 1968) of Victim (when backing down without expressing her feelings) and Rescuer (when worrying and helping others). Her life position was I'm Not OK, You're OK. (Ernst, 1971).

### Treatment

The therapy followed the manualised therapy protocol of Widdowson (2015). The treatment plan primarily focused on creating a therapeutic alliance, primarily providing Permission (Crossman, 1966) congruent with the client's injunctions, namely: *be important, feel and be close*. The therapist offered Caterina empathic listening, supporting her to feel and express her emotions, needs and wishes. During assessment sessions, the therapist also explained the ego state model, 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 Caterina's recognition of the importance of understanding her Child ego state needs for attention and being loved, exploring her experiences and analysing her script events, such as the relationship she has with the parents, which influences her actual difficulties in being independent, and her feelings of being always judged by others. Caterina attended all 16 sessions, although she skipped, and made up in the following week, session 12. In fact, session 11 has been very intense for her. Caterina reported "I knew I had to come, then I suddenly forgot... probably another example of boycott... I felt so thrilled to come, it was in my mind till few hours earlier... I felt so upset, especially because I thought all week about the things I had to tell my Child" (S12, C3-5).

### Analysis Team

The HSCED main investigator and first author of this paper is a Provisional Teaching and Supervising Transactional Analyst (Psychotherapy) (PTSTA-P) with 10 years of clinical experience, with a strong allegiance for TA. Despite recent literature suggesting that hermeneutic analysis should be carried out only by expert psychotherapists (Wall, Kwee, Hu & McDonald, 2016), we decided that when the research is investigating a new population or a therapy that lacks a research base, it is appropriate to follow Bohart (2000), who proposed that analyses can be carried out by a team of 'reasonable persons', not yet overly committed to any theoretical approach or professional role. The team comprised six postgraduate psychology students who were taught the principles of hermeneutic analysis by Professor John McLeod, in a course on case study research at the University of Padua. Following the indication of Elliott, Partyka, Wagner et al (2009), the students preferred to assume both affirmative and sceptic positions, and independently prepared their affirmative and sceptic cases. Then they met and merged their own cases, supervised by the main investigator, creating a consensual affirmative and sceptic brief and rebuttals.

### 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 he was involved in the final preparations of this article.

### Judges

The judges were three researchers in psychotherapy at the University of Padua and co-authors of this paper: Judge A, Vincenzo Calvo, clinical psychologist, psychotherapist trained in dynamic psychotherapy, PhD in development psychology, with expertise in attachment theory; Judge B, Stefania Mannarini, psychologist with

experience in research methodology; and Judge C, Arianna Palmieri, neuropsychologist and psychotherapist with a training in dynamic psychotherapy. Judges A and C had some basic knowledge of TA but had never engaged in any official TA training, whereas Judge B has some clinical experience but no knowledge of TA.

### Quantitative Outcome Measures

Three standardised self-report outcome measures were selected to measure primary target symptoms (depression) and secondary symptoms (anxiety and global distress).

*Patient Health Questionnaire 9-item for depression (PHQ-9;* Spitzer, Kroenke & Williams, 1999), which scores each of the nine DSM-5 criteria from 0 (not at all) to 3 (nearly every day), which has been validated for use in primary care (Cameron, Crawford, Lawton, et al, 2008). Total scores up to 4 are considered healthy, scores of 5, 10, 15 and 20 are taken respectively as the cut-off points for mild, moderate, moderately severe and severe depression. PHQ-9 score  $\geq 10$  has a sensitivity of 88% and a specificity of 88% for major depression (Kroenke, Spitzer, & Williams, 2001) and scores of  $< 10$  are considered subclinical.

*Generalized Anxiety Disorder 7-item for anxiety (GAD-7;* Spitzer, Kroenke, Williams, & Löwe, 2006), which scores each of the seven DSM-5 criteria as 0 (not at all), 1 (several days), 2 (more than half the days), and 3 (nearly every day). Total scores of up to 4 are considered healthy, scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety respectively. Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD and scores of  $< 10$  are considered subclinical. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%) (Kroenke, Spitzer, Williams, et al, 2007).

*Clinical Outcome for Routine Evaluation - Outcome Measure for global distress (CORE-OM)* (Evans, Connell, Barkham, Margison, Mellor-Clark, McGrath, & Audin, 2002). Each of the 34 items is scored on a 5-point scale ranging from 0-4 (0 = not at all, 4 = most of the time). Total scores up to 5 are considered healthy, scores between 5 and up to 9 are considered low level (sub-clinical), and scores of 10, 15, 20 and 25 are taken as the cut-off point for mild, moderate, moderately severe and severe distress, respectively. The cut-off of 10 yields a sensitivity (true positive rate) of 87% and a specificity (true negative rate) of 88% for discriminating between members of the clinical and general populations. CORE-OM was used in assessment sessions, in sessions 8, 16 and follow-ups, whereas CORE short form A and B were used in all other sessions (Barkham, Margison, Leach, Lucock, Mellor-Clark, Evans, McGrath et al, 2001).

All measures were evaluated according to Reliable and Clinical Significant Improvement (RCSI) (Jacobson & Truax, 1991). It is important to consider that even under the cut-off score there may be a subclinical disorder. To minimise Type I error (which occurs when cases with no meaningful symptom change are assumed to have improved) we employed also Reliable Change (RC) (Jacobson and Truax, 1991) to evaluate whether observed changes on a measure were statistically reliable and not due to chance. For example, Richards and Borglin (2011) proposed that a minimum reduction of 6 points in the PHQ-9 would be indicative of reliable improvement. Transition from clinical to non-clinical population and reliable change combine to produce a Reliable and Clinically Significant Change Index (RCSI), as robust evidence of recovery in psychological interventions (Evans, Margison & Barkham, 1998; Delgado, McMillan, Leach, Lucock, Gilbody & Wood, 2012).

See Table 1 for Clinical Significance (CS) and Reliable Change (RC) values for each employed measure. All these measures were administered prior to the beginning 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 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 (1, not at all; 7, maximum possible). Scores up to 3 are considered subclinical. In this case series, for the PQ we adopted a more conservative RC of two points, rather than the RC of one point already used in the previous case series.

All of these measures were administered in the pre-treatment phase in order to obtain a three-point baseline, and during the three follow-ups, except that in this case Caterina's PQ score was not obtained from session 1.

### 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 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 session 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 key aspects of 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 operationalised adherence checklist proposed by Widdowson (2012a, Appendix 7, p. 53-55) before agreeing on a final consensus rating. The conclusion of the three evaluators was that the treatment had been conducted coherently according to TA theory at a good to 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 both quantitative and qualitative measures. Change should be Clinically Significant (scores fall in 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 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 such as those due to a new relationship, work, or financial conditions;
7. Psychobiological causes which verify whether change is due to factors such as medication, herbal remedies, or recovery from medical illness;
8. Reactive effects of research, analysing the effect of change due to participating in research, such as generosity or goodwill 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.

Finally, each position is summarised in a narrative that offers a customised model of the change process that has been inferred, including therapeutic elements and an account of the chain of events from cause (therapy) to effect (outcome), including mediator and moderator variables.

#### Adjudication Procedure

Each single 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 positions.

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 factor(s).

## Results

In earlier published HSCED's 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, Elliott and Rodger (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

Caterina's quantitative outcome data are presented in Table 1. The initial depressive score (PHQ-9, 14.3) indicated a moderate level of depression. The anxiety score (GAD-7, 15) indicated a severe level of anxiety. The global distress score (CORE, 19) indicated a moderate level of global distress and functional impairment. The severity score of personal problems (PQ, 6.5) indicated that the client perceived her problems as very considerably to maximum possible bothering.

At session 8, (mid-therapy), all measures decreased. Depression (5) and anxiety (6) passed to subclinical mild range, presenting a clinically significant and reliable improvement. Global distress (11.8) passed to mild range with reliable improvement, and personal problems decreased to moderately bothering (4), with reliable improvement.

By the end of the therapy, all measures presented clinical significance and reliable change. Both the depressive (9) and anxiety (5) scores remained in the subclinical mild range, the global distress (7.9) decreased to subclinical low level range, and the personal problems (2.3) were rated very little, subclinical, bothering.

At the 1-month follow-up, all measures maintained clinical and reliable change. Anxiety passed into the healthy range, whereas depression and global distress passed to subclinical range, and personal problems passed to subclinical little bothering.

At the 3-month follow-up, all measures maintained clinical significance and reliable change, with anxiety returned to subclinical mild range, whereas the other measures remained in the previous range.

At the 6-month follow-up, all measures maintained clinical significance and reliable change. Depression (0) passed to the healthy range, and personal problems (2) passed to the very little bothering range.

Table 2 shows the 11 problems that the client identified in her PQ at the beginning of the therapy and their duration. 7 problems were rated as maximum possible bothering, 2 were rated very considerably and 2 considerably bothering. All problems but relationship at work (item 7, 3-5 years) were identified as bothering the client for more than 10 years. Problems are related to 5 main areas: symptoms (1, sadness; 5, concentrating), specific performances (9, late; 11 put off), relationships (7, take advantage; 8 over adapt), self-esteem (2, importance; 10, feeling less) and emotions/inner experience (3, oppressed; 4, frustrated; 6, bashful).

At the middle, 8 out of 11 problems showed a reliable change, and 3 of these also a clinically significant change. At the end of the therapy, all problems showed a reliable change, and 9 out of 11 also a clinically significant change. At the first follow-up, 10 problems maintained reliable change and 7 of these also a clinically significant change. At the second follow-up, 10 problems maintained reliable change and 9 of these also clinically significant change. At the third follow-up all problems lasting for more than 10 years showed a clinically significant and reliable change, and the only problem lasting from 3-5 years showed neither reliable nor clinical change.

### Qualitative Data

Caterina compiled the HAT form at the end of every session, reporting positive/helpful events and one hindering event. All positive events were rated from 8 (greatly helpful) to 9 (extremely helpful) and are reported in Table 3. The hindering event was reported in session 9 and rated 3 (moderately hindering): "I got here earlier believing I was late, I went away and then I got back (late), forgetting the money to pay the session. It has been hindering because this made me feel very anxious, which created in me this succession of events completely out of my control, which added up with other events that happened throughout my whole day".

She reported a rich description of therapeutic process, related to all five main areas reported in the PQ.

Caterina participated in a Change Interview 1-month after the conclusion of the therapy. In this interview she identified her main and significant changes (Table 4). Caterina described her therapy as "very helpful, I really needed it" (Client line 8). When Caterina started the

	Pre-Therapy <sup>a</sup>	Session 8 Middle	Session 16 End	1 month FU	3 months FU	6 months FU
<b>PHQ-9</b>	<b>14.3</b> Moderate	5 (+)(*) Mild	9 (+)(*) Mild	5 (+)(*) Mild	5 (+)(*) Mild	0 (+)(*) Healthy
<b>GAD-7</b>	<b>15</b> Severe	6 (+)(*) Mild	5 (+)(*) Mild	4 (+)(*) Healthy	5 (+)(*) Mild	6 (+)(*) Mild
<b>CORE-OM</b>	<b>19</b> Moderate	<b>11.8 (*)</b> Mild	7.9 (+)(*) Low level	7.6(+)(*) Low level	8.2(+)(*) Low level	6.8 (+)(*) Low level
<b>PQ</b>	<b>6.5</b> Very considerably	<b>4 (*)</b> Moderately	2.3 (+)(*) Very little	2.7 (+)(*) Little	2.6 (+)(*) Little	2 (+)(*) Very little

Table 1: Caterina's Quantitative Outcome Measure

**Note.** Values in **bold** are within the clinical range; + indicates clinically significant change (CS). \* indicates reliable change (RC). CORE = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002). 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). FU = follow-up.

Clinical cut-off points: CORE-OM  $\geq 10$ ; PHQ-9  $\geq 10$ ; GAD-7  $\geq 10$ ; PQ  $\geq 3$ . Reliable Change Index values: CORE-OM improvement of five points, PHQ-9 improvement of six points, GAD-7 improvement of four points, PQ improvement of two points.

<sup>a</sup>Mean value of pre-therapy assessment sessions.

Figures 1 to 4 allow visual inspection of the time series of the weekly scores of primary (PHQ9) and secondary (GAD-7, CORE and PQ) outcome measures, with linear trendline.

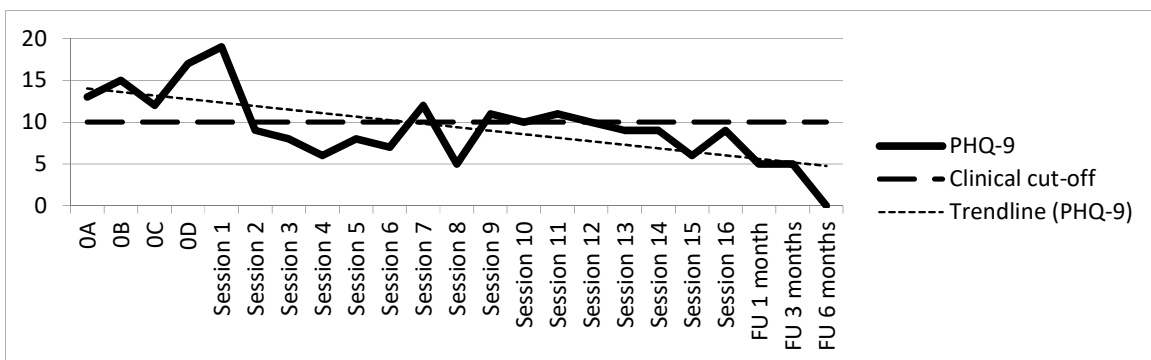


Figure 1: Caterina's weekly depressive (PHQ-9) score

**Note.** 0A, 0B, 0C and 0D = assessment sessions. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999). FU = follow-up.

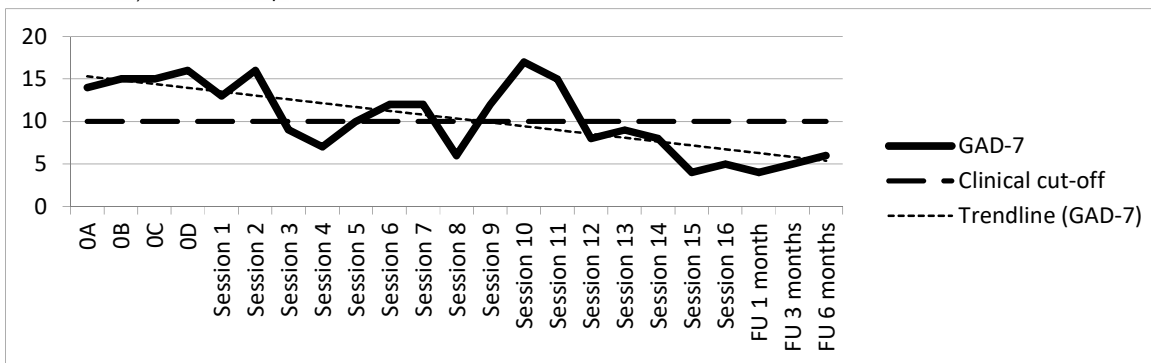


Figure 2: Caterina's weekly anxiety (GAD-7) score

**Note.** 0A, 0B, 0C and 0D = assessment sessions. GAD-7 = Generalized Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006). FU = follow-up.

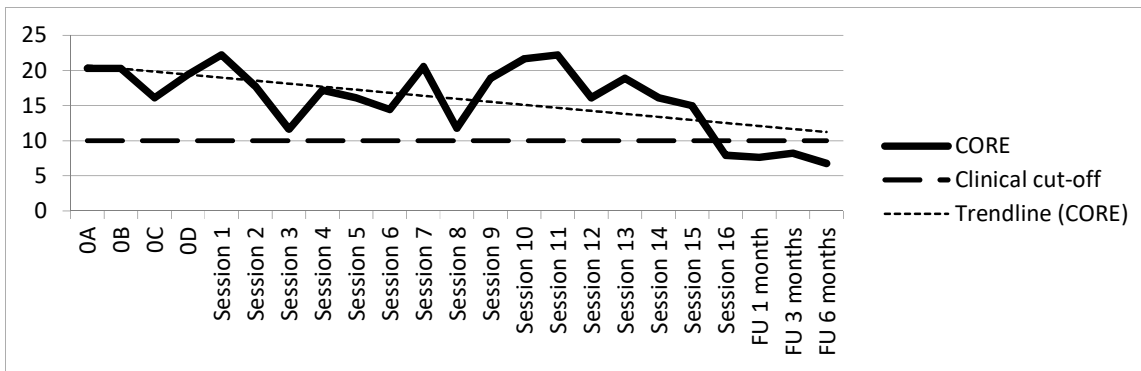


Figure 3: Caterina's weekly global distress (CORE) score

**Note.** 0A, 0B, 0C and 0D = assessment sessions. CORE = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002). FU = follow-up.

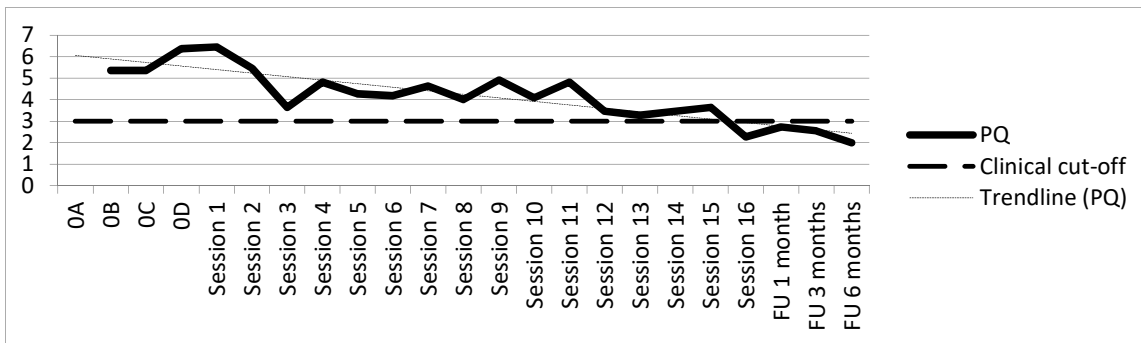


Figure 4: Caterina's weekly personal problems (PQ) score

**Note.** The first available score was in session 0B. 0A, 0B, 0C and 0D = assessment sessions. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). FU = follow-up.

therapy, she felt "so exhausted" (C83) and she "would have liked to exchange my life with any other one" (C18), whereas now she reports taking her life back (C82).

Caterina summarised six main areas of change. First, she observed an improvement in her way of giving importance to her life. Caterina referred to being surprised by such a result (rated 5, very much surprised), unlikely without therapy (1) and extremely important (5). The second and the third changes she identified were the decrease of her senses of oppression and frustration, with both as somewhat surprised (4) and that the changes would have unlikely happened (1) without therapy, rating them as extremely important for her (5). The fourth improvement was her "increase of self-esteem" (5), which would have unlikely happened without the therapy (1) and considered as extremely important (5). The last two changes were "greater respect at work" and "less devaluation of important things", identifying them somewhat surprising (4), somewhat unlikely without the therapy (2) and very important (4). Caterina also reported that some friends of hers told her she is now a better person (C28-29). Caterina felt that some sessions were "really painful, but were those that allowed me to go on" (C21).

### HSCED Analysis

#### Affirmative Case

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

#### Change in stable problems

Quantitative data (Table 1) show that there is a significant improvement in primary outcome measure (depression) that is clinically significant and reliable since the middle of the therapy and is maintained at the end and at 1-, 3- and 6-month follow-up, with a solid Reliable and Clinically Significant Improvement (RCSI). Secondary outcome measures depict an early RCSI in the anxiety (GAD-7) score, maintained throughout the follow-ups. At the end of the therapy there is also an RCSI for global distress (CORE), maintained at 1-, 3- and 6-month follow-up.

In the PQ (Table 2), Caterina identified 11 main problems at the beginning of the therapy that she was trying to solve, almost all rated as bothering her maximum possible (7). All problems standing from more than 10 years showed a RCSI at the 6-month follow-up. For these reasons, there is claim for a stable global reliable



	PQ items	Duration	Pre-Therapy <sup>a</sup>	Session 8 (middle)	Session 16 (end)	1 month FU	3 months FU	6 months FU
1	I'm very sad because my life is meaningless	>10y	<b>7 Maximum possible</b>	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all
2	I believe that others are more important than me	>10y	<b>7 Maximum possible</b>	<b>4 (*) Moderately</b>	1 (+)(*) Not at all	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all
3	I feel oppressed	>10y	<b>5 Considerably</b>	<b>4 Moderately</b>	2 (+)(*) Very little	<b>4 Moderately</b>	2 (+)(*) Very little	2 (+)(*) Very little
4	I feel frustrated	>10y	<b>6 Very considerably</b>	<b>4 (*) Moderately</b>	3 (+)(*) Little	3 (+)(*) Little	2 (+)(*) Very little	3 (+)(*) Little
5	I have difficulties in concentrating	>10y	<b>7 Maximum possible</b>	<b>4 (*) Moderately</b>	3 (+)(*) Little	2 (+)(*) Very little	<b>4 (*) Moderately</b>	3 (+)(*) Little
6	I feel bashful when other put me at the centre of the situation	>10y	<b>7 Maximum possible</b>	<b>4 (*) Moderately</b>	1 (+)(*) Not at all	1 (+)(*) Not at all	3 (+)(*) Little	1 (+)(*) Not at all
7	At work I feel that others take advantage of me	3-5y	<b>5 Considerably</b>	<b>5 Considerably</b>	1 (+)(*) Not at all	1 (+)(*) Not at all	3 (+)(*) Little	<b>4 Moderately</b>
8	In relationships I over-adapt	>10y	<b>7 Maximum possible</b>	3 (+)(*) Little	<b>4 (*) Moderately</b>	<b>4 (*) Moderately</b>	3 (+)(*) Little	3 (+)(*) Little
9	I'm always late	>10y	<b>6 Very considerably</b>	3 (+)(*) Little	<b>4 (*) Moderately</b>	<b>4 (*) Moderately</b>	<b>5 Considerably</b>	2 (+)(*) Very little
10	I have always felt less attractive, intelligent and interesting than others	>10y	<b>7 Maximum possible</b>	<b>5 (*) Considerably</b>	2 (+)(*) Very little	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all
11	I put off things that are important	>10y	<b>7 Maximum possible</b>	<b>6 Very considerably</b>	2 (+)(*) Very little	<b>5 (*) Considerably</b>	3 (+)(*) Little	1 (+)(*) Not at all
	Total		71	44	25	30	28	22
	Mean		<b>6.5 Very considerably</b>	<b>4.0 (*) Moderately</b>	2.3 (+)(*) Very little	2.7 (+)(*) Little	2.5 (+)(*) Little	2.0 (+)(*) Very little

Table 2: Caterina's personal problems (PQ), duration and scores

**Note:** Values in **bold** are within clinical range. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off point: PQ ≥3. Reliable Change: PQ improvement of two points. +=indicates clinically significant change (CS). \*=indicates reliable change (RC). The rating is on a scale from 1 to 7 and indicate how much each problem has bothered the client: 1 = not at all; 7 = maximum. m = months. y = year. FU= follow-up.

<sup>a</sup>Mean scores of pre-therapy assessment sessions.

S	Rating	Events	What made this event helpful/important	Any other helpful event
1	9 (extremely)	Being able to tell what I haven't been able to say at the right time, lacking of respect for myself.	I've felt lighter and able to formulate my thoughts. Even if I'm not sure I could be able to do it "face to face". The difficult part has been finding the words.	Realizing I felt the need of protection (and that a man should have protected me). Identifying the paradox between the search of an ongoing autonomy and the frustration of not being able to guarantee it. Or having to suffer "anything" to guarantee it to me.
2	8.5 (greatly)	Recognizing the 8 year old girl inside me, who hasn't received the possibility to "fly high", seeking something that she thought was the greatest expression of herself, an idea of happiness.	I understood I can't ignore my child side, if it remembers me my/its neglected needs.	Identify sadness as an ongoing mood. It remembered me a book I'm reading. The point is that more or less we are always sad. In the end sadness is not recognized anymore. And so you are not sad.
3	9 (extremely)	Understanding the mechanism that makes me entrust to others, judges about myself and of who I am.	It has been important to understand that according to this mechanism I AM NOT, if others don't say what I am. I gained an emptiness to fill: I, independently from others.	Giving credit where credit is due to the two parts of me that are still dealing with my ex.
4	9 (extremely)	It has been explained to me that there's a middle zone between the pedestal of perfection and the deep of devaluation, where it is possible to live a good life.	It has been important and reassuring "focusing" this mechanism. I've found it very liberating and it seems to me that I now have a clearer goal.	Connecting the dynamics of the pedestal and the deep in my relationships. Saving me from "raping" myself.
5	9 (extremely)	Finding out how, inside me, the importance of the inside and the substance of the appearance coexist.	I understood which are the origins of the war inside me. I understood why I act in a certain way, aiming at seduction and appearance.	Seeing the Parent, the Adult, the Child and myself.
6	8 (greatly)	Organizing my ideas and sharing my mood, my difficulties and the mechanisms that keep my tied to my job, have been very useful.	It's helpful because it forces me to find answers and it helps me focus on what I don't want for myself, at least until I don't know what I want.	It has been asked me to explain what it stops me from choosing another job, my lack of knowledge, my limits, because I know I want something else. I felt being able to give order to suspended or messed up thing in my perception. It seems to me I never COULD.
7	8 (greatly)	Finding out my feeling of solitude before a need of support and certainty that I lack of.	It's useful thinking about a feeling of certainty, stability and support and finding these inside me, and not delegating it to others.	Identifying the importance of the subjectivity in defying Right or Wrong. I added up different themes, arguments and thoughts without being able to be clear.
8	9 (extremely)	Everything I say has completely a negative aspect, whereas every negative thing or critic I give myself can have another aspect, opposite, positive.	Being able to give dignity to "how you are", even if it's not believed to be the most adapted in that specific contest.	Sharing my feeling of being survived and able to rebuild all that got destroyed has been helpful to me. And building for the first time something else (where I can have a good life).
9	8 (greatly)	It has been very useful finding the essence of a distinct and active role of my Adult in my way of living, that seems to be defined by a fight between my Child and my Parent.	I reinterpreted my childhood/adolescence in a more with more awareness, identifying a way of judging that left no space to my wish of freedom and expressing my Child.	
10	9 (extremely)	Feeling the need to cry, when everything came to me when the therapist asked me what I wanted.	I believe I've under lighted what the centre of my malaise may be. Like touching the centre of a livid.	The therapist illustrated me my defence mechanisms' ancient origins.

S	Rating	Events	What made this event helpful/important	Any other helpful event
11	9 (extremely)	It has been asked me how I would like others to describe myself. I found out that what I described already belongs to me and that I suppress them as a defence.	It's important to know that somewhere inside me there's a seed of who I would like to be, and that this seed can breed, if freed and supported.	Recognizing the anger
12	8 (greatly)	The therapist identified the different levels of dependence from others. The normal one about the delight of closeness and of reciprocal help, and the pathological one.	It's important to find out pathological examples I had in my life and being extremely scared about the idea of dependence.	It has been important understanding that the Child must firstly feel (and be) supported and protected.
13	9 (extremely)	Being able to speak about something I haven't been able to, since I was a little girl. The therapist identified this as the centre of my problems.	It's probably the origin of my way of living my life with detachment and without "active participation", but like an observer. It has been like getting it off my chest.	
14	8 (greatly)	I realised that an attitude of my father in his relationships is absolutely part of my way of relating sentimentally.	It emerged how I absorbed a compartmental model, the "winning" one between my parents, which I now believe to be wrong or not suited for me.	
15	9 (extremely)	I noticed that throughout the session, even when talking about other not yet reached "problems", it happened to talk about already reached goals. Few times, the therapist underlined them, and for the first time, I've had the feeling of speaking about reachable goals, within my reach and that I've already partially introjected.	It gave me a lot of optimism because no matter how long the path might be, it's not so uneven as I thought.	Identify the practical aspects like a sensation that, until today I felt like generalized apprehension, and find concrete answers that allow me to go over my obstacles, making it as a duty for myself (as a person with some value, who has necessities that deserve to be listened to).
16	9 (extremely)	When the therapist connected all my improvements to my giving more importance to myself as a person	It has been important because I understood I possess a strong base upon which I can build anything. Or create a solid base to sustain everything else. Recognizing the value and dignity of a person as his/her needs and wishes.	Realising the aptitude to consider sentimentally people that until recently I would have considered out of reach, without any possibility. Maybe because it leads to observe other as people (like myself) that live in this world like myself, and that can consider me as I consider them. See me as I see them. Not considering myself invisible before me and before others.

Table 3: Caterina's helpful aspect of therapy (HAT forms)

**Note.** The rating is on a scale from 1 to 9: 1 = extremely hindering, 5 = neutral, 9 = extremely helpful. HAT = Helpful Aspect of Therapy (Llewelyn, 1988).

change (reliable change in at least two out of three measures) in quantitative outcome measures. Qualitative data support this conclusion: in fact, in her Change Interview (CI) Caterina reports as a main achievement in therapy giving importance to her life, a long-standing problem (more than 10 years). She also reports that she changed her way in approaching life (CI, C13), in relating with others and her availability in opening up to others (CI, C26). She reports that friends saw her as a "better person" (CI, C28-C29).

Reading the session's transcriptions, from session 12 Caterina showed up with a higher mood, that is reflected in the scores of the outcome measures. In fact, in session 11, they worked on Caterina's tendency to suppress herself as a defence mechanism (Table 3, HAT 11), originated when she was a child and her mother made fun of her. She understood she needs to feel OK and love herself as her mother didn't do. This very intense session lead Caterina to skip the following one, breaking the alliance with the therapist. Nevertheless, this helped

Caterina rebuild the therapeutic alliance, triggering a new way of relating with others and giving importance to herself and her life. Thus, we claim that Caterina obtained a stable RCSI in major depressive disorder, in general anxiety disorder, in global distress and in long standing personal problems, in main areas such as symptoms, relationships, specific performances, self-esteem, emotion and inner experience.

*Retrospective attribution*

Caterina recognised in her Change Interview six important changes in different aspects of her life, which she attributes to therapy (Table 4). She also re-examines all PQ items, scoring for each one its improvement and importance. All her improvements are considered very or extremely important, all surprising or almost surprising and all unlikely or quite unlikely without the therapy. She recognised that therapy allowed her to give more importance to her life and taking her life back, which was her therapy contract. Before beginning the therapy she would have given up her life for any other one, whereas now she understands that she is able to “fix” her life (CI, C18). The client asserts that the therapy was very useful to her and that it was exactly what she needed to get better (CI, C8): “now it’s difficult for me to feel so bad like before starting the therapy” (CI, C14). In fact, she did not expect all these improvements for so long standing problems (CI, C36-C37), that without therapy would have been impossible to happen (CI, C82). She also affirms that the most painful sessions were the ones that allowed her to move on and work on herself (CI, C21). Previously, Caterina had been in therapy for four years, referring that “in four years I have never felt such big changes as I did

in such a short time in this one” (CI, C85). From session 11, when the therapist asked her how she would like others to describe herself, she noticed that everything she underlined already belonged to her. This achievement is recalled in session 15, when speaking about her problems, Caterina realised that she reached different goals throughout the therapy (Table 3, HAT 11, 15). For these reasons, we claim that the therapy had a causal role in Caterina's change.

*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 Caterina found helpful in each session. All reported positive events are considered greatly or extremely useful and are coherent with both the diagnosis, the treatment plan and the interventions reported in the therapist's notes. In particular, it is important to notice the therapeutic focus since the first session on applying in daily life the achievement; an attitude that is maintained throughout the therapy. Thanks to the therapist’s work, some items of the PQ (Table 2, item 1, 2, 7 and 8) show a clinically significant and a reliable change from session 12, maintained throughout the follow-ups, demonstrating an improvement in old aspects in her interpersonal life (Table 3, HAT 12, 13, 14, 16). In fact, in the HAT Caterina writes about these mechanisms used throughout the session (Table 3, HAT 2, 5, 9). Her work on her first two main changes (“Decrease sense of oppression” and “Decrease sense of frustration”) can be seen since HAT 4 and again in HAT 13; “I give importance to my life” and her feeling of having “greater respect at work” has been

Change	How much expected change was <sup>(a)</sup>	How likely change would have been without therapy <sup>(b)</sup>	Importance of change <sup>(c)</sup>
I give importance to my life	5 (very much surprised)	1 (unlikely)	5 (extremely)
Decrease sense of oppression	4 (somewhat surprised)	1 (unlikely)	5 (extremely)
Decrease sense of frustration	4 (somewhat surprised)	1 (unlikely)	5 (extremely)
Increase of self esteem	5 (very much surprised)	1 (unlikely)	5 (extremely)
Greater respect at work	4 (somewhat surprised)	2 (somewhat unlikely)	4 (very)
Less devaluation of important things	4 (somewhat surprised)	2 (somewhat unlikely)	4 (very)

*Table 4: Caterina's Changes identified In the Change Interview*

Note. CI = Change Interview (Elliott et al., 2001).

<sup>a</sup>The rating is on a scale from 1 to 5; 1= expected, 3 = neither, 5 = surprising. <sup>b</sup>The rating is on a scale from 1 to 5; 1=unlikely, 3 = neither, 5 = likely. <sup>c</sup>The rating is on a scale from 1 to 5; 1 = slightly, 3 = moderately, 5 = extremely.

focused specifically in HAT 6 (“It is useful to focus on what I don’t want for myself” and “It has been useful to share [...] the mechanisms that keep me tied to my job (which completely absorbs my life)”). Again, “I give importance to my life” and her “Increase of self-esteem” can be seen specifically in HAT 16 (“When the therapist referred me to all my improvements, that was giving me more value as a person”)

#### *Event-shift sequences (process to outcome mapping)*

The PQ mean score shows a progressive decrease of problems’ severity from the initial score (5.7, very considerably) to the final score (2.3, very little). The therapist’s confrontation of the client’s tendency to not give value to her life and feeling that others are more important than her (session 1), reflected respectively in the PQ item 1 and 2, that decreased since session two, became RCSI in session five and maintained through the follow-ups. Self-report data also shows a substantial change starting from session 11, thanks to the use of the rechilding technique (S11, C24), which allowed Caterina to recognise her anger (Table 3, HAT 11).

#### **Sceptic Case**

*1. The apparent changes are negative (i.e. involved deterioration) or irrelevant (i.e. involve unimportant or trivial variables).*

According to quantitative data, Caterina’s depression reached an early RCSI, maintained at the end of the therapy and throughout the follow-ups. Despite it, in session 16 she reports feeling still “depressed in specific contexts” (C16). For this reason, the changes reported in quantitative self-reported measures appear not supported by client’s statements. In the Change Interview, she also reports some changes that she feels being negative for her, like feeling “less responsible, [...] less disposed to be always available, day and night, for anything” (C35). She also reports “I should have more concentration, I should better optimise my time, I should have a schematic control of time and things, which I still don’t have, because I’m always late, I lose myself, I’m distracted, so I don’t believe I should allow myself to tone down my sense of duty and my responsibilities” (C35). Regarding her problems of relationships, in session 14 she reports having troubles in creating new relationships (C40). Furthermore, any positive change can be attributed to her past four years of therapy. Even if quantitative data support a positive change, it is highly improbable that such an improvement could have happened in only 16 weeks of therapy.

*2. The apparent changes are due to statistical artefacts or random errors, including measurement error, experiment-wise error from using multiple change measures, or regression to the mean.*

The sceptic team were not able to find any evidence within the rich case record which would support a claim that Caterina’s changes were associated with statistical artefacts or random errors.

*3. The apparent changes reflect relational artefacts 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.*

Even if Caterina in her CI and in her HAT forms did not report only positive comments/helpful events about the therapy and the therapist, (see Table 3, session 9), the sceptic team believes that Caterina’s improvement may be biased by her tendency to Please Others, in line with her dependent personality and submissiveness traits and over-adjustment. In fact, at the end of the therapy, the item 7 of her PQ (“In relationships I over-adapt”) is still scored 4 (moderately bothering).

*4. The apparent changes are due to cultural or personal expectancy artefacts; that is, expectations or scripts for change in therapy.*

Having been in therapy for four years and having her younger sister in therapy too might have unconsciously led Caterina into expecting something would have changed in a short time.

*5. There is credible improvement, but it involves a temporary initial state of distress or dysfunction reverting to normal baseline via corrective or self-limiting processes unrelated to therapy.*

The sceptic team were not able to find any evidence within the rich case record which would support a claim that Caterina’s changes were associated with a reversion to normal baseline via corrective or self-limiting processes unrelated to therapy.

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

When Caterina went on vacation (between session 7 and 8), all her scores dropped (PHQ-9 dropped from 12 to 5, reaching RCSI; GAD-7 from 12 to 6, also with RCSI; CORE from 20,6 to 11,8, with reliable change; and PQ from 4.6 to 4), but in session 9, all four measures returned to their previous score (PHQ-9 to 11; GAD-7 to 12; CORE to 18,9; and PQ went to 4.91, higher than before her holiday). Thus, the early change claimed by the affirmative team appears tied to vacation, rather than therapeutic effect. Furthermore, at the end of the therapy, she says that she was thrilled to participate in a formation program where she wanted to propose some innovations inside her company (S16, C29-30). As holidays helped her to get better, this event might have led her to feel better.

*7. There is credible improvement, but it is due to psychobiological processes, such as psychopharmacological mediations, herbal remedies, or recovery of hormonal balance following biological insult.*

The sceptic team were not able to find any evidence within the rich case record which would support a claim that Caterina’s changes were associated with psychobiological processes.

*8. There is credible improvement, but it is due to the reactive effects of being in research.*

In the Change Interview, Caterina reported that the research initially blocked her, making her feel the therapy was mechanical and difficult (C11), especially for being forced to make every single aspect of her life fit into a categorical definition (C86).

**Affirmative Rebuttal**

We can claim that all four measures support a Global Reliable Change. In only 16 sessions, Caterina made great improvements, reporting that she did not expect such a big change in a so short a period of time (CI, C37). Her being late and distracted is a passive-aggressive and oppositional defiant trait of her personality and changing difficult personality traits is a work that cannot be fully accomplished in only sixteen sessions. Even if she reports feeling still a little depressed, quantitative data show that there is a global and stable change in Caterina's depression, to a score of 0 at the 6-month follow-up. Furthermore, in session 16, speaking about the formation program in her work place, she was willing to propose a continuing education course for more efficient communication (C30), showing that she wanted to improve this aspect in which she feels she lacks. In fact, in the CI she reports a change in her way of approaching others and to life (C13). Also, according to what Caterina said, she found this actual therapy to be more efficient than the previous one because she felt the therapist was more empathic (CI, C83), declaring that "comparing these two therapies, this one is better" (CI, C85). Besides, she never speaks of the previous therapy, whereas she reports gaining more benefit from this one. Caterina also reports feeling better only after painful sessions (CI, C21). If she was complaisant towards the therapist, she would not have said she suffered. About extra-therapy events, there is no evidence that reports an improvement due to her participation in the formation program. Finally, her difficulties in dealing with self-report are only present at the beginning of the therapy, in fact she says: "it wasn't so difficult after all, and slowly it became natural and I didn't feel it so difficult [...], it was just an initial block" (CI, C11).

**Sceptic Rebuttal**

The sceptic team believes that Caterina's change is principally due to her previous therapy and that she needed this second one only to resume and fix the previous therapy work. If she will not continue with the therapy after the 6-month follow-up, she will inevitably return to her previously dysfunctional state of depression and anxiety.

**Affirmative Conclusion**

Caterina's depression, anxiety, global distress and personal problems were tied to childhood experiences of being devaluated when she was taking decisions, which led the client to have many difficulties in interpersonal patterns and intrapsychic patterns relating to inner experience, emotions, self-esteem. The therapist

created from the beginning a climate where the client explored appreciations of herself, expression of emotions such as sadness and anger, and achieved a new comprehension of her inner experience, allowing herself to relate with others and give value to her life. Furthermore, the therapist focused on Caterina's self-critical ego state internal dialogue, self-esteem, sense of identity, with regressive techniques. These experiences were reflected in changes in internal dialogues, interpersonal relationships, depressive symptoms, and personality traits of depressiveness, submissiveness, anxiety. Caterina's drop out between session 11 and 12 helped her to create a stronger alliance with the therapist, which affected her way of relating with others.

**Sceptic conclusion**

Caterina asked for therapy after a two-years suspension of a four-years therapy, consequent to her sister's doctor's advice. Her trait of personality (submissiveness, dependent) affected her relationships with the therapist and probably her outcome scores. Changes in intrapsychic and interpersonal patterns are probably due to the previous therapy and to the reassuring effect provided only by the presence of the therapist on her personality traits.

**Adjudication**

Each judge examined the rich case record and hermeneutic analysis and independently prepared their opinions and ratings of the case (Table 5). The judges' overall conclusions are that this was an outstanding clearly good outcome case, that the client made substantially to completely changes, and that the changes are substantially to completely due to the therapy.

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

**Judge A (VC).** This case appears to be a clearly good outcome (100% certainty). Quantitative data show a reliable and clinically significant change on all measures of primary outcome (PHQ-9) and secondary outcome (GAD-7, CORE, PQ) at the end and through 1-, 3- and 6-month follow-ups. Personal problems rated as lasting for more than 10 years present a clinical and reliable change, maintained through the follow-ups. It appears evident that there is a Global Reliable Change. Qualitative data from Change Interview clearly support such conclusion.

**Judge B (SM).** This is a clearly good outcome (80% certainty). Despite outstanding evidences of good change on quantitative measures, qualitative reports of the client support the conclusion that quantitative scores may be biased by personality traits.

**Judge C (AP)** This case is classifiable as good outcome case (100%). This opinion is based on quantitative measures and qualitative data that are coherent in indicating a stable global change in long-standing problems.

**Opinions about the degree of change**

**Judge A.** The client changed substantially (80% with 100% certainty). Quantitative measures support the claim that depressive symptoms are in the healthy range six months after the conclusion of the therapy, indicating a change in persistent, long standing depressive symptomatology. The clear improvement in anxiety symptoms, global distress and long standing personal problems suggest that the therapy, despite focused on depression, deeply changed personality traits.

**Judge B.** The client changed substantially (80% with an 80% certainty). Qualitative data suggest that in daily life the client experienced new ways to relate with others and a renewed self-esteem and inner experience.

**Judge C.** The client showed a complete change (100% with 80% of certainty), as showed in quantitative and qualitative data. With respect to the beginning, there is a global change in symptoms, relationships, perception of self. Hermeneutic analysis illustrated deep change in daily life that are beyond those expected in a short-term psychotherapy.

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

**Judge A.** The observed change is substantially (80% with 100% of certainty) due to the therapy. HAT and Change Interview present rich descriptions of change in the client’s life and their connections with the therapist’s interventions. Specific homework addressed the main daily difficulties of the client and were discussed with great attention to the therapeutic alliance. The therapist tends often to connect the experiences outside the therapy to what is happening within the session, allowing the client to experiment with change in maladaptive patterns within the secure therapeutic relationship, and then fostering the generalisation of the change within relationships outside the therapy.

**Judge B.** Change is substantially (80% with 80% of certainty) due to the therapy. There are clear statements in the Change Interview where the client affirms that the changes in her Personal Questionnaire were due to the therapy, and unlikely without it. The client presents a rate of change that is not usual in a short-term psychotherapy, probably due to the previous experience of psychotherapy, that acted as a solid base for the actual change.

**Judge C.** The change appears completely due to the therapy (100% with 100% of certainty). The client refers in her Change Interview to many important changes, unexpected and unlikely without therapy. We have no information about the previous therapy, but in the session transcription it appears that the actual change is not due to past or present external factors.

**Mediator Factors**

**Judge A.** Techniques such as regression to archaic relational episodes appear tied to deep and stable change in self-perception and relational patterns. The therapist explained the ego state model in early sessions and the client used often the specific language of the model, suggesting that the comprehension of what is going on may improve therapeutic alliance and psychotherapy process.

**Judge B.** The therapist challenged in an active way the beliefs and behaviours of the client, supporting imagination of what could happen from changing her way to think and to stay in relationship. The therapist also fostered the application of the new comprehension of self in the real relationship, accelerating the process of change. There is some doubt about the missed appointment after session 11, which may suggest an excessive burden of active interventions. Despite it, the therapist used the event for strengthening the therapeutic alliance, allowing the client to express her fantasies and emotion on the event.

	Judge A VC	Judge B SM	Judge C AP	Mean
How would you categorize this case?	Clearly good outcome	Clearly good outcome	Clearly good outcome	Clearly good outcome
How certain are you?	100%	80%	100%	93.3%
To what extent did the client change over the course of therapy?	80% Substantially	80% Substantially	100% Completely	87% Substantially to Completely
How certain are you?	100%	80%	80%	87%
To what extent is this change due to therapy?	80% Substantially	80% Substantially	100% Completely	87% Substantially to Completely
How certain are you?	100%	80%	100%	93.3%

*Table 5: Adjudication results.*

**Judge C.** Sharing the theoretical model since the beginning appears tied to a deeper comprehension of internal patterns of thoughts, feeling and behaviours. The therapist acted as a model of affective and nurturing parent, allowing the client to have a new experience and change internal dialogue and its effect on self-esteem.

#### **Moderator Factors**

**Judge A.** Previous therapy facilitated the assumption of the client role. Dependant traits may enhance the early development of the therapeutic alliance.

**Judge B.** the therapist appears able to create an affective climate that can hold rupture of therapeutic alliance.

**Judge C.** The client appears able to explore immediately, since the first sessions, the inner world, probably due to the previous therapy.

#### **Discussion**

This case aimed to investigate the effectiveness of a manualised TA treatment for depression in a client with moderate level of major depressive disorder (MDD) and general anxiety disorder. Primary outcome was depressive symptomatology, that showed an early reliable and clinically significant change since session 8, maintained at the end of the therapy and through the 1-, 3-, and 6 month follow-ups. Secondary outcomes were that anxiety, global distress and severity of personal problems all showed a reliable and clinically significant change at the end of the therapy and through the three follow-ups. The therapist conducted the treatment with a good to excellent adherence to the manual. Hermeneutic analysis pointed out changes in stable problem, retrospectively attributed to the psychotherapy, highlighting connections between outcome and process. The judges concluded that this is a clearly good outcome case, with a substantial to complete degree of change, substantially to completely due to the therapy. The treatment appears to be effective also for anxiety symptoms, suggesting that common mental health disorders such as depression and anxiety might share a common etiopathogenetic mechanism.

The therapeutic alliance appears to have been built on an active style, focused on personality traits associated to symptoms, transference and countertransference analysis. Specific TA techniques were: early sharing of the ego state model, exploration of inner dialogue, developing of Nurturing Parent, exploration of drivers Be Perfect and Please Me, racket analysis of guilt and sadness. This result appears partially moderated by previous treatment, that probably facilitated therapeutic alliance and early, deep exploration of interpersonal and intrapsychic maladaptive patterns.

#### **Limitations**

The first author has a strong allegiance to TA, is a teacher of the members of the hermeneutic groups and a colleague of the three 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.

#### **Conclusion**

This case study provides evidence that the specified manualised TA treatment for depression (Widdowson, 2016) has been effective in treating a major depressive disorder associated with generalised anxiety in an Italian client-therapist dyad. Despite results from a case study being difficult to generalise, this study adds evidence to the growing body of research supporting the efficacy and effectiveness of TA psychotherapy, and notably supports the effectiveness of manualised TA psychotherapy for depression as applied to persistent depressive disorder.

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