



## TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study – Giorgio

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### Abstract

This study is the fourth of a series of seven and belongs to the second Italian systematic replication of findings from previous series that investigated the effectiveness of a manualized transactional analysis treatment for depression through Hermeneutic Single-Case Efficacy Design. The therapist was a white Italian man with 17 years of clinical experience and the client, Giorgio, was a 23-year-old white Italian man who attended sixteen sessions of transactional analysis psychotherapy. Giorgio satisfied DSM-5 criteria for Major Depressive Disorder, Persistent Depressive Disorder, Panic Disorder, Agoraphobia and Dependent Personality Disorder. The treatment focused on both symptoms remission and conflicts at the core of dependent personality. The judges evaluated the case as a good outcome, mediated by the work on core conflicts of personality, that enhanced the treatment outcome and the remission of depressive symptoms. This case study suggests that the classical treatment for depression may be enhanced by considering the conflicts at the base of personality traits or disorders.

### Key words

Systematic Case Study Research; Hermeneutic Single-Case Efficacy Design; Manualized Transactional Analysis Psychotherapy; Major Depressive Disorder; Persistent Depressive Disorder; Panic Disorder; Agoraphobia, Dependent Personality Disorder.

### Introduction

This Hermeneutic Single-Case Efficacy Design (HSCED) is the fourth of a series of seven, and belongs to an Italian systematic replication of findings from previous case series (Widdowson 2012a, 2012b, 2012c, 2013, 2014; Benelli, 2016a, 2016b, 2016c, 2017a, 2017b, 2017c) and is conducted under the

auspices of the project 'Transactional Analysis meets Academic Research in order to become an Empirically Supported Treatment: an Italian two-year plan for publishing evidence of Transactional Analysis efficacy and effectiveness into worldwide recognized scientific journals', funded by the European Association for Transactional Analysis (EATA).

Previous publications have widely described the rationale for supporting by HSCED the accumulation of evidences of efficacy and effectiveness for those models of psychotherapy that are emerging or marginalized (Benelli, De Carlo, Biffi & McLeod, 2015) and specifically how this is important for recognition of TA and inclusion within the acknowledged treatments for common mental disorders (i.e., depression, anxiety and personality disorders) (Widdowson 2012a, 2012b, 2012c, 2013, 2014; Benelli, 2016a, 2016b, 2016c, 2017a, 2017b, 2017c).

The general aim of these case series is to investigate the effectiveness of the manualized TA treatment for depression (Widdowson, 2016). The specific aim of this case study is to investigate the effectiveness of the manualized TA treatment for a client with depression in comorbidity with anxiety and personality disorder. Indeed, comorbidity of several symptomatological disorders and personality disorders is often presented by clients that attend general clinical settings, in contrast with pure disorders that are usually investigated in highly selected clients attending experimental settings. Manualized treatments need to be flexible enough to allow clinicians to apply the treatments to the different presentations of the disorders (e.g., depression) and also in comorbidity with other disorders (e.g., anxiety) and personality disorders.

When treating clients with comorbidity of several disorders and personality disorders, the case

formulation (diagnosis, contract and treatment plan) should be tailored to specific problems and needs of the client. Thus, in this case we supplemented the recommendation for treating depression with the recommendation for treating personality disorders (Benelli, 2018), provided in a chapter added to the Italian translation of the manual (Widdowson, 2018). In that chapter have been developed five prototypical script-systems and consequent treatment plans for the five sub-types of depressive personality obtained by the studies conducted with the Shedler-Westen Assessment Procedure (SWAP-200, Westen & Shedler, 1999a; 1999b). Shedler and Westen proposed a taxonomy of personality syndromes alternative to that currently presented in the DSM-5 (American Psychiatric Association, 2013). According to their studies, depressive personality is the most common personality syndrome occurring in clinical practice, often in comorbidity with depressive disorders (major or persistent depressive disorder), but symptoms are better explained and treated by considering them as rooted in enduring personality patterns. They decline depressive personality disorder into five subtypes: avoidant, depressive with high functioning (neurotic), dependent-victimized, emotionally dysregulated (borderline) and hostile-externalizing. From each of their subtypes of depressive personality has been obtained a prototypical script system, with the typical script beliefs, script displays and reinforcing experiences that characterizes each subtype. The prototypical script systems are accompanied with tailored treatment plans that consider problems that can emerge in each treatment phase (Berne, 1961, 1966): alliance, decontamination, deconfusion and relearning. The treatment plans are based on the indication provided by both the SWAP-200 manual and the Psychodynamic Diagnostic Manual (PDM-2, Lingardi & McWilliams, 2017).

In this HSCED we investigate the effectiveness of the TA treatment for depression integrated with the indication for treating depressive personality – subtype dependent in the case of 'Giorgio', a 23-year-old Italian man with diagnosis of major depressive disorder in comorbidity with persistent depressive disorder, panic disorder, agoraphobia and dependent personality disorder. The primary outcome is the depressive symptomatology, and the secondary outcome is the global distress and the severity of personal problems as perceived by the client through a client-generated outcome measure.

## Ethical Considerations

The research protocol follows the requirements of the ethical code for Research in Psychotherapy of the Italian Association of Psychology, and the American Psychological Association guidelines on the rights and confidentiality of research participants. The research

protocol has been approved by the Ethical Committee of the University of Padua. Before entering the treatment, clients received an information pack, including a detailed description of the research protocol, and they gave a signed informed consent and written permission to include segments of disguised transcripts of sessions or interviews within scientific articles or conference presentations. Clients were informed that they would receive therapy even if they decided not to participate in the research and that they were able to withdraw from the study at any point, without any negative impact on their therapy. All aspects of the case material have been disguised, so that neither the client nor third parties are identifiable. All changes are made in such a way that does not lead the reader to draw false conclusions related to the described clinical phenomena. Finally, as a member checking procedure (Lincoln & Guba 1985), that is a qualitative research technique wherein the researcher compares their understanding of what an interview participant said or meant with the participant to ensure that the researcher's interpretation is accurate, the relevant parts of the final article in English language was translated by the therapist and read to the client, who confirmed that it was a true and accurate record of the therapy and gave his final written consent for its publication in English.

## 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 Disorders) (American Psychiatric Association, 2013) who agreed to participate in the research. Other current psychotherapy, active psychosis, domestic violence, bipolar disorder, active current use of antidepressant medication, alcohol or drug abuse were all 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 on a case by case.

### Client

Giorgio is a 23-year-old white Italian man who lives with his mother and her partner, who Giorgio considers "like a father", in a large metropolitan area in Italy. He has a close relationship with his mother and his girlfriend, both of whom he often asks for reassurance, advice, nurturance and support. He has not finished high school nor taken the driving licence exam and for these reasons he fears he is a failure. Since he was 18 years old he has been suffering from panic attacks in open places, or closed and overcrowded spaces, obstructing the possibility to go to concerts and to the movie theatre. He also has a strong fear that friends

and people he cares about will leave him or will not desire to spend quality time with him. He had an occasional job in a public office, but had to give up the last contract because of panic attack. At the beginning of therapy he was unemployed, but was recalled to work with a temporary contract between session 2 and 3. He describes a conflictual relationship with his natural father, whereas he had a positive and nourishing relationship with his grandmother, deceased about five years earlier. He has a stable relationship with his girlfriend who drives him everywhere. She is very supportive and encouraged him to seek therapy to solve his problems. He also reports having troubles in falling asleep due to ruminations about his future.

### Therapist

The psychotherapist is a 58-year-old, white, Italian man with 17 years of clinical experience and who has international certification as Provisional Teaching & Supervising Transactional Analyst (Psychotherapy) (PTSTA-P). For this case, he received monthly supervision by a Teaching & Supervising Transactional Analyst (Psychotherapy) (TSTA-P) with 30 years of experience.

### Intake sessions

The client attended three pre-treatment sessions (0A, 0B, 0C), which were focused on explaining the research project, obtaining consent, conducting a diagnostic evaluation according to DSM-5 criteria and the TA model, developing a case formulation and a treatment plan, defining the problems he 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 (global distress, personal problems) outcomes. In intake sessions he described as major symptoms: sleeping disorders from several months; panic attacks over about five years using metro and cars, standing in a crowd, being alone, in open and enclosed spaces; feelings of sadness, disappointment associated with frequent crying; inability to express anger; feelings of guilt; social withdrawal, loneliness, fear of being abandoned by girlfriend and friends; frequent requests for support, presence of others, reassurance and advice; desire to obtain support from both parents; fear to present his needs to others; and fear to be involved in new interpersonal situations.

### DSM 5 Diagnosis

During the diagnostic phase, Giorgio was assessed as meeting DSM 5 diagnostic criteria of moderate Major Depressive Disorder with anxious distress, Persistent Depressive Disorder, Panic Disorder, Agoraphobia and Dependent Personality Disorder. He experienced depressed mood most of the day, nearly every day, for more than two weeks (criterion A1), decreased interest

and pleasure in most activities (A2), insomnia (A4), feelings of worthlessness (A7) and diminished ability to concentrate (A8) with anxiety distress due to difficulties in concentrating because of worry (3) and fear that something awful may happen to him (4). Giorgio also met DSM 5 diagnostic criteria for panic disorder: he experienced recurrent unexpected panic attacks (A) with accelerated heart rate (A1), sweating (A2), smothering (A4) and feeling of choking (A5). He also met diagnostic criteria for agoraphobia which lasted for more than six months, when using public transportation (A1), in open spaces (A2), in enclosed spaces (A3), being in a crowd (A4), outside of the home alone (A5) and he avoids these situations fearing that help might not be available (B), which almost always provoke in him fear and anxiety (C) even in company of others (D). Furthermore, he met criteria for dependent personality disorder: difficulty making everyday decisions without an excessive amount of advice and reassurance from others (1), difficulty expressing disagreement with others because of fear of loss of support or approval (3), goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant (5), feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself (6), and is unrealistically preoccupied with fears of being left to take care of himself (8). According to the alternative model for personality disorder in DSM 5 Section III, a personality diagnosis was also conducted. This diagnosis allows for assessment of: 1) the level of impairment in personality functioning, and 2) pathological personality traits. Giorgio showed moderate impairment in the level of organization in the areas of identity, self-direction, empathy and intimacy. He showed also personality traits of: emotional lability, anxiousness, separation insecurity, anhedonia, depressivity, withdrawal and hostility.

According to the Shedler-Westen taxonomy of the personality syndromes (Westen & Shedler, 1999a, 1999b), Giorgio matched the prototype of Dependent-Victimized Personality, characterized by extreme dependency which leads him to subordinate his own needs to those of others. Within this taxonomy, Dependent Personality is considered a subtype of Dysphoric/Depressive Personality, characterized by extreme dependency, submissiveness to needs of others, inability to soothe or comfort. The diagnosis of dependent personality is supported also within the PDM-2.

## Case formulation (TA Diagnosis, contract, treatment plan)

### TA Diagnosis

Giorgio presented with Please Others and Be Strong drivers (Kahler, 1975) and the Injunctions (Goulding &

Goulding, 1976) Don't be important, Don't feel (emotions, anger), Don't grow up. Giorgio's racket system (Erskine & Zalcman, 1979) shows beliefs such as "I receive love only when disappointed", "I cannot manage my life alone", "Others do not care enough for me". His repressed authentic, primary feelings are anger and positive emotions toward himself, covered by substitute, secondary feelings of worthlessness, empty, disappointment (English, 1971). Interpersonally, Giorgio tends to alternate dramatic roles (Karpman, 1968) of Victim (in many aspects of his life, especially when feeling and expressing his feelings and emotions) and Rescuer (worrying about his mother, protecting her by not showing his difficulties). His life position is generally I'm Not OK, You're Not OK, except when relating to his mother, when it is I'm Not OK, You're OK (Ernst, 1971).

### **Contract**

Giorgio asked for a reduction in symptomatology of depressive and panic disorders and to learn how to protect himself, how to express his needs, thoughts and emotions to others, above all anger, and how to deal with his panic attacks.

### **Treatment plan**

This is a case with a complex diagnosis, including depressive and anxiety disorders and dependent personality disorders.

Thus, the treatment is based on the manualised therapy protocol of Widdowson (2016), integrated with the indication for treatment of dependant personality, as reported by SWAP-200 and PDM-2 (Benelli, 2018), with a focus on fear of loneliness, feeling of inferiority, recognition and expression of desires of autonomy, and recognition and expression of emotions of anger.

With Dependent-Victimized Personality clients, especially with a moderate or severe impairment of the level of personality functioning, it is necessary to evaluate real risks connected to abusive situations in which they tend to put themselves. While building the alliance, it is important to allow the client to develop dependence, but not as the therapy goal. The therapist must enhance every need and evolutionary wish of self-expression of the client, supporting the expression of taste, opinions and perspectives (Permission to be yourself). The therapist must also support the experience and expression of repressed emotions, especially rage (Permission to feel and express anger). During the decontamination phase it is appropriate to differentiate the client's needs from others', allowing the redecision of the driver Please Others and contaminations associated to feelings of being defenseless without supporting relationships. It is also necessary to show the client their contribution to creating and maintaining recurrent difficulties, which might lead into manifestations of angst and anger, tied to repressed emotions. In the deconfusion phase it is

essential to explore archaic scenes where script decisions tied to the fear of loneliness and abandonment have been formed, and to directly express rage. Finally, in the relearning phase it is appropriate to monitor the reactions of the client in situations where they express repressed emotions, support the construction of evolutionarily more mature relationships, and interpret those relationships where dependence is established once more.

## **Hermeneutic Analysis Team**

The HSCED main investigator and first author of this paper is a PTSTA-P with 15 years of clinical experience, with a strong allegiance for TA. Despite recent literature suggesting that hermeneutic analysis should be carried out by expert psychotherapists (Wall et al, 2016), we believe that such indication is suitable when the research is investigating a new population or a therapy that lacks a research base. In our case, we preferred to follow the indication of 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 of six postgraduate psychology 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. Following the indication of Elliott 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 consensual affirmative and sceptic briefs and rebuttals.

### **Judges**

The judges were three researchers 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. Judge 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.

## **Measures**

### **Statistical Analysis**

All quantitative outcome measures were evaluated according to Reliable and Clinically Significant Change (RCSC) (Jacobson & Truax, 1991), where 'change' stands for an improvement (RCSI) or for a deterioration (RCSA). Clinical significance (CS) is obtained when the observed score on an outcome measure drops below a cut-off score that discriminates

clinical and non-clinical populations. The PHQ-9 considers a score of  $\geq 10$  as an indicator of current moderate major depression (Kroenke, Spitzer & Williams, 2001). It is important to consider that even below the cut-off score there may be a subclinical disorder. The PHQ-9 considers a score between 0 and 4 an indication of 'healthy' condition, and a score between 5 and 9 as an indicator of mild (subclinical) depression. Reliable Change Index (RCI) is a statistic that enables the determination of the magnitude of change score necessary to consider a statistically reliable change on an outcome measure (Jacobson and Truax, 1991). In particular, it is helpful in minimizing Type I errors which occur when cases with no meaningful symptom change are assumed to have improved. Richards and Borglin (2011) proposed that a reduction of at least 6 points in the PHQ-9 score would be indicative of a reliable improvement. Only when we observe the presence of both CS and RCI do we have RCSC, which is considered a robust method for assessing recovery in psychological interventions (Evans, Margison & Barkham, 1998; Delgadillo, McMillan, Leach, Lucock, Gilbody & Wood, 2014). To control experiment-wise error which occurs when multiple significance tests are conducted on change measures, we consider that a RCSC is required in at least two out of three outcome measures, thus demonstrating a Global Reliable Change (GRC) (Elliott, 2015).

### Quantitative Measures

Three standardized self-report outcome measures were selected to measure primary (depression) and secondary outcomes (global distress).

*Patient Health Questionnaire 9-item for depression* (PHQ-9) (Spitzer, Kroenke & Williams, 1999) scores each of the nine DSM 5 criteria from '0' (not at all) to '3' (nearly every day), providing a total score of depression. It has been validated for use in primary care (Cameron, Crawford, Lawton, et al, 2008). Scores up to 4 are considered 'healthy', scores of 5, 10, 15 and 20 are taken as the cut-off point for mild, moderate, moderately severe and severe depression, respectively. 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. A change of at least 6 points on PHQ-9 score is considered to assess a reliable improvement or deterioration (RCI).

*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). 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). A change of at least 5 points on CORE-OM score is required in order to assess a reliable improvement or deterioration (RCI).

The *Personal Questionnaire* (PQ) (Elliott, Shapiro, & Mack, 1999; Elliott, Wagner, Sales, Rodgers, Alves & Café, 2016) is 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 3.25 are considered subclinical. In this case series, missing the Italian normative score, for the PQ we adopted a more conservative RCI of two points, rather than the RCI of 1.67 recently proposed by Elliott et al. (2016). The PQ procedure suggests including problems from five areas: symptoms, mood/emotions, specific performance or activity (e.g., work), relationships and self-esteem/internal experience.

### Qualitative Measure

The client was interviewed using the Change Interview protocol (CI) (Elliott, Slatick & Urman, 2001) five months 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=very much expected; 5=very much surprising); 2) how likely these changes would have been without therapy (1=very unlikely; 5=very likely), and 3) how important they feel these changes to be (1=not at all; 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 they identify 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 Operationalized Adherence Checklist proposed by Widdowson (2012a, Appendix 7, p. 53-55) and agreeing on a final consensus rating.

### HSCED Analysis Procedure

HSCED analysis was conducted according to Elliott (2002), and Elliott et al. (2009), as described in previous publications of this series (eg., Benelli, 2017c).

### Adjudication Procedure

Each judge received the rich case record (Session transcriptions, therapist and supervisor adherence forms and session notes, data from quantitative and qualitative measures and a transcript of the CI) 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 via consensus:

- 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.

### 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, CI, affirmative and sceptic briefs and rebuttal, judge opinions and comments) is available from the first author on request.

### Adherence to the manualized treatment

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.

### Quantitative Data

PHQ-9 and CORE-OM were administered in the pre-treatment phase in order to obtain a three-point baseline, and during the three follow-ups, whereas PQ was first administered in session 0C.

Giorgio's quantitative outcome data are presented in Table 1. The initial depressive score (PHQ-9, 11.33) indicated a moderate level of depression. The global distress score (CORE, 18.13) indicated a moderate

	Pre-Therapy <sup>a</sup>	Session 8 Middle	Session 16 End	1 month FU	3 months FU	6 months FU
PHQ-9	<b>11.33</b> Moderate	9 (+) Mild	3 (+)(*) Healthy	0 (+)(*) Healthy	0 (+)(*) Healthy	0 (+)(*) Healthy
CORE-OM	<b>18.13</b> Moderate	9.1 (+)(*) Low level	9.3 (+)(*) Low level	4.7 (+)(*) Healthy	1.8 (+)(*) Healthy	1.2 (+)(*) Healthy
PQ	<b>5.82<sup>b</sup></b> Considerably	<b>3.36 (*)</b> Little	1.64 (+)(*) Not at all	1.27 (+)(*) Not at all	1.27 (+)(*) Not at all	1.36 (+)(*) Not at all

**Note.** Values in **bold** are within the clinical range; + indicates clinically significant change (CS). \* indicates reliable change (RC). FU = follow-up. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999). CORE = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002). PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off points: PHQ-9 ≥10; CORE-OM ≥10; PQ ≥3.25. Reliable Change Index values: PHQ-9 variation of six points, CORE-OM variation of five points, PQ variation of two points.

Table 1: Giorgio's Quantitative Outcome Measure

level of global distress and functional impairment. The severity score of personal problems (PQ, 5.82) indicated that the client perceived his problems as bothering him more than considerably.

At session 8, (mid-therapy), all measures decreased. Depression passed into the subclinical mild range (9), global distress passed to subclinical range, with clinically significant and reliable improvement (9.1), and personal problems decreasing to little bothering (3.36) with reliable change.

By the end of the therapy, the depressive score obtained a solid reliable and clinically improvement (RCSI) (3), the global distress remained in the low level range (9.3), and the personal problems reached clinical and reliable significance becoming not bothering at all (1.64).

At the 1-month follow up, all measures: depressive scores passed to the healthy range (0), the global distress improved to a healthy range (4.7), and personal problems remained as not bothering at all (1.27).

At the 3-month follow up: depression and personal problems did not change, whereas global distress decreased within the healthy range (1.8).

At the 6-month follow up all scores remained the same: depression was still in the healthy range (0), global distress dropped a little bit more within the healthy range (1.2) and personal problems were still considered as not bothering at all (1.36). All measures maintained RCSI by the end of therapy.

Table 2 shows the 11 problems that the client identified in his PQ at the beginning of the therapy and their duration. Two problems were rated as maximum possible bothering, six were rated very considerably, two considerably bothering and one moderately bothering. Four problems lasted from 1 to 2 years, one from 6 to 11 months, three from 1 to 5 months and three from less than one month. Ten out of eleven problems showed a clinically significant and reliable change by the end of the therapy and one obtained reliable change, whereas all problems reached a clinically significant and reliable change in the 1-month follow up, maintained throughout the 3- and 6-month follow ups.

Problems are related to: symptoms (1, tearful; 4, insomnia; 9, panic attack; 11, can't do things when lonely); mood and emotions (2, repressed anger; 5, sad/alone; 10, fear estrangement); self-esteem and inner experience (3, insecure; 6, give up; 7, fear not important for others; 8, fearing will not fulfil).

Figures 1 to 3 allow visual inspection of the time series of the weekly scores of primary (PHQ9) and secondary (CORE and PQ) outcome measures, with linear trendline.

## Qualitative Data

Giorgio completed the HAT form at the end of every session (Table 3), reporting positive/helpful events and one hindering event. All positive events were rated from 7.5 (moderately helpful) to 9.5 (extremely helpful) as reported in Table 3. There was one hindering event, reported in session 15 and rated 3 (moderately hindering): "It has been hindering because it's a very wide open wound of my past". Giorgio also reported other helpful events in session 1: "At the end I felt in a bubble or armour and I closed myself in, and I really wanted to cry but I held on"; 3: "Yes, I like to open up and tell my problems, I feel lighter" and 4: "Close myself in, have mood swings, from happiness to sadness". He reported aspects on:

- symptoms: HAT 4, "being anxious"; HAT 7, "exploring panic attacks"; HAT 9, "I wished it reduced [fear]"; HAT 10, "adapt to the situation of fear or agitation"; HAT 13, "avoid facing crowded places";
- mood and emotions: HAT 1, "found myself at ease" and "never spoke about it"; HAT 5, "loneliness"; HAT 6, "free many parts of me and feel more tranquil"; HAT 8, "talking about my inner state of mind"; HAT 14, "being attached to his girlfriend";
- relationships: HAT 3, "estrangement of the person at my side";
- self-esteem/inner experience: HAT 2, "being criticized"; HAT 11, "what springs from a critic"; HAT 12, "facing the courage"; HAT 15, "avoid talking of my fears"; HAT 16, "dealing with my courage".

HAT 10 and 11 have been written with a very quivering hand. The following sentences have been cleaned up of many grammatical and orthographical mistakes to make them more understandable for the reader.

Giorgio participated in a Change Interview 5 months after the conclusion of the therapy. In this interview he looked back at his PQ for main and significant changes (Table 4).

Giorgio identified eleven main changes at the end of therapy (Table 4). He was somewhat surprised (rated 4) and very much surprised (5) by 8 changes, he considered seven changes to be unlikely to have happened without therapy (1), and rated 8 of these changes from 'very important' (4) to 'extremely important'.

## HSCED Analysis

### Affirmative Case

The affirmative team identified four lines of evidence supporting the claim that Giorgio 1) changed and 2) therapy had a causal role in this change.

	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 cry often (tearful)	1-5m	7 Maximum possible	3 (+)(*) Little	4 (*) Moderately	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
2	I don't express anger	6-11m	7 Maximum possible	1 (+)(*) Not at all				
3	I feel insecure, I keep asking to be sure	1-2y	6 Very considerably	2 (+)(*) Very little	1 (+)(*) Not at all			
4	Insomnia	1-2y	6 Very considerably	4 (*) Moderately	1 (*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
5	I feel sad when others leave me alone	1-5m	6 Very considerably	3 (+)(*) Little	1 (+)(*) Not at all			
6	I give up easily when I don't succeed in doing certain things and I feel incompetent, "I throw myself down"	<1m	6 Very considerably	4 (*) Moderately	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
7	I fear I'm not important to others	1-5m	6 Very considerably	4 (*) Moderately	2 (+)(*) Very little	2 (+)(*) Very little	1 (+)(*) Not at all	2 (+)(*) Very little
8	I fear I won't be able to fulfil or deal with my future life (will I ever be father, will I fight with all my dear ones...)	<1m	6 Very considerably	5 Considerably	2 (+)(*) Very little	1 (+)(*) Not at all	2 (+)(*) Very little	1 (+)(*) Not at all
9	Panic attack in crowded places (closed and open spaces)	1-2y	5 Considerably	4 Moderately	1 (+)(*) Not at all	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little
10	I fear others will drift apart from me	1-2y	5 Considerably	4 Moderately	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little
Cont/								

	PQ items	Duration	Pre-Therapy <sup>a</sup>	Session 8 (middle)	Session 16 (end)	1 month FU	3 months FU	6 months FU
11	I can't manage to do anything when I feel lonely	<1m	<b>4</b> Moderately	3 (+) Little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	2 (+)(*) Very little
	<b>Total</b>		64	37	18	14	14	15
	<b>Mean</b>		5.8 Considerably	3.4 Little	1.6 Not at all	1.3 Not at all	1.3 Not at all	1.4 Not at all

**Note:** Values in **bold** are within clinical range. +=indicates clinically significant change (CS). \*=indicates reliable change (RCI). m = months. y = year. FU= follow-up. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off point: PQ ≥3.25. Reliable Change: PQ variation of two points. 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.

<sup>a</sup>The first available score was in session 0C.

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

Session	Rating	Events	What made this event helpful/important
1	8 (greatly)	The event is when I found myself at ease to talk about my adolescence and childhood	It happened that I started to talk about my adolescence and childhood and it struck me a lot because I never spoke about it with anyone, so I found myself ease
2	8 (greatly)	Talk about being criticized	For me being criticized is very important because I want to be mistaken on my own in my life and I want to make mistakes or errors personally
3	8.5 (greatly)	Estrangement of the person at my side	For me the estrangement of the person at my side is a weak link because I can't start over my life or make a new one with the objectives I established
4	8.5 (greatly)	Being anxious to do something	For me anxiety is a feeling that I keep having and I would really like to defeat in order to complete my objectives like driving licence work and have a rich family
5	9.5 (extremely)	Deal with the problem of loneliness	For me loneliness is a great obstacle and I would really like to pass it and return to being calm and tranquil with my state of mind
6	8 (greatly)	Being listened to	For me being listened to is very important because I can free many parts of myself and I feel more tranquil with my state of mind
			Cont/

Session	Rating	Events	What made this event helpful/important
7	7.5 (moderately)	Explore panic attacks	I concluded that I must succeed in taking the underground, go to the movies or to a concert. Exposing the problem of these panic attacks or anxiety attacks has been useful
8	9 (extremely)	Talking about my inner state of mind	Talking and describing my mix of emotions has been fundamental in order to understand what I have inside, succeeding in being calmer with myself and succeeding in being less emotional
9	8 (greatly)	The event has been the one of placing the chairs	It has been very useful because I wished it reduced or vanished completely
10	8 (greatly)	The episode has been the drawing on the board where young Giorgio acts	The schema has been extremely important because it will be a way to adapt myself to the situation of agitation or fear
11	8 (greatly)	It occurred that it has been told what springs from a critic in my inner part	It has been a useful and important undertaking it because it really is not a normal sensation
12	8 (greatly)	It has been useful and important speaking about my facing the courage of not giving love to the person at my side	While speaking, [it has been] important exploring it
13	9.5 (extremely)	Avoid facing crowded places like the underground	It has been useful talking about it in order to understand what occurs when this difficulty of fear and terror ( <i>sic</i> ) happens to me in the underground in a crowded place with many people
14	8 (greatly)	Representing on the board my emotion liquidiser and imagining talking to my girlfriend	The event of imagining talking to my girlfriend has been useful and important in order to understand the value of being connected with her, so being attached
15	8 (greatly)	Avoid talking about my fears: avoiding	It has been important and useful speaking about it in order to find out my state of mind in order to avoid understanding what happens when I'm scared and not having the courage to admit it
16	8 (greatly)	Dealing with my absence of courage in telling things in order to don't give pain to the person	For me this event is useful and important because I found it to be difficult, because I would feel really uncomfortable and so I keep it inside

**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).

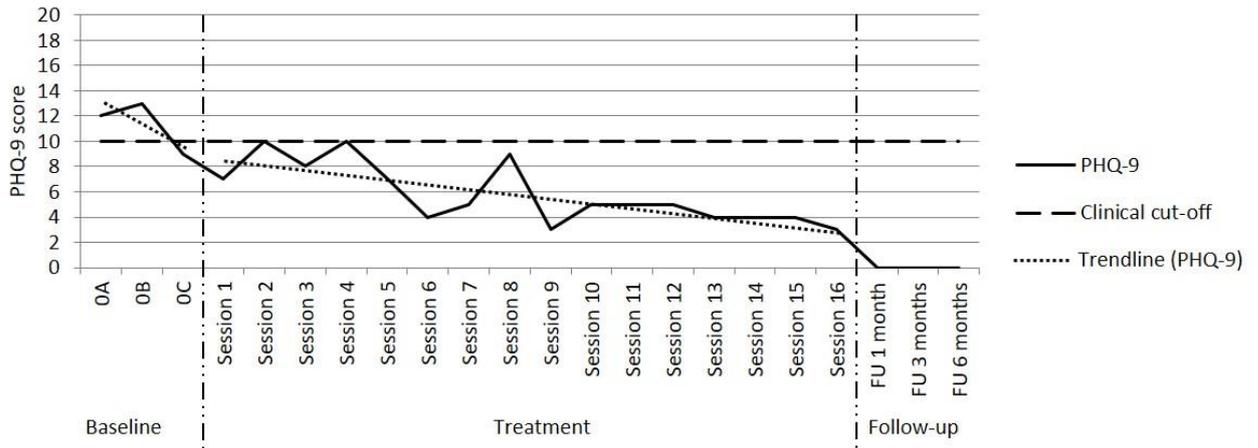
*Table 3: Giorgio's helpful aspect of therapy (HAT forms)*

	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>
1	I stopped crying	4 (somewhat surprised)	1 (very unlikely)	4 (very)
2	I express anger	5 (very much surprised)	5 (very likely)	4 (very)
3	I don't feel insecure, I don't ask to be sure anymore	5 (very much surprised)	1 (very unlikely)	5 (extremely)
4	I don't suffer of insomnia	3 (neither)	5 (very likely)	3 (moderately)
5	I don't feel sad when others leave me alone	5 (very much surprised)	1 (very unlikely)	5 (extremely)
6	I don't give up easily when I don't succeed in doing certain things. I stopped feeling incompetent	4 (somewhat surprised)	5 (very likely)	3 (moderately)
7	I don't fear I'm not important for others anymore	4 (somewhat surprised)	1 (very unlikely)	4 (very)
8	I don't fear I won't be able to fulfil or deal with my future life (will I ever be father, will I fight with all my dear ones...)	5 (very much surprised)	1 (very unlikely)	5 (extremely)
9	I don't have panic attacks in crowded places (closed and open spaces) anymore	3 (neither)	1 (very unlikely)	4 (very)
10	I stopped fearing others will drift apart from me	1 (very much expected)	1 (very unlikely)	3 (moderately)
11	I can do things when I feel lonely	5 (very much surprised)	5 (very likely)	4 (very)

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

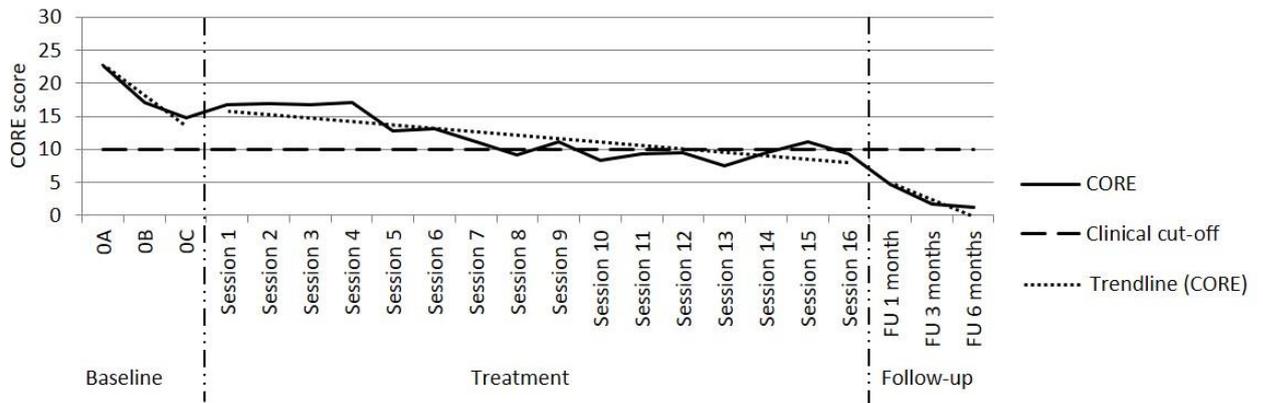
<sup>a</sup>The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very much surprised. <sup>b</sup>The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely. <sup>c</sup>The rating is on a scale from 1 to 5; 1 = not at all, 3 = moderately, 5 = extremely.

*Table 4: Giorgio's Changes identified in the Change Interview*



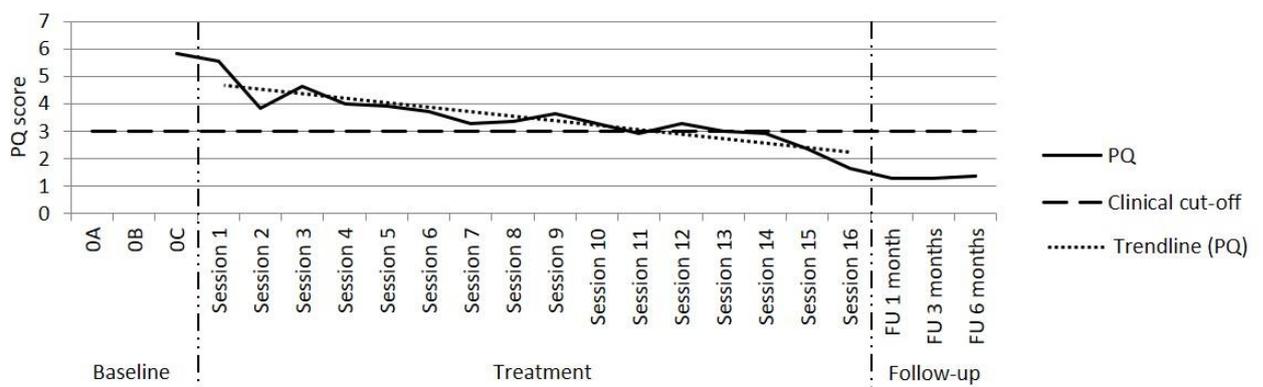
**Note.** OA, OB and OC = assessment sessions. FU = follow-up. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999).

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



**Note.** OA, OB and OC = assessment sessions. FU = follow-up. CORE = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002).

Figure 2: Giorgio's weekly global distress (CORE) score



**Note.** The first available score was in assessment session OC. OA, OB and OC = assessment sessions. FU = follow-up. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999).

Figure 3: Giorgio's weekly personal problems (PQ) score

### *1. Change in stable problems*

Quantitative data (Table 1) shows that there is a RCSI in primary outcome measure (PHQ9, depression) from session 9 that is maintained throughout the follow-ups. There is also a RCSI for global distress (CORE) from session 16, maintained in the follow up period. In the PQ (Table 2), Giorgio identified 11 personal problems at the beginning of the therapy that he was trying to solve, almost all rated as bothering him very considerably (6) to maximum possible (7). Giorgio's problems referred to issues with symptoms, mood/emotions, relationships, self-esteem/inner experience. At session 6, Giorgio's PQ mean score reached a reliable change, at session 13 it obtained the RCSI and maintained it throughout the follow-ups. At the end of the therapy ten problems out of eleven showed RCSI, whereas at 1-, 3- and 6-month follow up all eleven problems reached RCSI. Overall, there is support for a claim of global reliable change (reliable change in three out of three measures). Qualitative data supports this conclusion: in his CI he reported 11 changes that are related to symptoms, emotions and self-esteem stated in the PQ (Table 4). About depressive symptoms, at the end of the therapy he referred that he "stopped crying continuously" (S15, T18-C18; CI, C96). About panic symptoms he referred that "Before I couldn't take the subway, now I can... or going to work, if my mother's partner does not take me to work, I go on my own" (FU2, C21-27). Also, before therapy, Giorgio's girlfriend used to take him to different places, like to work or to sessions: "I go around alone... it's true, at first she always used to give me a ride, but now I say 'no, I don't want to go back being like before'" (FU2, C66-67). In session 15, he also referred "my mum, also my girlfriend tell me I've become more secure about taking public transport" (C21). About emotions and self-esteem, he reported being able to answer his mother when he gets angry with her (FU1, C128-129).

At the 3-month follow up Giorgio reported feeling "more positive, I believe more in myself, I can talk with people I was first afraid to lose, I'm more optimistic" (FU2, C5). Also, in the 3-month follow up Giorgio said: "I couldn't have goals, now I want to try... if I can't do something, if it goes wrong, I try again, I don't give up, I spur myself and I try to not fall down... I'm more courageous". We noted also some changes in dependent personality traits: for example, about asking others for reassurance and advices, he refers to being "focused on what I was doing" (FU1, C42), "before I kept asking for certainties, now I don't" (C47-C62), allowing himself to make mistakes when he is working: "if I now want to make a mistake, I have to do it on my own. Change happened" (FU3, C76). Also, about his difficulty expressing disagreement, he states that he is no longer scared of losing others, in fact he began saying 'no' to things he did not want to do, like

not going on holiday with a relative, without feeling afraid of losing his relationship with them (FU1, C92). Hence, Giorgio started to distinguish others' wills from his desires, not feeling forced anymore to do what others asked him, if these did not correspond to his wishes. To conclude, we believe that quantitative measurements show a Global Reliable Change and qualitative data support a change in symptoms, emotions, self-esteem and in dependent personality traits.

### *2. Retrospective attribution*

In his Change Interview, Giorgio looked back at his PQ, and reported that seven main changes were unlikely to have occurred without therapy. (Table 4). He considered them from 'moderately important' to 'extremely important' and he was surprised by five of them. In last sessions and in the CI too, Giorgio frequently repeated needing therapy very much and being sad for its end. He also referred to gaining a lot of benefit from having someone to talk to freely, both in sessions (i.e. S6, C81 "I released myself from a big weight, I feel lighter, like two weeks ago, I feel myself at ease, calmer"; S8, C8 "I want to keep going on with this path, I really like it, a lot, it's a very interesting path, nice, I never thought I could succeed in talking about my problems"; S14, C38 "I feel sorry... I came here with great pleasure, I came and I talked, told, starting [another therapy] all over again... but from now, I'd start from where I'm now") and in his HAT forms (i.e. S6 "Being listened"). In session 15, he realized that he has kept his weaknesses hidden because he was afraid his mother would have noticed and become sad (T80-C86), recognizing the influence of this behaviour on his emotions, thus he said to have "hit the target today, I'd consider this a victory, I did it, at the very end, but I made it" (C95-96). In the CI, he explained that therapy helped him in feeling more courageous (C75) and to have more self-esteem (C86). He considered the therapy to be "perfect and positive" (CI, C175, C179).

### *3. Association between outcome and process (outcome to process mapping)*

A change in symptoms was observed in outcome measures such as depression (PHQ-9), and in clinical evaluation such as anxiety and dependent personality traits. Changes in symptoms appear rather tied to a mix of processes than to specific techniques: empathic listening, supporting self-esteem, exploration and expression of emotions, analysis of the critical internal dialogues, exploration of autonomy. Depression and panic attack appear tied to dependent personality disorder that has been impacted throughout therapy. The therapeutic processes that both reinforced Giorgio's self-esteem and influenced his dependency traits have been the therapist's capacity to create an acceptant and empathic climate (HAT 1, "I found myself at ease to talk about my adolescence and

childhood"; 5, "deal with loneliness"; 6, "being listened"; 7, "exposing panic attacks" since he never spoke about this problem with anyone; 8, "talking and describing my mix of emotions"; and 12, "while speaking [it was] important exploring it"), working on his feeling of loneliness and improving relationships with others (HAT 5), exploring and expressing his emotional states (HAT 10, 13, 14, 15 and 16), and the possibility of expressing anger with others, reported in the 6-month follow up, without fearing to lose the relationship with his cousin, which is tied to the work done in session 15 to get in touch with his tendency to avoid (HAT 15 "Avoid talking about my fears") and 16 (HAT 16 "the courage in telling things").

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

The PQ mean score shows a progressive decrease in severity of his problems from the initial score (5.8, more than considerably) to the final score (1.6, less than very little). The therapist interventions on Giorgio's emotions allowed him to name them and understand them (session 1, 4, 6, 14, 15 and 16), which permitted him to be "relaxed, more tranquil... and I don't have that terror of taking the subway anymore" (FU1, P6-8). Furthermore, the therapist gave permission to talk freely and to feel his fears, two aspects that had always been undermined by his mother, making Giorgio aware that he was hiding his fears, avoiding them, which in the 1-month follow up he reported not doing anymore (FU1, P100 "now, when I have to say something to mom, I do it, without fears"). Imaginative techniques gave the client the opportunity to explore both his emotions and his need for autonomy, leading him to believe in himself and depend less on his mother and girlfriend, be more courageous and do things on his own, allowing himself to make mistakes and not calling for help (FU3, C28, C76). Also, at the beginning of the therapy, Giorgio asked others to take him to the therapist's studio. At session 0C they explored the necessity for Giorgio to do some experiences alone, and in fact, he "acted straight away" (S1, T16) and started going to the therapist's studio on his own from session 1, expressing autonomy. From the first sessions, and particularly in session 3, they worked on Giorgio's fear of being a complete failure, making this feeling blur and fade-out by the end of the therapy, with a reborn sense of optimism (FU2, C5).

#### **Septic Case**

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

The client entered the trial with moderate depression (PHQ-9, score 11.33), barely over the threshold for major depressive disorder. Besides, PHQ-9 reached clinical improvement already in session 0C, which supports the consideration that a natural reversal

might have also occurred without therapy. Giorgio had many difficulties in quantifying his problems and their duration, so quantitative data may be unreliable for this. For example, the duration of item 4 is incoherent: in quantitative data he reported suffering insomnia for 1-2 years, whereas in session 0A he said "when I can't sleep at night, from this summer" (C17), indicating that insomnia started between 6 and 11 months before therapy. Furthermore, he began the 6-month follow up with "I don't know if there is any progress" (C5) clearly in conflict with improvements in all quantitative data. Also, in the CI he reported that he is his own medicine (C8-9), and that the changes he did were due to his girlfriend who helped him and gave him strength. Regarding Giorgio's symptoms, like insomnia (PQ item 4), he said that when he would have started his new job, he would have been so tired at night that his insomnia would not have bothered him any longer (S4, C11), so any improvement on this aspect of his life might probably not be due to therapy. About his panic disorder, he reported: "Lately I have that nervous coughing, stomach ache, it bothers me like a panic attack meaning that I want to get out of the car, I can't manage to stay in the car, it didn't happen before, now this phobia came back" (FU3, C66). About Giorgio's panic attacks, they stopped occurring because he learnt the journey of the subway and that when he got on the subway it was not crowded. In fact, in session 2 he explained "I need to explore it first... then, when I explored it I say 'why don't I go by myself now? I know the place, I know everything else, why can't I go by myself?', so I go alone" (C33). Between session 9 and 10, there was a manifestation on a feast day and the subway was unusually overcrowded, generating a panic attack and the necessity to get off the subway and go back home by foot. In the 1-month follow up, when the therapist explained to Giorgio that he was going to have the CI in his colleague's studio on the other side of the city, he got a bit anxious (T133-C145), and only managed to go to the therapist 5 months later. In fact, during the CI he explained that he was driven to the session by his mother and her partner, and that sometimes he still asks to be driven to places (C71). Furthermore, there is an incongruence in the CI, where he reported taking the subway to go to work (C77) and being driven to work by his mother's partner every day (C79). In the 3-month follow up, Giorgio reported feeling anxious for long and new journeys with the subway, train or bus (C15). Regarding emotions and self-esteem, Giorgio's improvements in quantitative data do not appear to reflect a real change in his life. For example, the second item of the PQ reported that Giorgio learned to express anger, whereas at session 16 he was not capable to feel this emotion for his mother when she got angry during a discussion with Giorgio's girlfriend and he did not defend her. According to the PQ item 3, Giorgio did not feel insecure anymore, and stopped asking for help,

whereas in the 6-month follow up, the client reported still asking his mother's partner how to manage to do certain things at work (C28). About item 8 (fear of not being able to fulfil his goals), the score decreased from 'very considerably bothering' at the beginning of the therapy to 'very little bothering' at the end: despite this, in the 1-month follow up he said he was studying for his driving licence exam, but not paying much attention (C104-107) and being still afraid of driving a car (C111). In the 3-month follow up he explained he postponed his exam by two months (T50-C51), and in the CI 5 months after the end he reported having not yet tried passing the exam, suggesting that he still had difficulty in reaching his goals. Moreover, there is proof to support an absence of changes in personality traits. In session 15, when discussing not expressing his feelings of weakness, he reports "I'm happy [about protecting mom], I live happy, I'm proud of myself... it's like a medicine" (C107), showing that he is still egosyntonic in respect to the close relationship with his mother.

*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.*

All quantitative data baselines showed a decrease already in the assessment phase, which could lead to the conclusion that change would have happened anyway, even without therapy. Also, since the first assessment session, the client showed many difficulties in using quantitative measurements and in understanding that these instruments evaluate distress in different time frames (C58-64). He also explained having filled them in quickly; the therapist showed him he missed answering some questions (T63). In the 6-month follow up he explained having scored a 2 on item 7 because he did not want to exaggerate by giving all low scores: "then he [the therapist] says 'wow, so many improvements but like this they are too... excessive'" (C91-93). Finally, Giorgio scored only half of the CORE-OM of session 16, demonstrating that he was doing the tests with little attention.

*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 ending therapy.*

The sceptic team believes that quantitative data is unreliable not only for Giorgio's difficulties in placing temporally different events of this life, but also for a compliance effect. His tendency to 'Please Others' and his dependent personality disorder might be at the base of his scores' decrease in all quantitative tests that seem to not correspond in his life. In the CI he reported three times that he had to congratulate the therapist for the "great job he did, because I found

myself doing well" (C12). Also in qualitative data (HAT), there are no details of how sessions were helpful, and Giorgio limited himself to summarising the principal themes.

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

In session 1, he reported having already gone to therapy when he started having panic attacks (C6-9), so starting a new therapeutic process might have led Giorgio believe that it was going to help him again. Hence, an immediate decrease in quantitative data might also be explained by his extreme faith in therapy.

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

Referring to Giorgio's quantitative data decrease and to PQ's duration form, most of the problems were rated as bothering him for a few months, suggesting an alternative diagnosis of adjustment disorder with mixed anxiety and depressed mood.

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

At the beginning of therapy Giorgio got a job, which might have helped him feel better and lose his symptoms of insomnia, because at night he had no more time to ruminate due to being tired; therefore, Giorgio might have improved due to extra-therapy causes.

*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 was not able to find any evidence within the rich case record that would support a claim that Giorgio's changes were associated with psychobiological processes.

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

Giorgio might have forged his quantitative and qualitative results in order to not show others that he was "a nutcase... a madcap" (FU3, C9), which might be in interaction with the abovementioned tendency to 'Please Others' and protect important adults (his mother, his mother's partner, his therapist). In fact, in session 5, he was pretty interested about the research: "sessions are transcribed... but they hear them... privately? In a studio, alone?" (S5, C1); and again in the 6-month follow up: "who will get all these [data]?... and how will you send to him? By email?... Do you know this professor?... he will look at all these questionnaires and he'll be curious to see the path I

took" (C6-14). Finally, in the CI he explained that he already knew some questions of the Change Interview protocol because his therapist told him, and that he "prepared some sort of speech" (C187), and for this reason there is the possibility that he might have thought earlier about his answers, depicting a better situation than reality.

### Affirmative Rebuttal

1. Three out of three measures support the claim of a Global Reliable Change. About Giorgio's symptoms, his insomnia decreased because the therapist worked on reinforcing self-esteem and therefore his ruminations before going to sleep diminished. Furthermore, he reported finding more pleasure in doing things, like in his work: "I've improved a lot... I'm having fun" (FU3, C28). About his panic attacks, Giorgio reported feeling choking and stomach-ache only once in the car, but never had a panic attack on the subway or on the bus (FU3, T68-P69), and that he was "happy about having overcome my phobia, like bus, subway, train" (C75-76). About Giorgio's self-esteem, therapeutic interventions helped it to rise, which reflected on his job: in fact, when he received texts from his mother's partner it was for asking him whether he wanted to have lunch together or "he gives me advice, like to a son" (FU3, C30), and when he talked to him at work "now I pretend I don't know him, or I ask about his work experience" (C28). Finally, Giorgio's failure in attending his driving licence exam is clearly due to a trauma he had when he was sixteen: he had a car accident and his friend, who was driving, died. Unfortunately, therapy was not long enough to work also on this event and on Giorgio's panic attacks.

2. Regarding the baseline trend, Giorgio had a fluctuating vision of himself, and for this reason he might have had difficulties in quantifying duration of his distress and temporally placing events. Despite it, clinical notes confirm the deterioration of a long standing, persistent depression, supporting the diagnosis of major depression as correct and the PQ duration form as unreliable. About Giorgio's superficiality in filling in the questionnaires, the therapist believed it was better to administrate the short form of the CORE (except for assessment phase, sessions 1, 8, 16 and follow ups) and for this reason Giorgio likely had got used to the short form and in session 16 forgot to fill in the second page.

3. The affirmative team believes there was no compliance effect, because the client reached a state of talking about many things he never spoken about before, as for example about talking to his dead grandmother before falling asleep: "this thing... it's the first time I say it to someone. Neither mom, nor dad, no one, neither my girlfriend and usually I tell her everything" (S15, C57). Giorgio trusted the therapist in not judging him, making him feel free to talk about his

problems, and to have a positive attitude to therapy. It has also been widely reiterated that Giorgio had many difficulties in expressing; therefore it would have been unusual to find many details in his HAT forms.

4. Regarding the short therapy he did when panic attacks started, it dates back to when he was 16 years old. Furthermore, he reported "I went to a public clinic when I accepted my problem, but now I do this slowly, these sessions, I feel lighter, more at ease... they came at school to see my degrees, I didn't talk about my problems, I never told anyone" (S1, C7-9). Hence, this cannot be connected to his improvement with this therapy.

5. According to the therapist diagnosis, the client had a Major Persistent Depressive Disorder in comorbidity with Panic Disorder, Agoraphobia and Dependent Personality Disorder. Even if Giorgio evaluated suffering of his problems from a short period of time (from less than 1 month to maximum 1-2 years), which might suggest an adjustment disorder, in sessions transcriptions emerged that those problems lasted from a longer time. For example, according to PQ item 9, he was suffering from panic attacks for 1-2 years, whereas in session 0A he referred to "have been suffering these *scare attacks* since I was... 15, 16 years old... I was 11. I was young" (session 0A, C17), which means he was having panic attacks for at least 7 years, suggesting that his problems were all longstanding.

8. Finally, he asked how all the questionnaires and recordings were going to help the researcher do his job: "it's curious... he sees the journey, mine and others, it's something he chose... it intrigued me... I hope to be able to make a choice too in my life, like he did" (FU3, C14-15).

### Sceptic Rebuttal

Even if Giorgio's panic attacks have improved, it seems like he is having a relapse, reflecting a 'not stable' change after the end of therapy. Furthermore, in the course of the therapy, they never spoke about the accident he had; therefore there is no evidence that this might be connected with his fear of attending the driving licence exam. Regarding Giorgio's expectations of therapy, he said "the only person that could help me [grandmother] has been taken away from me... it's like talking to her every night before sleeping... I could vent with grandmother... it gave me courage, I was more secure in myself, when I talked to her, that word [a failure] never popped out" (S3, C78-88); "I came here with great pleasure, I came and I talked, told" (S14, C38); and as reported in his HAT form of session 3 ("I like to open up and tell my problems, I feel lighter"). Thus, his improvements can be due to telling his problems to somebody capable and willing to listen to him, like his grandmother was.

### Affirmative Conclusion

Giorgio's depression, global distress and personal problems were related to difficulties in inner experience such as self-esteem and emotions, his dependent personality disorder, and therefore an absence of autonomy, and interpersonal patterns, such as being egosyntonic with his mother and having a distorted internal representation of his relationships due to his fear of losing others. Since the beginning of therapy, the therapist created a positive climate where the client felt free to express and feel his emotions and problems, explored the possibility to appreciate himself and increase his self-esteem, without the necessity to call out for help, with the internalization of a Nurturing Parent. There has also been a partial loss elaboration regarding his grandmother thanks to the therapist's holding. These experiences were reflected in changes in internal dialogues, self-image, depressive symptoms and panic attacks. The areas that have changed most are mood/emotions, self-esteem and inner experience, and symptoms. In the analysis of the CI not many retrospective attributions emerged, which would have allowed connection of changes with therapy work. This could suggest a training need in the interviewer to stimulate a more evident attribution of changes to therapy.

### Sceptic conclusion

Giorgio asked for therapy with moderate depression, which reached a stable subclinical symptomatology already in the assessment session, so improvements might not be attributed to therapy. His dependent personality disorder and his fear of losing others affected his relationships with the therapist and probably his low outcome scores. Changes in depressive symptoms are therefore likely to be due to the spontaneous remission thanks to the presence of someone that listened to his problems. However, qualitative and quantitative data are not sufficient to establish whether the client improved, therefore

relational episodes are necessary to confirm any positive change.

### Adjudication

Each judge examined the rich case record and hermeneutic analysis and discussed their opinions reaching a consensus, reported in Table 5. The judges' overall conclusions are that this was a clearly good outcome case, that the client changed moderately and that these changes are substantially due to the therapy.

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

This case appears to be a 'clearly good' outcome (60% of certainty). Quantitative data show a reliable and clinically significant change on measure of depression (PHQ), global distress (CORE) and personal problems (PQ) by the end of therapy, maintained in the follow-ups. Also qualitative data support the conclusion that the client improved. In fact, his low self-esteem rose in the course of therapy, giving Giorgio the permission to have faith in his own capacities. Furthermore, his internal representations on relationships changed, allowing him to distinguish his own wishes from others, and to express his feelings without the fear of losing that relationship.

#### *Opinions about the degree of change*

The client changed moderately (40%, with 80% certainty). Qualitative data, as in the session transcriptions, show an improvement in Giorgio; however, he still has to work on many different aspects of his life, such as his tendency to postpone his diploma and the driving licence exam, which probably require more than sixteen sessions. Nevertheless, there is proof of a moderate change in his self-esteem (he does not believe anymore that he will lose his friends, girlfriend and mother if his desires are different from theirs) which allowed him to change his distorted internal representations.

	Judges' consensus rating
How would you categorize this case?	Clearly good outcome
How certain are you?	60%
To what extent did the client change over the course of therapy?	40% Moderately
How certain are you?	80%
To what extent is this change due to therapy?	80% Substantially
How certain are you?	80%

Table 5: Adjudication results.

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

The change appears considerably (80% with 80% of certainty) due to the therapy. Qualitative data in the HAT form (summarized in Table 3) of the client is extremely helpful in understanding what the client felt was important in the course of therapy, such as being listened to and feeling free to talk to someone that was not going to judge him, increasing self-esteem and stopping hurting himself in many different ways. Qualitative data (Change Interview) report a retrospective attribution to therapy of seven main changes out of eleven, especially improving self-esteem (three changes) and relational problems (three changes).

### *Mediator Factors*

Good therapeutic alliance and empathic listening helped him gain more self-esteem. During therapy, the therapist nourished Giorgio's dependent traits and gave him the permission to feel and name emotions that would be different from those of his mother or friends, with the awareness that this would not lead to a break up.

### *Moderator Factors*

The therapist appeared able to create a comfortable climate where the client could feel free to talk about his problems without the feeling of being judged or criticized.

## Discussion

This case aimed to investigate the effectiveness of a manualized TA treatment for depression (Widdowson, 2016) in a client with moderate level of Major Depressive Disorder, Persistent Depressive Disorder, Panic Disorder, Agoraphobia and Dependent Personality Disorder. Although the manual was originally designed for the treatment of depression, this case demonstrates its utility and effectiveness where there is comorbid panic disorder and personality disorder. The primary outcome was improvement in depressive symptomatology, which showed reliable and clinically significant change since the ninth session, was maintained at the end of the therapy and throughout the 1-, 3-, and 6-month follow-up periods. Secondary outcomes were improvements in global distress, which showed a RCSI by the end of therapy, maintained throughout the follow-ups, and in severity of personal problems, which reached a RCSI in the 14th session and maintained until the 6-month follow-up. The therapist conducted the treatment with a good to excellent adherence to the manual. Hermeneutic analysis pointed out changes in stable problems, retrospectively attributed to the psychotherapy, highlighting connections between outcome and process. The judges concluded that this is a clearly good outcome case, with a considerably to

substantially degree of change, which is considerably to substantially due to the therapy.

The case has been considered a good outcome by the judges, and changes are considerably or substantially due to therapy. The therapeutic alliance appears to have been built on an active style, focused on personality traits associated to symptoms, and transference and countertransference analysis. Specific TA techniques were: early sharing of the ego state model, exploration of inner dialog, developing of Nurturing Parent, exploration of drivers Be Strong and Please Others, and racket analysis of sadness.

### 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. 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 manualized TA treatment for depression (Widdowson, 2016) has been effective in treating a Major Depressive Disorder in comorbidity with Persistent Depressive Disorder, Panic Disorder, Agoraphobia and Dependent Personality Disorder in an Italian client-therapist dyad.

This case study suggests that the classical treatment for depression may be enhanced by considering the conflicts at the base of personality traits or disorders. Despite results from a case study being difficult to generalize, this study adds evidence to the growing body of research supporting the efficacy and effectiveness of TA psychotherapy, and notably supports the effectiveness of the manualized TA psychotherapy for depression as applied to complex depressive disorders in comorbidity with Dependent Personality Disorder.

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