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TA Treatment of Depression. A Simplified Hermeneutic Single-Case Efficacy Design Study - Margherita

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Abstract

This study is the seventh of a series of seven and belongs to the second Italian systematic replication of findings from previous series that investigated the effectiveness of a manualised transactional analysis treatment for depression through Hermeneutic Single-Case Efficacy Design. We address problems and difficulties that emerged in previous case series, such as: spending time in training a group of people to conduct the hermeneutic analysis, organising the involvement of external judges to give the final adjudication, and dealing with inconsistencies between quantitative and qualitative data. This study suggests a simplified method to conduct the hermeneutic analysis that require one person only, maintaining its validity. We integrated hermeneutic design with the pragmatic case evaluation methodology in order to follow pre-defined criteria in analysing qualitative material. Furthermore, we present a way to use the Script System to detect changes in depressive symptomatology and depressive personality. We tested this approach to HSCED in the case of 'Margherita', a 56-years old white Italian woman who attended 16 sessions of transactional analysis psychotherapy with a white Italian woman therapist with 5 years of clinical experience. The client satisfied DSM-5 criteria for moderately severe major depressive disorder with anxious distress, and SWAP 200 criteria for traits of depressive, dependent, avoidant and hostile personality types with a high level of functioning.

Key words

Systematic Case Study Research; Hermeneutic Single-Case Efficacy Design; Pragmatic Case Evaluation; Transactional Analysis Psychotherapy; Major Depressive Disorder; Anxious Distress; Depressive Personality Type; Dependent Personality Type.

Introduction

Recently, since the publication of the first Hermeneutic Single-Case Efficacy Design (HSCED) applied to transactional analysis (TA) treatment of depression (Widdowson, 2012a) there have been one direct replication of three single cases (Widdowson, 2012b, 2012c, 2013) and three Italian systematic replications of three single cases each (Benelli, Revello, Piccirillo, Mazzetti, Calvo, Palmieri, Sambin & Widdowson, 2016a; Benelli, Scottà, Barreca, Palmieri, Calvo, De Renoche, Colussi, Sambin, & Widdowson, 2016b; Benelli, Boschetti, Piccirillo, Quagliotti, Calvo, Palmieri, Sambin, & Widdowson, 2016c; Benelli, Moretti, Cavallero, Greco, Calvo, Mannarini, Palmieri & Widdowson, 2017a; Benelli, Filanti, Musso, Calvo, Mannarini, Palmieri & Widdowson, 2017b; Benelli, Bergamaschi, Capoferri, Morena, Calvo, Mannarini, Palmieri, Zanchetta & Widdowson, 2017c; Benelli, Procacci, Fornaro, Calvo, Mannarini, Palmieri & Zanchetta, 2018a; Benelli, Gentilesca, Boschetti, Piccirillo, Calvo, Mannarini, Palmieri & Zanchetta, 2018b; Benelli, Vulpiani, Cavallero, Calvo, Mannarini, Palmieri & Zanchetta, 2018c) aiming to recognise TA psychotherapy for depression as an Empirically Supported Treatment. Moreover, with the HSCED methodology Kerr (2013) evaluated TA treatment for emetophobia. However, even if HSCED has demonstrated to be an important and valid way to demonstrate the efficacy of TA, its application remained secluded in these three groups of research. A reason for this short-range application might be due to the onerous investment a hermeneutic design requires. We identified two main difficulties in conducting a HSCED: (a) involving a group of people and training them to conduct the hermeneutic analysis, which is time-consuming and probably possible only in an academic environment; and (b) including judges who have to read a substantial amount of qualitative data, interpret it, along with quantitative data, and who

must emit a verdict on the outcome of the case (good-, mixed-, or poor-outcome case), which is extremely demanding. Therefore, less expensive methods are necessary to evaluate the efficacy of a single-case in clinical practice.

In order to overcome these problems, in this simplified HSCED we decided to propose a variation of Elliott's (Elliott, 2002; Elliott, Partyka, Wagner, Alperin, Dobrenski, Messer, Watson and Castonguay, 2009) traditional method and of previous case series replications published in this journal. For problem (a) we suggest that the hermeneutic analysis can be conducted by one person only. However, leaving the analysis to a single person eliminates the multi perspective control, reducing internal validity. Therefore, to overcome this limitation, we decided to implement an additional method to analyse qualitative data in a more structured and systematic way, improving also internal validity: the 56 criteria of Bohart, hereinafter referred by us for ease of reference as 'Bohart's grid' (Bohart, Berry & Wicks, 2011; Bohart & Humphreys, 2000; Bohart, Tallman, Byock & Mackrill, 2011) for pragmatic case evaluation, already introduced in the case of 'Alastair' (Widdowson, 2014).

Bohart's grid allowed us also to solve problem (b). Involving judges to reach a final verdict on outcome was necessary to evaluate the efficacy of both treatment and hermeneutic analysis, which has been largely demonstrated with all previous case series in this journal. Therefore, for cases in which there are not substantial discordances between quantitative and qualitative data, the adjudication procedure can be left to the reader or to the researcher (Benelli, De Carlo, Biffi & McLeod, 2015), who can resort to Bohart grids for further matters.

Moreover, we identified another difficulty in some previous hermeneutic analyses: in fact, there have been cases (Benelli at al, 2016b, 2018a) in which hermeneutic teams have found difficulties in bringing evidence for both affirmative and sceptic briefs and rebuttals when significant incongruences emerged. Thanks to previous case series work, we have been able to pin-point these problematic aspects, and decided to shift the focus from evident changes in the client's behaviour to deeper and internal modifications. In an additional chapter in the Italian translation of *Transactional Analysis Treatment for Depression* (Widdowson, 2016), Benelli (2018) shows that it might be improbable for depression and depressive symptoms to exist outside of a structure of personality. Personality is a range of internal psychological processes (motivations, fantasies, peculiar patterns of thought and feeling, ways of experience of self and others, coping strategies, etc) which represents the individual in that circumstance (relationship, environment, culture, etc) (Lingiardi & McWilliams, 2018). Many clients are not aware of their personality disorder and are referred to the clinician by third parties, and others seek therapy for symptoms. However, even if dysfunctional aspects of personality are not clearly expressed as therapy goals, these are both directly and indirectly faced by the therapist and might inevitably undergo changes during therapeutic work. Therefore, it is sufficient for the researcher to keep in mind the client's pathological aspects of personality at the beginning of therapy and keep track of any modification in the course and at the end of therapy.

For these reasons, we decided to aim our attention also to pathological representations tied to depressive personalities using SWAP-200 (Westen & Shedler, 1999a, 1999b) taxonomy, which divides dysphoric (depressive) personality in five subtypes: avoidant, high functioning, dependent-victimised, emotionally dysregulated, and hostile-oppositional. A method to monitor deeper changes in depressive personalities is using the Racket System (Erskine & Zalcman, 1976), nowadays called Script System (O'Reilly-Knapp & Erskine, 2010), as suggested in Benelli's (2018) chapter.

The Script System is largely used in TA and its goals are listed in *Transactional Analysis: 100 Key Points and Techniques* (Widdowson, 2009).

The Script System helps both therapist and researcher to have a quick snapshot of the client's dynamics, identify script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories. The application of the analysis of the Script System in session transcriptions is innovative, because it allows focus not only on client's sufferance described in the Personal Questionnaire (PQ) (Elliott, Shapiro & Mack, 1999; Elliott, Wagner, Sales, Rodger, Alves & Cafè, 2016) but also monitors how different internal representations are established in the various phases of therapy. Moreover, using the Script System allows keeping track of possible incongruences between quantitative and qualitative data and resolve them by bringing evidence from the words of both client and therapist.

The general aim of this single case is to investigate the effectiveness of the manualised TA treatment of depression (Widdowson, 2016) with this simplified HSCED. Specifically, in this case we address the theme of focusing both on symptoms and personality disorders in diagnosis, treatment planning and treatment.

The present study is the seventh of a series of seven, and it analyses the treatment of 'Margherita', a 56-year-old Italian woman with a diagnosis of mild major

depressive disorder for more than ten years in comorbidity with anxious distress, worsening in the last month because she discovered that her husband could have cheated on her, and that she had no-one to talk to. The primary outcome is the depressive and anxious symptomatology and the secondary outcomes are global distress and severity of personal problems.

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 have received 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 were 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, the final article was presented to clients, who read the manuscript and confirmed that it was a true and accurate record of the therapy and gave their 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 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

Margherita is a 56-year-old white Italian woman who lives in a large metropolitan area in Italy. At the beginning of therapy she lives with her husband and their dog. Her husband has been in retirement for a few years. They have two children, one married a decade earlier and had children, whereas the second one left the family house a couple of years ago. Margherita is the first child of four daughters. When she was a little girl, her parents had a shop and while they both worked there, it was Margherita's duty to take care of her younger sisters. She feels she has never had a good relationship with her siblings: she refers to having always been called when they needed her help (dysphoric-high functioning depressive Script System, observable behaviours: take care of others), and never having the possibility to ask if she needed any help (dysphoric-high functioning depressive Script System, reinforcing experiences: ignore own needs). She feels betrayed by all of them: one flirted with her husband when they got married and still flirts with him nowadays; the other asked her for a big loan which she never paid back; and the last one, who suffered and suffers today from a very serious disease and tried to attempt suicide many times, mistreated her even when Margherita and their mother were the only ones to look after her (dysphoric-high functioning depressive Script System, observable behaviours: Saviour [Rescuer] and Victim). She has a very large family: all her sisters are married, with children and grandchildren too. She reports that the relationship her family members have between them is very good, but is not so with her, and she has the feeling they treat her like she is not doing enough for them (dysphoric-dependent victimised Script System, reinforcing experiences: abusive relationships). However, she explains she has never said "no" to anyone: when someone asks her something, she has always to do it, even if she does not want to, without complaining (dysphoric-dependent victimised Script System, observable behaviours: please others, be passive). Her mother is elderly and lives on her own with a dog, whereas the father of the client died many years before. At age 14, her parents did not allow her to go to high school, and made her work in their shop, whereas her siblings got the opportunity to study. Moreover, her parents arranged her engagement when she was underage and forced her to get married two years later, before turning eighteen (dysphoric-dependent victimised Script System, reinforcing experiences: no autonomy). Since she was "very young", Margherita worked on her own, in different shops and a coffee bar. At the beginning of therapy, she has been working in a shop for a "very long time", and feels that her boss always mistreats her, blaming her for everything (dysphoric with hostility externalization Script System, script beliefs about self: others take advantage of me). She has a depressed mood and is not able to express her feelings to sisters, mother, husband and boss, especially her anger, which she does not recognise (dysphoric with hostility externalization Script System,

repressed needs and feelings and reinforcing experiences: can't express anger, they taught me to keep my anger silent).

She starts therapy because she accidentally found out that a woman living in her neighbourhood was texting love messages to her husband. For this reason, she believed her husband was cheating on her, but he swore he did not even realise their neighbour was flirting with him, and never betrayed her. However, when she felt the urge to talk to someone about this situation, to ask for help or advice, she realised she had no one to talk to, because she knew she could not trust her sisters to keep the secret, and her only friend was facing a bad moment for the upcoming loss of a close relative, so she did not want to add to her problems. This friend went to therapy many years earlier, and for this reason, Margherita asked her if she recommended her ex-therapist to help her. After two sessions, the therapist proposed the client participate in the research and after a moment of embarrassment about recordings, she accepted.

She reported that when she found out about her sister's disease, she researched, reading not only scientific papers but also personal stories of similar experiences, and therefore expressed her willingness to share her story and help other people.

Therapist

The psychotherapist is a 42-year-old, white, Italian woman with 5 years of clinical experience and who has a certification as Certified Transactional Analyst (Psychotherapy) (CTA-P). For this case, she received monthly supervision by a Teaching & Supervising Transactional Analyst (Psychotherapy) (TSTA-P) with 15 years of experience.

Intake sessions

The client 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 (American Psychiatric Association, 2013), 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 measure for primary (depression and anxiety) and secondary (global distress, personal problems) outcomes.

DSM 5 and SWAP-200 Diagnosis

During the diagnostic phase, Margherita was assessed as meeting DSM 5 diagnostic criteria of moderately severe major depressive disorder with mild anxious distress: she experienced depressed mood most of the day, nearly every day, for more than two weeks (criterion A1), decreased interest and pleasure in activities (A2), increase in appetite (A3), insomnia (A4), feelings of worthlessness (A7) and indecisiveness (A8). Margherita also met specifier for anxious distress, feeling keyed up (1) and that she might lose control of herself (5).

Knowing the level of an individual's personality functioning and personality traits, provides the therapist with fundamental information for treatment planning. 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) personality traits. Margherita showed impairment ranging in the level of organization, and personality traits of identity, self-direction and intimacy, emotional lability, anxiousness, submissiveness, and depressivity.

Moreover, during the assessment phase, the therapist rated the computerised Shedler-Westen Assessment Procedure (SWAP-200) (Shedler, Westen & Lingiardi, 2014) that supported the diagnosis of high level of functioning, with traits of depressive, dependent, avoidant and hostile personality types.

Case formulation

TA Diagnosis

Case formulation was conducted according the TA diagnostic categories presented in the treatment manual. Margherita assumed a life position (Ernst, 1971; Berne 1972) of I'm Not OK, You're Not OK, that interacted with her stroke economy (Steiner, 1974), which was characterised by an absence of positive strokes and abundance of negative strokes. Furthermore, the underlying injunctions (Goulding & Goulding, 1976; McNeel, 2010): "Don't trust" (often I feel I am betrayed), "Don't be important" (I feel I must respond to everything), "Don't belong" (I feel as it no one likes me), "Don't be a child" (I'm always the caretaker, not the one cared for), "Don't want" (I give up easily and adapt to the desires of others), "Don't (be engaged with your life)" (whatever I do seems wrong), "Don't make it" (I feel a failure about my life), "Don't think" (I'm not very smart and feel inferior), and "Don't feel successful" (I always feel blamed) were also identified. This led to an internalisation of an under-functioning internal Nurturing Parent and an over-active internal Critical Parent, which activated intense self-critical internal dialogues (Kapur, 1987). In the drama triangle (Karpman, 1968) she assumes the role of Rescuer when taking care of everything and everyone, and Victim when her sibling did not show love to her and when she felt blamed for everything by her boss. Observable drivers (Kahler, 1975) of Be Strong, Try Hard and Please Others were also identified.

The Script System

In TA, the Script System (O'Reilly-Knapp & Erskine, 2010), previously called the Racket System (Erskine & Zalcman, 1979), allows to keep in mind all the associations of the client, like script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories. Margherita shows a dysphoric-depressive high functioning Script System (she takes cares of others for fear of being abandoned, she ignores her feelings), a dysphoric dependent victimised Script System (she stays in abusive relationships in which she pleases others and expresses anger in passive ways), and a dysphoric Script System with hostile externalization (she feels other mistreat and abuse her, she is not allowed to express anger which is manifested in passive ways). Moreover, the Script System involved all of the above-mentioned thoughts and behavioural manifestations, as well as repressed primary anger when she receives abuse or is not loved and considered by others, which was covered by secondary sadness, feelings of being unlovable. Finally, her script conclusions and decisions (Berne, 1961) were observable through script beliefs and contaminations (Berne, 1961; Stewart & Joines, 1987, 2012) such as: "I must take care of my sisters", "others are more important than me", "there is no time for me" and "I cannot get angry with others".

Treatment plan

Therapy followed the manualised protocol of Widdowson (2016). The treatment plan for Margherita's depression primarily focused on creating a therapeutic alliance, providing permissions (Crossman, 1966) congruent with the client's injunctions, namely: *trust*, *be important*, *belong*, *be a child*, *want*, *do*, *make it*, *think* and *feel successful*. Therapy was based on recognition and decontamination of script beliefs and emotion regulation, on changing internal dialogue from Critical to Nurturing Parent, on the creation of an I'm OK, You're OK relationship, and on problem solving strategies in daily situations with her sisters, her husband and her boss. The therapist offered Margherita empathic listening, supporting her to feel and express her emotions, needs and wishes.

Therapy process summary

Contract

Margherita asked to learn to find a balance for herself, to be able to express what she feels in her relationships, and to say "no" to others.

Sessions 1-8

In session 1 Margherita talks about being always compliant with her sisters and that this behaviour is not ok for her anymore, and when the therapist asks her "what do you want for yourself", Margherita realises she has subjugated her needs to those of others. In session 2 she explains how she has always been dependent on others' decisions and that her feelings were secondary. The therapist works on the importance of expressing emotions to stop feeling inferior. In session 3 the client is angry with herself because in her life she has always permitted others to take advantage of her. The therapist's aim has been to make Margherita realise that she does not have to be angry with herself, because this is what had been taught to her to do. In session 4 Margherita reports having been able to tell both her sister and her boss what she thought but having felt incompetent in doing it; therefore the therapist worked on the quality of anger expression. In session 5 client and therapist explore how Margherita's insomnia could be tied to the anger she feels against her sisters. Through an imaginative technique, she imagines what could happen if she spoke about her anger with her siblings. In session 6 Margherita speaks about her dependency from her family of origin (especially her mother) and how her mother's convalescence is reducing her time to spend with her husband, who she is not trusting. For this reason, the therapist suggests speaking with her husband to regain faith in him. In session 7 the client reports spending a lot of time house cleaning, and the therapist shows Margherita how she dedicates to things, moving her needs to the background, just like her husband does, and that they both ignore their couple needs. In session 8 Margherita refers to a family event in which her husband did not support her, so the therapist gives her permission to express herself in the couple, even if her feelings/wishes/needs are different from her husband's.

Sessions 9-16

In session 9 Margherita speaks about her lack of faith in her husband, so the therapist encourages her to find new ways to experience the relationship by doing things together. Furthermore, the client reports eating a lot of hazelnut cream when she is home alone and feeling angry when it happens. The therapist interprets it as an attempt to fill the emptiness and "sweetening the anger" of being alone. In session 10 Margherita talks about having enjoyed two daily trips she did with her husband, and how she feels reluctant to invest money for a new house. The therapist suggests this could be due to her need of finding place and time for herself, and not as a wish of ending their marriage. In session 11 the client reports feeling having changed since the beginning of therapy, and that her husband feels she is "terrorizing" him. The therapist explores this emotion and connects it with Margherita's lack of faith in her husband and encourages her to talk about it. In session 12 Margherita only reports improvements that happened from the beginning of therapy. In session 13 the client speaks about expressing anger

in an authoritarian way, so the therapist analyses the origin of this authoritarian expression, which could be arising from her anxiety and need to do things at her best. In session 14 Margherita reports that her anxiety is ancient, and the therapist helps her connect it with constant criticism by others due to her tendency of dispensing advice. In session 15 Margherita reports having re-established a balance with her husband, but she fears she has not been a good mother. The therapist works on this depreciation and underlines how this fear is not concrete, because she has proof of the contrary. In session 16 the therapist and the client make an evaluation of all progress Margherita has made and she attributes them to therapy.

Hermeneutic Analysis

Despite recent literature suggesting that hermeneutic analysis should be carried out by expert psychotherapists (Wall, Kwee, Hu & McDonald, 2016), in this case only one hermeneutic analyst was involved, a first-year TA psychotherapist student, who was taught the principles of hermeneutic analysis in a course on case study research at the University of Padua, by Professor John McLeod. Following the indications of Elliott et al. (2009), the researcher assumed both affirmative and sceptic positions, and created affirmative and sceptic briefs and rebuttals. The client's depressive personality was monitored from assessment phase throughout the entire therapy work and in the follow-up phase, to keep track of any change in the Script System. Furthermore, the hermeneutic analyst used Bohart's grid to enrich the evaluation of the case and solve slight incongruences between quantitative and qualitative data.

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 (RCSD). Clinical significance (CS) is obtained when the observed score on an outcome measure drops under a cut-off score that discriminates clinical and non-clinical populations. For example, the PHQ-9 considers a score of ≥10 as an indicator of current moderate major depression (Kroenke, Spitzer & Williams, 2001). It is important to consider that even under the cut-off score there may be a subclinical disorder. For example, 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 minimising Type I errors which occur when cases with no meaningful symptom change are assumed to have improved. For example, 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 a 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

Four standardised self-report outcome measures were selected to measure primary (depression and anxiety) and secondary outcomes (global distress and personal problems).

Patient Health Questionnaire 9-item for depression (PHQ-9) *(*Spitzer, Kroenke, Williams & Group, 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 ≥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).

Generalised 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'), respectively, providing a total score for anxiety. Scores 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 <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, Monahan & Löwe, 2007). A change of at least 4 points on GAD-7 score is required in order 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 ('not at all') to 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, 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 from 1 ('not at all') to 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) 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='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').

Furthermore, two qualitative measures have been implemented.

The representation of the *Script System* (O'Reilly-Knapp & Erskine, 2010) of the client has been created post hoc to: (a) detect areas of sufferance which might have not emerged as therapy goals or problems in the PQ and monitor any change in both depressive symptomatology and personality in the course of therapy, (b) focus on depressive personality aspects during the hermeneutic analysis, (c) monitor if changes in these areas are tied to therapeutic work, and (d) overcome incongruences between quantitative and qualitative data. To create a representation of the Script System the researcher makes a clinical evaluation of the most distressing problems presented by the client during sessions. The selection of the themes is based on: intensity of sufferance, recurrence of the theme, and pervasiveness within session and between sessions. The aspects the researcher is required to screen are similar to the areas of PQ (symptoms, mood/emotions, specific performance or activity, relationships, and self-esteem/internal experience) which have been rearranged according to the Script System structure (script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories). These themes have been selected in assessment sessions (Phase 1), and monitored during the first half of therapy (sessions 1-8, Phase 2), the second half of therapy (sessions 9-16, Phase 3), and in the Change Interview and follow-up period (Phase 4).

The *56 criteria of Bohart* (see Appendix 1) is a list of heuristics divided into three groups. The first 11 items bring evidence that the client has changed; items from 12 to 39 help enlighten specific changes; and the last 17 items (40-56) deal with evidence that it was therapy that helped the client change. These criteria have been transformed into structured grids by Widdowson (2014) for the case of 'Alastair', to indicate the source and the evidence for each item. Reported evidence supporting a criterion is taken from the words of the client from session transcriptions, which additionally helps with defining and describing quantitative data, and whether incongruent with qualitative data. For each of the 56 items, there are four possible evaluations: 'there is evidence', 'there is no evidence', 'there is some evidence' and 'not applicable', and for each group of items a 'plausible conclusion' is argued. It is possible to calculate a percentage of certainty of change (with 1-39 items) and a percentage of certainty of attribution to therapy (with 40-56 items). The proportion is calculated between the number of items 'with evidence' and the total number of items (39

including the first and second group, 17 for the third one). If there are not applicable criteria, these are not considered in the percentage calculation.

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 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) and agreeing on a final consensus rating.

Pragmatic Case Evaluation

HSCED analysis was conducted according to Elliott (2002) and Elliott et al. (2009) as described in previous publications of prior series.

After the hermeneutic analysis, the 56 criteria of Bohart have been applied to support both affirmative case and conclusions. In fact, the first 39 items of the criterion list mirror HSCED first affirmative point (specific changes for long standing problems), whereas the last 17 items reflect the second affirmative point (retrospective attribution). However, if there is little or no prof for a positive outcome case, Bohart's grid indirectly supports both sceptic case and conclusions. Therefore, a preponderance of evidence is more indicative of a positive change attributed to therapy.

Moreover, the first 39 criteria correspond to the first two questions of the adjudication procedure (described in previous publications of prior series) ("how would you categorise this case" and "to what extent did the client change over the course of therapy"), whereas the last 17 items represent the third question of the adjudication procedure ("to what extent is this change due to therapy").

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, 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, evidence in Bohart's criterion list and comments) is available from the first author on request.

Adherence to the manualised 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 GAD-7 were administered in the pre-treatment phase in order to obtain a four-point baseline, and during the three follow-ups, whereas CORE-OM was administered only from session 0D. PQ was generated during session 0B, therefore it has a three-point baseline.

Margherita's quantitative outcome data are presented in Table 1. The initial depressive score (PHQ-9, 15.5) indicated a moderately severe level of depression. The initial anxiety score (GAD-7, 11) indicated a moderate level of anxiety. The initial global distress score (CORE, 19.1) indicated a moderate level of global distress and functional impairment. The initial severity score of personal problems (PQ, 5.1) indicated that the client perceived her problems as bothering her more than 'considerably'.

At session 8, (mid-therapy), all scores obtained a clinically significant and reliable improvement (RCSI): depression and anxiety passed to a mild range (5), global distress passed to a 'low level' (8.8), and personal problems became 'little bothering' (3). By the end of the therapy, all scores maintained a RCSI: depression, (0), anxiety (0) and global distress (2.9) reached 'healthy' range, and her personal problems became 'very little bothering' (2).

At the 1-month follow-up: depressive scores remained in the 'healthy' range (1), anxiety remained unaltered (0), global distress level remained 'healthy' (0.9), and personal problems became 'not bothering at all' (1.8).

At the 3-month follow-up no significant change was present: depression (2), anxiety (1) and global distress (2.9) remained unchanged, whereas personal problems were considered 'very little' bothering (2.5).

At the 6-month follow-up all scores maintained RCSI: with a 'healthy' level in depression (1), anxiety (1) and global distress (2.1), and personal problems reached a 'not bothering at all' range (1.9).

Table 2 shows the 10 problems that the client identified in her PQ at the beginning of therapy and their duration. Two problems were rated as from 'maximum possible' to 'very considerably' bothering (6.5), four were rated from 'very considerably' to 'considerably' bothering (5.5), two were rated 'considerably' bothering, one was rated from 'moderately' to 'very little' bothering (3.5), and one was rated as 'very little' bothering. Three problems lasted from more than 10

	Pre-Therapy[a]	Session 8 Middle	Session 16 End	1-month FU	3 months FU	6 months FU
PHQ-9	**15.5** **Moderately severe**	5 (+)(*) Mild	0 (+)(*) Healthy	1 (+)(*) Healthy	2 (+)(*) Healthy	1 (+)(*) Healthy
GAD-7	**11** **Moderate**	5 (+)(*) Mild	0 (+)(*) Healthy	0 (+)(*) Healthy	1 (+)(*) Healthy	1 (+)(*) Healthy
CORE-OM	**19.1[b]** **Moderate**	8.8 (+)(*) Low level	2.9 (+)(*) Healthy	0.9 (+)(*) Healthy	2.9 (+)(*) Healthy	2.1 (+)(*) Healthy
PQ	**5.1[c]** **Considerably**	3 (+)(*) Little	2 (+)(*) Very little	1.8 (+)(*) Not at all	2.5 (+)(*) Very little	1.9 (+)(*) 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). GAD-7 = Generalised Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006). CORE-OM = 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; GAD-7 ≥10; CORE-OM ≥10; PQ ≥3.25. Reliable Change Index values: PHQ-9 variation of six points, GAD-7 variation of four points, CORE-OM variation of five points, PQ variation of two points.

[a]Mean score of pre-treatment measurements.

[b]First available score in session 0D.

[c]First available score in session 0B.

Table 1: Margherita's Quantitative Outcome Measure

years, one lasting from 3 to 5 years, three lasting from 1 to 2 years, and three from 6 to 11 months. Eight out of ten problems showed a clinically significant and reliable improvement by the end of the therapy, maintained in the 1-month follow-up. In the 3-month follow-up, six problems had a RCSI, whereas in the 6-month follow-up eight problems out of ten reached a RCSI.

Problems are related to: symptoms (4 guilty, 5 mood swings, 9 insomnia), mood/emotions (3 difficulties in expressing, 6 control reactions, 8 emotional, 10 cry); and relationships (1 hurt people, 2 unable to say "no", 7 inadequate in relationships). The longer lasting problems were related to relationships.

Table 3 shows the seven aspects of the Script System: (1) script beliefs about self, others and quality of life, (2) needs and feelings, (3) observable behaviours, (4) reported internal experiences, (5) fantasies, and reinforcing experiences through (6) current events and (7) old emotional memories. These aspects have been observed by the hermeneutic analyst during the assessment sessions (Phase 1), variations of these have been monitored in both the first part (Phase 2) and second part of therapy (Phase 3), and their maintenance and stability in the follow-ups (Phase 4).

In Phase 1, Margherita's beliefs about herself were to be always available for others; beliefs about others was don't trust; needs and feelings, such as expressing and getting angry, were repressed; as observable behaviours she had always to please others; reported internal experiences consisted of feeling inadequate and ruminating; reinforcing experiences refer to please others and be neglected.

In Phase 2, beliefs about others moved from a general "don't trust anybody" to a more specific "I don't trust my sister"; she started to express needs and feelings such as resentment; as observable behaviour she stopped letting others exploit her; reported internal experiences changed allowing her to tell others when she is upset; she realised that reinforcing experiences of resentment was causing her insomnia.

In Phase 3, Margherita's beliefs about self were to worry about herself too; beliefs about her husband changed to trusting him again; she reported expressing needs and feelings, as rage and anger; as observable behaviours she spoke to her sisters and husband about her wishes and feelings; she reported internal experiences of adequacy and of long nights sleep without ruminations; reinforcing experiences of better relationships.

	PQ items	Duration	Pre-Therapy[a, b]	Session 8 (middle)	Session 16 (end)	1-month FU	3 months FU	6 months FU
1	I'm afraid I'll hurt people if I talk	>10 y	**3.5 Little**	2 Very little	1 (+)(*) Not at all	1 (+)(*) Not at all	3 Little	2 Very little
2	I'm not able to say "no" to others	>10 y	**6.5 Very considerably**	4 (*) Moderately	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little
3	I've difficulties in expressing myself	3-5 y	**6.5 Very considerably**	4 (*) Moderately	3 (+)(*) Little	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little
4	I feel guilty if I cause anger in other people	>10 y	**5.5 Considerably**	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
5	I've mood swings even for little things	6-11 m	**5.5 Considerably**	3 (+)(*) Little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
6	I control my reactions	1-2 y	**5.5 Considerably**	**4 Moderately**	**6 Very considerably**	**5 Considerably**	**6 Very considerably**	**6 Very considerably**
7	I feel inadequate in my relationships	1-2 y	**5 Considerably**	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
8	I'm very emotional	6-11 m	**5 Considerably**	3 (+)(*) Little	2 (+)(*) Very little	2 (+)(*) Very little	**4 Moderately**	2 (+)(*) Very little
9	I suffer from insomnia	1-2 y	2 Very little	3 Little	2 Very little	2 Very little	**4 (*) Moderately**	1 (+)(*) Not at all
10	I easily cry	6-11 m	**5.5 Considerably**	3 (+)(*) Little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
	Total		**50.5**	30	20	18	25	19
	Mean		**5.05 Considerably**	3 (+)(*) Little	2 (+)(*) Very little	1.8 (+)(*) Not at all	2.5 (+)(*) Very little	1.9 (+)(*) 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'.

[a]Mean score of pre-treatment measurements.

[b]The first available score was in session 0B.

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

	Script System	Phase 1	Phase 2	Phase 3	Phase 4
1	**Script beliefs:** **- about self**	"I have to be available" (0A)	-	"Before I worried first about others, now there is me too" (S16)	-
	- about others	"I don't trust my husband because he could have cheated on me" (0A)	"I still can't trust him" (S6) "It's not my husband I don't trust, it's my sister because she flirts with him, but he ignores her. I'm insecure" (S7)	"I trust him" (S16)	"I trust him, I feel more tranquil" (FU3)
	- about quality of life	-	-	-	-
2	**Needs and feelings**	"I get angry, but I remain quiet otherwise I will hurt others" (0A), "I have difficulties in expressing myself" (0B)	"I want to be free to express myself" (S1) "I feel resentment" (S5) "I have resentment, people must accept me" (S6)	"My anger towards him emerged" (S9) "I'm not afraid to express my feelings, even if I still have to learn how to do it best" (S11) "I manage to find the right words" (S13) "I don't burst in rage, I control the way I express myself" (S16)	-
3	**Observable behaviours**	"I always please others, I never say no" (0A)	"I put some distance between us, I feel good" (S6) "If you hurt me, I hurt you; if you don't help me, I don't help you" (S7)	"Told sister we never had a healthy relationship" (S9) "I told them I've always felt put aside" (S9) "I told my husband he made me angry" (S10) "Asked to respect my needs" (S10) "I ask what I want too" (S11) "I talk when I want to" (S12)	"I count until ten before answering" (CI) "I feel considered, I say 'no' if I want" (FU1) "I learnt to say no" (FU3)

	Script System	Phase 1	Phase 2	Phase 3	Phase 4
4	**Reported internal experiences**	"I feel inadequate, inferior (with my boss and sisters) when I can't properly respond" (0A, 0B, 0D) "I can't sleep at night because I ruminate" (0B)	"I can't stay quiet anymore, everybody understands right away when I'm upset, but I don't want that others see my emotions, then I have to explain" (S5)	"I sleep all night long" (S9) "I don't feel inadequate" (S10) "I wouldn't want to wake up in the morning, I finally sleep" (S10) "I'm not their mother" (S11) "I don't even get angry, it slips through me" (S14) "It's really hot in these days, I have some difficulties, but not because I ruminate" (S15)	"I have some difficulties in falling asleep maybe because my sister tried to commit suicide, or because of my job" (FU2)
5	**Fantasies**	-	-	-	-
6	**Reinforcing experiences through current events**	The client refers of many episodes in which her siblings always contact her only when they need help (0C) and in which her husband repeatedly neglects her.	The client realised that her insomnia was due to the resentment she felt towards her sisters (S6) and thanks to this insight she successfully started sleeping all night long (S7)	The client reports a new feeling of strength, she feels able to have healthy relationships with both her sisters and her husband (S11), that she stopped running after her sisters (S11), that time with her husband improved qualitatively by enjoying each other's company (S15), and creating an equal relationship in which her needs have to be respected too (S15)	The client said to have found a balance with her sisters, to have stopped chasing them for their love (CI). She experienced a restored pleasure in her time with her husband (FU1), which she is able to maintain (FU3)
7	**Reinforcing experiences through old emotional memories**	The client explained she never had a sibling-relationship with her sisters, because her only duty since childhood has been to look after her sisters and help them whatever they needed (0D)	-	-	-

Note: Phase 1 = assessment sessions. Phase 2 = 1-8 sessions. Phase 3 = 9-16 sessions. Phase 4 = Change Interview and follow-up session. 0A, 0B, 0C and 0D = assessment sessions. CI = Change Interview. FU = follow-up

Table 3: How Margherita's Script System changed from Phase 1 to Phase 4

In Phase 4, her belief about her husband is that she still trusts him; in observable behaviour she explained she keeps the possibility to say “no” if she does not want to do something; her reported internal experiences focused on her sister’s attempted suicide and on her job; reinforcing experiences of better relationships is maintained.

Margherita’s script beliefs about self and others are representative of a dysphoric Script System with hostility externalization; both her repressed needs and feelings and observable behaviours are typical of dysphoric high functioning and dependent victimised Script System; her reinforcing experiences also reflect dysphoric high functioning and dependent victimised Script System.

Successively, these aspects have been compared with PQ items for any incongruence. Margherita’s Script System of needs and emotions reflects item 1 (hurt people if I talk), 3 (difficulties in expressing) and 4 (guilt). Her observable behaviour of being unable to say “no” is mirrored in item 2 (not able to say “no”). Finally, her reported internal experiences of feeling inadequate is represented in item 7 (inadequate) and her difficulties in sleeping because of rumination in item 9 (insomnia).

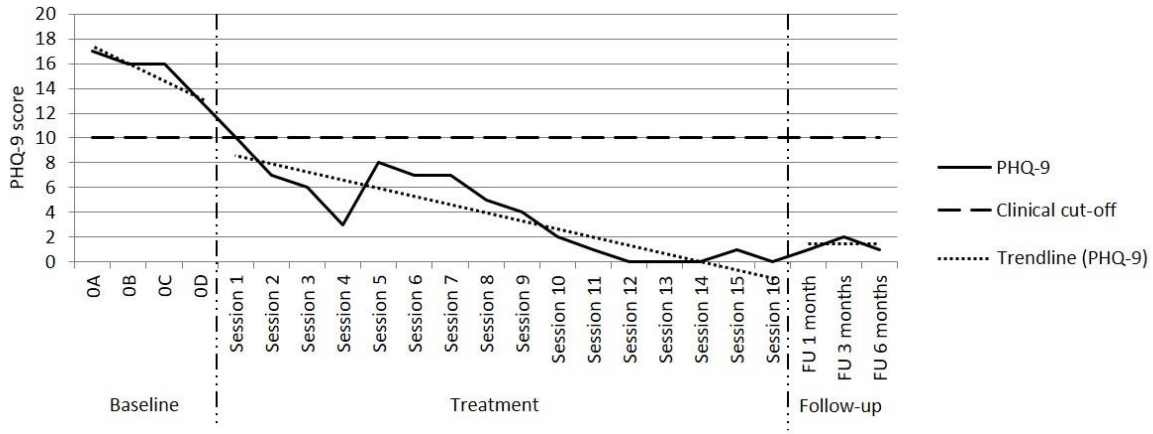
To conclude, there is evidence that there is an equal evolution of the Script System with scores in the PQ, except for item 9, regarding insomnia, which is rated from ‘very little bothering’ (3) to ‘not bothering at all’ (1) in all PQs, whereas in session transcripts of Phase 1 she reports being “unable to sleep” (0B) and in Phase 3 to “sleep all night long” (S9).

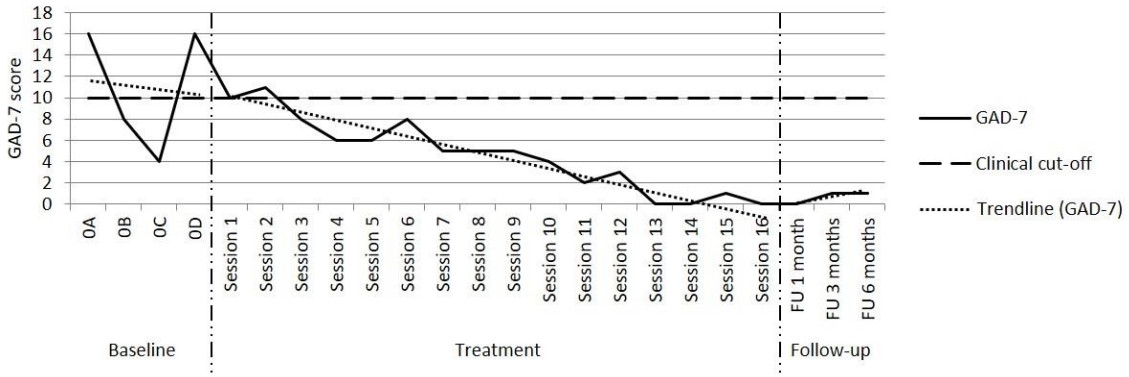
Figures 1 to 4 allow visual inspection of the time series of the weekly scores of primary (PHQ-9 and GAD-7) and secondary (CORE and PQ) outcome measures, with linear trendline.

Finally, Figure 5 and 6 represent Margherita’s SWAP-200 scores at session 1, and Figures 7 and 8 scores at 6-month follow-up. Both PD-T and Q-T scores have been considered.

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

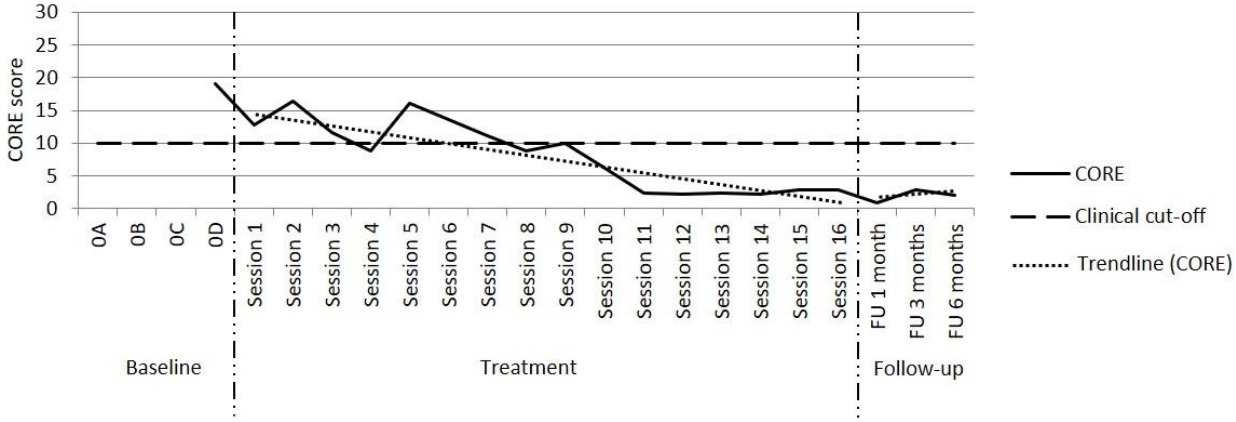
Figure 1: Margherita’s weekly depressive (PHQ-9) score





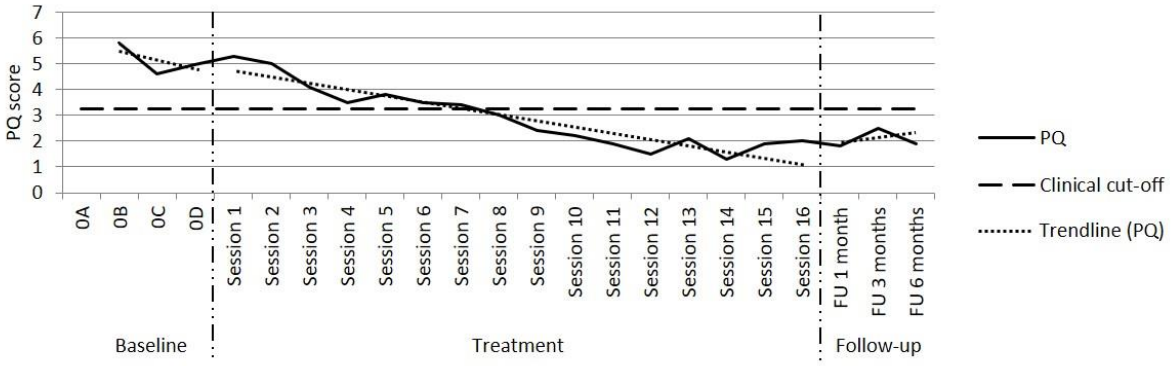
Note. *0A, 0B, 0C and 0D = assessment sessions. FU = follow-up. GAD-7 = Generalised Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006).*

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



Note. The first available score was in assessment session 0D. 0A, 0B, 0C and 0D = assessment sessions. FU = follow-up. CORE = Clinical Outcomes in Routine Evaluation (Evans et al., 2002).

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



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

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

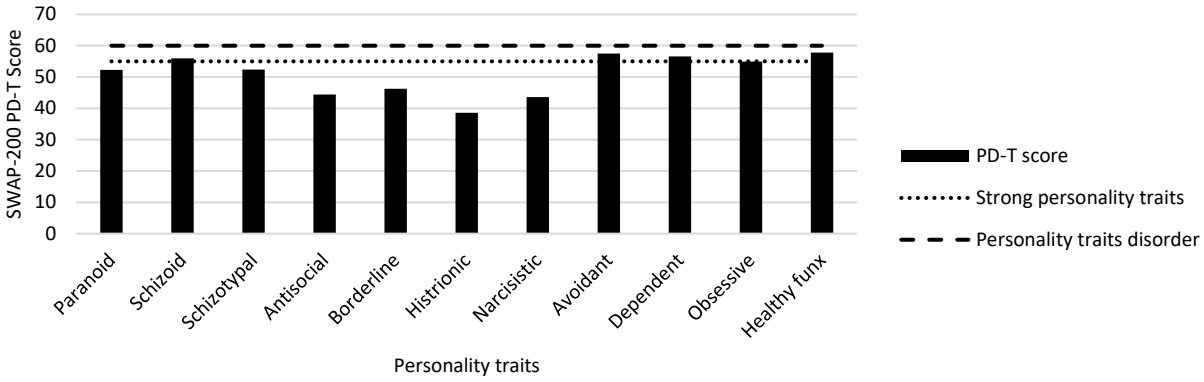


Figure 5: Margherita's SWAP-200 Session 1 PD-T score

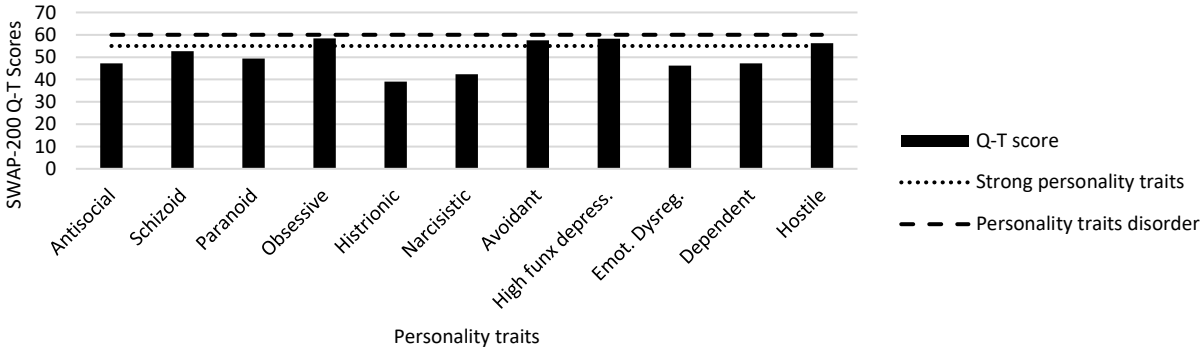


Figure 6: Margherita's SWAP-200 Session 1 Q-T score

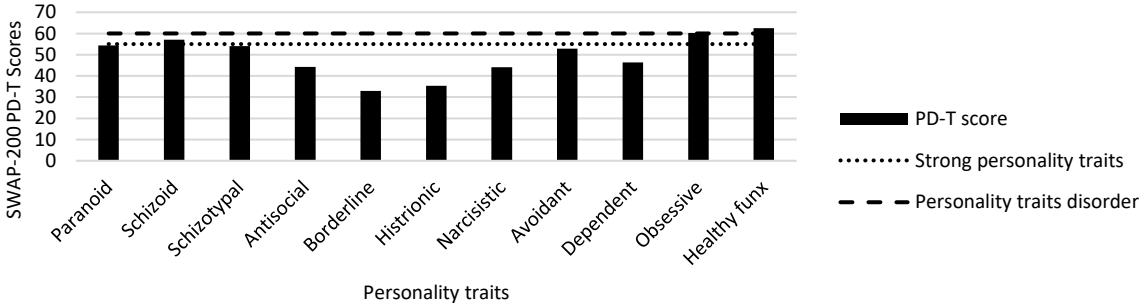


Figure 7: Margherita's SWAP-200 6-month follow-up PD-T score

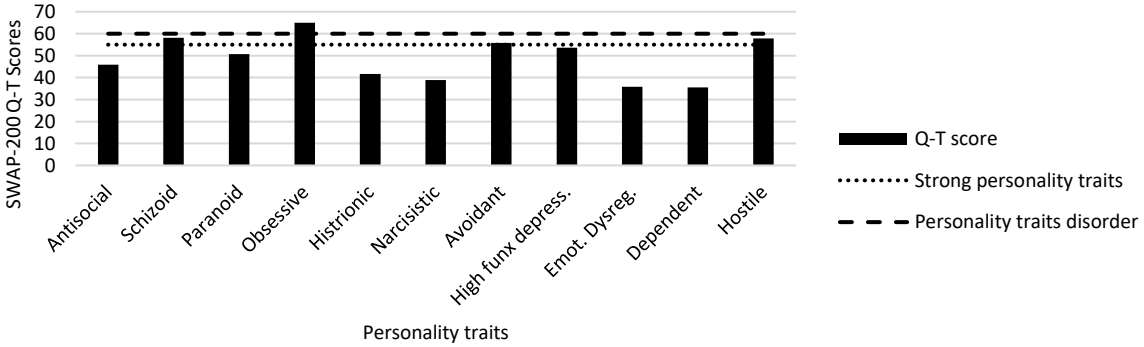


Figure 8: Margherita's SWAP-200 6-month follow-up 1 Q-T score

Session	Rating	Events
1	8 (greatly)	When I understood exactly why my distress began and I called into question my relationships with my relatives.
2	8 (greatly)	In this session, the therapist said that I should accept people like they are: I don't know why accepting my sisters for what they are is so difficult for me.
3	8 (greatly)	The most useful event has been when the therapist made me understand that it's me who decides what to say or do with "relatives".
4	8.5 (more than greatly)	In spite of my apparent calm, in this session the therapist made me notice the anger inside me towards my sisters.
5	7 (moderately)	The resentment and the anger which are latent in me are ready to explode, makes me live badly: this is what the therapist made me notice.
6	8 (greatly)	I don't know if it's useful or important, but the question of the therapist "Do you fear your sister?" is what made me reflect the most.
7	7.5 (more than moderately)	When the therapist said "there's always another choice" I was puzzled for its meaning, because I believe I've always done things "others" expected from me in all the different situations.
8	6.5 (more than slightly)	I participated in an event where all my family was present, and I felt isolated from them. The question is: do I isolate myself?
9	7 (moderately)	I and my husband should find a balance, now that we are a couple again… the therapist suggested.
10	7.5 (more than moderately)	We managed to find some time for ourselves…
11	7 (moderately)	We should talk to determine the right personal spaces…
12	8 (greatly)	I felt "lighter" after this session with the therapist…
13	8 (greatly)	"Are you an anxious person?" This is the question that made me reflect the most…
14	7.5 (more than moderately)	"Have you thought about the word 'sweetness'?" the therapist asked me…
15	8 (greatly)	I turned back to the starting point!!! It's true, it's not a euphemism…
16	8.5 (greatly)	Is faith 360-degree??

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 4: Margherita's helpful aspect of therapy (HAT forms) (Short version)

Qualitative Data

Margherita compiled the HAT form at the end of every session (Table 4, complete version in Appendix 2), reporting only positive/helpful events. All positive events were rated from 6.5 (more than slightly helpful) to 8.5 (more than greatly helpful). Margherita also reported other helpful events in session 1 ("I understood that my blood relatives involuntarily hurt me and that there are hidden wounds that I've never thought to exist"), and in session 4 ("The therapist suggested some advice on how to relate with my boss"). She reported aspects of symptoms (HAT 5 "can't sleep for my resentment and anger", 13 "am I anxious?"); mood/emotions (HAT 4 "the anger towards my sisters"; 10 "I listened to myself", 12 "work on the tone of my voice", 14 "sweetness"); relationships (HAT 1 "I've never had real relationships", 2 "accept people like they are", 3 "power to decide what to say to relatives", 6 "do I fear my sister?", 8 "do I isolate myself?", 9 "find balance now that we are a couple again", 11 "find a balance to trust him again", 15 "we are like newlyweds", 16 "faith is counting on someone when you need him"); and self-esteem and inner experience (HAT 7 "didn't know there is always another choice").

Margherita participated in a Change Interview 1-month after the conclusion of the therapy. In this interview, she identified seven changes since the beginning of therapy (Table 5), five were tied to self-esteem/inner experience (items 1, 3, 4, 6 and 7) and two were connected with relationships (items 2 and 5). She reported six changes to be 'very likely' (1) due to therapy. She was very much surprised (5) by being more present, saying what she thinks, being more herself, being aware that she exists too, and learning to give herself time. She rated the first two as 'very important' (4) and the others as 'extremely important' (5). Furthermore, she trusts herself more, rating it as 'somewhat surprised' (4) and 'extremely' important (5). Finally, she reported feeling lighter, which she is not sure if she expected or if she was surprised by it (3), however, 'somewhat unlikely' without therapy (2), but 'very' important (4).

	Change	How much expected change was [a]	How likely change would have been without therapy [b]	Importance of change [c]
1	I'm more present	5 (very much surprised)	1 (very unlikely)	4 (very)
2	I say what I think	5 (very much surprised)	1 (very unlikely)	4 (very)
3	I'm more myself	5 (very much surprised)	1 (very unlikely)	5 (extremely)
4	I trust myself	4 (somewhat surprised)	1 (very unlikely)	5 (extremely)
5	I exist too	5 (very much surprised)	1 (very unlikely)	5 (extremely)
6	I feel lighter	3 (neither)	2 (somewhat unlikely)	4 (very)
7	I learnt to give myself time	5 (very much surprised)	1 (very unlikely)	5 (extremely)

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

[a]The rating is on a scale from 1 to 5; 1 = 'very much expected', 3 = 'neither', 5 = 'very much surprising'.

[b]The rating is on a scale from 1 to 5; 1 = 'very unlikely', 3 = 'neither', 5 = 'very likely'.

[c]The rating is on a scale from 1 to 5; 1 = 'not at all', 3 = 'moderately', 5 = 'extremely'

.

Table 5: Margherita's Changes identified in the Change Interview

HSCED Analysis

Affirmative Case

Four lines of evidence were identified supporting the claim that Margherita 1) changed and 2) therapy had a causal role in this change.

1. Change in stable problems

Quantitative data (Table 1) shows that there is an improvement in primary outcome measure (depression, PHQ-9) with a stable and solid clinically significant and reliable improvement (RCSI) with constant improvement from session 7, maintained throughout the entire therapy, and in the follow-ups; anxiety (GAD-7) reached a constant RCSI in session 9, maintained for the rest of the therapy and in the follow-up period. There is also a constant RCSI for global distress (CORE) from session 10, maintained until the 6-month follow-up.

In the PQ (Table 2), Margherita identified 10 main problems at the beginning of the therapy that she was trying to solve, two rated as bothering her almost "maximum possible" (6.5), four more than "considerably" (5.5), two "considerably" (5), one as more than "little" bothering (3.5) and one as "very little" bothering (2). Three problems lasted from more than 10 years and obtained a clinically significant and reliable change in the course of therapy, and two maintained the RCSI until the 6-month follow-up, showing an improvement in long standing problems. All the problems referred to issues with symptoms, mood/emotions and relationships. At session 8, Margherita's PQ reached a RCSI, maintained until the end of therapy and in the follow-ups. At the end of the therapy eight problems out of ten dropped under the clinical cut off reaching RCSI. At the 6-month follow-up seven problems maintained RCSI, and one remained under the clinical cut off, whereas no change was quantitatively present in item 6 ("I control my reactions") and 9 ("I suffer from insomnia"). Overall, there is support for a claim of global reliable change (reliable change in at least three out of four measures) for long standing problems.

Qualitative data supports this conclusion. Regarding Margherita's depressive symptoms she said: "I'm not falling back to depression, I don't cry anymore, I try to find the problem and solve it" (CI, Line 587-588), "the most important thing that happened is that when I came here the first times I was always crying, if I think how I felt and how I feel today, strong, happy, I regained my way of being, I smile, I laugh also with my customers, I'm never sad, I started to be what I thought I would have never been again" (CI, L591-600). As for her insomnia (item 9 of the PQ), since the first assessment session she rated an extremely low score, and specified "I'm suffering from insomnia, but I got used to it" (0B, L430-431) specifying she slept only four hours per night (S3, L532) and that when "I wake up, I stay in bed, my head starts running through my problems, and I'm unable to fall back asleep" (L533). During session 5 she connected her difficulty in falling asleep to feelings of resentment and latent anger towards her sisters, and from this realisation her insomnia stopped (S5, L4-6, L55-57). Therefore, with the support of the Script System (Table 3), we assume that there is a reliable and clinically significant improvement also for item 9 of the PQ.

About Margherita's mood/emotions, in session 11 she explained: "I feel good, I can't even recognise myself, life was dark, I was angry, sad, like in a black and white movie, and I don't like black and white movies. Now I'm a colour film, and I love life in colours" (S11, L373-380), and to "have finally regained the pleasure in doing things I like" (L268-276). She reported that "if someone gets angry, I want her/him to know my thoughts and feelings about it too" (S12, L282-291), and in her CI she added "feel freer to express myself, instead before I kept everything inside" (CI, L126-131). Moreover, regarding item 6 of the PQ ("I control my reactions"), Margherita reported that such a high score was associated with a new control of her emotions, and not as something bothering (S13, L2-28). Therefore, elevated ratings since session 13 represent an improvement: "Before I always yelled without realising, now I'm able to control my emotions (S16, L288-294). For this reason, this PQ item should be considered as a reliable and clinically significant improvement.

As for Margherita's problems with relationships, she explained "don't feel inadequate in relationships anymore, I'm not afraid to express myself" (S11, L148-151), "I learnt to say no" (FU3, L88) and "if something I don't like happens, I say it out loud" (FU3, L158-164). Regarding Margherita's relationship with her siblings she stated that she became aware that she had the power to decide what to do and say to her siblings, (S4, L4-9; S9, L134-138; S14, L317-320; S14, L328-355; S16, L167-179; S16, L190-204). With her husband she reported to have found faith in him (FU3, L284-285), to have finally managed to talk to him about things she desired (S10, L1-10; S12, L437-444) and that she found a different way to be with her husband (S15, L322-329; FU1, L6-13). Moreover, Margherita said that also the relationship with her mother improved (S16, L161-166). Thus, we claim that Margherita obtained a stable RCSI in Major Depressive Disorder, in anxiety, in global distress and in personal problems, claiming a Global Reliable Change.

2. Retrospective attribution

In her Change Interview, Margherita reported seven changes, which she believed were from somewhat unlikely due to therapy to very unlikely without therapy. She considered these changes from 'very important' to

'extremely important' and she was from 'neither surprised nor expected' to 'very much surprised' by them (Table 5). Margherita was very much surprised by "feeling more present", "saying what I think", "being more myself", gaining the awareness that "I exist too", and "learning to give myself time", changes that very unlikely would have occurred without therapy, rating the first two as 'very important' for her, and the others as 'extremely important' for her. She also believed that another change is very likely due to therapy, which is "trusting myself", being somewhat surprised by it, and an 'extremely important' change for her. Finally, she rated "feeling lighter" as a change that would have somewhat unlikely happened without therapy, feeling neither surprised nor expected about such a change, however rating it as 'very important' for her.

Furthermore, in her CI, Margherita also looked back at her PQ: regarding her symptoms she explained that "now I say things without feeling guilty, before therapy I never had the courage to do so" (CI, L783-789, 793) (item 4), and about her mood swings (item 5) she said: "I was becoming unpleasant, now I don't keep things inside" (L802-805). About mood/emotion area, item 3 was about expressing herself, and she stated that "during therapy I realised that I was having difficulties in expressing myself because I had a big mess in my head" (L751-752). Furthermore, about items 8 and 10, she said "I'm sensitive only when I'm watching a touching movie, before I cried for nothing" (L826-832).

Finally, regarding her relationships, in particular item 1, she said "first I never talked, I feared to offend and to be offended, I thought people would get angry with me… but now it's not like this" (L712-727). About item 2, she reported that thanks to the therapist she learnt to say no if she did not want to do something (CI, L735-741). Moreover, item 7 was about her feeling inadequate with others, and she stated she felt at the same level (L812-814). Margherita also added that "when my friend told me 'go to a psychotherapist, he/she will help you', I didn't believe her, but sometimes you really need it" (L907-909). "Therapy helped me understand that if I need help I'll not wait until the point of no return to go back and start again" (L911-912). When in the CI Margherita was asked for some evidence or examples of therapy usefulness, she reported "therapy has been useful because the therapist led me to reflect on things I did and said… I realised I was evolving every session" (CI, L8-17), "in fact, my husband always says: 'when you come back from sessions, you change!'" (S16, L640). Finally, "the therapist helped me understand what was making me suffer" (CI, L548).

3. 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 Margherita found helpful in each session. All reported events are considered from 'more than slightly' to more than 'greatly' useful and are coherent with both the diagnosis and the interventions reported in the therapist's notes. One of the client's most important changes, reported in the CI and in the follow-ups, refers to being able to express and make herself valuable when with others (like sisters or husband), which improved her self-image. Margherita reported useful intervention and insight associated with the expression of her emotions in relationships, which was her therapeutic contract. In HAT forms (Table 4) 1 ("never had real relationships"), 3 ("accept people"), 4 ("anger") 8 ("do I isolate myself?"), 9 ("find a balance"), 10 ("time for us"), 11 ("trust"), 12 ("the tone of my voice"), 15 ("like newlyweds") and 16 ("faith"), Margherita explained the importance to have worked on healthy ways to relate with her siblings and with her husband.

In particular, in sessions' HAT forms 1, 3, 4, 8 and 12, she reported aspects about her emotions related to her relationship with her sisters, whereas in HAT forms of sessions 9, 10, 11, 14 ("sweetness"), 15 and 16 were about her emotions and her husband. In those sessions, the therapist worked on the permission of free expression, analysed the possible consequences that her reactions could bring, and gave Margherita different point of views to examine her emotions in specific contexts. In the CI, Margherita said that she gained the awareness that she exists too and learnt to say what she thinks, thanks to the therapeutic work on relationships. The therapist used decontamination to help the client understand that past situations are not likely to happen again in the present if she acts differently, and that if she expresses her needs others will listen to her. Moreover, on session 10, Margherita reported having insisted with her husband to go on a daytrip to the seaside, and to have had a pleasant holiday with him even if he did not agree at first (S10, L1-10). When the therapist asked how she managed to win over all her husband's objections (S10, L07-325), Margherita referred to the interventions of the therapist in the previous session ("If we need or want something, we can't take it for granted, we have to express it if we want a direct and clear answer", S9, L809-814), "it's important how you are in the relationship, S9, L824): "it's not fair he says 'no', there is me too, I have needs… I managed to open a new kind of dialogue with him" (S10, L341-379). In fact, in session 0C the therapist said: "let's make some exercise here, because life is made of simple things, and if we don't listen to simple things we want, then irritation comes out… 'hey, there is me too here! Look up!'… so what do you want now?... 'I want…?'" (0C, L412-432). In session 12, the client stated that she managed to find her own spaces inside the house and outside, and that she helped her husband find his own

spaces too (S12, L437-444), which is tied to previous therapist's interventions on her need to have her own personal space where she can do things she needs and want (S10, L466-468). During session 13, Margherita said that she learnt to control her actions and reactions thanks to the work she did in therapy (S13, L2-28): in fact, the therapist examined the origin of her anger, both toward her siblings and her husband and how to use it in a constructive way (S5, L353-377).

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

The PQ mean score shows a progressive decrease in severity of her problems from the initial score (5.05, more than 'considerably') to the final score (1.9, 'not at all' bothering). Initially the therapist worked on the expression of Margherita's needs with her sisters: in HAT form (Table 4) of session 2, she wrote about the affirmation of the therapist "you have to accept people for what they are" and in session 6 she realised that "I can't change them, I have to accept them, and they have to accept me"; in session 3 she gained the awareness that she had the power to decide how to act with her sisters which she never thought possible, repeating it at the beginning of the next session (S4, L4-9). In session 4 they spoke about her anger and resentment, and in the following session she reported "I thought about what we said last week, and it's true, I feel resentment towards my sisters, and when I realised it, that night I slept all night without waking up" (S5, L4-6), "so insomnia could be due to anger" (S5, L55-57).

Furthermore, when the therapist told Margherita that there is not only one way to do things, but there are many (S7, L439-440), the client started to act differently according to her script, and in session 8 said she did not approach her ill sister as she would have done (and did) in the past, accepting her choice of getting distance from her (S8, L47). In session 9 she explained that she spoke with another sister about all her problems with her siblings, that she never had a sister-relationship with them but more a mother-relationship, that she feels being isolated from them, and found out that unlike what she believed, this discussion led to a positive and constructive share of opinions with her sister (S9, L94-138). Moreover, in session 9 the therapist worked on the expression of anger (S9, L232-240), and in the following sessions Margherita said that she does not feel the anger anymore, "I think before replying… I'm trying to give myself the time I need to think before speaking" (S11, L64-74).

From session 9, the therapist started working on Margherita's relational problems with her husband, suggesting finding new ways to spend time together, because they are a couple again (both children left the house) (S9, L490-566), and the following week Margherita said that she spent a lovely weekend with her husband at the seaside like they had not done in years (S10, L1-23): "I always remember your [therapist's] words 'you have to talk'" (S10, L179-182), "it works, I speak now!" (S10, L198).

Still in session 9, Margherita reported having started eating many sweet things after dinner, when her husband was going out to take the dog for a walk (S9, L574-588): the therapist hypothesised that her urge to fill her stomach with sweet things was probably due to her feeling of emptiness in the couple (S9, L597-601), and from the following week she started filling that emptiness with quality time spent with her husband. Finally, in the last session, when the therapist asked Margherita if she regained faith in her husband, and she answered "not completely", the therapist added "trust 360-degree is an ideal, faith is when the other person is there for us when we need him… knowing what he's doing outside home is control, not faith" (S16, L363-430). Margherita then realised that she never thought how that was the meaning of faith, and therefore corrected herself "then I do trust him" (S16, L435-436), "thinking about faith in these terms makes me feel good, because it's true" (S16, L460-464).

Sceptic Case

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

The client entered therapy with moderately severe depression (PHQ-9, score 15.5), which was already decreasing in the pre-therapy phase. In session 0A, while filling in the PHQ-9, Margherita pointed out "these problems are not bothering me at all because no one around me noticed them, I managed to hide them very well" (0A, L194-196). PHQ-9 shows a clinically significant improvement already in the first session of therapy and a RCSI in session 2; GAD-7 show a clinically significant improvement in session 3 with a RCSI in session 7; CORE gained reliable change in session 6 and a RCSI in session 8; and PQ obtained a RCSI in session 8. Furthermore, her SWAP scores tied to her schizoid traits increased (from 52.68 to 58.21), as did her obsessive traits (from 58.38 to 65.06) (Figures 5, 6, 7, 8).

Regarding Margherita's depressive symptomatology, in session 9 she reported having started eating sweet things (hazelnut, ice-cream) when her husband left her alone during the evenings, indicating a rise of a depressive symptom tied to her unsatisfying relationship with her husband (S9, L612). Also, insomnia is still present at the end of therapy: in sessions 11 and 15 Margherita reported having difficulties in sleeping all night long (S11, L487-488; S15, L865). About her mood/emotions area, in session 5, Margherita reported that her husband called her "mean" (S5, L22-23). Moreover, in the 3-month follow-

up the client reported feeling sad without any apparent reason (FU2, L3-4). Instead, regarding Margherita's relational problems, in the last sessions and in the follow-ups she explained having still different problematics with her sisters, especially with the sick one, with her husband, and in her job too, in particular with her boss and a younger and slacker attendant. Moreover, in the last session, Margherita said she was unable to trust her husband completely (S16, L363), a sign that their relationship did not improve as she pointed out, and in follow-ups she added that she was still feeling a bit neglected by him (FU2, L527-529), that the quality in their time spent together decreased (FU3, L112-120), and that she did not completely regain faith in him (FU2, L775-783, FU3, L284-285). Finally, also at work, things got uncomfortable, due to a new young slacker attendant, which made her angry, making Margherita stress out and eat every half hour, until she decided to do his duties instead of explaining to him how to do his job (FU3, L241-245). This led Margherita to fall back in the previous mechanism she adopted with her siblings and husband, i.e. to keep silence until she burst out.

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, gaining a RCSI already in session 2 in her depression scores (PHQ-9), and a clinically significant change in session 3 in anxiety scores (GAD-7), which could lead to the conclusion that change would have happened anyway, even without therapy. Furthermore, the baseline of her global distress (CORE) is missing. Finally, there is evidence that Margherita's scores are unreliable due to her paying little attention in filling in the forms; the therapist asked her in session 14: "I saw that in this test [CORE SHORT FORM A] you scored 'I've felt ok about myself', 'not at all'…", "no, no, I made a mistake, it's 'often'" (S14, L309-312).

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.

Already in session 0B Margherita reported "feel better" (0B, L3) and that "talking to you [therapist] is different, it's like talking to a confidant, I have no difficulties in expressing myself with you" (0B, L444-449). In the CI she repeated different times that she felt the therapist was like a friend (CI, L94, L464, L632-634). Furthermore, Margherita's dependency traits and her tendency to be compliant and never say "no" might reflect a precocious decrease in all scores.

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

Margherita attended two sessions before being introduced to the research and agreeing to participate, and in session 0A (which was her third session), she stated that "since I've started to come here I've learnt to look inside me, reflect, think", which was what her friend told her about therapy, when suggesting her to start a therapeutic path. In fact, this friend of hers had been a client of Margherita's therapist too, and she knew her friend found therapy extremely useful to deal with her loss (therapist's notes). Therefore, personal expectancy artefacts might have influenced Margherita in feeling better already at the beginning of therapy. Furthermore, in session 12, she was speaking about her sick sister, who is following both medical and psychological treatments, and pointed out that "I read about psychological help and I found that psychotherapists are better than psychologists, my sister goes to a psychologist and the doctor said that she will never improve" (S12, L193-200), and in the CI she said "you therapists are so tranquil, you instil tranquillity, you are so calm" (CI, L632-634). For this reason, Margherita's scores might also be deformed by cultural and expectancy artefacts, and also by her readings.

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.

Margherita sought therapy because she found out that her husband could have cheated on her, and in her second session (the last one before agreeing to participate in the research) she told the therapist that she had spoken with her husband about her fears, and that since that moment he became sweeter, he felt terribly sorry for not realizing that this woman was flirting with him, and stopped seeing her before therapy actually started (therapist's notes), making her feel "more reassured" (S3, L437-450). Therefore, Margherita might have improved without therapy.

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

In session 4 Margherita said that seeing her sisters and talking to them was one of the causes of her distress and she declared that she had stopped relating directly with them (S4, L3-4), which is mirrored in a decrease in all scores. As previously reported, Margherita explained that her depression decreased since she spoke to her husband about her fear of him cheating on her, and from that moment "he stopped seeing her and I feel reassured" (S3, L437-450). Moreover, between sessions 11 and 12, they gave

away their dog, therefore her husband did not have the opportunity to have his evening walks and stayed at home with his wife, making Margherita feel more reassured and less neglected. Therefore, talking about her fears and feeling to her husband might have been sufficient even without therapy.

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.

For the sceptic case there was no evidence within the rich case record that would support a claim that Margherita's changes were associated with psychobiological processes.

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

For the sceptic case there was no evidence within the rich case record that would support a claim that Margherita's changes were associated with reactive effects of being in research.

Affirmative Rebuttal

1. For the affirmative case, all four measures support a claim in favour of Global Reliable Change. Margherita's SWAP scores on personality traits of high functioning depressive (Q-T score: from 58.25 to 53.65), emotional dysregulation (Q-T score: from 46.18 to 35.83) and dependency (PD-T score: from 56.54 to 46.35; Q-T score: from 47.16 to 35.58) dropped significantly under the clinical cut off, whereas healthy functioning level rose (PD-T score: from 57.84 to 62.50) (Figure 5, 6, 7, 8). Even if the sceptic case indicates that Margherita did not improve, quantitative scores' decrease is mirrored in qualitative data, in particular in the Script System. Furthermore, the client was very perceptive and has been able to obtain help since she first met the therapist.

Regarding Margherita's symptoms, since she and her husband went on their first trip together, their relationship started improving and that emptiness she felt started getting filled up. In fact, from session 11 in the PHQ-9 Margherita did not report feeling hungry for sweet things until the end of therapy. Furthermore, her depression did not decrease when she spoke to her husband about her fears, because first she had to learn to say "I" in their relationship, which she started expressing only from session 8. Therefore Margherita's depression decreased only when she started giving importance to herself and to her needs (between session 9 and 10). About the insomnia, she started to have difficulties in sleeping all night long "because of the weather, it's so hot" (SS11, L487-488; S15, L865), therefore insomnia is due to external factors.

Regarding Margherita's mood/emotions, when her husband said she was mean, she asked him why and he answered that he did not mean it (S14, L632-634). About her unexplained feeling of sadness in the 3-month follow-up, she said she had not realised until that moment that her feelings were due to her sister's last attempt of suicide the week earlier (FU2, L98-106). According to Margherita's words, her difficulties in relating with her siblings are now only tied to her sick sister, whereas with the one she had the worst relationship, it improved (FU1, L122).

2. A decrease in all her scores in the pre-treatment phase is firstly inferior to the reliable change index, thus is not reliable and may reflect the error measure of the test; second, the decreasing trend might be due to her strong intuition and openness to the therapist. Margherita has never been listened by anyone in her entire life, therefore finding receptive ears might have made her feel immediately positive about her therapeutic process. Furthermore, she attended two sessions before starting the pre-therapy phase, so an early improvement might also be reflected in having started therapy before filling in the questionnaires.

3. In her CI, Margherita reported "talking to the therapist is not like talking to a friend who is always on your side and doesn't give you advice, whereas the therapist listens to you and gives you those right tips you need" (CI, L640-643). Therefore, Margherita might not have improved without therapy. Second, unlike with others, the client was able to say "no" to any observation the therapist made that did not reflect her belief. Finally, her dependent trait decreased to subclinical levels (PD-T score: from 56.54 to 46.35; Q-T score: from 47.16 to 35.58) at the end of therapy, therefore her trend is not due to a compliance effect.

4. "Initially, when my friend told me to go to therapy I thought 'No, I don't need a therapist'" (CI, L907-909), so there were no personal expectancy artefacts. Furthermore, when she reported believing that psychotherapists are better than psychologists, the therapist explained that her sister's "doctor" must have been a psychotherapist too, therefore her cultural artefacts must have vanished (S12, L217).

5. Even if her husband stopped seeing that woman, Margherita would have not changed without therapy because her husband kept going out for a two-hours-walk every day with their dog (S9, L807-808; S10, L168-169). Only the therapist gave her the permission to tell her husband she was not happy about that situation (S9, 809-814). In fact, in session 10 she stated that she told her husband she did not like staying at home alone in the evenings (S10, L168-169).

6. Even if her husband stopped seeing the woman that sex-texted him, he kept going about with the dog during the evenings, and when they gave their dog away, he started taking out his mother-in-law's dog in the afternoons.

Sceptic Rebuttal

The sceptic case includes that Margherita's quantitative changes are not due to therapy but to a reverse to normal baseline due to a temporary state of distress, due to finding out that her husband was receiving sex-texts from another woman. Margherita's therapy contract consisted in learning to express herself, and in the follow-ups she reported that she was still keeping herself from answering to her sisters, which is a form of not expressing herself. Moreover, in the 3-month follow-up, the client reported having felt anxious and looking forward to her next session so she could ask the therapist how she could behave with her son who said she is not a present grandmother, unlike her husband, and what she should do about feeling neglected by her husband (FU2, L532-538). Finally, even if the relationship with her husband improved during therapy, in the 6-month follow-up Margherita reported to have lost quality in their time spent together, leading to a not stable change after the end of therapy.

Affirmative Conclusion

Margherita's depression, anxiety, global distress and personal problems were related to difficulties in mood/emotions and relationships, and interpersonal patterns, such as being unable to understand and address her anger and use it in a constructive way, feeling always sad, sensitive and tearful, being unable to stand up for her rights, needs and wishes (going on a daytrip holiday), being unable to say "no" to anyone's request, and feeling inferior to others (sisters and boss). She had structural problems since childhood and emotional dysregulation. Since the beginning of therapy, the therapist created a positive climate where the client felt free to express and feel her emotions and talk about her problems in her relationships, explored the possibility to appreciate herself and her emotions, learning to recognise them and apply them in relationships in a constructive way. Relational difficulties were present especially in her relationship with her siblings, behaving like a mother with them; with her husband, who she did not trust anymore; and with her oppressive boss.

The therapist taught her how to behave in a safer mode with her siblings, her husband and her boss. Margherita also had strong feelings of guilt when she thought of things on her own, and the therapist helped her get in contact with her needs and wishes and to express them. This step allowed Margherita's depression to decrease, and improved her relationship with her sisters and husband too. These experiences were reflected in changes in depressive symptoms and depressive personality, internal dialogues, script beliefs about self and others, needs and feelings, behaviours, internal experiences, self-identity, and interpersonal relationships. The areas that have changed for the most are mood/emotions and relationships.

Sceptic conclusion

Margherita asked for therapy with moderately severe depression, which reached a reliable and subclinical symptomatology already in session 2 after having spoken with her husband about the non-replied sex-texts he was receiving from another woman, which might suggest a reverse to a normal baseline of a temporary state of distress, therefore improvements might not be attributed to therapy. Changes in depressive symptoms might represent a self-correction due to extra-therapeutic factors, like when her husband stopped seeing that woman, and when they gave their dog away. Furthermore, Margherita's changes in relationships are not stable after the end of therapy; in fact, her relationship with her husband started losing quality, and she started to ignore her emotions and not expressing them in company of her siblings.

Pragmatic case evaluation

The entire list of evidence reported for the 56 criteria of Bohart is represented in Appendix 1.

In a preponderance of the evidence provided for specific changes with the first 39 considerations, there was clear evidence in 29 of the points. There was no evidence of these changes for 7 of the points, and 3 of the points were considered not applicable for this client. On balance, the evidence provided shows that: there has been a qualitative change in the client and that she reported clear and descriptive examples of the improvements in her life. Furthermore, in a preponderance of the evidence provided for the attribution of such changes to therapy with the last 17 considerations, there was clear evidence in 13 of the points. There was no evidence of these attributions in 1 point, and 3 were considered not applicable for this client.

To conclude, according to Bohart's grid, there is an 81% of certainty of change in the client and 93% of certainty that improvements were due to therapy.

Discussion

This case aimed to investigate the effectiveness of a manualised TA treatment for depression (Widdowson, 2016) in a client with moderately severe level of major depressive disorder with anxiety disorder. Although the manual was originally designed for the treatment of depression, this case demonstrates its utility and effectiveness where there is comorbid anxiety. The primary outcome was improvement in depressive and

anxious symptomatology, which showed a constant reliable clinically significant improvement (RCSI) from the seventh session till the end of therapy, maintained in the follow-ups; anxiety reached reliable and clinical significance in the ninth session, maintained until the 6-month follow-up.

Secondary outcomes were improvements in global distress and severity of personal problems: global distress reached reliable and clinical significance in the tenth session, maintained in the course of therapy and throughout the follow-ups; finally, also personal problems reached a stable reliable and clinically significant improvement from the eighth session, maintained throughout the entire therapy, until the 6-months 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 treatment appears to be effective also for anxiety symptoms, suggesting that common mental health disorders such as depression and anxiety may share a common aetiopathogenetic 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 dialog, developing of Nurturing Parent, exploration of drivers Be Strong, Try Hard and Please Others, racket analysis of guilt and sadness.

Furthermore, this case represents a variation of the traditional hermeneutic analysis proposed by Elliott (2002; Elliott et al, 2009). The adjudication procedure has been substituted with two qualitative measures: the Script System (O'Reilly-Knapp & Erskine, 2010) and the 56 criteria of Bohart (Bohart et al, 2011) for case evaluation. Using the structure of the Script System with script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories, allows monitoring of these categories before, during and after treatment. In this way the Script System becomes a magnifying glass to help the hermeneutic analyst select and classify the client's sufferance, partially expressed in the items of the PQ, and then monitor how these aspects of depressive personalities change during therapy. If there are improvements in the Script System, this will probably be indicative of an efficacious therapy. Moreover, these areas of sufferance are connected with the SWAP diagnosis and are coherent with symptoms and pathological traits of personality.

Limitations

The first author is a psychologist and is currently studying TA psychotherapy. Despite the reflective attitude adopted in this work, this may have influenced in subtle ways the hermeneutic analysis. Moreover, only one researcher was involved in the hermeneutic analysis, which might have had a potential impact on the briefs, rebuttals and conclusions. Furthermore, this new method to conduct a HSCED requires a training in the creation of the hermeneutic analysis, in the use of four quantitative measurements (in this case: PHQ-9 for depression, GAD-7 for anxiety, CORE for global distress and PQ for personal problems), in two qualitative measurements (CI, HAT), in the use of the Script System to conduct a structured analysis of the main changes in the course of therapy, and in the application of Bohart's grids to support a more objective evaluation of the case. Although the simplified HSCED method reduces the quantity of resources and personnel for the analysis, the research must be well-formed. Even if the use of the 56 Bohart criteria aims to support the final evaluation of the case, there is only one point of view, so validity problems could be consistent.

Future Development

This variation of the traditional HSCED method has been proposed when a group for the hermeneutic analysis, or at least two judges for adjudication procedure are not available, or when training a group of people becomes too time consuming. For future development we might suggest conducting the hermeneutic analysis by a person without or with little knowledge on the therapeutic model (i.e. TA), in order to decrease limitations regarding validity and allegiance. Furthermore, the use of the Script System is helpful both for the therapist and for the researcher to follow the therapeutic process and enlighten the deepest areas of sufferance of the client's personality and monitor them during therapy. Therefore, if the therapist monitors the evolution of the Script System of the client, she/he will be more able to adjust the therapeutic work to specific personality problems.

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 in an Italian client-therapist dyad, and provides evidence that hermeneutic analysis conducted by a single researcher, is possible with the use of the Script System (O'Reilly-Knapp & Erskine, 2010) for a deeper analysis and with the 56 criteria of Bohart (Bohart et al, 2011) for case evaluation. Despite results from a case study being difficult to generalise, this study adds evidence to the growing body of research supporting the efficacy and effective-

ness of TA psychotherapy, and notably supports the effectiveness of the manualised TA psychotherapy for depression as applied to major depressive disorder.

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APPENDIX 1: HAT Form Complete Version

Session	Rating	Events	What made this event helpful/important
1	8 (greatly)	When I understood exactly why my distresses began and I called into question my relationships with my relatives.	It has been important to understand that until today I've never had real relationships with my sisters, I guess like complicity, confidences, advices, I guess because I don't know what a familiar relationship is. I hope this awareness makes me stronger and more secure while with them.
2	8 (greatly)	In this session, the therapist said that I should accept people like they are: I don't know why accepting my sisters for what they are is so difficult for me.	This makes me reflect a lot: it's a thing I feel inside myself like a distress, but every time I meet one of them I'm defensive: why can't I let many things roll right off my back?
3	8 (greatly)	The most useful event has been when the therapist made me understand that it's me who decides what to say or do with "relatives".	It has been very useful in its simplicity because the power to decide what "to say", which means what you want to say to "relatives" it causes me many incomprehensions and "fits of anger".
4	8.5 (more than greatly)	Although my apparent calm, in this session the therapist made me notice the anger inside me towards my sisters.	All of this has been extremely useful because, even if I can decide what to say or do, the resentment that as accumulated with time and that is latent in me, induces me to be aggressive with them, and for this reason I prefer to avoid them.
5	7 (moderately)	The resentment and the anger which are latent in me are ready to explode, makes me live badly: this is what the therapist made me notice.	I probably can't sleep for more than few hours because of this anger inside, due to the many responsibilities I've always had. I don't remember being a little girl/adolescent and all of this is asking me to "pay up"…
6	8 (greatly)	I don't know if it's useful or important, but the question of the therapist "do you fear your sister?" is what made me reflect the most.	I don't know if this can be useful to me, but I've never asked myself if I do really fear my sister or not, but I can't give myself a clear answer. A part of me is self-convincing with the pros and the cons for those existing differences, which can't be, but rationally I'm not so sure, but I still can't understand the reason.
7	7.5 (more than moderately)	When the therapist said "there's always another choice" I was puzzled for its meaning, because I believe I've always done things "others" expected from me in all the different situations.	This event provoked in me a feeling of impotence. In the course of time I've always believed for certain that events had only one solution: for example when my mother is not feeling well, it's "me and my husband" who take care of her, and not doing it means not doing my duty and this generates guilt in me. When one of my sisters needed me, she always found me ready until a little time ago, today I feel I've become indifferent with them and I feel confused…
8	6.5 (more than slightly)	I participated in an event where all my family was present and I felt isolated from them. The question is: do I isolate myself?	I've asked this question for all the week, there are times in which I think I'd prefer to be alone, not only from those relatives I'm becoming indifferent to (probably it's this that keeps them away), but also alone without my husband, who I feel is not able to understand me, even if he's a bighearted person, and then I think that where he grew up didn't help him…

Session	Rating	Events	What made this event helpful/important
9	7 (moderately)	I and my husband should find a balance, now that we are a couple again… the therapist suggested.	Saying it is easy, but it's not like that. We spent many years facing our days independently and there has never been a great dialogue between us, and maybe it's for this reason we are having difficulties today. However, I have to be objective, I have difficulties in forgiving some recent things and what happened in the past, and probably I'm not able to give him faith, even if I'm learning that there is not only the absolute or everything or nothing.
10	7.5 (more than moderately)	We managed to find some time for ourselves…	It has been a long time since my husband and I spent a day alone out of our house. It has been a very pleasant trip for both of us. I experienced forgotten emotions, serenity, complicity, staying together like we haven't done from a long time. But I had the best feeling when the therapist made me understand that I managed to break down every objection my husband made, and listening to myself I feel stronger with him and with others.
11	7 (moderately)	We should talk to determine the right personal spaces…	The therapist believes that talking, my husband and I, we could manage to find the right balance in order for me to trust him again. I'm not doing it on purpose, but in spite of all the attention he's giving me, I can't still manage to trust my husband like before. Furthermore, I feel some possessiveness in him.
12	8 (greatly)	I felt "lighter" after this session with the therapist…	One simple question of the therapist and I realised having found again my positivity and the smile I once had, and all of this gives me a huge feeling of freedom, freedom to express myself with anyone without feeling guilty for having said or done something that could be bothering. But I realised I still have to work on the tone of my voice because I could still appear aggressive.
13	8 (greatly)	"Are you an anxious person?" This is the question that made me reflect the most…	We deepened the topic of my voice tone which could appear aggressive, but with the question "are you anxious?" the therapist astonished me. I've never considered myself an anxious person, however, reflecting, that's not entirely true.: I recall situations in which, without realizing it, my eyes seemed anxious because my interlocutor looked at me asking if something happened. I could ascribe all of this to my hurry in doing everything or am I really anxious and I've never realised it?
14	7.5 (more than moderately)	"Have you thought about the word 'sweetness'?" the therapist asked me…	Sweetness… I realised that I've learnt what it is thanks to my husband. My parents never told me "I love you", even if today I understand that they demonstrated in another way, in the past I felt imprisoned, and this is probably the reason I married at such a young age. However, today I realise that I haven't managed myself to demonstrate to my kids how much I love them, because even if this should be natural, I live it like a weakness moment. I've never seen my parents cuddle, and also today when my husband cuddles me in front of somebody else I feel a kind of shame.

Session	Rating	Events	What made this event helpful/important
15	8 (greatly)	I turned back to the starting point!!! It's true, it's not a euphemism…	I remember when I attended middle school, and a teacher told us that mankind arrives at a certain point in his evolution and then turns back to the starting point. This is what came up to my mind when the therapist made me notice that after many years, now that my children don't live with us anymore, my husband and I turned to be a couple again, like as soon as we got married, but it's not so easy because we were kids without any experience, instead now there's a new awareness and it's not easy to restore a balance. Certainly, we are more mature and so we see everything with a different perspective: it's like starting back over again with someone you have lived many years with, but you never actually ever knew…
16	8.5 (greatly)	Is faith 360-degree??	I've always thought that faith was believing blindly in your partner or to anyone who loves me, but today I understood that it's not like this because counting on someone, knowing that he is there when you need him is more important than the real faith, which is both with your husband and with your friends.

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).

APPENDIX 2: Evidence in Bohart's criterion list

Evidence that the Client Changed (item 1-39).

	Criterion	Source
1	Clients note themselves that they have changed	S11, 373-380; S16, 89-100, 160-162; FU3, 88; CI, 126-131
2	Client mentions things that make it clear that they either did something or experienced something different than what they normally do or experience in the course of their everyday lives	CI, 126-131; Changes reported in CI
3	Clients are relatively specific about how they have changed	S16, 89-100
4	They provide supporting detail	S16, 161-276; FU1, 748-753
5	They show changes in behaviour in the therapy session plausibly related to the kinds of changes they should be making outside the session	S10, 1-10; S8, 147
6	Plausible reports by the client that others have noted that the client has changed	S16, 640
7	Plausible indicators reported by the client: better grades, promotion at work, less use of medication, new activities such as jogging	S16 268-276; S10, 84-85; CI, 907-909
8	They mention problems that didn't change	CI, 525-598; Changes reported in CI
9	They mention problems that did change	S16, 624-628; S12, 297-306; Changes reported in CI
10	The changes mentioned seem plausible given the degree of difficulty of the problem, degree of time in therapy	-
11	If there is a major change reported, it is described in rich enough detail to be plausible	S11, 373-380, FU1, 748-753
12	If the client comes in depressed they show a reasonably consistent change in mood; more ups than downs as therapy goes on - i.e. they come to therapy less often depressed, seem less depressed, recover more quickly	From session 13 at the beginning of every session
13	If they report being anxious, they report either managing it better, or reductions in anxiety in key situations, and this shows a positive trend over therapy	FU3, 88; FU3, 46-48; FU3, 158-164
14	If they report being unable to leave their house (agoraphobia) they report an example suggesting that they made a new and more concerted effort to go out and it met with at least some degree of success, and their affect about trying it is positive and hopeful (i.e. there is an increase in perceived possibility for them that they can do it)	Not applicable
15	If their problem is a habit problem (studying, overeating, drinking, smoking, etc.) they report concrete changes. With a habit problem ONE incident of change is not usually enough to say that a substantial change has occurred. We would want evidence that this one change was something new, or a new attempt after having been discouraged. But we would like it better if the person could report several successes; a pattern of success. But if a few fresh changes were made and the person seemed optimistic, that we could take as preliminary evidence of change	S10, 1-13, 307-325; S6, 39-41, 65-70

	Criterion	Source
16	If the problem is a demoralisation problem ("I can't"), or involves demoralisation, the person begins to show hope and optimism - a sense of possibility, a sense that it will be a challenge. They become challenge oriented. If they fail they focus more on learning from the challenge than on what it means about them in terms of their inadequacy. In fact, they focus more on the difficulty of the task than on their inadequacies. In other words, when they fail they no longer see it as a complete sign of their inadequacy, or their failure. If they choose not to pursue it any further it is after a reasonable evaluation where they conclude reasonably that a shift in priorities is in order, or action plan.	Changes reported in CI
17	Evidence of new-found confidence in judgment.	CI, 8-14, 17-27
18	Evidence of greater competence in judgment - as the individual thinks out the problem he or she does it more proactively, considers alternatives, weighs them, uses good intuition. Does not seem driven by fear and jump to conclusions. They weight options aloud, think things out.	S10, 1-13, 307-325; S6, 39-41, 65-70
19	Evidence of greater proactive determination and persistence in relation to a reasonable goal.	Not applicable
20	If they make a risky choice, they seem to make it in a reasonable way	S10, 1-13
21	Arriving at a major decision that the person was struggling with.	-
22	Coming up with a whole new plan which is innovative.	S14, 328-355
23	Getting a new perspective which brings greater coherence, reduces debilitating guilt, gives new positive behavioural options, helps the person let go of something from the past	-
24	Gaining a new perspective where they seem to be acceptingly criticizing themselves, seeing their own limitations, but not in a defensive or overly critical way.	S10, 341-343
25	Gaining a perspective that "I am not my problem"	S13, 684-835
26	Identity work: clarifies fundamental goals and values. If no goals or values, begins to confront these issues. If has adopted goals and values from parents but is beginning to question them, begins to evaluate for self. If is in an "identity crisis," or moratorium, struggles with issues and makes progress in making commitments. Identity work can take place in any or all of the following areas: vocational goals, moral values, goals about relationships, goals about children, religious values, political values, values about what makes for a meaningful life, gender issues, sexuality, ethnicity and cultural background	S14, 328-355
27	Identity work: Real self-controversies - what is my real self, am I being untrue to my real self? Movement towards some kind of reconciliation or decision.	Not applicable
28	Traumatic experiences - signs of letting go of it, coming to terms with it, reductions in symptoms such as flashbacks or nightmares, or at least a greater sense that these can be handled and are not so debilitating	All S2; S16, 332-338
29	Achievement of specific goals - becoming more assertive, as evidence by self-report of concrete instances, perhaps seeming more assertive in the therapy session, rise in confidence	S8, 147; CI, 96-99; FU3, 46-48; SWAP scores
30	Interpersonal changes - reported changes in a positive fashion in relationships - handling anger better, less dependence, greater problem solving, greater realistic acceptance of others (i.e., but NOT accepting certain things such as abuse), greater empathy as demonstrated towards others and towards the therapist (more careful listening, less confrontative). With therapist acts more proactively, dialogically, less dependent, less aggressive, less need for dominance.	CI, 893
31	Specific changes: finished a project, made attempts to protect daughter, exercising. Made a new friend. Got and kept a job	S16, 363-365, FU2, 775-78, FU3, 284-285
32	Greater realization that there may be some things that will take ongoing work	FU1, 131-132

	Criterion	Source
33	Changes in self-relationship. Greater realisation and appreciation of accomplishments; more specific and concrete and accurate assessment of talents and effort; less global, negative self-attributions; greater self-empathy; greater self-listening to intuitions, felt experiencing; greater receptive internal dialogue; holding constructs more tentatively to evaluate them; more of an open, searching mentality; if overinflated self-esteem or self-confidence, taking a more careful look at how one might be doing, offending people, etc.	FU3, 591-600; S16, 268-276, S11, 373-380
34	Reduction in any presenting symptoms, such as feeling weak, fearful, tiring quickly, feeling no interest in things, feeling stressed, blaming oneself, feeling suicidal, unfulfilling sex life, feeling lonely, frequent arguments, difficulty concentrating, feeling hopeless about the future, having disturbing thoughts come to mind, upset stomach, sweating, dizziness, heart pounding, trouble getting along with others, trouble sleeping, headaches.	S15, 322-326
35	Increases in positive things: self-efficacy, enjoying spare time, feeling loved and wanted, greater happiness, greater sense of direction or optimism, greater acceptance of the injustices of life in a productive way.	S15, 322-326; FU1, 204-214
36	Better ability to define goals in a proactive and functional way.	-
37	Prosocial changes - volunteering, involvement in productive activities, new projects.	-
38	Changes in physiology - less sweating, calmer and relaxed in therapy.	-
39	Changes in appearance in a positive fashion (if observed).	-

Evidence that it was therapy that helped (item 40-56)

	Criterion	Source
40	Clients themselves report that therapy helped	Changes reported in CI; S16, 624-628; FU3, 411-414
41	Clients are relatively specific about how therapy helped, and it is described in a plausible way	CI, 288, 907-909; Changes reported in CI
42	Outcomes are relatively specific and idiosyncratic to each client and vary from client to client (if comparing across clients)	Not applicable
43	In their reports, clients are discriminating about how much therapy helped, i.e. they do not in general give unabashedly positive testimonials	-
44	They describe plausible links to the therapy experience	CI, 525-598; Changes reported in CI
45	To the rater a plausible narrative case can be made linking therapy work to positive changes. This includes the following (#46-56):	Mostly all S16 and all CI
46	Therapy provides a workspace where clients have an opportunity to talk, think, express. The things the client talks about are the things that change, or if other things change, the client notes a relationship of them to the therapy experience. Client notes that this helped.	0B, 451-459; 0C, 426; S10, 482-485
47	Therapist's empathic understanding, warmth, acceptance, seems to relate to client's increased engagement, willingness to try new things, productive exploration.	S15, 171-173; S16, 624-634
48	Therapist's encouragement, support, positive attitude seem to be related to client's overcoming demoralization, willingness to confront challenges, not be discouraged by failure. Therapist supports client productively when client fails. Keeps eye focused on productive behaviour and this seems to relate to client's doing so also.	0B, 497-498; 0D, 383-387; S2, 135-137

	Criterion	Source
49	Therapist's warmth, empathic listening, seems to provide safe atmosphere for client to confront painful experiences, and these in turn change.	0B, 277; 0C, 412-422
50	Therapist's in-tune questions, reflections, interpretations, or comments, seem to facilitate clients' exploration, gaining new perspectives, developing action plans, creativity. Client feels recognised.	S12, 304-306
51	Clients engage in concrete procedures in therapy and changes are congruent with what they are trying to achieve, and there is evidence of these changes. Examples: EMDR - clients work through a traumatic experience and then seem relieved afterwards, and at the next session; clients engage in chair work and either resolve an internal conflict, or come to terms with someone they have unresolved feelings towards; and this change persists or at least partially persists in subsequent sessions; clients challenge dysfunctional cognitions and show plausible changes in mood or behaviour	S10, 1-13
52	Issues client struggles with in therapy change plausibly over time in accord with the trajectory of the client's working on them e.g. client talks about them week after week, and has ups and downs, but gradually masters them, and the mastery seems related to their ongoing struggle with it in therapy. In other words, perhaps each week they talk about experiences related to resolving the problem, work on it, and gradually master it.	HAT 6; CI, 525-529
53	Clients report changes in trajectory from their past life in the problem. Clients report something new in regard to coping with the problem, and relate it to therapy, or it seems related to therapy. Clients report a history of failed coping with the problem, and now it is changing. Even if client reports having tried some of these things before, now reports that therapy has helped have confidence in the effort and helps him or her persist.	CI, 8-14, 75-88
54	There are no plausible life changes that could have assumed major responsibility for the change. Or, if there is a life change, it seems to be a result of therapist deliberative activity, or it gets incorporated into the therapy activity in a productive way	Not applicable
55	Topics not dealt with in therapy did not change, or, if they did change, there was a plausible reason why they changed from the therapy or from clearly independent reasons. In other words, they can be accounted for so that we can assume we are not talking about a global halo effect.	Not applicable
56	Clients' mastery experiences, problem actuation, and clarification and gaining of new perspectives that occurs in therapy are related to the changes.	Changes reported in CI