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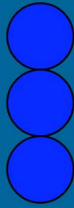
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## Editorial

### Julie Hay

This is a special issue, containing three papers that demonstrate the results of Hermeneutic Single-Case Efficacy Design (HSCED) studies, conducted in Italy, that investigate the effectiveness of transactional analysis psychotherapy for depression.

Mark Widdowson, who is an IJTAR Advisory Board member and an IJTAR Reviewer, provided us with comprehensive material on how to conduct HSCED studies, beginning with a paper in IJTAR Vol 2 Issue 1 (Widdowson 2011) that reviewed the strengths of case study methodology and responded to common criticisms, gave suggestions of a range of research resources relating to outcome and process measures, and included the presentation of an example of a hermeneutic single-case efficacy design. Also included was material on ethical considerations and an exhortation to the TA community to engage more widely in case study research.

Widdowson followed this up a year later, in what became a previous special issue on such studies within the UK, with a case in which he provided full working papers as appendices so that other could replicate his work. (Widdowson 2012a).

Later that year, he provided two more cases in the next issue (Widdowson 2012b, 2012c). A few months after that, he provided yet another case (Widdowson 2013) and a year after that the fifth case appeared (Widdowson 2014), based on a case of mixed anxiety and depression.

Widdowson's cases all took place within the UK – and now I am delighted to be able to publish three replications of the HSCED method he described that have been completed in Italy. Furthermore, the treatment in Italy was based on Widdowson's (2015) more recently published treatment manual, and Widdowson himself acted as a consultant to confirm that the studies were accurate replications of the methodology.

Many thanks to Mark Widdowson, and of course to Enrico Benell as lead author of the papers in this issue, and to the several others who contributed to the research processes. They have provided us with an expanding body of confirmation that transactional analysis is an effective treatment for depression, made even more impressive by the transparency of including cases that conclude with doubts.

### References

- Widdowson, Mark (2011) Case Study Research Methodology *International Journal of Transactional Analysis Research*, 2:1, 25-34
- Widdowson, M. (2012a). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Peter'. *International Journal of Transactional Analysis Research*, 3:1, 1-11.
- Widdowson, M. (2012b). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Denise'. *International Journal of Transactional Analysis Research*, 3:2, 3-14.
- Widdowson, M. (2012c). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Tom'. *International Journal of Transactional Analysis Research*, 3:2, 15-27.
- Widdowson, M. (2013). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Linda' - a mixed outcome case. *International Journal of Transactional Analysis Research*, 4:2, 3-15.
- Widdowson, M. (2014). Transactional Analysis Psychotherapy for a Case of Mixed Anxiety & Depression: A Pragmatic Adjudicated Case Study – 'Alastair'. *International Journal of Transactional Analysis Research*, 5:2, 66-76.
- Widdowson, M. (2015). *Transactional Analysis for depression: A step-by-step treatment manual*. Abingdon: Routledge.



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

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### Abstract

*This study is the first of a series of three, and represents an Italian systematic replication of previous UK findings (Widdowson 2012a, 2012b, 2012c, 2013) that investigated the effectiveness of a recently manualised transactional analysis treatment for depression with British clients, using Hermeneutic Single-Case Efficacy Design (HSCED). The various stages of HSCED as a systematic case study research method are described, as a quasi-judicial method to sift case evidence in which researchers construct opposing arguments around quantitative and qualitative multiple source evidences and judges evaluate these for and against propositions to conclude whether the client changed substantially over the course of therapy and that the outcome was attributable to the therapy. The therapist in this case was a white Italian woman with 10 years clinical experience and the client, Sara, was a 62-year old white Italian woman with moderate depression and three recent bereavements, who attended sixteen sessions of transactional analysis therapy. The diagnosis is based on the new DSM-5 criteria that allow differentiation between Depression and Bereavement. The conclusion of the judges was that this was a good-outcome case: the client improved early over the course of the therapy, reported positive experience of therapy and maintained the improvement at the end of the follow-up.*

### Key words

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

### Introduction

This article is the first of a series of three and represents an Italian systematic replication of previous findings in the UK (Widdowson 2012a, 2012b, 2012c, 2013) supporting the effectiveness of transactional analysis

(TA) treatment of depression, under the auspices of the project 'Toward a transactional analysis psychotherapy recognised as empirically supported treatment: an Italian replication series design', funded by the European Association of Transactional Analysis (EATA).

This present case study analyses process and outcome of brief treatment of 'Sara', a 62-year old Italian woman presenting with depression and bereavement. The psychotherapy was conducted according to manualised TA treatments of depression (Widdowson, 2015; Boschetti & Revello, 2013).

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

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

In order to define TA psychotherapy as an efficacious Empirically Supported Treatment (EST), its efficacy must have been established in at least one Randomized Clinical Trials (RCT) replicated by two independent research groups, or alternatively in at least three Single Case Efficacy Design studies (SCED), replicated by at least three independent research groups (Chambless & Hollon, 1998). Recently, a wide community of researchers proposed that treatment efficacy in psychotherapy is a complex object that cannot be adequately evaluated with the experimental approach of

RCT (Norcross, 2002; Westen, Novotny & Thomson-Brenner, 2004) and SCED (McLeod, 2010). Systematic case study research has been proposed as a viable alternative to RCT and SCED (Iwakabe & Gazzola, 2009), and Hermeneutic Single Case Efficacy Design (HSCED) (Elliott, 2002; Elliott et al., 2009) is nowadays considered the most comprehensive set of methodological procedures for systematic case study research in psychotherapy (McLeod, 2010). Recently, a systematic review of all HSCED studies published within English language peer reviewed journals highlighted methodological issues related to different levels of stringency, offering solid alternatives according to the availability of resources for research (Benelli, De Carlo, Biffi & McLeod, 2015).

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

### **Ethical Considerations**

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

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

## **Method**

### **Inclusion and exclusion criteria**

Participating psychotherapists were invited to include in the study the first new client with a diagnosis of depression who accepted to be involved in the research. Other current psychotherapy, active psychosis, domestic violence, bipolar disorder, antidepressant medication, alcohol or drug abuse were considered as exclusion criteria.

### **Client**

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

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

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

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

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

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

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

### **Therapist**

The psychotherapist is a 40 year-old, white, Italian woman with 10 years of clinical experience and a certification as Provisional Teaching and Supervising Transactional Analyst (Psychotherapy) (PTSTA-P). For this case, she received weekly supervision by another PTSTA-P of the same level of experience.

### **Intake sessions**

Sara attended two pre-treatment sessions which were focused on conducting a diagnostic interview evaluation according to DSM 5 criteria (American Psychiatric Association, 2013), developing a case formulation, creating a definition of the problems she was seeking help for in therapy, and collection of self-report outcome measure data relating to depression, anxiety and general distress. The therapist also proposed the research

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

### **DSM 5 Diagnosis**

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

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

### **TA Diagnosis and Case formulation**

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



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

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

### Treatment

The therapy followed the manualised therapy protocol of Widdowson (2015) and the treatment recommendations of Boschetti and Revello (2013). The treatment plan primarily focused on the empathic attunement of Sara's experience. Sara initially sought help in order to deal with her bereavement, feeling alone and extremely sad. In the first sessions, the therapist offered Sara an empathic listening, allowing Sara to express her emotions relating to the death of her partner. During these early sessions, the therapist also explained the ego state model, the drivers and the internal dialogue. The therapeutic alliance formed in the early sessions created an atmosphere of permission (Crossman, 1966) to enable Sara to move out of personality patterns relating to her injunctions. Particularly, the focus was on the injunctions; Don't be close, Don't be you, Don't be angry, and Don't enjoy. The therapy also explored archaic episodes regarding Sara's relationship with her mother and significant relational episodes relating to others. In discussing these relational episodes, Sara's internal dialogue, interpersonal options and racket analysis were explored when appropriate, to explore how Sara inhibited thoughts, emotions and physical sensations. In subsequent sessions, Sara made redecisions (Goulding & Goulding, 1979) relating to her Please Others and Be Strong drivers and the injunction Don't be angry. The final part of the therapy was focused on exploring permission to be herself and to enjoy life rather than be worried and adapt to the needs of the others.

### Analysis Team

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

### Judges

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

### Transparency statement

The research was conducted entirely independently of the previous case series (see Widdowson 2012a, 2012b, 2012c). The last author, Mark Widdowson, was involved

in checking that the research protocol and data analysis process was adhered to, in order to make the claim that this case series represents a valid replication of the initial study, (with minor changes) and was involved in the final preparations of this article.

### Quantitative Outcome Measures

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

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

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

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

### Qualitative Outcome Measurement

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

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

### Therapist Notes

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

### Adherence

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

### HSCED Analysis Procedure

#### Affirmative Case

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

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

#### Sceptic Case

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



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

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

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

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

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

#### Adjudication Procedure

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

- If the case were a clearly good outcome case, a mixed outcome case, or a poor outcome case;
- If the client had changed;
- To what extent these changes had been due to the therapy;

- Which aspects of the affirmative and sceptic arguments had informed their position.

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

## Results

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

#### Quantitative Outcome Data

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

#### Qualitative Data

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

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

|       | Clinical Cut-Off | Case Cut-Off | Reliable Change Index | Pre-Therapy | Session 8 (middle) | Session 16 (end) | 1 month FU  | 3 months FU    | 6 months FU |
|-------|------------------|--------------|-----------------------|-------------|--------------------|------------------|-------------|----------------|-------------|
| PHQ-9 | 10               | 15           | 6                     | <b>15</b>   | 8(+)(*)            | 5(+)(*)          | <b>12</b>   | 4(+)(*)        | 5(+)(*)     |
| CORE  | 10               | 15           | 5.1                   | <b>20.9</b> | <b>12,1(*)</b>     | 8,8(+)(*)        | <b>16,8</b> | <b>10,6(*)</b> | 9,1(+)(*)   |
| GAD-7 | 8                | 10           | 4                     | <b>8</b>    | 5(+)               | 5(+)             | <b>12</b>   | 5(+)           | 6(+)        |
| PQ    | 3                | 3.5          | 1                     | <b>5,3</b>  | <b>3,4(*)</b>      | 2,1(+)(*)        | <b>4(*)</b> | 2(+)(*)        | 1,9(+)(*)   |

**Table 2: Sara's Quantitative Outcome Data**

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

|   | PQ items  | Duration | Pre-Therapy | Session 8 (middle) | Session 16 (end) | 1 month FU | 3 months FU | 6 months FU |
|---|---|----------|-------------|--------------------|------------------|------------|-------------|-------------|
| 1 | I cannot get out of mourning  | 1-5 m    | <b>7</b>    | <b>4</b>           | 2                | <b>3</b>   | 2           | 2           |
| 2 | I feel guilty for my anger toward my mother                             | >10 y    | <b>3</b>    | <b>3</b>           | 2                | <b>5</b>   | 2           | 1           |
| 3 | I have always had difficulty in my relationship with men                | 6-10 y   | <b>3</b>    | <b>4</b>           | <b>3</b>         | <b>4</b>   | <b>3</b>    | <b>3</b>    |
| 4 | I feel afraid and anxious for the future                                | 1-2 y    | <b>7</b>    | <b>5</b>           | <b>3</b>         | <b>4</b>   | <b>3</b>    | <b>3</b>    |
| 5 | I feel lonely   | 1-5 m    | <b>6</b>    | <b>5</b>           | 2                | <b>3</b>   | 1           | 1           |
| 6 | I cannot share my suffering without feeling guilty                      | 1-5 m    | <b>5</b>    | <b>3</b>           | 2                | <b>4</b>   | 2           | 2           |
| 7 | I feel death upon me  | 1-5 m    | <b>7</b>    | 2                  | 1                | <b>5</b>   | 1           | 1           |
| 8 | I cannot express my anger   | > 10 y   | <b>4</b>    | 2                  | 1                | <b>4</b>   | 1           | 1           |
| 9 | I'm not capable of understanding people or solving my problem with them | > 10 y   | <b>6</b>    | <b>3</b>           | <b>3</b>         | <b>4</b>   | <b>3</b>    | <b>3</b>    |
|   | Total   |          | 48          | 31                 | 19               | 36         | 18          | 17          |
|   | Mean  |          | <b>5.3</b>  | <b>3.4</b>         | 2.1              | <b>4</b>   | 2           | 1,9         |

**Table 3: Sara's Personal Questionnaire items**

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

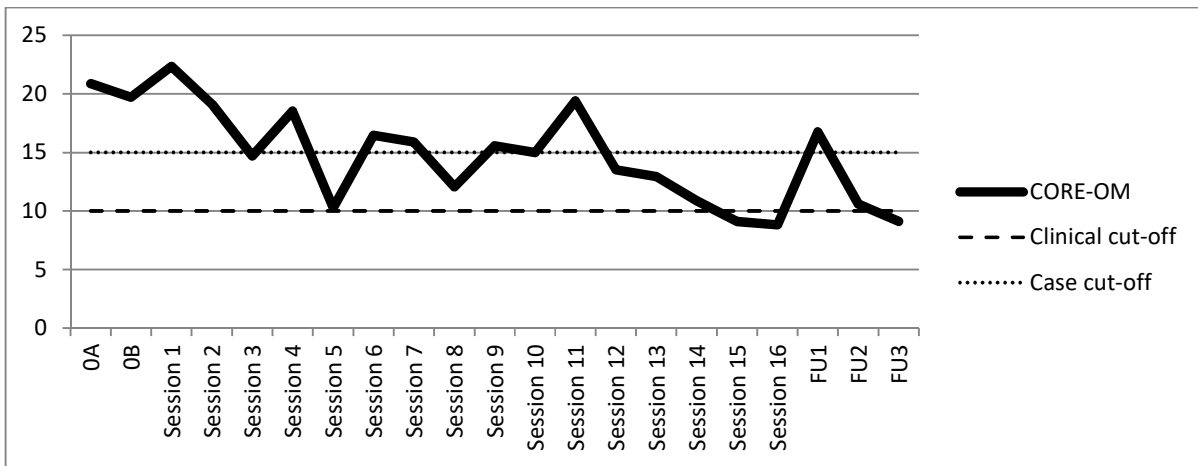


Figure 1: Sara's weekly CORE-OM score

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

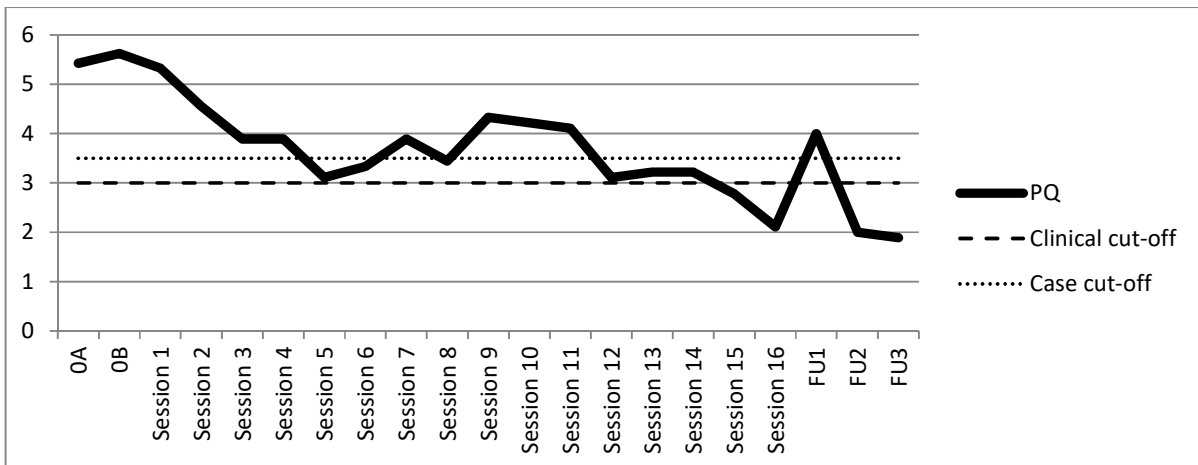


Figure 2: Sara's weekly PQ score

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

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

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

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

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

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

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

| CI Items   | How much was change expected <sup>1</sup> | How likely change would have been without therapy <sup>1</sup> | Importance of change <sup>3</sup> |
|--|---|--|-----------------------------------|
| The end of the sense of guilt toward my mother   | 5<br>(surprising)                         | 1<br>(unlikely)  | 5<br>(extremely)                  |
| To think about myself and my needs before pleasing others                                      | 4<br>(almost surprising)                  | 2<br>(quite unlikely)  | 5<br>(extremely)                  |
| Being able to create an intimate relationship with my son and to be able to share our emotions | 4<br>(almost surprising)                  | 1<br>(unlikely)  | 4<br>(very)                       |
| Being able to share emotions with others without annoying them                                 | 4<br>(almost surprising)                  | 2<br>(quite unlikely)  | 4<br>(very)                       |
| Being authentic without hiding myself behind a role  | 4<br>(almost surprising)                  | 2<br>(quite unlikely)  | 5<br>(extremely)                  |

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

<sup>1</sup>The rating is on a scale from 1 to 5; 1= expected, 3= neither, 5= surprising. <sup>2</sup> The rating is on a scale from 1 to 5; 1=unlikely, 3=neither, 5=likely. <sup>3</sup> The rating is on a scale from 1 to 5; 1=slightly, 3 = moderately, 5=extremely.

## HSCED Analysis

### Affirmative Case

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

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

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

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

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

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

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

#### *Sceptic Case*

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

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

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

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

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

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

#### *Affirmative Rebuttal*

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

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



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

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

#### *Sceptic Rebuttal*

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

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

#### **Adjudication**

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

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

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

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

*Table 6: Adjudication results*

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

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

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

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

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

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

**Judge A.** 'The therapy appears to have contributed considerably to the changes (60%), with 80% certainty. In the CI, the client affirms that the therapy determined 80% of her change. From observing her HAT forms, I notice that the client experienced several helpful within-session events. There is a clear link between many interventions described in therapist notes (e.g. working through emotions associated with expressing her rage to the mother), the client's perception reported in the HAT (e.g. "to talk about the passive anger of my mother"), and subsequent changes in her behaviour (e.g. express anger with ex-husband) and a decrease in PQ score (e.g. item 8, "I cannot express my anger"). It is unlikely that a change in this kind of long-standing problem would happen without therapy. Despite this evidence, some doubt remains about the extent of the influence of the previous therapy. Indeed, the client appeared to be involved in the therapeutic process since the beginning, and this may be due to her previous therapy that may have enhanced the process of change. The grieving process may have also enhanced the outcome'.

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

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

#### *Mediator Factors*

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

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

#### *Moderator Factors*

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

### **Discussion**

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

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

The therapeutic alliance appears to have been built on a non-directive style and modelling permissions corresponding to the client's injunctions. The therapist allowed the client to create an affective bond with an exchange of positive strokes. Specific TA techniques were; the explanation of the ego state model and internal dialogue, drivers and racket system analysis, which allowed the client to rapidly get in touch with her relational behaviours and mental processes. The main aspects related to change appear to be the racket system analysis of an archaic episode between the client and her mother, in which the client became aware of her buried emotions of anger covered by guilt. The client recognised that this therapy allowed her to change long-standing problems, and was surprised by her therapist's style: warm, non-directive and with few interventions, unlike the previous therapy.

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

#### **Limitations**

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

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

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

## Conclusion

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

This case represents the first Italian systematic replication of the case series by Widdowson (2012a, 2012b, 2012c, 2013) conducted solely with British clients. Although this single case cannot be used as evidence of the TA efficacy and effectiveness for the treatment of depression, it provides evidence that TA therapy has been effective with an Italian woman with moderate depression and recent bereavement and adds to the evidence base for the effectiveness of TA for depression.

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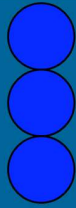
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## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Benelli, E., De Carlo, A., Biffi, D., & McLeod, J. (2015). Hermeneutic Single Case Efficacy Design: A systematic review of published research and current standards. *Testing, Psychometrics, Methodology in Applied Psychology*, 22, 97-133. doi:10.4473/TPM22.1.7
- Berne, E. (1964). *Games people play*. New York: Grove Press.
- Berne, E. (1972). *What Do You Say After You Say Hello?* New York: Grove Press.
- Bohart, A. C. (2000). *A qualitative "adjudicational" model for assessing psychotherapy outcome*. Paper presented at the meeting of the Society for Psychotherapy Research, Chicago.
- Boschetti, D., & Revello, B. (2013). Il trattamento della depressione secondo l'analisi transazionale: un'esperienza. (Treatment of depression according Transactional Analysis: an experience). *Quaderni Centro Psicologia Dinamica*, 15, 98-104. Padua: Cleup.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of consulting and clinical psychology*, 66:1, 7-18.
- Crossman, P. (1966). Permission and Protection. *Transactional Analysis Bulletin*, 5, 152-4.
- Elliott, R. (2002). Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*, 12(1), 1-21. doi:10.1080/713869614
- Elliott, R., Partyka, R., Wagner, J., Alperin, R., Dobrenski, R., Messer, S. B., Watson, J.C & Castonguay, L. G. (2009). An adjudicated hermeneutic single-case efficacy design study of experiential therapy for panic/phobia. *Psychotherapy Research*, 19(4-5), 543-557. doi:10.1080/10503300902905947
- Elliott, R., Shapiro, D. A., & Mack, C. (1999). *Simplified Personal Questionnaire procedure manual*. Toledo, OH: University of Toledo.
- Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychologische Beiträge*, 43, 69-111.
- Erskine, R. & Zalcman, M. (1979). The racket system: a model for racket analysis. *Transactional Analysis Journal*, 9, 51-9.
- Evans, C, Connell, J., Barkham, M., Margison, F., Mellor-Clark, J., McGrath, G. & Audin, K. (2002). Towards a standardised

- brief outcome measure: Psychometric properties and utility of the CORE-OM. *British Journal of Psychiatry*, 180, 51-60.
- Goulding, R. & Goulding, M. (1976). Injunction, decision and redecision. *Transactional Analysis Journal*, 6, 41-8.
- Goulding, R. & Goulding, M. (1979). *Changing lives through Redecision Therapy*. New York: Grove Press.
- Iwakabe, S., & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research*, 19(4-5), 601-611. doi:10.1080/10503300802688494
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59(1), 12-19. doi:10.1037/0022-006X.59.1.12
- Kerr, C. (2013). TA Treatment of Emetophobia – A Systematic Case Study – ‘Peter’. *International Journal of Transactional Analysis Research*, 4:2, 16-26.
- Khalil, E., Callaghan, P., & James, N. (2007). *Transactional analysis: A scoping exercise for evidence of outcome*. Report prepared for the Berne Institute. The University of Nottingham, School of Nursing.
- Kahler, T. (1975). Drivers: the key to the process of scripts. *Transactional Analysis Journal*, 5, 280-284.
- Llewelyn, S. (1988). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology*, 27, 223-238. doi:10.1111/j.2044-8260.1988.tb00779.x
- MacLeod, R., & Elliott, R. (2012). Emotion-focused therapy for social anxiety: A hermeneutic single case efficacy design study of a low-outcome case. *Counselling Psychology Review*, 27, 7-22
- McLeod, J. (2010). *Case study research in counselling and psychotherapy*. London: Sage Publications.
- McLeod, J. (2013a). Process and outcome in pluralistic transactional analysis counselling for long-term health conditions: A case series. *Counselling and Psychotherapy Research*, 13:1, 32-43.
- McLeod, J. (2013b). Transactional Analysis Psychotherapy with a woman suffering from Multiple Sclerosis. A Systematic Case Study. *Transactional Analysis Journal*, 43:3, 212-223.
- Norcross, J. C. (Ed) (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. Oxford: Oxford University Press.
- Ohlsson, T. (2010) Scientific Evidence Base for Transactional Analysis in the Year 2010 *International Journal of Transactional Analysis Research* 1:1 4-29
- Spitzer, R. L., Kroenke, K., & Williams, J. B. (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. *Journal of the American Medical Association* [http://en.wikipedia.org/wiki/JAMA\\_\(journal\)](http://en.wikipedia.org/wiki/JAMA_(journal)). Nov 10; 282:18, 1737-44. PMID 10568646
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166:10, 1092-1097. doi:10.1001/archinte.166.10.1092.
- Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, 130:4, 631-663.
- Widdowson, M. (2012a). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - ‘Peter’. *International Journal of Transactional Analysis Research*, 3:1, 1-11.
- Widdowson, M. (2012b). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - ‘Denise’. *International Journal of Transactional Analysis Research*, 3:2, 3-14.
- Widdowson, M. (2012c). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - ‘Tom’. *International Journal of Transactional Analysis Research*, 3:2, 15-27.
- Widdowson, M. (2013). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - ‘Linda’- a mixed outcome case. *International Journal of Transactional Analysis Research*, 4:2, 3-15.
- Widdowson, M. (2014). Transactional Analysis Psychotherapy for a Case of Mixed Anxiety & Depression: A Pragmatic Adjudicated Case Study – ‘Alastair’. *International Journal of Transactional Analysis Research*, 5:2, 66-76.
- Widdowson, M. (2015). *Transactional Analysis for depression: A step-by-step treatment manual*. Hove: Routledge





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

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### Abstract

*This study is the second of a series of three, and represents an Italian replication of a previous UK-based case series (Widdowson 2012a, 2012b, 2012c, 2013) that investigated the effectiveness of a recently manualised transactional analysis treatment for depression with British clients, using Hermeneutic Single-Case Efficacy Design (HSCED). The various stages of HSCED as a systematic case study research method are described, as a quasi-judicial method to sift case evidence in which researchers construct opposing arguments around multiple sources of quantitative and qualitative evidence and judges evaluate these to conclude whether the client changed substantially over the course of therapy, and whether the outcome was attributable to the therapy. The therapist in this case was a white Italian man in the third year of training to become a psychotherapist, and the client, Penelope, was a 45-year old white Italian woman with mild depression and anxiety. The conclusion of the judges was that this was a mixed-outcome case: the client improved some aspects of her problems, without obtaining a complete and stable remission. Interestingly, this case presents a minimal correlation between empirical and proxy-rated indexes of depression and anxiety and answers to self reported questionnaires, raising the question of validity of self report measures with specific typology of client.*

### Key words

Systematic Case Study Research; Hermeneutic Single-Case Efficacy Design; Transactional Analysis Psychotherapy; Depression; self report validity

### Editor's Note

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

### Introduction

This article is the second of a series of three and represents an Italian systematic replication of previous UK-based findings (Widdowson 2012a, 2012b, 2012c, 2013) investigating the effectiveness of transactional analysis (TA) treatment of depression. This case was run under the auspices of the project 'Toward a transactional analysis psychotherapy recognised as empirically supported treatment: an Italian replication series design', funded by the European Association of Transactional Analysis (EATA). This present case study analyses process and outcome of the brief treatment of 'Penelope', a 45-year old Italian woman presenting with depression. The psychotherapy was conducted according to a recently manualized TA treatment of depression (Widdowson, 2015).

The general aim of this study was to investigate the effectiveness of short-term TA treatment of depression in a naturalistic setting. This article is interesting also because: the treatment is carried out by a young (28 year-old) psychologist in the third year of specialisation in psychotherapy; there is no correlation between the client's self-reported measures of depression and anxiety and the therapist's proxy measures and judgement; and the outcome is mixed, with quantitative and qualitative data presenting conflicting pictures of change. Therefore, this study addresses multiple important issues that practitioner-researchers come across in their routine practice. These include issues related to the quality of therapy delivered by trainee psychotherapists within public services, the validity and reliability of self-report measures, and how to interpret data that presents an ambiguous picture of change, where the first examination of the results suggests no clear conclusion regarding outcome. This is perhaps the sort of situation where HSCED shows its particular strength, in the detailed



analysis and cross-examination of qualitative and quantitative data and developing arguments that account for complex pictures of change which are then subjected to further analysis and evaluation by a process of adjudication to draw conclusions regarding the outcome of the case.

TA is a widely practiced form of psychotherapy, but it is still under-recognised within the worldwide scientific community of psychotherapy. Although its clinical efficacy is experienced in the consulting room by thousands of Transactional Analysts every day, systematic empirical evidence regarding the effectiveness of TA with specific presenting problems has been scant and of poor quality until recent years (Khalil, Callaghan & James, 2007). Ohlsson (2010) provided a valuable reference list of TA research studies. In order to define TA psychotherapy as an efficacious Empirically Supported Treatment (EST), its efficacy must have been established in at least one Randomized Clinical Trial (RCT) replicated by two independent research groups, or alternatively in at least three Single Case Efficacy Design studies (SCED), replicated by at least three independent research groups (Chambless & Hollon, 1998), with each group conducting a case series of a minimum of three cases. Recently, a wide community of researchers have proposed that treatment efficacy in psychotherapy is a complex issue which cannot be adequately evaluated with the experimental approach of either RCT design (Norcross 2002; Westen, Novotny & Thompson-Brenner, 2004) nor SCED alone (McLeod, 2010). Systematic case study research has been proposed as a viable alternative to RCT and SCED (Iwakabe & Gazzola, 2009), and Hermeneutic Single Case Efficacy Design (HSCED; Elliott, 2002; Elliott et al., 2009) is nowadays considered the most comprehensive set of methodological procedures for systematic case study research in psychotherapy (McLeod, 2010). HSCED is a systematic case study research method which examines individual cases and can be used to: (a) evaluate whether change has occurred; (b) examine evidence causally linking client change to the therapy; (c) evaluate alternative explanations for client change; and (d) identify the specific processes that appear to have been responsible for change (Elliott, et al., 2009).

Recently, a systematic review of all published HSCED studies found within English language peer-reviewed journals highlighted methodological issues related to different levels of stringency, offering solid alternatives according to the availability of resources for research (Benelli, De Carlo, Biffi & McLeod, 2015).

Systematic case study research has already been applied to investigate TA effectiveness with people with long term health conditions (McLeod, 2013a; 2013b) and HSCED methodology have been already successfully applied to TA and widely described in this Journal by Widdowson (2012a). Recently, several HSCEDs supporting TA treatment for depression (Widdowson, 2012a, 2012b, 2012c, 2013) have been published, as

was an additional adjudicated study which demonstrated effectiveness of TA for mixed depression and anxiety (Widdowson, 2014). Furthermore a related study was published on the effectiveness of TA for emetophobia (Kerr, 2013). The case series by Widdowson has shown that TA can be an effective therapy for depression when delivered in routine clinical practice, in private practice settings, with clients who actively sought out TA therapy and with white British therapist and client dyads.

## Ethical Considerations

The research protocol follows the indications of the ethical code for Research in Psychotherapy of the Italian Association of Psychology and the American Psychological Association guidelines on rights and confidentiality of research participants. Before entering the treatment, the client received an information pack, including the detailed description of the research protocol, and gave her informed consent and written permission to use anonymised, disguised transcripts of segments of sessions or interviews within scientific articles and/or be presented at conferences. The client was informed that she would still have been entitled to attend therapy even if she decided against participating in the research and that she had the right to withdraw from the study at any time.

All aspects of the case material have been disguised, so that neither the client nor third parties are identifiable. All changes to anonymise the case have been made in such a way that would not lead the reader to draw false conclusions related to the described phenomena. Finally, this article, in Italian, was presented to the client following which she gave written consent for its publication.

## Method

### Inclusion and exclusion criteria

Participating psychotherapists were invited to include in the study the first new client with a diagnosis of depression who had agreed to participate in the research. The exclusion criteria for participation were: client in other current psychotherapy, active psychosis, domestic violence, bipolar disorder, antidepressant medication, and currently active alcohol or drug abuse.

### Client

Penelope is 45 years old and lives with her 12-year old son, whom she adopted when he was 20 months old. She divorced approximately one year prior to the start of therapy. She consulted a neuropsychiatry clinic regarding the behaviour of her son, who has been diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD). The psychologist of the service, noting that Penelope was tearful and clearly in palpable pain, suggested that she seek psychotherapy. Because of economic problems, she was referred to a psychologist specialising in psychotherapy, paying a small donation per session. At the first appointment, she spoke anxiously and quickly of many problems, crying often, especially when discussing

her relationship with her son, whom she described as overwhelming, insistent and demanding. She reported that he would often explode in uncontrolled anger when she tried to set boundaries for him. Given her son's reaction, she described how she starts to feel helpless and would like to get away, and then she feels incapable of managing the situation, and then begins a process of angry and guilty self-reproach connected to her feeling of not being able to manage. She described her situation as being unfortunate, and that no-one helps her, that she must carry out everything alone, and that she feels limited in every area of her life, stuck, frustrated, and unable to change things.

Penelope presented with a smart appearance and friendly manner. She described herself as generous, and that she does a lot for others, is able to give emotional support to others, and is surrounded by friends. She reported that in her friendships she feels confident and has fun. She described herself as a strong person who is able to find beauty in every aspect of her life, even when things go wrong. She tended to smile and cheerfully described painful or shocking events where she suffers severe abuse. Penelope reported that her work situation is good and that she has a good relationship with all of her colleagues.

She considers herself without any problems on a personal level, but overwhelmed by the external situations that she believes are unchangeable and therefore must be accepted. She appeared to be interested in participating in the therapy not to get personal change, but to help her child with his illness.

She described the recent divorce from her husband (about a year) after a long period of crisis, which began with the arrival of the child ten years earlier, which resulted in her ex-husband feeling that he was being overlooked. The ex-husband is described as physically violent, aggressive, demanding, both at work and with family members and relatives, unreliable in the role of parent and unable to care for the child in a responsible way (e.g., he does not pick up the son from school, did not accompany him to therapy or get involved in his sports activities). After the separation, he did not contribute economically, and indeed would repeatedly approach Penelope asking for money. Penelope reported that she always gave him money when asked, despite her own personal financial difficulties. She described his behaviour as intrusive, for example by calling her dozens of times a day. She described herself as resigned to suffer his behaviour and avoids telling him anything in order to prevent conflict.

Penelope briefly described that her father was an explosive and impulsive man who criticised others who expressed emotion. She described her mother as a person who becomes distressed every time she needs to make a decision.

### **Therapist**

The therapist, a 28 year-old Italian man, was a psychologist at the third year of the four-year post degree training in psychotherapy. He was supervised at the end of each session by a Certified Transactional Analyst (Psychotherapy) (CTA P) with five years of experience and every four sessions by a Teaching & Supervising Transactional Analysts (Psychotherapy) (TSTA P) with more than 20 years of experience.

### **Intake sessions**

Penelope attended two pre-treatment sessions which were focused on conducting a diagnostic interview evaluation according to DSM 5 criteria (American Psychiatric Association, 2013), developing a case formulation, creating a definition of the problems she was seeking help for in therapy, and for collection of self report outcome measure data relating to depression, anxiety and general psychological distress. The therapist also explained the research protocol and obtained informed consent from Penelope for her participation in this research. Penelope completed self-rated measures to assess her general suffering, depression and anxiety (see measures section). The scores of these measures were all within the 'healthy' range and did not indicate any clinical level of distress. However, the objective clinical examination revealed a depressive symptomatology. The therapist completed a proxy-rated measure to evaluate depression, generating a score which indicated moderate depression. Considering that Penelope tends to describe herself as a strong woman, who is used to doing everything alone without asking for help, it is possible that self-report measures did not reflect the true clinical situation, but were a reflection of her tendency to minimise her suffering. Due to the results of the diagnostic interview and the proxy-rated measure, the research team felt that including this case in the research project was justified.

### **DSM 5 Diagnosis**

The therapist, during the diagnostic interview, on the basis of the objective examination and their clinical judgement, determined that Penelope met DSM 5 diagnostic criteria of Major Depressive Disorder. The therapist observed feelings of despair, hopeless and tearful (criterion 1) and psychomotor agitation (5), and Penelope described a diminished interest in almost all activities (2), increased appetite (3), fatigue and loss of energy nearly every day (6), feeling of worthlessness and inappropriate guilt (7) and diminished ability to make decisions (8).

Knowing the level of an individual's personality functioning and pathological traits provides the therapist with fundamental information for treatment planning. Therefore, a diagnosis of personality was also conducted, using the alternative dimensional model developed for DSM 5 Section III. This diagnosis allows:

1) assessment of the level of impairment in personality functioning and 2) an evaluation of personality traits. A moderate level of impairment in personality functioning is required for the diagnosis of a personality disorder, in at least two of the following areas: Identity, Self-direction, Empathy and Intimacy. The client showed some impairment in these areas, which resembled the prototypical description of the moderate level, leading to a diagnosis of moderate level of impairment in personality functioning. According to the new dimensional model of personality the client has a personality characterised by the Domains of Negative Affectivity (vs. Emotional Stability), more finely defined by the following Facets: Emotional lability, Anxiousness, Submissiveness, Depressivity, Distractibility. Both the level of personality functioning and personality traits were considered in drawing up the treatment plan.

### **TA Diagnosis and Case formulation**

Penelope's depression was conceptualised as a consequence of painful internalisation of distress during her childhood that led to a pervasive sense of not being considered and supported by the other, which in turn led to a sense of inadequacy, inferiority and guilt. Penelope demonstrated a stroke filter (Steiner, 1974) that limited her perception of positive recognition. This supported the dominance of her powerful internalised critical Parent (Berne, 1967) and a lack of positive recognition from the protective nurturing Parent (Berne, 1964). She presented with Please Me and Be Strong drivers (Kahler & Capers, 1974), the injunctions (Goulding & Goulding, 1976) Don't be you, Don't be important, Don't feel and Don't express emotion (in particular anger and sadness). There was also some evidence of a Don't succeed injunction. Penelope's Racket System (Erskine and Zalcman, 1979) highlighted the following: Beliefs about self: "I am inadequate and inferior, weak and helpless"; Beliefs about others: "are better than me and will not help me"; Beliefs about life: "one must accept it as it is"; with repressed emotions of anger and sadness; Observable racket behaviours: 'pleasing' others, avoidance of loneliness; Reported internal experiences: some somatic symptoms, loss of energy; Reinforcing memory: archaic episodes of being criticized when showing suffering. Interpersonally, Penelope tended to present from a Victim role within the drama triangle (Karpman, 1968) and would counteract her sense of abandonment by then assuming a Nurturing Parent position and Rescuer role, taking care of others in order to keep them close.

### **Contract**

Penelope entered therapy with the sole purpose of helping her child with his suffering. During contract negotiations Penelope focused on external issues (her son's illness, the behavior of her husband) and was less involved in exploring her own thoughts, emotions, needs, desires. After some negotiation, the final contract was that she would learn how to protect herself, to express

her own needs, and set limits and boundaries with others who were acting abusively towards her (primarily, her ex-husband).

### **Treatment**

The therapy followed the manualised treatment of depression as described by Widdowson (2015), and tailored according to the level of personality functioning and personality traits in line with guidance from the treatment manual. To deal with a moderate level of impairment requires a permanent focus on the therapeutic alliance, creating a climate of Permission (Crossman, 1966) in contrast to the client's received injunction(s), providing a safe setting where she could feel and express repressed emotions, to explore her needs, to be herself, to explore options (Karpman, 1971), to change her behaviours and protect herself from others. The personality trait of Submissiveness requires a focus firstly on Protection (Crossman, 1966) in order to ensure that the client is not inadvertently exposed to violence or abuse, and is then followed by a rededication (Goulding & Goulding, 1976) about expressing her needs rather than avoiding conflict.

### **Analysis Team**

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

### **Judges**

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

### **Transparency statement**

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

### Quantitative Outcome Measures

Three standardized self-report outcome measures were selected to measure target symptoms: the Patient Health Questionnaire 9-item measure for depression (PHQ-9) (Spitzer, Kroenke & Williams, 1999), the Generalized Anxiety Disorder 7-item measure (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006) for anxiety and the Clinical Outcome for Routine Evaluation - Outcome Measure (CORE-OM; Phase 0, session 1, 8, 16 and follow-ups) (Evans, Connell, Barkham, Margison, Mellor-Clark, McGrath, & Audin, 2002) and short form (CORE-18; Pair session: short form A; despair sessions: short form B) (Evans, Mellor-Clark, Margison, Barkham, Audin, Connell & McGrath, 2000) for assessment of global functioning and distress. These measures were evaluated according to clinical significance and Reliable Change Index (RCI) (Jacobson & Truax, 1991). Clinical significance indicates that the client has moved from a clinical to a non clinical range score. RCI means that the change is reliable and not due to measurement errors. See Table 1 for RCI values for each measure.

All these measures were administered prior to each session to measure the on-going process and to facilitate the identification of events in therapy that produced significant change. Before each session, the client also rated the simplified Personal Questionnaire (PQ) (Elliott, Shapiro, & Mack, 1999), a client-generated measure in which clients specify the problems they would like to address in their therapy and rate their problems according to how distressing they are finding each problem. Furthermore the therapist compiled after every session the Hamilton Depression Rating Scale (HAM-D; Hamilton, 1960). All of these measures were administered also during the assessment phase to obtain a three-point baseline, and during the three follow-ups.

### Qualitative Outcome Measurement

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

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

### Therapist Notes

A 'structured session notes form' (Widdowson, 2012a, Appendix 6, p. 50-52) was completed by the therapist at

the end of each session. In this form the therapist provides a brief description of the session in which are identified the therapy process, the theories and interventions used, and an indication of how helpful the therapist felt the session was for the client.

### Adherence

The therapist and the two supervisors 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). Both supervisors compiled the adherence to treatment form and they indicated that the treatment was consistent with the TA theory to an adequate level of competence, with a slight improvement needed.

### HSCED Analysis Procedure

#### Affirmative Case

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

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

#### Sceptic Case

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

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



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

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

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

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

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

#### Adjudication Procedure

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

- If the case were a clearly good outcome case, a mixed outcome case, or a poor outcome case;
- If the client had changed;

- To what extent these changes had been due to the therapy;
- Which aspects of the affirmative and sceptic arguments had informed their position.

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

## Results

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

#### Quantitative Outcome Data

Penelope's quantitative outcome data are presented in Table 1. Penelope's initial scores were well below the 'caseness' cut-off range for inclusion in this study: her CORE was 6.8, PHQ-9 was 3 and GAD-7 was 4, all indicating non-clinical range or healthy condition. The PQ score was 4.6, indicating a moderately to considerably bothering level of the problems for which Penelope was seeking help. The proxy evaluation of depressive symptomatology made by the therapist through HAM-D had a score of 16, indicating moderate depression, above the caseness cut-off.

During the therapy sessions, the self rated scores of CORE, PHQ-9 and GAD-7 and PQ appear stable, with slight fluctuation without Reliable Change, whereas the proxy-rated score of HAM-D showed a decrease from 14 to 9 (indicating lower limit of mild depression) by Session 8, and improvement that continued until the end of the therapy, where Penelope was rated as having a score of 2, which is well below the clinical cut-off and indicates recovery to normal.

At the first Follow Up, we observe a deterioration in all four self-rated measures, with CORE and GAD-7 slightly above the clinical cut off. Of these four measures, only GAD-7 shows a reliable deterioration according to the RCI. Also the therapist HAM-D score demonstrated a deterioration.

At the second Follow Up, we observe an improvement in all self rated measures: CORE and GAD-7 show a clinically significant and reliable change, and even the PQ for the first time shows a clinically significant change. The therapist HAM-D shows a slight, non-significant improvement.

Finally, at the third Follow Up, all self and proxy measures tend to deteriorate: PHQ-9 and GAD-7 show

reliable deterioration, with GAD-7 scores that are once again over the clinical cut-off threshold. The CORE and PQ scores also show a reliable deterioration. The therapist HAM-D shows a score of 12 (indicating the upper limit of mild depression).

The problems that the client identified at the beginning of therapy in her Personal Questionnaire are reported in Table 2. Figures 1, 2 and 3 show respectively the CORE, the PQ and the HAM-D weekly scores.

### Qualitative Data

Penelope compiled the HAT form at the end of every session (Table 3), reporting only positive/helpful events within sessions, and with almost all sessions rated as 8 (very useful) with one rated 7 (useful). The first HAT form is missing.

Penelope participated in a Change Interview one month after the conclusion of the therapy, where she identified her main and significant changes that she felt were due to the therapy (Table 4). The first and the last reflect a behavioural change, whereas the others represent a change in self-perception. The researcher invited Penelope to describe her perception of the mechanisms of change and to what she attributed these changes. Penelope explained that she felt comfortable with the therapist and attributed her change to the ability of the therapist to support her disclosures (in the transcript, line P8), the ease with which she felt able to talk about her problems, and that the therapist provided a different perspective to that of her friends and was able to identify different view points (P26). She learned to think about how to put boundaries in place in order to protect herself and decide when other people were behaving abusively towards her (P21), to reduce the amount of her spare time that she had devoted to other people's needs (P28), and to be less passive and more assertive with others (P33). She felt supported by the therapist in expressing her emotions and thoughts, and in developing her ability to express her thoughts and feelings to other people, instead of her previous pattern of avoiding (P72). She felt that the therapist gave her a lot of space to express her feelings, without judgment or suggesting solutions, instead allowing her to find her own solutions (P83). On the other hand, Penelope suggested that her change may be due to the relationship with her new partner (P21) and that independently from the therapy, the new relationship gave her another kind of energy (P94). She also reiterated that most of her problems are due to other people (P33) and that her external problems are all still there (P94). Penelope did not identify any negative or unhelpful aspects of the therapy in her Change Interview. The only aspects that were considered negative by the client were the distance between the therapy practice and her home (about 20 km), the cost of the babysitter and the time required to travel to and attend sessions.

## HSCED Analysis

### Affirmative Case

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

The first line of evidence takes into account changes in stable/long-standing problems. As for quantitative data, in Table 1 we observe a mixed picture, with self-report outcome measure scores at the beginning scores within the 'healthy' range for functioning and distress (CORE), depression (PHQ-9) and anxiety (GAD-7), that are maintained with slight, but not reliable fluctuation until the end of the treatment phase (session 16). Despite this reported 'healthy' condition, the client refers to problems which bother her at the moderately to considerably level in her PQ. Indeed, the perception of the clinician assessing Penelope was of a woman who was clearly experiencing distress. This is reflected in the therapist's initial evaluation of moderate depression (HAM-D), that from Session 13 demonstrated a clinically significant (and reliable) change. This mixed picture suggests that the scores might be biased by social- and self-presentation effects. This is a well-known phenomenon, reported in the scientific literature by psychotherapists and physicians, and applies to a group of people who present low scores on self-report measures, but reveal evidence of significant suffering when assessed in other ways. For this reason, it appears that in this case the clinical judgment of the therapist may be more reliable than Penelope's self-report.

Qualitative data supports this conclusion: Penelope in her Change Interview recognised that she can change things for herself, even if others do not change. This aspect represents a clear break with her initial statement, when she stated that all of her problems had an external cause or were determined by others, and that she could only accept the situations as they were.

We observe a deterioration at the first follow up in all self- and proxy-rated measures: CORE and GAD-7 passed into clinical range indicating the emergence of mild distress and anxiety, and the therapist HAM-D rating is barely beneath the clinical range. This appears a transient effect of the conclusion of the therapy, that occurred during a period of distress for Penelope, who described difficulties in her relationship with her new partner.

In fact, at the second follow up we observe an overall improvement, with self-report measures showing the best scores since the beginning of the therapy. The PQ shows a reliable change, and is around the clinical cut-off level. During the second follow up, Penelope described herself as more able to think for herself, to feel less guilty and as more aware of her needs.



|       | Clinical Cut-Off | Case Cut-Off | Reliable Change Index | Pre-Therapy | Session 8 (middle) | Session 16 (end) | 1 month FU  | 3 months FU    | 6 months FU |
|-------|------------------|--------------|-----------------------|-------------|--------------------|------------------|-------------|----------------|-------------|
| CORE  | 10               | 15           | 5.1                   | 6.8         | 7.4                | 6.5              | <b>10.8</b> | 3.8            | 9.1         |
| PHQ-9 | 10               | 15           | 6                     | 3           | 2                  | 3                | 4           | 1              | 6           |
| GAD-7 | 8                | 10           | 4                     | 4           | 3                  | 4                | <b>8</b>    | 3              | <b>11</b>   |
| PQ    | 3                | 3.5          | 1                     | <b>4.6</b>  | <b>4.1</b>         | <b>4.1</b>       | <b>4.6</b>  | <b>3.1 (*)</b> | <b>4.6</b>  |
| HAM-D | 7                | 14           | -                     | <b>16</b>   | <b>9</b>           | 2 (+)            | 6 (+)       | 4 (+)          | <b>12</b>   |

*Table 1: Penelope's Quantitative Outcome Measure*

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

|   | PQ Items   | Duration   | Pre-Therapy | Session 8 (middle) | Session 16 (end) | 1 month FU | 3 months FU | 6 months FU |
|---|--|------------|-------------|--------------------|------------------|------------|-------------|-------------|
| 1 | I feel helpless facing my son's crisis           | 3-5 years  | <b>4</b>    | <b>4</b>           | <b>4</b>         | <b>5</b>   | <b>3</b>    | <b>4</b>    |
| 2 | I'm not able to help my son with homework        | 3-5 years  | <b>5</b>    | <b>5</b>           | <b>4</b>         | <b>5</b>   | <b>2</b>    | <b>3</b>    |
| 3 | I'm not able to be obeyed by my oppositional son | 6-10 years | <b>5</b>    | <b>5</b>           | <b>5</b>         | <b>6</b>   | <b>4</b>    | <b>5</b>    |
| 4 | I'm not able to feel peaceful                    | 3-5 years  | <b>5</b>    | <b>4</b>           | <b>4</b>         | <b>4</b>   | <b>3</b>    | <b>5</b>    |
| 5 | I feel alone managing my son's problems          | 3-5 years  | <b>7</b>    | <b>5</b>           | <b>6</b>         | <b>6</b>   | <b>6</b>    | <b>7</b>    |
| 6 | I feel stressed                                  | 1-2 years  | <b>4</b>    | <b>3</b>           | <b>3</b>         | <b>4</b>   | <b>3</b>    | <b>5</b>    |
| 7 | I'm not able to set limits to my ex-husband      | 3-5 years  | <b>3</b>    | <b>5</b>           | <b>5</b>         | <b>4</b>   | <b>3</b>    | <b>4</b>    |
| 8 | I feel up to the eyeballs                        | 3-5 years  | <b>4</b>    | <b>2</b>           | <b>2</b>         | <b>3</b>   | <b>1</b>    | <b>4</b>    |
|   | TOTAL  |            | <b>37</b>   | <b>33</b>          | <b>33</b>        | <b>37</b>  | <b>25</b>   | <b>37</b>   |
|   | MEAN   |            | <b>4,6</b>  | <b>4,1</b>         | <b>4,1</b>       | <b>4,6</b> | <b>3,1</b>  | <b>4,6</b>  |

*Table 2: Penelope's Personal Questionnaire items*

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

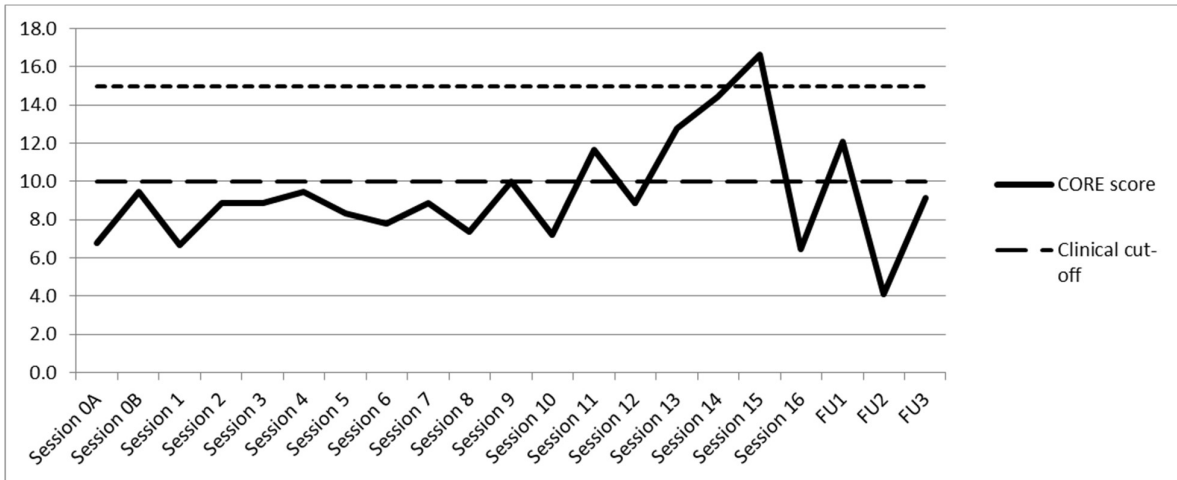


Figure 1: Penelope's weekly CORE score

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

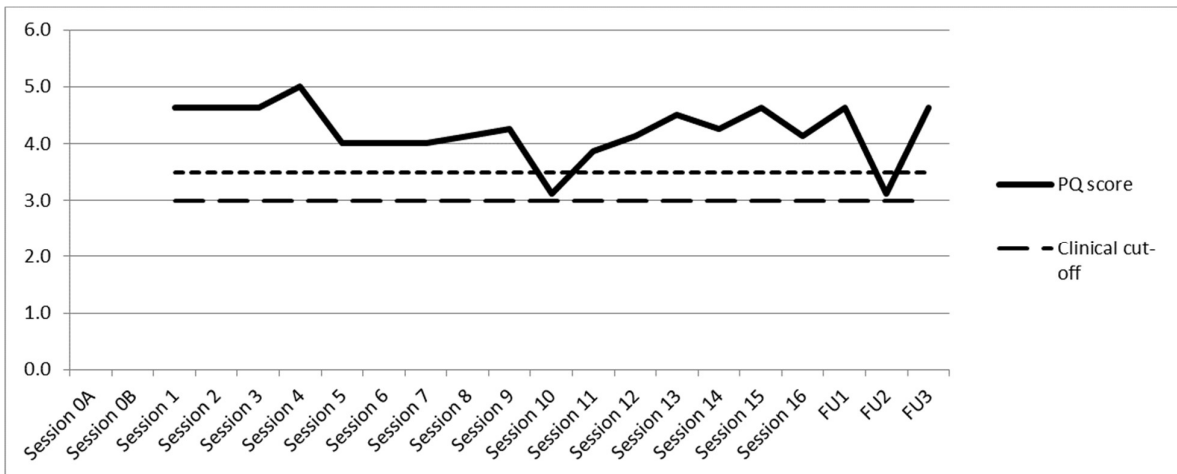


Figure 2: Penelope's weekly PQ score

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

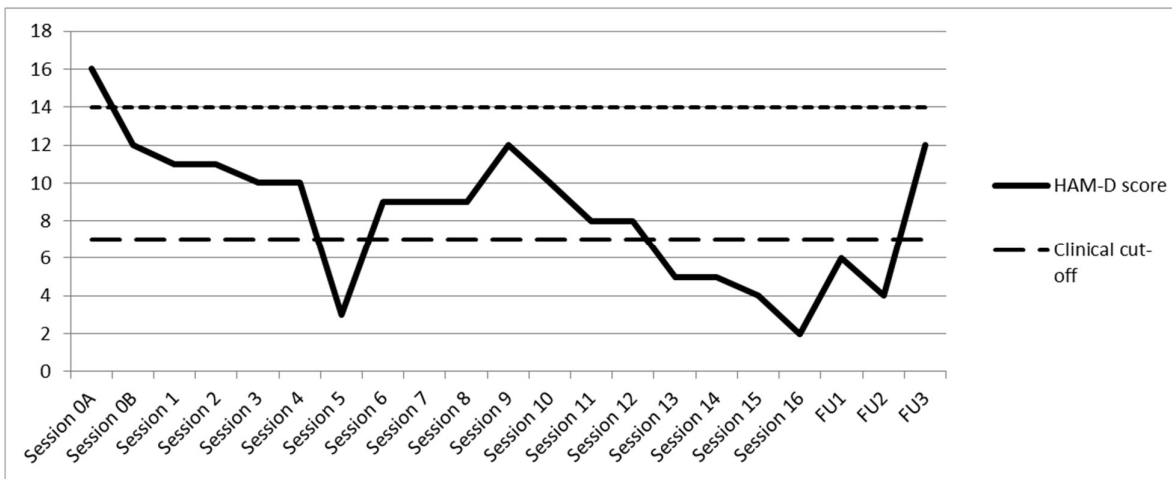


Figure 3: Therapist's weekly evaluation of Penelope depression - HAM-D score

Note. 0A and 0B = assessment sessions. HAM-D = Hamilton Depression Rating Scale (Hamilton, 1960). FU = follow-up.

| Session | Rating | Events / What made them helpful   |
|---------|--------|---|
| 1       | -      | missing   |
| 2       | 7      | express my feelings / The therapist understood my difficulty  |
| 3       | 8      | express "anger" for the scant help I receive from those who could and should help me (school/church); My change regarding the management of my child's homework / let off steam |
| 4       | 8      | reiterate that I have to face everything alone and that in any case I have energy enough to try to do something for myself  |
| 5       | 8      | telling the meeting with my new lover / express my positive feeling, hindered by my sense of guilt  |
| 6       | 8      | talk about my experiences with greater serenity / to be very relaxed in expressing my emotions  |
| 7       | 8      | express my emotions and my "conflict" about the relationship / to speak peacefully  |
| 8       | 8      | express my awareness about undergoing change / it was useful that the operator pointed out to me my change  |
| 9       | 8      | to show the conflict between reason and emotions / I am aware that I decided according to emotions, but I know that I have also the clarity of the reason                       |
| 10      | 8      | express my conviction of preserving what I have received of beautiful and good from my lover / important because make me feeling more strong and secure                         |
| 11      | 8      | establish my boundaries / useful to rediscover my inner strength  |
| 12      | 8      | express my new situation with my lover / I called into question once again a thought that I believed clear and unchangeable   |
| 13      | 8      | talk about the difficulties with the school of my son / express my anger and frustration about the behaviour of headmaster and teachers   |
| 14      | 8      | deal with the end of the relationship with my lover / unburden myself and express my emotions of suffering  |
| 15      | 8      | recognise that I have to give me time to understand how to cope with new experiences / do not judge myself and have a little patience   |
| 16      | 8      | link the management of the crisis of my child with his fear for my health / useful because I understood what was behind the anger of my son                                     |

Table 3: Penelope's helpful aspect of therapy - HAT

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

| CI items   | How much change was expected <sup>1</sup> | How /likely change would have been without therapy <sup>2</sup> | Importance of change <sup>3</sup> |
|--|---|---|-----------------------------------|
| To create boundaries in order to protect myself          | surprising (5)                            | quite unlikely (2)  | very (4)                          |
| not to get discouraged by the behaviour of my ex-husband | quite expected (2)                        | quite unlikely (2)  | very (4)                          |
| To self guard from others                                | surprising (5)                            | quite unlikely (2)  | very (4)                          |
| To think about my self                                   | neither (3)                               | unlikely (1)  | very (4)                          |
| If others do not change, I have to                       | surprising (5)                            | quite unlikely (2)  | very (4)                          |

**Table 4: Penelope's changes identified in Change Interview – CI (Elliott et al. 2001)**

<sup>1</sup>The rating is on a scale from 1 to 5; 1= expected, 3= neither, 5= surprising. <sup>2</sup> The rating is on a scale from 1 to 5; 1=unlikely, 3=neither, 5=likely. <sup>3</sup> The rating is on a scale from 1 to 5; 1=slightly, 3 = moderately, 5=extremely.

Despite this, at the third follow up all measures once again worsen. The PHQ-9 and the GAD-7 show the worst score ever, the PHQ-9 does not reach the clinical cut off, whereas the GAD-7 reached a score of 11, indicating moderate anxiety. The CORE touches on the clinical cut-off, with a score higher than the pre-therapy level, and the PQ returns to the pre-therapy score. Also the therapist rated the HAM-D with a score of 12 which indicates a relapse into mild depression. Deterioration at the third follow up appears to reflect adverse circumstances. Penelope described in particular experiencing some problems at work, with uncertainty around her future, together with many difficulties with her son who had just started middle school, and her troubled relationship. These problems all challenged her previous tendency of feeling overwhelmed by events that she feels she has no control over and that are due to external conditions.

Retrospective attribution - Penelope in the Change Interview (Table 4) describes five changes, all rated as very important. Penelope also reports that all changes would be quite unlikely or unlikely without therapy. She felt surprised that she had been able to put limits on others in order to protect herself (item 1), and realising that she is able to make personal changes, even if others do not change (5). These descriptions show an overall change in representations of self and others, self-esteem and relational patterns. She recognizes the role of the therapist when she states "I already spoke about my problems with my friends, but with the therapist I approached them in another way... He encouraged me to notice other aspects" (P 26). She affirms "the therapist got me thinking about how to set limits... I mean, a kind of protection for me." (P21). She also recognises that now "I have learned that if things that are wrong are not

changed by others, I must change them: just the question of setting limits with others. I mean... if they do not understand what... I want, mmh... it is logic I have to change".

Association between outcome and process (outcome to process mapping) - Penelope in her HAT forms (Table 3) reported several within session events that she rated 8, very useful (but the first, rated 7, moderately useful). In the first seven sessions, she describes that she felt understood and able to express her feelings, which is related to the therapist notes that report a focus on alliance and leaving room to express her feelings, providing permissions for Penelope to be herself and express her emotions. This appears to be tied in the Change Interview to the unexpected change of "thinking about my self" (item 4), instead of over-adaptation to others (as reported in the change interview, P 28). In the following sessions, the therapist's focus were on Penelope's needs, internal conflicts and how to express her feeling and needs to others. This also reflects her description of relationships gathered in the HAT forms about her former husband (11), her son (16), her new partner (10, 14) and the teachers of her son (13). These interpersonal change are reflected in the Change Interview in the first three items. It appears particularly important for Penelope and the relationship with her son that she started to understand the link between the aggressive behaviours of her son and his underlying emotion of fear (16).

Event-shift sequences – It appears that the change observed in Penelope is not tied to a pivotal moment in the therapy, such as a single session or technique, but appears related to the general relational climate experienced during the treatment.

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

Conclusions - Although quantitative self reported data on depression, anxiety and global distress appear to be unreliable, a proxy-rated measure of depression and qualitative data from the Change Interview support the claim that Penelope experienced a partial good outcome during the therapy, that appeared to have grown at the second Follow Up but was not maintained at the third Follow Up. The deteriorated scores on both proxy- and self-reported measures observed at the third Follow Up appear to be due to several external factors, and suggest that the client developed a major awareness about herself and her suffering in line with the therapist's perception, whereas at the beginning of the therapy her suffering was bodily expressed but not reported on questionnaires. The change appears linked to the treatment, particularly focused on empathic listening, permission to feel and express emotions and needs, analysis of the critical internal dialogue and the exploration of more self-protective options within relationships with others.

#### *Sceptic Case*

In Table 1 it appears that Penelope does not go above the caseness cut-off for any self reported measures, suggesting that she did not meet the inclusion criteria of the study. Even accepting that some social or personal factors may have biased the initial scores, we observe a negative change between the scores of the pre-therapy and the third Follow Up, suggesting a possible iatrogenic effect of the therapy. The therapist's rating of depression (Figure 3) shows a three-point decrease from baseline between the beginning of the assessment phase and the first Session included, suggesting that there is not a stable baseline from which the following results can be adequately compared. Furthermore, to rely solely on therapist-rated measures introduces a risk of experiment-wise errors, since the validity of his score may be biased by social and personal factors.

The apparently positive results observed at the second Follow Up (scheduled in mid June) might be tied to the end of the school year for Penelope's son and the start of the summer holidays; both external factors may have reduced Penelope's initial perception of being overwhelmed (as reported in the Personal Questionnaire items) and her distress. This would also explain why at the third Follow Up (in September) we observed deterioration which Penelope attributed to difficulties with her son's school and her work environment.

Qualitative data suggests a more positive picture, but from the fifth Session Penelope describes being in love with a new partner, making it difficult to differentiate between the effect of this event and the effects of the therapy on her self esteem and behavioural change with

her ex-husband and other persons. Furthermore, in her Change Interview Penelope affirms "surely the therapy helped me, but an event happened to me just at the beginning of the therapy... in the same period at a human level... I knew a person that... made me change" (P 21). Also, she affirms "I cannot quantify how much my problems are changed... I mean, my entire problems are still there... I mean, not that there are none, because unfortunately they depend on the people around me" (P 94), suggesting that the change, if any, is due to external factors and that her attribution style is not changed.

Conclusions - The sceptic case concludes that this therapy had a poor outcome. Quantitative self-reported measures show that the change is trivial and potentially negative, and quantitative proxy-rated measures of depression are biased and flawed due to the lack of a stable baseline. The improvement observed at the second follow up appears to be due to the start of the summer holiday period. Qualitative data supports the view that any positive change reported is due to external factors, such as the new relationship, and the summer vacations.

#### *Affirmative Rebuttals*

Although quantitative self-report measures did not justify the inclusion of Penelope in this research, inclusion criteria should not take precedence over clinical judgment. Self-report measures are biased by the same social and personal factors as proxy rated measures. The affirmative team believe that this argument raises a question about the usefulness of inclusion criteria, if clients like Penelope are considered healthy and therefore excluded from a study. An early decrease in depressive symptoms is observed also in clients who are on a waiting list, and this is associated to an effect associated with hope. It is not surprising that Penelope shows an early improvement of her symptoms, and this may support the accuracy of the therapist rating. The HAM-D score shows a substantial improvement in the fifth session, which corresponds with the beginning of the relationship with her new partner, again supporting the accuracy of the therapist observations.

The affirmative team concede that it is possible that the summer holidays had a beneficial effect on Penelope's distress, as well as the start of her new relationship, but also winter holidays occurred between the eighth and ninth Sessions, and Easter holidays too, immediately after the first Follow Up, neither of which appeared to have any positive effects on the self reported measures. Instead, it appears from transcriptions that during the therapy, Penelope got in touch with an increasing level of distress: growing tensions with her ex-husband, uncertainty about a possible redundancy, and even the new relationship which caused some pain. Such distress was discussed with the therapist, and had no impact on quantitative measures. We suspect that the ending of therapy contributed to a worsening of symptoms noticed during the follow-up period, but believe that an increase in her awareness about her level of distress was reflected

in her self-rated scores. In this sense, it is possible that her deterioration represents a more accurate perception of her own distress. The situation at the third follow up is described as more overwhelming than ever, with a deteriorating situation at work, with her ex husband and with her son. She feels helpless, unable to negotiate, and does not expect any change. Thus, the effect of the therapy has been present but is not sustained after the conclusion.

In her change interview, Penelope reports contradictory affirmations that brought about her change "I think that meeting this new partner is important" (P55), and that change "probably sooner or later would have happened the same, but maybe not so quickly" (P49), together with opposite affirmations such as "I understood I can understand situations in different ways, not in a passive way... having determination, not accepting criticism" (P 68) and "I feel stronger, I mean... more decisive, I can stop people... I can use a sort of protection" (P92). The overall meaning of this should be taken from a whole consideration of the Change Interview, HAT forms and transcripts of the session, rather than from a single sentence. Further, the tendency not to recognize her success is in line with her personality trait and diagnosis.

#### *Sceptic Rebuttal*

The problems reported by the client at the third Follow Up are not so severe, since they are common problems that any person can experience. The changes appear tied to the presence of the therapist and the client has not internalized sufficient resources to maintain change and deal with stress. Therefore, the therapy was not effective.

#### **Adjudication**

Each judge examined the rich case and hermeneutic analysis and independently prepared their opinions and ratings of the case (Table 6). The judges have considered that the quantitative data show an improvement in symptoms from the therapist's point of view, which has been confirmed in supervisions, but they show a deterioration from the client's point of view.

Moreover, they observed an inconsistency between quantitative and qualitative data, therefore both judges believe that this could be a mixed outcome case.

#### *Summary of opinions regarding how the judges would categorise this case*

According to Judge A (Calvo), the case appears mixed (60% of certainty) to poor (40% of certainty) outcome. Quantitative data do not allow for claims of a good outcome, and also qualitative information appears inconsistent and unduly influenced by significant external events.

According to Judge B (Palmieri) the case appeared to be a mixed (80% of certainty) to good outcome (20% of certainty). Neither quantitative or qualitative self-report data supports a clear claim of a positive outcome, but nonetheless it is possible to observe within the transcriptions of the sessions several relational episodes that indicate a change in behaviours, relationships and self-esteem. For example, the client is able to express herself more clearly to the husband and to the teacher and headmaster of the son's school; she recognises that her needs are as important as others' and reports a deeper comprehension about the needs of her son. This represent a clear change, even if not stable or complete.

#### *Summary of opinions regarding the extent to which the client had changed*

Judge A believes that this case presents a limited outcome, a moderate change with a certainty of 80%. There is some evidence of change, but the changes observed are not stable and are not maintained over time. The change does not appear in self-report instruments completed by the client and, at the beginning of the therapy, presented with sub-clinical scores for anxiety, depression and global distress. In her Change Interview the client refers to some important changes of her life, such as to identifying her own needs and an increased ability to protect herself by putting boundaries in place with others. In any case, the change is not maintained when the situation at workplace of the client

|  | <b>Judge A</b>        | <b>Judge B</b>        | <b>Mean</b>                       |
|--|-----------------------|-----------------------|-----------------------------------|
| How would you categorize this case?                              | Mixed to poor outcome | Mixed to good outcome | Mixed outcome                     |
| How certain are you?   | 60%                   | 80%                   | 70%                               |
| To what extent did the client change over the course of therapy? | 40% moderately        | 60% considerably      | 50% moderately to considerably    |
| How certain are you?   | 80%                   | 80%                   | 80%                               |
| To what extent is this change due to therapy?                    | 60% considerably      | 80% substantially     | 70% considerably to substantially |
| How certain are you?   | 60%                   | 80%                   | 70%                               |

*Table 6: Adjudication results*



becomes stressful and there were problems at her son's school. Therefore, although there are changes, they do not appear to be stable.

Similarly, clinical evaluation of the depression made by the therapist showed a significant improvement at the end of the treatment and in the first two Follow Up meetings, but is not maintained at the third Follow Up, confirming the hypothesis that the results achieved from the treatment are limited and not stable.

Judge B affirms that there was a considerable change, with 80% of certainty. Such affirmation is based on the consideration that the client showed some behavioural change in long-standing daily life situations such as the relationship with the husband and the son.

#### *Summary of opinions as to whether the changes were due to the therapy*

According to Judge A, the quantitative data shows a picture of limited change which is not lasting, although analysis of the qualitative data suggests significant changes occurred during therapy. Although the client stated in her Change Interview that the change could potentially be related to her new relationship, and the sceptic case also attributes change to her new relationship, these changes have not remained stable. Furthermore, the argument of the affirmative case that the client has learned to put boundaries in place with her new partner appears convincing and clinically meaningful. It appears unlikely that the change in the client's self-perception could occur without therapy. In addition, from the affirmative case perspective and from the transcripts of the sessions, what emerges is a clear relationship between the work carried out by the therapist and the perception of the client reported in HAT.

Judge B states that it appears improbable that such changes may be due only to external factors, and in particular that Penelope has learned "to express feelings, especially anger," recognise that she overcompensates due to feeling guilty for not having done enough, and deal with her critical internal dialogue between conflicting needs.

Both judges affirm that the changes are not of great magnitude, but are nevertheless meaningful and significant for the client and have an impact in her daily life with her son, her ex- husband, her new partner, her environment and her dealings with her son's school.

#### *Mediator factors*

The client seems to have experienced considerable benefit from the atmosphere of non-judgmental listening established within the sessions. The client describes the therapist's attitude "without judgment...he left much room...left the way you express yourself ... he gave no suggestions ...he (allowed for) things to come out". In addition, the therapist has created an atmosphere in which he accepted all of Penelope's emotions, giving continuous permissions to feel and express emotions; particularly anger and sadness. Also the focus on the

analysis of her negative internal dialogue between critical Parent and Child ego states also appears to have been important. Finally, the systematic exploration of new options for expressing needs and enforcing boundaries with others was important in this case.

#### *Moderator factors*

The positive effects of the therapy may have been moderated by the client's supporting network of friends, which potentially represented a protective factor against depression. As for negative moderator factors, Judge A pointed out that this case is characterised by low initial client motivation, low willingness to engage in treatment and that the therapy approach had not been actively sought out or chosen by the client. All these elements are known to be associated with poor outcome (Norcross, 2002).

## **Discussion**

The general aim of this paper was to investigate the effectiveness of short-term TA treatment of depression in a naturalistic setting. The judges agreed that this is a mixed outcome case and Penelope did change as a result of the therapy, but the change is not sustained. It is therefore likely that this case does not add support to the recognition of TA as an Empirically Supported Treatment.

However, this case underlines some aspect of research in psychotherapy on which it may be useful to reflect. First of all, this case was been conducted by a young psychologist in training to become a psychotherapist. In Italy, most of the therapy provided within public services are carried out by therapists at this same level of expertise. This study suggest that young therapists provide treatment at an adequate level of competence, even if some improvement is needed.

This case also raises questions about the reliability of self-report measures. Shedler and colleagues (1993) identified a group of people defined with the term 'illusory mental health' who tend to record low scores on self-report measures, but present with clear and genuine distress. These people do not generally appear in controlled clinical trials because they would be excluded due to not meeting inclusion criteria. According to McLeod (2001), the impact of an effective therapy on such clients is to increase scores in measures related to their denied suffering. Although the use of self-report measures dominates the field of psychotherapy research, there are several different points of view that are worthy of consideration. Firstly, self-report measures may be considered insensitive to situational factors that influence behaviour. A second potential problem is of minimal correlation between answers to a questionnaire and an empirical index that assesses the same variable such as overt behaviour or overt impairment in functioning (Holzman and Kagan, 1995). Where there is a high correlation between the variable (e.g. anxiety or depression) and social desirability ratings, people are likely to be influenced by the social desirability of each item whilst answering questionnaires (Edwards, 1957).

Thirdly, this case raises the question of how to evaluate qualitative and quantitative data that are inconsistent with each other. It appears clear, for example, that Penelope experienced during her therapy a kind of relationship that changed her comprehension of both her emotions and those of her son. A change like this, clearly reported in the HAT and within the session transcripts, appears relevant to a psychotherapist, but is usually not investigated by research design.

### Limitations

This study may be biased by the role of the first author who is also the supervisor of the therapist and a teacher of the members of the hermeneutic groups, and who collaborates professionally with both judges. Despite the critical reflexive attitude and the auditing of expert researchers (Dr Mark Widdowson and Professor John McLeod), bias may nevertheless have influenced the results and analysis in subtle ways.

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

### Conclusion

The present case does not appear to support the effectiveness of TA short treatment of depression. However, it does provide an example of the various challenging situations that a practitioner can come across when trying to do research in his/her routine practice. A deep examination of session notes or transcripts allows an expert clinician to establish the gravity of a client's distress, and the magnitude of a change in a way that self-report cannot estimate. Despite this, the empirical support of many psychotherapy models is greatly influenced by findings taken from self-report measures. We do not wish to discount the importance of such questionnaires and self-rated measures, but believe it is important to enrich and integrate such measures with proxy rating, clinical judgement and qualitative data.

More research is needed to support the growing body of evidence relating to the efficacy and effectiveness of TA psychotherapy for depression, and to enable recognition of TA as an empirically supported treatment.

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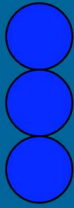
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### References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Benelli, E., Biffi, D., De Carlo, A., & McLeod, J. (2015). Hermeneutic Single Case Efficacy Design: a systematic review of published research and current standards. *TPM: Testing, Psychometrics, Methodology in Applied Psychology*, 22(1).
- Berne, E. (1964). *Games people play*. New York: Grove Press.
- Bohart, A. C. (2000). *A qualitative 'adjudicational' model for assessing psychotherapy outcome*. Paper presented at the meeting of the Society for Psychotherapy Research, Chicago.
- Chambless, D.L. and Hollon, S.D. (1998) Defining Empirically Supported Therapies". *Journal of Consulting and Clinical Psychology*, 66(1): 7-18
- Crossman, P. (1966). Permission and protection. *Transactional Analysis Bulletin*, 5(19), 152-154.
- Edwards A. L. (1957) *The Social Desirability Variable in Personality Assessment and Research*. New York: Dryden.
- Elliott, R. (2002). Hermeneutic single-case efficacy design. *Psychotherapy Research*, 12, 1-21.
- Elliott, R., Shapiro, D. A., & Mack, C. (1999). *Simplified Personal Questionnaire procedure manual*. Toledo, OH: University of Toledo.
- Elliott, R., Partyka, R., Wagner, J., Alperin, R., Dobrenski, R., Messer, S. B., Watson, J. C., & Castonguay, L. G. (2009). An adjudicated hermeneutic single-case efficacy design study of experiential therapy for panic/phobia. *Psychotherapy Research*, 19, 543-557.
- Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychologische Beiträge*, 43, 69-111.

- Erskine, R. G., & Zalcman, M. J. (1979). The racket system: A model for racket analysis. *Transactional Analysis Journal*, 9(1), 51-59.
- Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., & McGrath, G. (2000). CORE: Clinical outcomes in routine evaluation. *Journal of Mental Health*, 9, 247-255.
- Evans, C., Connell, J., Barkham, M., Margison, F., McGRATH, G. R. A. E. M. E., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: psychometric properties and utility of the CORE—OM. *The British Journal of Psychiatry*, 180(1), 51-60.
- Goulding, R., & Goulding, M. (1976). Injunctions, decisions, and redecisions. *Transactional Analysis Journal*, 6(1), 41-48.
- Hamilton, M. (1960). A rating scale for depression. *Journal of neurology, neurosurgery, and psychiatry*, 23(1), 56.
- Holzman, P., & Kagan, J. (1995). Whither or wither personality research. In P. E. Shrout, & S. T. Fiske (Eds.), *Personality research, methods, and theory: A Festschrift honoring Donald W. Fiske* (pp. 3-11). Erlbaum Hillsdale, NJ: Psychology Press
- Jacobson, N.S. & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59, 12–19.
- Kahler, T., & Capers, H. (1974). The miniscript. *Transactional Analysis Journal*. 4:1 26-42
- Khalil, E., Callaghan, P., & James, N. (2007). *Transactional analysis: A scoping exercise for evidence of outcome*. Report prepared for the Berne Institute. The University of Nottingham, School of Nursing.
- Karpman, S. (1968). Fairy tales and script drama analysis. *Transactional Analysis Bulletin*, 7(26), 39-43.
- Karpman, S. (1971). Options. *Transactional Analysis Journal*, 1(1), 79-87.
- Kerr, C. (2013). TA Treatment of emetophobia — A systematic case study — “Peter.” *International Journal of Transactional Analysis Research*, 4, 16-26.
- Iwakabe, S., & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research*, 19(4-5), 601-611.
- Llewelyn, S. P. (1988). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology*, 27(3), 223-237.
- MacLeod, R., & Elliott, R. (2012). Emotion-focused therapy for social anxiety: A hermeneutic single case efficacy design study of a low-outcome case. *Counselling Psychology Review*, 27, 7-22
- McLeod, J (2001): An administratively created reality: Some problems with the use of self-report questionnaire measures of adjustment in counselling/psychotherapy outcome research, *Counselling and Psychotherapy Research*, 1:3, 215-226. <http://dx.doi.org/10.1080/14733140112331385100>
- McLeod, J. (2010). *Case study research in counseling and psychotherapy*. London, UK: Sage.
- McLeod, J. (2013a). Process and outcome in pluralistic transactional analysis counselling for long-term health conditions: A case series. *Counselling and Psychotherapy Research*, 13:1, 32-43.
- McLeod, J. (2013b). Transactional Analysis Psychotherapy with a woman suffering from Multiple Sclerosis. A Systematic Case Study. *Transactional Analysis Journal*, 43:3, 212-223.
- Norcross, J. C. (Ed) (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. Oxford: Oxford University Press
- Ohlsson, Thomas (2010) Scientific Evidence Base for Transactional Analysis in the Year 2010 *International Journal of Transactional Analysis Research* 1:1 4-29
- Shedler, J., Mayman, M., & Manis, M. (1993). The illusion of mental health. *American Psychologist*, 48(11), 1117.
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Patient Health Questionnaire Primary Care Study Group. (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. *Jama*, 282(18), 1737-1744.
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166, 1092-1097.
- Steiner, C. (1974). *Scripts people live: Transactional analysis of life scripts*. Grove Press.
- Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, 130(4), 631.
- Widdowson, M. (2012a). TA Treatment of depression — A hermeneutic single-case efficacy design study — “Peter.” *International Journal of Transactional Analysis Research*, 3, 1-11.
- Widdowson, M. (2012b). TA Treatment of depression — A hermeneutic single-case efficacy design study — ‘Denise’ *International Journal of Transactional Analysis Research*, 3, 3-14.
- Widdowson, M. (2012c). TA Treatment of depression — A hermeneutic single-case efficacy design study — ‘Tom’ *International Journal of Transactional Analysis Research*, 3, 15-27.
- Widdowson, M. (2013). TA Treatment of depression — A hermeneutic single-case efficacy design study — ‘Linda’— A mixed outcome case. *International Journal of Transactional Analysis Research*, 4, 3-15.
- Widdowson, M. (2014). Transactional Analysis Psychotherapy for a Case of Mixed Anxiety & Depression: A Pragmatic Adjudicated Case Study – ‘Alastair’. *International Journal of Transactional Analysis Research*, 5:2, 66-76.
- Widdowson, M. (2015). *Transactional Analysis for depression: A step-by-step treatment manual*. Hove: Routledge



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

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### Abstract

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

### Key words

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

### Editor's Note

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

### Introduction

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

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

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

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

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



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

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

## Ethical Considerations

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

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

## Method

### Inclusion and exclusion criteria

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

### Client

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

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

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

### Therapist

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

### Intake sessions

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

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

research, which is to depict a realistic picture of real clients in daily clinical practice.

### DSM 5 Diagnosis

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

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

### TA Diagnosis and Case formulation

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

### Treatment

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



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

### Analysis Team

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

### Judges

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

### Transparency statement

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

### Quantitative Outcome Measures

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

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

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

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

### Qualitative Outcome Measurement

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

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

## Therapist Notes

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

## Adherence

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

## HSCED Analysis Procedure

### Affirmative Case

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

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

### Sceptic Case

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

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

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

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

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

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

## Adjudication Procedure

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

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

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

## Results

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

### Quantitative Outcome Data

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

### Qualitative Data

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

Luisa participated in a Change Interview 1-month after the conclusion of the therapy. In this interview she identified her main and significant changes (Table 5). Luisa described her therapy as "helpful, I felt better just coming out from the study" (CI, Patient line 9), "I felt I feel more relieved, more serene" (P 10). She "would not have ever thought to talk about those things with a stranger... but it was very easy... there was feeling, lets say" (P16). She was surprised "at 65 years... to be still able... I mean,

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

### HSCED Analysis

#### Affirmative Case

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

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

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

**Table 1: Luisa's Quantitative Outcome Data**

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

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

**Table 2: Luisa's Personal Questionnaire items**

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

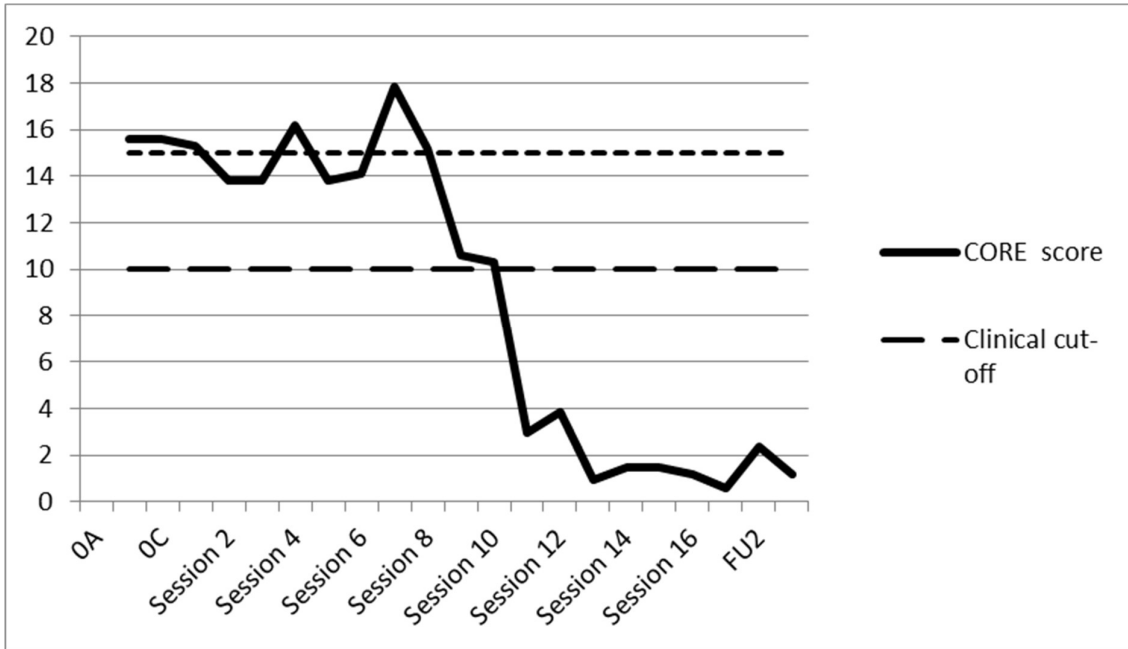


Figure 1: Luisa's weekly CORE-OM score

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

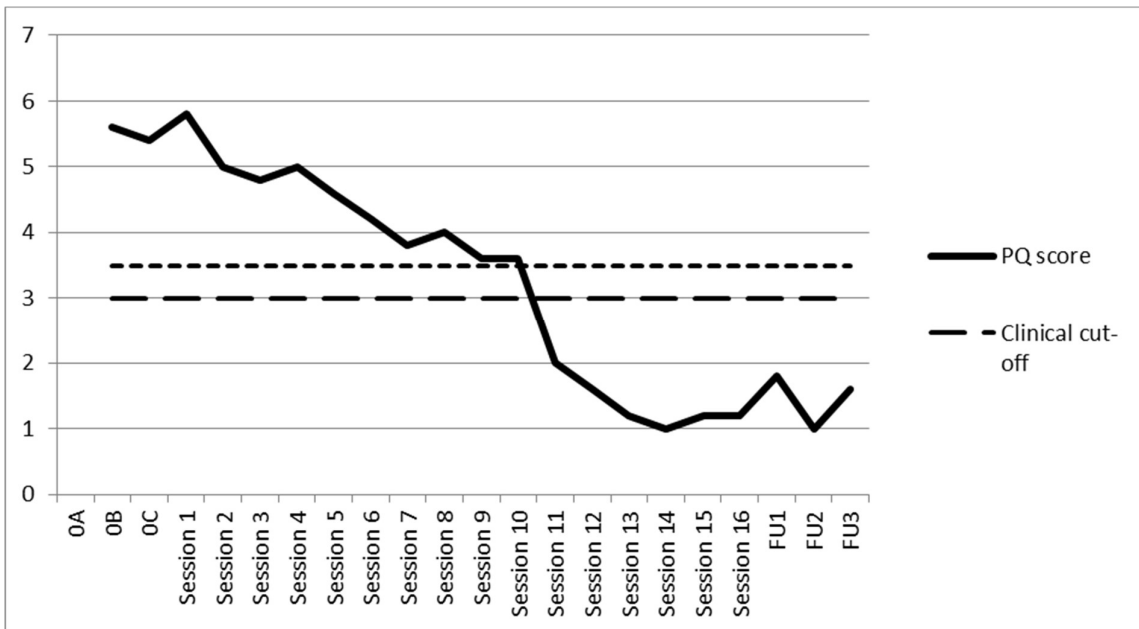


Figure 2: Luisa's weekly PQ score

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



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

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

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

| CI Items  | How much was change expected <sup>1</sup> | How likely change would have been without therapy <sup>2</sup> | Importance of change <sup>3</sup> |
|---|---|--|-----------------------------------|
| To have a better communication with others                                  | 5<br>(surprising)                         | 1<br>(unlikely)  | 5<br>(extremely)                  |
| To overcome my health problems (weight loss, insomnia, gastritis, shingles) | 1<br>(expected)                           | 3<br>(neither)   | 5<br>(extremely)                  |

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

<sup>1</sup>The rating is on a scale from 1 to 5; 1= expected, 3= neither, 5= surprising. <sup>2</sup> The rating is on a scale from 1 to 5; 1=unlikely, 3=neither, 5=likely. <sup>3</sup> The rating is on a scale from 1 to 5; 1=slightly, 3 = moderately, 5=extremely.

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

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

Retrospective attribution - Luisa recognised in her Change Interview two important changes in different aspects of her life which she attributes to therapy (Table 5). Both the improvement in her communication with others and in her health condition are considered extremely important, the first unexpected and unlikely without therapy, and the second expected and neither likely nor unlikely without therapy. She recognised that the therapy allowed her to change different aspects of her relationships with others. The first change was not identified by Luisa in the PQ at the beginning of therapy, but emerged in the end as fundamental issues that Luisa addressed and changed during therapy. The client asserts that the therapy was very useful to her, in particular for the kind of relationship established, that she describes as very warm and hospitable. She also affirms

that there were no negative aspects, obstacles or unhelpful aspects to her therapy.

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

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

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

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

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

#### *Sceptic Case*

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

2. The apparent changes are due to statistical artifacts or random errors, including measurement error, experiment wise error from using multiple change measures, or regression to the mean - On several occasions Luisa voiced some ambivalence about completing the outcome questionnaires. Some of her measures contained mistakes (e.g. forgot to fill in the last item of the GAD-7 (that is very close to the score line) suggesting

inattentiveness, are uncompleted or missing because she refused to fill them in (as the HAT in Session 8). Starting from Session 13, every test is filled in almost identically, assigning the lowest score possible. There is some evidence that in the final sessions she filled in the CORE (with a line of 0 scores), somewhat mechanically, thus wrongly scoring 4 in the inverted items and then correcting them. This negative attitude towards the questionnaires cast doubts on the overall accuracy of her self-reported scores and answers, which the sceptic team feels more accurately suggests global unreliable change.

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

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

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

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

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

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

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

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

#### *Affirmative Rebuttal*

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

2. Luisa's minimal education may account for some of the errors and incongruences in filling in tests. The tendency to repeat the same minimal scores when she felt better in the last part of the therapy may reflect a lack of subtle differentiation between similar levels; for example she

may have struggled with differentiating between 'not at all' or 'only occasionally' (CORE) or from 'very little' and 'little' (PQ).

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

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

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

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

#### *Sceptic Rebuttal*

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

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

### Adjudication

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

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

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

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

#### Opinions about the degree of change

**Judge A.** 'Luisa changed moderately (40%, with 80% of certainty) both her symptoms and long standing relational patterns. There is strong evidence that she is now able to express herself in a way that she was not able to prior to therapy. This change appears stable in

the follow up, even if it is not completely pervasive. I was also impressed by the improvement in the patient's ability to perceive and voice her emotions. The patient had limited goals at the beginning of the therapy, most of which were related to symptoms and she was not interested in a deeper change; for such reasons her change may not be considered more than moderate.'

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

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

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

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

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

Table 6: Adjudication results



### Mediator Factors

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

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

### Moderator Factors

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

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

## Discussion

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

The effectiveness of TA psychotherapy in this case appears to be tied to the focus on permissions coherent with the client's injunctions, gentle challenge and redecision processes. The therapeutic alliance appears to have been built on a non-directive style and modelling permissions corresponding to the patient's Injunctions. The therapist allowed the client to create an affective bond with an exchange of positive strokes. Specific TA techniques were: the explanation of the ego state model and internal dialogue, drivers, redecisions and racket system analysis, all of which allowed the patient to

rapidly get in touch with her relational behaviours and mental processes. We note that the therapy did not use regressive techniques, remaining focused most on here-and-now. This appears coherent with the client's request of a change focused on symptoms remission rather than in deep script analysis. Furthermore, the therapy appears to be consistent with the manualised therapy described by Widdowson (2015), and suggests that the treatment described in that manual can be effective for the psychotherapy of depression.

### Limitations

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

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

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

## Conclusion

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

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## References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Benelli, E., De Carlo, A., Biffi, D., & McLeod, J. (2015). Hermeneutic Single Case Efficacy Design: A systematic review of published research and current standards. *Testing, Psychometrics, Methodology in Applied Psychology*, 22, 97-133. doi:10.4473/TPM22.1.7

Berne, E. (1964). *Games people play*. New York: Grove Press.

Bohart, A. C. (2000). *A qualitative "adjudicational" model for assessing psychotherapy outcome*. Paper presented at the meeting of the Society for Psychotherapy Research, Chicago.

Boschetti, D., & Revello, B. (2013). Il trattamento della depressione secondo l'analisi transazionale: un'esperienza. (Treatment of depression according Transactional Analysis: an experience). *Quaderni Centro Psicologia Dinamica*, 15, 98-104. Padua: Cleup.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of consulting and clinical psychology*, 66:1, 7-18.

Crossman, P. (1966). Permission and Protection. *Transactional Analysis Bulletin*, 5, 152-4.

Elliott, R. (2002). Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*, 12(1), 1-21. doi:10.1080/713869614

Elliott, R., Partyka, R., Wagner, J., Alperin, R., Dobrenski, R., Messer, S. B., Watson, J.C., & Castonguay, L. G. (2009). An adjudicated hermeneutic single-case efficacy design study of experiential therapy for panic/phobia. *Psychotherapy Research*, 19(4-5), 543-557. doi:10.1080/10503300902905947

Elliott, R., Shapiro, D. A., & Mack, C. (1999). *Simplified Personal Questionnaire procedure manual*. Toledo, OH: University of Toledo.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychologische Beiträge*, 43, 69-111.

Erskine, R. & Zalcman, M. (1979). The racket system: a model for racket analysis. *Transactional Analysis Journal*, 9, 51-9.

Evans, C, Connell, J., Barkham, M., Margison, F., Mellor-Clark, J., McGrath, G. & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. *British Journal of Psychiatry*, 180, 51-60.

Goulding, R. & Goulding, M. (1976). Injunction, decision and redecision. *Transactional Analysis Journal*, 6, 41-8.

Iwakabe, S., & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research*, 19(4-5), 601-611. doi:10.1080/10503300802688494

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59(1), 12-19. doi:10.1037/0022-006X.59.1.12

Kerr, C. (2013). TA Treatment of Emetophobia – A Systematic Case Study – 'Peter'. *International Journal of Transactional Analysis Research*, 4:2, 16-26.

Khalil, E., Callaghan, P., & James, N. (2007). *Transactional analysis: A scoping exercise for evidence of outcome*. Report prepared for the Berne Institute. The University of Nottingham, School of Nursing.

Kahler, T. (1975). Drivers: the key to the process of scripts. *Transactional Analysis Journal*, 5, 280-284.

Karpman, S. (1968). Fairy tales and script drama analysis. *Transactional Analysis Bulletin*, 7(26), 39-43.

Llewelyn, S. (1988). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology*, 27, 223-238. doi:10.1111/j.2044-8260.1988.tb00779.x

MacLeod, R., & Elliott, R. (2012). Emotion-focused therapy for social anxiety: A hermeneutic single case efficacy design study of a low-outcome case. *Counselling Psychology Review*, 27, 7-22

McLeod, J. (2010). *Case study research in counselling and psychotherapy*. London: Sage Publications.

McLeod, J. (2013a). Process and outcome in pluralistic transactional analysis counselling for long-term health conditions: A case series. *Counselling and Psychotherapy Research*, 13:1, 32-43.

McLeod, J. (2013b). Transactional Analysis Psychotherapy with a woman suffering from Multiple Sclerosis. A Systematic Case Study. *Transactional Analysis Journal*, 43:3, 212-223.

Norcross, J. C. (Ed) (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. Oxford: Oxford University Press

Ohlsson, T. (2010). Scientific Evidence Base for Transactional Analysis in the Year 2010. *International Journal of Transactional Analysis Research* 1:1 4-29

Spitzer, R. L., Kroenke, K., & Williams, J. B. (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ

- primary care study. *Journal of the American Medical Association*. Nov 10; 282:18, 1737–44. PMID 10568646
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166:10, 1092-1097. doi:10.1001/archinte.166.10.1092.
- Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, 130:4, 631-663.
- Widdowson, M. (2012a). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Peter'. *International Journal of Transactional Analysis Research*, 3:1, 1-11.
- Widdowson, M. (2012b). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Denise'. *International Journal of Transactional Analysis Research*, 3:2, 3-14.
- Widdowson, M. (2012c). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Tom'. *International Journal of Transactional Analysis Research*, 3:2, 15-27.
- Widdowson, M. (2013). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Linda'- a mixed outcome case. *International Journal of Transactional Analysis Research*, 4:2, 3-15.
- Widdowson, M. (2014). Transactional Analysis Psychotherapy for a Case of Mixed Anxiety & Depression: A Pragmatic Adjudicated Case Study – 'Alastair'. *International Journal of Transactional Analysis Research*, 5:2, 66-76.
- Widdowson, M. (2015). *Transactional Analysis for depression: A step-by-step treatment manual*. Abingdon: Routledge.