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Contents

Editorial

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Seasons greetings and best wishes for 2019 from IJTARP Editor, IJTARP Administrative Editor, and the IJTARP Editorial Board.

We have plenty of exciting news in this issue. Our apologies that our 2018 issues have been published later than the pattern in previous years – as we explained last time this was linked to the change in sponsorship of the journal. In spite of the problems associated with this, I am delighted that we are now publishing the second issue for 2018 before the end of the year.

This issue includes three more case study articles that demonstrate the efficacy of TA treatment of depression – these are part of a series of seven that form an Italian systematic replication of findings from previous case series – and are adding to the evidence needed for recognition of TA as an acknowledged treatment for common mental disorders

We also have four articles that have been translated from Portuguese and are reproduced here by permission of UNAT-Brasil - they are the first of several and cover an interesting range of topics: working with therapeutic symbiosis; death and the grieving process; psychotherapy supervision; and ways in which rituals promote autonomy.

We have more research articles in the pipeline, and more papers from Brazil are currently being translated. So our next issue should be out soon in 2019, after which we hope to get back to our regular publishing dates.

And we do of course welcome more submissions – and are very happy to to hear from both experienced and first-time authors.

Let me conclude by repeating the exciting news announced in the previous issue - IJTARP is listed in the Directory of Open Access Journals (www.doaj.org) so that we are accessible in more databases and to many more potential readers. Because we are an open access journal, ownership of each article stays with the author so we have been able to work with them to put their papers into Academia (www.academia.edu) where they are available to over 60 million academics.

Please help us to raise the profile of TA generally by alerting your colleagues to the existence of this journal, which can be accessed by anyone – nowadays they do not even have to tell us who they are or set up a password – although if they do they will then receive regular reminders when a new issue appears. All they have to do is go to www.ijtarp.org and they can access all eight years of issues.

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

© 2018 Enrico Benelli, Mario Augusto Procacci, Antonella Fornaro, Vincenzo Calvo, Stefania Mannarini, Arianna Palmieri & Mariavittoria Zanchetta

Abstract

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

Key words

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

Introduction

This Hermeneutic Single-Case Efficacy Design (HSCED) is the fourth of a series of seven, and belongs to an Italian systematic replication of findings from previous case series (Widdowson 2012a, 2012b, 2012c, 2013, 2014; Benelli, 2016a, 2016b, 2016c, 2017a, 2017b, 2017c) and is conducted under the auspices of the project 'Transactional Analysis meets Academic Research in order to become an Empirically Supported Treatment: an Italian two-year plan for publishing evidence of Transactional Analysis efficacy and effectiveness into worldwide recognized scientific journals', funded by the European Association for Transactional Analysis (EATA).

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

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

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

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

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

Ethical Considerations

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

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

Method

Inclusion and exclusion criteria

Psychotherapists participating in this case series were invited to include in their studies the first new client with a disorder within the depressive spectrum as described in DSM-5 (Major, Persistent or Other Depressive Disorders) (American Psychiatric Association, 2013) who agreed to participate in the research. Other current psychotherapy, active psychosis, domestic violence, bipolar disorder, active current use of antidepressant medication, alcohol or drug abuse were all considered as exclusion criteria. As the overall aim of this project is to study the effectiveness of TA psychotherapy in routine clinical practice, comorbidity is normally accepted and both inclusion and exclusion criteria are evaluated on a case by case.

Client

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

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

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

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

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

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

Case formulation (TA Diagnosis, contract, treatment plan)
TA Diagnosis
Giorgio presented with Please Others and Be Strong drivers (Kahler, 1975) and the Injunctions (Goulding &

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

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

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

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

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

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

Hermeneutic Analysis Team
The HSCED main investigator and first author of this paper is a PTSTA-P with 15 years of clinical experience, with a strong allegiance for TA. Despite recent literature suggesting that hermeneutic analysis should be carried out by expert psychotherapists (Wall et al, 2016), we believe that such indication is suitable when the research is investigating a new population or a therapy that lacks a research base. In our case, we preferred to follow the indication of Bohart (2000), who proposed that analyses can be carried out by a team of 'reasonable persons', not yet overly committed to any theoretical approach or professional role. The team comprised of six postgraduate psychology students who were taught the principles of hermeneutic analysis in a course on case study research at the University of Padua, by Professor John McLeod. Following the indication of Elliott et al. (2009), the students preferred to assume both affirmative and sceptic positions, and independently prepared their affirmative and sceptic cases. Then they met and merged their own cases, supervised by the main investigator, creating consensual affirmative and sceptic briefs and rebuttals.

Judges
The judges were three researchers at the University of Padua and co-authors of this paper: Judge A, Vincenzo Calvo, clinical psychologist, psychotherapist trained in dynamic psychotherapy, PhD in development psychology, with expertise in attachment theory; Judge B, Stefania Mannarini, psychologist with experience in research methodology; and Judge C, Arianna Palmieri, neuropsychologist and psychotherapist with a training in dynamic psychotherapy. Judge A and C had some basic knowledge of TA but had never engaged in any official TA training, whereas Judge B has some clinical experience but no knowledge of TA.

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

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

Quantitative Measures

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

Patient Health Questionnaire 9-item for depression (PHQ-9) (Spitzer, Kroenke & Williams, 1999) scores each of the nine DSM 5 criteria from '0' (not at all) to '3' (nearly every day), providing a total score of depression. It has been validated for use in primary care (Cameron, Crawford, Lawton, et al, 2008). Scores up to 4 are considered 'healthy', scores of 5, 10, 15 and 20 are taken as the cut-off point for mild, moderate, moderately severe and severe depression, respectively. PHQ-9 score ≥10 has a sensitivity of 88% and a specificity of 88% for major depression (Kroenke, Spitzer, & Williams, 2001) and scores of <10 are considered subclinical. A change of at least 6 points on PHQ-9 score is considered to assess a reliable improvement or deterioration (RCI).

Clinical Outcome for Routine Evaluation – Outcome Measure for global distress (CORE-OM) (Evans, Connell, Barkham, Margison, Mellor-Clark, McGrath, & Audin, 2002). Each of the 34 items is scored on a 5-point scale ranging from 0-4 (0=not at all, 4=most of the time). Scores up to 5 are considered 'healthy', scores between 5 and up to 9 are considered 'low level' (sub-clinical), and scores of 10, 15, 20 and 25

are taken as the cut-off point for mild, moderate, moderately severe and severe distress, respectively. The cut-off of 10 yields a sensitivity (true positive rate) of 87% and a specificity (true negative rate) of 88% for discriminating between members of the clinical and general populations. CORE OM was used in assessment sessions, in sessions 8, 16 and follow ups, whereas CORE short form A and B were used in all other sessions (Barkham, Margison, Leach, Lucock, Mellor-Clark, Evans, McGrath et al, 2001). A change of at least 5 points on CORE-OM score is required in order to assess a reliable improvement or deterioration (RCI).

The *Personal Questionnaire* (PQ) (Elliott, Shapiro, & Mack, 1999; Elliott, Wagner, Sales, Rodgers, Alves & Café, 2016) is a client-generated measure in which clients specify the problems they would like to address in their therapy and rate their problems according to how distressing they are finding each problem (1, not at all; 7, maximum possible). Scores up to 3.25 are considered subclinical. In this case series, missing the Italian normative score, for the PQ we adopted a more conservative RCI of two points, rather than the RCI of 1.67 recently proposed by Elliott et al. (2016). The PQ procedure suggests including problems from five areas: symptoms, mood/emotions, specific performance or activity (e.g., work), relationships and self-esteem/internal experience.

Qualitative Measure

The client was interviewed using the Change Interview protocol (CI) (Elliott, Slatick & Urman, 2001) five months after the conclusion of the therapy. The CI is a semi-structured qualitative change measure which asks clients how they feel they have changed during the therapy and how they think these changes came about, what they felt was helpful or hindering in the therapy, and what changes they feel they still need to make. Clients are asked to identify key changes they made and to indicate on a five-point scale: 1) if they expected to change (1=very much expected; 5=very much surprising); 2) how likely these changes would have been without therapy (1=very unlikely; 5=very likely), and 3) how important they feel these changes to be (1=not at all; 5=extremely).

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

Therapist Notes

A structured session notes form (Widdowson, 2012a, Appendix 6, p. 50-52) was completed by the therapist at the end of each session. In this form, the therapist provides a brief description of the session in which they identify key aspects of the therapy process, the

theories and interventions used, and an indication of how helpful the therapist felt the session was for the client.

Adherence

The therapist, the supervisor, and the main researcher were all transactional analysts and they each independently evaluated the therapist's adherence to TA treatment of depression using the Operationalized Adherence Checklist proposed by Widdowson (2012a, Appendix 7, p. 53-55) and agreeing on a final consensus rating.

HSCED Analysis Procedure

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

Adjudication Procedure

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

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

- If the client had changed;

- To what extent these changes had been due to the therapy;

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

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

Results

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

Adherence to the manualized treatment

The conclusion of the three evaluators was that the treatment had been conducted coherently according to TA theory at a good to excellent level of application.

Quantitative Data

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

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

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

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

Table 1: Giorgio's Quantitative Outcome Measure

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

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

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

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

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

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

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

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

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

Qualitative Data

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

- symptoms: HAT 4, "being anxious"; HAT 7, "exploring panic attacks"; HAT 9, "I wished it reduced [fear]"; HAT 10, "adapt to the situation of fear or agitation"; HAT 13, "avoid facing crowded places";

- mood and emotions: HAT 1, "found myself at ease" and "never spoke about it"; HAT 5, "loneliness"; HAT 6, "free many parts of me and feel more tranquil"; HAT 8, "talking about my inner state of mind"; HAT 14, "being attached to his girlfriend";

- relationships: HAT 3, "estrangement of the person at my side");

- self-esteem/inner experience: HAT 2, "being criticized"; HAT 11, "what springs from a critic"; HAT 12, "facing the courage"; HAT 15, "avoid talking of my fears"; HAT 16, "dealing with my courage".

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

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

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

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

	PQ items	Duration	Pre-Therapy[a]	Session 8 (middle)	Session 16 (end)	1 month FU	3 months FU	6 months FU
1	I cry often (tearful)	1-5m	7 **Maximum possible**	3 (+)(*) Little	**4 (*) Moderately**	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
2	I don't express anger	6-11m	7 **Maximum possible**	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
3	I feel insecure, I keep asking to be sure	1-2y	6 **Very considerably**	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
4	Insomnia	1-2y	6 **Very considerably**	**4 (*) Moderately**	1 (*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
5	I feel sad when others leave me alone	1-5m	6 **Very considerably**	3 (+)(*) Little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
6	I give up easily when I don't succeed in doing certain things and I feel incompetent, "I throw myself down"	<1m	6 **Very considerably**	**4 (*) Moderately**	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
7	I fear I'm not important to others	1-5m	6 **Very considerably**	**4 (*) Moderately**	2 (+)(*) Very little	2 (+)(*) Very little	1 (+)(*) Not at all	2 (+)(*) Very little
8	I fear I won't be able to fulfil or deal with my future life (will I ever be father, will I fight with all my dear ones…)	<1m	6 **Very considerably**	5 **Considerably**	2 (+)(*) Very little	1 (+)(*) Not at all	2 (+)(*) Very little	1 (+)(*) Not at all
9	Panic attack in crowded places (closed and open spaces)	1-2y	5 **Considerably**	**4 Moderately**	1 (+)(*) Not at all	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little
10	I fear others will drift apart from me	1-2y	5 **Considerably**	**4 Moderately**	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little
								Cont/

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

Note: Values in **bold** are within clinical range. +=indicates clinically significant change (CS). *=indicates reliable change (RCI). m = months. y = year. FU= follow-up. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off point: PQ ≥3.25. Reliable Change: PQ variation of two points. The rating is on a scale from 1 to 7 and indicate how much each problem has bothered the client: 1 = not at all; 7 = maximum.
[a]The first available score was in session 0C.

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

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

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

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

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

|	Change	How much expected change was [a]	How likely change would have been without therapy [b]	Importance of change [c]
1	I stopped crying	4 (somewhat surprised)	1 (very unlikely)	4 (very)
2	I express anger	5 (very much surprised)	5 (very likely)	4 (very)
3	I don't feel insecure, I don't ask to be sure anymore	5 (very much surprised)	1 (very unlikely)	5 (extremely)
4	I don't suffer of insomnia	3 (neither)	5 (very likely)	3 (moderately)
5	I don't feel sad when others leave me alone	5 (very much surprised)	1 (very unlikely)	5 (extremely)
6	I don't give up easily when I don't succeed in doing certain things. I stopped feeling incompetent	4 (somewhat surprised)	5 (very likely)	3 (moderately)
7	I don't fear I'm not important for others anymore	4 (somewhat surprised)	1 (very unlikely)	4 (very)
8	I don't fear I won't be able to fulfil or deal with my future life (will I ever be father, will I fight with all my dear ones…)	5 (very much surprised)	1 (very unlikely)	5 (extremely)
9	I don't have panic attacks in crowded places (closed and open spaces) anymore	3 (neither)	1 (very unlikely)	4 (very)
10	I stopped fearing others will drift apart from me	1 (very much expected)	1 (very unlikely)	3 (moderately)
11	I can do things when I feel lonely	5 (very much surprised)	5 (very likely)	4 (very)

Note. CI = Change Interview (Elliott et al., 2001).
[a]The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very much surprised. [b]The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely. [c]The rating is on a scale from 1 to 5; 1 = not at all, 3 = moderately, 5 = extremely.

*Table 4: Giorgio's Changes identified in the Change Interview*
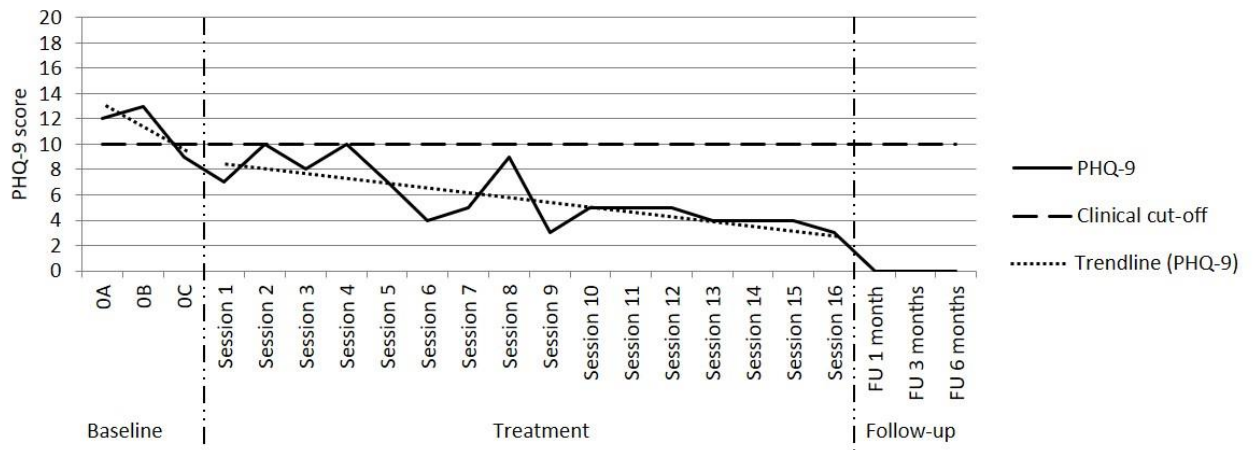
Note. 0A, 0B and 0C = assessment sessions. FU = follow-up. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999).

Figure 1: Giorgio's weekly depressive (PHQ-9) score
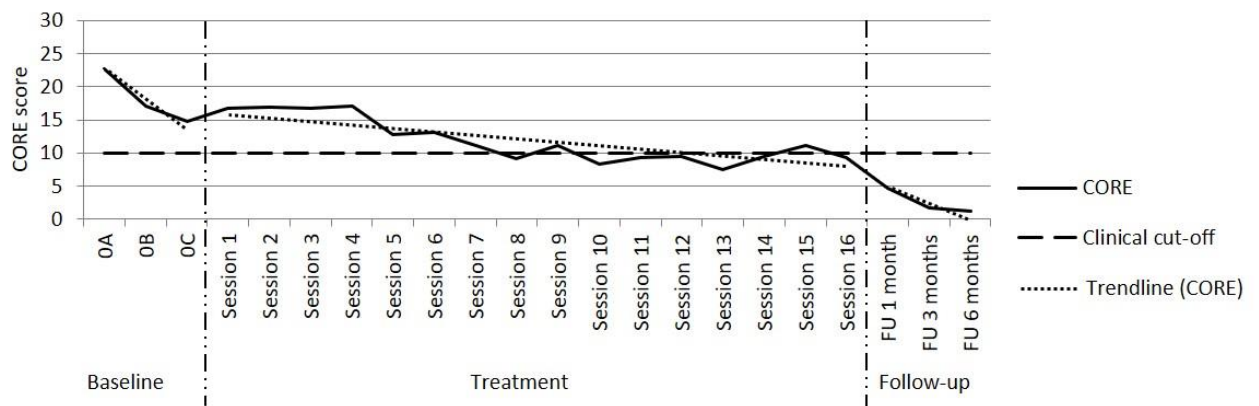
Note. 0A, 0B and 0C = assessment sessions. FU = follow-up. CORE = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002).

Figure 2: Giorgio's weekly global distress (CORE) score
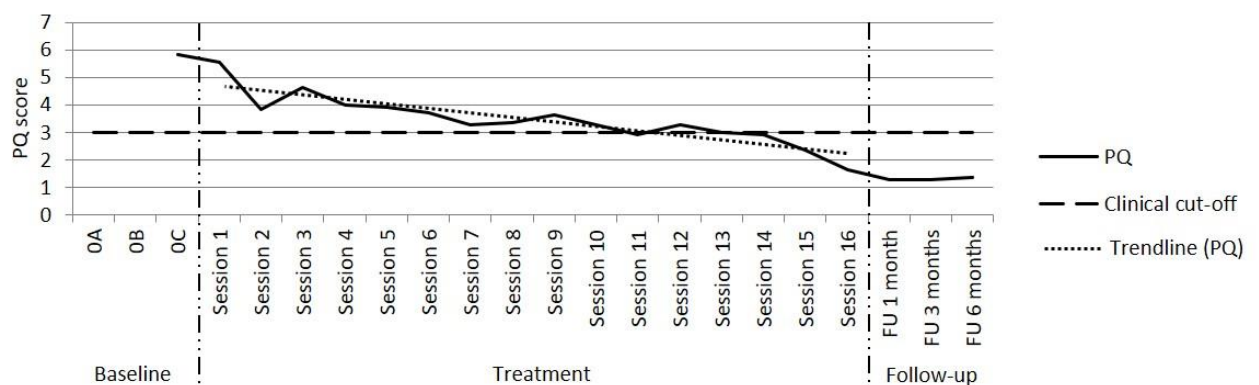
Note. The first available score was in assessment session 0C. 0A, 0B and 0C = assessment sessions. FU = follow-up. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999).

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

1. Change in stable problems

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

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

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

2. Retrospective attribution

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

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

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

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

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

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

Sceptic Case

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

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

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

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

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

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

3. The apparent changes reflect relational artefacts such as global 'hello-goodbye' effects on the part of a client expressing his or her liking for the therapist, wanting to make the therapist feel good, or trying to justify ending therapy.

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

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

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

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

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

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

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

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

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

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

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

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

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

Affirmative Rebuttal

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

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

3. The affirmative team believes there was no compliance effect, because the client reached a state of talking about many things he never spoken about before, as for example about talking to his dead grandmother before falling asleep: "this thing… it's the first time I say it to someone. Neither mom, nor dad, no one, neither my girlfriend and usually I tell her everything" (S15, C57). Giorgio trusted the therapist in not judging him, making him feel free to talk about his problems, and to have a positive attitude to therapy. It has also been widely reiterated that Giorgio had many difficulties in expressing; therefore it would have been unusual to find many details in his HAT forms.

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

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

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

Sceptic Rebuttal

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

Affirmative Conclusion

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

Sceptic conclusion

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

Adjudication

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

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

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

Opinions about the degree of change

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

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

Table 5: Adjudication results.

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

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

Mediator Factors

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

Moderator Factors

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

Discussion

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

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

Limitations

The first author has a strong allegiance to TA, is a teacher of the members of the hermeneutic groups and a colleague of the three judges. Despite the reflective attitude adopted in this work, these factors may have influenced in subtle ways both the hermeneutic analysis and the judges' evaluations.

Conclusion

This case study provides evidence that the specified manualized TA treatment for depression (Widdowson, 2016) has been effective in treating a Major Depressive Disorder in comorbidity with Persistent Depressive Disorder, Panic Disorder, Agoraphobia and Dependent Personality Disorder in an Italian client-therapist dyad.

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

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

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Abstract

This study is the fifth of a series of seven and belongs to the second Italian systematic replication of findings from previous series that investigated the effectiveness of a manualized transactional analysis treatment for depression through Hermeneutic Single-Case Efficacy Design. The therapist was a white Italian woman with 5 years of clinical experience and the client, Sergio, was a 39-year old white Italian man who attended sixteen sessions of transactional analysis psychotherapy. Sergio satisfied DSM 5 criteria for Persistent Depressive Disorder (Dysthymia) with melancholic features, Post-Traumatic Stress Disorder (PTSD) with Obsessive Personality traits. The treatment focused on the permission to enjoy and on self-protection. The focus on both depressive symptoms and obsessive traits allowed a remission of his dysthymia within the end of therapy. The judges evaluated the case as a good outcome: the depressive and anxious symptomatology clinically and reliably improved over the course of the therapy and these improvements were maintained at the follow-ups. Furthermore, the client reported significant change in his post-treatment interview and these changes were directly attributed to the therapy.

Key words

Systematic Case Study Research; Hermeneutic Single-Case Efficacy Design; Transactional Analysis Psychotherapy; Persistent Depressive Disorder (Dysthymia) with Melancholic features; Post-Traumatic Stress Disorder; Obsessive-Compulsive Personality Disorder.

Introduction

This Hermeneutic Single-Case Efficacy Design (HSCED) is the fifth of a series of seven, and belongs to an Italian systematic replication of findings from previous case series (Widdowson 2012a, 2012b,

2012c, 2013, 2014; Benelli, 2016a, 2016b, 2016c, 2017a, 2017b, 2017c) and is conducted under the auspices of the project 'Transactional Analysis meets Academic Research in order to become an Empirically Supported Treatment: an Italian two-year plan for publishing evidence of Transactional Analysis efficacy and effectiveness into worldwide recognized scientific journals', funded by the European Association for Transactional Analysis (EATA).

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

The aim of this study was to investigate the effectiveness of the manualised TA treatment of depression (Widdowson, 2016) applied to a persistent depressive disorder (dysthymia) with melancholic features in comorbidity with post-traumatic stress disorder (PTSD) and traits of obsessive personality. The present study analyses the treatment of 'Sergio', a 35-year-old Italian man who had been suffering from depressive and post-traumatic stress symptoms, with a personal and family history of depression, and steadily getting worse in the last few months due to being present during a terrorist attack. The quantitative primary outcomes investigated were depressive and anxious symptomatology, the secondary outcomes were global distress and client-generated personal problems.

Ethical Considerations

The research protocol follows the requirements of the ethical code for Research in Psychotherapy of the

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

Methodology

Inclusion and exclusion criteria

Psychotherapists participating in this case series were invited to include in their studies the first new client with a disorder within the depressive spectrum as described in DSM-5 (Major, Persistent or Other Depressive Disorders) (APA, 2013) who agreed to participate in the research. Other current psychotherapy, active psychosis, domestic violence, bipolar disorder, active current use of antidepressant medication, alcohol or drug abuse were all considered as exclusion criteria. As the overall aim of this project is to study the effectiveness of TA psychotherapy in routine clinical practice, comorbidity is normally accepted and both inclusion and exclusion criteria are evaluated on a case by case.

Client

Sergio was a 39-year-old white Italian man who lived with his wife and his young children in a small city in north Italy. He worked for a big commercial company and at the beginning of therapy he received a promotion, becoming the head manager of his sector. He was the youngest of two brothers, and when he was 20 his older brother died in an accident. When his brother died, Sergio had a black-out period of one month, of which he has no memory. His mother found great relief in him in keeping the family intact, whereas

his father fell in a severe depression. His father had a personal history of three depressions. Sergio had many passions, he loved biking and acting in theatrical representations. He was intelligent, curious, altruistic, with many positive values and good self-reflective and evaluative capacities. However, since the death of his brother he felt the necessity to do everything possible in his capacities and even more, making him feel he was not enjoying his life by working too much. He reported having a "disease" that forced him to do everything in the best way possible and get in charge of other persons' duties if he noticed they were not doing as he expected or wanted. He sought therapy after being present in a terrorist attack with his older child. He reported that his wife had always suggested him to begin therapy, and after the attack he decided independently to start therapy because he felt depressed. His son attended some sessions of therapy too with a friend of Sergio, a colleague of his therapist.

Therapist

The psychotherapist was a 30 year-old, white, Italian woman with 5 years of clinical experience. For this case, she received monthly supervision by a Teaching & Supervising Transactional Analyst (Psychotherapy) (TSTA-P) with 15 years of experience.

Intake sessions

The therapy was conducted in private practice, once a week, and part of the therapy was paid by insurance. However, the client decided to give that money to charity and pay for the entire therapy himself. The client attended four pre-treatment sessions (0A, 0B, 0C, 0D), which were focused on explaining the research project, obtaining consent, conducting a diagnostic evaluation according to DSM-5 criteria (American Psychiatric Association, 2013), defining the problems he was seeking help for in therapy along with their duration and severity, developing a case formulation including TA diagnosis, treatment plan and contract, and collecting a stable baseline of self-reported measures for primary (depression and anxiety) and secondary (global distress and personal problems) outcomes.

Note

In previous series, after the end of therapy, there have been three follow-ups, at 1-, 3- and 6-months after the end of therapy. However, Sergio was relocated abroad for work and therefore arranging his 6-month follow-up session with him has not been possible.

DSM 5 Diagnosis

The initial diagnostic phase identified the client's primary diagnosis. Sergio was assessed as meeting DSM 5 diagnostic criteria of mild Persistent Depressive Disorder, with melancholic features. He experienced depressed mood in daily activities for more than ten years, most of the day every day

(criterion A1), the presence of insomnia (B2) fatigue (B3), and feelings of hopelessness (B6), and his melancholic features are experienced by a loss of pleasure in all activities (A1), a lack of reactivity to usually pleasurable stimuli (A2), a distinct quality of depressed mood characterized by profound despondency, despair and moroseness (so called empty mood) (B1), early-morning awakening (B3), inappropriate guilt (B6). Sergio also met DSM 5 diagnostic criteria for Post-Traumatic Stress Disorder, experiencing symptoms from one month: he had been exposed to threatened death, directly experiencing the traumatic event (A1), witnessing, in person, the events as it occurred to others (A2), with the presence of intrusive symptoms associated to the traumatic event, beginning after the traumatic event occurred, like recurrent, involuntary, and intrusive distressing memories of the traumatic event (B1), and intense psychological distress at exposure to external cues that resemble an aspect of the traumatic event (B4). Furthermore, he presented negative alterations in cognitions and mood associated with the traumatic event, worsening after the traumatic event occurred, as evidenced by a persistent negative emotional state (D4), and persistent inability to experience positive emotions (D7). Moreover, Sergio met also DSM5 criteria for Obsessive-Compulsive Personality Disorder, being preoccupied with details, order, organization (1), shows perfectionism that extends time for task completion (2), is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (3), is reluctant to delegate tasks or to work with others (6) and shows rigidity and stubbornness (8). Knowing the level of an individual's personality functioning and personality traits provides the therapist with fundamental information for treatment planning. According to the alternative model for personality disorder in DSM 5 Section III, a personality diagnosis was also conducted. This diagnosis allows for assessment of: 1) the level of impairment in personality functioning, and 2) personality traits. Sergio showed moderate impairment in the level of organization in the areas of identity, self-direction, empathy and intimacy. He showed also personality traits of: emotional lability, hostility, anhedonia, depressivity, restricted affectivity, grandiosity, and rigid perfectionism. The therapist also rated the computerised Shedler-Westen Assessment Procedure (SWAP-200) (Shedler & Westen, 1999) that supported the diagnosis of high level of functioning, principally with traits of obsessive personality type.

Case formulation

TA Diagnosis

Sergio assumed a life position (Ernst, 1971; Berne 1972) I'm OK, You're Not OK with his subordinate, and I'm Not OK; You're OK with his superiors, that interacted with his stroke economy (Steiner, 1974), which was characterized by an absence of positive strokes and abundance of negative strokes. This in turn led to internalization of an over-active internal Critical Parent, which activated intense self-critical internal dialogues (Kapur, 1987). Furthermore, the underlying injunctions (Goulding & Goulding, 1976; McNeel, 2010): Don't be engaged in your own life (he feels to do everything wrong), Don't make it (he feels he is not good enough), Don't feel successful (he must take care of everything), Don't enjoy (he does not enjoy happy aspects of his life), Don't feel (he is not able to feel and share), Don't relax (he overwhelms) and Don't share your life (he tends to be superior or inferior to others) were also identified. These led to the observable drivers (Kahler, 1975) of, Hurry Up, Try Hard and Please Others and the assumption of drama triangle roles (Karpman, 1968) such as Rescuer with his colleagues at work, and Persecutor of himself by setting too high goals without any alternative. Script conclusions and decisions (Berne, 1961) were observable through script beliefs and contaminations (Berne, 1961; Stewart & Joines, 1987, 2012) such as: "I am wrong" "Others are more important than me", "I cannot be angry with others", "I must take care of others' problems". The script system (Erskine & Zalcman, 1979; Erskine, 2010) involved all of the above-mentioned thoughts and behavioural manifestations, as well as repressed primary anger for not being able to control his depression.

Treatment plan

The therapy followed the manualized therapy protocol of Widdowson (2016), including the 12 key tasks and the research-based principles. Throughout the treatment, the therapist focused on 1) building the therapeutic alliance by providing empathic listening, 2) giving strong support to the client's self-esteem and recognizing his resources and positive strengths; 3) developing the observing self and TA problem solving protocol, in order to enhance Adult functioning, and 4) permeating the sessions with permissions (Crossman, 1966), especially those congruent with the client's injunctions, namely: *engage*, *feel successful*, *enjoy*, *feel*, relax, *share*, and *protect yourself*. In the first phase (sessions 1-4) the focus was on the recognition and decontamination of script beliefs. In the second phase (sessions 5-16) the therapist focused also on the expression of his emotions and on creating a shield of protection at work.

Contract

Sergio asked to learn how to protect himself, how to express his emotions to himself and to others, and to learn to enjoy his life.

Hermeneutic Analysis Team

The HSCED main investigator and first author of this paper is a Provisional Teaching and Supervising

Transactional Analyst (PTSTA-P) with 15 years of clinical experience, with a strong allegiance for TA. Despite recent literature suggesting that hermeneutic analysis should be carried out by expert psychotherapists (Wall et al, 2016), we believe that such indication is suitable when the research is investigating a new population or a therapy that lacks a research base. In our case, we preferred to follow the indication of Bohart (2000), who proposed that analyses can be carried out by a team of 'reasonable persons', not yet overly committed to any theoretical approach or professional role. The team comprised of six postgraduate psychology students who were taught the principles of hermeneutic analysis in a course on case study research at the University of Padua, by Professor John McLeod. Following the indication of Elliott et al. (2009), the students preferred to assume both affirmative and sceptic positions, and independently prepared their affirmative and sceptic cases. Then they met and merged their own cases, supervised by the main investigator, creating consensual affirmative and sceptic briefs and rebuttals.

Judges

The judges were three researchers at the University of Padua and co-authors of this paper: Judge A, Vincenzo Calvo, clinical psychologist, psychotherapist trained in dynamic psychotherapy, PhD in development psychology, with expertise in attachment theory; Judge B, Stefania Mannarini, psychologist with experience in research methodology; and Judge C, Arianna Palmieri, neuropsychologist and psychotherapist with a training in dynamic psychotherapy. Judge A and C had some basic knowledge of TA but had never engaged in any official TA training, whereas Judge B has some clinical experience but no knowledge of TA.

Measures

Statistical Analysis

All quantitative outcome measures were evaluated according to Reliable and Clinically Significant Change (RCSC) (Jacobson & Truax, 1991), where 'change' stands for an Improvement (RCSI) or for a Deterioration (RCSD). Clinical significance (CS) is obtained when the observed score on an outcome measure drops below a cut-off score that discriminates clinical and non-clinical populations. The PHQ-9 considers a score of ≥10 as an indicator of current moderate major depression (Kroenke, Spitzer & Williams, 2001). It is important to consider that even below the cut-off score there may be a subclinical disorder. The PHQ-9 considers a score between 0 and 4 an indication of healthy condition, and a score between 5 and 9 as an indicator of mild (subclinical) depression. Reliable Change Index (RCI) is a statistic that enables the determination of the magnitude of change score necessary to consider a statistically

reliable change on an outcome measure (Jacobson and Truax, 1991). In particular, it is helpful in minimising Type I errors which occur when cases with no meaningful symptom change are assumed to have improved. Richards and Borglin (2011) proposed that a reduction of at least 6 points in the PHQ-9 score would be indicative of a reliable improvement. Only when we observe the presence of both CS and RCI do we have RCSC, which is considered a robust method for assessing recovery in psychological interventions (Evans, Margison & Barkham, 1998; Delgadillo, McMillan, Leach, Lucock, Gilbody & Wood, 2014). To control experiment-wise error which occurs when multiple significance tests are conducted on change measures, we consider that a RCSC is required in at least two out of three outcome measures, thus demonstrating a Global Reliable Change (GRC) (Elliott, 2015).

Quantitative Measures

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

Patient Health Questionnaire 9-item for depression (PHQ-9) (Spitzer, Kroenke & Williams, 1999) scores each of the nine DSM 5 criteria from 0 (not at all) to 3 (nearly every day), providing a total score of depression. It has been validated for use in primary care (Cameron, Crawford, Lawton, et al, 2008). Scores up to 4 are considered healthy; scores of 5, 10, 15 and 20 are taken as the cut-off point for mild, moderate, moderately severe and severe depression, respectively. PHQ-9 score ≥10 has a sensitivity of 88% and a specificity of 88% for major depression (Kroenke, Spitzer, & Williams, 2001) and scores of <10 are considered subclinical. A change of at least 6 points on PHQ-9 score is considered to assess a reliable improvement or deterioration (RCI).

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

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

Personal Questionnaire (PQ) (Elliott, Shapiro, & Mack, 1999; Elliott, Wagner, Sales, Rodgers, Alves & Café, 2016) is a client-generated measure in which clients specify the problems they would like to address in their therapy and rate their problems according to how distressing they are finding each problem (1, not at all; 7, maximum possible). Scores up to 3.25 are considered subclinical. In this case series, missing the Italian normative score, for the PQ we adopted a more conservative RCI of two points, rather than the RCI of 1.67 recently proposed by Elliott et al. (2016). The PQ procedure suggests including problems from five areas: symptoms, specific performance or activity (e.g., work), relationships, mood/emotions and self-esteem/internal experience.

Qualitative Measure
The client was interviewed using the Change Interview protocol (CI) (Elliott, Slatick & Urman, 2001) one month after the conclusion of the therapy. The CI is a semi-structured qualitative change measure which asks clients how they feel they have changed during the therapy and how they think these changes came about, what they felt was helpful or hindering in the therapy, and what changes they feel they still need to make. Clients are asked to identify key changes they made and to indicate on a five-point scale: 1) if they expected to change (1=very much expected; 5=very much surprising); 2) how likely these changes would have been without therapy (1=very unlikely; 5=very likely), and 3) how important they feel these changes to be (1=not at all; 5=extremely).

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

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

Adherence
The therapist, the supervisor, and the main researcher were all transactional analysts and they each independently evaluated the therapist's adherence to TA treatment of depression using the Operationalized Adherence Checklist proposed by Widdowson (2012a, Appendix 7, p. 53-55) and agreeing on a final consensus rating.

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

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

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

- If the client had changed;

- To what extent these changes had been due to the therapy;

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

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

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

comments) is available from the first author on request.

Adherence to the manualized treatment

The conclusion of the three evaluators was that the treatment had been conducted coherently according to TA theory at a good to excellent level of application.

Quantitative Data

PHQ-9, GAD-7, and CORE-OM were administered in the pre-treatment phase in order to obtain a four-point baseline, and during the two follow-ups. The first PQ score was available in session 1.

Sergio's quantitative data are presented in Table 1.

Sergio's initial depressive score (PHQ-9, 5) indicated a mild level of depression. The anxiety score (GAD-7, 3.75) indicated a healthy level of anxiety. The global distress score (CORE, 7.1) represented a low level of distress. The severity score of personal problems (PQ, 3.13) indicated that the client perceived his problems as bothering him somewhere between little and moderately.

At session 8, (mid-therapy), depression (0), anxiety (0) and global distress (2.4) passed to the healthy range. Severity of personal problems decreased to not at all bothering (1.38).

By the end of the therapy, both depression and anxiety scores moved into the healthy range (1), whereas

global distress (2.4) and personal problems (1.38) remained constant.

At the 1-month follow-up, all scores remained unaltered: depression (0), anxiety (0) and global distress (2.4) scores remained in the healthy range, whereas personal problems were maintained at not at all bothering (1.38).

At the 3-month follow-up, he maintained the same scores as the previous follow-up.

Table 2 shows the 8 problems that the client identified in his PQ at the beginning of the therapy and their duration. Problems are related to: specific performance or activity (1, what I like; 5, reprimanding; 7, get in charge), and self-esteem and inner experience (2, not doing enough; 3, judged; 4, don't enjoy; 6, throw away my life; 8, examine my behaviour). Two problems were rated as moderately bothering, five were rated little bothering, and one very little bothering. He rated the duration of only five problems as lasting from more than ten years.

At the end of the therapy 5 out of the 8 problems became not at all bothering and 3 very little bothering. At the 1- and 3-month follow-up he maintained the same score for each item of the PQ.

Figures 1 to 4 allow time series' visual inspections of the weekly scores of primary (PHQ9 and GAD-7) and secondary (CORE and PQ) outcome measures.

	Pre-Therapy[a]	Session 8 Middle	Session 16 End	1 month FU	3 months FU
PHQ-9	5 (Mild)	0 (Healthy)	1 (Healthy)	0 (Healthy)	0 (Healthy)
GAD-7	3.75 (Healthy)	0 (Healthy)	1 (Healthy)	0 (Healthy)	0 (Healthy)
CORE-OM	7.1 (Low level)	2.4 (Healthy)	2.4 (Healthy)	2.4 (Healthy)	2.4 (Healthy)
PQ	3.13[b] (Little)	1.38 (Not at all)	1.38 (Not at all)	1.38 (Not at all)	1.38 (Not at all)

Note. Values in **bold** are within the clinical range; + indicates clinically significant change (CS). * indicates reliable change (RC). 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). CORE = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002). PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). FU = follow-up.
Clinical cut-off points: PHQ-9 ≥10; GAD-7 ≥10; CORE-OM ≥10; PQ ≥3.25. Reliable Change Index values: PHQ-9 variation of six points, GAD-7 variation of four points, CORE-OM variation of five points, PQ variation of two points.
[a]Mean scores of pre-treatment measurements.
[b]First available score in session 1.

Table 1: Sergio's Quantitative Outcome Measure

	PQ items	Duration	Session 1[a]	Session 8 (middle)	Session 16 (end)	1 month FU	3 months FU
1	I'm not sure of what I like	>10y	**4** **(Moderately)**	2 (+)(*) (Very little)	2 (+)(*) (Very little)	2 (+)(*) (Very little)	2 (+)(*) (Very little)
2	I'm scared I'm not doing enough for my children	-	2 (Very little)	2 (Very little)	1 (Not at all)	1 (Not at all)	1 (Not at all)
3	I'm afraid I'll be judged if I make a mistake	>10y	3 (Little)	1 (*) (Not at all)	1 (*) (Not at all)	1 (*) (Not at all)	1 (*) (Not at all)
4	I'm not able to enjoy my life	>10y	**4** **(Moderately)**	1 (+)(*) (Not at all)	2 (+)(*) (Very little)	2 (+)(*) (Very little)	2 (+)(*) (Very little)
5	I have difficulties in reprimanding people I care about	-	3 (Little)	1 (*) (Not at all)	1 (*) (Not at all)	1 (*) (Not at all)	1 (*) (Not at all)
6	I fear I'm throwing away my life thinking too much about my job	>10y	3 (Little)	2 (Very little)	2 (Very little)	2 (Very little)	2 (Very little)
7	I get in charge of everything	>10y	3 (Little)	1 (*) (Not at all)	1 (*) (Not at all)	1 (*) (Not at all)	1 (*) (Not at all)
8	I constantly examine my behaviour	-	3 (Little)	1 (*) (Not at all)	1 (*) (Not at all)	1 (*) (Not at all)	1 (*) (Not at all)
	Total		25	11	11	11	11
	Mean		3.13 (Little)	1.38 (Not at all)	1.38 (Not at all)	1.38 (Not at all)	1.38 (Not at all)

Note: Values in **bold** are within clinical range. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off point: PQ ≥3.25. Reliable Change: PQ variation of two points. +=indicates clinically significant change (CS). *=indicates reliable change (RCI). The rating is on a scale from 1 to 7 and indicate how much each problem has bothered the client: 1 = not at all; 7 = maximum. m = months. y = year. FU= follow-up.
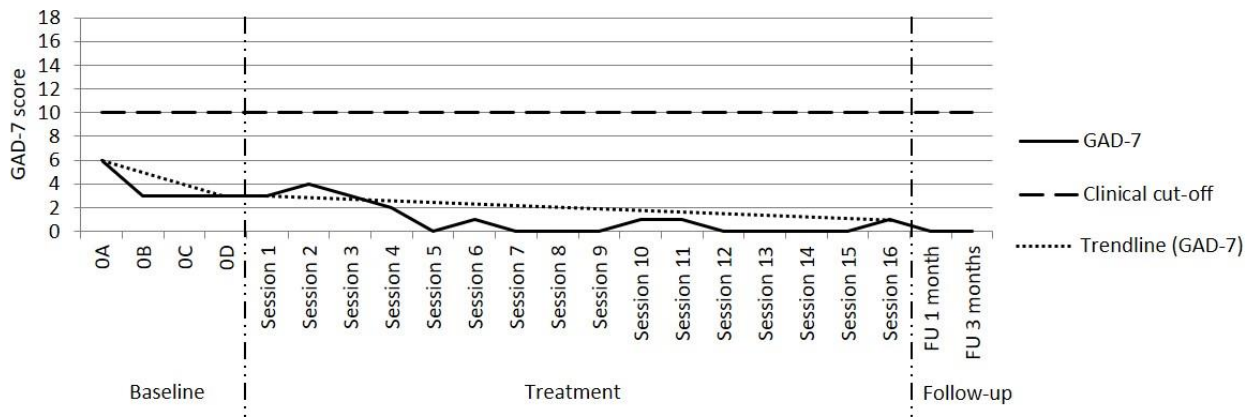[a]Pre-therapy score is missing, the first available was in session 1.

*Table 2: Sergio's personal problems (PQ), duration and scores*
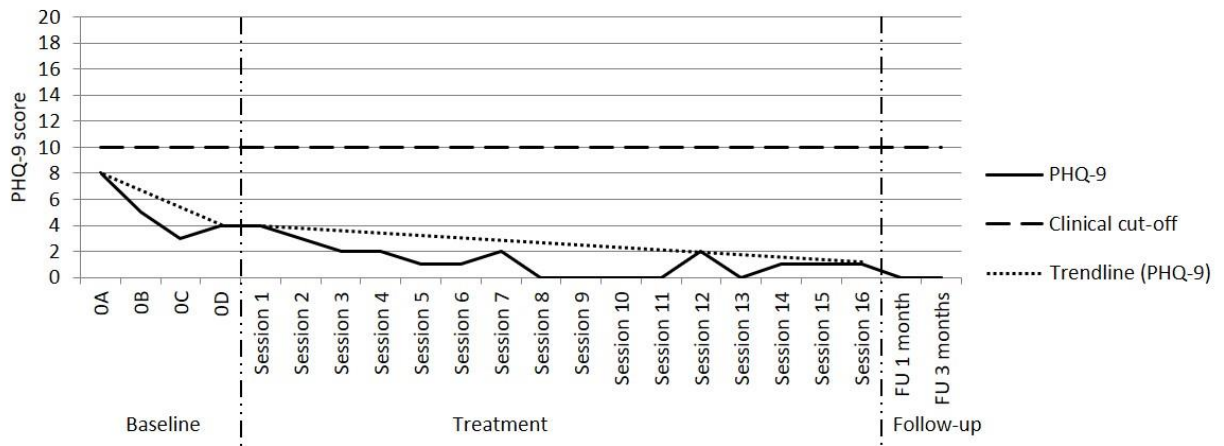
Note. 0A, 0B, 0C and 0D = assessment sessions. FU = follow-up. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999).

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

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

Figure 2: Sergio's weekly anxiety (GAD-7) score
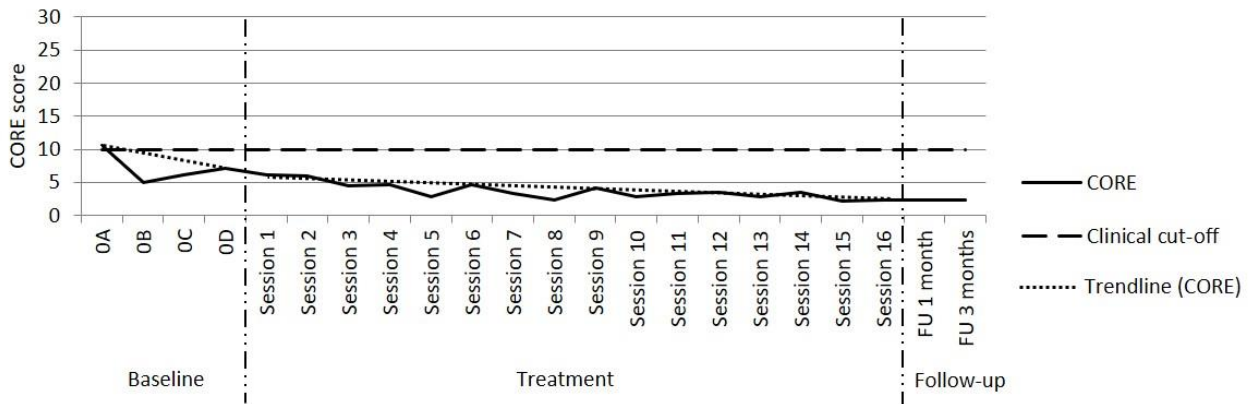
Note. 0A, 0B, 0C and 0D = assessment sessions. FU = follow-up. CORE = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002).

Figure 3: Sergio's weekly global distress (CORE) score
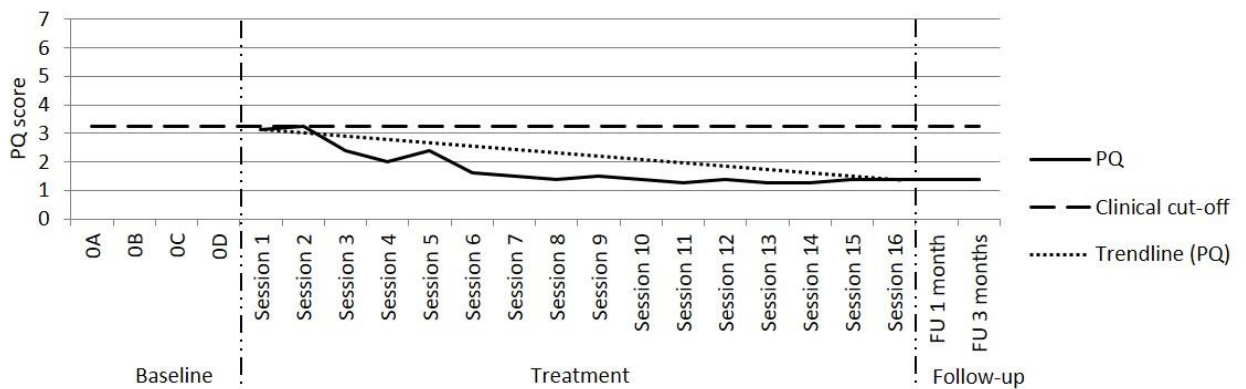
Note. The first available score was in session 1. 0A, 0B, 0C and 0D = assessment sessions. FU = follow-up. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999).

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

Session	Rating	Events	What made this event helpful/important
1	8 (greatly helpful)	Explanation and drawing of the ego state model	Awareness and feeling lighter
2	8 (greatly helpful)	Crux notion of having spoken about myself which brings relief	The fatal adding up of the heaviness decreases from time to time
3	8 (greatly helpful)	Not a particular event, but having been able to be here!	Taking care of me
4	8 (greatly helpful)	Awareness of the personal journey (I've been good at it!)	Strength and less problems with myself
5	8 (greatly helpful)	Give importance to protection	Protection is not a synonym of weakness
6	8 (greatly helpful)	Having mainly reinforced the concept of protection	Protecting lead to a stronger self-confidence
7	8 (greatly helpful)	Having recalled the personal journey of the past difficulties and having shared them ("delivered")	I'm satisfied for having dealt with it in a lighter way, without heaviness in speaking about it
8	8 (greatly helpful)	Having dealt with the "black hole" of my life (=one month amnesia after the funeral of my brother)	Recalling it not alone
9	8 (greatly helpful)	Having been here despite being "worn out" (first day of holiday → decrease of adrenaline)	Having been here!
10	8 (greatly helpful)	Speaking about the "blackmail". Pushing myself over the limit as a personal "blackmail"? Namely to strain myself so much	Greatly useful because it emerged during the session and not premeditated. Spontaneous so real
11	8 (greatly helpful)	Having the awareness that lowering the bar can be home run	Expressing it, sharing it and really feeling it
12	8 (greatly helpful)	Speaking about the "heaviness" that I thought "giving" others when talking about my suffering	Being more aware of it
13	8 (greatly helpful)	Taking care of me	Being every time more aware of it
14	8 (greatly helpful)	Sharing the reached goals obtained during therapy	The awareness of the reached path
15	8 (greatly helpful)	Acknowledgement of the "child that needs to pour out"	Having spoken about it without having "previously thought about it"
16	8 (greatly helpful)	For the whole session I haven't spoken about my job	It has been the best session yet. We spoke only of me

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

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

	Change	How much expected change was [a]	How likely change would have been without therapy [b]	Importance of change [c]
1	More desire of speaking about myself	3 (neither)	1 (very unlikely)	4 (very)
2	Awareness that the path I'm doing it's right	4 (somewhat surprising)	1 (very unlikely)	4 (very)
3	More awareness of what happens during therapy	4 (somewhat surprising)	1 (very unlikely)	5 (extremely)
4	More awareness that I have a problem and that I needed therapy	2 (somewhat expected)	1 (very unlikely)	4 (very)
5	I reached the responsibility of being in therapy	1 (very much expected)	1 (very unlikely)	4 (very)
6	The way I see how I act, changed	4 (somewhat surprising)	1 (very unlikely)	5 (extremely)
7	I took care of myself	4 (somewhat surprising)	1 (very unlikely)	5 (extremely)

Note. CI = Change Interview (Elliott et al., 2001).
[a]The rating is on a scale from 1 to 5; 1= very much expected, 3 = neither, 5 = very much surprising. [b]The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely. [c]The rating is on a scale from 1 to 5; 1 = not at all, 3 = moderately, 5 = extremely.

Table 4: Sergio's Changes identified in the Change Interview

Qualitative Data

Sergio compiled the HAT form at the end of every session (Table 3), reporting only positive/helpful events. All positive events were rated 8 (greatly helpful). He reported helpful aspects on: mood/emotion (1 lighter, 7 no heaviness, 8 remembering, 12 suffering), and self-esteem/inner experience (2 and 16 speak about me, 3 and 13 take care of me, 4 less problems, 5 and 6 protection, 9 being, 10 blackmail, 11 lower the bar, 14 reached goals, 15 need to pour out).

At the 3-month follow-up, he maintained the same scores as the previous follow-up.

Qualitative Outcome Data

Sergio participated in a Change Interview 1-month after the conclusion of the therapy. In this interview he identified seven changes (see Table 4). Sergio described his therapy as "needing it" (Line 47) "it changed my life completely" (L73), "therapy helped me in reordering my mind" (L75-78), "it strained me, but it led to results" (L99) and "for this reason I recommend everyone have therapy" (L122-126). He also said that

"when I went home, for the following days I kept thinking about the therapy" (L114). When Sergio started the therapy, he did not believe in the therapeutic work (L122-126), but when he saw it was helping him he became "very content about the therapy" (L141). "After the first four or five sessions I emptied myself and then everything became more positive" (L340-341). He said he had learned to speak about himself, to "talk about what hurts you" (L317-322) and "especially I reached the awareness that I really needed someone to help me, therapy" (L395). Sergio in his CI did report one negative, obstructive or unpleasant aspect of therapy: "even if it's not negative, the fact that therapy can become like a drug, something that you need and you do for the rest of your life, for every different problem, you bring a new problem then another" (L433-435).

Five changes reported by Sergio are related to his awareness of what happened in therapy (items 1, 2, 3, 4 and 5). One change referred to his change of perspective (6), which was related to his initial problems (PQ items 1, 2, 5, 6, 7, 8) (L867-880) and

one regarded self-protection (7). He was somewhat surprised (4) by 4 of these changes, all 7 have been rated as very unlikely to have occurred without therapy (1), and 4 were considered as very important (4) and 3 as extremely important (5). According to Sergio, all these improvements happened because he "already had all these things in my mind, I needed someone to help me reorder them (L75-78). Sergio also reported that thanks to therapy he felt calmer and that "protecting myself doesn't mean that I'm weak… because I learnt to find time for myself in therapy" (L153-158). "Therapy gave me the awareness that I had a problem and that I needed help to solve it, because I was not capable to deal with all of this on my own" (L395).

HSCED Analysis

Affirmative Case

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

Change in stable problems

Quantitative data (Table 1) shows that all scores have a decreasing trendline. In the PQ (Table 2), Sergio identified 8 main problems at the beginning of the therapy that he was trying to solve. By the end of the therapy, 2 problems reached clinical and reliable improvement and 4 problems reached a reliable improvement. Sergio rated the duration of only 5 problems, as lasting from more than 10 years, and 4 of these reached RCSI. During the CI, Sergio reported that at first he did not like filling up questionnaires, and that he thought they were not useful, but by the end of the therapy he realized that they showed him his improvement (CI, L300-330). In the notes of the therapist, on session 10 the therapist reported that Sergio's questionnaires are not representative of his emotions and sufferings: "Even though the client told me the high emotional impact of the fight with his colleague… this weighted him down, worsening every day, in his tests this does not emerge" (Therapy notes). Qualitative data supports changes in stable problems. About his depressive symptoms, he reported that he "finally managed to speak freely about death, about the death of my brother and about the attack… many things exploded" (S12, L1032-1048). In the same session, he also added that he speaks with the therapist about things he does not speak about with anyone, not even his wife (S12, L800), even though he started speaking more with his wife: "I deleted a veil, first I thought that if I told others my problems I would have put my weight on them, but now I realized that this is not true" (S12, L814-848). Moreover, Sergio stated being unable to enjoy positive things in his life (item 4 of the PQ), and in session 14, he reported having "enjoyed the things I did without feeling guilty for enjoying" (L43-46); "when I finish

something, now I'm able to say 'wow'" (502), and "I felt important today, for the first time ever I felt important at work, now I really feel it" (S15, L21-24). Regarding Sergio's specific performances and activities, he said that "the 90% of my worries were tied to my work… before I lived my life on a 5, 6 range, now I live on an 8.5 range, and it's the first time in 15 years, and I like my job" (S15, L305-314). Finally, on session 16, he explained that he has no more fear of reprimanding people he cares about (item 5 of the PQ), because "I know that this doesn't mean that I'll lose the relationship, whereas before I feared to lose them, so I preferred getting in charge of everything to reprimand nobody" (L577-582). Furthermore, Sergio reported some changes in his self-esteem and learned to protect himself. In session 10 he reported "before therapy the word 'I' did not exist for me, I was the saviour, at home, at work" (L169-173). In session 11 he understood that "protecting myself does not mean that I'm weak… this perspective is changing me" (L668-672). The following session, he explained that he "started sleeping peacefully, I live more peacefully… I allowed myself to be peaceful, and this is something I never did before in my life" (S12, L308-329). Finally, at the end of therapy, he stated "if it had been six months ago I would have been scared of their judgment, but today zero, nothing" (S15, L188-192) "I've started telling myself 'good job!'" (S15, L237).

Retrospective attribution

Sergio identified in his Change Interview seven important changes, all rated very unlikely without therapy (Table 4). Sergio said that "even if at the beginning I thought that these questionnaires were useless, after some sessions I understood their importance… especially the personal questionnaire… because it shows your results, how you improve each time" (L300-330). He also recognised that the therapy allowed him to change perspective, to gain the awareness he needed in therapy to help him (L618-619). "A very important aspect of therapy was talking about my behaviour and the therapist pigeonholed them in the ego state model… this has been fundamental for me" (L687-689). In the course of therapy, Sergio repeatedly told the therapist that since he started therapy, his wife and his colleagues felt he changed, that he had a different light in his eyes, that they saw him as more peaceful (S12, L279-285). Moreover, the therapist of his eldest son told him that his son improved and that "[my son] doesn't need therapy anymore because the therapeutic work his dad is doing is having good effects on him too" (S8, L90-96). About the client's symptoms, he reported that therapy helped the sad child he was to vent (S15, L453-454), "I needed therapy… I've always had difficulties in creating deep relationships, but the therapeutic relationship was different… it was professional… it allowed me to create that kind of

relationship I never managed to create" (L502-515). Regarding Sergio's protection and self-esteem, he also said that he is extremely happy about his therapeutic journey (L141) because he learnt to "find some time for myself only" (L153-156) and that "I needed this space, it's for me, I'm depriving no one of this space" (S16, L514-515). Finally, he stated that "therapy helped me reacquire joy, something that I never managed to do alone… I asked for help and you helped me in reordering up those things there were messed up in my mind" (S16, L61-87).

Association between outcome and process (outcome to process mapping)

Changes in depression (Table 1) and personal problems (Table 2), in particular, feelings of being judged at work, of having to be constantly impeccable in his job, and of not enjoying his life, appear tied to interventions of giving him permission to protect himself (HAT, Table 4, sessions 3, 5, 6, 13), finding a place where he could vent, learning that he can share his problems with others without weighing on them (HAT, Table 4, sessions 2, 3, 4, 7, 8, 12, 15), having started talking about himself and not only worrying about others (HAT, Table 4, sessions 2, 3, 4, 7, 8, 10, 11, 12, 14, 15, 16) and acquiring the awareness of the importance of going to therapy (HAT, Table 4, sessions 3, 9). This outcome is also mirrored in the client's changes reported in the CI, where he stated that "the most helpful aspect of therapy has been when the therapist pigeonholed my behaviour in the ego state model" (CI, L636-637).

Event-shift sequences (process to outcome mapping)

The greatest effect on depressive symptoms appeared to be tied to interventions on his specific performances at work and on his self-esteem. Regarding the first point, in sessions 5 and 6 Sergio and the therapist worked on his need to protect himself and to do not take charge of everything at work, which is reflected in his PQ scores (Table 2, sessions 5, 6, 7, items 1, 4, 5, 6, 7, 8) and on his HAT (Table 4, sessions 5, 6). Instead, for his self-esteem area, the therapist has been able to create a good therapeutic alliance and a safe place for Sergio, giving him the awareness of the permission to have a place where he could talk about himself, his problems, without feeling it would weigh on his wife or colleagues at work. From session 4, the therapist focused on energizing the Adult (therapist's notes, session 4) and on decontamination (therapist's notes, session 4, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16) in order to help Sergio get in touch with his emotions and feel joy. Furthermore, the therapist worked on creating a strong therapeutic alliance, showing Sergio that he could trust her and that he could talk to her. In fact, since the beginning of the therapy, the therapist focused the interventions on accepting and holding

Sergio and his problems, on reassuring him and on giving him the permission to have a place where he could take care of himself. This led to a change in his score at the CORE's item "I have felt I have someone to turn to for support when needed" (item 3 of the CORE-OM and item 13 of the CORE short form B) from session 12, which passed from only occasionally to often by the end of therapy, maintained until the last follow-up. In fact, in the 3-month follow-up he explained that at the beginning of therapy he did not trust other's help because he feared their judgment (FU2, L192-195), and that "therapy deleted that filter and that made me possible to trust and work on myself later on" (FU2, L192-195).

Sceptic Case

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

All the quantitative measures used (PHQ-9, GAD-7, CORE and PQ) were under the clinical cut off since the beginning of therapy, therefore the client should have not been included in the research. Furthermore, there is no reliable change in any measure. SWAP scores also confirm an absence of real change in Sergio. Q-T scores at the end of the therapy regarding his obsessive personality trait increased from 64.06 to 71.05, demonstrating how Sergio did not change this aspect of this life tied to his work and to his tendency to take charge of everything. Furthermore, his score of high functioning depressive personality did not change from the assessment phase to the last therapy session supporting the conclusion that no reliable change occurred. Also, in the Change Interview, Sergio reported that he did not want to think whether something did not change "because then it's a big mess" (CI, L460). At the beginning of therapy, he reported to have decided to seek it because his wife was telling him to do so for ten years (S5, L727-729), but not believing in therapy itself as a method to solve his problems. He used to think "this person should go to therapy" as an insult (S16, L109) and that he started therapy "feeling angry about" (S13, L671-687). Moreover, In session 12, he said "I still have that 'disease' that others come first, then there is me" (S12, L413). In the CI, he also said "thinking too much about the consequences of my actions… has not changed completely" (CI, L451-455). In fact, in session 11 he reported thinking about his son's future and the consequences of the teachers' decision to put him in another class: "I've felt impotent since the beginning of therapy" (S1, L56-87). Finally, about his problematic area of specific performances, in session 15, he explained that "I defeated the fear of judgement because I'm the boss, it is me who decides" (S15, L208-210).

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

The sceptic team was not able to find any proof demonstrating an apparent change due to statistical artefacts or random errors.

3. The apparent changes reflect relational artefacts such as global 'hello-goodbye' effects on the part of a client expressing his or her liking for the therapist, wanting to make the therapist feel good, or trying to justify his or her ending therapy.

In the course of therapy the client explained having been led to seek therapy on his wife advice: "I feel guilty for not having listened to her before, because… who knows… I could have lived better these last ten years" (S5, 733-738), and in his CI he repeated "for this reason I tried to speed up things" (CI, L107-108). Therefore, it is possible that Sergio's tendency to 'please' his wife might have affected both his quantitative measures and liking therapy.

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

In his CI, Sergio reported "I went to therapy with the expectation of fixing and reordering everything in my life… I knew I made a mess, and I knew I wanted to fix it" (L464-470). Furthermore, his wife repeatedly told him that therapy helped him with his depression (S7, L661-669) because "I have the depression gene, like my father" (L723-726), who had three depressive episodes in his life (L569-572). Moreover, in the 3-month follow-up, Sergio reported that a friend he respects (who is also a psychotherapist) recommended him to go to that therapist and that "she would have never sent me randomly to someone or recommended me wrong" (FU2, L179-183). This suggests that the change can be partially tied to his wife's desire of seeing him get better, self-persuasion and personal expectancy of a resolution of his problems by going to a recommended therapist.

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

The sceptic team believes that Sergio's improvement could be due to a resolution of an adjustment disorder. In fact, two weeks before starting therapy, Sergio had been involved in a terrorist attack but in session 3 he said he had already elaborated what happened (L620). Moreover, at the beginning of therapy, Sergio reported having received a promotion at work and being very stressed about it, not being sure whether he should accept or decline, deciding to accept such promotion on the third session of assessment (0C).

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

At the beginning of therapy, Sergio received a promotion, which he accepted between assessment session 0B and 0C. The sceptic team believes that his improvement in depression and anxiety from session 0C might be due to his professional climb. Moreover, any positive change reported by Sergio in enjoying his life might have been due to experiencing the terrorist attack. In fact, he explained "when I was experiencing the attack, I got angry, because I couldn't die without having fully enjoyed my life" (0B, L812-814) and "the attack gave me the awareness that I was throwing away my life" (S5, L764-768).

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

The sceptic team was not able to find any proof demonstrating an apparent change due to sychobiological processes.

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

Participating in the research might have influenced Sergio's quantitative scores. In assessment session 0A he said he was willing to help if research needs his collaboration (L831), and in the following session he reported to "must give one hundred percent in everything, otherwise… I feel a failure" (0B, L456-458). Furthermore, in session 7 he added: "depression is the worst illness in the world, for you and for everyone around you… but I'm an immune carrier" (S7, L685-726). According to the client's words, we believe that Sergio's quantitative and qualitative improvements do not reflect real changes in his life, but are more representative of how he did not want to show others that he was "a failure" nor "sick".

Affirmative Rebuttal

1. Sergio subclinical depression is represented by his diagnosis of dysthymia, which is confirmed by the SWAP scores (high functioning depressive personality score 60.64 at the beginning of therapy) and by the duration form of his PQ (Table 2, 5 out of 8 lasting for more than 10 years). Regarding his depressive symptoms and his incapacity to feel joy, he explained that since his brother's death he was living without being able to enjoy his life (0B, L133-140), and that he felt guilty for being happy so stopped feeling positive (0B, L427-431). From session 2 he reported the first event in which he truly enjoyed a hazelnut cream sandwich with his son in the middle of the night (S2, L373-385). In the following session, he also reported joy for his professional success (S3, L486-490). In

session 4, he said he had enjoyed the holidays (S4, L10-11) because he managed to put his children before work (S4, L228-236). About his specific performance, he reported having started protecting himself from his tendency to overwork from session 5 and to have found pleasure at the seaside with his wife and children, underlining his joy during the weekend (S5, L226-236). According to Sergio, his problems tied to his self-esteem and inner experience changed significantly. On session 6, he said that he felt he had started improving since the first session of therapy (S6, L588-591). He admitted having started therapy in a not positive mood, however after the first sessions he understood he needed a place where he could vent with someone able to listen to him without weighing on his wife: "she would worry and I don't want her to worry about my professional problems... she'd faint!" (S1, L853-958), explaining in session 3 that "I'm happy to be here… since I started therapy I feel different… I changed my point of view… I'm more optimistic" (S3, L8-42) and realized that "if you need help, you can ask for it" (S3, L37-42) and that communicating it is fundamental (S3, L110-112). He referred to the therapist as a walking stick (S7, L536-541) and even if he had many walking sticks in his life, he never wanted to use them because "I can do it on my own" (S7, L550-555). In fact, he decided to suspend therapy for one month (between session 9 and 10) "to see if I was able to recharge on my own" (S10, L689-708), however, he resumed therapy because he realized he was not able to do it alone and that the therapist was attentive to his needs, "so I came back" (S10, L722-724).

3. In his CI, Sergio reported how, in the course of the first sessions, he gained the awareness of being depressed and that he actually needed help, therefore, even if his wife pushed him to seek therapy, he started manifesting the first improvements after having realized that therapy was the place where he could learn to take care of himself (0D, L829).

4. When he started therapy he believed that it was going to be useless for him, because he did not believe in a therapeutic journey, therefore, the affirmative team believes that Sergio's expectations were not positive. In fact, in the CI, he rated 4 improvements out of 7 to have been somewhat surprising. Furthermore, in the 3-month follow-up he reported "therapy brought unexpected results" (FU2, L141).

5. Sergio reported that since the death of his brother (more than 10 years earlier) he had not lived enjoying, therefore a diagnosis of adjustment disorder does not satisfy DSM 5 criterion E (once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months).

6. Even if Sergio received a promotion, anxiety and personal problems tied to his work started improving

only from session 6 (Table 2, PQ items 2, 5, 6, 7, 8), after the therapist's interventions in session 5.

8. In the course of the entire therapy, Sergio never demonstrated any interest in the research.

Sceptic Rebuttal
The sceptic team believes that Sergio's improvements are not due to therapy itself but to extra-therapeutic events, like the "big blow" that the terrorist attack gave him. Moreover, in session 16 he explained that acting in a theatrical group was therapeutic for him (S16, L359-362), therefore, his hobby might have helped his recovery from the terrorist attack and his anxiety due to the promotion in his job. Also, in session 7, Sergio reported feeling the therapist is like a "walking stick" and to not believing in walking sticks because "after a while you don't need it anymore, you start walking alone" (S7, L536-541). Finally, regarding his depressive symptoms and his difficulties in feeling joy, he said that the birth of his first son has been a new rebirth for him after the loss of this brother, giving him his joy back (S7, L628).

Affirmative Conclusion
Sergio entered therapy with a dysthymia, due to past familiar relationships that inhibited pleasure and joy since the death of his brother more than 10 years earlier. The loss made him start living every second of his life like it was the last, leading him to overwork and to be unable to enjoy his life. He sought therapy because he was involved in a terrorist attack, which made the trauma of the loss re-emerge. The therapeutic work focused on reinforcing his self-esteem, decontaminating his convictions to overwork, and giving him the permission to listen to his needs, and to trust the therapist in helping him without feeling judged. The therapist also nourished his narcissistic traits to make him believe in his successes.

Sceptic conclusion
Sergio entered therapy with subclinical quantitative scores with mild depression which was due to his involvement in a terrorist attack, whereas his low anxiety level was due to a promotion he received. Participating in the attack opened his eyes, making him realize he was throwing away his life working, and his depressive symptoms decreased. Instead, when he accepted the promotion, he got used to his new position and his many responsibilities, therefore his anxious symptoms ceased once he adapted to such change. Therefore, global improvement in Sergio might have been due to spontaneous remission.

Adjudication
Each judge examined the rich case record and hermeneutic analysis and compared their opinions reaching a consensus, reported in Table 5. The judges' overall conclusions are that this was a clearly good outcome case, that the client changed

substantially and that these changes are substantially due to the therapy.

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

This is a clearly good outcome (60% of certainty) with aspect of a mixed outcome (40% of certainty). Qualitative data, such as session transcriptions and therapist notes support the conclusion that, although quantitative scores are under threshold, a change in long-standing problems occurred because Sergio reported having started enjoying life again since the death of his brother. He also managed to find time for himself and he learnt to protect himself from his own tendency to overwork and also do other people's work.

Opinions about the degree of change

The client's change is substantial (80%, with 80% of certainty). Qualitative data, as the session transcriptions and the Change Interview, show that Sergio feels happier, able to enjoy his work, his free time, his family, and stopped fearing his subordinates' and his client's judgement. He does not fear or feel anymore being a failure and does not need to overwork in place of others to avoid judgement.

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

The observed change is substantially (80% with 80% of certainty) due to the therapy. In his Change Interview, Sergio reported seven changes all due to therapy. Furthermore, qualitative data in the HAT form (summarized in Table 3) of the client is extremely helpful to understand what the client felt important in the course of therapy, such as gaining the awareness that he could protect himself without being a weak person. Therapy helped him to find a place for himself, where he could vent freely without weighing on people

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he cared for and that would have worried them, and without feeling judged.

Mediator Factors

Good therapeutic alliance, empathic listening and decontamination helped Sergio to take care of himself and to get in touch with his emotions, therefore allowing himself to feel joy.

Moderator Factors

Sergio was an introspective, very practical and determined man, therefore these capacities and his willingness to change his life aided the therapeutic process.

Discussion

This case aimed to investigate the effectiveness of a manualized TA treatment for depression in a client with mild level of persistent depressive disorder (PDD) in comorbidity with PTSD. Primary outcomes were depressive and anxiety symptomatology, and secondary outcomes were global distress and personal problems, which were sub-clinical and that did not show a reliable and clinically significant change. The therapist conducted the treatment in a good to excellent adherence to the manual. The judges concluded that this is a clearly good outcome case, with a 80% degree of change, and which was 80% due to the therapy. These conclusions provide a further support for the effectiveness of the manualized TA treatment for depression in adults. Creating an early therapeutic alliance, supporting self-esteem, changing self-critical internal dialogues, developing an internal Nurturing Parent, providing appropriate permission tailored to the specific needs of the client and developing problem-solving ability all appeared to be mediators of change in this case, which were moderated by the high cognitive resources of the client.

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

Table 5: Adjudication results

Conclusion

This case study provides evidence that the specified manualized TA treatment for depression (Widdowson, 2016) has been effective in treating a persistent depressive disorder. Despite results from a case study being difficult to generalize, this study adds evidence to the growing body of research supporting the efficacy and effectiveness of TA psychotherapy, and notably supports the effectiveness of the manualized TA psychotherapy for depression applied to persistent depressive disorder.

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

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Abstract

This study is the sixth of a series of seven and belongs to the second Italian systematic replication of findings from previous series that investigated the effectiveness of a manualized transactional analysis treatment for depression through Hermeneutic Single-Case Efficacy Design. The therapist was a white Italian woman with 10 years of clinical experience and the client, Beatrice, was a 45-year old white Italian woman who attended sixteen sessions of transactional analysis psychotherapy. Beatrice satisfied DSM 5 criteria for Major Depressive Disorder, Anxious Distress, with Dependent and Histrionic Personality Traits. The judges evaluated the case as a good outcome: the depressive and anxious symptomatology clinically and reliably improved over the course of the therapy and these improvements were maintained throughout the duration of the follow up intervals. Furthermore, the client reported significant change in her post-treatment interview and these changes were directly attributed to the therapy.

Key words

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

Introduction

This Hermeneutic Single-Case Efficacy Design (HSCED) is the sixth of a series of seven, and belongs to an Italian systematic replication of findings from previous case series (Widdowson 2012a, 2012b, 2012c, 2013, 2014; Benelli, 2016a, 2016b, 2016c, 2017a, 2017b, 2017c) and is conducted under the auspices of the project 'Transactional Analysis meets Academic Research in order to become an Empirically Supported Treatment: an Italian two-year plan for

publishing evidence of Transactional Analysis efficacy and effectiveness into worldwide recognized scientific journals', funded by the European Association for Transactional Analysis (EATA).

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

The aim of this study was to investigate the effectiveness of the manualised TA treatment of depression (Widdowson, 2016) applied to a major depressive disorder in comorbidity with anxious distress. The quantitative primary outcomes investigated were depressive and anxious symptomatology, the secondary outcomes were global distress and client-generated personal problems, which were analysed both quantitatively and qualitatively.

The present study analyses the treatment of 'Beatrice', a 45-year-old Italian woman with diagnosis of major depressive disorder in comorbidity with anxious distress, dependent and histrionic personality disorder.

Ethical Considerations

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

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

Methodology

Inclusion and exclusion criteria

Psychotherapists participating in this case series were invited to include in their studies the first new client with a disorder within the depressive spectrum as described in DSM-5 (Major, Persistent or Other Depressive Disorders) (APA, 2013) who agreed to participate in the research. Other current psychotherapy, active psychosis, domestic violence, bipolar disorder, active current use of antidepressant medication, alcohol or drug abuse were all considered as exclusion criteria. As the overall aim of this project is to study the effectiveness of TA psychotherapy in routine clinical practice, comorbidity is normally accepted and both inclusion and exclusion criteria are evaluated on a case by case.

Client

Beatrice is a 45 year-old white Italian woman who lives in a large metropolitan area in Italy. At the beginning of therapy she was living with her partner of five years, with whom she was trying to have a baby before finding out that she was not able to have biological children after many In Vitro Fertilizations (IVFs). Her relationship with this man was contaminated by his taking care (economically and emotionally) of the sister of his dead ex-girlfriend, who lived next door. Between sessions 3 and 4 Beatrice met another man with whom she fell rapidly in love and left her partner, but only between session 10 and 11 did she move into a new house by herself, even though her new partner slept in her house every night. Her new and actual

partner had a child from a previous relationship, who lived in a city far away from the father, who visited one or two weekends each month. Beatrice had never been single since she was 18 years old, and every relationship ended because she noticed the many problematic aspects of the current relationship and consequentially fell in love with somebody else. She had the tendency to lie to her current partner about her needs and feelings because she feared these would have made him break up with her and leave her alone, until she found a new man interested in her. Beatrice believed that she was only capable of making people she loved suffer. Nevertheless, she had many and very different long-lasting relationships. When she was younger she got pregnant by the then current partner but decided to abort because she did not love him anymore and because she was studying at university. She is a very intelligent and intuitive woman, she reported to be very good in her job and to like it, even though she felt embarrassed when she had to talk in front of her colleagues. She loves her parents but she had always felt to have been unwanted by them, especially by her mother. Her mother became pregnant with her when she was breastfeeding her first son, had at a very young age one year earlier. She loves her brother too, but she had always felt to be failing compared to him, even if he flunked at high school and she had always got the highest scores. She decided to start therapy after being addressed by her gynaecologist for her impossibility of having biological children.

Therapist

The psychotherapist is a 40 year-old, white, Italian woman with 10 years of clinical experience and who has a certification as Provisional Teaching & Supervising Transactional Analyst (Psychotherapy) (PTSTA-P). For this case, she received weekly supervision by a Teaching & Supervising Transactional Analyst (Psychotherapy) (TSTA-P) with 15 years of experience.

Intake sessions

The client attended three pre-treatment sessions (0A, 0B, 0C), which were focused on explaining the research project, obtaining consent, conducting a diagnostic evaluation according to DSM-5 criteria (American Psychiatric Association, 2013) and the TA model, developing a case formulation and a treatment plan, defining the problems she was seeking help for in therapy, as well as their duration and their severity (i.e., preparing the Personal Questionnaire, see later), and collecting a stable baseline of self-reported measure for primary (depression and anxiety) and secondary (global distress, personal problems) outcomes. In intake sessions she described as major symptoms: loss of pleasure, sadness for the incapacity to give birth, guilt, sleeping disorders, excessive anxiety, difficulties in talking to many people.

DSM 5 Diagnosis

During the diagnostic phase, Beatrice was assessed as meeting DSM 5 diagnostic criteria of moderate Major Depressive Disorder, Anxious Distress, Dependent and Histrionic Personality Disorder. She experienced depressed mood most of the day, nearly every day, for more than two weeks (criterion A1), decreased interest and pleasure in sexual activities (A2), decrease in appetite (A3), insomnia (A4), and feelings of worthlessness (A7) and diminished ability to concentrate (A8). Beatrice also met DSM 5 diagnostic criteria of anxious disorder: she experienced excessive anxiety and worry occurring more days than not for at least 6 months (A), she finds it difficult to control the worry (B), her anxiety and worries are associated with feeling keyed up or on edge (1), irritability (4) and sleep disturbance (6). According to the alternative model for personality disorder in DSM 5 Section III, a personality diagnosis was also conducted. This diagnosis allows for assessment of: 1) the level of impairment in personality functioning, and 2) pathological personality traits. Beatrice showed moderate impairment in the level of organization in the areas of identity, self-direction, and intimacy. She showed also personality traits of: emotional lability, anxiousness, separation insecurity, submissiveness, depressivity, attention seeking and impulsivity.

The therapist also administered the Millon Clinical Multiaxial Inventory-III (MCMI-III) (Millon, Davis, & Millon, 1997), which highlighted high self-defeating and extremely high anxiety levels.

Case formulation

TA Diagnosis

Beatrice presented with Be Strong, Try Hard, Hurry Up and Please Others drivers (Kahler, 1975) and the injunctions (Goulding & Goulding, 1976) Don't think (when taking important decisions), Don't exist (without others), Don't be yourself (be the person others want), Don't be intimate (do not share feelings), Don't want (because you do not deserve), Don't make it (because you cannot), and Don't feel (be overwhelmed). Beatrice's Racket System (Erskine & Zalcman, 1979) showed beliefs such as "I am wrong", "Others are more important than me", "I cannot be angry with others". Her repressed authentic, primary feeling is anger toward herself and her mother, covered by substitute, secondary feeling of emptiness and disappointment (English, 1971). Interpersonally, Beatrice tends to alternate dramatic roles (Karpman, 1968) of Victim (she will always feel unhappy and there is nothing she can do to change this), and Rescuer (worrying and taking care of the problems of her partners). Her life position is generally I'm Not OK, You're OK (Ernst, 1971).

Treatment plan

The treatment plan primarily focused on creating a therapeutic alliance, providing permission (Crossman, 1966) congruent with the client's injunctions, namely: *think*, *exist*, *be yourself*, *be intimate*, *want*, *make it*, and *feel*. During pre-therapy sessions, the therapist focused on creating a solid therapeutic alliance and understanding that her problems generate from a hyper-adjustment and devaluation of her needs. Then, the therapist focused on decontamination and deconfusion. From session nine she instead focused more on reappraisal, and a partial loss elaboration for her impossibility to give birth. For the entire therapy, the therapy worked on supporting Beatrice's recognition of the importance of understanding her needs and emotions and feeling them, exploring her experiences and analysing her script events, such as the relationship she had with her mother when she was a little girl, and with her previous and current partners.

Contract

Beatrice asked to learn to weigh what she thinks and feels and act congruently according to these, to not devalue her thoughts and her emotions, and to do not let others decide these for her and tell her what to do. In session 12, Beatrice and the therapist agreed upon creating a new therapeutic contract "about the building of this story, to undertake a path towards being a parent… on the theme of adoption" (S12, Line 123-126).

Notes on the case

When Beatrice started therapy, she was living in a very complicated situation: her current partner was taking care of the sister of his dead ex-girlfriend and was very tied to her family, whereas Beatrice did not like this situation. The client wanted to have children with him and after many attempts, she asked for IVF. She had quite a few IVF, paying them on her own, because her partner believed it was her problem, her responsibility to try to get pregnant. He was not open minded about adoption, so having a biological child was the only solution Beatrice had with him. Furthermore, she was sent by the gynaecologist with a diagnosis of depression for her incapacity to have children, to work on her loss elaboration. However, the therapist believed the etiopathology of her depression consisted in her difficulty to express emotions and in her tendency to act impulsively, and therefore believed that her depression was not directly tied to her infertility, but that the infertility influenced her self-image crisis which worsened her symptoms. For this reason, the therapist worked mainly on her emotions, and only afterwards, from session 12, on her loss elaboration.

Hermeneutic Analysis Team

The HSCED main investigator and first author of this paper is a PTSTA-P with 15 years of clinical experience, with a strong allegiance for TA. Despite recent literature suggesting that hermeneutic analysis should be carried out by expert psychotherapists (Wall et al, 2016), we believe that such indication is suitable when the research is investigating a new population or a therapy that lacks a research base. In our case, we preferred to follow the indication of Bohart (2000), who proposed that analyses can be carried out by a team of 'reasonable persons', not yet overly committed to any theoretical approach or professional role. The team comprised of six postgraduate psychology students who were taught the principles of hermeneutic analysis in a course on case study research at the University of Padua, by Professor John McLeod. Following the indication of Elliott et al. (2009), the students preferred to assume both affirmative and sceptic positions, and independently prepared their affirmative and sceptic cases. Then they met and merged their own cases, supervised by the main investigator, creating consensual affirmative and sceptic briefs and rebuttals.

Judges

The judges were three researchers at the University of Padua and co-authors of this paper: Judge A, Vincenzo Calvo, clinical psychologist, psychotherapist trained in dynamic psychotherapy, PhD in development psychology, with expertise in attachment theory; Judge B, Stefania Mannarini, psychologist with experience in research methodology; and Judge C, Arianna Palmieri, neuropsychologist and psychotherapist with a training in dynamic psychotherapy. Judge A and C had some basic knowledge of TA but had never engaged in any official TA training, whereas Judge B has some clinical experience but no knowledge of TA.

Measures

Statistical Analysis

All quantitative outcome measures were evaluated according to Reliable and Clinically Significant Change (RCSC) (Jacobson & Truax, 1991), where 'change' stands for an improvement (RCSI) or for a deterioration (RCSD). Clinical significance (CS) is obtained when the observed score on an outcome measure drops below a cut-off score that discriminates clinical and non-clinical populations. The PHQ-9 considers a score of ≥10 as an indicator of current moderate major depression (Kroenke, Spitzer & Williams, 2001). It is important to consider that even below the cut-off score there may be a subclinical disorder. The PHQ-9 considers a score between 0 and 4 an indication of healthy condition, and a score between 5 and 9 as an indicator of mild (subclinical) depression. Reliable Change Index (RCI) is a statistic

that enables the determination of the magnitude of change score necessary to consider a statistically reliable change on an outcome measure (Jacobson and Truax, 1991). In particular, it is helpful in minimizing Type I errors which occur when cases with no meaningful symptom change are assumed to have improved. Richards and Borglin (2011) proposed that a reduction of at least 6 points in the PHQ-9 score would be indicative of a reliable improvement. Only when we observe the presence of both CS and RCI do we have RCSC, which is considered a robust method for assessing recovery in psychological interventions (Evans, Margison & Barkham, 1998; Delgadillo, McMillan, Leach, Lucock, Gilbody & Wood, 2014). To control experiment-wise error which occurs when multiple significance tests are conducted on change measures, we consider that a RCSC is required in at least two out of three outcome measures, thus demonstrating a Global Reliable Change (GRC) (Elliott, 2015).

Quantitative Measures

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

Patient Health Questionnaire 9-item for depression (PHQ-9) (Spitzer, Kroenke & Williams, 1999) scores each of the nine DSM 5 criteria from 0 (not at all) to 3 (nearly every day), providing a total score of depression. It has been validated for use in primary care (Cameron, Crawford, Lawton, et al, 2008). Scores up to 4 are considered healthy scores of 5, 10, 15 and 20 are taken as the cut-off point for mild, moderate, moderately severe and severe depression, respectively. PHQ-9 score ≥10 has a sensitivity of 88% and a specificity of 88% for major depression (Kroenke, Spitzer, & Williams, 2001) and scores of <10 are considered subclinical. A change of at least 6 points on PHQ-9 score is considered to assess a reliable improvement or deterioration (RCI).

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

Spitzer, Williams, et al, 2007). A change of at least 4 points on GAD-7 score is required in order to assess a reliable improvement or deterioration (RCI).

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

The *Personal Questionnaire* (PQ) (Elliott, Shapiro, & Mack, 1999; Elliott, Wagner, Sales, Rodgers, Alves & Café, 2016) is a client-generated measure in which clients specify the problems they would like to address in their therapy and rate their problems according to how distressing they are finding each problem (1, not at all; 7, maximum possible). Scores up to 3.25 are considered subclinical. In this case series, missing the Italian normative score, for the PQ we adopted a more conservative RCI of two points, rather than the RCI of 1.67 recently proposed by Elliott et al. (2016). The PQ procedure suggests including problems from five areas: symptoms, mood/emotions, specific performance or activity (e.g., work), relationships and self-esteem/internal experience.

Qualitative Measure
The client was interviewed using the Change Interview protocol (CI) (Elliott, Slatick & Urman, 2001) one month after the conclusion of the therapy. The CI is a semi-structured qualitative change measure which asks clients how they feel they have changed during the therapy and how they think these changes came about, what they felt was helpful or hindering in the therapy, and what changes they feel they still need to make. Clients are asked to identify key changes they made and to indicate on a five-point scale: 1) if they expected to change (1=very much expected; 5=very much surprising); 2) how likely these changes would have been without therapy (1=very unlikely; 5=very likely), and 3) how important they feel these changes to be (1=not at all; 5=extremely).

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

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

Adherence
The therapist, the supervisor, and the main researcher were all transactional analysts and they each independently evaluated the therapist's adherence to TA treatment of depression using the Operationalized Adherence Checklist proposed by Widdowson (2012a, Appendix 7, p. 53-55) and agreeing on a final consensus rating.

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

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

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

- If the client had changed;

- To what extent these changes had been due to the therapy;

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

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

Results
In earlier published HSCED's the rich case records, along with hermeneutic analysis and judges' opinions were often provided as online appendices (Benelli et al., 2015). Since all the material is in Italian language,

we adopted here the solution of providing a summary of the main points, as proposed in MacLeod, Elliott and Rodger (2012). The complete material (session transcriptions, CI, affirmative and sceptic briefs and rebuttal, judge opinions and comments) is available from the first author on request.

Adherence to the manualized treatment

The conclusion of the three evaluators was that the treatment had been conducted coherently according to TA theory at a good to excellent level of application.

Quantitative Data

PHQ-9, GAD-7 and CORE-OM were administered in the pre-treatment phase in order to obtain a three-point baseline, and during the three follow-ups, whereas PQ was first administered in session 0C.

Beatrice's quantitative outcome data are presented in Table 1. The initial depressive score (PHQ-9, 11) indicated a moderate level of depression. The initial anxiety score (GAD-7, 9.7) indicated a mild level of anxiety. The global distress score (CORE, 11.6) indicated a mild level of global distress and functional impairment. The severity score of personal problems (PQ, 5.3) indicated that the client perceived her problems as bothering her more than considerably.

At session 8, (mid-therapy), depression remained unaltered (11), anxiety increased to moderate level (12), global distress increased to a moderate level (15.9), and personal problems decreased to little bothering (3.5).

By the end of the therapy, the depressive score passed to a mild range (7), anxiety obtained a clinically improvement passing to a mild level (7), global distress obtained a reliable and clinically significant improvement (RCSI) passing from a moderate to low level of distress (8.8), and the personal problems reached RCSI becoming very little bothering (2.7).

At the 1-month follow up: depressive scores remained in the mild range (7), anxiety score obtained a RCSI in the mild range (5), the global distress maintained its low level score (8.2), and personal problems remained as very little bothering (2.5).

At the 3-month follow up all scores improved obtaining RCSI: depression reached RCSI passing to a healthy range (0), anxiety passed to a healthy level (0), global distress entered healthy range (1.8), and personal problems became not bothering at all (1.1).

At the 6-month follow up depression, anxiety and global distress remained in the healthy range, maintaining clinically significant and reliable change, whereas personal problems became very little bothering (2), however still with RCSI. All measures maintained RCSI by the end of therapy.

	Pre-Therapy[a]	Session 8 Middle	Session 16 End	1 month FU	3 months FU	6 months FU
PHQ-9	**11** **Moderate**	**11** **Moderate**	7 (+) Mild	7 (+) Mild	0 (+)(*) Healthy	2 (+)(*) Healthy
GAD-7	9.7 Mild	**12** **Moderate**	7 (+) Mild	5 (+)(*) Mild	0 (+)(*) Healthy	0 (+)(*) Healthy
CORE-OM	**11.6** **Mild**	**15.9** **Moderate**	8.8 (+)(*) Low level	8.2 (+)(*) Low level	1.8 (+)(*) Healthy	4.1 (+)(*) Healthy
PQ	**5.3**[b] **Considerably**	**3.5** **Little**	2.7 (+)(*) Very little	2.5 (+)(*) Very little	1.1 (+)(*) Not at all	2 (+)(*) Very little

Note. Values in **bold** are within the clinical range; + indicates clinically significant change (CS). * indicates reliable change (RC). FU = follow-up. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999). GAD-7 = Generalized Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006). CORE = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002). PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off points: PHQ-9 ≥10; GAD-7 ≥10; CORE-OM ≥10; PQ ≥3.25. Reliable Change Index values: PHQ-9 variations of six points, GAD-7 variation of four points, CORE-OM variation of five points, PQ variation of two points.
[a]Mean score of pre-treatment measurements.
[b]First available score in session 0C.

Table 1: Beatrice's Quantitative Outcome Measure

	PQ items	Duration	Pre-Therapy[a]	Session 8 (middle)	Session 16 (end)	1 month FU	3 months FU	6 months FU
1	I've many feelings of guilt that I'm not able to deal with	6-10y	5 Considerably	5 Considerably	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
2	I've the feeling that I'll always be sad and that there is no way to solve this situation	6-10y	6 Very considerably	4 (*) Moderately	4 (*) Moderately	3 (+)(*) Little	1 (+)(*) Not at all	2 (+)(*) Very little
3	I've difficulties in planning my future	>10y	7 Maximum possible	4 (*) Moderately	4 (*) Moderately	4 (*) Moderately	1 (+)(*) Not at all	3 (+)(*) Little
4	I'm angry because life deprived me of the joy of being a mother	>10y	7 Maximum possible	4 (*) Moderately	4 (*) Moderately	5 (*) Considerably	2 (+)(*) Very little	5 (*) Considerably
5	I'm not able to adapt myself to some daily social circumstances (i.e. spend time with people I don't like)	6-10y	5 Considerably	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
6	In the current time my sexual desire is lacking ("I've difficulties to make love for myself")	1-2y	7 Maximum possible	2 (+)(*) Very little	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
7	I'm worried for the future of my relationship ("I'm not able to see myself in a couple without kids, maybe I should stay single?")	1-2y	7 Maximum possible	4 (*) Moderately	5 (*) Considerably	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all
8	I'm not able to believe in my work abilities	>10y	5 Considerably	2 (+)(*) Very little	1 (+)(*) Not at all	3 (+)(*) Little	1 (+)(*) Not at all	2 (+)(*) Very little
9	I struggle to assume my responsibilities	>10y	4 Moderately	5 Considerably	4 Moderately	3 (+) Little	1 (+)(*) Not at all	2 (+)(*) Very little
10	I've sudden states of anxiety, especially during the night	1-2y	4 Moderately	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all
								Cont/

	PQ items	Duration	Pre-Therapy[a]	Session 8 (middle)	Session 16 (end)	1 month FU	3 months FU	6 months FU
11	I feel awkward talking in front of an audience	>10y	**4** **Moderately**	**5** **Considerably**	2 (+)(*) Very little	**4** **Moderately**	1 (+)(*) Not at all	**4** **Moderately**
12	I suffer because mom disappointed me	>10y	3 Little	**4** **Moderately**	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
	Total		**64**	**42**	32	30	13	24
	Mean		**5.3** **Considerably**	**3.5** **Little**	2.7 (+)(*) Very little	2.5 (+)(*) Very little	1.1 (+)(*) Not at all	2 (+)(*) Very little

Note. Values in **bold** are within clinical range. +=indicates clinically significant change (CS). *=indicates reliable change (RCI). m = months. y = year. FU= follow-up. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off point: PQ ≥3.25. Reliable Change: PQ variation of two points. The rating is on a scale from 1 to 7 and indicate how much each problem has bothered the client: 1 = not at all; 7 = maximum.

[a]The first available score was in session 0C.

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

Session	Rating	Events	What made this event helpful/important
1	9 (extremely)	The therapist asked me to explain and understand how I feel.	I feel, now, <u>aware</u> about what I feel which must be understood for what it is, namely myself.
2	8 (greatly)	The event is tied to a request of the therapist about my lack of trust in myself in important situations. I don't act according to what I know I want.	It has been possible to reinterpret some events/behaviours from another perspective. It's not easy to mirror and immediately see yourself for what you are. It's something which I have many difficulties in doing, but that I feel useful for me.
3	8 (greatly)	The session has been very intense. Repeatedly I had the sensation of falling through space and losing myself in the incapacity of coming to decisions and the opposite sensation to be able to do and decide what I want in my life	The therapist felt my insecurity and helped me to look inside me from different sides. The important event and what made it so important has been when I asked the therapist to help me to come to decisions and instead I understood that everything depends on me.
4	8 (greatly)	The last session has been narrative (coming back from the summer break). I found myself giving explanations and telling important events that changed my life in the last month. I came to some important decisions that make me feel good.	It's nice to stay with yourself.
			Cont/

Session	Rating	Events	What made this event helpful/important
5	9 (extremely)	During the session we talked about the management of the end of my relationship and, even though until last week I was feeling that I was satisfying myself by that decision and facing it, I understood that I'm repeating some behaviours and ways of agreement with my ex-partner, which give me anger, a feeling of suffocation and the feeling that I'm being managed by others, which should be appropriate to deal with.	First of all, I immediately reacted and came to some decisions I felt right until the session. I don't like not being able to control myself any more and subordinating my desires to others' expectations.
6	9 (extremely)	During the current session I spoke about an emotion which made me call into question important decisions. Solicited by the psychologist I recalled similar situations where the emotions (positive and negative) led me to not thoughtful decisions.	I understood that I need to learn to deal with/accept/live with/understand the emotions of this type without feeling at the mercy of them.
7	7 (moderately)	The therapist prompted me to reflect about my perception of having always made people who loved me suffer, especially my men.	I recalled the events tied to different moments of my life. Especially, my relationship with my mother. I feel extreme difficulty to talk about my mother like the responsible or the cause of some problematics tied to the growth of my personality. It's something that doesn't put me at ease and gives me feelings of guilt.
8	-	It's been a very complicated session. It's difficult to describe an event, maybe the entire session was an event. I felt emotionally fragile especially when the therapist asked me to give voice to the mom inside me.	I'm not sure what I got out of this. I felt in a liquidiser of different emotions. Sadness for being a missed mother. Anger because I'd want to be a less severe mother with myself. I've also felt an inadequate mother because I'm unable to give myself the self-confidence I need.
9	8 (greatly)	During the session I talked about an episode of my childhood after which I started to use some strategies that the therapist defined as "adaptive solutions", explaining to me what it meant.	I realized that until today I apply "adaptive solutions" in order to try to face difficulties and emotionally complicated situations that I'm not able to resolve and deal with in other ways. I understood that I don't like these situations and adaptive behaviours anymore. I understood that I don't want to adapt but face situations and people engaged in a more mature way.
10	8 (greatly)	During the session we discussed about my difficulty to face the situations when I imagine all possible scenarios. The tendency is to imagine only the extremity (white or black). The therapist made me notice that it's possible to think for intermediate steps and then face complex situations with different methods from the ones I currently use.	It has been useful especially because it gave me the possibility to behave in different ways, which considerably decreased my anxious states, whereas my solutions made them increase.

Session	Rating	Events	What made this event helpful/important
11	8 (greatly)	We faced the theme of maternity and of my suffering for the possibility to become a mother, naturally or biologically, and of the fear to imagine a different solution for me, like adoption.	The important event consists in understanding that imagining this different possibility for me is the beginning of a probable path. Nevertheless, it's a thought that tastes like planning the future. A constructive attitude that, beyond its realization, makes me feel good.
12	9 (extremely)	The most important event has been gaining the awareness of my capacity of calling myself into question and of being ready to change my life (house, job, city) in order to follow a goal, a project. Maybe it's the awareness of the fact that I can have a project to be the <u>event</u> for me.	The event is extraordinarily useful because I had a strong feeling that I'm still able to breath with my lungs. To take deep breaths and look at my future life with curiosity and joy. I don't have that feeling of being condemned to unhappiness and loneliness anymore.
13	8 (greatly)	During the session we discussed about the relationship between me, my partner and his son. In particular, I focused that I have to protect myself not only from the daydream, but also to build a family unit. The event consists in identifying brightly that mom, dad, and son are a family.	I understood that lately I have to work on that aspect of my relationship. I feel that I need to protect myself from false illusions, that give me great suffering.
14	8 (greatly)	During the session we mainly discussed about the relationship between me, my partner and his son and to the right attention I have to give to the emotional part to deal with this relationship. I wouldn't say that an event occurred, even though I clarified further the critical aspects that need to be clarified and faced to maintain my relationship and myself from unsolved business and never fully examined.	The discussion certainly helped me to consider with more attention the important elements to build a relationship.
15	8 (greatly)	In particular, a question struck me, also frequent even in other sessions, which is to try to understand how I feel about events that concern me personally.	What strikes me every time but this time with more evidence, is the difficulty that I have when they ask me this question. It's difficult for me to read inside myself, because sometimes what I feel, how I feel, do not correspond with what I'd want or I should feel and I feel inconclusive and immature.
16	8 (greatly)	It struck me about the question of the therapist about my method of coming to the decision of breaking up a relationship and to my decisions at the bottom of these breaking ups.	I understood that I come to decisions according to strong emotions that determine them and that change reality or the perception that I have in a very short time. I have to give myself the possibility to understand the weight and the importance of the emotions I feel in order to come to a decision in a more tranquil way.

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

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

|	Change	How much expected change was [a]	How likely change would have been without therapy [b]	Importance of change [c]
1	I'm able to have no feelings of guilt	1 (very much expected)	1 (very unlikely)	5 (extremely)
2	Plan the future	5 (very much surprised)	3 (neither likely nor unlikely)	5 (extremely)
3	I'm able to deal with strong emotions	1 (very much expected)	1 (very unlikely)	5 (extremely)
4	I have no more anxious states (panic)	1 (very much expected)	1 (very unlikely)	4 (very)
5	I've been able to assume the responsibility for my decisions	1 (very much expected)	1 (very unlikely)	5 (extremely)

Note. CI = Change Interview (Elliott et al., 2001).
[a]The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very much surprising. [b]The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely. [c]The rating is on a scale from 1 to 5; 1 = not at all, 3 = moderately, 5 = extremely.

Table 4: Beatrice's Changes identified in the Change Interview
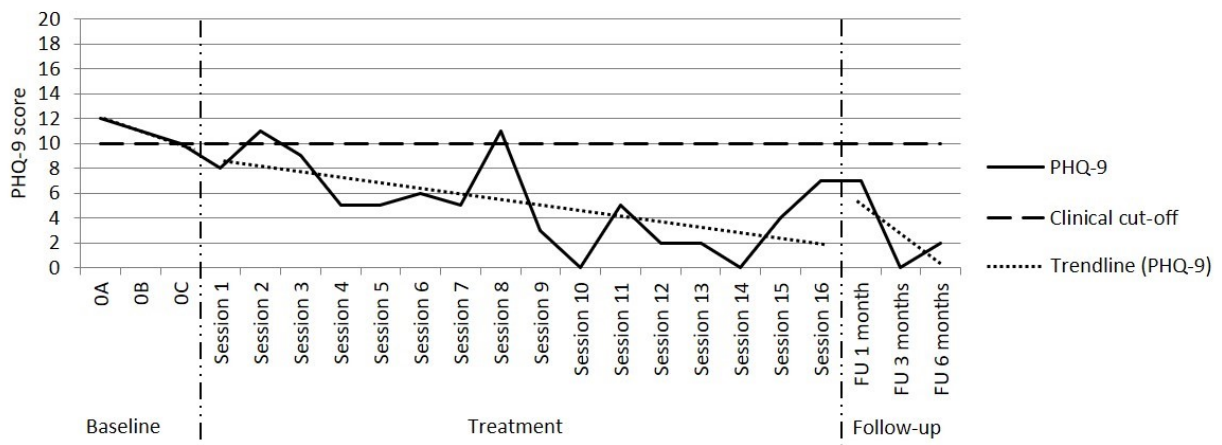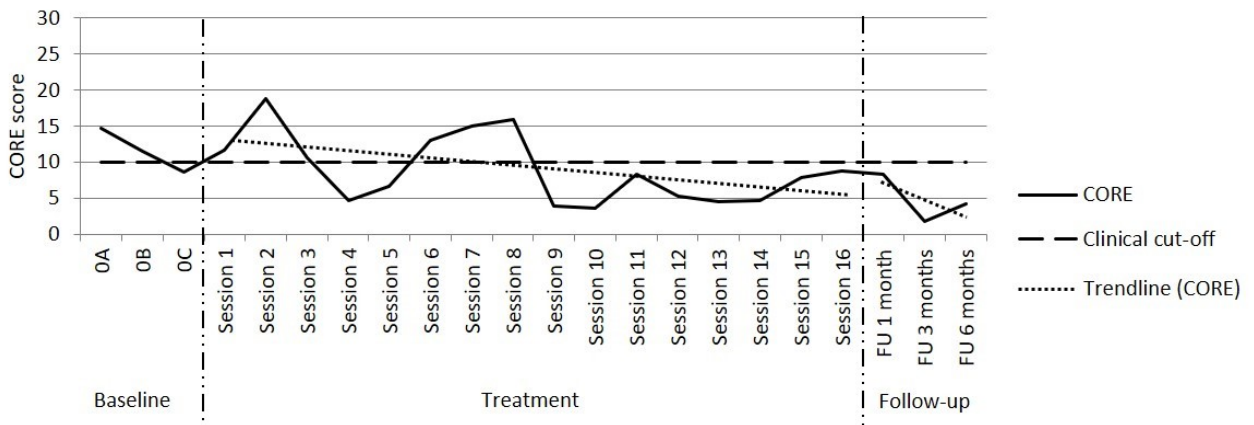

Note. 0A, 0B and 0C = assessment sessions. FU = follow-up. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999).

*Figure 1: Beatrice's weekly depressive (PHQ-9) score*
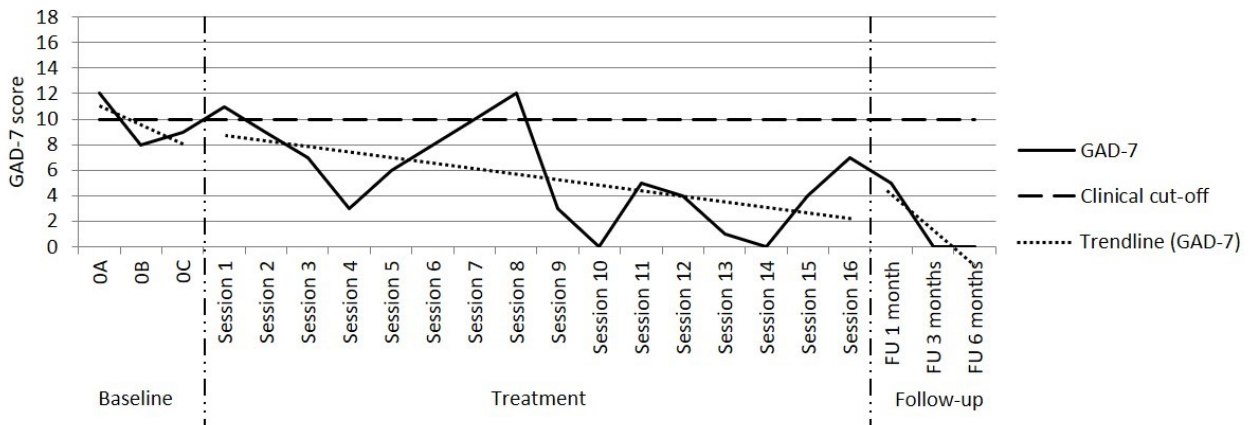
Note. 0A, 0B and 0C = assessment sessions. FU = follow-up. GAD-7 = Generalized Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006).

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

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

Figure 3: Beatrice's weekly global distress (CORE) score
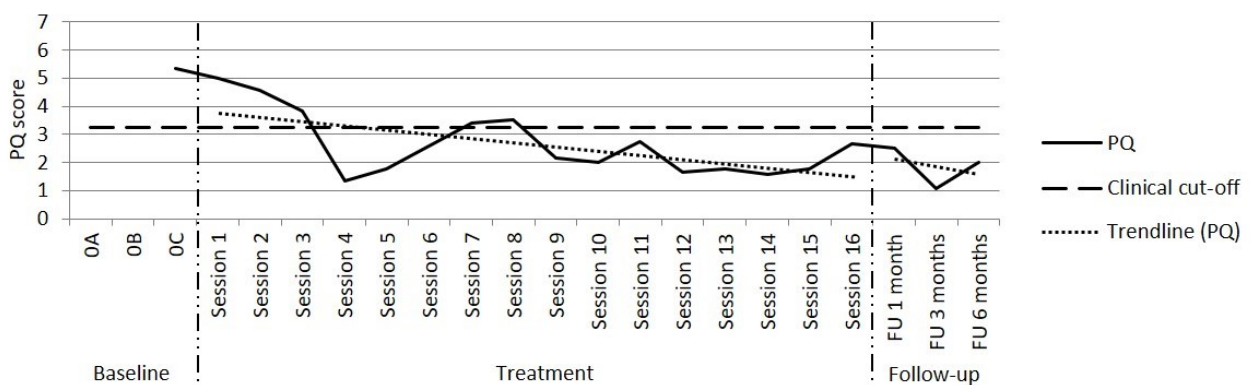
Note. The first available score was in assessment session 0C. 0A, 0B and 0C = assessment sessions. FU = follow-up. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999).

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

Table 2 shows the 12 problems that the client identified in her PQ at the beginning of the therapy and their duration. Four problems were rated as maximum possible bothering, one was rated very considerably, three considerably bothering, three were rated moderately bothering, and one little bothering. Six problems lasted from more than 10 years, three as lasting from 6 to 10 years, and three as lasting from 1 to 2 years. Seven out of twelve problems showed a clinically significant and reliable change by the end of the therapy and four obtained reliable change. In the 1-month follow up nine problems reached RCSI and two obtained reliable change whereas all problems reached a clinically significant and reliable change in the 3-month follow up. In the 6-month follow-up, ten problems maintained clinically significant and reliable change.

Problems are related to: symptoms (1 guilt, 10 anxiety); mood/emotions (2 sad, 4 angry, 6 sexual desire lacks, 12 suffer); specific performance/activity (8 work abilities, 11 talking to an audience); relationships (5 adapt to social circumstances, 7 worried for relationship); self-esteem and inner experience (3 planning future, 9 responsibilities).

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

Qualitative Data
Beatrice compiled the HAT form at the end of every session (Table 3), reporting only positive/helpful events. All positive events were rated from 7 (moderately helpful) to 9 (extremely helpful) as reported in Table 3. Beatrice also reported other helpful events in session 5 ("The therapist asked me why I thought about the IVF like a path/problem that was only about me and not the couple. The question was asked because I thought I had to deal with the costs on my own"), 7 ("Always about my relationship with my mother, I had the opportunity to reflect on my thoughts of use I made with truth/lies in my interpersonal relationships"), and 12 ("The event consists in creating a new therapy contract with the therapist. The contract is about my path towards the possibility to face with my partner the creation of our family through adoption"). She reported aspects on:

- symptoms (HAT 10, "decreased my anxious states");

- mood/emotions (HAT 1, "understand how I feel"; HAT 3, "sensation of falling through space"; HAT 6, "deal with emotions"; HAT 8, "liquidiser of emotions"; HAT 12, "no more condemned to unhappiness"; HAT 15, "what I feel, how I feel"; HAT 16, "come to decisions according to strong emotions");

- relationships (HAT 9, "I don't want to adapt"; HAT 14, "critical aspects that need to be clarified and faced");

- self-esteem and inner experience (HAT 2, "lack of trust in myself"; HAT 4, "decisions that made me feel good"; HAT 5, "don't like subordinating what I want"; HAT 7, "difficulty to talk about my mother like the responsible"; HAT 11, "planning future makes me feel good"; HAT 13, "protect myself from day dreams/illusions").

Beatrice participated in a Change Interview 1 month after the conclusion of the therapy. In this interview, she identified five main changes (Table 4). She was very much surprised (5) by one but was not sure whether this was due to therapy (3). Beatrice very much expected (1) four changes, that would have unlikely occurred without therapy (1), and rated one change as very important (4) and four changes as extremely important (5).

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

1. Change in stable problems
Quantitative data (Table 1) shows that there is an improvement in primary outcome measures: depression (PHQ9) with RCSI from session 9 until session 15, regained in the 3-month follow up; anxiety (GAD-7) reached RCSI in session 9 until session 15, re-obtained in the 1-month follow up. There is also RCSI in personal problems (PQ, Table 2) from session 9, maintained until the end of therapy and in the follow-up period. In her PQ, Beatrice identified 12 main problems at the beginning of the therapy that she was trying to solve, four rated as bothering her maximum possible (7), one very considerably (6), three considerably (5), three moderately (4) and one little. All the problems referred to issues with symptoms, mood/emotions, specific performance/activity, relationships, and self-esteem and inner experience. At the end of the therapy seven problems out of twelve dropped under the clinical cut off reaching RCSI, and four other problems gained reliable improvement. At the 1-month follow up, ten problems reached reliable change and nine gained also clinical improvement. At the 6-month follow up all problems gained RCSI. Overall, there is support for a claim of global reliable change (reliable change in four out of four measures) for long standing problems. Qualitative data supports this conclusion: in the Change Interview, Beatrice reports that "there have been many changes" (Line 417). Regarding her depressive symptoms, she stated: "before I thought that anything was my fault, now I understood that this is not true" (L187-192), and that she has no more feelings of guilt, an aspect that

gained a stable RCSI in her PQ in session 12, maintained throughout the follow-ups. About anxiety symptoms, she explained: "I'm not suffering with anxiety attacks" (L364), "when I started therapy my anxiety was the highest possible… there has been an improvement" (L417-421). Beatrice also reported changes in her emotions: about her anger for the inability to become a biological mother, she said "I'm not angry anymore, I'm trying to live with this" (CI, L412-415). She added that making love (item 6 of the PQ) "is not a problem anymore" (L405). Moreover, during therapy, Beatrice realized that she has always acted following strong emotions she currently felt, whereas now she gives herself the permission to think, to be aware and to be able to deal with these emotions (L444-447): "I listened [to the therapist] and followed your advice, giving me the time to think without coming to any quick decision based on emotions" (FU1, L3-5), "with hindsight I could have taken this time even in the past" (L22-23). Regarding Beatrice's difficulties in relationships (item 5 of the PQ), she stated: "I thought I was antisocial, now I don't have these problems anymore… the meaning of this item changed" (L355-357). Finally, according to Beatrice's self-esteem problematics, she reported different changes. First of all, she said "I make more thoughtful decisions, before therapy everything seemed a tragedy… I had the incapacity to deal with confrontations… terror... now it's a lot less" (L67-72). Second, that she learnt "a different capacity to understand myself, I'm more tranquil when facing problems that first I believed to be insurmountable (CI, L455-458). At last, in her CI she rated being able to plan the future (item 2 of the CI, also present as item 3 in the PQ) as an extremely important (5) change she was trying to solve for more than 10 years. Thus, we claim that Beatrice obtained a stable RCSI in Major Depressive Disorder, in anxiety, in global distress and in personal problems, claiming a Global Reliable Change.

2. Retrospective attribution

In her Change Interview, Beatrice looked back at her PQ, and reported that four out of five main changes would have very unlikely occurred without therapy. (Table 4). Beatrice was very much surprised by only one change ("plan future"), which she is not sure whether this is due to therapy or not, however rating it as extremely important. In her HAT forms (Table 3, i.e. S5, "the therapist asked me why I thought about IVF like a path/problem that was only about me"; S9, "I started to use some strategies that the therapist defined as 'adaptive solutions'"; S10, "the therapist made me notice that it's possible to think for intermediate steps"; and S15, "a question… which is to try to understand how I feel") Beatrice reported some interventions of the therapist that reflect changes in her way of behaving and coping with herself. Regarding her symptoms, in her CI she attributed to

therapy having no feelings of guilt, and no more anxious states (very unlikely without therapy). About her mood/emotion problematics, she reported that "with the therapist I've been able to know myself… that I act following strong and impulsive emotions without reflecting… whereas now I reflect" (L54-61). The questions of the therapist forced me to reflect, to understand and adapt (L279-281), "she told me 'it seems like you are giving up living in the present'… it's like if she opened a gash… when you hear it, you realize that it's exactly true" (L296-300). Furthermore, "the therapist told me things that made me feel and understand what I felt and how I should have felt… I obtained self-awareness" (L305-308). In session 12, Beatrice stated that therapy also helped her in her relationship: "the work we are doing here on me, is useful for the couple, this is the difference from previous relationships" (S12, L275-279). Finally, according to her CI, Beatrice attributed to therapy also changes in self-esteem: "therapy has been useful for me in order to exchange views, understand things about me (CI, L35), "exchanging views with someone makes you realize that your perception of some problematic aspects is different" (L41-42), "feeling that there was someone that listened to me and took care of me by asking me 'how do you think to take care of this?'… she threw me into crisis because I've never thought about taking care of myself" (L312-316).

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

A change in Beatrice's problematic area of mood/emotions, which was her therapeutic contract, has been observed. She learnt to give herself time to think before acting according to strong emotions, which is mirrored to specific interventions of decontamination and reappraisal in seven HAT forms (Table 3), specifically in HAT 1, ("understand how I feel"), HAT 3 ("sensation of falling through space"), HAT 6 ("deal with emotions"), HAT 8 ("liquidiser of emotions"), HAT 12 ("no more condemned to unhappiness"), HAT 15 ("what I feel, how I feel"), HAT 16 ("come to decisions according to strong emotions"). Furthermore, Beatrice reported changes in self-esteem which allowed her to increase her self-esteem and be able to cope more with her dependency traits, reflected in insights during session reported in six HAT forms: HAT 2 ("lack of trust in myself"), HAT 4 ("decisions that made me feel good"), HAT 5 ("don't like subordinating what I want"), HAT 7 ("difficulty to talk about my mother like the responsible"), HAT 11 ("planning future makes me feel good"), HAT 13 ("protect myself from day dreams/illusions").

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

The PQ mean score shows a progressive decrease in severity of her problems from the initial score (5.3,

more than considerably) to the final score (1.1, not at all bothering). In session 1, they worked on Beatrice's difficulty in spending time with people she does not like (PQ, item 5) connecting with an episode that had occurred in the previous week. From this event until session 8, the therapist connected to Beatrice's low self-esteem and her dependency traits focusing on helping Beatrice becoming more aware of how she decides to give no importance to her needs (model of Schiff, from therapist's notes, S1). Especially in session 8 the therapist asked Beatrice how she felt (L509): "scared" (L513), and the therapist continued "what do you do with a frightened child?" (L514), she answers "you reassure him" (L515), "how can you do that without denying your own thoughts and needs?... if you had been in his [her partner] situation, what would you have done?" (L516-524). In fact, in the 1-month follow up, Beatrice reports having understood that what she wanted was not finding a place where she could live on her own, but finding a way to recover things she feels she needs (FU1, L52-56). In the second part of the therapy, the therapist focused more on Beatrice's emotions and on reappraisal techniques, giving Beatrice the awareness that her partner's child is not their son, and on giving Beatrice the permission to imagine other possible scenarios in which she could be the mother of someone, through adoption. In fact, when her partner's child called her "mom" and her partner was happy for it, she realised that that was inappropriate and protected herself from further contamination and tangling with others' emotions and wishes (FU1, L256-257). Furthermore, Beatrice arrived in session 16 very discouraged, with the intention to break up with her partner on that same night. During the session they worked on her tendency to follow the current strong emotion without reflecting on her needs and wishes. This led Beatrice to the thoughtful decision of not following those strong emotions on the spot, and at the 3-month follow up she confirmed to have "maintained her commitment with herself" (FU2, therapist notes). Moreover, for the entire therapy the therapist focused on decontaminating her belief that she makes everybody suffer who loves her, especially men. The affirmative team believes that empathic listening has been fundamental for Beatrice to improve in problematic areas of emotions and self-esteem: "feeling that there was someone that listened to me and took care of me" (CI, L312-314). Beatrice also reported that therapeutic interventions made her "feel and understand what I felt and how I should have felt" (CI, L305-307). Furthermore, the therapist nourished Beatrice's independent traits, giving her the permission to believe in herself and in her emotions, allowing her to feel her own emotions, and not others'. This is reflected in HAT 2 ("request of the therapist about my lack of trust in myself"), and 3 ("the therapist felt my insecurity and helped me to look inside me… when I asked the therapist to help me to come to

decisions and instead I understood that everything depends on me").

Sceptic Case

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

The client entered the trial with moderate depression (PHQ-9, score 11), barely over the threshold for major depressive disorder and mild level of anxiety (GAD-7, score 9.7). Besides, all measures have a sawtooth wave trend, which might reflect Beatrice's affective lability, therefore quantitative data might be unreliable. Furthermore, all measures RCSI in session 4, after having broken up with her current partner, turned to pre-therapy or higher in session 8, when her ex-partner was leaving the State and she thought that her current partner would not have allowed her to go to a goodbye dinner with his friends, and then dropped back to RCSI in the following session. Moreover, the sceptic team found different contradictions in the client's data. In the CI protocol, she wrote "plan future" as one of the main changes, whereas during the interview she reported "I have many difficulties in thinking… planning the future" (CI, L102), and in her PQ the score to item 3 ("I've difficulties in planning my future") was rated as moderately bothering (4). Furthermore, Beatrice reported to have started to try to have kids from two years ago, and that when she got pregnant ten years before she did not want to have children. For this reason, the sceptic team believes that the duration of the fourth item of the PQ is not 'from more than 10 years' but more probably 'from 1 to 2 years', supporting the hypothesis that quantitative measures might be unreliable. Qualitative data reflects absence of change and no attribution to therapy for Beatrice's problematic areas. She reported that she found useful having someone that listened to her (CI, L312-314), therefore it is possible that therapeutic techniques might not have been the cause of any improvement in Beatrice. She also stated that she was not feeling at ease when talking in a negative way about her mother (CI, L325-330), an aspect that led to a break up in the therapeutic alliance in session 7. Regarding Beatrice's mood/emotion problems, during therapy she did not face her difficulty noted on item 6 ("In the current time my sexual desire is lacking"), which vanished since she met the man for which she left her partner between sessions 3 and 4. Moreover, she reported having sought therapy to alleviate the suffering of not being able to have any biological child (CI, L202-204), which has been faced in the specific only from session 12, leading to no reliable improvement since the new therapy contract, and still being "a little bit emphasized" (L227) in the 1-month follow up. About her problems in specific performance/activity, Beatrice and the therapist did not work on both of those items of the PQ, respectively

item 8 ("I'm not able to believe in my work abilities") and 11 ("I feel awkward talking in front of an audience"), and in the CI she stated "I'm considered quite good in my job but I don't have this feeling of myself, I don't like talking to an audience… it puts me in extreme difficulty and embarrassment" (CI, L141-143), therefore any improvement in these items cannot be due to therapy. Finally, Beatrice's dependence traits of personality did not change, which is mirrored in her still present tendency and script behaviour to break up every unhappy relationship only after having met another man, just like she left every previous partner.

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

All quantitative data baseline showed a decrease already in the assessment phase, which could lead to the conclusion that change would have happened anyway, even without therapy.

3. The apparent changes reflect relational artefacts such as global 'hello-goodbye' effects on the part of a client expressing his or her liking for the therapist, wanting to make the therapist feel good, or trying to justify his or her ending therapy.

In her CI, the client reported no hindering aspects of therapy (CI, L322-323), and in the HATs she never pointed out any hindering aspect, not even when the therapist tried to work on her early age problematics with her mother in session 7, leading to a break-up in the therapeutic alliance. In fact, the sceptic team believes that quantitative data is unreliable not only for Beatrice's dependency traits, but also for her tendency to be compliant with others because of her fear of losing the relationship whenever she expressed different emotions and behaved differently from what she believed others expected. Her tendency to 'Please Others' might be at the base of her scores' decrease in all quantitative measurements in the follow ups. In fact, in the CI she said that she had no suggestions for the therapy because "the therapist has been very good, so there is no need" (CI, L340-341). Furthermore, this 'compliance effect' is mirrored in all Beatrice's HATs, where she rated fourteen sessions from 'greatly' to 'extremely' helpful, whereas in the therapist's notes all sessions are rated 'slightly' or 'moderately' helpful.

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

In her CI, the client reported four problems out of five as 'very much expected', therefore it is probable that expectancy artefacts are at the base of Beatrice's apparent changes. Furthermore, an immediate decrease in quantitative data from the assessment

phase might also be explained with her extreme faith in therapy. Moreover, the client has been sent to the therapist from her gynaecologist as a support for her incapacity to have biological children, so for this reason she could have had expectations thanks to the medical advice.

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

According to the considerations made in the first sceptic point, Beatrice sought therapy to solve her impossibility to be a biological mother, which was lasting from no more than one month before the beginning of therapy. Her depressive and anxious state seems tied to this biological incapacity, therefore Beatrice's diagnosis could be incorrect. The sceptic team suggests an adjustment disorder diagnosis: the client discovered her impossibility to give birth straight before beginning therapy, which might have led to a self-image crisis and consequentially to depressive and anxious symptoms. However, during therapy, Beatrice and the therapist did not work on this problem until session 12, and the PQ item (4) tied to this problematic remained mainly over the clinical cut off for thirteen sessions, and also in the 1-month follow up, whereas her depressive and anxious state decreased. Any loss elaboration for the impossibility to be a biological mother is not due to therapeutic interventions, but to the reverting to a normal baseline thanks to the flow of time. Therefore, Beatrice might have improved without therapy.

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

In the CI she stated that "my life has changed generally… I'm not sure how much is due to therapy, I haven't understood this" (CI, L49-51). In particular, as already explained in the first point of this case, it seems that Beatrice is at the mercy of the many extra-therapeutic events that happen and involve her personally. Beatrice left her partner with whom she was having many different problems (planning future with him, living with him, his consideration that infertility was only her problem, his strong attachment to his dead ex's sister and family, her anxieties at night correlated to her lack of desire to have sex with him, their difficulty in communicating and listening to each other's need and wishes) and started a relationship with a man that she felt to be very close to her needs, who gave her the attention she needed, and who understood straight away her emotions. In fact, there is RCSI from session 4 (when she left her previous partner). Furthermore, when Beatrice moved to a new house to live on her own for the first time in her life, she reported feeling independent and happy (S10, L43). Moreover, in session 12 she received a marriage

proposal in order to have the possibility to ask for adoption, which might have led to a reversal of the crisis of Beatrice's self-image, and an improvement in quantitative measurements might be due to extra-therapeutic events.

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

At the beginning of the treatment, Beatrice used to take alprazolam for her anxiety and difficulties in sleeping at night (CI, L31). Therefore there is no evidence that improvements in the client are tied to therapeutic interventions and not to psychopharmacological effects.

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

The histrionic and dependent traits of the client could have had a role in Beatrice's CI due to the presence of a different person. Furthermore, Beatrice reported to have started working as a researcher for a short period of her life, and this might have led her to be compliant to research itself.

Affirmative Rebuttal

1. We claim that four out of four measures support a claim in favour of Global Reliable Change. Even if the sceptic team believes that Beatrice was at the mercy of extra-therapeutic events, and, therefore, that quantitative measurements are unreliable, according to the therapist's clinical experience the client satisfied DDM and anxiety disorder criteria. The therapist also administered Beatrice the MCMI-III, which highlighted high self-defeating and extremely high anxiety levels. Furthermore, Beatrice was prescribed alprazolam for her anxious states, her PQ item regarding anxiety was high, so anxiety is differently measured with different instruments. Moreover, not only are Beatrice's problems structural, but she has high level borderline functioning (Kernberg), and 16 sessions therapy are not sufficient for these kind of problematics. Regarding her difficulties in planning the future that she cited during the CI, she was referring to her own description: "for all my life I had this image of me, with kids… to do things with a family… well I can still have a family, but with adoption, and this leads to difficulties in planning the future… I changed the image I had of me… I feel different" (CI, L99-104). In fact, adoption is a long and complicated journey and Beatrice knows that: "it's possible, but it's not easy… it's a journey you have to do with serenity, we need to settle a little bit more first" (S11, L122-123), "there are many things that have to be done first… marriage… there is time… talking about adoption with someone you met three months ago it's a little bit premature" (L144-146). About the sceptic challenge on the duration of the fourth item, the affirmative team rebuttal is based on Beatrice narration

in session 0B: "I felt nothing until I woke up after the abortion… I remember it like it was yesterday… I focused on that and I felt completely empty, all my body, from my head to my feet, and then I understood… that I did a very serious thing, I was only thinking that I didn't want a child from a man I didn't love… I was not ready to be a mother, but I didn't think about it the way I should have" (S0B, L258-275). Moreover, there is no evidence that Beatrice never wanted to have kids after the abortion, so her frustration could have been present from more than ten years, like she scored in the PQ Duration Form. The sceptic team suggested that changes in Beatrice cannot be due to therapy; however, in her HAT forms she reported many therapeutic interventions that she considered useful, therefore changes in her are tied to those questions and sentences spoken by the therapist. About Beatrice's lack of sexual desire (item 6 of the PQ), the therapist did not work on that because the client had already attributed it to her infertility and consequently to her unsatisfying relationship. Moreover, the therapist did not work on her two specific performance/activity items (8 and 11 of the PQ) because Beatrice's suffering was tied to her incapacity to have biological children, and the therapist believed it was more important for Beatrice to work on her unheard and unmet needs and emotions correlated to her aspects of personality, and not directly on her symptomatology, and only afterwards, from session 12, focused on her incapacity to give birth and on her wish to be a mother even through adoption. Finally, Beatrice did not break up with her previous partner with the same modality she used with ex partners. In session 4, she stated that she spoke and explained him that she was unhappy "like a woman, like a mother, in this couple, with no plan, the cohabitation… we are different… I told him I was feeling like a second choice" (S4, L6-48), whereas in previous break-ups she "started the crisis, screaming, unhappy, mean… so after a while they would break up with me, and I've always ended up clean… I don't like this part of me" (S0B, L216-222). Finally, when the therapist suggested to Beatrice to reflect on her decision to leave her partner in session 16, she reflected and reported in the follow-ups to be still with her partner.

2. A decrease in the PHQ-9 score in the pre-treatment phase is inferior to the reliable change index, thus is not reliable and may reflect the error measure of the test.

3. Even if Beatrice started therapy with high levels of dependency, she did not act in a compliant way with the therapist. In fact, in session 2 the therapist made an early interpretation of her tendency to let others decide what she had to feel and think, just like her brother did with her when she was a little girl, and

Beatrice refuted it. Besides, if Beatrice had been compliant, her scores would had been in constant decrease, and not so fluctuating. Furthermore, there has been a break-up in the therapeutic alliance in session 7 when the therapist hypothesized that her feeling of making people who love her suffer, and her tendency to lie to prevent further sufferings, was generated from Beatrice's relationship with her mother when she was a little girl. In fact, in the following session (8), Beatrice explained to the therapist that in the previous session when she was criticizing her mother she left feeling guilty "because mom always did the best for me and I feel sorry talking like this about her, I'd want only to go and cuddle her in these moments" (S8, L187-189). Moreover, when the therapist rated the SWAP at the first follow-up, there were no more dependency traits in Beatrice (SWAP dependency PD-T score 51.8, and Q-T score 53.83), so for this reason a decrease in quantitative scores in the follow-ups is not tied to compliance and dependent traits.

4. We have no proof that Beatrice had any expectations from the therapy due to medical advice.

5. As previously stated, they started working on her incapacity of being a biological mother and on her possibility in the future to adopt a child only from session 12, when they decided together that the therapeutic contract had been unsatisfied. Beatrice needed first to get in touch with her emotions and needs and listen to them, which was her initial therapy contract, before working on her maternal loss.

6. When Beatrice referred to not being sure whether the changes in her life were likely due to therapy or not, she was talking about leaving her ex-partner and going to live on her own, and then she added "actually some changes depend on exchanging views with the therapist, because it gave me the opportunity to know myself better, to know my feelings and my desires better… for example, I understood that I took decisions based on strong emotions… and very impulsive decisions… without reflecting, instead I do reflect now" (CI, L54-61).

7. In the CI, Beatrice reported to have taken alprazolam before assessment session 0A, but having stopped straight after beginning therapy (CI, L31). Furthermore, in session 2, she stated that she kept it in her bedside table and to have taken it only when needed, and not very often (S2, L19-21). Also, there is no evidence of a rebound of insomnia after having quitted with the drug, a frequent collateral effect of benzodiazepines.

8. There is no evidence that Beatrice had been compliant to the research and to the therapist that conducted the CI for having worked for a short time as a researcher.

Sceptic Rebuttal

The sceptic team believes that Beatrice's quantitative changes are not due to therapy but to extra-therapeutic events. In fact, at the end of therapy quantitative scores rose corresponding to frequent fights and arguments she had with her partner, and PHQ-9, GAD-7 and CORE lost their reliable change. Just as in sessions 15 and 16, high scores at the beginning of therapy might correspond to fights with her previous partner about the wedding in which he wanted to participate and she did not, and about the holidays he wanted to spend with the family of his dead ex-girlfriend and she did not. For this reason, quantitative measurements might be unreliable. Regarding Beatrice's emotions, since session 12, when the therapist and the client decided to work on a new therapeutic contract, the score of item 4 ("I'm angry because life deprived me of the joy of being a mother") of the PQ increased, losing clinical significance. Furthermore, the client acted according to her strong emotions throughout the entire therapy by having fallen in love with the new partner. About Beatrice's dependence personality traits, she still acts according to her script behaviour, because she started the new relationship with her current partner with high idealization (changing house and city for him, marrying him), following high devaluation both of her needs (not feeling free to call her ex and have dinner with him) and of the partner (thinking of breaking up with him in session 16). Also, in the 1-month follow up, Beatrice reported that she was still together with her last partner, however, that she was acting according to her script, which is not breaking up with men even if she does not like how their current relationship has turned out to be: "he is happy that his son calls me 'mom', but this is wrong" (FU1, L90-91); "I don't want to do what I've done in the past, to drag… because this never led me to feel good" (L273-279). So, at the end of therapy and in the 6-month follow up, Beatrice reported to be still stuck in her script and desire to become a mother, without working on all her needs and wishes in a relationship. Finally, regarding the decreasing trendline that characterizes Beatrice's quantitative scores, improvements in the GAD-7 and CORE are reliable.

Affirmative Conclusion

Beatrice's depression, anxiety, global distress and personal problems were related to difficulties in emotions, self-esteem and interpersonal patterns, such as staying with a man even if their relationship was not satisfying for her anymore, not understanding nor listening to her needs and emotions and letting others decide them for her, acting and deciding according to strong, impulsive and not thoughtful emotions, and to finding out that she was not able to have biological children. She had a high level borderline functioning, structural problems, and

dependent personality traits. Since the beginning of therapy, the therapist created a positive climate where the client felt free to express and feel her emotions and problems, explored the possibility of appreciating her emotions, without having others tell her what was right for her. Beatrice's depression was also tied to her introjected characteristics, like introjecting blame and guilt into herself, and for her belief of always hurting people she loved and who loved her and, therefore not trusting her own perceptions. The therapist worked on adjusting guilt and on focusing on her emotions in order to understand and trust her feelings and wishes, which made Beatrice's symptoms decrease and allowed her to express and understand herself, instead of acting impulsively and retreating, increasing her self-esteem. There has also been a partial loss elaboration regarding her incapacity to give birth and, nevertheless, to the possibility to still be a mother through adoption. These experiences were reflected in changes in depressive symptoms, internal dialogues, acting out, self-identity and interpersonal relationships. The areas that have changed for the most are relationships, emotions and self-esteem.

Sceptic conclusion

Beatrice asked for therapy with moderate depression, which reached a reliable and subclinical symptomatology already in session 4 after having broken up with her partner, and might have been due to an adjustment disorder, so improvements might not be attributed to therapy. Changes in depressive symptoms are therefore likely to be due to a self-correction of the crisis for the alteration of her self-image, and extra-therapeutic events, such as finding a man that gave her the attention she needed, that asked her to marry him, and that wanted to adopt a child with her. Therefore, quantitative improvement is unreliable and does not correspond to qualitative statements of the client in the follow ups.

Adjudication

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

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

This is a clearly good outcome (60% of certainty) with aspect of a mixed outcome (40% of certainty). Quantitative data show a reliable and clinically significant change on measures of depression (PHQ), anxiety (GAD) global distress (CORE) and personal problems (PQ) before the end of therapy, regained in the follow-ups. The spikes at the end of the therapy are representative of critical extra-therapeutic events, and not to the inefficacy of the therapeutic work. Also qualitative data support the conclusion that the client improved. Beatrice learnt to give voice to her emotions and desires, not allowing others (her ex and her current partner) decide them for her. Her internal representation on hyper-adjustment and having to be and behave like others wanted is not present anymore. She is able to protect herself from her partner's desires and decisions. Moreover, she learnt to not listen to her strong and impulsive emotions without reflecting first.

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

Table 5: Adjudication results

Opinions about the degree of change

The client's change is considerable (60%, with 80% of certainty). Qualitative data, as in the session transcriptions, show both big changes in her life due to extra-therapeutic events, and a true improvement in Beatrice's impulsive acting outs. However, therapy has not been long enough to deeply explore and lead to a complete elaboration of her incapacity to give birth, which seemed to be still present at the end of therapy. Nevertheless, there is proof of a moderate change in her dealing with both her and others' emotions, she is able to protect herself from contaminations and give voice to her wishes and feelings, which allowed her to come out from that vicious cycle of hyper-adjustment.

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

The observed change is considerably (60% with 80% of certainty) due to the therapy. Qualitative data in the HAT form (summarized in Table 3) of the client and the Change Interview are extremely helpful to understand what the client felt important in the course of therapy, such as the therapist interventions and questions that made her realize that she was hyper-adjusting to people, and that she was acting impulsively in the grip of strong emotions. Furthermore, qualitative data from the Change Interview report a retrospective attribution to therapy of four main changes out of five, especially improving her depressive and anxious symptoms (two changes), dealing with emotions and inner experience (two changes).

Mediator Factors

Good Therapeutic Alliance and therapist interventions on decontamination helped Beatrice to gain the awareness of her hyper-adjustment to others and of her actions that were based on strong emotions. The therapist worked on Beatrice's personality, on her tendency to introject blame and guilt, and to give others the permission to decide how she had to feel. Therefore, the therapist gave her the permission to recognize her emotions, listen to them, and decide on her own, without retreating.

Moderator Factors

Beatrice was a very intuitive, intelligent and introspective person, therefore therapist interventions led to very deep deep insights and to Beatrice's comprehension of having always acted according to ancient script belief.

Discussion

This case aimed to investigate the effectiveness of a manualized TA treatment for depression in a client with major depressive disorder in comorbidity with anxiety. Primary outcomes were depressive and anxiety symptomatology, and secondary outcomes were global distress and personal problems. The therapist conducted the treatment with good to excellent adherence to the manual. The judges concluded that this is a clearly good outcome case, with a 60% degree of change, and which was 60% due to the therapy. These conclusions provide a further support for the effectiveness of the manualized TA treatment for depression in adults. Creating an early therapeutic alliance, supporting self-esteem, changing self-critical internal dialogues, developing an internal Nurturing Parent, providing appropriate permission tailored to the specific the needs of the client and developing problem-solving ability all appeared to be mediators of change in this case, which were moderated by the cognitive resources and self-observing attitude of the client.

Limitations

The first author has a strong allegiance to TA, is a teacher of the members of the hermeneutic groups and a colleague of the three judges. Despite the reflective attitude adopted in this work, these factors may have influenced in subtle ways both the hermeneutic analysis and the judges' evaluations.

Conclusion

This case study provides evidence that the specified manualized TA treatment for depression (Widdowson, 2016) has been effective in treating a major depressive disorder. Despite results from a case study being difficult to generalize, this study adds evidence to the growing body of research supporting the efficacy and effectiveness of TA psychotherapy, and notably supports the effectiveness of the manualized TA psychotherapy for depression applied to major depressive disorder.

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Autonomy or Dependence: Working with Therapeutic Symbiosis in the Non-Psychotic Therapist-Client Relationship

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Abstract

Symbiosis is a concept developed by Schiff and others in her work with clients with severe psychoses such as schizophrenia. It is our intention with this article to propose a reflection on its applicability with our non-psychotic clients, within the practice of consultation. By reviewing the theory of development, by authors with a theoretical framework of transactional analysis, we seek to establish the possibilities of what can happen within the primary symbiosis through its non-resolution, within each period of development of the human being from conception to the adult phase. In this primary symbiosis, when unresolved, the establishment of script and the matrix of the various relationships of dependence in life will be developed. Resolution of this through therapeutic symbiosis in the therapist-client relationship may lead to attainment of Berne's autonomy with its components of awareness, spontaneity and intimacy.

Keywords

Introduction

Dependency relationships permeate the interactions between elements, in the universe, in the solar system and in nature. Many species depend on each other for their survival, and this occurs in a similar way in the human species. Initially, there is an energetic and physiological dependence and, with growth, also a psychological one. And this is the cause, if not resolved, of relationships of dependence that last a lifetime.

Every structure of the human personality is developed within an initial symbiotic relationship towards autonomy, the natural and ultimate goal of growth. It is our purpose, when making a theoretical approach, from the point of view of transactional analysis (TA), to evaluate in which moments of biophysiological development, our autonomy is gradually replaced by the construction of a dependency and leads us to establish relationships through the rest of our lifetime that are similar to the matrix of the initial relationshipship with our mother [or other primary caregiver].

Schiff (1986) focused her work on symbiosis when dealing with serious psychopathologies. By stating that "every meaningful relationship will have, at some time, an element of symbiosis," (p. 5) she provides support for her studies to be adapted to the milder psychopathologies found in day-to-day practices.

An analysis of the symbiotic events occurring during the developmental stages will allow us to process therapeutic intervention in the therapist-client relationship during the course of the therapy process. To better understand this, we will take a theoretical tour - our emphasis - through the stages of development of the human being identifying relationships between the phases of establishment of the primary symbiosis and the possibilities that may have occurred by making it a fixed gestalt.

Many authors have addressed the theme of developmental stages, including Freud, Piaget, Spitz, Erikson, Spock, Gesell, and Winnicott among others; we will remain, however, with those who did it under the theoretical framework of TA: Berne (1977, 1988), Schiff (1986), English (1977), Levin-Landheer (2010), Kertész (1985) and Del Casale (1986).

Autonomy as a goal

To be autonomous, it is necessary to acquire the possibility of governing oneself, determining one's destiny, taking responsibility for one's actions and feelings, discarding inadequate beliefs and values in order to live in the here-and-now with emancipation and independence. Within the concepts of TA "the attainment of autonomy is manifested by the liberation or recovery of three capacities: awareness, spontaneity and intimacy." (Berne, 1977, p.155)

To be aware is to have the knowledge of what is happening here-and-now, to perceive the world through your own contact with it instead of seeing it as it has been taught, to be present and consonant with your body, thoughts and emotions. "The conscious person is alive because he knows what he feels, where he is and the moment he lives." (Berne, 1977, p.157)

To have spontaneity is to have behaviours that flow naturally and easily, to be timely, to be able to change effortlessly according to the demands and needs of each moment, to have an integrated response, to be flexible, responsible for our choices and to make our own decisions. It should not be confused with doing anything anytime, anywhere, anyways. To have spontaneity, for Berne (1977), "means being freed from the compulsion to have only the feelings one has learned to have." (p.157)

To be in intimacy is to be connected with feelings of affection to people in a relationship, be it emotional, physical, intellectual or even spiritual. It is to be able to express feelings of warmth and tenderness, to be able to contact other people and to let oneself be contacted by them in a natural way, with proximity making each encounter a unique and satisfying experience.

Symbiosis as a way

From our conception, we begin our existence within a relationship of dependence. A relationship of dependence with our great first love, our Mother. (sic) Popular wisdom says that *Mother is like chickenpox. Have it once and it will leave a mark forever* - our emphasis -. The simplicity of this phrase translates and contains the strength and importance of our first love relationship, which will shape all our affective relationships.

In TA we call a symbiosis a relationship of dependence that is what "occurs when two or more individuals behave as though between them they form a whole person" (Schiff, 1986, p. 5). Schiff further clarifies that symbiosis is a natural occurrence between parents and children until they can live on their own and this primary symbiosis becomes pathological when it interferes with the development of autonomy when we reach adulthood.

In this unresolved or pathological relationship of symbiosis, according to Schiff, we must take into account three important aspects that maintain and justify it: non-productive or passive behavior, discounting and grandiosity.

In pathological symbiosis two positions can be occupied: either the person will put themself in a position where another will take care of them and the problems become the caregiver's and must be solved by the caregiver, or the person will put themself in the role of taking care of the other, who is then the owner or the cause of the problems and cannot live without the caregiver to solve them.

Thus, the resolution of symbiosis, whether natural or pathological, is the way to achieve autonomy.

Before birth

Primary symbiosis, which is fundamental in the development of the human being, begins with conception, when the couple prepares to have a child, and continues throughout the gestation until birth, lasting until the end of adolescence, when it should be resolved.

In this first phase, if conception is desired and performed with love, the mother-child bond begins to be constructed in a positive way. The result may be quite different if the conception is the result of a relationship occurring by chance or rape and aggression.

Throughout the gestation the baby, in visceral contact with the mother, will be receiving vibrations from the mother as well as all her biochemical production. The baby will receive, from the context within which the parents function, positive influences within a healthy emotional environment or negative from an emotionally rejecting environment in an unwanted pregnancy. In this period, there will also be expectations about the child, such as what gender it will be, choice of name or the role it will play in the life of the parents.

As the primary symbiosis begins to establish itself between the mother and the baby, there is also a symbiosis, of support, between the father and the mother. This is the ideal setting for gestation. In contrast, abortion attempts as well as stress or serious maternal illness can occur during gestation and will shape an unfavorable environment for the establishment of primary symbiosis.

Often an intense disqualification of the needs of the parental Child ego state will also provide an early establishment of unhealthy primary symbiosis, as it will develop within an ambivalent environment of love and anger, being a product of the resentment of the Child ego state of the parents.

The first months

Healthy primary symbiosis, established physiologically during gestation, at birth organizes, supports, and is complemented by the onset of the parenting process of the child. This is necessary and fundamental since the child is born only with the Child ego state - C1- or natural, active Child. In this first stage begins the primary neuropsychophysiological organization that gives the bases and the structure for the formation of the personality. The discovery of one's own existence occurs and the baby learns "that there is a part of the world which they *are* and part which they *are not*" (italics in original) (Schiff, 1986, p.35).

This is the time to receive food, warmth and shelter and a nourishing diet of strokes that includes warm, intimate and pleasurable physical contact. Up to two months, especially if breastfeeding, primary symbiosis provides an intense bond between the mother and the baby, and a long separation between the baby and the caregiver responsible for feeding is not advisable.

If all this happens in a healthy way this symbiosis starts its way to resolve itself. However, this is not always the case.

With many infants, crying and nursing may not occur with satisfaction, as crying may cause irritation to the mother and breastfeeding may not be satisfactory, since the mother's tension will cause unsatisfactory and frustrating milk flow to the baby. The feeling of hunger, crying, hitting the arms - motility - may not be satisfied by breastfeeding, requiring from the baby an increase in the energy employed to be able to satisfy its need. There is, therefore, an increase in arrhythmic movements - Agitation without direction, without focus - generating what will later become one of the non-productive types of passive behaviour, Agitation, according to Schiff.

In contrast, mother's overprotective behaviours by not allowing the baby to call for food with crying and arrhythmic movements can lead to passive behaviours of do nothing or Overadaptation.

Slow and mechanical breastfeeding, with few strokes, can also lead to the passive behaviour of Agitation.

The motility - unintended arrhythmic movements - of the baby should be stimulated and uninhibited yet infants may spend much of the time *wrapped* - our emphasis - in blankets or covers. This behaviour of preventing motility can establish the passive do nothing-behaviour in addition to sending Do Not Move, Do Not Act messages. This passive Do Nothing behaviour can trigger, at later stages, behaviours of shyness or withdrawal, or resemble depression, due the child´s lack of movement.

Advancing to the sensory-motor phase

The baby enters the sensory-motor stage when it goes from motility to mobility - intentional movement. At this stage, the strokes come through a continuous supply of physical affection, and support permissions and qualification for action, curiosity, intuition. The formation of the Little Professor begins - A1.

With the pain caused by the eruption of teeth or the onset of colic, infants experience total helplessness and that of their caregivers, generating a phase of great frustration, as English (1977) emphasizes.

This moment is also one of great discoveries and the beginning of independence, for it is now that crawling and walking occur, the exploration of the environment, at the same time that vision, hearing and touch develops.

As Levin-Landheer (2010) observes, the incipient beginning of the resolution of primary symbiosis arises at this stage and needs to be viewed with tranquillity by the mother, and not as abandonment or loss of her baby who was so dependent and obedient -

At this stage begins the process of introducing solid nutrition with the subsequent weaning of the child.

The process of resolution of primary symbiosis may have its beginning or be prevented, depending on the events at this stage.

The baby begins to explore the world and the parents use methods to stop them moving and send messages of Don't Move, which can lead to passive Doing Nothing, Overadaptation and Agitation due to the restriction of locomotion and curiosity.

The mother, for fear of losing her little baby, does not start the weaning process and instead sends Do Not Grow messages, generating do nothing, Overadaptation and, often, Agitation, by preventing the search for food outside the mother's lap. It is important to emphasize that in the process of weaning the role of the father is important, requesting that the wife come back to being his spouse instead of being only mother.

The process of crawling and beginning to walk needs to be carried out with much support and protection. The baby has to hold the hand of the mother, the father or someone who gives security. Beginning to walk holding onto legs of chairs and furniture sends messages of unprotection, using a walker sends messages such as You are not Able, You will not succeed. These actions on the part of those who take care of the child can also induce, Doing Nothing, Overadaptation and, often, Agitation because the child

feels restrained and unprotected. Insufficient surveillance of the small explorer can lead to conclusions of fear of new situations or a propensity to frequent accidents that generate strokes and later care. Such incapacitation or violence may lead in the future to the search for security in prison or in a psychiatric hospital, says English, (in Barnes, 1977).

18 months to 3 years old

Now the child enters the stage of independence, individuality and separation, "when the Adult ego state is first forming." (Levin-Landheer, 2010, p.187; original in English 1982, p.132).

Schiff (1986) comments that: "Curiosity emerges as a driving force, and children are hopeful, if not convinced, that when they complete their exploration of the universe they will have control over all things. The rapid learning which naturally happens at this time reinforces that expectation". (p.38)

Also the formation of P1 begins - the Parent in the Child - where begin to be recorded the messages of parenting that are now verbal. The injunctions begin to be recorded. Many of them impede the spontaneity and intimacy characteristic of the child's relationships with the world.

Berne (1988) observes: "A child's job is to find out what his parents really mean. This helps to maintain their love, or at least their protection, or in difficult cases, his mere survival". (p.92 – original in English 1972, p.101).

Now is the time for children to want space, to be different and unique. It becomes difficult for them to understand and control the world around them and to begin to understand that people have needs and feelings that are not necessarily the same. Now begin the years of rebellion where the "no" predominates. It is the 'terrible two's'. Children become angry, grumpy, and sometimes depressed as Schiff (1986) clarifies. According to English (in Barnes, 1977), the events of this phase will be repeated quite intensely in adolescence where real battles occur.

This incipient process of resolution of the primary symbiosis can be prevented by the parents through behaviours that stop the healthy social adaptation of the child to the conviviality of others. They may allow or encourage them to demonstrate their rebellion inappropriately or prevent them from perceiving the possibility of such separation in a protected manner.

The child now begins to learn to name the emotions and this is done by the parents or the caretaker. The child begins to perceive which feelings are approved and which are not, the latter being therefore dangerous to the obtaining of strokes. The child begins learning of the substitute emotions in counterpart to the authentic emotions that are perceived as forbidden. Don't Feel what you are feeling, Feel ... – this substitute emotion -, Don't Express what you are feeling. Don't Show what you feel or Act Uncontrollably.

Montheiro (2011) focuses on: "Since the emotion cannot be recognized and/or expressed it cannot motivate the social behavior linked to its satisfaction. As a substitute, the person may develop symptoms such as migraine, palpitation, nausea, for example (Erskine and Zalcman, 2006), which is the origin of psychosomatic problems, quite frequent in children with school difficulties such as headaches, nausea, vomiting, diarrhoea. Or, instead of the initial emotion, feel another. For example, by not being able to get in touch with her anger - which would motivate her to transform the situation that bothers her - the person becomes excessively "good" or overly agitated". (p.36)

As Montheiro clarifies, it is in the field of learning what emotional expression or performance is allowed or not, in the primary symbiosis, that some passive behaviour is established.

The do nothing behaviour that comes from the prohibition of expressing anger, for example, often leads to the substitute emotion of depression, for anger is intimately tied to the momentum of action toward what one wants to do. This can often be the cause of reactive depressions in very small children. Beginning to express or act upon the emotions that are allowed to you in a way to please parents will establish Overadaptation behaviour.

Substitute emotion, when expressed, does not allow the necessary discharge of the energy produced by the natural emotion and the quantum of energy that is retained can provoke the behaviour of Agitation and be a diagnostic factor in hyperactive children and with Attention Deficit Disorder - so common nowadays.

Passive behaviour can come from transforming the *quantum* of emotional energy retained into physical symptoms, enabling the child to partially discharge this unexpressed or liberated energy. Such a situation is often reinforced by intense stroking.

The injunction to act without control can lead to violence that, depending on the quantum of suppressed energy, causes the child to break household objects, toys, assault other children or even adults. It is the *impossible children that no one can control* - author's emphasises. These injunctions and emotion-related behaviours stem from the need for parents to keep their children in symbiosis, dependent on their care.

The child's natural rebellious behaviours and parents' inadequacy in dealing with them - whether repressing manipulatively – "You are bad!" or "Mom will no longer like/care for you if you continue like this" - or by encouraging by giving the child power she cannot have

because she does not know what to do with it – "I do not know what to do with this boy, he´s getting impossible!" or That's right, break everything and I'll clobber [hit] you!" - also lead to Do Not Do, Overadaptation, Agitation, incapacitation or violence that does not allow the symbiosis to dissolve.

3 to 8 years - establishing an existential position and the primitive model of script

During three to eight years, the child is now moving towards the structuring of the existential position, as English (in Barnes, 1977) puts it: "... I agree with Berne that between the ages of three and four the young child settles into an existential position which becomes the bedrock for his future script, because around that age he develops a need for a point of view for his relationships with others." (p.319).

She continues: "Children develop an "I'm not-Ok, You're OK" defensive position if, by age three, they have established a high proportion of conclusions related to helplessness and to being overpowered. In reverse, they will develop an "I'm OK, You're not-OK" defensive position if, so far, they have many conclusions about their power to "make" their caretakers feel good, or angry, or scared or guilty." (p. 320).

From the structuring of these existential defensive positions is outlined which type of symbiosis will be established in adult life: if the individual structures the defensive position - / + they will seek complementary symbiosis with an individual who has structured the defensive position +/- and vice versa, developing the passive behaviour necessary to maintain this symbiosis.

It is also from three to eight years that the child structures the primitive script model. "We want to find out in a new way who we are and what it means to be the sex we are. We experience social relationships and become preoccupied with power", (Levin-Landheer, 2010, p. 188 – original in English 1982, p. 132) At the end of this period, the development of the Parent ego state - P2 - is fundamental to the structuring of this primitive script model with all its apparatus – script payoff or curse, script Injunctions or stopper, provocation or 'come-on', pattern or program, impulses or demon, antiscript or internal release (Berne, 1988). Berne goes on to state that the anatomy of the script apparatus consists of the script controls - curse, stopper, and come-on - and the elements that can be used to counteract it - injunction, pattern, impulses, and antiscript.

Kertesz (1985), adds that the sequence of formation of this first script model begins with verbal and mainly non-verbal parent behaviours accompanied by strokes that are captured and analysed as messages by A1 based on the necessity of survival and consequently registered as injunctions in P1. Each recorded injunction will be linked to substitute emotions, existential position and concrete behaviours learned within psychological games. This first script protocol is being tried by testing behaviours that will be reinforced by the family with inappropriate strokes and any deviation from this pattern will be punished or ignored. At later ages the child will act this script outside the family, seeking partners who fit complementary roles.

Crema (1985), notes that the script is a routine, therefore without awareness, spontaneity and intimacy: "The description of the world, nurtured by the internal dialogues, conditions our habit of existing, which is the behavioral expression of the script. As a plan, at the structural and intrapsychic level, the script consists of the recording of mandates, injunctions and decisions of survival, which is expressed, phenomenologically, in the form of patterns of actions and habitual reactions. In other words, the script is an existential routine." (p. 209)

Script injunctions, according to Berne (1988), are the most important part of the script apparatus and can range from the most severe to the softest, all incorporated through blackmail or fear. The main ones are: Don't Live, Don't Enjoy, Don't Think, Don't Feel – any emotion or a specific emotion - Don't Grow Up, Hurry to Grow Up, Don't Overcome Me, Don't Be Yourself Be Like ..., Don't Be Close, Don't Succeed, Don't Act, Don't Leave Me.

The injunctions related to not growing up and growing up fast are important in delineating the type of symbiosis that the individual will establish in the future. Those who received the injunction Don't Grow Up will seek to develop unresolved primary symbioses, and those who received the Grow Up fast injunction will develop secondary symbiosis.

We can infer that passive behaviours that maintain dependency relationships also serve elements of the script apparatus and play an important role in staying within the script.

Doing Nothing obeys some injunctions such as Don't Act, Don't Think, Don't Grow Up, Don't Overcome Me. Overadaptation also meets some injunctions - Don't Be You, Don't Overcome Me - and the script pattern or program and Agitation, Incapacitation and Violence relate to the provocation and the final script payoff.

In addition to the script injunctions, another important factor in this period of child growth are the attributes, that tell the child what to do or how to be. Steiner (1976), says that "Attributions when followed are reinforced, injunctions when disobeyed are punished." (p.67 – original in English 1975 p.74).

Attributions can be of various types:

- You are a clown, laughing all the time; reinforces the injunction of Don't Enjoy;

- You are a fool, you don't make sense- reinforces the Injunction Don't Think;

- You are shy or You are withdrawn - reinforces Don't Approach;

- You are a sissy, you're a cry baby - reinforces Don't Feel;

- You are mommies baby - reinforces Don't Grow Up;

- You are the little man of the house, so responsible - reinforces Grow Up, Don't be a Child

- You are clumsy, you will never get where I am - reinforces Don't Overcome or Don't Act, and many others.

An important attribution that reinforces the injunction Don't Be You, Be Like ... is the choice of the child's name.

A reminder - injunctions come from P1 of the parents and the attributions from P2.

These considerations, discussed above, refer to what happens up to the age of eight within the primary symbiosis, and thus create the boundaries of the degree and form of adaptation - by submission or rebellion - that the child will need to resort to in order to align with the reality that surrounds it. We emphasize that if the adaptation is by submission the predominant passive behaviour will be Do Nothing and Overadaptation with little energy discharge in the Agitation and Incapacitation or Violence conduits. If the adaptation is by rebellion, the predominant passive behaviour will be Agitation or Incapacitation or Violence with a lot of energy discharge instead of Do Nothing or Overadaptation behaviours. According to a Steiner (1976), "This process is a crucial point in the development of scripts and is called the decision." … A script results from a decision that is both premature and enforced, because it is made under pressure and therefore long before a decision can be properly made." (p.74– original in English 1975 p.82-83). These decisions are made by Little Professor - A1 - with incomplete data, distorted reality and need for survival. These decisions will guide the individual, later, to seek the partners, in symbiotic relationships of dependence, to be able to keep his or her script.

Adolescence

From the age of eight until the end of adolescence, the basic premises of the script are already internalized, and it is time to start acting in social life. At this stage, the parenting process is influenced by other parent figures such as teachers, parents of friends, older teens, sports instructors, etc. The parenting occurring

at home and now in society is forming the Parent ego state - P2 - as an autonomous ego state that will guide future decisions of behaviours; no longer from P1, by fear or gratification, but by a range of values and rules introjected in P2.

It is important to emphasize that in this phase the resolution of the primary symbiosis or its crystallization to guide future relationships will be finalized. The child and/or adolescent actively begins to exhibit behaviours of defiance or defence against the values of the parents. In response, acting to challenge authority may not be the best way, but neither is believing they can solve everything on their own. Conflict and confusion are typical of this time and the best way to deal with it is orientation, acceptance, dialogue and limits, so that the young person can succeed in resolving problems.

Levin-Landheer (2010), writes that "we periodically need to develop new tools, learn skills, and decide on values which are consistent with our goals. To do this we argue and hassle with others' morals and methods, often wanting to do things our own way and no one else's. " (p.199 – original in English 1982, p.133). Berne (1988), clarifies that "there are some people who rebel against their scripts, apparently doing the opposite of what they are "supposed" to. Common examples are the "rebellious" adolescent ..." (p. 117 – original in English 1972, p.132).

During this period, concerns about sexuality begin to appear and adolescents begin their sexual experiences. In today's life, where appeals to sexuality come from all sides, having a conservative position based on fear will be highly problematic and will make it difficult to approach. Controlling or wanting to ignore are two opposites that need to be avoided.

We need to take into account that it is at this stage that the Parent-Adult-Child ego states of the individual are newly completed and that the lability of the cathexis is intense, because the membranes are not yet totally individualised and it is up to the parents, with guidance, empathy and protection, to help organize this cathexis. An Integrated Adult ego state of the parents will foster this integration in the children.

"Some parents are reluctant to experience the separation; others are glad to have successfully discharged their responsibility, and are eager to see the children as independent." (Schiff, 1986, p.46)

The primary symbiosis that would be *mature* - our emphasis - to be solved may not be so and analysing this non-resolution from the theoretical perspective of the miniscript of (Kahler and Capers, 2010), we can make some correlations with the passive behaviours of symbiosis. Timid children and adolescents, with little creativity, egocentric, with little volition, masking depressive behaviours, would be discounting

themselves, which enables the start of the negative miniscript, with Do Nothing behaviour.

From miniscript position 1, failing to comply with the drivers of Please People, Hurry Up, Try Hard, Be Strong or Be Perfect, the person moves to Position 2, the Stopper or to Position 4, Final Payoff. The demeanour of quiet and well-behaved children and adolescents as they move through the miniscript, characteristic of the phase, would be Overadaptation.

Agitation and violence would be the behaviours in Position 3 of the miniscript, under the influence of the Vengeful Child, common in children and adolescents who are overly rebellious and destructive with antisocial behaviours. These behaviours would often come from acting in line with antiscript.

The very common Incapacitation behaviour of position 4 – I'm not OK, You're not OK - of the Final Payoff of the miniscript, would lead to frequent consultations with doctors and hospitals;

For good completion of the adolescence phase of development, and therefore the resolution of primary symbiosis, important messages are those such as: ""It's OK to learn how to do things your own way, to have your own morals and methods." "You don't have to suffer to get what you need." "You can do it your way." "You can think before you make that your way." "It's OK to disagree." "Trust your feelings to guide you."" (Levin-Landheer, 2010, p.190 – original in English 1982, p.134).

Entering adult life

Completing the cycle and entering fully into adulthood the personality is formed. Uncertainties and insecurities regarding the future are lived intensely. It is when they are looking for a new place in the world, to be successful is the goal, taking responsibility for their actions, being sexual, being who they are, and being able to count on their parental references.

Here is what Montheiro (2011) says: "Many events that have shaped or transformed our structure at the present time may not be useful, functioning as limitations. By eliminating these patterns, actualizing beliefs, dissolving tensions, amplifying the life force, gaining flexibility, internal expansion, and a new physical and emotional awareness." (p.39)

One is in search of a companion to connect to emotionally and to support the constitution of a family distinct from the original one, of social relationships and relationships of work. All these relationships may occur from a position of autonomy or a pathological symbiosis and dependence.

Final considerations

After this *tour* - our emphasis - we can make some reflections, trying to bring some of the references of these theorists to our therapeutic practice.

The whole structure of the human personality - ego states, the stroking system, emotional education, social structuring of time and the script, which will determine a framework - is built within a relationship of symbiosis that lasts no more and no less than eighteen years.

Each person will structure an affective relationship matrix to be employed in each relationship throughout life, whether loving a partner or in a family, social or professional context. Invitations to any relationship will interact with this matrix and seek to satisfy it.

The symbiosis is the scenario in which the script of each one unfolds, with the individual being the main character and the others the supporting players in the diverse relationships of dependence.

The therapist-client relationship will not escape this pattern and therapeutic symbiosis, which will be proposed later by the client, will need to be accepted as a manoeuvre and worked on to be resolved. The client will need to be led to the identification of which points in their development their primary symbiotic relationship has been maintained instead of being resolved, in order to be able to close the gestalts that have been formed.
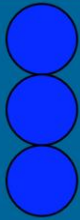
We propose that in the therapeutic relationship, redefinitions, discounts, grandiosities and passive behaviours that justify, maintain and perpetuate the symbiotic relationship pattern, are worked out, so they can be solved, step by step, in a comforting and protective manner.

We propose to reflect on the possibility that this affective matrix of relationship, standardized back then, being resolved in a relationship, will be closed and will provide the rescue and liberation of autonomy and the possibility of relations in the here-and-now with awareness, spontaneity and intimacy.

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Death and the Grieving Process: Transactional Analysis Contributions

Abstract

Loss, death, and grieving are situations involving people at various points in their lives. The purpose of this article is to present an approach on the psychic reaction determined by experience with death or loss, analysing the process of grieving, correlating the description of the five stages of Kübler-Ross with the discounting levels of Schiff. Considering that loss and death occur in the lives of people, and is generally a factor of great stress, we explain the stages through which mourners pass to elaborate the process of grieving. We conclude that working with the process of grieving through interventions on discounting and correlating them with the phases experienced in this period, proved useful in overcoming problems in the therapeutic process.

Keywords

Grief, Death, Loss, Mourning, Transactional Analysis, Discounting.

Introduction

"Gautama Buddha, the founder of Buddhism, once said this existence of ours is as transient as autumn clouds. To watch the birth and death of beings is like looking at the movements of a dance. A lifetime is like a flash of lightning in the sky, rushing by like a torrent down a steep mountain." (Chopra, 2006, online).

I have observed both in clinical practice and social networks that we generally address issues such as health, family, profession, relationships, and we hardly talk about death or dying. However, when we are confronted with this situation, the need to make contact and talk about it arises.

In order to develop the topic proposed here, a search of material found only a few articles about mourning, loss and death in transactional analysis (TA) literature, which became a challenge in the elaboration of this work.

Although we find it difficult to deal with death and loss, we experience these events throughout life and they are part of human development. Death is a situation that generates changes in the lives of people facing a loss, and not only from a material point of view. Changes in assets and finances occur in emotional areas, generating changes in affective relationships, habits and routines, and in social areas, such as status and position, and any change involves losses and gains leading to transformations.

With each new stage of human development, we have to give up or lose something and that makes us grow. During our evolutionary process, there are several losses and we need to learn to live with these physical and psychological separations.

The way of proceeding, the way of operating or solving the feeling of grief or pain for someone's death seems to us unique, that is, proper and different for each individual.

The person will react according to their own frame of reference, which Schiff (1986) defines as "... the structure of associated (conditioned) responses (neural pathways) which integrates the various ego states in response to specific stimuli." (Schiff, 1975, p.49) This will depend on the bond with the deceased person, the various roles that were played and how one deals with losses in the course of their own life.

We understand that, by cultural, social and family tradition, each individual brings a representation of death. According to Viorst (1990) "to begin to realize how our responses to the losses shaped our lives can be the beginning of wisdom and promising change, so to understand our lives we need to understand how we face our losses" (p.14-15).

Observing, analysing and experiencing how we face our losses seems important to us in understanding the elaboration of the grieving process. We seek to contextualize what happens with a bereaved person and thus contribute to understanding this process, because it seems important, as psychotherapist, to understand the stages of mourning and to help individuals mourn their losses in relationships and thus elaborate their mourning in a healthy way. According to Kübler-Ross (1998) "If we were to make a superhuman effort to face our own death, to analyse the anxieties that permeate our concept of death, and to help others become familiar with such thoughts, there might be less destruction around us." (p.17).

From the studies found we seek to establish in Transactional Analysis a form of intervention for the mourning process. It is important to keep in mind that a necessary and fundamental process for its elaboration takes place and that, in fact, mourning can be a normal and even expected reaction, characterized by a set of reactions caused by the loss of significant bonds. However, when it is prolonged indefinitely or the lack of immediate reactions to the death exist, presenting later symptoms of distorted grief, it becomes complicated, and in this case intervention is necessary for its resolution. Most authors agree that we complete the main part of the grieving process after about a year, sometimes less, but usually more (Viorst, 1990).

The purpose of this article is to present an approach to the psychic reaction determined by experience with death or loss, analysing the grieving process, correlating the description of Kübler-Ross's five stages with the discounting levels (Schiff, 1986, 2010).

The Grieving Process

How we elaborate or do not elaborate our grief will depends on a number of factors - our age and the age of who we lose, and under what circumstances they were lost, our history of past losses, our personality structure, external support, and our life script.

Pain arising from any significant loss, whether from a loved one or even an esteemed object, results in a void that needs to be filled, entering a necessary and fundamental process to elaborate the loss. There seems to be a typical pattern in normal mourning, consisting of stages or phases for adaptation to loss to happen, but the stages are not fixed sequences that

all bereaved people must pass through to recover from loss.

It can be observed that there are people who work out their losses and react in a healthy way, giving new meaning, rebuilding and reorganizing their lives, and others who cannot and get stuck in some of the stages. Parkes (1998) recalls that "the pain of mourning is as much a part of life as the joy of living; and may be the price we pay for love, the price of commitment. To ignore this fact or to pretend that it is not so, is to blind oneself emotionally, so as to be unprepared for the losses that will inevitably occur in our lives, and also to help others to face their own losses (p. 22).

The loss caused by death represents the rupture of an irreversible emotional bond and this experience generates changes in cultural, social, family, emotional and somatic domains.

Even if we can master death on several levels, it still constitutes a "ghastly, dreadful event, a universal fear" (Kübler-Ross, 1998, p.9).

"In our unconscious we can only be killed; it is inconceivable to die of natural causes or advanced age. Therefore, death itself is linked to a bad action, a fearful event, something that in itself claims reward or punishment (Kübler-Ross, 1998, p.6).

The process of grieving does not only happen when the death of loved ones occurs; it is also present in all processes involving reactions to losses, such as an important separation, loss of social or professional status or even the loss of a part of the body, as in amputation, and this understanding can help us to help individuals deal with their losses.

When we identify this issue, whether it is illness or loss of a loved one, we realize that we are not familiar with talking about it. We have the impression that talking about death makes us uncomfortable, perhaps because we need to understand the problems that arise from it. With this we resort to some defence mechanisms to deal with what is inevitable, with the fact that we cannot escape; but nevertheless defences, whilst protecting us from the fear of death, may also restrain us.

As defence mechanisms, we refer to a psychological process that the Ego uses in order to reduce the tension felt in the form of anguish arising from conflicts, keeping it out of the field of consciousness so that it is not recognized. This concept highlights how much the death situation impacts people.

We observe that people often respond passively to the situation; passivity in feeling, thinking or doing. According to Schiff and Schiff (2010), passivity can be understood as the lack of reaction to stimuli, which

results from symbioses that are established through passive behaviours, maintained through mechanisms of discounting and justified through grandiosity.

This lack of reaction to stimuli is something that is not conducive to resolving the grieving process; however, if there is awareness of the stimulus, one can use this knowledge to explore the loss in a healthy way, having the clarity that "awareness helps, that recognizing what we are doing helps, and that self-understanding can enlarge the field of our choices and possibilities "(Viorst, 1990, p.15).

Schiff's Conceptual Elements

Schiff (1986) carried out her work focusing on the relationships of dependence and the misalignments that these promote in the person who establishes the symbiotic relationship. She used concepts such as frame of reference, redefining and discounting. Discounting may well occur when faced with death and losses.

Frame of Reference

TA theory holds that there are three integral parts of the personality, called the Parent, Adult and Child ego states – with initial capitals these words refer to the personality and in lower case to people. Berne (1988) defines ego states as "coherent systems of thought and feeling manifested by corresponding patterns of behaviour" (p.25 – in English 1972, p.11).

In discussing frame of reference, Schiff (1986) says that "It provides the individual with an overall perceptual, conceptual, affective and action set, which is used to define the self, other people, and the world, both structurally and dynamically (p.58-59 - in English 1975, p. 50). So the frame of reference refers to a global structural and functional matrix.

The frame of reference is learned from parental figures and establishes a structure of characteristic thoughts, feelings and behaviours, defining the individual's belief system.

The different script options come from the different frames of reference structured in the individuals, making each individual resort to specific internal mechanisms to face grieving. Script, according to Berne (1988) "is an ongoing program, developed in early childhood under parental influence, which directs the individual's behaviour in the more important aspects of his life" (p.332 – in English 1972, p 418).

Considering death as one of these aspects, limiting beliefs about oneself, others, or reality are likely to inhibit spontaneity and limit flexibility in problem solving and interpersonal relationships, and the possibilities for choices become restricted to deal with the fact of death.

Redefining

When a stimulus does not conform to an individual's frame of reference there is a need to redefine in order to fit it into that frame of reference. This internal mechanism is called redefining, which Mellor and Schiff (2010a) refer to as "… The mechanism people used to maintain their established view of themselves, other people in the world in order to advance their scripts. It is the means by which people defend themselves against stimuli which are inconsistent with their frames of reference, and redefine the stimuli to fit into the frames. (p. 115 – in English 1975, p.303).

Depending on the script elements of the individual, the stimulus brought about by death will have a certain meaning and the person will react by redefining this stimulus to fit their frame of reference. For some, death can represent loss, rupture, the end of a cycle, for others, surrender, rest or even relief.

Discounting

We assume that "… there is a consensually definable reality, and that discounting involves a frame of reference which distorts or is inconsistent with that reality" (Schiff, 1986, p.18 – in English 1975, p.14).

Discounting is an internal mechanism, outside consciousness, that ignores or distorts stimuli that reach the person. Discounting, because it is not conscious, undermines effective thinking and the ability to evaluate reality. English (2010) wrote "Real feelings and perceptions are here-and-now responses to internal or external stimuli. An authentic person can allow himself to know and accept any and all feelings that occur in his Child, whether his Parent likes them or not. His Adult can separate feeling from action; he can also choose what and when to show or to express. (p. 91 – in English 1972, p.23).

We realize that the process of mourning is necessary for the individual to restore his balance, accepting the reality of loss and being allowed to express his pain according to his frame of reference.

According to Schiff (1986), discounting is "an internal mechanism which involves people minimising or ignoring some aspect of themselves, others, or the reality situation" (p. 18 – in English 1975, p.14). Through discounting, people can maintain or reinforce a dysfunctional frame of reference, practice psychological games and carry forward their scripts, whilst trying to reinforce or confirm dependency relationships with others.

Discounting is not operationally observable. What can be perceived are some manifestations of discounting such as passive behaviours, redefining, and transactions and behaviours in the drama triangle

(Karpman, 1986) positions of Rescuer, Persecutor and Victim which occur in psychological games - "… an ongoing series of complementary ulterior transactions progessing to a well-defined and predictable outcome." (Berne, 1974, p.49 – original in English 1968, p.44).

A transaction is the exchange of stimuli and responses, and for a single stimulus there is only one verbal or nonverbal response. The transaction is the basic unit of social relationship.

According to Berne (1988) "Death is not act, not even an event, for the one who dies. It is both for those who survive. What it can be, and should be, is a transaction."(p.164 – in English 1972, p.194).

If we think of the transaction when we lose someone, there is an action - stimulus-death and a reaction-response. However, our relationship with the person who dies is interrupted and we stop interacting with them, there is absence or loss of contact and this leaves a void which needs to be filled.

For Mellor and Schiff (2010b), "Discounting can be categorised in terms of three areas (self, others, and situation), three types (stimuli, problems, and options) and each of these may be discounted in for modes, (existence, significance, change possibilities, and personal abilities)."(p. 139 – in English 1975, p.302)

We observe some manifestations of discounting that occur with bereaved relatives. In many situations it is third parties who provide the funeral, since the relatives demonstrate passive behaviours in these situations.

Conceptual Elements of Kübler-Ross: The Five Stages of the Grieving Process

Kübler-Ross (1998) developed her work in hospitals, dealing with terminally ill patients, and identified five psychological stages through which they are faced with the closeness of death: denial, anger, bargaining, depression and finally, in the final stage, acceptance. These emotional phases are also experienced by people facing a loss.

Denial and Isolation - when confronted with the news, the person goes into a state of initial shock and then verbalizes the impossibility of the event. Denial works as a defence against what happened. This mechanism helps the person to alleviate the impact of the news, being necessary to keep their balance to continue life. At a later stage, the person may fall into a situation of personal isolation.

Anger - after an initial period of denial, the person may experience rage and anger. Relationships can become problematic and the ambience feels hostile.

Bargaining - at this stage people abandon anger and adopt negotiation strategies through promises and prayers, usually made to divine entities and usually kept secret.

Depression - when it is no longer possible to deny, attack and revolt, and bargaining did not work, a feeling of great loss arises, resulting in the phase of depression, manifested many times by crying, sadness, disinterest, fatigue and regret.

Acceptance - at this stage the person no longer experiences despair and does not deny their reality. It is a moment of serenity and hope.

Below we combine the Mellor and Schiff (2010b) discount matrix (p.137) with the five stages described by Kübler-Ross (1998).

Schiff's internal discounting mechanism in the five stages of the Kübler-Ross mourning process

We use below the discount matrix by Mellor and Schiff (2010b, p.137), considering the two variables of types and modes, and aligned with the stages of the mourning process of Kübler-Ross (1998).

Analysis of discounting

We can analyse discounting based on the types and modes. The three types are stimuli, problems and options. Stimuli can be internal - feelings, sensations, perceptions of the self - or external - information, events or signals of the other or the situation. Problems are the identifications of questions to be addressed and options are the possible alternatives to address them. Each can be discounted from four different modes - existence, meaning, possibility of change, and personal abilities.

In existence, one does not become aware of the existence of stimulus-death-awareness of loss.

In significance, the person recognizes the existence of the stimulus – death - but distorts the meaning.

In the possibility of change, the person is aware of the stimulus of death, understands its meaning, but believes that it is not possible to deal with the situation of death and, in personal skills, the person recognizes the existence of the stimulus of death, understands its meaning, believes that it is possible to deal with death, but disqualifies their own ability to deal with it.

In the Mellor and Schiff discount matrix there are hierarchical discounting relationships.

In the vertical discounting hierarchy, for each discounting type in the table, a discounting in some mode usually involves discounting in all modes below it.

Modes	Types		
	Stimulus	**Problem**	**Options**
Existence	T1 Existence of stimulus	T2 Existence of problem (**Denial**)	T3 Existence of options (**Anger**)
Significance	T2 Significance of stimulus (**Denial**)	T3 Significance of problem (**Anger**)	T4 Significance of options (**Bargaining**)
Change possibilities	T3 Change possibilities of stimulus (**Anger**)	T4 possibilities to resolve the problem (**Bargaining**)	T5 Viability of options (**Depression**)
Personal capabilities	T4 Personal capability to react differently (**Bargaining**)	T5 Personal capability to solve problems (**Depression**)	T6 Personal capability to implement options (**Acceptance**)

Adapted from Mellor and Schiff (2010b, p. 137 - in English 1975, p.301)

In the horizontal hierarchy, for a given mode, a discounting of any type involves a discounting of all types to the right.

In the diagonal hierarchy, a discounting at any point in the table involves a discounting in mode below and type to the left of it, and at the same time in mode above and type on the right.

In order to work out our losses we have created strategies to defend us against the pain of separation.

In the framework of discounting there is a moment when the person does not know the fact - T1 - The person discounts the existence of the stimulus.
One example is a wife who was found washing the floor of her house on the day of her husband's funeral and told her children that he would arrive and that he would be very angry if he found the house in disorder.

Whether the loss has been anticipated or not, the first sensation is of shock, apathy, and a sense of disbelief, in which periods of pain alternate with periods of astonished misunderstanding. Our mind seems to be immobilized by the shock and difficulty of under-standing the situation and we need time to be able to assimilate the idea of the death of the person we love and that this be accepted as a reality.

According to Clark (2001) "We experience shock at the news of the death of a loved one, even if expected, for it represents the loss of that relationship." (p.157).

Kübler-Ross (1998) also comments that the patient's first reaction may be a temporary state of shock from which they gradually recover.

Denial - T2- discounting of the significance of the stimulus and the existence of problems.
Once the initial feeling of numbness is over, the person recovers and tends to react with disbelief - No, it cannot be happening to me or No, it is not possible!

For Kübler-Ross (1998) "denial functions as a bumper after unexpected and shocking news, letting the patient recover over time, mobilizing other less radical measures" (p.44).

Denial is a mechanism that assists the person to alleviate the impact of the news, serving as a necessary defence of their balance. Reality is regarded as non-existent or transformed so as not to appear more unpleasant or distressing. What is knowingly intolerable is rejected by a protective mechanism of non-perception.

"Denial is an unconscious wish that something not be so. When confronted with our own experience of significant loss, our first reaction, after the shock, usually is to experience some sort of denial (Clark, 2001, p.157).

Minimizing or ignoring aspects of oneself - pain of loss - or of the actual situation - death of the loved one - generally involves denial.

Jacobs (2010) states that "the strength of our denial is related to the depth of our fears" (Jacobs, 1991, p.5).

Exemplifying the denial phase - "I'm not sad" said with a smile by someone who just got word of the death of his son. The person discounts the existence of the meaning of the stimulus - death of the child.

Using Schiff's discounting levels, we can think of denial of feeling such as an example of denial of some aspect of others "Mother is fine, she does not seem to have lost her husband from so many years of marriage" said by a son who may be denying the existence of any sense of mother's pain.

According to Kübler-Ross (1998) "denial is a temporary defence and is soon replaced by partial acceptance" (p.45).

Anger- T3 - discounting of the changeability of the stimulus, the significance of the problem and the existence of options.
Kübler-Ross (1998) states that "when it is no longer possible to hold firm the first stage of denial, it is replaced by feelings of anger, rebellion, envy and resentment, and this anger can spread in all directions and project itself into the environment, often without plausible reason (p.55-56).

This stage is characterized by feelings that vary in intensity, ranging from mild annoyance or irritation to intense fury or rage, usually accompanied by muscle tension and hyperactivity. It is usually expressed with aggressive behaviours to other people or objects in the environment.

Clark (2001) writes that "Anger is a normal response to the perception of betrayal or injustice. It is a way of trying to make someone else do something. Doing something or to take seriously an event or experience. It is a way of trying to change the environment, the situation, all the course of events." (p.157).

We perceive individual differences in the willingness to experience and express anger; or these feelings are experienced and expressed or are repressed and kept. Some people tend to invest a lot of energy in monitoring and preventing the experience and expression of anger, and excessive control can result in passive behaviours, isolation and depression.

Exemplifying the phase of anger - the son expresses his anger, entering into friction with the doctor who had been attending his mother in her terminal state and who died, saying – "You did nothing to make her better". The person discounts the meaning of the problem that is the death of the mother. The stimulus is 'dead mother' and the child does not use this information properly to define the meaning of the problem and therefore the existence of options.

Kübler-Ross (1998) considers that "the problem is that few place themselves in the patient's place and ask where this anger comes from" (p.56). The feeling of anger allows us to set boundaries and gives us the strength to defend ourselves against the sense of threat or loss and when anger is used in a healthy way, energy is directed toward solving the problem.

We understand that when we give time and attention to bereaved people, respecting and understanding them, they will soon tone down and diminish their irascible demands on others and or the environment, feeling recognized in their pain, realizing that they are human beings of value and in need of care. The relief from being able to express your anger will help the person to better accept the event of death.

Bargaining - T4- discounting of the personal ability to react differently to the stimulus, the possibility of solving the problem and the significance of the options.
The third stage is that of bargaining. Clark (2010) comments that "bargaining, as well as denial and anger, is the mental, physical, and behavioural attempt to solve a problem. It is an effort to repair something." (p.158).

We have identified magical thinking at this stage as an attempt to escape the anxieties and conflicts of both the inner and outer worlds, as if the act of thinking could control, modify, or explain the reality of loss, and thus obtain some reward such as recovering somehow the lost link. People demonstrate manifestations of a strong need to find, recover, and reunite with the deceased.

Magical thinking gives people a sense of control and security, and manifests through beliefs, rituals, and superstitions, including prayers and sacrifices, as a way of rationalizing death.

We observe that people at this stage negotiate, usually with divine entities, as a strategy to ease their pain and sorrow. "Most bargains are made with God, they are usually kept secret, spoken in between the lines or in the chaplain's confessional" (Kübler-Ross, 1998, p.89).

As examples, thoughts or verbalizations at this stage - If I pray enough, I can have him/her back; I'll light a lot of candles so I can find her/him again.

Depression-T5- discounting of personal ability to solve problems and the viability of options.
We observe that when the individual can no longer deny the reality of the loss, realizing that they cannot change the situation with their anger, they cannot mitigate the loss with bargaining, and now seeing the loss as definitive, a feeling of great loss begins to emerge, and a deep sadness is felt that is generally labelled as despair.

At this stage, behaviours can range from a mild despondency or feeling of indifference, to desperate hopelessness. We observe that people manifest sadness, disinterest, discouragement, fatigue, insomnia, lack of appetite, often showing themselves as quiet, restrained and inhibited. Their attitudes demonstrate discouragement, despair and also loss of initiative.

Berne (1995) cites that " Despair is precipitated by a dialogue between the patient's Adult in the outside world which is overheard by the patient's Child, while depression is a dialogue between his Parent and his Child with little Adult intervention. If the patient is already in despair, the therapist's refusal to play his residual games will intensify his bad feelings. (p.254 – in English 2001 p.278).

Clark (2001) considers that in death the losses are immense. Loss of hope, plans, connection, way of life, possessions - all have a profound impact on us.

Therefore, sadness is a natural and even expected reaction to the breakup of a meaningful relationship. Avoiding or suppressing pain will probably prolong the grieving process.

Kübler-Ross comments that "our first reaction to people who are sad is to try to cheer them up, tell them not to face the hard facts. We try to encourage them to look at the smiling side of life, the positive and colourful things that surround it. Generally, this is a consequence of our own needs, of our inability to endure such a negative physiognomy for very long (p. 93).

We find that people need to talk about their losses, because talking about losses is talking about broken bonds, and that they also need to feel recognized and qualified in their pain. The sadness that accompanies the loss, through death or an important separation, seems to us to be regarded as a process of restoring the person to the loss, for if we allow them to exteriorize their grief, they will more easily accept the situation.

To quote Kübler-Ross again "in grief there is little or no need for words. It is more a mutually expressing sentiment, usually translated by a touch of the hand, a caress in the hair, or by a silent "sitting by the side"" (p. 94).

We emphasize the importance of being together with the person, embracing the pain so that it can feel welcomed and not necessarily issuing words of comfort.

Examples of the depression phase - In tears the person verbalizes - "Why did this happen to me?" The desperate person says - "What will I do with my life without him/her; without him/her my life has no meaning." "No one wants to know what I'm feeling, I do not understand the emptiness I feel" the person says in a desperate tone.

Acceptance- T6- Personal ability to act on the options.
At this stage the person no longer experiences despair and does not deny their reality.

We find that there are two moments. Initially, the person discounts their ability to act on the options; they demonstrate that they are aware that the options exist, are important and possible, but not for the self or for the other. In a second moment, the person begins to accept death and to be aware that they and others can deal with this new reality.

The person is aware of the fact of death and that they can continue their life, adapting to the new situation. They demonstrate a new acceptance of life, meeting the demands of the environment, playing roles for which they were not accustomed, developing skills and being able to move forward with a revalued sense of life, reinvesting emotions in life and in living.

Often at this stage people turn to spirituality and religiosity in an attempt to deal with the helplessness felt by the loss of meaningful attachment.

What is important at this stage is for the individual to attain acceptance in peace, with dignity and emotional well-being. Thus occurring, this stage can be experienced in a climate of serenity on the part of the individual, with comfort, understanding and collaboration for themselves and others.

Examples of verbalizations or thoughts in the Acceptance phase – "I think of him/her, I miss those days and I will continue his/her businesses." "Wow! It's true, they've gone! I did not want it, but it happened."

Final considerations

The process of grieving depends on our ~~history~~ of love and loss, our script, and in the process we go through some stages to work out our mourning, this being a slow and gradual path.

We begin with the shock, not taking cognizance of the death stimulus; then the negation of the fact, where we do not attribute a meaning to this stimulus, so it will not be defined as a problem. We go through the feeling of anger, because we are aware of death and we attribute a meaning to it, but we do not see options to deal with it. We generally deal with divine entities because we disqualify our ability to react differently to death and also the possibility of solving the problem; and we go through the acute pain phase, not recognizing our ability to deal with death and not seeing options. Finally, we go on to what is considered the end of mourning, acceptance, when we are aware of death, and recognize that we can deal with it. And although sometimes we still cry, and we still miss, that end means an important degree of recovery, acceptance and adaptation.

Each of these phases has its characteristics, and there are considerable differences from one person to another, depending on life scripts in terms of both the duration of and way in which each phase develops, and there may be oscillations in the stages. In these, a succession of emotional states that merge and replace themselves become evident.

A greater awareness and understanding of the possible paths that each individual can take to recover from a loss allow a greater acceptance of the innumerable differences that the process of grieving has from person to person.

Time turns out to be the best ally in this process, allowing for a slow and gradual recovery.

The possibility of establishing a connection between Kübler-Ross's mourning stages and the TA concept of discounting proved useful, enhancing the therapeutic work in the process of completing mourning.

Understanding the process of grieving through this approach, in our view, enables us to have a sensitive encounter with the other; assisting in awareness of feelings and perceptions during the grieving process, how to organize the experience of loss, and how to create meaning for it by developing personal skills.

We realize that through the empathic validation of the individual's feelings and needs, which implies welcoming and listening; making time to listen and share the feeling of loss, we allow them to let their emotions go. In this way, we can offer support and security at this stage and also come to view the grieving process as a healthy way of dealing with painful and unpleasant situations.

The externalization of feelings when losing someone very close is a healthy attitude in dealing with the loss, not allowing feelings of guilt, anger or despair to remain hidden by the individual to themselves and others.

The lack of understanding on the part of the psychotherapist to understand the process of mourning can lead to containment of mourning and leave unresolved losses. However, if we are consciously aware of this process, we can guide clients to their evolution, to a new acceptance of life. Clients will be able to regain stability, energy, hope, the ability to take pleasure and invest in life.

Considering the difficulty in finding material on the subject of grief among the specific publications of TA, I hope that this approach makes a contribution to psychotherapists given the breadth it requires.

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Supervision in Psychotherapy from the Perspective of Transactional Analysis

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Where possible, quotations have been adjusted to reflect original English publications, particularly for TA publications.

Abstract

This article deals with supervision in clinical psychology that is distinct from pedagogical practice in psychology. The objective is to expand the reflection about supervision, the role of the supervisor and the training of psychotherapists from the perspective of supervision in the methodology of transactional analysis. Supervision is about a process of professional development that must qualify the skills of the trainee, develop those that are lacking and expand their potential to achieve professional success, since the construction of psychotherapeutic knowledge is not limited to theoretical content and must include training practical skills, professional posture and ethics.

Introduction

Newly qualified as a Teacher of the National Union of Transactional Analysts, supervising newly graduated students and student psychotherapists of transactional analysis, besides accumulating the position of guest professor at the Graduate School of Medical Sciences of Santa Casa de Misericórdia in São Paulo, for some time I have observed and reflected on the roles of supervisor and supervising. Having occupied the position of Director of Teaching and Certification of UNAT-BRASIL, this interest led me to look for ways to improve the training of supervisors.

Supervision differs from clinical practice and pedagogical practice of psychology. Clinical practice focuses on diagnosis, intervention and cure. The pedagogic practice aims to acquire scientific and theoretical knowledge of psychology. Supervision is about a process of maturation and professional development.

Sakamoto (2006) considers that the core of supervision "is to meet the demands of the theoretical-technical integrations of clinical practice involved in attendance, the demands of the specific clinical practice of the approach adopted, and also helping the student in a professional training process with the acquisition of a professional identity "Supervision, therefore, can occur in two contexts: 1) supervision in clinical school - in psychology courses for students in their last years, and 2) supervision in university extension courses for trained professionals who want to acquire new techniques of psychotherapeutic approach or receive support to improve their professional performance.

The supervision exercised in the university context has as variables: the curricular grid, which limits the number of hours for the supervision process; the fact that it is the first experience of customer service by the student; the obligation to get credits, even for those students who are not interested in the clinical area; and the designation of the supervisor based on the teachers available. This teacher does not always have the profile and the interest necessary for this task, and sometimes, in the supervisory space, replicates the methodology of the classroom.

The student / psychotherapist has two main motivations: 1) the professional task of the clinical care of their patient, and 2) the integration of theory and technique that form the basis of professional identity.

Supervision can also be exercised in the context of university extension courses: courses in psychoanalysis, cognitive-behavioural, transactional analysis, psychodrama and others. The variables that interfere here are the volunteer's choice as trainee, their experience as a trained psychologist, the desire to expand his knowledge, expand the scope of techniques, learn new theories and find support for difficulties in clinical practice. In this case, supervision is part of a tripod that characterizes the theoretical model of these courses' theoretical knowledge, psychotherapy and supervision. The supervisor, in this case, chooses supervision as a method of work, invested in their training, and is dedicated to developing and improving their competence in this area. This fact distinguishes them from the university professor, assigned to the role of supervisor.

Zaslavsky et al (2003) states that, in this context "supervision is a process of qualification of the candidate. In this sense, the supervisor's attitude should stimulate, in supervising, the development of his own abilities. One of the main functions of supervision is to develop in supervising the ability to perceive their own difficulties. This would be the way to achieve independence, following the learning process through self-criticism." (p.3)

In this context, supervision can be considered to be of a trainee who is in the process of training to acquire a new skill during the creation of identity in the role of psychotherapist. Therefore, I will use the word "training" as synonymous with "supervising".

I believe that the experience in the certification of transactional analysts of the National Union of Transactional Analysts - UNAT-BRAZIL, can contribute to the reflection on the role of the supervisor in the process of creating the professional identity of the psychotherapist.

Psychotherapy Training - Eric Berne's Experience

In the early 1960s in the USA, psychiatrist Eric Berne was responsible for training physicians residing at McAuley Hospital in San Francisco, California, proposing a training method that included: customer service, presentations and theoretical discussion in seminars and staff conferences.

Originally the psychotherapy group sessions conducted by Berne were attended in a mirrored room by resident physicians, until one day a schizophrenic patient in outbreak threw a chair breaking the mirror. Faced with this situation, Eric Berne invited the residents to participate as observers in the same room as the group. At the end of the psychotherapeutic work he asked patients to switch places with medical observers and proposed that residents, now in the centre of the group being watched by clients, would

talk about what they had observed. The practice proved to be efficient, the resident doctors referred to clients with more objectivity and respect, and clients were interested in the discussion. Berne decided to include this proposal as a method of teaching in the hospital, conducting all team conferences in the presence of clients. He later included other staff members in the discussion, including nurses and social workers.

Berne considered that the therapist-client relationship should happen in an OK / OK basis which, in TA terms means that each have value and qualities independent of their roles; both are healthy and deserving of respect. If, on the one hand, the doctor / psychotherapist has privileged access to technical information, on the other, the client has privileged access to his / her history and the construction of his / her psychological process. This type of training method for residents and psychotherapists was not properly a model of supervision but was included as a working philosophy in the methodology of the processes of training transactional analysts of both ITAA and UNAT-BRASIL.

Creating the OK / OK space between client and psychotherapist, between supervisor and trainee; means generating a dialogical space of mutual respect and interest with a balance of power between the parties. The best way to build an OK / OK process of competence acquisition is through questions, as quoted by Andersen (1991):

"We consider that our contribution consists basically of questions, in particular those which our interlocutors generally do not ask themselves, and which give rise to many answers which, in turn, can generate new questions." (p.59)

The same author comments that a reflexive posture includes: the review of spontaneous and automatic response usually centred on certainty (judgment); personal investigation generating intrasubjective movement (thoughts, feelings); the construction of a collaborative context; and the transformation of the conversation into an external dialogue of internal dialogues in order to generate what he calls "dialogue of dialogues".

In the context of supervision, this posture requires the supervisor to listen to the trainee, to question the impact the supervision has, and to make room for feedback on the trainee's interventions. On the other hand, the trainee, when answering the supervisor's questions, may reflect on their certainties and uncertainties, find out the impact of their actions and what feelings are mobilized as a result. When the dialogue between supervisor and trainee happens in this way, both are enriched by the experience. The trainees appropriate their own knowledge and

questions while the supervisor, instead of presenting themselves as all knowing, places trainees in the position of asking the questions, thus helping the trainees find their own answers.

This attitude creates an environment conducive for the trainee to listen to the client: both within the case and the client's feedback on the psychotherapeutic procedure; to listen to themself in the role of psychotherapist, and to listen to feedback from supervisor or peers.

It is necessary to consider that both supervisor and trainee have backgrounds: their life experiences, maturity, needs and knowledge. The questioning of the premises behind statements and the deepening awareness of the motives that lead supervisor and trainee to choose certain positions, allow the revelation of the background that surrounds them. And both trainee and supervisor are affected by their backgrounds, as well as the personal and emotional issues underlying performance. The backgrounds of the supervisor and the trainee must be heard, respected and at the same time relaxed by dialogue, leaving the dangerous territory of a presumed knowledge that limits access to the acquisition of new learning or questioning.

The OK/OK posture, therefore, presupposes balanced participation and responsibility of the parties. It is important that the contract between them is clear, establishing the goals to be achieved, the method for attendance and supervision, and what is expected of the performance of supervisor and trainee, including the motivation, expectations and fantasies of both. When these premises are established from the beginning of the supervisor/trainee relationship, problems, difficulties and transference processes can be discussed and solved.

When creating the dialogical space and the balance of forces between supervisor and training, a plan of action that addresses the training needs of the trainee is urgently needed.

Development Needs

The opening to acquiring new skills occurs differently for each trainee. One must consider the motivation, the theoretical knowledge, the maturity and the stage of development for each. At each stage of learning, the trainee experiences different needs. This is similar to the stages of early childhood development, where specific skills are developed as the child deals with the learning opportunities that life naturally provides. Levin (1982) cites six stages of development that apply from child development to the acquisition of knowledge and new skills:

Phase 1: Being - The basis of our existence from birth to six months - development needs relate to existing

and living, communicating what you need, trusting and having your needs met.

Phase 2: Doing - The world of sensations and action between six and eighteen months - development needs are about trusting others, learning that it is safe and wonderful to explore the world, believe in your intuition, be creative and active and get support for these activities.

Phase 3: Thinking - The domain of concepts - between eighteen months and three years - development needs are about thinking for oneself, solving problems, expressing and managing feelings, especially anger, initiating the process of individualization .

Phase 4: Identity - The continuous evolution of the self - between three and six years of age - development needs are about affirming one's own identity, acquiring information about the body, sex, roles, about the world, socializing, learning to deal with the consequences of their actions and separating fantasy from reality.

Phase 5: Becoming Skilled - The 'hows' and 'whys' of life - between six and 12 years - development needs refer to the act of learning new skills (without having to be perfect), learning from mistakes and being appropriate, testing your skills and comparing yourself to others, testing ideas and values between different families.

Phase 6: Integration - Creation and reproduction - from 12 to 18 years - development needs are about achieving a clear separation from the family, developing independence, integrating sexuality with your identity.

Of course, in each stage of development the human being faces situations that invite them to develop each skill. The first opportunity to acquire these skills occurs in childhood, but as in a spiral, each of these phases can be recycled into adulthood. The opportunity for recycling is naturally offered by life and its challenges.

The learning context is one such opportunity. When the necessary conditions, encouragement, and recognition are offered, the person quickly uses their skills to explore the new experience and acquire a suitable repertoire for their development.

Supervision in a Developmental Context

The supervisor, when considering these elements in the supervision process, is able to provide a unique attention to each trainee, qualifying their development needs and offering them the stimulus necessary for their evolution. This can also be done within training groups.

An important element to consider is the quality of feedback from the supervisor to the trainee. Often, by

focusing on the result, the supervisor points out faults and points to be corrected in the trainee's performance, promoting negative feedback. If this happens too often, the level of anxiety and resistance during the supervision process can become high.

Napper & Newton (2000) applied the concept of Levin's Development Phases to student training. This model allows the supervisor to create a repertoire of stimuli and positive feedback that stimulate the motivation of the trainee and enable the balance between motivation and demand.

In Phase 1: Being - The basis of our existence

In adult life, the trainee recycles this phase at the beginning of any new activity, whenever accepting a new challenge, as for example, the beginning of working as a psychotherapist.

According to Sakamoto (2006), the "apprentice" psychotherapist experiences "expectations about professional competence, fantasies, desires about impotent or omnipotent behaviours, anxiety about the new and unknown professional situation" (p.2).

Considering these needs can be very helpful to the supervisor, who can stimulate the trainee with "You're doing well", "You can ask me at any time", "You can use imagination, fantasies can help learning", "Go at your pace, you have time, you do not have to hurry. "

The supervisor should provide a predictable structure, focused on theoretical knowledge. Identify the strengths and weaknesses of the trainee, because the way in which they apply them in their practice creates a baseline from which future knowledge will be built. At this point, the supervisor is seen as a model and indicates the 'how-to' through case-discussion, role-playing, pieces of therapy, providing a repertoire to be "copied" by the novice psychotherapist.

The supervisor should also be an OK / OK relationship model with the trainee. When, from the beginning, a safe dialogue space is created for the trainee to express their fears, insecurities, fantasies, in a climate of unconditional acceptance, in which any question is welcome, a trust bond is generated between supervisor and trainee. In a group, this posture creates the space to talk about personal experiences and exchange feedback with respect and security. When the trainee feels safe, they go naturally to Phase 2 and begins to explore the new world that opens up to them.

Phase 2: Doing - The world of sensations and action

The trainee begins to explore the new information, trying to put it into practice. Like a child who begins to crawl and broaden their experiences, the trainee wants to experience everything a little. The very act of exploring various situations is already gratifying, and there is still no clear enough relationship between theory and practice. Various flavours are experimented with, as well as looking a little at everything, getting to know and creating an image of this new world.

The needs of the trainee can be met by the supervisor with an attitude that involves statements such as "I like the way you ask questions", "You have creative and excellent ideas", "You make good correlations", "Let's build on what you have observed", "I encourage you to think about your ideas and experiences", "I will help you relate your experiences to theoretical references." This is the time to encourage the trainee to act, test their skills and knowledge. As the trainee gains some mastery of theory then the focus is on developing a sense of confidence, helping them feel comfortable and secure in the role of psychotherapist, recognizing and appropriating what they already know.

This can be achieved by encouraging the application of skills, help and positive reinforcement for what is being done. With the encouragement of the supervisor, the trainee can explore different types of techniques, procedures and attitudes, seek to relate theoretical knowledge to practice, locate and fill possible gaps in their studies, learn to describe the behaviours of the clients and relate them to diagnostic hypotheses, and to observe the results of their interventions. After much exploration, the trainee naturally begins to draw conclusions and to trust their own perception, moving to Phase 3.

Phase 3: Thinking - the domain of concepts

In adulthood, the trainee begins to master theoretical concepts, knows how to put them into practice, and needs to find their own method of doing things.

The needs of the trainee can be met by the supervisor in an attitude that involves statements such as "You work well with details", "You can think of a way to solve this problem", "What do you think of this?", "You have an excellent ability to think, "How do you feel about these thoughts?"

This is also a good time to begin analysing transference processes by asking the trainer about the feelings that affect them in their relationship with the client or with the supervisor or peers in the supervision group. It is important to learn to think about what they feel and also to perceive the feelings that arise from these thoughts.

Evaluation and feedback on results achieved and information on skills not yet acquired will be the basis for acquiring new knowledge. Helping the trainee to exercise their 'inner gaze', describing their contact with their own emotions, memories, beliefs and fantasies, while observing the client's behaviour and phenomenological experiences, and placing them in a theoretical context: "Now I am aware that you ...

(external observation) "," Now I am aware that I ... (internal observation: feelings, fantasies, physical reactions) ".

Questions about what the trainee observes in the client, in them, in the supervisor and the dynamics between them may be important. It is common at this stage for the trainee to test their own ideas, seeming to oppose the supervisor's suggestions. This requires patience from and understanding by the supervisor, because the more space there is for different points of view, the faster the trainee can feel recognized in their own way of thinking, moving on to the next step.

Phase 4: Identity - The Continual Evolution of the Self

Here the trainee already possesses some mastery of theory, knows how to apply it and can observe themselves in the therapeutic process. At this stage, the goal is to build an identity as a psychotherapist, refine methodology and learn to do therapeutic planning.

The supervisor can stimulate the trainee by saying, "You can find out what happens as a result of your actions," "What would be your way of dealing with this situation?", "I like the way you risked doing this," "You're figuring out how to handle this information very well." It's time to invite the trainee to dare to do it their way.

It may be useful to work in a group at this time when the variety of possible responses for a given situation can be observed, discussing and evaluating the therapeutic process from new perspectives, observing the interventions performed and comparing success and points of resistance; giving and receiving feedback, valuing both positive and corrective aspects. As theoretical knowledge increases, one invests in planning the treatment and next steps, exploring other intervention options. The trainee should be encouraged to look at and learn from their mistakes.

Some questions that might help: "What would you do differently if you could repeat this therapy session?", "What will you do next time you work with this client?"

This is the time to work with countertransference, defined here as all the psychotherapist's reactions to the client, which are the result of unresolved conflicts of the therapist. It may include beliefs, reinforcement memories, expectations, and anticipations. The supervisor may suggest that the trainee go through a process of psychotherapy to work on their personal issues that are interfering with their objectivity as a psychotherapist.

One can also use the comparison between different approaches, authors or techniques to deal with a situation, discussing the pros and cons of each and

valuing the background of the trainee. At that moment, valuing the individual response and highlighting the skills already acquired may be fundamental. It is a good time to encourage the trainee to share and compare their experience with other trainees, which gradually strengthens their confidence, leading them to the next phase.

Phase 5: Becoming Skilled - The "hows" and "whys" of life

In adulthood, the trainee needs to test self and others, find out where they can go and where their limits are. These needs can be met by the supervisor in an attitude that involves statements such as "Trial and error is the best way to learn", "This test is just for you to have an idea of how you are going, not to define your skills or your ability," "What can you do to improve your performance? "

It is a good time to discuss values and ethics in the relationship with the client, with the peers, with multidisciplinary teams and with society. Skills and theoretical knowledge are already well established, and the supervisor can deepen the questioning about the reasons that led to the choice of a particular intervention and what it is expected to achieve. Evaluation of results and planning of future actions are the main topic to be addressed at that time.

Theoretical discussions are important so the trainee can explore new possibilities for action. To create dialogical space for the trainee to test opinions different from those of the supervisor and to be respected in their own uniqueness is fundamental. Critical analysis and new theoretical discoveries can be very interesting to arouse the taste in the trainee for scientific writing.

You can ask the trainee to summarize the supervision: "What was the problem presented?", "What did you learn from the client work and supervision?", "What did you learn about yourself?", "What can you do differently next time?"

Phase 6: Integration - Creation and reproduction

The trainee at this stage needs to create independence and broaden their view on the different aspects of therapy. The supervisor can encourage them by saying, "I believe you can describe well what you do," "Tell me what and how you are doing.", "You are summarizing information/ideas brilliantly!"

Trainees should be given an opportunity to explore, experiment, and gradually develop a unique therapeutic style of their own.

Working in groups, you can establish something to be observed; each one speaks to an aspect that has not yet been mentioned; and in the end the trainee reports what they learned from the different observations.

It is also possible to vary the topics to be discussed and, as far as possible, to begin to relate different approaches through a case study: a) The trainee should describe the problem based on behavioural observation, b) Analyse this observation through a theoretical approach, c) Raise a hypothesis about the client from this theory, d) Develop one or more interventions that are consistent with the theory and hypothesis raised, e) If the trainee goes well thus far, they may be challenged to examine the behaviour from other perspectives, and possible theoretical hypotheses and interventions.

The supervisor will then stimulate the discussion of the various possibilities for intervention. Advanced trainees may be asked to supervise other trainees, develop scientific research, or come up with new ideas.

At this point, it is necessary to prepare the trainee for the disconnection of both the supervisor and the protected environment of the supervision group. The moment of farewell comes when the trainees leave excited about what they have learned, able to think critically about their work and able to relate to colleagues with interest and respect.

Conclusion

There are several ways for the supervisor to stimulate the motivation of the trainee in the supervision process. In addition to aspects of theoretical knowledge, technical and ethical skills, the supervisor should also be aware of the ability of the future psychotherapist to self-develop, stimulating them according to the level of development, valuing the trainee's background and skills already acquired.

The quality of the supervisor-trainee relationship is critical to successful supervision and success in the practice of the psychotherapist. The art of asking and giving feedback can be precious tools in the supervisory process.

The supervisor should constantly invest in their own improvement, as much as they invest in the improvement of their trainees.

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Rituals as Promoters of Autonomy

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Where possible, quotations have been adjusted to reflect original English publications, particularly for TA publications.

Abstract

For Eric Berne, the psychiatrist who developed transactional analysis, Ritual is a form of time structuring that provides less recognition in relationships. This article aims to re-signify the concept by bringing the understanding that ritualization can be understood not as submission to patterns programmed by tradition and social customs, but as an action that provides an environment that stimulates the development of autonomy. The reflections of authors in the fields of anthropology, psychology and sociology, including van Gennep, Terrin, Bell, Zoja, Tambiah and Turner are used to illustrate and explain the study of rituals as practices replete with symbolism and meanings. Through Eliade and Bateson the notions of the sacred and consecration are considered. Autonomy is referred to as Berne perceived it, implying capacity for awareness, intimacy and spontaneity.

Key words

Transactional Analysis; Rituals; Consecration; Autonomy

Introduction

The study of rituals is a constant theme in Western social and anthropological research, which is far from being exhausted. Rituals have existed in various cultures throughout history and over time have been losing space and meaning in the modern world. Changes in our lives and closings of cycles are constant and rituals had as their objective demarcating and consecrating them. Within transactional analysis (TA) (Berne, 1988), ritual is identified as one of six

possible forms of social structuring of time. This article proposes to re-signify the concept by bringing the understanding that ritualization can be understood not as submission to patterns programmed by tradition and social customs, but as an action that provides an environment that stimulates the development of autonomy.

What are rituals?

Berne (1988) conceptualizes ritual as one of the six forms of time structuring. Following withdrawal, Berne views rituals as the second most secure form of social action. He writes that these are highly stylized exchanges that may be informal or formalized in ceremonies that are completely predictable and of little information. In this concept, the transactions constituting rituals are signs of mutual recognition. The units of a ritual are called strokes, by analogy with the way in which babies are recognized by their mothers. These are programmed by tradition and social customs. Rituals understood in this way seem simple acts with limited meanings in which little information is available to those involved. The understanding of rituals as submission to patterns programmed by tradition and social customs limits its potency, since the existence of rituals goes beyond simple formalities. Analysis of rituals encompasses a vast exposition of meanings.

In van Gennep (2011) it is observed that if on the one hand there is protocol, the rituals go beyond limited information because they are filled with symbolisms, as for example, in commensality. This concept is based on the notion that a meal offered and shared can be a stage of great importance between a foreigner and a tribe, in which the act of eating together is part of a rite of aggregation, considering the acceptance of the intention behind the gesture, the entry of a new member into the tribe gradually, and that non-acceptance of the meal may be perceived as a refusal to engage. From this analysis, it is clear that rituals contain symbolic acts that, when experienced with their purpose, carry within themselves a sense of

legitimizing moments. The symbolic act demonstrates this richness found in rituals: "In the context of the rituals of *ndembo* (a society that lives in small and mobile villages in Central Africa), every object used, every gesture performed, every chant or prayer, every unit of space and time represents, by conviction, something different from itself. It is more than it seems to be and often much more "(Turner, 1974, p.25). So we can say that symbolism is full of meanings. The action is not merely representative, it is an autonomous act, and not an automatism, when this significance is present.

In order to conceptualize rituals and rites, this work uses the view of Terrin (2004), in which the use of the term "rite" refers to an action performed in a certain time and space (initiation makes the child an adult, baptism makes the child Christian). These are actions, with beginning, middle and end, which are different from the actions of ordinary life. Already, the word ritual refers to a general idea, of which the rite is a specific instance. Ritual is an abstraction, while the rite is what is something you do and experience in a particular religion or culture. Terrin (2004) describes the rite as a concept of culture, perceiving that it runs through several dimensions: theological, phenomenological, historical, religious, anthropological, linguistic, psychological, sociological, ethnological and biological. For this author, the act of ritualizing is the process by which rites are formed or created - actions that, over time, are ritualized (a person is led to have a ritualistic behaviour and ritualizes himself to act, becoming formal and repetitive). It is seen as a positive process. Ritualism, in turn, is when there begins to be a negative connotation to the process. A stereotyped behaviour, devoid of any symbolic content. Terrin cites behaviours in major religions as they become repetitive, standardized, and formal, and when a client resorts to ritualized ways to combat distress, such as washing their hands several times. Nowadays, however, the term rite is so broad that it includes any activity performed in a standardized, formalized and repeated way.

Today´s society deals with some important passages of life in a celebratory and sometimes ceremonial way, using formalities and rituals, but the ritualistic act often loses its significance and deep meaning, ending up being stereotyped repetitions, emptied of its symbolic significance. This merely celebratory perception makes it impossible to experience these ceremonies in a ritualistic way.

Bell (1992) creates a framework of analysis of the types of activities generally understood as ritual. On a fundamental level, this structured attempts to return such ritualistic activities to the context of human action in general. She proposes that we may see a ritual as

a way of acting, as the ritualization of activity. Ritualization, in this sense, is a way of doing things to provokes the perception that these practices are distinct, and the associations they generate are ritualized and differentiated from other acts. A ritualistic process is thus used to bring intensity to the experience. Ritualization has purpose and meaning that communicate beyond words. We can see rituals as a way of being an interaction that resists, repeating patterns of little meaning, referred to by Terrin (2004), as ritualism, or we can use them to seek the opposite, ritualization (Bell, 1992), with a deep meaning and the surrender of a moment of autonomy through a ritualized action. A rite, according to Tambiah (1985) is defined as: "culturally constructed systems of symbolic communication." (p.124), continuing that therefore the performative character of the rite validates its expression: "Efficacy derives from the performative character of the rite in three senses: what is said and done a conventional act, in a performance that uses various means of communication through which the participants intensely experience the event, and finally, in the sense of referring to values which are linked or inferred by the authors during the performance as the link between form and content" (p.128).

Ritual action is not mere representation; as the ritualistic actions are said and done, they are consummated in the act itself, such as the "yes" spoken by the bride and groom at the altar. How important is it to ritualize celebrations and life passages? "Legitimation is one of the most powerful things that ritual does" (Bell, 1992, p.196). For the author, rituals are political. Ritual is a thing of its own. It is the power of ceremony and interaction. Ritualization as a strategic mode of practice produces subtle relationships of power, relationships characterized by negotiated acceptance and resistance, redemptive appropriation and reinterpretation of the hegemonic order. "Ritualization involves the differentiation and privilege of particular activities." (Bell, 1992, p.197). The ritualistic process happens this way, precisely demarcating passage, change, something beyond the ordinary and trivial, that needs a special framework to be effective. Efficacy is the consummation of the rite which, as it is experienced, carries within it its purpose. From the definitions of rituals Tambiah (1985) brings an open definition and is at the same time, precise when he says: "The events that anthropologists define as rituals seem to share some traits: an ordering that structures them, a sense of collective fulfilment with definite purpose, and also a perception that they are different from the everyday. But ritual is part of a cosmology." (p.130)

The realization of ritualistic events as a collective needs a collective that sees itself as a community. The

community in the ritual acts so that the subject assimilates and experiences its passage. For example, at a funeral the ritualized collective role will have a tendency, as van Gennep (2011) points out, in the direction of marking and symbolizing separations. In a marriage, collective action tends to dramatize the aggregation of the subject who is changing the group, whereas in a marginal period, such as pregnancy, engagement, initiation, the sequence of ritualistic actions of the community apply across the margins of the subject to go through the ritualistic moment such that it is seen in an individualized way. There is a dialogue between community and subject, supporting the action of transition of the passage itself, and the rite fulfils the functions of assimilation, surrender and legitimacy.

Zoja (1992) notes that through rites, the psychic and social life of all communities is structured and ordered to seek organization. Rules also exist to assist in the development of the psyche. From this perspective, the author perceives the lack of rites today as a psychic prejudice since they have occupied a place of great value and expression in all traditional societies that were not yet industrialized; the disappearance of rites is a recent phenomenon within our modern Western culture. Changes in our lives and the closing of cycles are constant and rituals were intended to demarcate and consecrate them.

Rituals as Instruments of Consecration

Consecration can be seen as one of the purposes of rituals. A consecration is about making sacred what was profane; in the case of the rite, to make sacred the moment and its meaning. Eliade (1992) says: "To consecrate is to seek communion with the sacred." (p.25) and we can speak of the sacred and the profane as two forms of being in the world, two possible dimensions of human existence. The very word consecration has as one of its meanings "to legitimize, to make legitimate." by making it sacred, legitimacy happens.

In this sense, making a ritual sacred would be like legitimizing it for oneself. The sacred form of existence is consecrating, making ritualistic action sacred. To see reality in a totally de-sacralised way is a recent discovery in the history of humanity. Legitimacy happens, for while in the profane one takes up the automatism of daily life, in the sacred there is a deep contact with the present moment and relationships in the here-and-now. In this sense, rituals work toward this purpose, letting abundance enter, providing contact between structure and meaning, for all this psychic change occurs through and in contact with the here-and-now. "Between the profane world and the sacred world there is incompatibility, to such an extent that the passage from one to the other cannot be made

without an intermediate stage." (van Gennep, 2011, p.23). The intermediate stage seeks a ritual. Thus we can think of the ritualistic process as a collective action of consecration in which the people involved are aware of their purpose, of witnessing change, of facilitating it, and of blessing it. Studying the sacredness of a phenomenon requires the study of its relationships.

How does a group become sacred? In the combination of the analogical information of the more verbal and analytical field of the left brain, with the right, more intuitive and non-verbal through the experiential, the symbolic is produced in a significant density that words alone cannot express, inviting the sacred to establish itself, bringing possibilities of personal interpretation and sense to the subject that passes through the ritual. The ritualistic form provides an experience beyond dialogue and reason. It enables sensations through the symbolic, the dramatizations, the poetic image, establishing the sacred.

Ego States and Living a Ritual

Berne (1988), when referring to personality structure, brings the understanding of three psychic organs: exteropsyche, neopsyche and archeopsyche, which present themselves phenomenologically and operationally through three types of ego states called Parent, Adult and Child, with these being considered states of mind and their related patterns of behaviour. Every person will transition between these states. Thus, the Child, Adult and Parent are phenomena based on concrete realities. As we relate with others, we encourage certain ego states in our communication and that of others. The ceremonies experienced only as a series of rituals coordinated by parental stimuli - this is how it happens, it is time, it is what is expected - it leads the person to live moments of change in a repetitive and unconscious way, in which the one in charge is the Adapted Child, not promoting autonomy. Here we have an Adapted Child that tends to repeat moments experienced by their parents or by a certain institution. Thus the subject who passes through the ritual can easily submit, but the act in itself ceases to be an action that ritualizes and becomes a mere ritualism. In ritualism the presence of the subject becomes a simple passage of an undifferentiated time and nothing happens in the development of the psyche. Script is repeated, and the obedience is to a disciplinary culture that reinforces validation of an introjective attitude. A Critical Parent tends to stimulate an Adapted Child.

In order for awareness to expand requires a moment of passage, and contact with the here-and-now is fundamental for bringing purpose into focus. The foreseeable ceremony, with merely standardized, formalized and repetitive rituals emptied of symbolic content, is more a disciplinary practice that does not promote autonomy for change; the celebration alone

does not legitimize or change status. Psychic change requires expansion of consciousness. In the celebratory moment, in a profane way, resistance to change is reinforced. In a creative and intuitive ritual in which the sacred is incorporated, the Little Professor is invited to participate, and the parental part serves as an anchor to bring the individual into deep contact with the experience of the moment and its meaning, anchoring the moment of passage like a midwife, who shelters and anchors the rite so that the baby and the mother can pass through the experience - the passage always requires a sacrifice. If the subject loses the power of contact with the present moment and its profound sense, the transition, the change, the unconscious fear of the dissolution of the way of being, means the possibility of a psychic change occurring decreases, being restricted to a practice without any sense of internalisation. If the subject recognizes and engages in ritualistic experience, they will be conducted through the process, and affected by it, so the possibility of a psychic change happening increases. Sacred rituals depend on a Protecting Parent - we need to validate what is happening in the sacred through the symbolism provided by the four entrance doors of being: feeling, significance, sensations and thinking - so the Child can pass through the unknown - since it is a passage - through the collective function: of providing separation, if the ritual is of separation; of aggregation if it is aggregator; or boundary if it is a threshold (van Gennep, 2011). This allows a greater assimilation of the subject - the adult person who is experiencing the recognition of the change that is to come, making contact with their emotions, validating the intensity of the impact, the meaning of the situation for themselves and, when sharing with the collective, legitimizing this change. It provides the "give-and-take" - "I'm changing". The richness of the contact experience depends on a person's ability to perceive its full impact.

The symbolic experience brings the invitation so that there is no hesitation but rather surrender. The preparation, the ritual, invites the personal presence, the subtle accompaniment of the here-and-now, facilitating ritualization and consummation. The community facilitates the process, witnesses the walk.

Autonomy

For Berne (1977) autonomy is directly related to the improvement and re-establishment of three aptitudes: awareness, spontaneity and intimacy.

The capacity of awareness requires living in the here-and-now. What Berne conceptualizes as a more visible ability in children, to observe birdsong with delight, and being less intellectualized, is also what we treat as sacred. Bringing awareness into the here-and-now may be the ultimate goal of ritual action, so that the person can consciously perform its actions of

change. Sacralising would be a way of dealing with reality without denying its greatness, being affected by it in the here and now.

"The aware person is alive because he knows what he feels, where he is and the moment he lives." (Berne, 1977, p.157). The ritualistic format provides an experience beyond dialogue and reason. It enables the intense experience of the present through sensations, through the symbolic, the dramatizations, the poetic image. By enabling the establishment of the sacred, this "affirms itself as the experience of reality and the origin of the consciousness of existing in the world" (Bateson, 1993, p.34). The purpose of living a ritualistic moment is to choose to leave a profane moment and bring awareness of its importance.

The ability of spontaneity means, for Berne, choice, freedom to choose and express existing feelings. Bell (1992) promotes the idea that often the work practiced through ritualization is mistakenly understood by the notion of control. Social ritualization is not a matter of transmitting shared beliefs, instilling the dominant ideology as an internal subjectivity, or even giving participants the concepts to think about a particular construction. The interaction of power relationships effected by ritualization defines, empowers, and constrains. Ritualized practices, by necessity, require the external consent of the participants. They do not function as an instrument or symbols of control. Ritualization, like any form of social control, even if indirectly defined, will only be effective when control can afford to be a bit loose. Ritualization will not function as social control if it is perceived as not amenable to some degree of individual appropriation. If practices deny all forms of individual choice, or all forms of resistance, they would take a different form of ritualization.

For Berne the capacity for intimacy is a frank Child-to-Child relationship with no mutual exploration psychological game. It is established by the Adult ego states of the parties involved, so that they understand their contracts and reciprocal commitments very well, sometimes without uttering a single word on the subject. As this understanding becomes clearer, the Adult gradually leaves the stage, and if the Parent does not interfere, the Child becomes more and more relaxed and free. Intimate transactions happen between two Child ego states. The Adult remains in the background as an observer to ensure the maintenance of commitments and limitations. The Adult also has the task of keeping the Parent away so that this ego state does not interfere with or spoil the situation. In fact, the suitability for intimacy depends on the Adult and Child ego states' abilities to keep the Parent at bay if necessary, and it is even better if the benevolent Parent gives permission or, better still, encourages the relationship. "In an intimate

relationship, each party returns to the original naïve Child ego state ... can see, hear and taste in its purest form what the world has to offer" (Berne, 1976a, p.104 - in English Berne, 1973, p. 128).

The community in ritualistic action is focused on the purpose and experience that consummates the rite. It serves as a witness. To witness is to really look at the other person. "… any two people who really look at each other, and rarely see each other, and talk straight to each other, always (as far as these and similar 'encounters' go [the intimacy experiment] end up liking each other." (Berne, 1976a, p.166 – in English Berne, 1973, p.129). Elsewhere Berne (1976b) writes: "Pastimes and games are substitutes for the real living of real intimacy. Because of these they may be regarded as preliminary engagements rather than as unions, which is why they are characterised as poignant forms of play. Intimacy begins when individual (usually instinctual) programming becomes more intense, and both social patterning and ulterior restrictions and motives begin to give way. It is the only completely satisfying answer to stimulus-hunger, recognition-hunger and structure-hunger. Its prototype is the act of loving impregnation." (p.22 – in English Berne, 1968, p.17).

In intimacy, when preparing and executing a ritualistic ceremony for the purpose of consecrating a moment, the whole collective is witness to this opportunity. The speeches, the actions, the context, everything is full of meaning.

When we experience a celebration in a ritualistic way we are contracting with the collective and the person involved that the ground will be constructed starting from their preparation with respect and witnesses - who truly look at the person who goes through the rite - bringing through the ritual the permission and paternal benevolence, so that the person is in a naive state, capable of feeling and witnessing, seeing, hearing, savouring the rite as one who crosses a fertile ground that is gradually fertilized with love for all individuals who recognize and legitimize passage, which happens at the same time as it is experienced.

Final Understanding

This paper proposes the rethinking of two important terms based on the proposed objective of re-signification of the concept of ritual in TA and bringing the understanding that ritualization can be understood not as submission to the patterns programmed by tradition and social customs, but as the enabling action of an environment that stimulates the development of autonomy. Referring to the term ritualism, (Terrin, 2004), we can see rituals with little meaning, not a priori but by the absence of the action of ritualization, (Bell, 1992) where the meaning is experienced deeply. Ritual may have turned into ritualism, but it can be

redeemed in its original sense and intention. For example, in a rite of passage ceremony, we can introject it as if swallowing without chewing, and therefore incorporate external patterns, as for example a generalization such as – "That's how it is, as soon as I've learned, so it will be." We can project, for example – "It's time to be a mother. It's what they expect of me" - and live through a celebration without taking responsibility for change. We can deflect, treating the moment in a dispersive and superficial way, without realizing the true meaning of the moment, discounting the emotions and the abundance of the encounter, substituting for tiresome speeches. We can come together, seeking relevance and belonging and the necessary individuation from the experience but without the proper sense of ritual or internalization of the process.

We can, however, seek the meaning of rituals and transform a moment of passage into a ritualistic act. The ritual experience facilitates the contact with what needs to be lived, since the whole collective gets involved and prepares to welcome. By passing unconsciously as something repetitive, the function of the collective and the individual purpose present in the rite are discounted. We can thus think that the ceremony can lead to consecration or not, depending on how it is experienced. When ritualization occurs, formalizing a rite brings the invitation to live the moment from the Adult (choice and purpose) and with the engagement of the Child. A ritual transforms a ceremony, a celebration into something sacred, significant, and by giving space to symbolism, creates the space necessary for the Adult to recognize choice and, through the identification of purpose, to bring awareness to the realization of it. The ritual´s process is experienced as a call to the Adult to experience, in the here-and-now, the necessary transformation. In this sense, ritual, as well as ceremonial, is also psychic, legitimates a consecration, a remembrance of what is experienced, and a collective and individual provision of change. Rituals can facilitate collective organization between the person, the family and the community, and between the past, the present, and the future.

The ritual consecrates because it aims to make sacred the moment and its meaning through a series of ritual actions with symbolic purposes and gestures, experienced by those who pass through the rite and by the community that witnesses and participates in the consecration. Through the act of consecrating, it legitimizes itself, because by making it sacred, legitimacy happens. The promotion of autonomy is made a part of the ceremony. The community conducts the person to experience what must be experienced in a conscious way, so the ritual can be a moment of deep intimacy that is shared with others,

who witness this moment of change and collaborate to make it happen. The ritual experienced as such provides autonomy, and through it change is possible, for it is lived with awareness, spontaneity and intimacy.

From this reflection, the understanding of ritual differs from ritualism; it is not understood only as submission to patterns programmed by tradition and social customs, but also as providing an environment that stimulates the development of autonomy when experienced in a symbolic way through a genuinely ritualistic process.

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