



## 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, nearly 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  $\geq 10$  as an indicator of current moderate major depression (Kroenke, Spitzer & Williams, 2001). It is important to consider that even below the cut-off score there may be a subclinical disorder. The PHQ-9 considers a score between 0 and 4 an indication of healthy condition, and a score between 5 and 9 as an indicator of mild (subclinical) depression. Reliable Change Index (RCI) is a statistic that enables the determination of the magnitude of change score necessary to consider a statistically

reliable change on an outcome measure (Jacobson and Truax, 1991). In particular, it is helpful in 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  $\geq 10$  has a sensitivity of 88% and a specificity of 88% for major depression (Kroenke, Spitzer, & Williams, 2001) and scores of  $< 10$  are considered subclinical. A change of at least 6 points on PHQ-9 score is considered to assess a reliable improvement or deterioration (RCI).

*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 <sup>a</sup>	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 <sup>b</sup> (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.

<sup>a</sup>Mean scores of pre-treatment measurements.

<sup>b</sup>First available score in session 1.

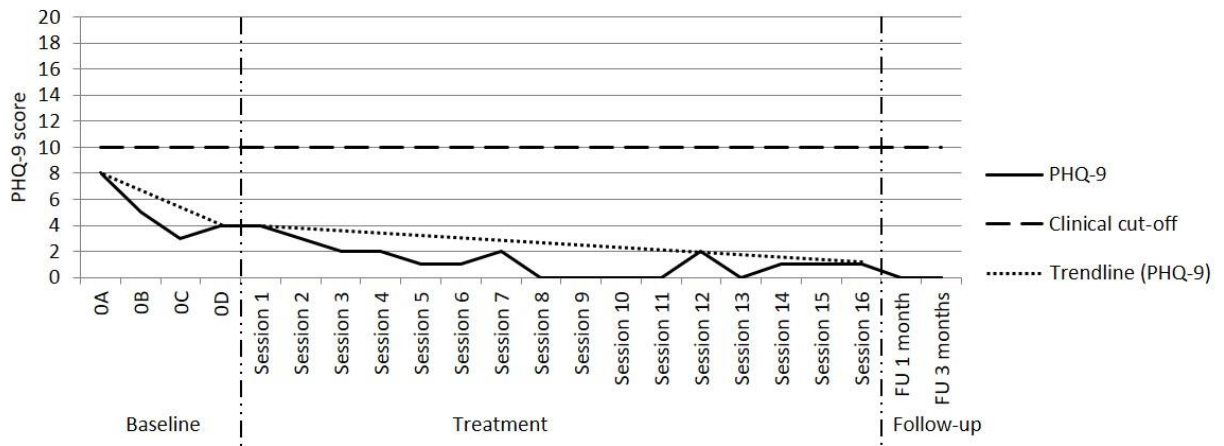
Table 1: Sergio's Quantitative Outcome Measure

	PQ items	Duration	Session 1 <sup>a</sup>	Session 8 (middle)	Session 16 (end)	1 month FU	3 months FU
1	I'm not sure of what I like	>10y	<b>4</b> (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	<b>4</b> (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.

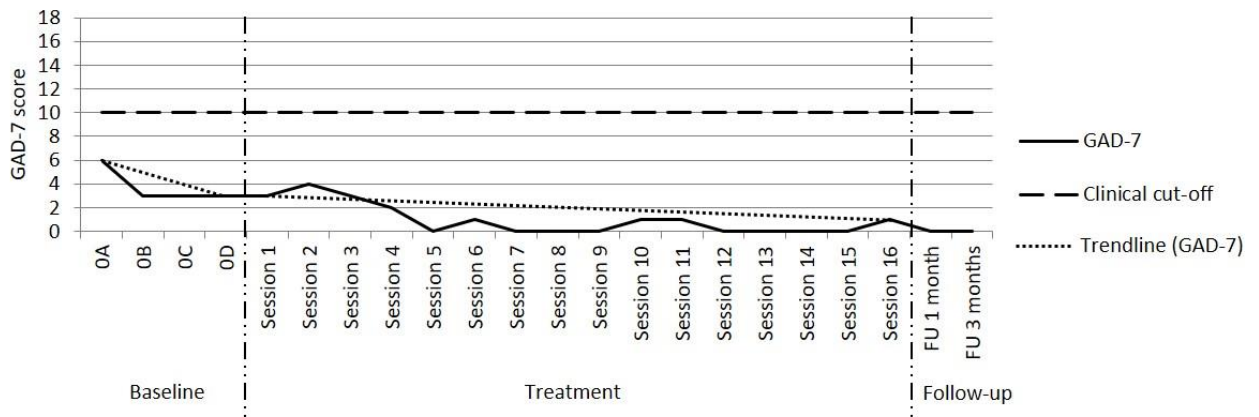
<sup>a</sup>Pre-therapy score is missing, the first available was in session 1.

*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).

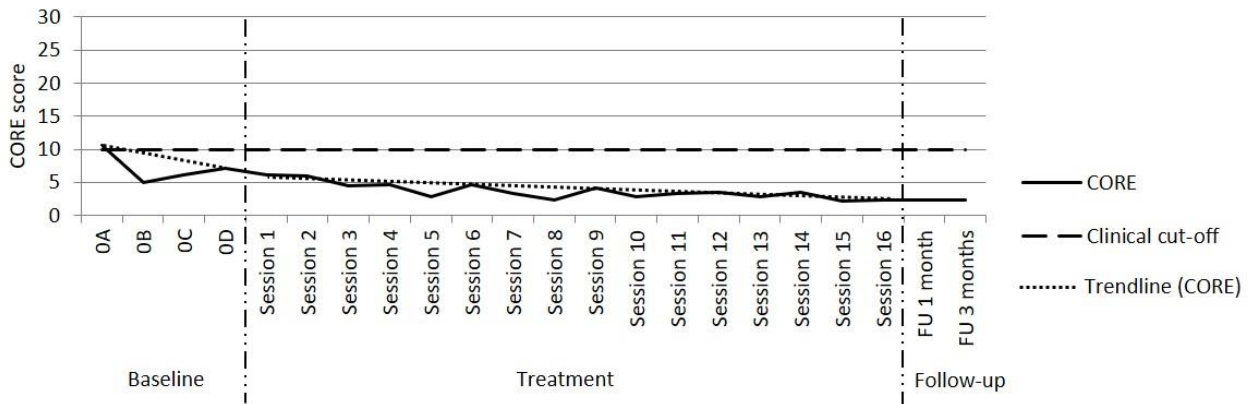
Figure 1: Sergio's weekly depressive (PHQ-9) score



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

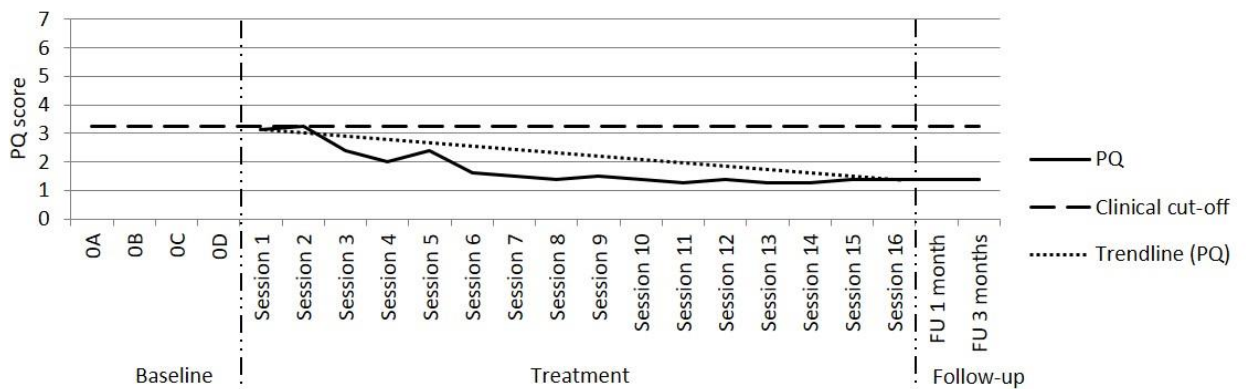
Figure 2: Sergio's weekly anxiety (GAD-7) score





**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 <sup>(a)</sup>	How likely change would have been without therapy <sup>(b)</sup>	Importance of change <sup>(c)</sup>
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).

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

*Table 4: 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 psychobiological 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 (OD, 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

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*



## 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 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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## Funding

This study was supported by grants from the European Association for Transactional Analysis, as part 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' and from the Centre for Dynamic Psychology

- Padua, a transactional analysis-oriented School of Specialization in psychotherapy.

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