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

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Abstract

This study is inspired by previous case series replications of Hermeneutic Single-Case Efficacy Design which aimed to evaluate the effectiveness of a manualised transactional analysis treatment for depressive disorders and depressive personality. We address problems and difficulties that emerged in previous case series, such as: spending time in training a group of people to conduct the hermeneutic analysis, organising the involvement of external judges to give the final adjudication, and dealing with inconsistencies between quantitative and qualitative data. This study suggests a simplified method to conduct the hermeneutic analysis that requires one person only, maintaining its validity. We integrated hermeneutic design with the pragmatic case evaluation methodology in order to follow pre-defined criteria in analysing qualitative material. Furthermore, we present a way to use the Script System to detect changes in depressive symptomatology and depressive personality. We tested this approach to HSCED in the case of 'Giovanni, a 17-year old white Italian male who attended 16 sessions of transactional analysis psychotherapy with a white Italian woman specialsing in psychotherapy with 2 years of clinical experience. The client satisfied DSM-5 criteria for moderate major depressive disorder and generalised anxiety disorder. This is the second investigation which has evaluated the effectiveness of transactional analysis psychotherapy for depressed adolescents.

Key words

Systematic Case Study Research; Hermeneutic Single-Case Efficacy Design; Pragmatic Case Evaluation; Transactional Analysis Psychotherapy; Major Depressive Disorder; Generalized Anxiety Disorder; Adolescence.

Introduction

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

In order to overcome these problems, in this simplified HSCED we decided to propose a variation of Elliott's

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

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

Moreover, we identified another difficulty in some previous hermeneutic analyses: in fact, there have been cases (Benelli at al, 2016b, 2018a) in which hermeneutic teams have found difficulties in bringing evidence for both affirmative and sceptic briefs and rebuttals when significant incongruences emerged. Thanks to previous case series work, we have been able to pin-point these problematic aspects, and decided to shift the focus from evident changes in the client's behaviour to deeper and internal modifications. In an additional chapter in the Italian translation of *Transactional Analysis Treatment for Depression* (Widdowson, 2016), Benelli (2018) shows that it might be improbable for depression and depressive symptoms to exist outside of a structure of personality. Personality is a range of internal psychological processes (motivations, fantasies, peculiar patterns of thought and feeling, ways of experience of self and others, coping strategies, etc) which represents the individual in that circumstance (relationship, environment, culture, etc) (Lingiardi & McWilliams, 2018). Many clients are not aware of their personality disorder and are referred to the clinician by third parties, and others seek therapy for symptoms. However, even if dysfunctional aspects of personality are not clearly expressed as therapy goals, these are both directly and indirectly faced by the therapist and might inevitably undergo changes during therapeutic work. Therefore, it is sufficient for the researcher to keep in mind the client's pathological aspects of personality at the beginning of therapy and keep track of any modification in the course and at the end of therapy. For these reasons, we decided to aim our attention also to pathological representations tied to depressive personalities using SWAP-200 (Westen & Shedler, 1999a, 1999b) taxonomy, which divides dysphoric (depressive) personality in five subtypes: avoidant, high functioning, dependent-victimised, emotionally dys-regulated, and hostile-oppositional. A method to monitor deeper changes in depressive personalities is using the Racket System (Erskine & Zalcman, 1976), nowadays called Script System (O'Reilly-Knapp & Erskine, 2010), as suggested in Benelli's (2018) chapter.

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

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

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

Major Depressive Disorder (MDD) affects all age groups, and is considered the fourth leading cause of disability in Europe and North America, calculated by Disability Adjusted Live Years (DALYs) (Murray et al., 2012). Depression in childhood and adolescence has an estimated prevalence of 2,8% amongst children and 5,9% amongst adolescents (Costello, Erkanli & Angold, 2006). In childhood and adolescence, it is also common to see a clinical presentation of comorbid anxiety and affective disorders, with some evidence that the former anxiety precedes and could cause the latter affective disorder (Seligman & Ollendick, 1998). Therefore, it appears appropriate to develop standardised inter-ventions targeting MDD in childhood and adolescence.

The present study analyses the treatment of 'Giovanni', a 17-year-old Italian young boy with a diagnosis of moderate major depressive disorder for more than six

years, in comorbidity with generalised anxiety disorder, worsening in the last two years when he began feeling terrified by one of his teachers. The primary outcome is the depressive and anxious symptomatology and the secondary outcomes are global distress and severity of personal problems.

Ethical Considerations

The research protocol follows the requirements of the ethical code for Research in Psychotherapy of the Italian Association of Psychology, and the American Psychological Association guidelines on the rights and confidentiality of research participants. The research protocol has been approved by the Ethical Committee of the University of Padua. Before entering the treatment, clients received an information pack, including a detailed description of the research protocol, and they gave a signed informed consent and written permission to include segments of disguised transcripts of sessions or interviews within scientific articles or conference presentations. Clients were informed that they would have received therapy even if they decided not to participate in the research and that they were able to withdraw from the study at any point, without any negative impact on their therapy. All aspects of the case material were disguised, so that neither the client nor third parties are identifiable. All changes are made in such a way that does not lead the reader to draw false conclusions related to the described clinical phenomena. Finally, as a member checking procedure, the final article was presented to clients, who read the manuscript and confirmed that it was a true and accurate record of the therapy and gave their final written consent for its publication.

Method

Inclusion and exclusion criteria

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

Client

Giovanni is a 17 year-old white Italian male who lives with his parents and three older siblings in a small city in north Italy. He has difficulties in relating with his father, described like someone who only cares about his son's school grades, and also in the relationship with his two older siblings, with whom he does not interact frequently. He reports that in his family his privacy is not respected, especially when he is in the bathroom and in his room. Giovanni is an intelligent, curious, creative and playful teenager, with many positive values, and who has bad self-reflective and evaluative capacities, due to a low self-esteem (dysphoric high functioning depressive Script System, script beliefs about others: others are better; dysphoric-dependent victimised Script System, script beliefs about others: I need others' help). Giovanni has few friends, but he is afraid to ask them to go out together because he fears he would only receive rejections (dysphoric high functioning depressive Script System, needs and feelings and fantasies: fear of abandonment; dysphoric-dependent victimised Script System, needs and feelings: fear of rejections), therefore he prefers to spend his free time on his computer playing online videogames and creating gameplay videos for his channel with a friend. He is somewhat expert in computers and technology, however this ability is not shared with his family, nor recognised by his parents, especially by his father (dysphoric high functioning depressive Script System, reinforcing experiences through old emotional memories: repression of joy). Giovanni feels neither understood nor listened to by his parents and friends, sometimes he feels bullied and when he engages in cyber bullying he always defends other victims (dysphoric high functioning depressive Script System, observable behaviours: Victim and Saviour). Nevertheless, Giovanni reports working very hard on his homework to obtain generally good grades, and to not wasting time playing on his computer if he has an exam to prepare. Moreover, he reports that due to his school duties, his parents do not allow him to go out on weekends during the school year (dysphoric-dependent victimised Script System, script beliefs about self: I cannot decide what to do), practice sports or play a musical instrument. He reports having difficulties in mathematical classes only during written exams, which led him to fail and to resit the final exams at the end of the summer. In the course of therapy (between session 12 and 13), he is administered some tests for the evaluation of any learning disability, which he also did when he was younger, and receives a dyscalculia diagnosis. Finally, Giovanni reports great difficulties in relating with one school teacher, who seems to terrify him when he is having an oral exam and when she corrects his mistakes; this is the reason that led him ask for help and seek therapy.

Therapist

The psychotherapist was a 38-year-old, white, Italian woman with 2 years clinical experience. For this case, she received monthly supervision by a Provisional Teaching and Supervising Transactional Analyst (Psychotherapy) (PTSTA-P) with 16 years experience.

Intake sessions

The client attended five individual pre-treatment sessions (0A, 0B, 0C, 0D, 0E), which were focused on explaining the research project, obtaining consensus, 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 measure for primary (depression and anxiety) and secondary (global distress and personal problems and problematic behaviours) outcomes.

DSM 5 Diagnosis

During the diagnostic phase, Giovanni was assessed as meeting DSM 5 diagnostic criteria of moderate major depressive disorder: he experienced depressed mood in daily activities for more than one year, most of the day, nearly every day (criterion A1), decreased pleasure in most activities (A2), restlessness when he felt anxious (A5), overwhelming feelings of worthlessness (A7), diminished ability to think and concentrate (A8). Giovanni also met DSM 5 diagnostic criteria of generalised anxiety disorder: excessive anxiety and worry (criterion A), that were uncontrollable (B), easily fatigued (C2), difficulty in concentration (C3) and muscle tension (C5). Between session 12 and 13 he also met criteria for mild Specific Learning Disorder with impairment in mathematics: he had difficulties in calculation (criterion A5) and difficulties with mathematical reasoning (A6).

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. Giovanni showed impairment ranging in the level of organization, and personality traits of identity, self-direction, anxiousness and depressivity.

Case formulation

TA Diagnosis

Case formulation was conducted according the TA diagnostic categories presented in the treatment manual. Giovanni assumed a life position (Ernst, 1971; Berne 1972) of I'm Not OK, You're Not OK, that interacted with his stroke economy (Steiner, 1974), which was characterised by an absence of positive strokes and abundance of negative strokes. This in turn led to internalization of an under active and under-functioning internal Nurturing Parent and an over-active internal Critical Parent, which activated intense self-critical internal dialogues (Kapur, 1987). Furthermore, the underlying Injunctions (Goulding & Goulding, 1976): "Don't be well" (no one ever pays attention to me), "Don't trust" (often I feel I am betrayed), "Don't belong" (I feel like no one likes me), "Don't want" (I give up easily), "Don't be separate" (I feel I exist in the opinion of others and try my best to create a pleasing image), "Don't be engaged in your own life" (there are many things in life I won't do, but would like to do), "Don't think" (I'm not very smart and I feel inferior), "Don't feel" (no one cares what I feel) were also identified. In the drama triangle (Karpman, 1968) he assumes the role of Rescuer with friends or strangers when he joined in with cyber bullying, Victim when feeling helpless in front of failure (the teacher picks on me; I cannot manage to do this alone; I'm not good enough), and Persecutor with people he did not like or did not know (they probably all do drugs, I don't want to go out with them). Observable drivers (Kahler, 1975) of Try Hard and Be Strong were also identified.

The Script System

In TA, the Script System (O'Reilly-Knapp & Erskine, 2010), previously called the Racket System (Erskine & Zalcman, 1979), allows to keep in mind all the associations of the client, like script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories. Giovanni shows a dysphoric-depressive high functioning Script System (others are better than him, he fears being abandoned, he ignores his needs) and a dysphoric dependent victimised Script System (I cannot decide on my own, I need others, fear rejections, passive aggressiveness). Moreover, the Script System involved all of the above-mentioned thoughts and behavioural manifestations, as well as repressed primary anger when his privacy is not respected and his needs are unheard by his parents, which was covered by secondary sadness, helplessness, loneliness, which in turn triggered the memory recall of episodes of criticism and neglect. Finally, his script conclusions and decisions (Berne, 1961) were observable through script beliefs and contaminations (Berne, 1961; Stewart & Joines, 1987, 2012) such as: "I feel I'm not good enough", "I need others to help me", "others don't listen to me", "I don't like others", "others don't like me", "I feel judged".

Treatment plan

The therapy followed the manualised therapy protocol of Widdowson (2016). The treatment plan for Giovanni's depression primarily focused on creating a therapeutic alliance, providing permissions (Crossman, 1966) congruent with the client's injunctions, namely: *trust*, *belong*, *don't give up* and *believe*. Therapy was based on recognition and decontamination of script beliefs and emotion regulation, on changing internal dialogue from Critical to Nurturing Parent, on the creation of an I'm OK-You're OK relationship, and widening his script, providing reassurance and substituting emotional parasites, supporting him to express his needs and wishes.

Therapy process summary

Contract

In the first part of therapy, Giovanni asked to learn how to protect himself from the terror he felt in front of his teacher. From session 10, he asked to learn how to face his fear of feeling judged by others which prevented him from going out with his friends.

Sessions 1-8

In session 1 Giovanni talks about his relationship with peers and girls, his interests and free time, and the therapist tries to stimulate his wishes and pleasant memories of enjoyable activities he used to do when he was younger. In session 2 he speaks about his parents' expectations of his school grades, how he experiences school and relationships with his classmates, and his incapacity to handle stressful situations (i.e. oral examinations). The therapist helps Giovanni review some strategies he uses to cope with his anxiety, exploring possible past traumatic experiences. In session 3 he talks about the feeling of unfairness, both with peers and authorities, bringing a school episode, and the therapist works on the emotions he felt during that day. In session 4 Giovanni speaks about his fear of falling asleep and themes of death, love and anger emerged, and the therapist investigates his emotions and behaviours about these arguments. In session 5 he critically talks about his difficulties in creating friendly relationships and possible love relationships, and the therapist works on other ways of evaluating his own capacities, focusing on functional strategies he already used in the past. In session 6 Giovanni speaks about his anger toward his friend's brother who mistreats him and other players while playing online videogames. The therapist tries to connect this episode to what happens at school with his teacher, and at home when his parents do not respect his spaces. In session 7 Giovanni talks about school duties (many examinations because the end of the academic year is close) and about his ungrateful relationship with his father who approaches his son only to discuss school grades. The therapist uses empathic transactions. In session 8 Giovanni reports improvements in relating with the teacher that scares him and speaks also about his anger and feeling of not belonging in his family due to the difficult relationship with his father, and the therapist tries to stimulate Giovanni to emerge from this passivity with his father.

Sessions 9-16

In session 9 Giovanni is sad because he failed in two out of three tests at school, and the therapist works on his depreciation, reinforcing his positive strategies to cope with problems (i.e. organise study and homework, reduce anxiety). In session 10 school is over but he is very tired and sad because in September he will not see many of his classmates any more. The therapist tries to suggest meeting his friends outside school boundaries, but he refuses, fearing rejections by his friends. In session 11 Giovanni speaks about his anger, which expression shifts from desires of vengeance to repression mixed with powerlessness, and his desire to keep relationships with his classmates but fearing any possible rejection. The therapist tries to reinforce his desire to keep these relationships and works on his fears. In session 12 Giovanni is happier and more relaxed than usual and he speaks about a pleasant weekend spent with his cousin and friend of his, which allowed the therapist to work on his fears of being rejected by peers. In session 13 he depreciates his enthusiasm for the pleasant weekend spent with his cousin, and speaks about his anger towards his parents who he feels do not recognise his needs and wishes. The therapist works on permissions and recognition of his emotions. In session 14 Giovanni speaks about a creative work he is doing with a friend but keeps depreciating his capacities and fearing criticism by others who will see it. The therapist works on his fear of being judged which blocks him from growing. In session 15 resistances to exposure in relationships emerge, tied to his magical belief that others will understand his wishes and therefore his inexpression of them, and the therapist works on the depreciation of himself. In session 16 Giovanni brings pleasant experiences spent with some friends and the therapist embraces the possibility to speak about nice things too. Finally, they speak about the end of the research and of the possibility to resume therapy after the summer break if he wants.

Notes

Unlike previous cases in which the client attended three follow-up sessions at 1-, 3- and 6-month after the end of therapy, Giovanni attended only two follow-up sessions at 1- and 8-months.

Hermeneutic Analyst

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

Measures

Statistical Analysis

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

Quantitative Measures

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

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

Generalised Anxiety Disorder 7-item for anxiety (*GAD-7) (*Spitzer, Kroenke, Williams, & Löwe, 2006), which scores each of the seven DSM 5 criteria as 0 ('not at all'), 1 ('several days'), 2 ('more than half the days'), and 3 ('nearly every day'), respectively, providing a total score for anxiety. Scores up to 4 are considered 'healthy', scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD and score <10 are considered subclinical. It is moderately good at screening three other common anxiety disorders – panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%) (Kroenke, Spitzer, Williams, 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). Each of the 34 items is scored on a 5-point scale ranging from 0 ('not at all') to 4 ('most of the time'). Scores up to 5 are considered 'healthy', scores between 5 and up to 9 are considered 'low level' (sub-clinical), and scores of 10, 15, 20 and 25 are taken as the cut-off point for mild, moderate, moderately severe and severe distress, respectively. The cut-off of 10 yields a sensitivity (true positive rate) of 87% and a specificity (true negative rate) of 88% for discriminating between members of the clinical and general populations. CORE OM was used in assessment sessions, in sessions 8, 16 and follow-ups, whereas CORE short form A and B were used in all other sessions (Barkham, Margison, Leach, Lucock, Mellor-Clark, Evans, McGrath 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 from 1 ('not at all') to 7 ('maximum possible'). Scores up to 3.25 are considered subclinical. In this case series, missing the Italian normative score, for the PQ we adopted a more conservative RCI of two points, rather than the RCI of 1.67 recently proposed by Elliott et al. (2016). The PQ procedure suggests including problems from five areas: symptoms, mood/emotions, specific performance or activity (e.g., work), relationships, and self-esteem/internal experience.

Qualitative Measure

The client was interviewed using the *Change Interview protocol* (CI) (Elliott, Slatick & Urman, 2001) one month

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

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

Furthermore, two qualitative measures have been implemented.

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

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

Therapist Notes

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

Adherence

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

HSCED Analysis Procedure

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

Pragmatic Case Evaluation

After the hermeneutic analysis, the 56 criteria of Bohart have been applied to support both affirmative case and conclusions. In fact, the first 39 items of the criterion list mirror HSCED first affirmative point (specific changes for long standing problems), whereas the last 17 items reflect the second affirmative point (retrospective attribution). However, if there is little or no prof for a positive outcome case, Bohart's grid indirectly supports both sceptic case and conclusions. Therefore, a preponderance of evidence is more indicative of a positive change attributed to therapy. Moreover, the first 39 criteria correspond to the first two questions of the adjudication procedure (described in previous publications of prior series) ("how would you categorise this case" and "to what extent did the client change over

the course of therapy"), whereas the last 17 items represent the third question of the adjudication procedure ("to what extent is this change due to therapy").

Results

In earlier published HSCED's the rich case records, along with hermeneutic analysis and judges' opinions were often provided as online appendices (Benelli et al., 2015). Since all the material is in Italian 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, evidence in Bohart's criterion list and comments) is available from the first author on request.

Adherence to the manualised treatment

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

Quantitative Data

PHQ-9, GAD-7 and CORE were administered in the pre-treatment phase in order to obtain a five-point baseline, and during the two follow-ups, whereas PQ was generated during the assessment phase, are therefore administered from session 0E. Since the client expressed some discomfort in completing some items of the CORE, we chose to calculate the mean score considering only answered items.

Giovanni's quantitative data are presented in Table 1. The initial depressive score (PHQ-9, 12.6) indicated a moderate level of depression. The initial anxiety score (GAD-7, 10.6) indicated a moderate level of anxiety. The initial global distress score (CORE, 16.8) indicated a moderate level of distress. The initial severity score of personal problems (PQ, 4.7) indicated that the client perceived his problems as bothering him somewhere between 'moderately' and 'considerably'.

At session 8, (mid-therapy), his scores remained unchanged, showing a constant moderate depression (12), anxiety (10), and also global distress (17.3) showed no significant change. Instead, the severity of personal problems decreased to 'little' bothering (3.1), with a clinically significant change (CS).

By the end of the therapy, depression (8) and anxiety (9) scores passed into the mild range gaining clinical significance, and global distress score decreased to mild range too gaining a reliable and clinically significant improvement (RCSI), whereas personal problems (3.64) rose without reliable deterioration, bothering him somewhere between 'little' and 'moderately'.

At the 1-month follow up, depression scores remained in the 'mild' range (9) with clinical significance, whereas mild anxiety levels decreased (6), gaining RCSI, global distress decreased to a 'low level' (7.9) with a RCSI, and personal problems returned to be 'little' bothering (3.3).

Finally, at the 8-month follow up, depression remained in the 'mild' range, gaining RCSI, anxiety (5) and global distress (6.8) remained unaltered with RCSI, and personal problems became 'very little' bothering, gaining RCSI.

	Pre-Therapy[a]	Session 8 Middle	Session 16 End	1 month FU	8 months FU
PHQ-9	**12.6 Moderate**	**12 Moderate**	8 (+) Mild	9 (+) Mild	6 (+)(*) Mild
GAD-7	**10.6 Moderate**	**10 Moderate**	9 (+) Mild	6 (+)(*) Mild	5 (+)(*) Mild
CORE-OM	**16.8 Moderate**	**17.3 Moderate**	11.8 (*) Mild	7.9 (+)(*) Low level	6.8 (+)(*) Low level
PQ	**4.7[b] Moderately**	3.1 (+) Little	3.64 Little	3.3 Little	2.6 (+)(*) 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 = Generalised Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006). CORE-OM = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002). PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off points: PHQ-9 ≥10; GAD-7 ≥10; CORE-OM ≥10; PQ ≥3.25. Reliable Change Index values: PHQ-9 variation of six points, GAD-7 variation of four points, CORE-OM variation of five points, PQ variation of two points.

[a]Mean score of pre-treatment measurements.
[b]First available score in assessment session 0E.

Table 1: Giovanni's Quantitative Outcome Measure

	PQ items	Duration	Pre-Therapy[a, b]	Session 8 (middle)	Session 16 (end)	1 month FU	8 months FU
1	I get scared when teachers yell at me	1-2y	**6 Very considerably**	1 (+)(*) Not at all	**4 (*) Moderately**	1 (+)(*) Not at all	2 (+)(*) Very little
2	I get depressed when I can't manage to do things on my own	6-10y	**6 Very considerably**	3 (+)(*) Little	3 (+)(*) Little	1 (+)(*) Not at all	2 (+)(*) Very little
3	I feel impotent when my anger is unheard	6-11m	**7 Maximum possible**	1 (+)(*) Not at all	**4 (*) Moderately**	3 (+)(*) Little	3 (+)(*) Little
4	I freeze when teachers insult me instead of answering them	1-2y	**5 Considerably**	2 (+)(*) Very little	**4 Moderately**	2 (+)(*) Very little	2 (+)(*) Very little
5	I'm afraid to make mistakes when I have to do important things because then these cannot be changed	1-2y	**4 Moderately**	**6 (*) Very considerably**	3 (+) Little	**4 Moderately**	**4 Moderately**
6	I'm afraid to make mistakes when others watch me correct my mistakes	6-10y	3 Little	**4 Moderately**	**5 (*) Considerably**	3 Little	**4 Moderately**
7	I feel anger because from the start I give up doing things that are important to me	6-11m	**5 Considerably**	2 (+)(*) Very little	**5 Considerably**	2 (+)(*) Very little	3 (+)(*) Little
8	I get sad because I feel I'm losing important occasions	6-10y	**4 Moderately**	**6 (*) Very considerably**	3 (+) Little	2 (+)(*) Very little	3 (+) Little
9	I get depressed when I can't manage to say what I think and feel	6-11m	**4 Moderately**	**4 Moderately**	2 (+)(*) Very little	**5 Considerably**	3 (+) Little
10	I feel sad because I can't manage to regulate and protect those relationships that are important to me	6-11m	3 Little	2 Very little	2 Very little	1 (*) Not at all	1 (*) Not at all
11	I don't feel accepted (negatively judged) when I'm with peers	1-2y	-	-	**5 Considerably**	2 (+)(*) Very little	1 (+)(*) Not at all
	Total		47	31	40	36	8
	Mean		**4.7 Moderately**	3.1 (+)(*) Little	3.6 Little	**3.3 Little**	2.6 (+)(*) 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]Mean score of pre-treatment measurements.
[b]The first available score was in assessment session 0E.

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

Table 2 shows the 11 problems that the client identified in his PQ (10 at the beginning of therapy, 1 added from session 14) and their duration. One problem was rated as bothering him 'maximum possible', two as 'very considerably', two were rated 'considerably' bothering, three as 'moderately' and two as 'little' bothering. Two problems were initially rated under the clinical cut off, therefore cannot show clinical significance. Three problems lasted from 6 to 10 years, four from 1 to 2 years and four from 6 to 11 months, representing an almost stable and longstanding baseline. At the end of the therapy 4 out of the 8 problems above the clinical cut off showed clinical significance (CS), 2 showed a reliable improvement (RCI) and 2 gained RCSI. At the first follow up 8 items out of 11 showed a RCSI, whereas at the 8-month follow up, 2 problems showed a CS and 7 problems reached RCSI.

Problems are related to: mood/emotions (1 scared, 3 impotent when angry, 7 anger when giving up, 8 sadness), relationships (10 unable to protect relationships, 11 feel judged), self-esteem/inner experience (2 depressed when alone, 5 and 6 afraid to make mistakes, 9 incapacity to express thoughts and feelings), and symptoms (4 I freeze). The longer lasting problems were related to mood and self-esteemTable 3 shows the seven aspects of the Script System: (1) script beliefs about self, others and quality of life, (2) needs and feelings, (3) observable behaviours, (4) reported internal experiences, (5) fantasies, and reinforcing experiences through (6) current events and (7) old emotional memories. These aspects have been observed by the hermeneutic analyst during the assessment sessions (Phase 1), variations of these have been monitored in both the first part (Phase 2) and second part of therapy (Phase 3), and their maintenance and stability in the Change Interview (Phase 4).

In Phase 1, Giovanni's beliefs about himself were of low self-esteem and incapacity to express and make his parents respect his needs; beliefs about others were that others are better and fear that others will criticise him; beliefs about life is that he had no power in changing things with his teacher; needs and feelings, such as expressing and getting angry, were repressed and not considered in his family, making him feel impotent, and he felt scared in front of a teacher; as observable behaviours he could not defend his privacy between domestic walls, he isolated in his room, and he showed anxious symptoms; fantasies were about fear of rejections of girls and friends in going out and spend time together.

In Phase 2, beliefs about self were of fragility and absence of courage; however, he started speaking out his needs during therapy ("I would like"); about others remained the same ("they don't want to go out with me"); needs and feelings of anger were still repressed and devaluated, whereas insomnia due to anxiety ceased (S2 vs S6); as observable behaviours he made others respect his privacy; as reported internal experiences he says he felt ignored by his parents; fantasies were that if he went out, he would be alone; reinforcing experiences through current events were that friends ditched his invitations to go out, and that his father ignored his son unless it was about school grades; reinforcing experi-ences through old memories were an episode of a second-grade teacher who yelled at him.

In Phase 3, from Giovanni's beliefs about self emerged his desire and determination to go out with friends ("I will go"), whereas his parents kept ignoring his wishes; about others he reported that peers are not good people, fearing their judgment; needs and feelings changed from not enjoying and devaluing going out with friends (S13) to enjoying it without bringing up pretexts (S16); furthermore he does not feel scared by his teacher any more; as for observable behaviours he felt bullied, he protected other victims when involved cyberbullying; furthermore he started going out with friends; as for fantasies he reported fears of failing tests and of peers' rejections; moreover he believed his parents should know his needs and feelings even if he does not tell them; as for reinforcing experiences through current events he reported episodes of repression of enjoyable things, of fault, loneliness and of constant rejections; and reinforcing experiences through old memories were tied to happy events that today do not occur again.

In Phase 4, as a belief about self he reported to have gained self-confidence and to be shy no more; as for needs and feelings he reported that he did not suffer from insomnia anymore, and that he enjoyed going out with friends; observable behaviours were better relationships and going out with friends; and for reported internal experiences he did not feel depressed or stressed anymore.

Giovanni's script beliefs about self and others were representative of a dysphoric dependent victimised personality; script beliefs about life are representative of a dysphoric high functioning depressive personality; his repressed needs and feelings are typical of dysphoric high functioning depressive and dependent victimised personalities; observable behaviours were repre-sentative of a dysphoric avoidant personality; his fantasies reflect a dysphoric high functioning depressive personality; reinforcing experiences through current events were representative of dysphoric high functioning depressive and avoidant personalities.

Successively, these aspects have been compared with PQ items. Giovanni's Script System of script beliefs about self reflect item 2 (incapacity to do things alone), 7 (I don't try on my own) and 9 (I don't express my thoughts, feelings [needs]); script beliefs about others reflect item 4 (I freeze when I'm criticise d), 6 (I'm afraid of making mistakes) and 11 (I don't feel accepted). Needs and feelings reflect item 1 (I'm scared), 3 (I feel impotent), 4 and 9; observable behaviours reflect item 9; and fantasies reflect item 6, 9, 10 (I can't protect my relationships) and 11.

Furthermore, there is evidence that there is similar evolution between the Script System and PQ scores.

Qualitative Data

Giovanni compiled the HAT form at the end of every session (Table 4), reporting only positive/helpful events. All positive events were rated from 7 (moderately helpful) to 9 (extremely helpful). Giovanni also reported other useful events in session 2 ("The fact that my fear of aggressive teachers started when I was in second grade"), session 3 ("When we talked about the ego states model (GAB) which led me understand that my fear started long time ago through an old teacher"), session 5 ("I found a method to distract my mind from my sleeping phobia"), session 8 ("One of my classmates didn't show up in school, making others end in trouble (I vented)"), and session 13 ("Asking my parents to start playing the guitar"). He reported helpful aspects on: symptoms (HAT 4 "fear of falling asleep"), relationships (HAT 2 "got over the fight", 6 "my friend's brother's behaviour", 7 "conversation with dad", 11 "my friend's brother cyber-bullying", 12 "I want social interactions", 13 "fear of being judged", 14 "my friend's brother spoils my work", 15 "planning date", 16 "the date I went to"), and self-esteem/inner experience (HAT 1 "I opened up", 3 "importance of talking about sadness and anger", 5 "not wrong feeling interest", 8 "privacy parents don't give me", 9 "felt more tranquil and no anxiety", 10 "I vented").

Giovanni participated in a Change Interview (CI) 1-month after the conclusion of the therapy. In this interview he identified seven changes (Table 5) since he started therapy, three tied to his depressive and anxious symptoms (items 4, 6 and 7), two related to his relationships (items 1 and 2), and two connected with his self-esteem and inner experience (items 3 and 5). Four out of six rated changes are considered to be unlikely to happened without therapy, and two would have occurred even without therapy. Only item 1 (dating peers more often) was rated as 'very important' change (4), and item 1 and 3 were considered unexpected changes. However, according to Giovanni, all "changes occurred thanks to aspects of therapy, to the therapist's suggestions, she gave me courage, like asking friends to go out together, and I did… I don't think I would have ever managed to do this on my own" (Change Interview, Line 408-416), because "when I came here I reflected and this led to changes in my behaviour outside of therapy… it helped me think" (CI, L421-423). The client also reported that friends around him see he changed: "they tell me they see me different, I'm calmer, I'm more playful, I don't take offence for jokes" (CI, L216-232), in fact, "my relationships improved, before I didn't care about others' interests, now I do", (CI, L451-480), "they said that last year I was a pain in the neck, whereas now they say I'm not a pain in the neck anymore" (CI, L489-498). Giovanni also said that "therapy gave me self-esteem, self-confidence, which made me improve in my homework, because it gave me the strength to stay there and succeed, not giving up like I did before" (CI, L609-616). Finally, he reported that "therapy helped me in trying, being more myself" (CI, L433-452).

HSCED Analysis

Affirmative Case

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

1. Change in stable problems

Quantitative data (Table 1) shows that from session 10, Giovanni's primary outcome measure (PHQ-9, depression) not also dropped in frequency during the last two weeks, but the intensity of the disturbance of these problems changed from being 'somewhat difficult' from assessment session 0A to session 5 and 'very difficult' from session 7 to session 9, to 'not difficult at all' from session 10 until the end of therapy and in the follow-ups. However, from session 10, the client's PHQ-9 score remained threshold until the end of therapy. Giovanni's anxiety (GAD-7) obtained clinical significance from session 10, with a RCSI maintained in the follow ups. Global distress (CORE) reached a reliable change in session 13, and a RCSI in the follow-ups.

In the PQ (Table 2), Giovanni identified 11 main problems that he was trying to solve. Two out of three long lasting problems (from 6 to 10 years) reached clinical significance at the end of therapy and one obtained RCSI. In the 1-month follow up eight out of eleven problems reached RCSI, whereas in the 8-month follow up nine problems showed a CS, seven of which obtained RCSI too. Overall, there is support for claiming a global reliable change.

Qualitative data supports these changes in stable problems. In his Change Interview (CI) Giovanni said: "I solved many of my problems" (CI, L64), "all the problems I brought out here I managed to solve them, so therapy worked" (CI, L579-580). About his symptoms, Giovanni reported that "I don't freeze

anymore" (CI, L740), "when my teacher yells at me, she doesn't scare me like before, this feeling diminished a lot" (S8, L21-26), "I'm not afraid of falling asleep anymore" (CI, L746-747) and "before therapy I bit my fingernails" (CI, 204). Giovanni also reported that he gained self-confidence and self-esteem: "I thought I was inept, unable to do many things, then I learnt to do things on my own, and I understood that it wasn't as I thought" (CI, L603-606). He explained that thanks to his better self-esteem, not only did he start going out with his friends, but also his relationships improved: "before I hated dating others because I felt embarrassed" (CI, L138-140), "I feared their judgment and I started to shiver, whereas now this problem ceased a lot" (CI, L650-654), "I try to understand others before judging them" (CI, L154-161). Finally, according to item 2 "I get depressed when I can't manage to do things on my own", he reported "I'm planning my summer vacations, I'm projecting some gameplays" (S10, L438-439), "I'm arranging a tournament of my favourite online game with some friends" (S13, L78-81).

2. Retrospective attribution

Giovanni identified in his Change Interview seven important changes, four of them rated "unlikely" or "somewhat unlikely" without therapy (Table 4). Giovanni described his therapy as "a place where I brought out my problems and we [the therapist and I] solved them together" (CI, L122-129), even if "at the beginning I didn't believe in it, then when I came here I talked about different problems and how to face them and I understood that talking was something positive" (CI, L33-36) and "I managed to solve all the problems I brought out in here" (CI, L579-580). "Having someone that listened to me and helped me face my problems and find solutions to them helped me a lot, and this is a rare thing for me, at home or with friends" (CI, L553-560). "I felt she [the therapist] listened to me, even friends can listen to you, but they don't care about helping you like she [the therapist] did" (CI, L562-563), "and I understood she cared about what I said because she didn't stay quiet all the time, she gave me advice, we were having a bidirectional conversation" (CI, L574-576). He recognised that therapy allowed him to find new strategies to solve his problems, like how to cope with his fear of falling asleep: "thanks to the therapist… I talked about my night paralysis and she helped me create a list of possible solutions I could do to solve this problem and it worked" (CI, L46-54). Giovanni also reported that the therapist helped him gain self-confidence and self-esteem (CI, L609-616) both in doing his homework and in going out with his peers (CI, L433-443). In fact, he believed that peers would have rejected his invitation to go out together and for this reason he did not want to go out (S13, 680-697), "but the therapist told me to try and to be myself, and I did, so now I go out" (CI, L433-443), and, "therapy helped me in being more confident and believe in myself" (CI, L451-452) and for this reason "my relationships improved" (CI, L461).

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

The HAT completed at the end of each session provides us with regular and immediate reports of what Giovanni found helpful in each session. All reported events are considered from "moderately" to "extremely" useful and are coherent with the diagnosis, the treatment plan and the interventions reported in the therapist's notes. Changes in depression and anxiety symptoms (Table 1), in particular, feeling unable to be successful in doing something completely on his own, feeling lonely and unable to have social interactions, feeling he was not listened to by anyone, feeling scared of being judged, feeling afraid of teachers (and adults) that yelled at him, freezing when he had to face an exam, and fearing to fall asleep (PQ, Table 2) appear tied to interventions in almost all sessions, on changing his internal dialogue from Critical Parent to Nurturing Parent (reported in particular in the HAT, Table 4, in sessions 1, 5, 7, 13) and on his self-esteem (in particular in the HAT, sessions 9, 12, 13), and also on recovering the origin of his fears and how to cope with them (HAT, sessions 2, 3, 4), and on his relationships, especially on his fear of being judged by others (HAT, sessions 6, 10, 11, 14, 15, 16). Changes in his depressive symptoms seem more tied to interventions of decontamination (sessions 4, 5, 8, 13, 14) about his beliefs in his limits (I can't do anything alone), abilities (I'm not good enough), and peers (they all do drugs), and to the therapist's interventions to create a global concept of I'm OK, You're OK (sessions 1, 2, 5, 7, 8, 9, 12, 14).

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

The greater effect on depressive symptoms appeared to be tied to interventions throughout the entire therapy, which focused on changing the client's self-critical internal dialogue associated with his feelings of incapacity and social estrangement. The therapist's interventions are mirrored in particular in Giovanni's words during his Change Interview "now I'm more self-confident, I have more self-esteem" (CI, L603-616), and in HAT Forms (Table 3, sessions 12, 15, 16). The therapist's intervention of decontamination and desensibilization in session 3 (S3, L209-350) regarding Giovanni's fear of his teacher, helped him feel more comfortable during the rest of the academic year and stopped him feeling scared by her (S8, L21-28). Moreover, the therapist worked on

	Script System	Phase 1	Phase 2	Phase 3	Phase 4
1	**Script beliefs: - about self**	"I'd like to go out with friends, but my parents won't let me" (0A) "I'm not good in doing this… I don't even try on my own" (0B) "I can't manage to do things on my own because I'm not capable" (0C) "I don't have self-esteem" (0D) "I'm insecure" (0D) "I feel impotent" (0D) "I'd like to learn playing the guitar, but dad doesn't want because he believes I'd give up" (0E)	"I'd like to go out with my friends… but I don't want my parents to worry" (S1) "I shouldn't get traumatised, I'm a grownup, but I'm fragile, I crack easily" (S2) "I'm not courageous" (S3)	"I'm unlucky" (S9) "This summer I'll go out with my friends" (S10) "My parents don't want me to learn to play the guitar, they won't take me to classes, they say that when I like something then I get bored and I give up" (S13)	"I'm shy but I solved it, I don't get angry easily, I'm funny" (CI) "I gained self-confidence" (CI)
	- about others	"I need mum's help" (0B) "Others are better than me in doing things" (0D) "I prefer to do homework in a couple or with others" (0D) "I fear how my teacher will correct my mistakes in front of the class" (0D)	"Friends don't ask me often to go out together" (S5)	"Peers smoke weed and swear all the time" (S13) "I fear others will criticise and judge me" (S13)	-
	- about quality of life	"I cannot change my teacher's point of view, I cannot tell him/her that he/she scares me" (0B)	-	-	-
2	**Needs and feelings**	"I feel terrified in front of a teacher" (0A) "I feel impotent when mum invades my privacy and she does not respect my anger" (0D) "When I'm angry my parents ignore me" (0E)	"I didn't sleep last night because the following day I had a test and I was scared" (S2) "I'm angry with my classmates that ditched class… anxious, couldn't stay still. I was scared the teacher would have examined my study level" (S3) "My moments of anger are ridiculous, I laugh about them" (S6) "I'm not nervous, I sleep well" (S6)	"The teacher doesn't scare me like before" (S8) "I cried because I won't see many of my classmates next year" (S10) "I didn't enjoy going out with my cousin and his friends" (S13) "I enjoyed going out with my friends" (S16)	"I'm not afraid of falling asleep and sleeping any more" (CI) "I like staying with friends and they like spending their time with me" (C)I)
3	**Observable behaviours**	"They [mother and father] forbid me to lock the bathroom door and they [family members] don't respect my privacy" (0A) "I isolate myself in my room playing videogames because it makes me feel more emotions" (0E) "I'm nervous, I bite my	"I lock the bathroom door, so others will respect my privacy" (S6)	"A classmate bullied me all year" (S10) "My classmates and I went out for an end-of-the-year pizza" (S10) "I get angry and defend victims when I get involved in cyberbullying" (S11) "I went out with my cousin and his friends" (S13)	"My relationships improved, I go out" (CI) "I go out now, before I hated it because I was embarrassed" (CI)

	Script System	Phase 1	Phase 2	Phase 3	Phase 4
		fingernails, I shake my leg, I sweat" (0E)		"I'm not asking some friends to go out for my birthday because dealing with rejections is too stressful… I fear their answer" (S15) "I went out with some friends" (S16)	
4	**Reported internal experiences**	-	"I get tired easily, I struggle to concentrate" (S1) "I feel like my dog that is considered only when he makes you angry" (S7)	-	"I'm not depressed anymore" (CI) "I'm not stressed anymore, only before oral examinations, before I got stressed for everything" (CI)
5	**Fantasies**	"I fear her [girl] rejection" (0A) "I'm afraid to make mistakes when others watch me doing things, I feel embarrassed" (0D)	"I don't know with whom to go out, I'd be alone" (S5)	"I failed two tests out of three… I think, I guess I failed them" (S9) "I'd like to ask my classmates to go out, but I don't want to be bothering during the summer break" (S10) "I don't ask this girl to go out because I'm scared I'll make a gaffe" (S12) "My parents don't understand my needs and wishes [I don't tell them, they should know]" (S13) "I don't go out because I'm afraid I'll make a gaffe with new people" (S13)	-
6	**Reinforcing experiences through current events**	-	"Middle school friends don't answer me when I ask them to go out" (S5) "The only thing dad wants to talk about with me is school and this makes me feel bad… or we talk about school or we fight" (S7)	"I don't play anymore, I study, all my energies are for studying" (S9) "If I fail the exam, every time dad says that it's my fault" (S9) "My friends stood me up four times" (S10) "I stopped asking my parents things I'd like to do because I'm used to receive rejections" (S13)	-
7	**Reinforcing experiences through old emotional memories**	-	"In second grade a teacher yelled at me" (S2)	"Happy memories of my childhood are when we went to the amusement park, now we don't go anymore" (S8)	-

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

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

loosening his script regarding fear of being judged by people he did not know, which prevented him going out with friends. By the end of the therapy, he reported having gone out on a date with his friends and new people, and to have liked it (HAT Form, session 16), which is confirmed in the CI: "now I go out, before I felt embarrassed" (CI, L138-13). Furthermore, according to the client statement "talking to someone that was genuinely interested in me really helped me, because this is rare" (CI, L553-560); hence the affirmative case includes that the strong therapeutic alliance and the space therapy gave Giovanni to share his passions (for the guitar, online games and creation of gameplays) and explaining his underestimated abilities (in game strategies and in editing videos) with a receptive and interested listener, helped him express his desires and needs, an aspect that he reported to be absent in his family (S14, L254-265). Finally, since the beginning of therapy, the therapist focused on giving strokes and recognitions when Giovanni spoke about his technological talent and about his desires of doing new things he liked (going out with friends, going on a trip with his family to a close place he wanted to visit, asking his parents to learn to play the guitar).

Sceptic Case

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

Four of the quantitative measures used (PHQ-9, GAD-7, CORE and PQ) are not validated for adolescence, thus should not be adopted in this case study. Furthermore, Giovanni's PQ scores did not improve significantly, and there is also no evidence that the therapist's interventions were tied to the different items of the PQ. For such reasons, we reject the claim of a global reliable change. In his CI, he also reported that since he started therapy, he began to act with more revenge if someone bothered him, "this thing got worse, one year ago I would have never done something similar" (CI, L303). He also said that "I don't see all these changes in me" (CI, L244), in fact, items 5, 7 and 11 of the PQ "didn't change, they are as before" (CI, L644, 663, 682). Moreover, in the course of therapy, there are many incongruences in Giovanni's words: i.e. wanting to start a sport but can't because parents won't let him (session 0A) versus not wanting to do any sport because he doesn't like sports (session 0C) versus "I wanted to start martial arts and my parents didn't allow me to go to the gym" (session 13); and also in the PQ's first item "I get scared when teachers yell at me", which is still from 'moderately' to 'considerably' bothering even after the end of the scholastic year. Therefore, positive changes at the end of therapy might be due to similar incongruences.

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.

Even considering PHQ-9, GAD-7, CORE and PQ as valid measures for depression in adolescence, the visual inspection of the five-point baseline shows an unstable pattern in all measurements, making it difficult to calculate a reliable change. Furthermore, Giovanni did not fill in many different items of the CORE, highlighting a lack of attention in completing the questionnaires, which might have influenced quantitative data.

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, waiting to make the therapist feel good, or trying to justify his or her ending therapy.

In his quantitative data, the client scores show a RCSI in the PHQ-9, GAD-7 and CORE in all four measures from the 8-month follow up. This could be tied to compliance effect, because he rated improvements also after the end of therapy. In fact, it seemed that Giovanni showed compliance towards the therapist because she listened to him, a rare thing for him (CI, L553-560). Moreover, in his CI, Giovanni reported only positive comments about the therapy and the therapist, and in his HAT forms he reported no hindering event.

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

The sceptic team was not able to find any proof of changes due to cultural or personal expectancy artefacts.

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

Even accepting that data from PHQ-9, GAD-7, CORE and PQ changes and widely fluctuating scores are normal in adolescence, all observed changes can be attributed to normal fluctuations associated with adolescence. Furthermore, Giovanni started therapy after a teacher yelled at him, an event that generated in him a strong feeling of fear every time he stood in front of that teacher. Therefore, the significant drop of depression and anxious scores in both PHQ-9 and GAD-7 between session 9 and 10, could be tied to the end of the academic year, which led Giovanni to an immediate recovery and return to the normal baseline.

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

As previously mentioned, improvements in Giovanni's quantitative data from session 10 may

have been due to the end of the academic year and to the beginning of summer vacations: "having finished school sent me like in to a coma, a state of calm" (S10, L9-11). Furthermore, in session 13 he received a diagnosis of dyscalculia, which "made me feel better, because now my bad grades in maths have a reason: I've been doing tests for normal people, that's why doing exercises was so difficult" (S13, L38-39), and solved his low self-esteem tied to his incapacities in exams. Furthermore, in his CI, Giovanni reported that "my behaviour changed even because I grew up, so I don't know whether this is due to therapy or me maturing" (CI, L189-190). Finally, in his HAT Form (Table 4, session 16) he reported that he managed to have a pleasant evening with new friends because they were friendly, therefore their tendency to be friendly might have positively influenced Giovanni's mood.

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

There is no evidence that Giovanni's improvements are 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, talking about his problems and being recorded made Giovanni feel embarrassed and strange (CI, L567-568), which might have affected quantitative and qualitative data. In fact, during therapy, he did not want to say the names of his classmates nor friends "I don't want to say their names… so let's call this person Lorenzo" (S5, L75-76, 237).

Affirmative Rebuttal

1. A search for existing literature indicated that there are several studies which support the use of PHQ-9, GAD-7, CORE and PQ with adolescents. Studies indicate that disorder sensitivity and specificity in adolescence are similar to those of the adult population, suggesting only a slightly higher clinical cut off. Even if there is not a validated version for Italian adolescents, there is no reason to suppose a different result might occur in light of the other validations. Thus, we affirm the presence of a global reliable change. The therapist decided not to work directly on the patient's PQ items, because thanks to her clinical experience, she believed that to help Giovanni solve his problems, his self-esteem had to grow. Therapeutic interventions focused on improving his self-confidence and his self-image. In his CI, Giovanni reported that all the problems he brought up during therapy were resolved; therefore, even if not all the items of the PQ reached a RCSI, the patient felt that what he desired to improve, did. Finally, the incongruences reported in the sceptic case could reflect a typical tendency of adolescents to change their mind about things they experience in order to create a congruent and stable self-image. As for the scores in the first item of the PQ, in session 13 the patient specified that "I'm not referring to teachers, but to people in general" (S13, L66-70).

2. Fluctuation in the PHQ-9 scores in the pre-treatment phase are inferior to the reliable change index, thus are not reliable and may reflect the error measure of the test. For the CORE items that were not filled in, Giovanni asked "some of these are stupid questions, for example 'I have achieved the things I wanted to'… what if I didn't plan any achievement? Because I didn't have a specific goal this week" (S12, L187-189) and the therapist answered that he could decide to answer if that event occurred, or leave it blank if he felt that the options for answering it did not mirror his feelings (S12, L202-203).

3. The creation of a friendly relationship is considered a necessity to engage adolescents in therapy, therefore, especially because he felt unheard between domestic walls, but listened to by the therapist, this helped Giovanni to express his desires and wishes. Furthermore, in his CI, the patient appeared able to describe the problems he did not solve during therapy, and about new emerging problems, like being unfriendly to people that bother him (CI, L290-291). Finally, after the end of therapy, the patient decided to continue his therapeutic journey with his therapist, discrediting the hypothesis of a compliant attitude with the therapist.

5. When Giovanni presented for therapy, his condition was worsening, which is mirrored in the intensity of the difficulties of the problems he marked in the PHQ-9, which rose from 'somewhat difficult' to 'very difficult', and to the slightly raising trendline of the GAD-7 and of the CORE in the pre-treatment phase. However, when school ended, his problems tied to teachers and exams ceased, but his self-esteem was still low, and his relational difficulties were also present. Therefore, finishing school has not been the event that triggered Giovanni's wellness, even because the duration of his problem tied to his low self-esteem lasted from '6 to 11 months' to 'from 6 to 10 years', which contradicts a 'reverse to normal baseline' hypothesis.

6. His improvements cannot be tied to the end of the academic year because the 8-month follow up took place exactly one year after session 9 (three weeks before the end of the academic year): in session 9 his scores represented a moderately severe depression (PHQ-9, 19), a moderate anxiety (GAD-7, 14), a moderate global distress (CORE, 18.8) and

moderately bothering problems (PQ, 4.2), whereas at 8-month follow up they showed a mild depression (PHQ-9, 6), a mild anxiety (GAD-7, 5), a 'low level' of global distress (CORE, 6.8) and his problems were 'very little' bothering (PQ, 2.6). If school's final exams made him feel so stressed, one year after he should have had a similar pattern; instead he maintained a higher self-esteem, which helped him cope with his daily life problems. Even when Giovanni received a diagnosis of dyscalculia, this did not improve his low self-esteem tied to his grades, because the resits he did in order to be promoted were not simplified for dyscalculic people. Giovanni reported to have studied hard throughout the summer: "I've already started taking private maths lessons, because I have the time, so why not use it?" (S15, L18-27).

7. The overall transcriptions of the sessions show that Giovanni expressed without censoring himself, furthermore in his CI Giovanni specified "after the first sessions I did not even remember about the recorder in the room, because you talk and you don't care about it" (CI, L570) and "during therapy I've said only what I truly felt" (CI, L242-246).

Sceptic Rebuttal

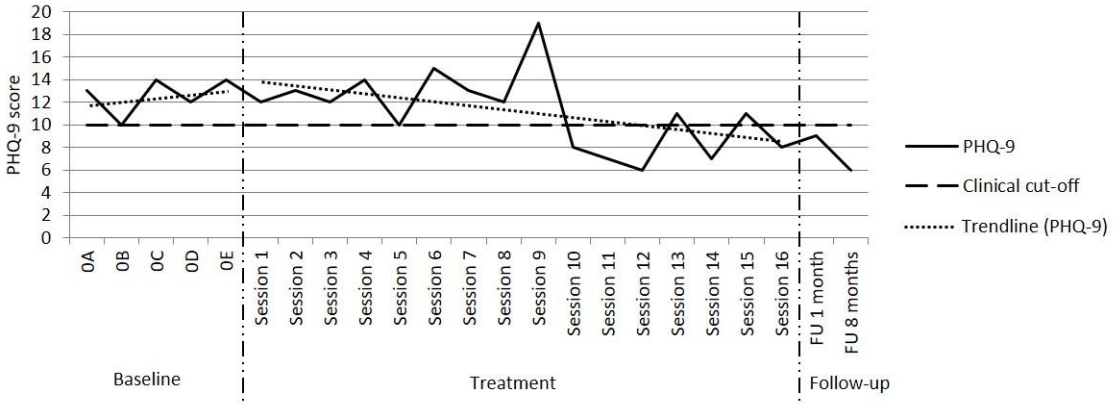
Even accepting the use of outcome measures not validated for adolescence, there still remain the difficulties in the use of questionnaires for adolescents. There are several indications that Giovanni found some difficulties, inconsistencies and confusion in completing the questionnaires. For example, during the CI, he forgot to score the last two items, and in session 16 the therapist pointed out that he missed filling in an item, asking him whether this was intentional or not, and he said he forgot about it. This shows an inattention to the questionnaires, so quantitative data is not only not valid, but it might also be unreliable. Finally, the end of the academic year, growing up and maturing, as he said, might have influenced Giovanni's attitude and self-esteem.

Affirmative Conclusion

Giovanni's depression, anxiety, personal and behavioural problems were related to difficulties in sustaining a self-nurturing internal dialogue, self-criticism and difficulty in solving problems. The therapist created a warm relationship where the client felt free to be open and experienced strong support for his low self-esteem. The focus on awareness of his internal dialogue, differentiation between internal dialogues from Critical and Nurturing Parent, loosening his script, helping him gain self-esteem and self-confidence, have been fundamental for Giovanni to create relationships with peers. The therapist gave the client permissions which contrasted with the constant injunctions he reported receiving, which led to a stable change in depressive and anxiety symptoms, especially worthlessness. These experiences were reflected in changes in depressive symptoms and depressive personality, internal dialogues, script beliefs about self and others, needs and feelings, behaviours, internal experiences, self-identity, and interpersonal relationships. The areas that have changed the most are self-esteem and relationships.

Sceptic conclusion

Giovanni's symptoms arose after a teacher yelled at him because he was not prepared for an exam, which made his anxiety rise and his self-esteem decrease. Some quantitative measures are not validated for adolescents and the tests also present several errors in their compilation. Several extra-therapeutic events may have had a prominent role in the reversal of symptomatology. The observed change could be due to a spontaneous remission.

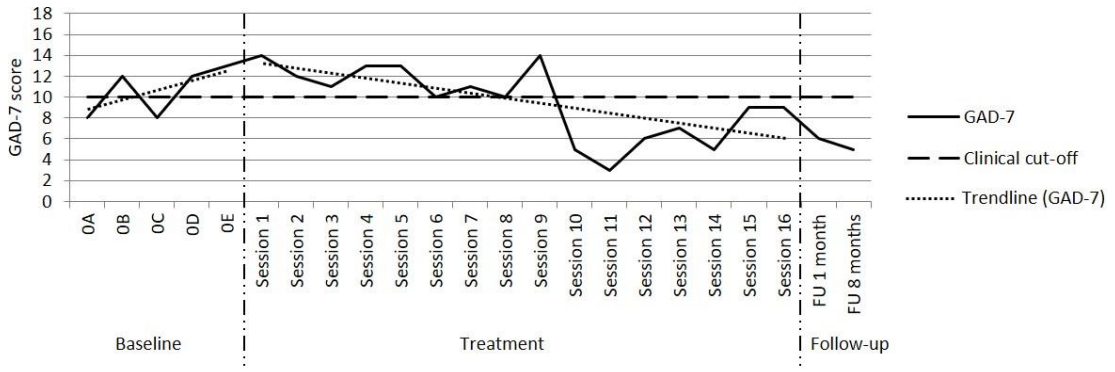


Note. 0A, 0B, 0C, 0D and 0E = assessment sessions. FU = follow-up. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999).

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

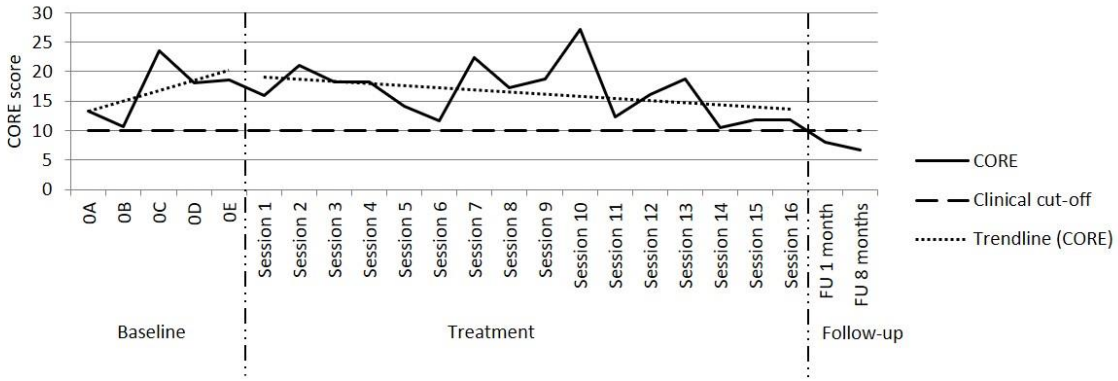
Figures 1 to 4 allow visual inspection of the time series of the weekly scores of primary (PHQ-9 and GAD-7) and secondary (CORE and PQ) outcome measures, with linear trendline.

Filling in the PHQ-9, at the question "If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?" in session 0A, 0B, 0C, 0D, 0E, 1, 2, 3, 4, 5 he rated those problems as 'somewhat difficult', in session 7, 8, 9 as 'very difficult' and in sessions 6, 10, 11, 12, 13, 14, 15, 16, FU1, FU2 as 'not difficult at all'.



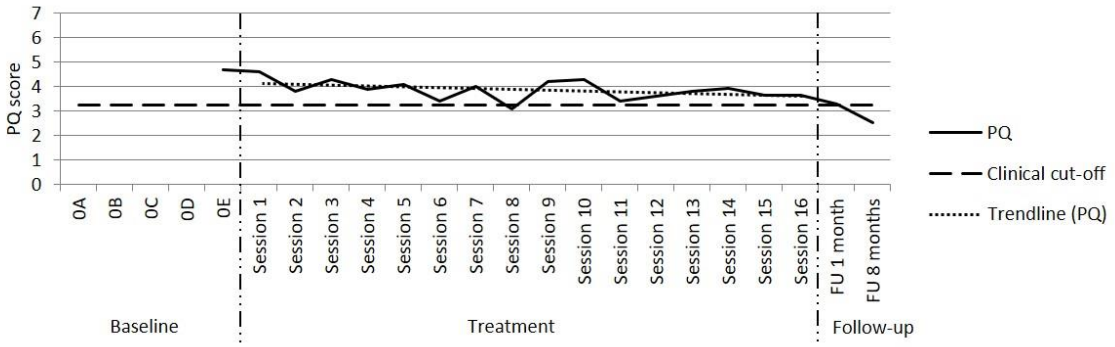
Note.0A, 0B, 0C, 0D and 0E = assessment sessions. FU = follow-up. GAD-7 = Generalised Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006).

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



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

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



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

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

Session	Rating	Events	What made this event helpful/important
1	8 (greatly)	When we spoke about my passion for music and my desire to learn to play the guitar.	This event has been useful because I opened up to someone about this (I shared this passion).
2	7 (moderately	The fight with my classmate.	It's been like if I got over it, now it's not a problem anymore, it's not important.
3	9 (extremely)	It's been important to talk about my classmates who skipped class to ditch the oral exam.	The classmates I could trust left me alone with few people in class, making me risk an interrogation and feel that anger and sadness again.
4	9 (extremely)	The fear of falling asleep.	We looked for different strategies to fight my phobia of falling in a state of unconsciousness while I sleep.
5	8 (greatly)	When we spoke about a second girl I like.	The fact that I got to the conclusion that it's not wrong feeling interest for more girls.
6	9 (extremely)	The most useful event has been talking about my friend's younger brother and his behaviour.	It confirmed for me that I must keep making him feel like his own victims.
7	7 (moderately	Talking about the conversation with my dad.	Speaking or finding an excellent topic of conversation with my dad is difficult.
8	9 (extremely)	The privacy I don't have and that my parents don't give me.	-
9	9 (extremely)	Speaking about the two out of three exams in which I failed.	The fact that I felt more tranquil speaking about it with someone that listened to me instead of passing his anxiety on to me.
10	8 (greatly)	Talking about the classmate that doesn't respect others and that spent the whole academic year offending me.	I vented saying what I think about my classmate's behaviour.
11	8 (greatly)	When we spoke about my friend's younger brother's cyber-bulling against another friend of mine.	This kid dared to insult a friend of mine he didn't know, while we were playing online.
12	8 (greatly)	Speaking about the fact I want to have social interactions with peers.	When I'm home I frequently get bored, therefore I'd like to spend a part of my time with my peers.
13	9 (extremely)	Talking about my fear of being judged by people I don't know.	Going out with new people generates an embarrassing silence that could be interrupted with conversation. According to how you approach, you can be seen negatively.
14	8 (greatly)	Speaking of the constant problems that my friend's younger brother is creating in my videos.	This kid keeps spoiling my work when I'm editing a video.
15	9 (extremely)	Talking about planning to go out with peers.	I can't or I don't want to plan dates with my schoolmates or with my peers because I'm afraid that they won't consider me their friend and won't answer me.
16	8 (greatly)	Talking about the date I went to with peers I didn't know and the excellent consideration I had since the beginning.	I went out with people I didn't know and with some other friends of mine, and because they were friendly I bonded straight away, and I managed to spend a pleasant night.

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

Table 4: Giovanni'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 go out more often with my friends. I try to be more social	4 (somewhat surprised)	2 (somewhat unlikely)	4 (very)
2	I look at others with another perspective. I want to understand their intentions	2 (somewhat expected)	5 (very likely)	3 (moderately)
3	I try to think before I say something	5 (very much surprised)	2 (somewhat unlikely)	3 (moderately)
4	I'm more tranquil. Before I kept biting my fingernails and shaking my legs	2 (somewhat expected)	1 (very unlikely)	2 (slightly)
5	I don't take offence for the jokes on the bus anymore	3 (neither)	4 (somewhat likely)	3 (moderately)
6	I don't freeze any more	-	-	-
7	When I go to bed I'm not afraid to close my eyes any more	-	2 (somewhat unlikely)	-

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

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

Pragmatic case evaluation

The entire list of evidence reported for Bohart's grid is represented in Appendix 1.

In a preponderance of the evidence provided for specific changes with the first 39 considerations, there was clear evidence in 27 of the points. There was no evidence of these changes for 5 of the points, and 7 of the points were considered not applicable for this client. On balance, provided evidence shows that there has been a qualitative change in the client and that he reported clear and descriptive examples of the improvements in his life. Furthermore, in a preponderance of the evidence provided for the attribution of such changes to therapy with the last 17 considerations, there was clear evidence in 14 of the points. There was no evidence of these attributions in 2 points, and 1 was considered not applicable for this client.

To conclude, according to Bohart's grid, there is an 84% of certainty of change in the client and 88% of certainty that improvements were due to therapy.

Discussion

This case aimed to investigate the effectiveness of a manualised TA treatment for depression (Widdowson, 2016) in an adolescent client with moderate level of major depressive disorder in comorbidity with generalised anxiety disorder. Although the manual was originally designed for the treatment of depression in adulthood, this case demonstrates its utility and effectiveness both with adolescence and with comorbid anxiety. The primary outcome was improvement in depressive symptomatology, which showed a subthreshold level of depression from the tenth session till the end of therapy, maintained in the follow-ups; anxiety reached clinical significance in the tenth session, maintained until the 8-month follow up.

Secondary outcomes were improvements in global distress and personal problems: global distress reached reliable change in the fourteenth session, maintained throughout the follow-ups; personal problems show a little improvement thoughtout the entire therapy, reaching RCSI only in the 1-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 treatment appears to be effective also for anxiety symptoms, suggesting that common mental health disorders such as depression and anxiety may share a common aetiopathogenetic mechanism. The therapeutic alliance appears to have been built on an active style, focused on personality traits associated to symptoms, transference and countertransference analysis. Specific TA techniques were: early sharing of the ego

state model, exploration of inner dialogue, developing of Nurturing Parent, exploration of drivers "Try Hard" and "Be Strong", racket analysis of loneliness and sadness.

These conclusions provide a further support to the effectiveness of TA manualised treatment for depression for adolescents too, being the second evidence that TA was effective in the treatment of a male adolescent with comorbid depression and anxiety.

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

Limitations

The first author is a psychologist and is currently studying TA psychotherapy. Despite the reflective attitude adopted in this work, this may have influenced in subtle ways the hermeneutic analysis. Moreover, only one researcher was involved in the hermeneutic analysis, which might have had a potential impact on the briefs, rebuttals and conclusions. Furthermore, this new method to conduct a HSCED requires a training in the creation of the hermeneutic analysis, in the use of four quantitative measurements (in this case: PHQ-9 for depression, GAD-7 for anxiety, CORE for global distress and PQ for personal problems), in two qualitative measurements (CI, HAT), in the use of the Script System to conduct a structured analysis of the main changes in the course of therapy, and in the application of Bohart's grids to support a more objective evaluation of the case. Although the simplified HSCED method reduces the quantity of resources and personnel for the analysis, the researcher must be well-formed. Even if the use of Bohart's grid aims to support the final evaluation of the case, there is only one point of view, therefore validity problems could be consistent. Finally, quantitative measurements (PHQ-9, GAD-7, CORE and PQ) are not validated for adolescents.

Future Development

This variation the traditional HSCED method of Elliott (2002, 2009) has been proposed when a group for the hermeneutic analysis, or at least two judges for adjudication procedure, are not available, or when training a group of people becomes too time consuming. For future development we might suggest conducting the hermeneutic analysis by a person without or with little knowledge on the therapeutic model (i.e. TA), in order to decrease limitations regarding validity and allegiance. Furthermore, the use of the Script System is helpful both for the therapist and for the researcher to follow the therapeutic process and enlighten the deepest areas of sufferance of the client's personality and monitor them during therapy. Therefore, if the therapist monitors the evolution of the Script System of the client, she/he will be more able to adjust the therapeutic work to specific personality problems. As for adolescent clients, future research could use quantitative measurements validated for adolescents.

Conclusion

This case study provides evidence that the specified manualised TA treatment for depression (Widdowson, 2016) has been effective in treating a major depressive disorder in an Italian adolescent client-therapist dyad, and provides evidence that hermeneutic analysis developed by a single researcher is possible with the use of the Script System (O'Reilly-Knapp & Erskine, 2010) for a deeper analysis and with Bohart's grid for case evaluation. Despite results from a case study being difficult to generalise, this study add evidence to the growing body of research supporting the efficacy and effectiveness of TA psychotherapy for adolescents too, and notably supports the effectiveness of the manualised TA psychotherapy for depression as applied to major depressive disorder.

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References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author. https://doi.org/10.1176/appi.books.9780890425596

Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., Benson, L., Connell, J., Audin, K. & McGrath, G., (2001). Service profiling and outcomes benchmarking using the CORE-OM: Toward practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology*, Vol 69(2), 184-196. https://doi.org/10.1037/0022-006X.69.2.184

Benelli, E. (2018). Trattamento analitico transazionale dei disturbi depressivi di personalità. (Transactional Analysis Treatment of Depressive Personality Disorders). In Widdowson, M., *Analisi Transazionale per i disturbi depressivi. Manuale per il trattamento.* (Transactional Analysis for Depression: A step-by-step treatment manual) (pp. 233-266). Milano. FrancoAngeli.

Benelli, E., Bergamaschi, M., Capoferri, C., Morena, S., Calvo, V., Mannarini, S., Palmieri, A., Zanchetta, M. & Widowson, M. (2017c). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - 'Deborah'. *International Journal of Transactional Analysis Research*, 8(1), 39-58. https://doi.org/10.29044/v8i1p39

Benelli, E., Boschetti, D., Piccirillo, C., Quagliotti, L., Calvo, V., Palmieri, A., Sambin, M. & Widdowson, M. (2016c). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - 'Luisa', *International Journal of Transactional Analysis Research*, 7 (1), 35-50. https://doi.org/10.29044/v7i1p35

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

Benelli, E., Filanti, S., Musso, R., Calvo, V., Mannarini, S., Palmieri, A. & Widdowson, M. (2017b). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - 'Caterina'. *International Journal of Transactional Analysis Research*, 8(1), 21-38. https://doi.org/10.29044/v8i1p21

Benelli, E., Gentilesca, G., Boschetti, D., Piccirillo, C., Calvo, V., Mannarini, S., Palmieri, A., & Zanchetta, M. (2018b). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - Sergio. *International Journal of Transactional Analysis Research & Practice*, 9(2). 23-41 https://doi.org/10.29044/v9i2p23

Benelli, E., Moretti, E., Cavallero, G. C., Greco, G., Calvo, V., Mannarini, S., Palmieri, A. & Widdowson, M. (2017a). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - 'Anna'. *International Journal of Transactional Analysis Research*, 8(1), 3-20. https://doi.org/10.29044/v8i1p3

Benelli, E., Procacci, M., Fornaro, A., Calvo, V., Mannarini, S., Palmieri, A., & Zanchetta, M. (2018a). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - Giorgio. *International Journal of Transactional Analysis Research & Practice*, 9(2). 3-22. https://doi.org/10.29044/v9i2p3

Benelli, E., Revello, B., Piccirillo, C., Mazzetti, M., Calvo, V., Palmieri, A., Sambin, M. & Widdowson, M. (2016a). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - 'Sara'. *International Journal of Transactional Analysis Research*, 7(1), 3-18. https://doi.org/10.29044/v7i1p3

Benelli, E., Scottà, F., Barreca, S., Palmieri, A., Calvo, C., De Renoche, G., Colussi, S., Sambin, M. & Widdowson, M. (2016b). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - 'Penelope'. *International Journal of Transactional Analysis Research*, 7(1), 19-34. https://doi.org/10.29044/v7i1p19

Benelli, E., Vulpiani, F., Cavallero, G., Calvo, V., Mannarini, S., Palmieri, A., & Zanchetta, M. (2018c). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - Beatrice. *International Journal of Transactional Analysis Research & Practice*, 9(2). 42-63 https://doi.org/10.29044/v9i2p42

Berne, E. (1961). *Transactional analysis in psychotherapy: a systematic individual and social psychiatry*. New York: Grove Press.

Berne, E. (1972) *What do you say after you say Hallo?* New York: Grove Press.

Bohart, A.C., Berry, M. & Wicks, C. (2011). Developing a systematic framework for utilizing discrete types of qualitative data as therapy research evidence. *Pragmatic Case Studies in Psychotherapy*, 7(1), 145-155.

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

Bohart, A.C., Tallman, K.L., Byock, G. & Mackrill, T. (2011). The "Research Jury" Method: The application of the jury trial model to evaluating the validity of descriptive and causal statements about psychotherapy process and outcome. *Pragmatic Case Studies in Psychotherapy*, 7(1), Article 8, 101-144,

Cameron, I. M., Crawford, J. R., Lawton, K., et al. (2008). Psychometric comparison of PHQ-9 and HADS for measuring depression severity in primary care. *British Journal of General Practice*; 58(546):32-6. https://doi.org/10.3399/bjgp08X263794

Costello, E.J., Erkanli, A., & Angold, A. (2006). Is there an epidemic of child or adolescent depression? *Journal of Child Psychology and Psychiatry*, *47*(12), 1263-1271. https://doi.org/10.1111/j.1469-7610.2006.01682.x

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

Delgadillo, J., McMillan, D., Leach, C., Lucock, M., Gilbody, S., & Wood, N. (2014). Benchmarking routine psychological services: a discussion of challenges and methods. *Behavioural and cognitive psychotherapy*, 42(01), 16-30. https://doi.org/10.1017/S135246581200080X

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

Elliott, R. (2015). Hermeneutic Single Case Efficacy Design. In Strauss, B., Barber, J. P., & Castonguay, L. (Ed.). *Visions in psychotherapy research and practice: Reflections from the presidents of the society for psychotherapy research*. (pp. 188-207). New York, NY; Abingdon. Routledge.

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

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

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

Elliott, R., Wagner, J., Sales, C., Rodgers, B., Alves, P., & Café, M. J. (2016). Psychometrics of the Personal Questionnaire: A client-generated outcome measure. *Psychological assessment*, 28(3), 263-278.

Ernst, F. H., Jr. (1971). The OK corral: The grid for get-on-with. *Transactional Analysis Journal*, 1(4), 33-42. https://doi.org/10.1177/036215377100100409

Erskine, R. & Zalcman, M. (1979). The racket system: a model for racket analysis. *Transactional Analysis Journal*, 9, 51-9. https://doi.org/10.1177/036215377900900112

Evans, C, Connell, J., Barkham, M., Margison, F., Mellor-Clark, J., McGrath, G. & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. *British Journal of Psychiatry*, 180, 51-60. https://doi.org/10.1192/bjp.180.1.51

Evans, C., Margison, F., & Barkham, M. (1998). The contribution of reliable and clinically significant change methods to evidence-based mental health. *Evidence Based Mental Health*, 1(3), 70-72. https://doi.org/10.1136/ebmh.1.3.70

Goulding, R. & Goulding, M. (1976). Injunction, decision and redecision. *Transactional Analysis Journal*, 6, 41-8. https://doi.org/10.1177/036215377600600110

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

Kapur, R. (1987). Depression: an integration of TA and paychodynamic concepts. *Transactional Analysis Journal*, 17:29-34.

Kahler, T. (1975). Drivers: the key to the process of scripts. *Transactional Analysis Journal*, 5, 280-284. https://doi.org/10.1177/036215377500500318

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

Kerr, C. (2013). TA Treatment of Emetophobia - A Systematic Case Study - 'Peter'. *International Journal of Transactional Analysis Research*, 4:2, 16-26. https://doi.org/10.29044/v4i2p16

Kroenke, K., Spitzer, R. L., Williams, J.B.W. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medecine*. 16(9), 606-13. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Kroenke, K., Spitzer, R. L., Williams, J.B.W., Monahan, P.O. & Löwe, B. (2007). Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection.

Annals of Internal Medecine. 146(5), 317-25. https://doi.org/10.7326/0003-4819-146-5-200703060-00004

Lingiardi, V., & McWilliams, N. (2015). The psychodynamic diagnostic manual-2nd edition (PDM-2). *World Psychiatry*, 14(2), 237-239. https://doi.org/10.1002/wps.20233

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

MacLeod, R., Elliott, R., & Rodger. (2012). Process-experiential/emotion-focused therapy for social anxiety: A hermeneutic single-case efficacy design study, *Psychotherapy Research*, 22:1, 67-81. https://doi.org/10.1080/10503307.2011.626805

Murray, C. J., Vos, T., Lozano, R., Naghavi, M., Flaxman, A. D., Michaud, C., ... & Aboyans, V. (2012). Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *The lancet*, *380*(9859), 2197-2223. https://doi.org/10.1016/S0140-6736(12)61690-0

O'Reilly-Knapp, M., & Erskine, R. G. (2010). The script system: An unconscious organization of experience. Life scripts: *A transactional analysis of unconscious relational patterns*, 291-308. https://doi.org/10.4324/9780429476686-13

Richards, D. A. & Borglin, G. (2011). Implementation of psychological therapies for anxiety and depression in routine practice: two year prospective cohort study. *Journal of Affective Disorders*, 133, 51-60. https://doi.org/10.1016/j.jad.2011.03.024

Seligman, L. D., & Ollendick, T. H. (1998). Comorbidity of anxiety and depression in children and adolescents: An integrative review. *Clinical Child and Family Psychology Review*, *1*(2), 125-144. https://doi.org/10.1023/A:1021887712873

Spitzer, R. L., Kroenke, K., & Williams, J.B.W .and the Patient Health Questionnaire Primary Care Study Group (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. *Journal of the American Medical Association*. Nov 10; 282:18, 1737-44. PMID 10568646 https://doi.org/10.1001/jama.282.18.1737

Spitzer, R. L., Kroenke, K., Williams, J. B.W. & Löwe, B. (2006). A brief measure for assessing generalised anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166:10, 1092-1097. https://doi.org/10.1001/archinte.166.10.1092

Steiner, C. (1974). *Scripts people live*. Grove Press. New York.

Stewart, I., & Joines, V. (1987). *TA today: A new introduction to transactional analysis*. Nottingham: Lifespace Publishing

Stewart, I., & Joines, V. (2012). *TA today: A new introduction to transactional analysis* (2nd edn). Nottingham: Lifespace Publishing.

Wall, J. M, Kwee, J. L, Hu, M. & McDonald, M. J. (2016). Enhancing the hermeneutic single-case efficacy design: Bridging the research-practice gap. *Psychotherapy Research*. https://doi.org/10.1080/10503307.2015.1136441

Westen, D. & Shedler, J. (1999a). Revising and assessing Axis II: I. Developing a clinically and empirically valid assessment method. *American Journal of Psychiatry*. 156, 258-272. https://doi.org/10.1176/ajp.156.2.258

Westen, D. & Shedler, J. (1999b). Revising and assessing Axis II: II. Toward an empirically based and clinically useful classification of personality disorders. *American Journal of Psychiatry*, 156, 273-285. https://doi.org/10.1176/ajp.156.2.273

Widdowson, M. (2009). Transactional analysis: 100 key points and techniques. London: Routledge.

Widdowson, M. (2012a). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Peter'. *International Journal of Transactional Analysis Research*, 3:1, 3-13. https://doi.org/10.29044/v3i1p3

Widdowson, M. (2012b). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Denise'. *International Journal of Transactional Analysis Research*, 3:2, 3-14. https://doi.org/10.29044/v3i2p3

Widdowson, M. (2012c). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Tom'. *International Journal of Transactional Analysis Research*, 3:2, 15-27. https://doi.org/10.29044/v3i2p15

Widdowson, M. (2013). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Linda' - a mixed outcome case. *International Journal of Transactional Analysis Research*, 4:2, 3-15. https://doi.org/10.29044/v4i2p3

Widdowson, M. (2014). Transactional Analysis Psychotherapy for a Case of Mixed Anxiety & Depression: A Pragmatic Adjudicated Case Study - 'Alastair'. *International Journal of Transactional Analysis Research*, 5:2, 66-76. https://doi.org/10.29044/v5i2p66

Widdowson, M. (2016). *Transactional Analysis for depression: A step-by-step treatment manual*. Abingdon: Routledge. https://doi.org/10.4324/9781315746630

APPENDIX 1

Evidence in Bohart's criterion list

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

	Criterion	Source
1	Clients note themselves that they have changed	Changes reported in the CI
2	Client mentions things that make it clear that they either did something or experienced something different than what they normally do or experience in the course of their everyday lives	Changes reported in the CI
3	Clients are relatively specific about how they have changed	CI, 635-637; 650-654; 672-673; 676; 769-770
4	They provide supporting detail	CI, 64; 138; 194-196; 216-232; 461; 579-80; 609-616;
5	They show changes in behaviour in the therapy session plausibly related to the kinds of changes they should be making outside the session	CI, 579-580; 609-616
6	Plausible reports by the client that others have noted that the client has changed	CI, 216-232
7	Plausible indicators reported by the client: better grades, promotion at work, less use of medication, new activities such as jogging	CI, 138-143; 194-196; 609-616
8	They mentioned problems that didn't change	CI, 242; 322-328; 635-637; 644; 663; 682
9	They mention problems that did change	Changes reported in CI; 64; 138; 194-196; 216-232; 461; 579-80; 609-616; 635-637; 650-654; 672-673; 676; 769-770
10	The changes mentioned seem plausible given the degree of difficulty of the problem, degree of time in therapy	Changes reported in the CI
11	If there is a major change reported, it is described in rich enough detail to be plausible	CI, 609-616
12	If the client comes in depressed they show a reasonably consistent change in mood; more ups than downs as therapy goes on - i.e. they come to therapy less often depressed, seem less depressed, recover more quickly	CI, 672-673
13	If they report being anxious, they report either managing it better, or reductions in anxiety in key situations, and this shows a positive trend over therapy	CI, 194-207
14	If they report being unable to leave their house (agoraphobia) they report an example suggesting that they made a new and more concerted effort to go out and it met with at least some degree of success, and their affect about trying it is positive and hopeful (i.e. there is an increase in perceived possibility for them that they can do it)	S13, 122, S13, 221-233; S16, 13-20; CI, 138-143
15	If their problem is a habit problem (studying, overeating, drinking, smoking, etc.) they report concrete changes. With a habit problem ONE incident of change is not usually enough to say that a substantial change has occurred. We would want evidence that this one change was something new, or a new attempt after having been discouraged. But we would like it better if the person could report several successes; a pattern of success. But if a few fresh changes were made and the person seemed optimistic, that we could take as preliminary evidence of change.	Not applicable
16	If the problem is a demoralisation problem ("I can't"), or involves demoralisation, the person begins to show hope and optimism--a sense of possibility, a sense that it will be a challenge.	CI, 609-616

	Criterion	Source
	They become challenge oriented. If they fail they focus more on learning from the challenge than on what it means about them in terms of their inadequacy. In fact, they focus more on the difficulty of the task than on their inadequacies. In other words, when they fail they no longer see it as a complete sign of their inadequacy, or their failure. If they choose not to pursue it any further it is after a reasonable evaluation where they conclude reasonably that a shift in priorities is in order, or action plan.	
17	Evidence of new-found confidence in judgment.	CI, 154-161; 478-485; 489-498;
18	Evidence of greater competence in judgment - as the individual thinks out the problem he or she does it more proactively, considers alternatives, weighs them, uses good intuition. Does not seem driven by fear and jump to conclusions. They weight options aloud, think things out.	CI 154-161; 172-176
19	Evidence of greater proactive determination and persistence in relation to a reasonable goal.	Not applicable
20	If they make a risky choice, they seem to make it in a reasonable way.	Not applicable
21	Arriving at a major decision that the person was struggling with.	CI, 138-143
22	Coming up with a whole new plan which is innovative.	Not applicable
23	Getting a new perspective which brings greater coherence, reduces debilitating guilt, gives new positive behavioral options, helps the person let go of something from the past.	No
24	Gaining a new perspective where they seem to be acceptingly criticizing themselves, seeing their own limitations, but not in a defensive or overly critical way.	CI, 478-485
25	Gaining a perspective that “I am not my problem”	Not applicable
26	Identity work: clarifies fundamental goals and values. If no goals or values, begins to confront these issues. If has adopted goals and values from parents but is beginning to question them, begins to evaluate for self. If is in an “identity crisis,” or moratorium, struggles with issues and makes progress in making commitments. Identity work can take place in any or all of the following areas: vocational goals, moral values, goals about relationships, goals about children, religious values, political values, values about what makes for a meaningful life, gender issues, sexuality, ethnicity and cultural background	No
27	Identity work: Real self-controversies--what is my real self, am I being untrue to my real self? Movement towards some kind of reconciliation or decision.	No
28	Traumatic experiences--signs of letting go of it, coming to terms with it, reductions in symptoms such as flashbacks or nightmares, or at least a greater sense that these can be handled and not so debilitating.	Not applicable
29	Achievement of specific goals--becoming more assertive, as evidence by self-report of concrete instances, perhaps seeming more assertive in the therapy session, rise in confidence.	CI, 609-616
30	Interpersonal changes--reported changes in a positive fashion in relationships--handling anger better, less dependence, greater problem solving, greater realistic acceptance of others (i.e., but NOT accepting certain things such as abuse), greater empathy as demonstrated towards others and towards the therapist (more careful listening, less confrontive). With therapist acts more proactively, dialogically, less dependent, less aggressive, less need for dominance.	CI, 138-143; 154-161; 172-174; 216-232; 461; 478-485; 489-498
31	Specific changes: finished a project, made attempts to protect daughter, exercising. Made a new friend. Got and kept a job.	CI, 461; 478-485
32	Greater realization that there may be some things that will take ongoing work.	No

	Criterion	Source
33	Changes in self-relationship. Greater realization and appreciation of accomplishments; more specific and concrete and accurate assessment of talents and effort; less global, negative self-attributions; greater self-empathy; greater self-listening to intuitions, felt experiencing; greater receptive internal dialogue; holding constructs more tentatively to evaluate them; more of an open, searching mentality; if overinflated self-esteem or self-confidence, taking a more careful look at how one might be doing, offending people, etc.	CI, 143; 154-161; 172-174; 478-485;
34	Reduction in any presenting symptoms, such as feeling weak, fearful, tiring quickly, feeling no interest in things, feeling stressed, blaming oneself, feeling suicidal, unfulfilling sex life, feeling lonely, frequent arguments, difficulty concentrating, feeling hopeless about the future, having disturbing thoughts come to mind, upset stomach, sweating, dizziness, heart pounding, trouble getting along with others, trouble sleeping, headaches.	CI, 194-207; 672-673
35	Increases in positive things: self-efficacy, enjoying spare time, feeling loved and wanted, greater happiness, greater sense of direction or optimism, greater acceptance of the injustices of life in a productive way.	CI, 769-770
36	Better ability to define goals in a proactive and functional way.	No
37	Prosocial changes--volunteering, involvement in productive activities, new projects.	S14, 9-10
38	Changes in physiology--less sweating, calmer and relaxed in therapy.	S10, 9-11; S11, 1-6
39	Changes in appearance in a positive fashion (if observed).	Not applicable

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

	Criterion	Source
40	Clients themselves report that therapy helped.	CI, 33-36; 40-42; 64-66; 122-129; 408-416; 421-423; 433-443; 451-452; 512-529; 553-560; 562-563; 579-580; 609-616
41	Clients are relatively specific about how therapy helped, and it is described in a plausible way.	CI, 33-36; 40-42; 408-416; 421-423; 433-443; 451-452; 512-529; 553-560; 562-563; 579-580; 609-616
42	Outcomes are relatively specific and idiosyncratic to each client and vary from client to client (if comparing across clients).	Not applicable
43	In their reports, clients are discriminating about how much therapy helped, i.e. they do not in general give unabashedly positive testimonials.	CI, 242-246; 274-277; 290-291; 303; 322-328; 644; 663; 682
44	They describe plausible links to the therapy experience.	CI, 421-423; 433-443; 448; 504-529; 609-616
45	To the rater a plausible narrative case can be made linking therapy work to positive changes. This includes the following (#46-56):	HAT of all sessions and therapist's nots on sessions
46	Therapy provides a work space where clients have an opportunity to talk, think, express. The things the client talks about are the things that change, or if other things change, the client notes a relationship of them to the therapy experience. Client notes that this helped.	CI, 408-416; 421-423; 559-560; 553-560; 562-563

	Criterion	Source
47	Therapist's empathic understanding, warmth, acceptance, seems to relate to client's increased engagement, willingness to try new things, productive exploration.	CI, 408-416; 433-443; 553-560; 562-63
48	Therapist's encouragement, support, positive attitude seem to be related to client's overcoming demoralization, willingness to confront challenges, not be discouraged by failure. Therapist supports client productively when client fails. Keeps eye focused on productive behavior and this seems to relate to client's doing so also.	CI, 408-416; 421-423; 559-560; 553-560; 562-563
49	Therapist's warmth, empathic listening, seems to provide safe atmosphere for client to confront painful experiences, and these in turn change.	S2, 4-12; S7, 456-60; S9, 451-56; S10, 682-685; S16, 573-581; CI, 553-560
50	Therapist's in-tune questions, reflections, interpretations, or comments, seem to facilitate clients' exploration, gaining new perspectives, developing action plans, creativity. Client feels recognised.	CI, 408-416; 421-423; 559-560; 553-560; 562-563
51	Clients engage in concrete procedures in therapy and changes are congruent with what they are trying to achieve, and there is evidence of these changes. Examples: EMDR--clients work through a traumatic experience and then seem relieved afterwards, and at the next session; clients engage in chair work and either resolve an internal conflict, or come to terms with someone they have unresolved feelings towards; and this change persists or at least partially persists in subsequent sessions; clients challenge dysfunctional cognitions and show plausible changes in mood or behaviour.	CI, 138-143; 478-485; 609-616
52	Issues client struggles with in therapy change plausibly over time in accord with the trajectory of the client's working on them. E.g. client talks about them week after week, and has ups and downs, but gradually masters them, and the mastery seems related to their ongoing struggle with it in therapy. In other words, perhaps each week they talk about experiences related to resolving the problem, works on it, and gradually masters it.	CI, 138-143; 478-485; 609-616
53	Clients report changes in trajectory from their past life in the problem. Clients report something new in regard to coping with the problem, and relate it to therapy, or it seems related to therapy. Clients report a history of failed coping with the problem, and now it is changing. Even if client reports having tried some of these things before, now reports that therapy has helped have confidence in the effort and helps him or her persist.	CI, 33-36; 40-42; 64-66; 122-129; 408-416; 421-423; 433-443; 451-452; 512-529; 553-560; 562-563; 579-580; 609-616
54	There are no plausible life changes that could have assumed major responsibility for the change. Or, if there is a life change, it seems to be a result of therapist deliberative activity, or it gets incorporated into the therapy activity in a productive way	No
55	Topics not dealt with in therapy did not change, or, if they did change, there was a plausible reason why they changed from the therapy or from clearly independent reasons. In other words, they can be accounted for so that we can assume we are not talking about a global halo effect.	No
56	Clients' mastery experiences, problem actuation, and clarification and gaining of new perspectives that occurs in therapy are related to the changes.	Changes reported in the CI