EFFECTIVENESS OF CCRT APPROACH WITH CLIENTS WITH ANXIETY AND DEPRESSION: TWO CASE STUDIES.

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EFFECTIVENESS OF CCRT APPROACH WITH CLIENTS WITH ANXIETY AND DEPRESSION: TWO CASE STUDIES

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Abstract

Evidenced-based practices are extremely valuable in the field of psychology. Randomized clinical trials have been considered the gold standard of evaluating the effectiveness of treatments. However, the importance of single-subject design and its focus on individual differences to understanding what therapeutic interventions works for whom offers complementary evidence. This study examined the efficacy of brief psychodynamic therapy using Luborsky's (1999) core conflictual relationship theme (CCRT) approach with two clinical case studies in the treatment of major depressive disorder and generalized anxiety disorder. The participants were selected based on convenience sampling. A single-subject method with time series data was utilized. Statistical methods of Percentage of Non-Overlapping Data (PND) and Reliable Change Index (RCI) were used for analysis. Outcome measures used to assess change across treatment included the Brief Symptom Inventory (BSI) and Participant Health Questionnaire-depression and anxiety disorders (PHQ-SADS). The results of the present study indicate that CCRT approach provided clinically significant improvement for depression and anxiety concerns for both clients. All areas of functioning assessed using BSI and PHQ-SADS demonstrated significant and positive changes.

Keywords: Core Conflictual Relationship Theme (CCRT), Short-term psychodynamic treatment, depression, anxiety, brief therapy, single-subject design, PND, RCI, clinical case study

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Literature Review

Although group-level randomized controlled trials (RCTs) are frequently regarded as the "gold standard" for psychotherapy research, single-subject research designs provide complementary, idiographic data that is not obtainable with group-level designs. Proponents of single-subject designs have described clinical practice as a "natural laboratory for psychotherapy research" (Borckardt et al., 2008). Kazdin (2018) notes that the term "single-subject" could be misleading, since this design is not necessarily limited to just one individual, but could be utilized with a large group of participants where the data analytic approach remains individualized. A key feature of single-subject designs is that it combines actual clinical treatment, as it occurs naturally, and empirical evaluation. Whether carried out with one or more clients, single-subject designs enable clinicians to use the client as their own control, which means treatment effects can be investigated in terms of client's symptoms and adaptive functioning over time. In other words, single-subject designs emphasize within-subject change, whereas group-level designs emphasize between-subject change.

Strengths and Limitations of Randomized Controlled Trials

Hariton and Locascio (2018) described the strengths of RCTs that have led these designs to be regarded as the gold standard of evidence-based practice. One of the major factors that make RCT exceptional is its ability to evaluate causality and reduce bias by using randomization. Biases such as selection bias, performance bias, assessment bias and confounding errors are minimized when using RCT method. This also allows researchers to account for individual differences, which are presumably "washed out" between groups through the randomization process. Another advantage of RCTs is that they allow for comparisons between treatment modalities and are able to establish relative superiority and

non-inferiority. This makes it the strongest source of evidence regarding the efficacy of psychological treatments.

However, it is important to understand the limitations of this "gold-standard" group level design. Westen (2004) argues that RCTs are far from perfect and cites several limitations of this methodology. First, he contends that many RCTs make assumptions that are not validated or applicable to all disorders and treatments. For example, many RCTs assume that psychopathology can be controlled, that most clients can be treated for a single disorder, and that psychopathology can be treated independent of personality aspects. Second, he notes that many RCTs do not account for comorbidities due to ruling out participants with particular comorbid conditions that are common in clinical practice. Goldfried (2000) found that RCTs for brief therapy frequently lacked systematic data to guide the length of treatment. Instead, psychotherapy researchers commonly based the prescribed length of treatment on assumptions adopted from medication studies. There were also problems with basing treatment research on DSM categories, as the sheer number of distinct disorders listed in the DSM makes having manuals for all unrealistic.

Westen and colleagues (2006) also identified significant limitations in the evidence obtained from psychotherapy RCTs. For instance, they found RCTs of treatment for major depressive disorder commonly excluded participants with symptoms of suicidality or substance abuse, resulting in questionable generalizability for patients with depression seen in practice. This creates challenges for clinicians, as they might be trying to apply results of an RCT to a client that may likely have been excluded from the RCTs (Zane, 2004).

Strengths and Limitations of Single-Subject Designs

Kazdin (2018) suggests that single-subject methodologies provide viable designs for clinicians as data provides information regarding whether therapeutic change has occurred. Borckardt et al. (2008) suggest that all practitioners might want to assess whether there is an

effective change from the baseline to treatment phase, and single-subject designs can provide relevant evidence regarding psychotherapy outcomes and processes (e.g., how change in treatment unfolds over time and under what circumstances). Single-subject time series methods are also advantageous in bridging the gap between evidence derived under highly controlled experimental settings and practice-based knowledge. Single-case designs are considered to provide systematic and detailed analysis for clinical interventions and allow for valid results (American Psychological Association, 2018)

Elaborating on using single-subject methodologies as a way to evaluate treatment in clinical settings, Kazdin (1983) suggested that single-subject designs compliment research from experimental settings where conditions often differ from those in actual clinical practice. For clinicians wanting to conduct single-subject research, Kazdin (1983) recommends first identifying a specific treatment and a measurable goal that would be expected to be achieved through treatment. This entails selecting measures that can reflect client progress in treatment (e.g., measures that quantify mutable, clinically relevant constructs rather than trait-based measures that would be insensitive to change). Second, Kazdin emphasizes the importance of continuous assessment that examines clients' clinical status over time. He concludes that single-subject methods help strengthen inferences beyond those derived from uncontrolled case studies.

Psychotherapy process and outcome data provided by single-subject research designs help clarify group-level validity evidence of psychological treatments (Sexton-Radek, 2014). Benefits of single-subject designs include the fact that they are relatively cost-effective, easy to implement, and able to provide immediate feedback to clients. Rapoff and Stark (2008) and Lenz (2015) further note that single-subject designs are flexible and allow clinicians to make modifications as new information comes to light. Further, this method is amenable to small samples, which allows for studying rare disorders where group-level research designs would

be prohibitive. Single-subject methods also allow for flexibility as it might include marginalized populations that might be difficult to recruit for large scale RCTs. Whereas group-based designs ideally aim to ensure standard procedures for all through fidelity checks, single case designs are flexible to accommodating treatment depending on individualized client needs. The data that is provided by single-subject designs enables clinicians to obtain in-depth understanding of the client and understanding of not just whether treatment works, but whom it might not work with (Lobo et al., 2017).

Through the use of repeated measures, single-subject designs are able to test for causal relationships regarding the impact of treatment that can be directly interpreted. Lastly, it promotes meaningful evidence-based practice. As noted by Romeiser and colleagues (2008), by capturing the ebb and flow of symptoms over the course of treatment, single-subject designs offer a particularly nuanced window into psychotherapy process that if often neglected in group-based designs.

Although single-subject designs afford considerable benefits, these strengths come at the cost of external validity, creating challenges to the generalizability of results. Rather than generalizing results of single-subject psychotherapy research to large and heterogeneous groups of individuals, a more conservative approach is warranted to focus on individuals who have similar characteristics to the research subject(s), psychological concerns, and prognostic characteristics. However, generalizability might not be of paramount importance for clinicians seeking to specifically test the effectiveness of their treatment modality with their specific client. Further, because individual clinicians frequently see similar types of clients, it is possible that the evidence derived from their single-subject studies might generalize quite directly to groups of clients typically seen in their own practice.

Analytic Approaches to Case Study Research

There are several empirical approaches to analyzing psychotherapy process and outcome in single-subject designs. Common across these approaches, single-subject designs require, at a minimum, one pre-treatment and one post-treatment data point. For several empirical approaches, multiple baseline and treatment data points are required, with daily measures typically representing the high end of the measurement frequency spectrum.

Percentage of Non-Overlapping Data.

Alresheed and colleagues (2013) described the percentage of non-overlapping data (PND) approach as one of the oldest methods of calculating effect sizes in single-subject research designs. To determine if the treatment is effective using the PND approach, the percentage of non-overlapping data between baseline and treatment is calculated.

Alresheed et al. (2013) describe several circumstances under which the PND approach is limited. First, if the data has many outliers, it can misrepresent the effectiveness of the intervention. Second, the PND approach must be interpreted carefully in order to identify situations in which the treatment had negative effects (e.g., a decrease in desirable behavior or increase in undesirable behavior), as these situations might lead to low levels of overlapping data between baseline and treatment phases that carry distinct implications. Another disadvantage, the PND approach is sensitive to extreme baseline scores. For example, if a client obtains a score of zero at baseline on a symptom inventory, the PND approach would not be able to detect any symptom improvement (Olive & Franco, 2008). Lastly, PND is unable to analyze continuous trends in the data (Allison & Gorman, 1993). Alresheed and colleagues (2013) recommend scoring based on multiple matrices for estimating effectiveness of treatment and combining statistical analysis with visual analysis.

There are several notable strengths of the PND approach, which is one of the most used methods for testing meaningfulness of change (Lenz, 2013; Olive & Franco, 2008). One major advantage of the PND score is that researchers are able to easily interpret data. A PND

score is also easy to calculate and intuitive. It also lends itself to visual analysis, which enables researchers to understand what it means when 90% of data are not overlapping with baseline. Further, because the method relies on individual data points rather than the distribution, it does not require parametric assumptions about the distribution of data (Parker et al., 2011).

Reliable Change Index

Another approach created by Jacobsen and Truax (1991) is the Reliable Change Index (RCI). The RCI is used to evaluate clinically significant changes between pretest and posttest. They defined clinical significance as when clients in therapy move from a dysfunctional range to a functional one. Statistically, the RCI measures whether symptom change is larger than would be expected due to simple measurement error, and as a result the RCI is calculated as a function of the pre- and post-treatment scores, along with the standard error of the measurement instrument. When the amount of change is small – or within the range of expected measurement error – it is deemed unreliable. For treatment effects to be considered reliable it should pass two stages. Firstly, it must prove to be statistically reliable using RCI, and secondly, clients must pass from a dysfunctional to functional range. This means that each client in the treatment study could be classified as recovered (if passed clinical significance criteria and RCI), improved (passed only RCI criteria), unchanged or indeterminate (passed neither) or deteriorated (if RCI is significant in the opposite direction as that expected, indicating an increase in symptoms larger than would be expected from simple measurement error).

Evidence for Psychodynamic Therapy

This research focuses on testing the effectiveness of Luborsky's (1999) Core Conflictual Relationship Theme (CCRT) approach to brief psychodynamic therapy with two clients suffering from depression and generalized anxiety disorder (GAD). The following

section describes the efficacy of psychodynamic therapy generally before discussing CCRT specifically.

Hilsenroth and colleagues (2003) and Barber et al. (2012) studied the effectiveness of brief psychodynamic therapy for patients with depression. In Hilsenroth et al.'s (2003) study, 27 participants were recruited with a diagnosis of major depressive disorder from a community outpatient setting. Four participants prematurely terminated after about four sessions. A total of 21 participants (11 men, 10 women) completed the study. Treatment involved twice weekly sessions of short-term psychodynamic therapy (STPP) across 30 sessions. Treatment was aided by integrating four STPP treatment manuals based on management of depression. The therapists were ten advanced graduate students enrolled in an APA-accredited program. Participants were assessed before and after treatment using three self-report measures: the Symptom Checklist-90-Revised (SCL-90-R), Social Adjustment Scale (SAS), and DSM-IV rating scales. The participants also answered two questions assessing their confidence in treatment and credibility. Sessions were rated using the Comparative Psychotherapy Process Scale (CPPS-PI). Results were calculated using paired *t*-tests assessing pre- and post-treatment changes. The mean CPPS-PI pre-test score was 1.21 (*SD* = 0.27) and the posttest was 3.56 (*SD* = 0.79). Therapeutic focus was found to be significantly associated with reduced depression symptoms ($t = 11.54$, $p < .001$) indicating that this therapy worked to reduce depression symptoms. Results indicated that the credibility, satisfaction, and perceived effectiveness were all high.

Driessen and colleagues (2013) compared the relative efficacy of psychodynamic therapy and CBT for depression in a randomized controlled trial designed to test non-inferiority. The sample of 341 patients were treated for depression in psychiatric outpatient clinics. Participants were selected based on meeting DSM-IV criteria for Major Depressive Disorder and a score above 14 on the Hamilton Depression Rating Scale (HAM-D).

Participants were randomly assigned to 16 sessions of short-term psychodynamic therapy or manualized CBT treatment. Results were calculated using HAM-D scores to examine treatment effectiveness immediately following treatment and at one-year follow-up. The primary outcome measure was posttreatment remission rate, defined as HAM-D scores below seven. Secondary outcomes were measured at one-year follow using HAM-D scores and score on the Inventory of Depressive Symptomology-Self Report (IDS-SR). Results showed that 22.7% of all patients met remission criteria at posttreatment and after one year follow up 26.8% showed remission rates. No differences were observed between the psychodynamic and CBT conditions, supporting the non-inferiority of psychodynamic therapy for depression relative to CBT.

Leichsenring (2001) also compared the effectiveness of psychodynamic treatment and CBT for clients with depression. A sample of sixty participants were recruited from outpatient clinics with a DSM-IV diagnosis of depressive disorder. Participants were randomly assigned to CBT or psychodynamic intervention groups. Manualized CBT and short-term psychodynamic therapy were applied for 16 sessions. The Beck Depression Inventory (BDI) was utilized to assess depression symptoms pre- and post-treatment. Results showed significant symptom reduction in both conditions, with effect sizes ranging between 0.94 and 2.44. Consistent with Driessen et al.'s (2013) non-inferiority trial, psychodynamic therapy was found to be as effective as CBT with regard to symptom reduction.

Ajilchi et al. (2016) examined whether intensive short-term dynamic therapy (ISTDP) would result in reduced symptoms of depression and improved executive functioning. Participants with a DSM-IV diagnosis of Major Depressive Disorder (MDD) and a score of over 20 on the Beck Depression Inventory-II (BDI-II) were recruited from a mental health outpatient clinic in Iran. This study recruited sixteen participants who were randomized to ISTDP or a to a waitlist control group. Pre- and post-test measures were used to calculate

differences between groups. Outcome measures included the BDI-II, which was used to measure depression symptoms, and the Wisconsin Card Sorting Task (WCST) and Stroop test, both of which measure executive functioning. Results showed significant improvements in depressive symptoms and executive functioning from pre- to post-treatment for the ISTDP group, and participants in the active treatment condition showed significantly greater improvements than those in the waitlist control condition.

Monti et al. (2014) analyzed the effectiveness of psychodynamic therapy (PDT) (n = 29) and CBT (n = 40) for anxiety disorders in university students at the University of Bologna. Dropout rates were higher in the CBT (n = 10) condition than in the PDT condition (n = 5). Participants were administered the Symptom Questionnaire (SQ) at the beginning, middle, and end of treatment to measure symptom change. There were no specific manuals used for CBT or PDT, only core principles of each therapy were applied. The duration of treatment was one year of weekly 50-minute sessions. Results showed significant effect within-group effects of treatment on the SQ anxiety scale, such that post-treatment scores were significantly lower than pretest scores (ps < .001). There were no significant differences in between-group scores or the interaction between within and between group scores. Both treatments led to significant decrease in anxiety symptoms after one year, and consistent with the findings above, no differences were detected between CBT and psychodynamic psychotherapy.

Leichsenring et al. (2013) conducted a multicenter randomized trial to study the effectiveness of psychodynamic therapy and CBT for social anxiety disorder. Patients (N = 495) from an outpatient clinical setting were randomly assigned to a manualized CBT condition, manualized psychodynamic condition, or a waitlist condition. All participants had a diagnosis of social anxiety disorder and were administered the Structural Clinical Interview for DSM-IV (SCID-IV) and Liebowitz Social Anxiety Scale. Assessments were conducted at

the start, week eight, week 15, and at the end of treatment. CBT and psychodynamic treatment went on for 25 sessions (once a week and 50 minutes). Results indicated that CBT and psychodynamic therapy were superior to the waitlist condition. In this study, remission rate is understood as treatment leading to no longer meeting criteria for diagnosis and response rate is a patient's reduction in symptoms over the course of treatment. There were significant differences when comparing CBT and psychodynamic therapy in terms of remission rate in favor of CBT, such that remission rates for CBT, psychodynamic, and waitlist conditions were 36%, 26%, and 9%, respectively. However, results showed no difference in response rates between CBT (60%) and psychodynamic (52%) conditions, with improvements in depressive and anxiety symptoms found with each of these therapies.

Bögels et al. (2014) researched the efficacy of CBT versus psychodynamic therapy for social anxiety disorder (SAD). Forty-seven participants were recruited based on a SAD diagnosis according DSM-IV based on evaluation with the SCID. Outcome measures used at pre- and post-test included the Social Phobia and Anxiety Inventory- Social Phobia subscale (SPAI), the Social Sensitivity subscale from the Symptom Checklist-90 (SCL-90), Social Phobia Disorders Severity and Change Scales (SPDSC), Social Phobic Beliefs Inventory (SPB), and the Defense Mechanism Inventory (DMI). Participants were randomly assigned to psychodynamic (n = 22) or CBT (n = 27) conditions. Psychodynamic treatment was time limited and focused and guided by Malan's principles. CBT treatment was manualized. Results showed that there was no difference between PDT and CBT treatments and indicated that both treatments were highly efficacious, with remission rates over 50%. These results also were similar to Driessen et al.'s (2013) study in finding no difference in SAD remission rates between CBT and PDT.

CCRT description

Luborsky et al. (1994) developed the Core Conflictual Relationship Theme (CCRT) as a brief psychodynamic treatment model. Luborsky described that the CCRT model as focused on self-other narratives as a way of identifying "relationship episodes" for the purpose of understanding the ways in which these episodes illuminate the etiology and maintenance of psychological distress. Depending on a client's psychological resources and level of impairment, Luborsky suggested that clients require different types of interventions that fall on a continuum, from supportive to expressive. Supportive interventions are described as those that strengthen ego functioning and existing defenses. By contrast, expressive interventions are described as aiming to develop increased self-understanding, such as bringing previously unconscious material to conscious awareness. In essence, supportive and expressive approaches can be considered interventions aimed at either bolstering existing psychological resources versus loosening overly restrictive defenses, respectively. Interventions along both ends of the supportive-expressive continuum focus on relationship patterns as they impact clients' current difficulties.

Luborsky's development of a CCRT manual was unique among psychodynamic theorists and, as a result, his approach has become widely adopted by psychodynamic psychotherapy researchers. Luborsky's (1994) CCRT manual includes selection criteria for clients working with expressive and insight-oriented therapy. These include client having good ego strength, in terms of having intact reality testing, adequate capacity to be reflective and not impulsive, adequate frustration tolerance, and adaptive defenses. Other factors include a client's capacity to be psychologically minded, that is, able to see connections between past and present, an ability to view oneself as agent as much as victim, and the motivation and capacity to engage and disengage readily.

Book (1998) developed a guided manual to practice the CCRT approach. This manual is an extensive guide that helps practitioners apply a 16-session version of CCRT. According

to Book (1998), CCRT has three phases of treatment. Phase one is between the first and fourth sessions. This period involves helping clients to identify their wish (W) in narratives and to develop insight. The Wish, is an impulse, what a individual *wants* to do, and needs to do to effectively deal with a situation. However, the wish can also be something that's very often blocked by defenses and maladaptive efforts avoid the anxieties that are aroused by the wish. The aim is to enable the client to see how the CCRT affects a person's day-to-day life. The therapist's role is to be active, direct, and to focus on relationship episodes (RE). The therapist also encourages clients to discuss interactions and relationships.

Phase two of treatment occurs between sessions five and 12. This phase involves identifying and working through the response from others (RO) and response to self (RS), which entails helping the client understand how the response of others, whether real or imagined, influences their reactions to their wish. The RO is often anxiety-arousing, and so the psychological operations that follow are aimed at minimizing this anxiety. That is, it is the product of defenses doing what they are originated to do, which is, reduce anxiety. The RS consists of a behavioral component and an affective component. It pertains to what the client did and what he, she or they felt. The therapist at this stage supports the client in understanding how others might shape their own response and to begin working with transference that might arise in the therapeutic alliance. In CCRT, the transference is referred to as enactments, which are seen as a way of helping the client process the responses of others in the here-and-now of the therapy office. The client's ability to understand repetitive patterns is strengthened in this phase as they become better able to understand the patterned and self-defeating nature of their relationship episodes.

Finally, phase three of treatment is between sessions 13 and 16. This phase involves the termination process. The therapist must pay particular attention to termination-related unconscious comments by the eighth session. In this phase therapist shares the progress made

in the CCRT developed with the client. The therapist also engages the patient in discussions surrounding the patient's thoughts, concerns, and fears regarding ending therapy.

CCRT Conceptualization

Wilczek and Weinryb (2010) examined the validity of CCRT conceptualizations in distinguishing between different psychological disorders. The aim of the study was to assess if CCRT patterns differed for patients with different DSM-III diagnoses. Another objective was to compare CCRT conceptualizations of clients with and without a DSM diagnosis. They recruited 55 participants from clients who had registered to participate in therapy. Trained clinicians collected relationship episodes (REs) and identified and scored each component to identify the primary W, RO, and RS for each client. Results indicated that participants mostly had a diagnosis of depression (65%) and their CCRT reflected a negative perception of response of other (RO) and an immature dependency in object relation terms in their interpersonal patterns. Other common diagnoses included anxiety disorders (59%); these participants tended to have more paranoid responses to RO's and had problems establishing meaningful relationships. Clients without a DSM diagnosis tended to have both positive and negative ROs. Based on these patterned differences across diagnostic (and undiagnosed) groups, these authors concluded that CCRT conceptualizations provide discriminant validity.

Tallberg et al. (2020) analyzed the inter-rater reliability of CCRT conceptualizations using a limited set of categories to classify client's wishes, response from others, and response to self. In this study, patients were randomly assigned to seven therapists who were trained in CCRT. Relationship episode coding options were limited to create a user-friendly CCRT conceptualization tool. They provided clinicians with eight categories of W, eight categories of RO, and eight categories of RS. The categories are shown in the table below:

Table 1

Tallberg et al. (2020) categories

Wishes (W)	**Response from Others (RO)**	**Response to Self (RS)**
Wishes (W)	Response from Others (RO)	Response to Self (RS)
Achieve and help others	Strong and independent	Helpful
Asserting self and being independent	Controlling	Unreceptive
Opposing hurt and controlling others	Upset	Respected and accepted
Be controlled, hurt and not responsible	Bad	Oppose and hurt others
Be distant and avoid conflict	Rejecting and opposing	Self-controlled and self-confident
Be close and accepting	Helpful	Helpless
Be loved and understood	Likes me	Disappointed and depressed
To feel good and comfortable	Understanding	Anxious and shameful

Note. Items are derived from Tallberg et al. (2020).

Results indicated inter-rater reliabilities ranging from .33 to .75, which ranged from unacceptable to good. Despite these limitations, the authors suggest that the reliability demonstrated in this study is generally on par with previous, more complex CCRT conceptualization coding systems. Additionally, given that case conceptualization is a complex process known to result in lower reliability than is typically seen with psychological tests, the authors conclude that these results are promising. It should be noted that this study was only concerned with the inter-rater reliability of generating a CCRT conceptualization regarding the W, RO, and RS and did not examine whether the resultant conceptualizations were associated with treatment outcomes. The method involved using the semi-structured dynamic interviews for 2 hours and the raters rated based on those interviews. The inter-rater reliability for assessing results was measured by Cohen’s kappa coefficient. There were eight standardized clusters for wish, relationship with others and relationship with self-themes. The

research scored one or more categories in each theme. The mean Kappa for Wishes (W) was .33, Response from others (RO) was .71 and Response from Self (RS) was .75. The results indicated that rater agreements of wish theme showed the lowest level of agreement and the agreements for relationship with self and others theme showed the highest level of agreement. The researchers discuss that moderate level of inter-rater reliability was found and this was mainly due to the difficulty to score what categorizes as wishes for participants.

Evidence for CCRT with Anxiety Disorders and Depressive Disorders

Crits-Christoph and colleagues (1996) evaluated brief supportive therapy for individuals suffering from generalized anxiety disorder (GAD). In a sample of 26 individuals with GAD from different clinical settings, participants were provided 16 weeks of supportive expressive CCRT therapy provided by trained clinicians. The interpersonal conflicts that emerged in therapy were analyzed by clinicians using the CCRT approach emphasizing wishes, responses of others, and responses to self. The SCID and Hamilton scales was used to measure anxiety and depression. Results showed a statistically significant reduction in symptoms and overall quality of life after 16 weeks of CCRT therapy. Specifically, the authors reported that 79% of the participants did not meet criteria for GAD any longer, a remission rate much higher than that observed by Leichsenring et al. (2013). Additionally, the average symptom severity rating for non-remitted participants was 4.2 at post-treatment, compared to 7.8 at baseline.

Connolly and colleagues (1998) recruited 33 patients with a diagnosis of depression and provided 16 weekly sessions of Supportive-Expressive therapy following CCRT principles. Participants were administered the Schedule for Affective Disorders and Schizophrenia Change version (SADS-C) and Penn Adherence/Competence scale for SE therapy (PACS-SE) to evaluate clinician's fidelity to the treatment. Results showed that SADS-C scores decreased significantly, from 17.9 to 7.8, across treatment. Results indicated

that 16 weekly sessions using SE therapy helped participants reduce symptoms, improve relationships, and improve overall quality of life.

Dos Santos and colleagues (2020) compared the effectiveness of cognitive behavioral therapy (CBT) and brief psychodynamic therapy using the CCRT approach for Major Depressive Disorder using a randomized clinical trial. They recruited 50 patients between 18 to 60 years old. All participant's diagnosis was based on DSM-IV and they were administered the Beck Depression Inventory-II (BDI-II) and Functioning Assessment Short Test (FAST). CBT was conducted using Beck's manual and short-term dynamic therapy for 16 weeks using Luborsky's manual. Across all participants, 82% showed significant symptom reduction. BDI-II total scores from baseline were 29 and post-treatment scores dropped to 6 for participants in CCRT group. Further, results showed that social functioning improved for participants who participated in brief psychodynamic therapy to a greater extent than those who participated in CBT. However, both psychotherapies were found to be equally effective and efficient forms of treatment for depressive symptoms.

In a small study, Jarry (2010) assessed the effectiveness of brief psychodynamic therapy using CCRT to reduce anxiety and depression and improve overall self-growth. The Rosenberg Self Esteem Scale (RSES) was used to measure self-esteem, the Symptom Checklist-90 – Revised (SCL-90-R) was used to test for clinical symptoms, the BDI-II was used to measure depression, and the State Trait Anxiety Inventory (STAI) was used to assess for anxiety. These measures were administered once during the pre-treatment phase and again after 16 sessions. Results showed that patients who received CCRT showed significantly increased self-esteem and significantly decreased anxiety. Additionally, CCRT appeared to improve relationship styles and defenses in interpersonal situations. Jarry (2010) recommended conducting future studies on clients diagnosed with depression to study the effectiveness of CCRT since participants in their study did not have a formal diagnosis.

Client Descriptions

These case studies focus on two clients, a male and female.

Presenting problem (Client 1)

The client is a 25-year-old Caucasian female, residing with her partner and 8-month-old infant. She recently stopped working outside the home following the birth of her child and is currently a homemaker. The client has three siblings and her mother and father are separated. She had several stepfathers and two stepmothers in her childhood. Her siblings are all younger than her; she "adores" them and finds herself frequently placed in the role of being their caregiver. She shared that her maternal grandparents also lived with her as a child and she feels extremely close to her grandmother. She sought therapy services due to feeling anxious, experiencing physical symptoms, and stress. Additionally, she was facing family and relationship issues which she described as further heightening her symptoms. Recently, she reported feeling extremely worried about her infant's health and well-being.

The client described experiencing tightness in her chest quite often. She mentioned going to the doctor for this and he suggested that she might be feeling anxious. She shared being affected by her family problems and feeling anxious when her siblings have any problems in their life. She described having difficulty sleeping, worrying constantly about something bad happening, and feeling upset often about her relationship with partner. For instance, client reported waking up two to three times each night and finding it difficult to sleep as she is worried about her sister. Client shared that sometimes she also worries about health concerns and "Googles" them, which increases her anxiety.

History and Background

The client was born to a low SES family. She described being Caucasian and also identifies with "Black and Latinx" experiences and culture more than White mainstream culture. This she shared for her means living in a neighborhood with people of color and

struggling with issues similar to them such as lacking resources and living in difficult situations. As a child she used to live with her mother and grandparents as her father was suffering from substance use problems. Her parents separated in her early years, and she does not recall much from this time. She has three siblings and they had lived separately for a few years. Her three siblings came in to her life beginning when she was 10 years old. She shared being extremely close to them and "practically raising" them. She believes that her mother was not as supportive and involved as she should have been. Client described herself as a parental figure for her siblings. Her father returned to their lives when she was about 12 years old and visited her frequently. She described always wanting to live with her father but, because his schedule was busy, she was never able. She shared that her stepbrother's father raised her until she caught her mother being unfaithful to him.

Client's relationship with her mother has always been complicated. She felt like her mother did not validate her feelings or support her throughout her childhood. She described that her mother was a child of an abusive father and developed poor communication skills. Her mother tends to avoid taking responsibility, which has caused distress for client. After client graduated from high school she moved out of her house and has not reached out to her mother since. Client has always been independent and believes her mother does not feel that she needs to worry about her. She also believes that her mother's anxious nature has rubbed off on her. However, client described being close to her stepmother, whom she viewed as a trusting caregiver and relied on her for support. She also felt supported by her grandmother who lived next door at the time.

Client's relationship with her biological father has been good, despite his lengthy absence during her childhood she perceives him as a source of support and views him in a positive lens. She did not get to spend time with him when she was a child as he was traveling

for work and her mother had custody of her. Presently, her father messages her a lot. He is often saying something positive and visits her too.

Client is attached to her siblings and loves them like a mother. She feels the need to advocate for them because of their age differences. Her sister has had suicide attempts, which make her feel protective of her. Her brother identifies, as transgender but is not comfortable around their mother as his mother is unaccepting. Client is extremely concerned for her brother and resents the way her mother treats them. She feels responsible for her siblings as she took care of them as children.

Moreover, regarding her social relationships, she discussed that she has had close and meaningful relationships. Prior to giving birth she was in a relationship where she became very attached to this person; however, the relationship ended because he moved to another city. She tried to reach out and connect with him but he became dismissive of her. Her current relationship has lasted for five years; she is with the father of her child. She shared that her partner is extremely supportive and they are happy. However, she has recently been having problems in the relationship because of partner's frequent decision to watch pornography. She believes it is an addiction and feels insecure about his choice to watch it. She also seems to suspect that her partner has been unfaithful in the past as she found another woman’s clothing in his bag. Although, at the time they had a roommate who was female and clarified that it became entangled with his belongings. Client fails to believe this entirely.

Client is a social person but is not able to maintain friendships as she recently became a mother and is busy with that. She described that she is close to family and is mostly the support system for everyone else. She feels that she can rely on her partner for something’s but recently he is busy at work and she feels emotionally distanced.

Client has previously worked and kept herself “extremely” busy. She has had diverse jobs some related to health services and few that required to her to travel. She enjoyed

working. However, after giving birth she has not worked and finds it challenging to just be at home. She has been informed that because she was liked, she would be permitted to join back again in the future. Client has an interest in further pursuing her Master's degree as she enjoys studying.

Additionally, relevant to her medical and mental history she reported that her mother and sister both are diagnosed with an anxiety disorder and her sister is diagnosed with depression as well. Her father suffers from a history of substance use problems. She shared that she has had therapy in the past and worked on coping skills. She believes that therapy was helpful and seeks services again as she has been anxious and had some panic attacks. She described her physical health as being good and she does not take any medication.

Regarding trauma history, she described that as a child her maternal uncle had molested her and when she told her mother about it, her mother did not believe her. This has been a constant struggle in her relationship with her mother. However, her father believed her and wanted to get her tested and file a report but her mother convinced her not to report this. At the time she never realized that this was abuse and as an adult she feels it does significantly affect her life.

Client denied any substance use. She used to smoke cigarettes but quit after she became pregnant. She denied any suicidal ideation or attempts. The strengths of this client include that she is able to recognize that she is struggling and sought therapy and she is hopeful about life. She is goal oriented.

Diagnosis

F41.9 Generalized Anxiety Disorder

Z63.0 Relationship Distress with Intimate Partner

Client reported feeling anxious about self, others, relationships which she is not able to control, and anxiety interfering with day-to-day tasks at home and at work. She also

mentioned feeling irritable, fatigued, restlessness, and experiencing difficulty sleeping as she "over thinks". Therefore, she meets criteria for generalized anxiety disorder. Client also reported having relationship issues and feeling stressed because of interactions with her partner, therefore meeting criteria for relationship distress with intimate partner.

Treatment Plan

Based on the CCRT approach her treatment plan included objectives related to her Wish, Response to self, and Response from others.

1. Client will note down what triggers her anxious thoughts and the wishes/reactions that come to mind.
2. Client will identify relationship patterns in therapy in her daily reactions
3. Client will develop healthy communication pattern in treatment based on expressing her wishes.
4. Client's anxious thoughts and feelings will decrease based on ratings on screeners administered in the beginning, middle and end of treatment.

CCRT Case Formulation

Client presented as insightful, confident, and guarded. She described feeling like the "caregiver" in all situations and not receiving support from anybody. She described wanting to be needed in relationships and having this underlying Wish of having her emotional needs met and understood. Client desired to protect self from the world and felt like she could not trust anybody "completely." She shared being hesitant to trust her partner or mother as they both seemed to have "betrayed" her when she wanted to be cared for. Her mother, though physically present, emotionally abandoned her as a child. This gave way to her feeling like needing to step in and take responsibility of others. Her partner seemed to have triggered feelings of anxiousness for her, as she had constant thoughts of him being unfaithful to her.

She believed that her partner did not understand her, but she did love him and he was a great caregiver to her infant daughter.

Throughout her childhood she expressed feeling burdened by this need to be “perfect” that caused anxious feelings of failure. She described feeling anxious regarding every small detail in life. While growing up she was anxious about not living up to her parents’ expectations, her siblings falling apart, not being loved and falling ill. She shared being worried about her health and her family’s well-being.

Client is consciously trying to be someone who her partner can rely on and can be supported. She wishes to have this love and support that she gives others for herself. She is able to understand everyone’s needs and work towards making everyone happy. However, she wishes that she were the one receiving this love and attention. As a child, Client had witnessed her parent’s divorce and arguing, and does not want the same thing for her relationship. She tends to avoid conflict and be open with her feelings as, she fears her partner will reject her. She unconsciously compares her relationship with her parents and is consciously afraid of losing partner and the relationship ending which prevents her from discussing her difficulty around trust. As a child, she tended to blame herself for the divorce and this is the same pattern playing out in her relationship. Client blames herself for her partner dismissing her or rejecting her needs.

Moreover, Client believes her infant is a way to strengthen their relationship. Her partner’s constant rejection of her needs of support has triggered her to seek therapy and she wants to learn to express her needs. Her fear of asserting herself again arises from the idea that if she does that their relationship will somehow weaken and they would separate. Client feels insecure of relationship as partner is watching porn and is anxious about him rejecting her and not valuing her body.

Client struggles with establishing boundaries with family members, and later becomes upset when they cross those boundaries and “take advantage” of her. She identifies as a “mother” for her siblings which cause immense anxiety related to their wellbeing and feeling responsible for their shortcomings in life.

Overall, client wants people in her life to understand her, maintain healthy boundaries and support her needs like she does with them. Her anxious feelings seem to be related to this main theme of trust and communication patterns in her relationships with others.

Course of Treatment

Pretreatment phase involved a two-hour intake which included socialization process, where in, clinician gathered information and appropriateness of client for CCRT was established. Client was shared information about how CCRT would work and based on mutually agreed upon consent CCRT was adopted as the treatment model.

During phase one of treatment client was made aware of the CCRT approach and what we would work on in our 16 sessions. Sessions one to four she described feelings of hurt, distrust and difficulty expressing her needs with family members and her partner. Client explored and identified her wishes in intersections with others with the help of clinician. She seemed to have motivation to address agreed upon goals for treatment. Client felt misunderstood in her interactions and described always trying to help others but people did not understand her or care for her needs. For instance, she shared a conversation with her partner where she wanted to discuss with him that she did not appreciate him working overnight. However, before starting this discussion her partner talked about needing to spend more time at work and she agreed since she wanted to be understanding of him.

Client also shared that when talking to “anyone” she tends to be extremely understanding and supportive except for her mother. She described underlying feelings of anger and resentment towards her. For instance, in one conversation her mother talked about

sharing pictures of client's baby on social media and client became annoyed with her. Client shared in session that she wished that her mother called and asked how she and her baby were doing instead of posting pictures and "acting like she cared." Applying Tallberg et al.'s (2020) typology of CCRT themes, client showed clear themes of a desire for others to be close and accepting, to achieve and help others, be loved and understood, and to feel good and comfortable. By session 4 we solidified her exploration and identification of wishes.

While sharing the CCRT with client it was made sure that it was a collaborative process. Client seemed to be reflecting on her conversations outside of therapy and bringing them to sessions to be able to identify her patterns of interactions. The CCRT formulation involved clarification questions, in-depth discussion of patterns and collaborative reflections. Client described wanting to be cared for, loved and supported in any relation, however, in her patterns of interaction she felt others controlling her, taking advantage of her and her response was to be helpful and secretly feel angry with self and others. Her response to self included, being silent based on expectations that others will disappoint. This CCRT was shared on the second session and when shared with her was shared by using her words and being reflective which resonated with the client. She agreed with her CCRT and showed interest in changing her patterns and actualizing her wish.

During phase two of treatment (sessions five to twelve), client worked with therapist on identifying relationship with others and understanding the impact of this on her life. We worked on focusing on the uniqueness of her CCRT. Initially clinician and client analyzed relationship episodes for the client. Client described episodes where she felt others misunderstood her, with a tendency to describe interactions where she believed that she was trying to be helpful and she wished for the other person to be helpful in response. However, often experienced the responses from others as angry and contributing to misunderstandings and arguments. For instance, she invited him to spend time with her in order to improve and

nurture their relationship, instead of immediately going to his room and being on his mobile phone. She described that in the conversation she felt hurt as he refused to and wanted his space. Her response to self was becoming upset, withdrawing and started to cry. The response from others she experienced was retaliation and an argument and response to self was to feel helpless and cry.

Another example she described was a wish to be loved and understood by her mother. She described calling her mother to talk with her and tell her how she was doing. Her mother responded instead by talking about her problems and things that were going wrong in her life. Client then became an understanding ear for her mother. She described feeling angry with her mother but not being able to express it. Client could not express her wish to be understood and instead her response to self was to feel disappointed and decided to not call her mother again. She also shared a conversation with her mother where she wished that her mother showed her love. She described expressing to her mother that she did not appreciate her putting client's baby's photo on social media since she did not call client or behave like she cared for her. Her mother responded (response from others) by becoming angry with client which led to an argument. Client's response to self was to blame self, shut down and not want to talk to her mother again.

Client also described interaction with sister where she wished to seek love and support. She described calling her sister to tell her about her day and her sister started talking about how she was feeling suicidal and client had to be supportive of sister instead. In this RE, the RO is to reject client's feeling or what had happened for her to call, and RS is client feeling dissatisfied with the conversation.

During the second phase of treatment clinician paid attention to statements like "it could have been better", "I hoped for this" and other statements clients made to indicate her wishes in interactions with others. We also focused on processing client's response to others

and understanding her past interactions that how she felt when other's response did not fit her wish. Client expressed feeling upset, having self-doubt and feeling anxious about not feeling loved and supported. This phase also involved enactments with clinician. Client tended to repeat pattern of interaction with clinician. The clinician processed then in the here-and-now therapy space through immediacy client's feelings in session. Client expressed in the sixth session her feeling of mistrust to the world and how she was unable to trust since people would eventually betray her trust. When clinician asked if this is how she felt about therapy she nodded. Client and clinician worked toward working through this enactment to allow for further exploration of CCRT process. Clinician and client discussed several RE's like above and slowly moved towards forming client's CCRT and started on the third phase of treatment.

Phase two also involved the thrust of therapeutic work where client and clinician processed client's interactions in past that have led to her interactions in the present. We worked through childhood patterns, understanding response to others and response to self. She disclosed on the sixth session pervasive feelings of always being taken for granted, as her mother was never present, she felt the need to be independent and take control of everyone at home, which included siblings and her father. She shared wanting to be supported and not having anyone to go to as she became everybody's support person. She cared and loved for everyone; it became important to be understanding but she believed nobody cared for her. In therapy we worked on understanding patterns in interactions and reframing ways she would express her wish and response to others. Client identified interactions where she was cared for by her partner and father. We worked on actualizing her wish of being understood, loved and supported.

During session 13 to 16 the focus was on termination. Client shared her anxieties around termination. She shared being worried that the problem would arise again or she might not be able to express her needs without therapy. We processed her feelings and helped her

understand that she was already using her tool box outside of therapy and would be able to function just has she has been through the therapy process. Client and therapist also discussed alternatives such as coming back for therapy if another problem arises or checking in with another clinician if need be. In the last session client shared her sadness about therapy coming to an end but also discussed the skills she had gained and the ability to express her needs had helped her in all areas of life. She reported better relationship with partner, family and self. She shared her future goals of going to graduate school and accomplishing some other goals that she could not express with others earlier.

Presenting problem (Client 2)

The client is a 25-year-old Caucasian male. He resides with his wife. Client sought services as he has been struggling with depression and anxiety. He described that recent career changes have led to stress and he wants to prevent it from impacting his relationships and work. As a child, client had requested his parents to take him for therapy as he felt like he was depressed, however his parents refused.

Client described that he tends to over think and worries in relationships about people being angry with him. He reported overcompensating and trying to keep people happy or he believes they will leave him. Client reported few obsessions, which involve thinking about doors being locked; compulsions of going back and checking to make sure the door was locked. Also, obsesses on whether or not he left the iron on. He mentioned compulsively picking on his fingernails. He more recently has been constantly thinking about his worth. He said he wants to learn to communicate better in relationship as he feels he has some issues in communicating. Client also reported feeling depressed at times for no reason and at those times he does not want to talk to anybody and portrays a flat affect.

History and Background

Client described his childhood, as having challenges but overall, it was good. He lived with his parents and younger brother as a child. His brother and him have a 13-year age gap; client felt like a parent figure for sibling and was almost always left to supervise him.

Client scared being close with his mother. His mother is similar to him and mostly they get along well but sometimes they need a break from each other. His mother would encourage him to perform his best academically. His father was always out for work, rarely physically present but they were close. Presently, his father and him have a conflictual relationship as his father has negative feeling about client earning more money than him and choosing his own career path. His parents were going through a divorce during his teen years and this caused him a lot of emotional turmoil. He experienced his parents as being emotionally abusive, as they would manipulate him. For instance, he explained that his father would tell him things like his mother never wanted him to be born and he would blame his mother for client's problems. His father has negative opinions about women that client identified as being unhealthy. Client feels a lot of his perceptions about being a "man" are also influenced by his father and he understands that he needs to work on these. His mother would be upset and depend on client to take care of her. He wished his mother would stand up to his father.

Client's relationship with his younger brother has been good. He always wanted to protect his brother from his mother and father, and would distract brother when parents were arguing. He now feels guilty since his brother is still living with parents and client has moved out. They live in different states so they meet each other once or twice a year. They stay in contact with each other and play video games regularly. Client wants his brother to live with him but parents would not agree.

Moreover, client met his current wife in college and they have been together for seven years. They have been married for three years. He described his wife as his best friend. They

are very close and he is able to trust her. He believes she is the “single most positive part” of his life. Recently, they have been having issues, client expressed that he has been having difficulty being open about his emotions. He believes his mood has been changing and sometimes he becomes quiet for no reason, which starts fights. Client worries about becoming like his parents. Part of seeking therapy was that he does not want his issues to become a part of their relationship. His wife is patient with him, supportive and understands that he is going through some things.

Client expressed having few close friends and he was able to get support from them. However, he mentioned that he tends to push people away and create boundaries, which has reduced his friend circle.

In school, client had been bullied and this has really bothered him. He described being bullied because of his hair color and physical appearance. Later as a teen he became popular and he resorted to being the bully to protect himself. He stated this was the time his parents were going through a conflictual period and he acted out in school. He said he did not really like school as a child but as a teen he enjoyed it. He pursued his Master’s degree and has been working in a company in a head position for a while. He mostly is satisfied with his career but wants to be successful and move out of where he is working currently.

Additionally, regarding trauma history, client shared his father was physically abusive towards him when he was 14 years old. He said his brother had a metabolic disorder, his parents were always low on sleep and client was responsible for waking them up to keep check on his brother. He said one day when he woke his father up, his father got furious and just pressed client’s arm violently and lay on him in a physically powerful way. Client felt like his father was relieving his aggression on him for no reason. Client has experienced bullying which he found traumatic.

Client reported that his maternal grandmother has been diagnosed with bipolar disorder; paternal grandmother with major depressive disorder and paternal grandfather suffers from anxiety and likely has a drinking problem. He believes that at least two of his aunts on his father's side have been diagnosed with depression and anxiety. Regarding his medical history, client is suffering from Crohn's disease and in the past he has had his rectum removed. He described his overall health as fair. He takes medication for Crohn's disease. He shared feeling like his Crohn's disease as something he has been dealing with and feels "okay" about it currently.

Furthermore, client was first introduced to alcohol by his father when he was 13 years old. He said he occasionally drinks with his partner on weekends. He does not smoke or use drugs.

The strengths for him include that he is able to express his difficulties and he wants to work towards becoming a better version of himself. He also enjoys exercising and taking walks to cope with his mood.

Diagnosis

F41.9 Generalized Anxiety Disorder

F33.0 Major Depressive Disorder, recurrent, Mild

Z63.0 Relationship Distress with Intimate Partner

Client described feeling anxious about several situations such as meeting new people, leaving the door unlocked and having ruminative negative self-thoughts. He reported worrying about work, family and his marriage. He described frequently feeling irritated, trouble falling asleep due to worry thoughts and difficulty making decisions. Therefore, client meets criteria for generalized anxiety disorder. Client also described feelings of low self-esteem, self-worth, feeling sad and lack of motivation. He described feeling inferior to others and having distressing thoughts about the future. He meets criteria for major depressive

disorder. It is also important to note that his diagnosis of Crohn's disease could also be a adding or causing some of his depressive and anxiety concerns. Addolorato et al. (1997) and Panara et al. (2014) discussed the impact of bowel diseases as factors that increase and lead to depression and anxiety concerns when compared to the normal population.

Client shared that he was having several arguments with partner, feeling disconnected with his wife and struggling to describe his feelings to her. Therefore, meeting criteria for relationship distress with intimate partner.

Treatment Plan

Based on the CCRT approach her treatment plan included objectives related to his Wish, Response to self and Response from others.

1. To better understand self, client will identify and report what triggers his depression and anxiety
2. To decrease negative thoughts about self, client will identify interactions in daily life and what he wishes outcomes were. He will develop healthy coping and communication skills.
3. To have more satisfying and meaningful relationship with wife, client will express his needs in therapy and work towards communicating emotions and feelings.
4. Client's depressive and anxious thoughts and feelings will decrease based on ratings on screeners given in the beginning, middle and end of treatment.

CCRT Case Formulation

Client sought services to improve relationship with self and others. He described being reserved and not sharing how he feels so that he does not "hurt" the other person. He seemed to foster low self-worth and thoughts of being a failure. His interaction with family seemed to include his father playing a dominant role and telling him what to do and client following this. He presented in therapy with wanting to change this pattern on doing what others expect of

him. He struggled with being assertive and communicating his needs to friends, family, wife and colleagues at work. His interaction with his boss seemed to be based on self-doubt as his boss referred to him as “loser” and talked down to him a couple of times a day. He described this relationship as “dominating” and “hating” feeling like a child but not knowing how to change this.

His self-esteem seemed to be dependent on how others in his life thought or expected out of him. He was always wished to please people and be appreciated, however, response from others was always looking at him as inferior to them and not being a “man.” He described wishing to be able to be kind and assertive at the same time. He felt stuck in this idea of wanting to impress his father and also be respected by him. Client’s relationship with mother seemed to be based on one sided care and support. He described that his mother leaned on him for emotional support which was exhausting for him. He shared wishing that he could share how he feels with her and have a “balance” of needs met.

Client’s relationship with wife has been healthy, however, recently he feels that feeling depressed as interfered with their interaction. He described avoiding talking about his feelings with her and struggling to feel “connected” to her. They argue about client’s recent emotional withdrawal from her as he is unable to understand his needs. He is struggling to cope with the pressures of a marriage and seems to wish that his wife understands his needs without him expression them. Client wishes to be supportive of wife and take on traditional “masculine” roles but at the same time struggles with understanding her needs which leads to arguments. For instance, he shared that he was not picking up her phone calls to help her understand that he was “busy” at work like other “men” are, however, she perceived this as a sign of ignoring her immediate needs. He also tends to avoid arguments and escape them by emotionally withdrawing form wife.

In conclusion, client's relationship cycles involve him trying to be supportive of other's needs, caring for them, however, response from others includes belittling him or shaming him for this support, or taking advantage of his support and response to self is low self-worth and seeing self as inferior to others, especially not seeing self as a typical "man." Client wishes to be understood and supported just as he thinks he is doing with others. He perceives self as open, understanding and wanting to care for others but also strong like a "man." When he cries or feels emotions other than anger he responds negatively to self and feels ashamed.

Course of Treatment

Pretreatment phase involved a two-hour intake which included socialization process, where in, clinician gathered information and appropriateness of client for CCRT was established. Client was shared information about how CCRT would work and based on mutually agreed upon consent CCRT was adopted as the treatment model.

Phase one of treatment between sessions one to four involved sharing his unique CCRT and identifying his wish, response to others and response to self. Client was open to brief method of treatment and described wanting to try other ways of interacting in relationships. First session therapist and client explored what CCRT means and formulating the base of treatment. From sessions two to four, we focused on uniqueness of his CCRT when making statements like "I really want to be more assertive", he was able to identify his wish as accomplishing his needs in relationship and wanting to be assertive. He identified his actual way of conveying this was trying to be supportive and taking care of other's needs or becoming angered with another. His response to other as giving up and listening to what somebody else is telling him to do. He tends to be understanding when he wishes to be able to stand up for his needs. He also identified wanting to be a "man" without having to be this person who is seen as stereotypically strong and not expressing emotions.

He described some relationship episodes, for instance, when his father talked about politics, and client did not agree with his beliefs he tend to shut down since his father spoke in a louder voice which made him seem powerful and client left conversation feeling ashamed about self. Another example, when he went to share with his mother his feelings of depression, his mother was quick to dismiss him and talk about what she needed him to do as a man. He left conversation feeling resentful for bringing this up in the first place. With his wife, he described feeling guilty for putting his needs or telling her that he needs some space in the relationship as she would always take care of him and is considerate of his feelings. He tended to instead only share his feelings when frustrated and drinking which made her feel upset and in turn, he felt upset about sharing this with her. At work, whenever he tried to talk to his boss about wanting to transition to a different department his boss would shame him and yell at him in front of other office members, his response to self then would be to go home and cry and feel ashamed. He described when he felt upset or when he was unable to communicate what he needed his anxious behaviors would increase like checking if the door was locked or worrying that he left the iron on and wanting everybody to check for him. Phase one ended with helping client gain insight about the uniqueness in his patterns of interactions. Whenever he wants to share his needs, he worries about feeling ashamed or feels frustrated with self. By session four we solidified his exploration and identification of wishes.

During phase two of treatment (between sessions five and 12) therapist and client worked on response from others and response to self. Client's response from others seems to mostly be dismissal or getting angry with him. Client recalled that as a child whenever he tried to talk to his father about feeling sad or being bullied his father would ignore his feelings and be angry at him for not being tough or acting like a "man." He also recalled his mother telling him about her needs and his younger brother's needs come before him and he would have to take care of them once he is older. Therapist and client during middle phase worked

on understanding how these childhood patterns of interactions and experiences are repeating in his current relationships. He explored and identified his wish as a child was to be understood and supported by his parents but when he met with dismissal or disapproval his response to self was feeling dissatisfied and doubting self. This feeling of not understanding self is something he has felt and is repeated in his response to self.

While exploring his response to self he identified behavioral aspects such as crying, becoming angry isolating self and often feeling confused about expectations. During session 10 therapist worked on bringing some unconscious aspects such as expecting reactions from others based on his past experiences. He recalled how he withdrew from a conversation with his wife as he expected her to dismiss that his needs. He described wanting to tell her feeling upset about his friend yelling at him and then she shared about her mother being sick and he immediately decided not to tell her about his day since he respected her needs more than his. He tended to put others first instead of taking care of self which is something his mother had said to him in childhood. During phase two he was able to bring his wish of needing to express his needs and take care of self into awareness. We then worked through ways he could actualize his wish. He shared trying out in a conversation with his wife talking about how he felt misunderstood by his father and allowing her to support him and then asking her about her day. He discovered that she did not dismiss his needs and did not react the way he expected or based on previous patterns in his responses from others.

During phase two therapist also worked through responses from others that client feared. He described a conversation with a friend wherein he agreed to do something he did not want to. He shared his friend needing him to take care of his pet, however client had allergies to that breed. Client felt compelled to say yes because he was afraid his friend would get angry or they would no longer remain friends. He then explored how his father would never feel like whatever client did was “good enough” and this feeling kept returning in

conversations which he would expect others to respond similarly to his relationship episodes with his father. When this transference of interaction was made aware to client, he was able to explore the guilt he felt and the anger that he had repressed towards his father. This second phase helped client uncover early experiences and transference reactions that hindered him expressing his actual wish or needs.

After client and therapist worked through hindrances and relationship episodes to help actualize his wish, we moved towards phase three. During phase three of treatment (between sessions 13 to 16) the focus was on termination and exploration of gains. We explored client's progress in therapy and experiences where he was able to actualize his wish. There were also instances of client regressing to his core conflictual relationship theme which were processed and focus was kept on ability to identify response to self and actualization of wish. We also explored client's anxiety around separation from therapy and focused on using these insights gained in therapy to practice expressing his wishes and being able to identify response to self and response to others. The client was able to share instances of interactions wherein he identified CCRT and was able to actualize his wish without fear of rejection or dismissal which helped establish termination and dealing with reactivation after termination. He was able to achieve his goals and termination was successful after 16 sessions.

Clinical Research Questions

Psychotherapy outcome questions

Q1. Does the client get better in terms of reduced symptoms after the 16 sessions of CCRT?

Q2. Did treatment improve their interaction in relationships?

Q3. If the clients improved on symptom scales, was the improvement on the symptom scales reflected on pre-treatment/post-treatment research measures, and was the magnitude of the symptom change greater than would be expected due to measurement error?

Chapter 2

Method

Research design

A single-subject time series design was utilized to examine symptom change across phases of treatment (Borckardt & Nash, 2002). Time series analysis is a method used to track changes in target behavior. Pre-treatment data provides a baseline by which to evaluate symptom change across treatment (Hudson et al., 2019), which in this case involved 16 sessions of CCRT therapy. This time series study involved collecting data at three phases of intervention to evaluate symptom change.

Participants

This case study involved two Caucasian participants, one male and female, both 25 years of age. Initially five participants were selected, however, two dropped out after session three and one after session one. Participants were selected based on convenience sampling from an outpatient private clinic and the two who completed 16 sessions were selected. Client 1 met criteria for diagnosis: Generalized Anxiety Disorder and Relationship Distress with Intimate Partner. Client 2 met criteria for diagnosis: Generalized Anxiety Disorder, Major Depressive Disorder, recurrent, Mild and Relationship Distress with Intimate Partner. They were both assessed during the baseline phase, treatment and post treatment phase to track changes. CCRT therapy was implemented followed using Book's (1998) manual. This manual provides a detailed guide for the clinician to practice CCRT, described above. Participants were informed earlier that they were entering CCRT because of dissertation consent and measurement process which required researcher to label the treatment as CCRT earlier than may have happened according to Book's treatment manual.

Measures

Participants were administered the Patient Health Questionnaire-Depression and Anxiety Disorders (PHQ-SADS) and Brief Symptom Inventory (BSI). Participants completed PHQ-SADS at baseline, after session 8 (mid-treatment), and after 16 sessions (post-treatment). The BSI was administered at baseline and at the last session. The clients were also asked three survey questions designed by this clinician at the end of treatment. These questions included: 1) How do you feel about your relationships? (Good, Could be improved/worked on, Do not have many close friends or relationships); 2) Do you feel a change in your interaction with others? (Yes or No); 3) If yes, in what way? (Positive or Negative).

The PHQ-SADS is a self-report measure of somatic symptoms, depression, and anxiety. It is comprised of the PHQ-9, PHQ-15, and GAD-7. The normative data for PHQ-SADS is based on 5,031 subjects and a mean age of 18 years. The PHQ-9 is a measure screening and assessing depression symptoms and identifying depressive disorders. It consists of 9 questions and questions are scored on a scale of 0 to 3. The scores range from 0 to 27. The score of 5, 10 and 15 act as cut off for mild, medium and severe depressive symptoms respectively. The questions are based on the Diagnostic and Statistical Manual of Mental disorders, 4th edition (DSM-4) criteria for depressive disorders. This scale was initially developed for primary care clients and has since has been validated for the general population. It has a sensitivity and specificity of 88%, internal consistency reliability of .86, and criterion validity with other measures of depression of .89 (Gilbody et al., 2007).

The PHQ-15 is a 15-item somatic symptoms questionnaire. It measures 15 somatic symptoms and accounts for more than 90% of physical complaints. Each item is rated on a scale from 0 to 2 with total scores ranging from 0 to 30. Research has shown an internal consistency reliability of 0.85 and relevant criterion validity of 0.80 (Han et al., 2009). The

scores of 5, 10, and 15 have been recommended as cut-offs for classifying mild, moderate, and severe somatic symptoms, respectively.

The GAD-7 is a 7-item scale that measure anxiety symptoms. It was developed to identify cases of generalized anxiety disorder and questions are based on diagnostic criteria from DSM-4. Total scores range from 0 to 21 and scores of 5, 10 and 15 have been recommended as cut-offs for classifying mild, moderate, and severe anxiety symptoms, respectively. It has a sensitivity of 89% and specificity of 82% in primary care patients. It has also been shown to correlate with the Beck Anxiety Inventory (BAI) at $r = 0.72$ (Spitzer et al., 2006). It has been validated in the general population and meta-analytic results support its psychometric properties (Plummer et al., 2006).

The BSI is a 53-item self-report measure appropriate for individual's ages 13 years and older. Items are rated on a five-point Likert scale ranging from 0 to 4. It includes nine symptom scales: Somatization (SOM), Obsessive Compulsive (O-C), Interpersonal Sensitivity (I-S), Depression (DEP), Anxiety (ANX), Hostility (HOS), Phobia Anxiety (PHOB), Paranoid Ideation (PAR), and Psychoticism (PSY). It has been shown to correlate with the MMPI-2 scales at .89, supporting it's convergent validity (Adawi et al., 2019).

Statistical Approach

This study uses the percentage of non-overlapping data (PND) approach and Reliable Change Index (RCI) to measure change across treatment. With the PND approach, treatment effectiveness is estimated based upon the percentage of non-overlapping data between baseline and treatment. When values are expected to decrease, such as in the case of measuring depressive symptoms across psychotherapy, PND is calculated as the percentage of treatment and/or post-treatment phase depressive symptom measures that are lower than the lowest depressive symptom value obtained during baseline. When values are expected to increase, such as in the case of a measure of wellness across psychotherapy, PND is the

percentage of treatment phase data that are higher than the highest value obtained during baseline. Possible PND scores range from 0 to 100, and higher scores (closer to 100) indicate higher levels of effectiveness (i.e., there is more discrepancy between baseline and treatment symptoms). Interpretively, Scruggs and Mastropieri (1998) suggest that scores less than 50% indicate that the treatment is ineffective, between 50 and 70% questionable, between 70% and 90% effective, and higher than 90% means the treatment is very effective. Because the current study includes two post-baseline measures from the PHQ-SADS and one post-baseline measure with the BSI, the possible PND values are limited. For the PHQ-SAD, possible PND values include 0, 50, or 100 percent; for the BSI, possible PND values include 0 or 100 percent. Given this limitation, the RCI was also used as a complementary empirical approach.

Table 2

PND Scores and interpretation

PND Scores	**Interpretation**
0%-50%	Not effective
50%-70%	Questionable
70%-90%	Effective
90%+	Very effective

Note. Table is derived from data from Scruggs et al. (1998)

Jacobsen and Truax (1991) introduced the reliable change index (RCI) to estimate whether the observed symptom change across treatment is greater than what would be expected solely due to measurement inconsistency. The formula for calculating RCI is: RCI = (x2 –x1)/Sdiff. In this equation, x1 is the participant's pre-treatment test score and x2 is the participant's post-treatment test score, and Sdiff is the standard error of difference between the two test scores. The Sdiff is computed as the standard error of measurement, which will be derived from each test's technical manual or other sources of psychometric information.

The RCI provides an estimate of whether statistically significant change has occurred, accounting for the reliability of the measure(s) used. With the RCI, scores of positive or negative 1.96 correspond to the 95% confidence interval, and therefore RCI scores of at least 1.96 are considered to be statistically significant (i.e., treatment was associated with a reliable change). Scores for RCI scores between -1.96 and 1.96 are considered absence of change.

Chapter 3

Results

Client 1

Client was administered Patient Health Questionnaire-depression and anxiety disorders (PHQ-SADS) test three times, including at baseline, mid-treatment, and post-treatment. The PHQ-SADS is a 16-item self-report measure devised for screening functional impairment in the areas of depression, anxiety and somatic concerns. Anxiety, depression and somatic concerns commonly co-occur and hence this measure was developed to reflect this (Miller, 2019). The PHQ-SADS was developed from a combination of three existing measures, including the PHQ-9 (measures depression), PHQ-15 (measures somatic concerns), and GAD-7 (measures anxiety). Client was also administered the Brief Symptom Inventory (BSI) at baseline and posttreatment. The results are displayed in the table below.

Table 3

PHQ-SADS Scores for Client 1

PHQ-SADS	Baseline	Mid-Treatment	Post-treatment
PHQ-15	10	7	3
GAD-7	10	8	5
PHQ-9	11	7	0

On the PHQ-SADS, client's scores at baseline suggest moderate somatic symptoms, moderate symptoms of anxiety, and moderate symptoms of depression. Client reported panic attack symptoms the night before the session. She described she felt like the baby or she was shaking and she started to feel breathless and her heart was racing. On this questionnaire, when asking her how difficult these problems made it to do her work, take care of things around the home or get along with people, she said, "Very difficult."

The results on her mid-treatment PHQ-SADS suggest mild to moderate somatic symptoms, mild to moderate anxiety symptoms and mild to moderate depression symptoms. Her symptoms in each of these domains were decreased relative to baseline. When asking her how difficult these problems made it to do her work, take care of things around the home or get along with people, she said, "Somewhat difficult."

The post-treatment PHQ-SADS results displayed continued improvement in each domain and showed little to no somatic symptoms, mild anxiety symptoms, and no depression symptoms. Client denied having a panic attack in the past 4 weeks. When asking her how difficult these problems made it to do her work, take care of things around the home or get along with people, she said, "Not difficult."

Moreover, her BSI profile scores were as displayed:

Table 4

BSI scores for Client 1

BSI	Baseline	Posttreatment
Somatization	4	3
Obsession-Compulsion	1	0
Interpersonal Sensitivity	4	0
Depression	8	2
Anxiety	9	2
Hostility	2	0
Phobic anxiety	1	0
Paranoid ideation	6	2
Psychoticism	4	2

Her scores on the baseline BSI measure suggest mild somatic symptoms, minimal obsessive-compulsive symptoms, mild interpersonal sensitivity, mild depression symptoms,

mild to moderate anxiety symptoms, minimal hostility symptoms, minimal phobic anxiety symptoms, mild paranoid ideation, and mild psychoticism. Her total score was 39 indicating moderate psychological distress.

On the post-treatment BSI scores suggest minimal somatic symptoms, no obsession compulsion symptoms, no interpersonal sensitivity, minimal depression symptoms, minimal anxiety symptoms, no hostility symptoms, minimal phobic anxiety symptoms, minimal paranoid ideation and minimal psychoticism. Her total score was 11 suggesting minimal psychological distress.

In this study, two treatment measures are used to assess effectiveness Brief symptom inventory (BSI) which was administered baseline phase and posttreatment and Patient Health Questionnaire-Depression and Anxiety Disorders (PHQ-SADS) which was administered baseline phase, mid-phase and posttreatment.

Figure 1

PND analysis of BSI scores client 1

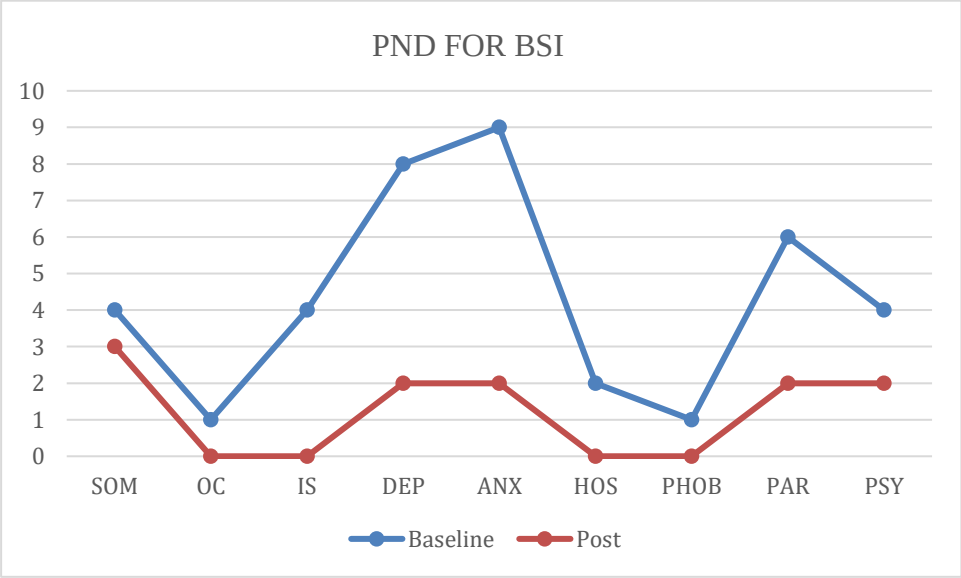
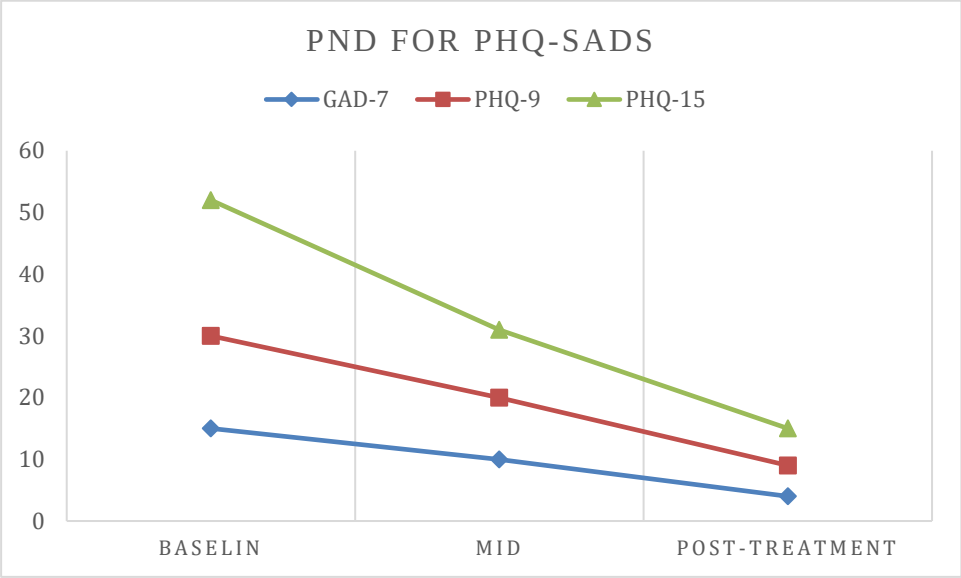


Figure 2

PND analysis of PHQ-SADS scores client 1



Using the PND to calculate results for BSI for client 1, from baseline phase to posttreatment her scores for the Somatization scale, Obsession-compulsion scale, Interpersonal Sensitivity scale, Depression scale, Anxiety scale, Hostility scale, Phobic anxiety scale, Paranoid ideation scale and Psychoticism all decreased as shown on table 4 and figure 1. That is, the percentage of symptom measures during posttreatment phase are lower than the lowest symptom value obtained during baseline phase for all scales. This means that the treatment PND score is 100% which suggests that treatment was very effective for client 1. For PHQ-SADS, the scores for client 1 for scales PHQ-15, GAD-7 and PHQ-9 consistently decreased from baseline, to mid-treatment to posttreatment as shown on table 3 and figure. This indicates, the percentage of symptom measures during posttreatment phase are lower than the lowest symptom value obtained during baseline phase and mid-treatment phase for all scales. This means that the treatment PND score is 100% which suggests that the CCRT approach to therapy was very effective for client 1.

Table 5 below, lists the RCI for 9 Clinical scales of the BSI, for the BSI lower scores from pre to post treatment suggest better functioning. Table 5 showcases the RCI results for

client 1, all the BSI scores have RCI scores>1.96 which means that this client has achieved reliable change (i.e., RCI > 1.96, $p < .05$).

Table 5

RCI Data for BSI, Client 1

BSI Scales	Mean	SD	Test-retest reliability	SEm	RCI	Interpretation
SOM	0.945	0.8715	0.68	0.493	2.87	Reliable change
OC	0.884	0.7698	0.85	0.298	2.37	Reliable change
IS	0.856	0.7986	0.85	0.309	2.28	Reliable change
DEP	1.225	0.8264	0.84	0.331	12.84	Reliable change
ANX	1.244	0.7936	0.79	0.364	13.60	Reliable change
HOS	0.978	0.8103	0.81	0.353	4.00	Reliable change
PHOB	0.931	0.8073	0.91	0.242	2.92	Reliable change
PAR	1.101	0.8516	0.79	0.390	7.24	Reliable change
PSY	1.239	0.8854	0.78	0.415	3.40	Reliable change

For client 1, the Somatic scale score changed from four to two over the course of treatment and the RCI score is 2.87 which means client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Her score for Obsession-Compulsion scale changed from one to zero the RCI score is 2.37 which means client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). For interpersonal sensitivity scale her scores changed from four to zero and RCI score is 2.28 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). For Depression scale her scores changed from eight to two and RCI score is 12.84 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Her Anxiety scale scores changed from nine to two and RCI score is 13.6 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Her Hostility scale scores changed from two to zero and RCI score is 4.00 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Her Phobic Anxiety scale score changed from one to zero and RCI score is 2.92 which suggests client has achieved reliable

change and made improvement (i.e., RCI > 1.96, $p < .05$). Her Paranoia scale score changed from six to two and RCI score is 7.24 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Lastly, her Psychoticism scale score changed from four to two and RCI score is 3.40 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Overall, results for BSI for client 1 suggests that CCRT was an effective treatment as indicated by her positive and clinically significant RCI scores for all scales.

Table 6

RCI Data for PHQ-SADS, Client 1

PHQ-SADS	Mean	SD	Test-Retest Reliability	SEm	RCI	Interpretation
PHQ-15	3.2	3.8	0.82	1.62	3.07	Reliable change
GAD-7	4.6	4.7	0.88	1.59	1.81	Reliable change
PHQ-9	3.3	3.8	0.86	1.42	5.47	Reliable change

For client 1, Table 6 above shows PHQ-SADS, RCI scores from baseline to post-treatment. Her PHQ-15 changed from 10 to three and RCI score is 3.07 which suggests client has achieved reliable change and made improvements (i.e., RCI > 1.96, $p < .05$). Her GAD-7 scale score changed from 10 to five and RCI score is 1.81 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Lastly, her PHQ-9 scale score changed from 11 to zero and RCI score is 5.47 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Overall, results for PHQ-SADS for client 1 suggests that CCRT was an effective treatment as indicated by her positive and clinically significant RCI scores for all scales.

In addition, clients were also asked two survey questions post treatment 1) How do you feel about your relationships? (Good, could be improved/worked on, do not have many close friends or relationships); 2) Do you feel a change in your interaction with others? (Yes

or No); 3) If yes, in what way? (Positive or Negative). Client one responded to survey question one as good and question two as yes and in a positive way.

Client 2

Client was administered the PHQ-SADS at baseline, mid-treatment, and post-treatment. Client was also administered the BSI at baseline and post-treatment. The results are displayed in the table below.

Table 7

PHQ-SADS Scores Client 2

PHQ-SADS	Baseline	Mid-Treatment	Posttreatment
PHQ-15	15	10	4
GAD-7	15	10	5
PHQ-9	22	11	6

On his baseline PHQ-SADS scores suggest severe somatic symptoms, severe symptoms of anxiety, and severe symptoms of depression. Client denied having a panic attack in the past 4 weeks. On this questionnaire, when asking him how difficult these problems made it to do his work, take care of things around the home or get along with people, he said, "Extremely difficult."

The results on his mid-treatment PHQ-SADS suggest moderate somatic symptoms, moderate anxiety symptoms and moderate depression symptoms. When asking him how difficult these problems made it to do his work, take care of things around the home or get along with people, he said, "Somewhat difficult." Client mentioned having a panic attack within the past 4 weeks. He described being overwhelmed at work. The results also indicate a decrease in overall symptoms from baseline to mid-phase of treatment.

The results for post-treatment PHQ-SADS show minimal somatic symptoms, mild anxiety symptoms, and mild depression symptoms. Client denied having a panic attack in the past 4 weeks. When asking him how difficult these problems made it to do his work, take care of things around the home or get along with people, he said, "Somewhat difficult." The results in table 7 also indicate a decrease in overall symptoms from mid-phase of treatment to posttreatment.

Moreover, his baseline BSI profile scores were as follows:

Table 8

BSI Scores for client 2

BSI	Baseline	Posttreatment
Somatization	4	2
Obsession-Compulsion	10	5
Interpersonal Sensitivity	9	1
Depression	13	6
Anxiety	9	4
Hostility	6	0
Phobic anxiety	10	6
Paranoid ideation	5	1
Psychoticism	5	1

His baseline BSI scores suggest minimal somatic symptoms, moderate obsession compulsion symptoms, mild to moderate interpersonal sensitivity, moderate depression symptoms, moderate anxiety symptoms, mild hostility symptoms, moderate phobic anxiety symptoms, mild paranoid ideation and mild psychoticism. His total score was 71 indicating high psychological distress.

On his post-treatment BSI, the scores suggest minimal somatic symptoms, minimal obsession compulsion symptoms, minimal interpersonal sensitivity, mild depression symptoms, minimal anxiety symptoms, no hostility symptoms, mild phobic anxiety symptoms, minimal paranoid ideation and minimal psychoticism. His total score was 26 indicating mild psychological distress.

Figure 3

PND analysis for BSI scores client 2

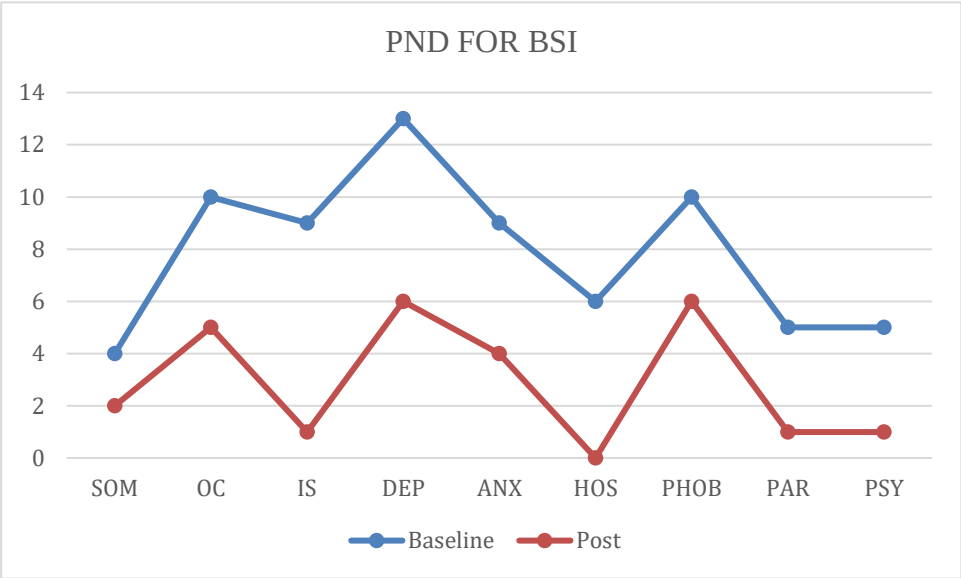
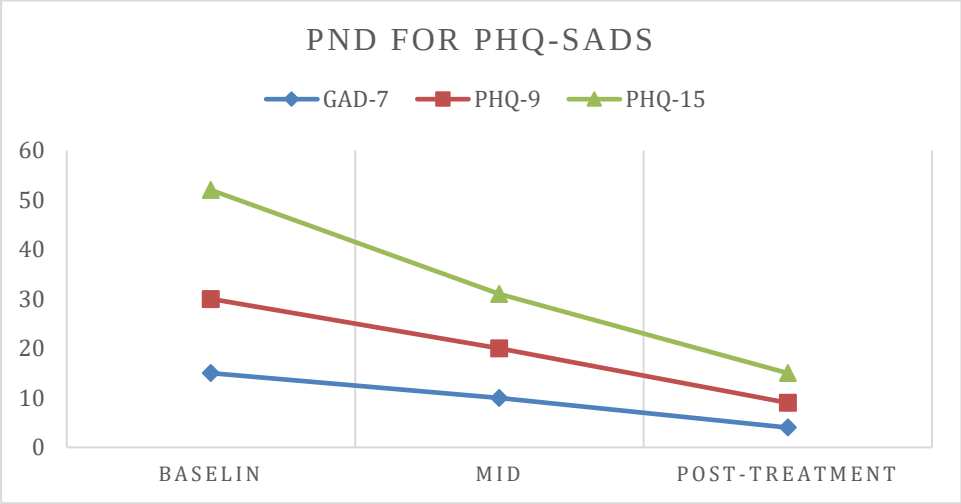


Figure 4

PND analysis for PHQ-SADS scores client 2



Using PND method for client 2, to calculate results for BSI, his scores from baseline phase to posttreatment for the Somatization scale, Obsession-compulsion scale, Interpersonal Sensitivity scale, Depression scale, Anxiety scale, Hostility scale, Phobic anxiety scale, Paranoid ideation scale and Psychoticism all decreased as shown on table 8 and figure 3. That is, the percentage of symptom measures during posttreatment phase are lower than the lowest symptom value obtained during baseline phase for all scales. This means that the treatment PND score is 100% which suggests that the CCRT approach to therapy was very effective for client 2. For PHQ-SADS, the scores for client 2 on scales PHQ-15, GAD-7 and PHQ-9 consistently decreased from baseline, to mid-treatment to posttreatment as shown on table 7 and figure 4. This indicates, the percentage of symptom measures during posttreatment phase are lower than the lowest symptom value obtained during baseline phase and mid-treatment phase for all scales. This means that the treatment PND score is 100% which suggests that the CCRT approach to therapy was very effective for client 2.

In addition, the RCI varies due to the factor that the smaller the test-retest reliability coefficient the larger the RCI and since the RCI uses SD in calculation the larger the SD the larger the RCI score. All scores larger than 1.96 signify positive reliable change indicating improvement of client due to treatment. Table 9 below, lists the RCI for 9 Clinical scales of the BSI, for the BSI lower scores from pre to post treatment suggest better functioning. Table 9 showcases the RCI results for client 2, all the BSI scores have RCI scores>1.96 which means that this client has achieved reliable change (i.e., RCI > 1.96, $p < .05$).

Table 9

RCI data for BSI, Client 2

BSI Scales	Mean	SD	Test-retest reliability	SEm	RCI	Interpretation
SOM	0.945	0.8715	0.68	0.493	3.13	Reliable change
OC	0.884	0.7698	0.85	0.298	9.13	Reliable change
IS	0.856	0.7986	0.85	0.309	3.91	Reliable change
DEP	1.225	0.8264	0.84	0.331	11.45	Reliable change

ANX	1.244	0.7936	0.79	0.364	7.72	Reliable change
HOS	0.978	0.8103	0.81	0.353	10.47	Reliable change
PHOB	0.931	0.8073	0.91	0.242	10.71	Reliable change
PAR	1.101	0.8516	0.79	0.390	6.5	Reliable change
PSY	1.239	0.8854	0.78	0.415	6.93	Reliable change

For client 2, the Somatic scale score changed from four to two over the course of treatment and the RCI score is 3.13 which means client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). His score for Obsession-Compulsion scale changed from ten to five and RCI score is 9.13 which means client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). For interpersonal sensitivity scale his scores changed from nine to one and RCI score is 3.91 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). For Depression scale his scores changed from 13 to six and RCI score is 11.45 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). His Anxiety scale scores changed from nine to four and RCI score is 7.72 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). His Hostility scale scores changed from six to zero and RCI score is 10.47 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). His Phobic Anxiety scale score changed from ten to six and RCI score is 10.71 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). His Paranoia scale score changed from five to one and RCI score is 6.50 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Lastly, his Psychoticism scale score changed from five to one and RCI score is 6.93 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Overall, results for BSI for client 2 suggests that CCRT was an effective treatment as indicated by her positive and clinically significant RCI scores for all scales.

Table 10

RCI Data for PHQ-SADS, Client 2

PHQ-SADS	Mean	SD	Test-Retest Reliability	SEm	RCI	Interpretation
PHQ-15	3.2	3.8	0.82	1.62	4.83	Reliable change
GAD-7	4.6	4.7	0.88	1.59	4.34	Reliable change
PHQ-9	3.3	3.8	0.86	1.42	7.95	Reliable change

For client 2, Table 10 above shows PHQ-SADS, RCI scores from baseline to post-treatment. His scores for PHQ-15 changed from 15 to four and RCI score is 4.83 which suggests client has achieved reliable change and made improvements (i.e., RCI > 1.96, $p <$ .05). His GAD-7 scale score changed from 15 to five and RCI score is 1.81 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Lastly, his PHQ-9 scale score changed from 22 to six and RCI score is 7.95 which suggests client has achieved reliable change and made improvement (i.e., RCI > 1.96, $p < .05$). Overall, results for PHQ-SADS for client 2 suggests that CCRT was an effective treatment as indicated by his positive and clinically significant RCI scores for all scales.

In addition, clients were also asked two survey questions post treatment 1) How do you feel about your relationships? (Good, could be improved/worked on, do not have many close friends or relationships); 2) Do you feel a change in your interaction with others? (Yes or No); 3) If yes, in what way? (Positive or Negative). Client two responded to question one as good and question two as yes and in a positive way.

Chapter 4

Discussion

This study aimed to evaluate the effectiveness of Core Conflictual Relationship Theme (CCRT), a brief psychodynamic therapy, in treatment of two clients suffering from depression and anxiety disorders. The CCRT is a 16-session brief therapy it is a manualized treatment (Book, 1998). I conducted CCRT therapy with two clients identified as male and female. This research focused on a single case study method used a time series component. Researcher used Brief Symptom Inventory (BSI), Patient Health Questionnaire Depression and Anxiety Disorders (PHQ-SADS) and two survey developed questions over the course of treatment to evaluate effectiveness. The PHQ-SADS was administered baseline, mid-phase and posttreatment, the BSI was administered pre and posttreatment and the survey questions were asked posttreatment. Statistical measures of Percentage of Non-Overlapping Data (PND) and Reliable Change Index (RCI) were used to assess clinically significant change and effectiveness of treatment. The PND and RCI values indicated that treatment was associated with meaningful reductions in each of these clients' primary symptoms.

In comparison to previous research conducted by Luborsky (1994), Leichsenring et.al. (2013), Hilsenroth et al. (2003), Ajilchi et.al. (2016) and Jarry (2010) this study also found short-term psychodynamic therapy using CCRT to be an effective treatment to decrease symptoms of depression and anxiety. This study does not compare CCRT with another treatment modality, however, similar to Bögels et al. (2014), Monti et al (2014), Driessen et al. (2013) and Dos Santos (2020) this study found that short-term psychodynamic therapy is comparable to any other treatment modality in allowing for progress in a brief period of time.

One unique finding, is that this study was able to also assess effectiveness of CCRT in treatment of interpersonal and relationship concerns that have not been integrated in previous research finding, this study using BSI and research questions designed to understand

effectiveness of treatment specifically with relationships found that CCRT is effective in helping with relationships, as both client's perceived meaningful improvement in their interpersonal interactions.

This study also is specifically focused on single-subject design with two clients one male and one female, this specificity allowed for in-depth understanding of gendered navigation of relationships and effectiveness of CCRT particularly with both genders in their different views of the world. It is interesting to note that both client's BSI scale scores for psychoticism and obsessive-compulsive symptoms also reduced, however, there is research yet to be conducted on brief psychodynamic models specifically targeting obsessive compulsive and psychoticism treatment. This study provides some evidence of CCRT being effective with these symptoms, however, the original intent of the study was to only measure effectiveness with depression and anxiety.

One of the major limitations of this case study is its inability to generalize findings to a larger clinical body. More generalizability could have been obtained if the sample was larger. There is a need for researchers to further evaluate the effectiveness of CCRT approach with a larger population. Since PND method was used for statistical analysis, in this study, PND was constrained as only two or three follows were possible for BSI and PHQ-SADS over the course of treatment which results in limited data. Another limitation includes diversity variables, this case study is focused on clients who identified as Caucasian and heterosexual. It is recommended that further research must be developed to assess the effectiveness of CCRT with clients from diverse ethnicities, gender and sexual orientations. Moreover, in the case of single subject designs, the lack of a control group has implications. For instance, clients present for therapy typically when they are in acute distress and research shows that with some therapy or, even waitlist controls show some improvement, even if it's generally of a smaller magnitude than the treatment groups. It is worth noting that some

decreases are probably expected, regardless of treatment, owing to this fact (Cook et al., 2017). However, the magnitude of the symptom reductions found in this study based on RCI results for both clients being RCI > 1.96, $p < .05$ were clinically significant and also account for some improvements that could be possible due to general treatment as change here is statistically larger than would be expected from measurement error. Given this, although the lack of a control group is a limitation, even in its absence this data appears to offer fairly reliable evidence that these clients benefited from CCRT.

Another limitation included clients dropping out for therapy initially five participants were selected. However, only two moved forward and completed from sessions one to 16. Leichsenring at al. (2019) shared 50 to 60% of participants prematurely terminate from therapy in randomized control trials. In this study, about 40% prematurely dropped out of the three, two of them dropped out after session three and one of them dropped out after session one. However, the dropout rates for this study are not greater than other studies that use CBT, CPT and other forms of brief therapy as stated in Leichsenring at al.'s (2019) and Fernandez et al.'s (2015) papers. This suggests that CCRT can still be considered as effective as other brief therapy models.

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