Revista Electrónica de Psicología Iztacala

Universidad Nacional Autónoma de México

Vol. 27 No. 3 **Septiembre de 2024**

ASSESSMENT OF THE THERAPEUTIC ALLIANCE IN COGNITIVE-BEHAVIORAL THERAPY OF DEPRESSIVE SYMPTOMS IN A UNIVERSITY STUDENT: A CLINICAL CASE STUDY

Regina de Cássia Rondina[1] Pamela Colenzio Maranhão[2], Karina Ananda Tittón[3], Marcia Regina Fortes Wagner[4] y Raul Aragão Martins[5]
São Paulo State University
Brasil

RESUMEN

Esta investigación consiste en un estudio de caso clínico sobre el tratamiento de los síntomas depresivos y somáticos a través de la terapia cognitivo conductual. El objetivo fue investigar las asociaciones entre características de la alianza terapéutica y la evolución del cuadro clínico. La participante era una estudiante universitaria, atendida en un centro de asistencia psicológica (Universidad Estatal de São Paulo, São Paulo, Brasil). Para la recolección de datos, se utilizaron: Inventario de Depresión de Beck II; Inventario Cognitivo-Conductual para la Evaluación de la Alianza Terapéutica; Escala de Empatía (Versiones para Terapeuta y Paciente) y entrevista semi-estructurada. Se realizó triangulación de datos, integrando la información obtenida a través de escalas e inventarios, con las perspectivas del terapeuta y del paciente sobre el curso de la terapia. Hubo una reducción significativa en los síntomas de la paciente al final de la terapia. Los resultados sugieren que el uso de herramientas para evaluar las características de la alianza terapéutica en terapia cognitiva conductual puede

[1] * Professor Doctor at the Department of Education and Human Development (DEPEDH) - São Paulo State University (UNESP, Marília, SP). Brazil. Email: regina.rondina@unesp.br
[2] Clinical Psychologist. R. Marilia, Sao Paulo, Brazil. Email pamela.colenzio@hotmail.com
[3] Clinical psychologist . Marilia, São Paulo, Brazil Email: titton_ka@hotmail.com.
[4] Prof. Doctor of the Graduate Program in Psychology, Coordinator of the Research Group Interpersonal Relations, Emotion, Behavior and Cognition (GEPRIECC), ATITUS Educação, Passo Fundo, RS, Brazil. mfwagner2018@gmail.com
[5] Professor at the Department of Education - São Paulo State University (UNESP, São José do Rio Preto, SP), Brazil. Email: raul.martins@unesp.br

retroalimentar el desempeño del terapeuta, maximizando los resultados del tratamiento. Aún son necesarios nuevos estudios que impliquen la aplicación de instrumentos de esta naturaleza que contengan, simultáneamente, las perspectivas del terapeuta y del paciente. El Inventario Cognitivo-Conductual para la Evaluación de la Alianza Terapéutica podría mejorarse y/o ampliarse para incluir también la visión del paciente. Se sugiere reelaborar el instrumento en el formato "versión terapeuta y paciente", para aumentar su alcance o cobertura.
Palabras Clave: Terapia, Cognitivo-Conductual, Alianza Terapéutica, Depresión, Estudiantes Universitarios.

ABSTRACT

This research consists of a clinical case study on the treatment of depressive and somatic symptoms in a cognitive behavioral therapy approach. The objective was to investigate the associations between characteristics of the therapeutic alliance and the evolution of the clinical picture. The participant was a university student, attended at a psychological assistance center of São Paulo State University(Marilia, São Paulo, Brazil). For data collection, the following were used: Beck Depression Inventory II; Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment; Empathy Scale (Therapist and Patient Versions) and semi-structured interview. Data triangulation was performed, integrating the information obtained through scales and inventories, with the therapist's and patient's perspectives on the course of therapy. There was a significant reduction in the patient's symptoms at the end of therapy. The results suggest that the use of tools to assess the characteristics of the therapeutic alliance in Cognitive Behavioral Therapy can provide feedback on the therapist's performance, maximizing treatment outcomes. New studies are still needed, involving the application of instruments of this nature containing, simultaneously, the perspectives of the therapist and the patient. Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment could be improved and/or expanded to include the patient's vision as well. It is suggested to re-elaborate the instrument in the "therapist and patient version" format, to increase its scope or coverage.
Keywords: Therapy, Cognitive-Behavioral, Therapeutic Alliance, Depression, University Students.

In recent decades, Cognitive–Behavioral Therapy has been widely used to treat psychiatric disorders (Brandtner & Serralta, 2016). This approach seeks to promote cognitive changes with lasting emotional and behavioral effects (Rangé, 2011; Beck, 2013); is based on the development of teaching and learning processes through a collaborative relationship between therapist and patient. The therapist uses a range of intervention strategies, such as behavioral experiments and cognitive reframing, which characterize metacognition (Beck, 2013). Aspects relevant to the therapeutic process in this approach make it personalized, such as collaborative empiricism and

therapeutic alliance. A collaborative therapeutic relationship presupposes the union of forces between therapist and patient, in order to achieve goals (Kuyken, Padesky & Dudley, 2011). The term “therapeutic alliance” can be understood as a favorable and necessary relationship between therapist and patient for to unfold of the therapeutic process (Maia, Araujo, Silva, & Maia, 2017).

Historically, the literature has highlighted technique as an agent of change in CBT; currently, the alliance has been considered an integral part of the treatment (Araujo & Lopes, 2015). A growing focus of interest is to investigate aspects related to alliance formation (Martins Oliveira, Vasconcelos, & Carvalho, 2018; Singulane & Sartes, 2018); since failures in its establishment can increase the risk of abandoning therapy (Oliveira & Benetti, 2015). On the other hand, there is evidence that a positive therapeutic alliance is related to better treatment outcomes (Maia et al. 2017). The way the therapist communicates with the patient can interfere with the relationship (Brandtner & Serralta, 2016). Other aspects, such as the personality and needs of each patient, as well as the therapist's specific skills and issues, can also interfere in the relationship (Araujo & Lopes, 2015; Oliveira & Benetti, 2015). Aspects considered central to the establishment and maintenance of the alliance are collaboration, patient feedback, the patient's view of therapy and the therapist's reactions. The patient's view refers to the degree of understanding of himself about the role of the therapist and about the therapy itself (Beck, 2013; Araujo & Lopes, 2015).

It is essential to establish, maintain, check and improve the alliance throughout treatment (Sudak, 2008; Beck, 2013). It is advisable to use strategies to improve the alliance, such as requesting feedback from the patient, to facilitate the understanding of the learning processes and increase the level of trust or understanding between the parties, maximizing the chances of patient adherence to the tasks of home, for example (Sudak, 2008; Beck, 2013). For a solid alliance, the therapist must also arouse trust through empathy and attention (Sudak, 2008; Brandtner & Serralta, 2016).

The literature highlights the importance of preparing and validating inventories to check aspects related to the quality of the alliance (Maia et al. 2017; Vernmark et al.

2019). When having an assessment tool, the therapist can detect possible necessary changes and review his behaviors, maximizing the chances of continuity and success of the therapy (Araujo & Lopes, 2015). However, experts say that the client's assessment of the alliance does not always coincide with that of the therapist. There are indications that the client's perspective is the one that most tends to predict treatment outcomes (Araujo & Lopes, 2015), although there is still no consensus in this regard (Vernmark et al. 2019). The simultaneous use of instruments to find out how both perceive the relationship can be effective in detecting possible ruptures in the alliance that could go unnoticed (Araujo & Lopes, 2015). Interest in research on therapeutic alliance scales in Brazil is considered incipient. More research is still needed on this topic, in therapies guided by a cognitive-behavioral approach (Maia et al. 2017). The only Brazilian instrument of this nature is the Cognitive Behavioral Inventory for Therapeutic Alliance Assessment (Araujo & Lopes, 2015), recently available in the literature. The inventory was prepared based on Beck's perspective (2013) and assesses 29 statements related to the dimensions: active collaboration with the patient, patient feedback, the patient's view of empathy and therapist reactions (Araujo & Lopes, 2015).

The present work consists of a clinical case study on the subject. The objective was to investigate the associations between characteristics of the therapeutic alliance and the evolution of the clinical condition during the treatment of depressive symptoms in a university student, in a cognitive behavioral approach. It is assumed that characteristics of the relationship between therapist and client interfere in the evolution of the clinical picture and in the remission of the patient's symptoms (Maia et al.2017; Vernmark et al. 2019).

METHOD

This is a longitudinal study, in the form of a Systematic Case Study (Edwards, 1998) with a mixed, quantitative and qualitative design. It searches for variables that contribute to patient change, using repeated and potentially replicable assessments (Brandtner & Serralta, 2016).

- Institution: The research was carried out at the Center for Psychological, Psycho-educational and Research Assistance, of a Brazilian public university.

- Participant: Female student, 19 years old, enrolled in the first year of an undergraduate course.

- Instruments for data collection**:**

• Beck Depression Inventory II (Beck, Steer & Brown, 2011), Brazilian version: to assess depressive symptoms. This is a self-administered instrument composed of 21 items, which measures the intensity of depression in adults and adolescents according to a Likert scale. Each item is rated on a four-point scale and the maximum total score is 64 points. As cut-off points, values between 0 and 13 are considered as “minimal depression” or “no depression”, values between 14 and 19 as “mild depression”, values between 20 and 28 as “moderate depression” and values above 28 as “severe depression”. Regarding reliability, it has a Chronbach's alpha of 0.9 for the total sample.

● Cognitive-Behavioral Inventory of Therapeutic Alliance Assessment (Araujo & Lopes, 2015): to investigate the therapist's perspective on alliance characteristics. The instrument assesses four dimensions of the therapeutic alliance, through a Likert-type scale, containing 29 items: In the Collaboration dimension, scores can vary from zero to 45 points; in the Feedback dimension, from zero to 30 points; in the Patient's Vision dimension, from zero to 30 and in the Therapist's Reactions dimension, from zero to 40 points. The Total score can range from zero to 145 points. The instrument has Cronbach's Alpha reliability index = 0.853 (Araújo & Lopes, 2015).

● Empathy Scale, Patient and Therapist versions (Burns & Auerback 2005): to assess the therapist's ability to empathize, from the perspective of the therapist and the patient. The instrument is constructed in the form of a Likert scale, containing 10 items with maximum scores of 7 points. The answers range from absolutely no (zero) to extremely (6) and reflect the therapist's and client's perceptions of aspects such

as friendliness, genuineness, and empathy. In the first series, the 5 items are written in an affirmative way and in the second series, in a negative way. The second series (which refers to lack of empathy) is subtracted from the first (which reflects positive empathy characteristics), resulting in the total score (Johnson, Burlingame, Olsen, Davies & Gleave, 2005).

- Semi-structured Interview: Investigated the student's perceptions of the impact of therapy on her quality of life and academic performance, in addition to the role of the therapeutic alliance in treatment.

- Procedures: Student Ana (not her real name) sought pshychological assistance in April 2021. During the initial assessment, she reported complaints of a depressive nature, such as: sadness, anguish, frequent crying spells, demotivation, discouragement, low self-esteem and difficulties with attention and concentration, which had been affecting her academic performance. In the past, she even had suicidal ideation, without subsequent recurrence. Ana also reported frequent somatic symptoms, such as stomach pain and menstrual cramps, gastritis, vomiting and migraine. The symptoms were characterized by physicians as being of “psychosomatic origin” and psychological counseling was advised. In addition, she presented complaints such as anxiety and problems in the relationship with her family members and with her current boyfriend. According to Ana, the symptoms of anxiety, depressive mood and somatic began in childhood and worsened in 2017, after the end of a love relationship. By the time she sought the Psychology service, she had been in another relationship for three years. With her current boyfriend, the relationship was in crisis and Ana stated that this was causing her a lot of anguish. She feared that the symptoms would worsen as they did in 2017, when the previous relationship ended.

At the end of the interviews, the Beck Depression Inventory-II was applied and the score obtained was 20, situated in the “moderate” range of the instrument (Beck, Steer & Brown, 2011). Based on the assessment stage, it was found that the student had complaints, signs and symptoms commonly related to depressive disorders, such as sad, empty or irritable mood, accompanied by somatic and cognitive alterations, which affect the patient’s functioning (American Psychiatric Association

[APA], 2013). However, the condition did not fulfill official diagnostic criteria for depressive or anxiety disorders (APA, 2013). Ana was informed about the possibility of referral to cognitive behavioral therapy and expressed interest in participating. After signing the informed consent, the patient was referred to therapy. Data were collected on the student's difficulties and on her expectations regarding the treatment, as well as the main contents that she wanted to work on in therapy. A preliminary hypothesis for conceptualizing the problem was outlined (Sudak, 2008; Beck, 2013); as well as a list of difficulties and goals for delimiting the objectives to be achieved (Beck, 2013).

At the beginning of each session, the participant was asked to identify, on a hypothetical scale from zero to ten, the mean of her mood in the last week; being considered the zero point “very bad” and the point 10, “very good”. At the end of each session, feedback was requested from the session and the completion of the Empathy Scale - Patient Version; the therapist, in turn, completed the Therapist Version (Burns & Auerback, 2005) and the Cognitive-Behavioral Inventory of Therapeutic Alliance Assessment. Every three sessions, the patient completed the Beck Depressión Inventary-II again. After the end of therapy, a follow-up stage (Follow Up) was performed for 6 months. In the first meeting, the semi-structured interview and the application of the Beck Depressión Inventary-II were carried out; which was reapplied, respectively, 30, 120 and 180 days after discharge.

-Ethical aspects**:** The work was approved by the Research Ethics Committee under CAAE 20651019.0.0000.5406. The patient completed a Informed Consent Form (ICT) before starting therapy.

Results and discussion

Psychoeducation was carried out on topics such as: the nature of the patient's symptoms; relationship between emotions/feelings, thoughts and behaviors; the cognitive behavioral intervention model; collaborative relationship between therapist and patient, among others. There was good receptivity on the part of Ana, who presented positive feedback in the first session, expressing understanding about the information received.

In the first three sessions, a survey was carried out on the patient's life history. The therapist asked Ana, from the second session, to fill in the Daily Record of Dysfunctional Thoughts (Beck, 2013), according to the basic record model, containing Situations / Events, Automatic Thoughts, Emotions and Behaviors. Later, Ana filled in a more complex model; in which the patient was guided to respond to her thinking in more rational ways; identifying the intensity of emotions on a scale from zero to 100% (Sudak, 2008). A cognitive conceptualization was then outlined (Beck, 2013; Wainer & Piccoloto, 2011), containing the diagnostic hypothesis about the patient's difficulties (Box 01):

Box 01: COGNITIVE CONCEPTUALIZATION DIAGRAM

Relevant historical data: episodes of depressive mood and anxiety, symptoms of a somatic nature, since childhood; death of her grandfather, who was her reference of affection; critical and demanding parents; compared to the brother; conflicts with sexuality; learning difficulties
Core Beliefs: **Helplessness:** Being incapable, being inadequate, intellectually inferior
Intermediate Belief: **Attitude:** “Being rejected is terrible!” **Rule:** “I have to have support and be approved always!” **Assumption:** If I live up to people's expectations, then I will have support and admiration.
Compensatory strategies: Rigidly follow religious precepts; perfectionism regarding academic performance; avoid expressing her opinions and feelings in interpersonal situations;

Situation 1	Situation 2	Situation 3
She fights with boyfriend	*She fights with brother*	*Parents stating that “she*

		would not pass Medicine" during High School.
Automatic thinking *The courtship will end.*	**Automatic thinking** *My parents are unfair to me, they prefer my brother.*	**Automatic thinking** *I will never be able to do well in school.*
Meaning of AT *I am unable to maintain a relationship. I will be abandoned*	**Meaning of AT** *I'm inferior. I will be rejected.*	**Meaning of AT** *I'm incompetent. I will fail.*
Emotion *Sadness*	**Emotion** *Sadness*	**Emotion** *Sadness*
Behavior *She initiates conversations with the boyfriend in order to identify and "fix" her mistakes.*	**Behavior** *Discuss with parents and siblings.*	**Behavior** *She got quiet, silent, crying crisis, she gave up trying to do the Medicine entrance exam.*

The therapist discussed the diagram in partnership with the patient, highlighting the interrelationship between her life history and the construction of dysfunctional beliefs and behavioral responses. The therapist established the hypothesis that Ana avoids expressing her opinions and feelings in certain conflict situations, for fear of other people's disapproval; which may be contributing to the appearance of symptoms of a somatic nature / depressive mood / anxiety. It was informed that the diagram could be made more flexible later. Ana stated that she agreed with the diagram and the hypothesis and then, patient and therapist collaboratively elaborated a List of Difficulties and Goals, also with the possibility of flexibility.

List of Difficulties and Goals

Main Difficulties: Difficulties in family interactions and affective relationships. She cannot adequately express feelings and points of view. Now shut up; now responds and enters discussions. Symptoms of anxiety and depressive mood, frequent crying crisis, sadness, discouragement, low self-esteem. Difficulties in maintaining memory and attention processes. Somatic symptoms, mainly severe menstrual cramps and gastritis, stomach pains, which make daily activities difficult. Conflicts in the area of sexuality

Goals: Improvement in mood, anxiety and somatic symptoms; Improving communication skills; Improve attention and memory processes, especially in studying; Improve interpersonal functioning; Discuss issues related to sexuality.

Ana was taught techniques to control anxiety, such as diaphragmatic breathing training and progressive muscle relaxation practice (Caballo, 2002) with instructions for practice at home. Psychoeducation was also carried out on the relationship between daily life style and mental health, highlighting the importance of developing healthy habits, such as physical exercise, balanced diet and regular sleep pattern. The therapist identified, in partnership with the patient, cognitive distortions activated in specific situations, such as: Overgeneralization, Catastrophizing; Disqualification of the positive; Mind reading; Affirmations such as: I should or I would; Hasty conclusions, among others (Sudak, 2008; Matos & Oliveira, 2013). Interventions for cognitive restructuring were carried out through the challenge of dysfunctional thoughts, promoting more realistic cognitions (Matos & Oliveira, 2013). The goal was to promote guided discovery through Socratic questioning (Knapp, 2004).

The focus of the interventions was mainly directed at situations related to the appearance of anxious symptoms and depressive mood, based on strategies such as questioning the evidence, alternative thoughts, descending arrow, cognitive *continuum*, among others (Beck, 2013; Matos & Oliveira,2013).To improve depressive symptoms, therapist and patient prepared a worksheet with activities, identifying skills and leisure (Knapp, 2004).In partnership with the therapist, Ana progressively built alternative thoughts and interpretations. As an example, she reported that she always idealized affective relationships and that she feared being the only one to blame for the breakups; identifying in-between beliefs/rules, such as

“If I went through three relationships that didn’t work out, then it’s my fault.” The student was encouraged to construct alternative interpretations. The therapist asked questions, such as: What makes a relationship work, does it only depend on one side? Or the two people? The therapist also encouraged the patient to reflect on the current relationship, regarding their roles; future expectations regarding the relationship; as well as her feelings towards her boyfriend.

In addition, from the situations of interpersonal conflicts reported in the sessions and from the records in Daily Record of Dysfunctional Thoughts, an assessment of Ana's interpersonal functioning was carried out. The therapist carried out a psycho-education on the nature of the patient's difficulties and on Social Skills, highlighting the importance of Social Skills Training. Training was then planned and developed to promote improvements in interpersonal functioning (Caballo, 2002; Del Prette & Del Prette, 2009), with skills in assertiveness being trained. The therapist collaboratively discussed with the patient the List of Basic Human Rights (Caballo, 2002). She performed psycho-education on the nature and consequences of issuing assertive, non-assertive and aggressive responses in conflict situations. Ana identified the role of automatic thoughts activated in situations in which she presented non-assertive responses. Communication skills were also trained, such as active listening and adequate expression of feelings (Caballo, 2002; Del Prette & Del Prette, 2009); especially in interactions with the patient's boyfriend and family members.

As the therapy progressed, Ana reported that she was progressively able to identify events usually associated with the appearance of sadness and anxiety. She reported understanding the relationship between her automatic thoughts, conditional rules, mood, and behavioral responses, as well as their consequences. According to her, especially in situations of interaction with family members and with her boyfriend, it was possible to experience several insights in this regard; and from there, manage feelings of anxiety and mood. As the sessions progressed, Ana reported that somatic complaints decreased in frequency and intensity. She also informed that she chose to end the relationship with her boyfriend for various reasons.

In session 11, Ana reported that, during the last week, she experienced a brief return of symptoms of depressed mood, anxiety and also signs of gastritis/stomach pain, which happened shortly after a conflict with family members. A new psychoeducation work was then carried out, highlighting the learning carried out by the patient and the evolution of the symptoms during the therapy. Ana was informed that the appearance of “relapses” or fluctuations in symptoms is common during the therapeutic process and that this would not necessarily mean a setback. Therapist and patient collaboratively analyzed the events of the previous week and their possible association with “relapse”, performing a new identification of communication difficulties, with subsequent training in assertive communication and problem-solving skills.

Still in session 11, therapist and patient collaboratively reviewed the List of Difficulties and Goals. Ana informed that she agrees with the cognitive conceptualization diagram and the List of Difficulties and Goals, initially proposed. She expressed a desire to maintain the goals set, also adding the last item on the list not yet completed; that is, addressing issues related to sexuality and their relationship with her religious beliefs in therapy. The patient was then encouraged to freely express content related to sexuality and religious convictions. The therapist ensured, beforehand, full acceptance and respect for the patient's religious convictions and options/behaviors regarding her sexual life, adopting a neutral and non-directed posture. Ana was able to express and reflect on topics, such as her experiences in the area of sexuality during childhood and adolescence, the option to maintain chastity in her last relationship and also on her religious convictions. At the same time, the management of difficulties related to family relationships and academic performance continued. The problem-solving technique was used in the face of situations reported by Ana. Training of social skills was also continued, focusing on assertiveness and expression of opinions and feelings (Caballo, 2003; Del Prette & Del Prette, 2009).

Ana expressed, during the following sessions, that when she chose to maintain chastity in her courtship, she associated the practice of premarital sex with the notion of sin. In making this decision, she feared that her choice would not be accepted by

her boyfriend; even though he had stated at the time that he would agree to abstinence. According to Ana, talking about her conflicts in the area of sexuality in therapy (and being able to talk about a topic treated as taboo in her family), feeling free from judgments, made her feel much better. She noticed a posture of acceptance on the part of the therapist; which, in her view, led her to have several "insights" in this regard and came to the conclusion that, although the sexual relationship with her last boyfriend was satisfactory, in fact, she used the church's chastity determinations as a strategy to avoid sexual relations. The option was due to feelings of guilt, given the history of negative experiences in the area of sexuality since childhood. Ana reported that being able to express her feelings and conflicts feeling validated by the therapist made her feel extremely relieved, as she thought it would be more difficult. In her view, this contributed to an improvement in symptoms of depressive mood and anxiety and a decrease in somatic complaints.

In session 15, the therapy ended. The therapist provided a feedback on the evolution of symptoms. Relapse prevention work was also carried out (Matos & Oliveira, 2013), based on a review of the techniques that proved to be most effective during treatment. At the end of therapy, Ana reported seeing improvements in all aspects of her life. She considered that she was more organized and that the planning of activities had contributed to the optimization of attention and memory processes; which, according to her, was reflected in better academic performance. In her view, the improvement in the quality of life at the university was also due to greater control of anxiety and mood crises. She reported that with therapy, she began to monitor automatic thoughts and beliefs. And, in the family sphere, she considers that there have been advances in assertive communication and in the expression of feelings. She also informed that she had not experienced any somatic symptoms in recent weeks.

Figure 01 shows the evolution of the scores in the Beck Depression Inventory II. As previously described, the pre-treatment score was 20. Elevation was observed in the first sessions, followed by a decrease in the following sessions. There was a slight increase in Session 9 and a further decrease until the end of therapy. In the last

session, the score was 2, classified as “minimal symptomatology” (Beck, Steer & Brown, 2011).

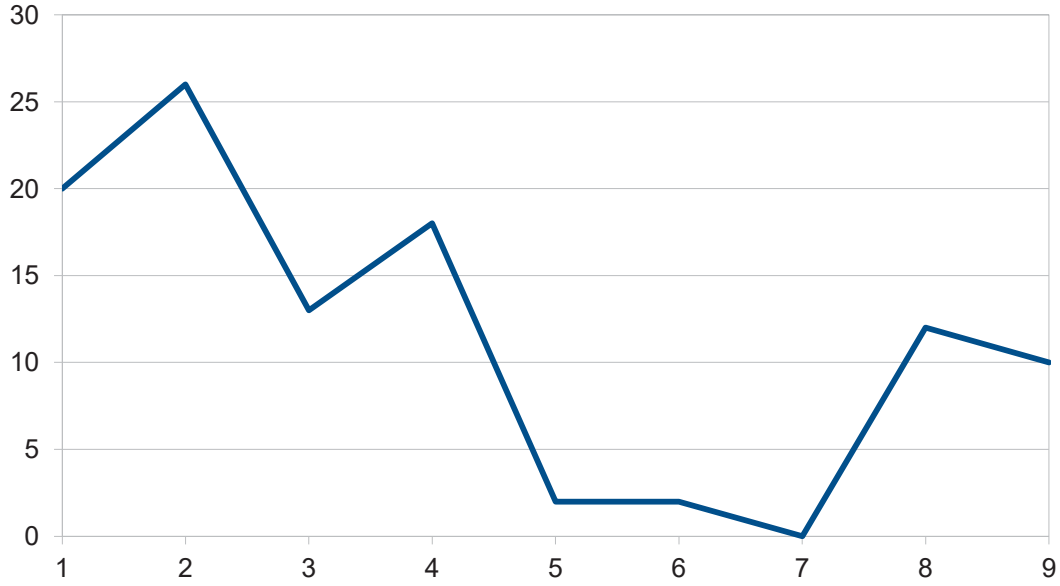

Figure 01 - Beck Depression Inventory II scores

In the Follow-up period (30 days after discharge), Ana obtained a score of zero, indicating remission of symptoms. In the assessments carried out 120 and 180 days after the end of therapy, Ana presented scores of 12 and 10, respectively, situated in the “minimum” range (Beck, Steer & Brown, 2011). The reliable change index was applied to assess the evolution of scores. Table 1 shows the results of the JT method (Del Prette & Del Prette, 2008), of the comparisons between the pre-therapy session, the final session and the three follow-ups (30, 120 and 180 days). The Psycho-Info program was used (Villa, Aguiar & Del Prette, 2011):

Table 1

Results of comparisons between the pre-therapy session and sessions 15 and the follow-up (30, 120 and 180 days), in the Beck Depression Inventory, using the JT Method

	Session 15	Follow-up 30 days	Follow-up 120 days	Follow-up 180 days
Clinical Significance	28.790	28.790	28.790	28.790
Confidence Interval for CS	0.217	0.217	0.217	0.217
Standard Error of Difference (SEdiff)	4.023	4.023	4.023	4.023

RCI Confidence Interval	7.885	7.885	7.885	7.885
Reliable Change Index	4.474*	4.971*	1.989*	2.486*

Source: survey data. * = Reliable Positive Change

The analysis shows reliable positive change in the four comparisons, suggesting the effectiveness of the therapy. As mentioned, in all sessions, the patient was asked to rate her mood on a scale from zero to ten; with zero being considered “bad” and ten, “great”. Figure 02 shows the evolution of scores:

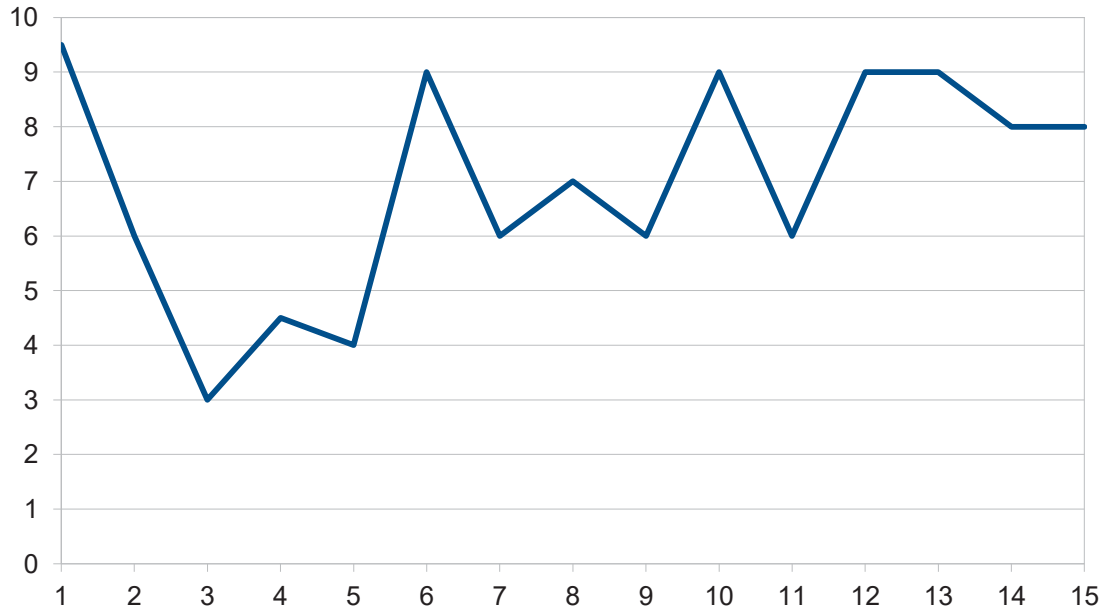

Figure 02: Self-Assessment of Mood

Mood was considered good in the first session and there was a worsening in the initial stage of therapy (between sessions 2 to 5), followed by further improvement. A slight worsening was observed, respectively, in sessions 9 and 11; and subsequent lift/stabilization, until closure. In the last session Ana reported a good mood. The set of these data denotes compatibility between the BDI-II results and the patient's self-assessment, with a slight discrepancy at some points. The scores on a scale of zero to ten in sessions 3,6,9,12 and 15, respectively, are similar to the results of the Beck Depression Inventory II, in the same sessions.

These results are consistent with expectations. Similar studies denote a reduction in depressive symptoms through Cognitive Behavioral Therapy (Oliveira, 2019).

Regarding the treatment of depressive conditions, it is assumed that the way in which people experience emotions and the way they behave are strongly associated with the filter through which they perceive and interpret situations, themselves, the world around you and even the future; this feature is called the cognitive triad. Generally, individuals do not assess whether there is evidence that confirm their thoughts, relying only on a portion of reality to interpret everyday events. As a result, they tend to be more vulnerable to unpleasant emotions (Beck, 1967). It is assumed that the cognitive and behavioral interventions enabled the cognitive restructuring and the consequent improvement of Ana's mood symptoms.

Figure 03 presents the scores on the Empathy Scale. High scores were awarded throughout the process. Up until approximately the fourth session, the patient's scores were slightly higher compared to the therapist's. From then on, the results suggest compatibility until termination; with the exception of session 11, where the therapist again presented a lower score than the patient.The skill in empathy involves cognitive, affective and behavioral components. In the clinic "(...) corresponds to the skill that the therapist must have to put in the patient's shoes, understanding his feelings and thoughts, without leaving aside the objectivity necessary to identify cognitions and maladaptive behavior patterns" (Martins et al., 2018, p.51).

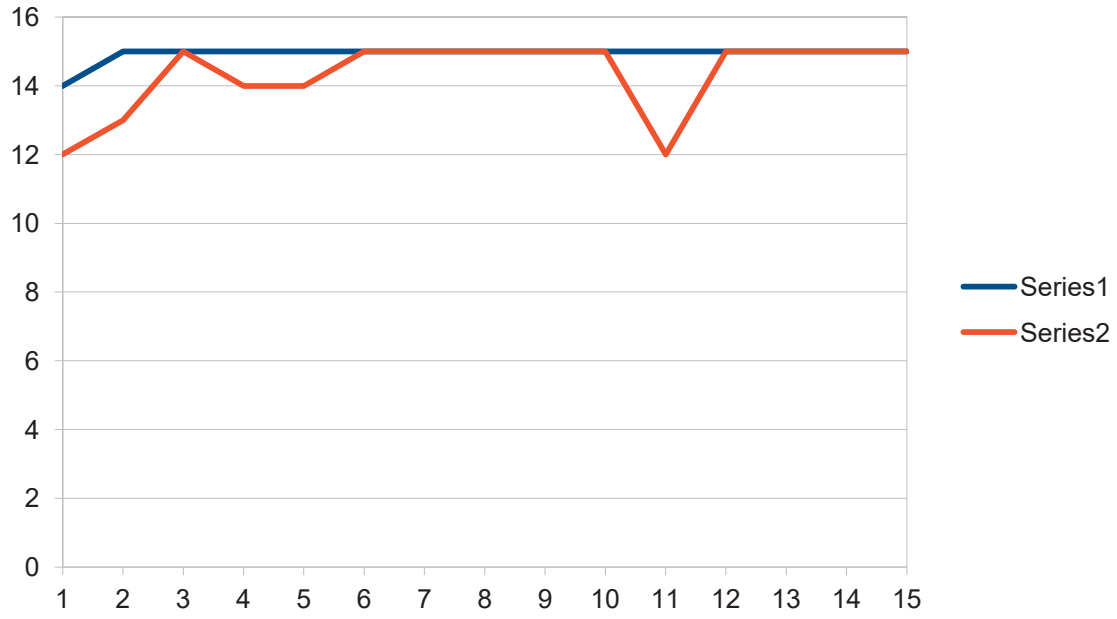

Figure 03: Scores on the Empathy Scale, Therapist and Patient Version

Empathic behavior facilitates cooperation between the parties. The therapist's skill to put himself in the patient's shoes facilitates the identification of difficulties he may experience, contributing to the improvement of the alliance and maximizing the chances of successful treatment (Brandtner & Serralta, 2016; Martins et al. 2018). Studies on emotional synchrony, for example, show that non-verbal messages influence communication and infect the other; being that the empathic posture, on the part of the therapist, can exert positive effects, minimizing reactions such as the patient's anger and the risk of breaking the alliance (Araujo & Lopes, 2015).

It is possible that, in the present study, the therapist's self-assessment through the Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment and the Empathy Scale contributed, in some way, to the improvement of her acting; and, consequently, for the evolution of the clinical picture. The scores attributed by the patient, the verbalizations and the feedbacks converge in this sense. The results suggest a good performance of the therapist in this aspect. Figure 4 presents the scores assigned by the therapist in the Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment.

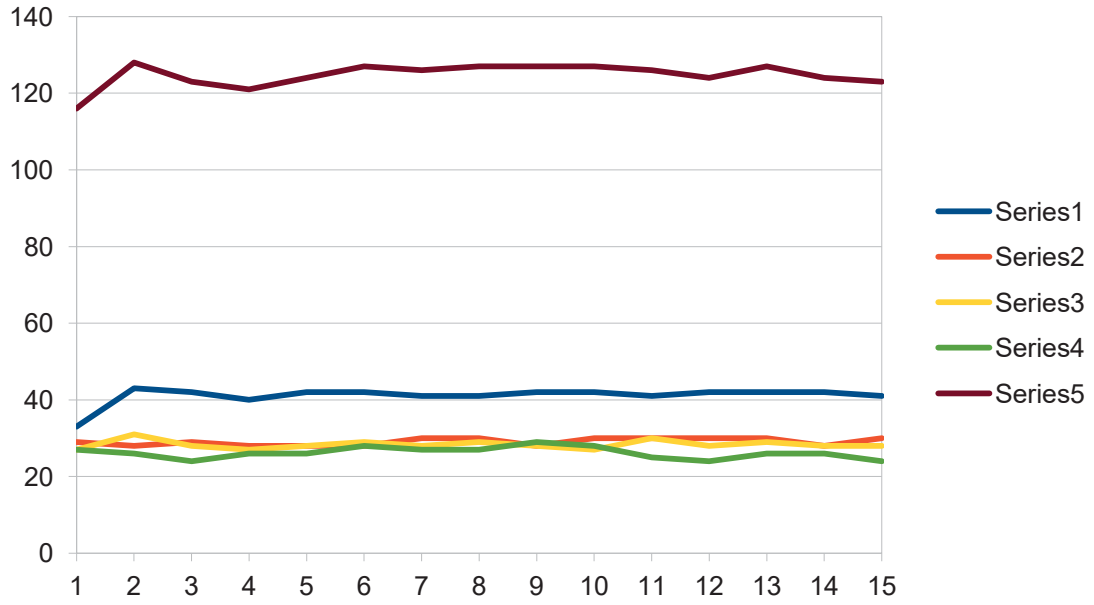

Figure 04: Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment scores

The total scores were high, which suggests a positive therapeutic alliance in the therapist's perception. In Collaboration, the therapist assigned high scores in all sessions (generally greater than 40 points). This dimension investigates the extent to which the therapist acts as a team with his patient, assuming the role of guide (Araujo & Lopes, 2015). It is possible to affirm that the therapist's perception in this sense was compatible with what was observed during the course of the therapy, leading to the belief that there was a work in partnership. Ana expressed understanding about the nature of cognitive behavioral therapy and adhered to the interventions. She carried out activities such as building List of Difficulties and Goals, filling in Daily Record of Dysfunctional Thoughts, among others. The feedbacks presented also confirmed the establishment of a collaborative relationship between the parties.Collaboration is considered a central aspect of cognitive behavioral therapy (Maia, et al. 2017). Difficulties in establishing collaboration may result from several consequences, such as failures in the therapist's performance or the patient's perceptions of the therapist (Araujo & Lopes, 2015). A positive therapeutic relationship facilitates the establishment of a partnership; cooperation and participation contribute to the success in meeting the goals and solving the patient's complaints and difficulties (Martins, et al.2018).

In the Therapist's Reactions dimension, the scores ranged from 27 to 30 points. The literature stresses the importance of self-assessment, on the part of the therapist, around his possible dysfunctional reactions to negative thoughts about the patient (Leahy, 2008; Martins et al. 2018). By being aware of his own reactions, the therapist can identify difficulties that are interfering with therapy. From there, he can refine skills and/or review cognitive conceptualization and/or work planning, redefining the course of therapy according to the particularities of each case. It is necessary for the therapist to always monitor his thoughts and his mood in relation to the patient (Araujo, 2014; Leahy,2008); the therapist's cognitions and mood can make it difficult to adopt problem-solving strategies. When the therapist has a tool in this sense, he can perceive any obstacles or difficulties and restructure his performance, maximizing the chances of success of the therapy (Maia, et al. 2017).

The set of data collected in this clinical case is compatible with this premise, leading to the belief that filling out the Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment may have facilitated the therapist's self-monitoring of his own reactions, feelings and thoughts; thus contributing to the formation and maintenance of the alliance and to the effectiveness of the therapy.

In the Therapy Vision dimension, the curve swung. However, it denotes that, in the therapist's perception, the patient had a positive view of the therapy and the therapist's performance. Ana's verbalizations and feedback corroborate this perception, demonstrating that the patient expressed an understanding of cognitive behavioral therapy. At various times, she claimed to have understood the results of the assessments carried out through inventories, as well as the evolution of her clinical case, the purpose of the interventions, the importance of the tasks performed at home, in addition to expressing a positive view of the therapist. As an example, at the end of the first session, Ana reported that “she felt welcomed by the therapist and that she left with good expectations about the process”. This result is in agreement with the literature. The patient's perception can facilitate the establishment of a positive alliance, contributing to the success of the therapy. The view of therapy denotes an understanding of the nature of the therapeutic process and also, how the patient perceives the therapist; when the image is positive, the possibility is greater that the patient believes in the effectiveness of the treatment and in the competence of the therapist (Araújo & Lopes, 2015; Beck, 2013).

In the Feedback dimension, the therapist's self-assessment remained stable during the sessions, ranging from 28 to 30 points, indicating the request for feedback from the patient in all sessions. The set of feedbacks presented by Ana was also compatible with the other results obtained in this study. Ana stated, for example, that “*She thought it was very important to have received the feedback about the scores obtained in the BDI-II inventory, followed by the therapist's explanations; that in all sessions, she had come away calmer and relieved after therapy; that she was feeling confident in the therapeutic process; who had been feeling more autonomous in managing everyday situations after training in social skills*”, among other similar statements. This leads us to believe that the patient understood the role of data

collection instruments, the information provided by the therapist about the interventions and also the results of the Beck Depression Inventory II, corroborating the score attributed by the therapist in the "patient view" dimension of the Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment and in other dimensions. Everything suggests a positive view on the part of the patient regarding cognitive behavioral therapy and the therapist's performance. It also appears that there was success in establishing cooperation between Ana and the therapist. Asking for feedback conveys to the patient the notion that the therapist cares about the patient's perspective. Feedback allows the patient to reflect on the course of therapy, allows the therapist to review his performance and also to correct failures in understanding between the parties (Araujo & Lopes, 2015; Beck, 2007; Beck 2013).

In addition, it is important to note that Ana stated that *"(...) she perceived neutrality, non-judgment, acceptance on the part of the therapist, which was positive for the therapy"*, evidencing the importance of empathy in the therapeutic relationship. It is the therapist's skill to validate the patient's thoughts and emotions, avoiding judgment or belittling (Martins, et al. 2018). Possibly, empathic behavior has contributed to the establishment of a positive therapeutic alliance and, consequently, to the effectiveness of treatment.

A reading and systematization of the reports in the interview was carried out, according to the perspective of Bardin (2008). Four temathic categories were extracted:

- Evolution of symptoms: This category includes the patient's perceptions about the evolution of depressive symptoms, anxiety and somatic complaints;
- Relationship with the therapist: It describes Ana's perceptions regarding the quality of interactions between therapist and patient;
- The therapist's experience in cognitive-behavioral therapy / performance: It refers to the perceptions about CBT and the therapist's competence / performance;
- The Impact of Therapy on Academic Life: It describes the extent to which the therapy interfered with the patient's quality of life at the university.

1. Evolution of symptoms

The reports evidence the perception that the therapy minimized the symptoms of anxiety, depressive mood and somatic complaints, improving the student's quality of life:

It also changed in terms of anxiety that interfered a lot with my studies (...) It improved a lot, helped me to focus, without thinking that I was not going to make it, that I was not smart; all these things bothered me and made me sad, paralyzed.

This speech suggests that the intervention strategies adopted in therapy favored guided discovery. Guided discovery encourages patients to examine their cognitive beliefs and distortions, enabling them to adopt new strategies to deal with problems (Beck, 2013; Brandner & Serralta, 2016). The testimonies show that the therapy enabled Ana to build alternative forms of interpretation in the face of specific events; which, in turn, resulted in reflexes on mood and behavioral pattern:

It changed because then I was no longer anxious about other things. And when I was with college things, I could handle it in a better way.

The reports corroborate what was observed by the therapist, reinforcing the results of the Beck Depressión Inventory II and the patient's self-assessment of mood. They also confirm the feedbacks. The set of these results is in line with the literature on the treatment of depressive disorders through cognitive behavioral therapy. Distortions of a cognitive nature influence mood and behavior. By assessing thinking more realistically, the patient experiences improvement in emotions and behaviors (Beck, 2013).

2. The experience in cognitive-behavioral therapy / therapist performance

The reports denote a positive view, in this sense:

My Gosh! I think it was really good, it was amazing, I didn't expect it to be this good.; One main thing was that she didn't make the decisions for me; she didn't tell me what I had to do, she taught me how to make my own decisions and remembering that I would suffer the consequences; and not people, for example. So our relationship was very good, it surprised me a lot.”; “Relying on my inner experience, I developed an attachment relationship with my previous therapist; so, the previous therapist, she made the decisions for me, and I did, and it ended up that I didn't have

that autonomy, I couldn't make a decision (...). I felt like I wasn't going to be able to get out of therapy. And now with this therapist, that didn't happen." "So I think it was very good in general, having the tests, this follow-up, she always gave me feedback on how the test answers had been (...) The way we organized it to be able to address all issues, everything I think it had a lot of quality, it was really good".

An environment of cooperation is indispensable for the conceptualization of the case. And the development of a good therapeutic relationship is intertwined with a set of therapist skills, such as encouraging change, reducing patient resistance levels, empathy, authenticity and acceptance, among others (Matos & Oliveira, 2013; Martins, et al. al., 2018). When Ana says, for example, that *"we organized ourselves to address all issues" and that "she did not make the decisions for me",* she confirms what the literature predicts. A quality therapeutic relationship presupposes the joint search for solutions to the patient's problems (Martins, et al., 2018).The statements suggest a collaborative relationship between the parties, corroborating the Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment scores data, the patient's feedback and the therapist's observations.

3. Relationship with the Therapist

The reports show, among other aspects, the perception of an empathic behavior on the part of the therapist:

"We got along very well, in the sense that I could talk and she could understand me. She was always very clear with me, so our relationship for me was very good, she wouldn't belittle what I was going through, in any way (...) if I hadn't sympathized with her, or if I hadn't developed this trust, without attachment relationship (...); I think it would be different, I would not have achieved this autonomy".

This corroborates the results measured in the Empathy Scale and the feedbacks. The literature emphasizes the role of empathy in establishing the therapeutic alliance. It is the skill to enter the patient's thoughts, validating them, letting go of one's own perspectives and/or judgments. Empathy allows the patient to express himself, without his problems being underestimated (Martins et al.2018). The therapist must, however, maintain the objectivity necessary to identify maladaptive beliefs and/or patterns of behavior. The skill to empathize is considered essential for

strengthening the therapeutic bond and, consequently, for patient adherence to therapy (Beck, 2013; Martins et al. 2018).

4-The Impact of Therapy on Academic Life

The reports suggest that the therapy positively influenced the student's academic life:

I noticed a lot of change, huh? (...) Because mainly this issue, right, of self-esteem related to studies (...). Because I felt like I wasn't going to make it, that I wasn't smart, and seeing that there was a whole issue back there, from my beginnings in school. And then seeing this encouraged me to understand this, encouraged me to study more, to work harder; knowing that didn't mean I wasn't smart.

If I stood still thinking that I wasn't going to make it... then it was very good because it messed with everything, you know, I started to look at things in a different way and then that made the college experience better for me.

The statements suggest the restructuring of the patient's dysfunctional beliefs regarding intellectual performance. This possibly changed her attitude towards college, influencing her willingness to study and, consequently, positively affecting her academic life. And when Ana says *"Because I felt I wouldn't make it, that I wasn't smart, and seeing that there was a whole issue back there, from my beginnings in school",* she demonstrates an understanding of the interconnection between transformations at a cognitive and behavioral level, confirming what the literature predicts: "The therapist with the objective of promoting changes must offer adequate support, in which the patient feels safe and engages in new experiences, then the therapist teaches the client to modify thoughts and behaviors dysfunctional" (De Souza Ramos, de Souza & Brito, 2021, p.111)

Possibly, the therapist's ability to promote guided discovery and Ana's commitment to performing her homework (among other factors) were decisive in the evolution of the clinical case. These and other strategies aim to strengthen the skills and learning acquired by the patient, favoring the effectiveness of the therapy (Brandner & Serralta, 2016; Matos et al. 2013). The statements, as a whole, confirm the feedbacks, the results of the mood measurement and the Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment data. It is possible that the patient's

perception of cognitive behavioral therapy and the therapist's competence/performance contributed to a positive alliance, favoring the therapy effectiveness. The testimonies also confirm what was found by the therapist in the sessions. It is assumed that the therapist's self-assessment (by completing the Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment and the Empathy scale) has contributed to this regard.

CONCLUSION

The objective of this study was to assess the interrelationship between characteristics of the therapeutic alliance and the evolution of the clinical picture during the treatment of symptoms of a depressive nature in a university student, using cognitive behavioral therapy. Compatibility was observed between the results obtained through the Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment and the other data collection instruments. It is possible that the aforementioned inventory can provide feedback on the therapist's performance, favoring the effectiveness of cognitive behavioral therapy. This work confirms the importance of promoting the practice of self-assessment among professionals in Clinical Psychology. As already mentioned, so far, the Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment is the only Brazilian instrument for assessing the therapeutic alliance in a cognitive-behavioral approach. The literature shows that the instrument has satisfactory levels of reliability; however, it still needs studies for validation and improvement. The bibliography also suggests that new instruments are still needed to assess the characteristics of the therapeutic alliance in cognitive behavioral therapy to evaluate, simultaneously, the perspectives of the therapist and the patient. The Cognitive-Behavioral Inventory for Therapeutic Alliance Assessment could be improved and/or expanded to include the patient's vision as well. It is suggested to re-elaborate the instrument in the “therapist and patient version” format, to increase its scope or coverage.

ACKNOWLEDGEMENTS

To the Fundação de Amparo à Pesquisa do Estado de São Paulo, for the funding that made the work possible.

BIBLIOGRAPHIC REFERENCES

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

Araújo, Mara Lívea., & Lopes, Renata Renata Ferrarez (2015). Desenvolvimento de um inventário cognitivo-comportamental para avaliação da aliança terapêutica. *Revista Brasileira de Terapias Cognitivas*, *11*(2), 86-95. https://doi: 10.5935/1808-5687.20150013

Araújo, Mara Lívea. (2014). Empatia e aliança terapêutica sob a ótica dos terapeutas cognitivo-comportamentais.(dissertação de mestrado não publicada). Universidade Federal de Uberlândia. Uberlandia, MG, Brasil.

Bardin, Laurence (2008). Análise de conteúdo. Lisboa: Edições 70.

Beck, A.T. (1967) Depression: causes and treatment. Philadelphia: University of Pennsylvania.

Beck, A.T., Steer, R. A., & Brown, G. K. (2011). BDI-II Inventário de Depressão de Beck. *São Paulo: Pearson/Casa do Psicólogo*.

Beck, J. S. (2007). Terapia cognitiva para desafios clínicos: o que fazer quando o básico não funciona. Porto Alegre: Artmed Editora.

Beck, J.S. (2013).Terapia Cognitivo-Comportamental: teoria e prática. Porto Alegre: Artmed.

Brandtner, M., & Serralta, F. B. (2016). Cognitive-Behavioral Therapy for Compulsive Buying: A Systematic Case Study. *Psicologia: Teoria e Pesquisa*, *32*(1), 181-189. https://doi.org/10.1590/0102-37722016012116181188

Burns, D.D., & Auerbach, A. (2005). Empatia terapêutica em terapia cognitivo comportamental: ela realmente faz diferença? Em: P.M. Salkovis (Ed.), **Fronteiras da terapia cognitiva. (**pp. 127-150). São Paulo. Casa do Psicólogo.

Caballo, Vicente E., & Claudino, Marta Donilo. (2002). Manual de técnicas de terapia e modificação do comportamento. São Paulo: Santos Editora.

Caballo, Vicente E. (2003) Manual de Avaliação e Treinamento das Habilidades Sociais. São Paulo: Santos Editora.

de Sousa Ramos, Aline Rocha , de Sousa, Ana Carolina Aquino, Brito, Rayana Cartibani Lima, & dos Santos Gomes, Ueliton. (2021). Aliança Terapêutica na Terapia Cognitivo Comportamental: uma análise cienciométrica. *Psicologia em Ênfase*, *2*(2), 108-121.

Del Prette, Zilda Aparecida Pereira, & Del Prette, Almir. (2008). Significância clínica e mudança confiável na avaliação de intervenções psicológicas. *Psicologia: teoria e pesquisa*, *24*,497-505. https://doi.org/10.1590/S0102-37722008000400013

Del Prette, Zilda Aparecida Pereira, & Del Prette, Almir. (2009) Psicologia das Habilidades Sociais: Diversidade teórica e suas implicações. Petrópolis: Vozes.

Edwards, D. J. (1998). Types of case study work: A conceptual framework for case-based research. *Journal of Humanistic Psychology*, *38*(3), 36-70. https://doi.org/10.1177/00221678980383003

Johnson, J. E., Burlingame, G. M., Olsen, J. A., Davies, D. R., & Gleave, R. L. (2005). Group climate, cohesion, alliance, and empathy in group psychotherapy: Multilevel structural equation models. *Journal of counseling psychology*, *52*(3), 310. https://doi 10.1037/0022-0167.52.3.310

Kareem, M., & Taher, D. H. (2022). Effect of Relaxation Training Techniques on Anxiety and Depression among Breast Cancer Patients. *Open Access Macedonian Journal of Medical Sciences*, *10*(G), 674-681.

Knapp, P. (2004). Principais Técnicas. Em: P. Knapp (Ed.), Terapia Cognitivo Comportamental na Prática Psiquiátrica (pp.133-158). Porto Alegre: Artmed

Kuyken, W., Padesky, C. A., & Dudley, R. (2011). *Collaborative case conceptualization: Working effectively with clients in cognitive-behavioral therapy*. Guilford Press.

Leahy, R.L. (2008). The therapeutic relationship in cognitive-behavioral therapy. *Behavioural and Cognitive Psychotherapy*, *36*(6), 769-777. https:// doi:10.1017/S1352465808004852

Maia, Rodrigo da Silva, de Araújo, Tereza Cristina Santos , da Silva, Neuciane Gomes & Maia, Eulália Maria Chaves. (2017). Instrumentos para avaliação da aliança terapêutica. *Revista Brasileira de Terapias Cognitivas*, *13*(1), 55-63. http://dx.doi.org/10.5935/1808-5687.20170009

Martins, Julia Santos, Oliveira, Luna Singulane, Vasconcelos, Rosa Cristina da Costa , & Carvalho, Ana Lúcia Novais (2018). Empatia e relação terapêutica na psicoterapia cognitiva: Uma revisão sistemática. *Revista Brasileira de Terapias Cognitivas*, *14*(1), 50-56. http://dx.doi.org/10.5935/1808-5687.20180007

Matos, Ana Cristina Santana & de Oliveira, Irismar Reis (2013). Terapia cognitivo-comportamental da depressão: relato de caso. Revista de Ciências Médicas e Biológicas, 12(4), 512-519. https://doi.org/10.9771/cmbio.v12i4.9203

Oliveira, Antoniel Campos (2019). Eficácia da terapia cognitivo comportamental no tratamento da depressão: revisão integrativa. *Revista Brasileira de Terapias Cognitivas*, *15*(1), 29-37. http://dx.doi.org/10.5935/1808-5687.20190006

Oliveira, Natacha Hennemann & da Cruz Benetti, Sílvia Pereira (2015). Aliança terapêutica: estabelecimento, manutenção e rupturas da relação. *Arquivos Brasileiros de Psicologia*, *67*(3), 125-138. https://www.redalyc.org/articulo.oa?id=229044976010

Rangé, Bernard (2011). Psicoterapias cognitivo-comportamentais: um diálogo com a psiquiatria. 2 ed. Porto Alegre: Artmed.

Singulane, Bianca Aparecida Ribeiro., & Sartes, Laisa Marcorela Andreol (2017). Aliança terapêutica nas terapias cognitivo-comportamentais por videoconferência: uma revisão da literatura. *Psicologia: ciência e profissão*, *37*, 784-798. https://doi.org/10.1590/1982-3703000832016

Sudak, Donna. M., & Costa, Ronaldo Cataldo (2008). Terapia cognitivo-comportamental na prática. In *Terapia cognitivo-comportamental na prática* (pp. 182-182). Porto Alegre: Artmed.

Vernmark, K., Hesser, H., Topooco, N., Berger, T., Riper, H., Luuk, L., Baklund, L., Carlbring, P. & Andersson, G. (2019). Working alliance as a predictor of change in depression during blended cognitive behaviour therapy. *Cognitive behaviour therapy*, *48*(4), 285-299. https://doi.org/10.1080/16506073.2018.1533577

Villa, M.B.; Aguiar, A.A.R.; Prette, Z.A.P. Software Web PSICOINFO. 2011. https://www.psicoinfo.ufscar.br.

Wainer, Ricardo. & Piccoloto, Neri Maurício. (2011). Conceitualização cognitiva de casos adultos. Em: Bernard Rangé (ed.), Psicoterapias cognitivo-comportamentais: um diálogo com a psiquiatria (p.120-131). Porto Alegre: Artmed.