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Effectiveness of the Integrated Psychotherapy Method in Major Depressive Disorder: A Retrospective Multiple-Case Single-Case Experimental Design Study

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Abstract

This study examined the effectiveness of the Integrated Psychotherapy Method (IPM) in the treatment of Major Depressive Disorder (MDD) using a retrospective multiple-case Single-Case Experimental Design (SCED). Five adults with moderate-to-severe depression completed standardized outcome measures reconstructed across three phases: baseline (A), initial intervention (B1), and consolidation (B2). Depressive symptoms (BDI-II), psychological distress (OQ-45.2), and quality of life (WHOQOL-BREF) were analyzed using Reliable Change Index (RCI), Tau-U effect sizes, percentage change, and confidence intervals. Qualitative idiographic analysis explored subjective and symbolic dimensions of change. Across cases, clinically meaningful reductions in depressive symptoms and psychological distress were observed, alongside improvements in psychological and social quality-of-life domains. RCI and Tau-U analyses indicated reliable and moderate-to-large treatment effects in most participants. Qualitative findings revealed a consistent pattern of change involving restoration of cognitive regulation, reconnection with emotional and relational life, emergence of symbolic meaning, and existential reintegration. Improvements at symptom and functional levels were accompanied by progressive reorganization of identity and autonomy. Findings provide preliminary evidence supporting IPM as a structured, process-oriented integrative approach for MDD, facilitating recursive psychological reorganization beyond symptom reduction. Although limited by its retrospective design and small sample, this study contributes idiographic evidence to a broader research program. Prospective investigations, including two planned randomized controlled trials on depression, are warranted to further evaluate the model's efficacy and mechanisms of change.

1. Introduction

Depression is one of the leading causes of disability worldwide, affecting approximately 5% of adults (WHO, 2021). Despite advances in evidence-based psychotherapies, many patients show partial response or relapse (Cuijpers et al., 2021). Integrative and process-based approaches have emerged to address the limitations of single-school treatments (Norcross & Wampold, 2011).

Given the limitations of conventional treatments, psychotherapy integration has gained increasing prominence as an approach capable of addressing the multifactorial nature of depression. Integrative models combine evidence-based techniques from different orientations to provide individualized interventions that reflect the heterogeneity of depressive presentations (Norcross & Goldfried, 2019; Cuijpers et al., 2021). The Integrated Psychotherapy Method (IPM) operationalizes this principle by sequencing interventions from Cognitive Behavioral Therapy, Analytical Psychology, and Existential Analysis according to the participant's stage of change.

Rooted in Living Systems Theory (Maturana & Varela, 1995), the IPM conceptualizes personality as a self-organizing system composed of interdependent levels—cognitive-conscious, self-reflective, personal-unconscious, and collective-unconscious—allowing clinical work to progress from symptom regulation to existential integration. This systemic structure provides coherence for combining

empirically supported techniques while preserving theoretical depth, aligning with the contemporary movement toward process-based integration (Ciarrochi et al., 2024). An integrative predictive processing model of psychotherapeutic interventions illustrates how common process variables and specific therapeutic factors interact to produce change, offering a useful theoretical frame for understanding multilevel integration (Villiger, 2025).

Accordingly, the present study evaluated the effectiveness of the IPM in the treatment of Major Depressive Disorder using a retrospective multiple-case Single-Case Experimental Design (SCED). For this paper, it was hypothesized that, compared to baseline, IPM would produce clinically significant reductions in depressive symptoms and improvements in psychosocial functioning and quality of life, reflecting deeper reorganization of personality and emotional regulation.

2. Method

2.1 Design

The study employed a retrospective Single-Case Experimental Design (SCED; Morley, 2017) to examine the effectiveness of the Integrated Psychotherapy Method (IPM) in patients with Major Depressive Disorder (MDD). Depression severity and psychosocial functioning were assessed with the Beck Depression Inventory–II (BDI-II; Beck et al., 1996) and the Outcome Questionnaire–45.2 (OQ-45.2; Lambert et al., 2004). The SCED framework allowed precise evaluation of within-person change and heterogeneity of response in depression (Kazdin, 2011), consistent with the IPM's focus on personalized intervention (Norcross & Wampold, 2011).

Assessments were organized into three phases: baseline (A), initial intervention (B1), and consolidation (B2). This structure enabled the analysis of progressive effects of IPM components on symptoms and functioning, addressing the 30–40% nonresponse rates observed in conventional single-model treatments (Cuijpers et al., 2021).

2.2 Systemic Foundation

The Integrated Psychotherapy Method (IPM) is grounded in Living Systems Theory (Maturana & Varela, 1995, 1997), which conceives the psyche as a self-organizing system that regulates itself through continuous interaction with its environment. Within this systemic framework, psychological functioning emerges from recursive processes of adaptation and reorganization (Maturana, 1998).

The model integrates complementary traditions—Cognitive Behavioral Therapy, Analytical Psychology, and Existential Analysis—across four interconnected levels of functioning: symptomatic, functional, identity-related, and existential. Interventions at each level influence the whole system, so that cognitive regulation can foster relational, symbolic, and existential transformation.

Each level corresponds to empirically supported mechanisms of change: cognitive restructuring, self-reflection, emotional integration, and meaning reconstruction (Hayes et al., 2019; Wampold & Imel, 2015;

Norcross & Goldfried, 2019). This systemic conception aligns the IPM with the contemporary movement toward process-based integration (Ciarrochi et al., 2024). Living Systems Theory provides the ontological foundation for understanding change as recursive self-organization, while process-based and contextual models translate it into observable mechanisms such as cognitive flexibility, emotion regulation, and symbolic transformation (Hayes et al., 2012; Lane, 2023).

2.3 Intervention

The intervention followed the structure of the Integrated Psychotherapy Method (IPM), which organizes treatment into sequential phases according to the participant's stability and depth of psychological work. The process comprised three phases: 1) Phase A (Baseline): Pre-intervention period reflecting the client's clinical condition before structured treatment. 2) Phase B1 (Initial Intervention): Sessions 1–16, focusing on cognitive and behavioral stabilization through psychoeducation, behavioral activation, identification of dysfunctional thoughts, and cognitive restructuring. These strategies, grounded in Cognitive Behavioral Therapy (CBT; Beck, 2021), aimed to reduce symptoms and strengthen self-regulation, preparing participants for deeper work. 3) Phase B2 (Consolidation): Sessions 17 to the end of therapy, emphasizing interventions from Analytical Psychology (Jung, 1959) and Existential Analysis (Frankl, 1963), including dream analysis, symbolic exploration, and reflection on meaning and identity. This stage sought to consolidate cognitive gains and promote symbolic and existential integration.

All sessions were conducted individually and online, once per week, lasting approximately 50 minutes. Treatment was delivered by the last author, a licensed clinical psychologist and developer of the IPM. As the method was under development, no independent fidelity assessment was conducted, although detailed session records documented procedures, ensuring transparency in the application of IPM techniques.

The sequential integration of CBT, Analytical, and Existential approaches operationalizes the systemic rationale of the IPM—stabilizing cognition and behavior, elaborating symbolic content, and reorganizing meaning as interdependent mechanisms of change (Beck, 2021; Jung, 1959; Frankl, 1963).

2.4 Instruments

Outcome assessment employed validated measures sensitive to change in depressive symptoms, psychosocial functioning, and quality of life. Depression severity was assessed using the Beck Depression Inventory–II (BDI-II; Beck et al., 1996), psychosocial functioning with the Outcome Questionnaire–45.2 (OQ-45.2; Lambert et al., 2004), and quality of life with the WHOQOL-BREF (WHOQOL Group, 1998). All instruments demonstrated strong psychometric properties and were administered in validated Brazilian Portuguese versions (Gorenstein et al., 2011; Gomes-Oliveira et al., 2012).

Each participant retrospectively rated their condition at three time points—baseline (A), initial intervention (B1), and consolidation (B2)—corresponding to pre-treatment, mid-treatment, and integration phases. This procedure followed SCED recommendations for retrospective single-case evaluations

(Morley, 2017; Smith, 2012). Cross-validation across instruments and consistency checks with qualitative material supported reliability.

Empirical analyses have shown that retrospective reconstructions yield reliable within-person estimates when phase anchors are clearly defined and multiple outcome measures are used (Manolov & Moeyaert, 2025; Tate et al., 2016). In the present study, all cases met these criteria: therapy exceeded one year, clinical notes documented transitions, and multiple indicators (BDI-II, OQ-45.2, WHOQOL-BREF) were triangulated. Consequently, the retrospective approach was considered methodologically sound for identifying intraindividual change patterns in depression.

Table 1
Standardized instruments employed to assess depressive symptoms, psychological distress, and quality of life.

Instrument	Purpose	Items	Cronbach's α	Validity
Beck Depression Inventory–II (BDI-II)	Assesses severity of depressive symptoms across cognitive-affective and somatic domains	21	0.89–0.93	Strong internal consistency and test–retest reliability; validated for clinical and research use (Beck, Steer, & Brown, 1996)
Outcome Questionnaire – OQ-45.2	Evaluates psychological distress, interpersonal relationships, and social role functioning	45	0.93	Validated for psychotherapy outcome monitoring; robust sensitivity to clinical change (Lambert et al., 2004; Kaiser et al., 2024)
WHOQOL-BREF	Measures perceived quality of life in physical, psychological, social, and environmental domains	26	0.89	Developed by WHO; widely validated across cultures and clinical contexts (WHOQOL Group, 1998; Bernardis et al., 2023)

Note. All measures demonstrated high internal consistency and validity across clinical and community samples. Portuguese-language versions were used, ensuring linguistic and conceptual equivalence for Brazilian participants (Gorenstein et al., 2011; Gomes-Oliveira et al., 2012).

2.5 Quantitative Analysis

Clinical significance was evaluated using the Reliable Change Index (RCI; Jacobson & Truax, 1992) to determine whether individual score changes exceeded measurement error. RCI values were calculated for each phase transition (A–B1, B1–B2) based on normative data for the BDI-II and OQ-45.2, with $|RCI| \geq 1.96$ indicating reliable improvement and final scores below clinical cut-offs confirming recovery.

Treatment effects were also estimated with Tau-U, a non-parametric effect size statistic combining phase non-overlap and baseline-trend correction (Parker et al., 2011). Values were interpreted using established benchmarks for small-sample single-case designs.

Percentage change was further computed to express clinical improvement, with reductions ≥ 70% denoting clinically significant change and < 30% minimal response, following criteria from large-scale trials (Cuijpers et al., 2021; Lambert et al., 2018). For WHOQOL-BREF domains, calculations were reversed to represent gains.

Descriptive statistics and visual inspection of trajectories (line and bar plots) illustrated overall trends. The complementary use of RCI and Tau-U provided convergent evidence of individual and aggregate change, consistent with recommendations for quantitative analysis in SCEDs (Manolov & Moeyaert, 2025; Tate et al., 2016).

2.6 Qualitative Analysis

A qualitative idiographic analysis complemented the quantitative findings to capture participants' subjective experiences of change. Narrative data came from two sources: (a) open-ended written forms describing perceived changes across phases (A = baseline, B1 = initial intervention, B2 = consolidation), and (b) therapist clinical notes documenting key therapeutic events.

Qualitative and process-based research highlights how patient characteristics interact with therapy experiences to shape outcomes, underscoring the complexity of therapeutic change beyond symptom scores (Grzesiuk, Szymańska & Dobrenko, 2025).

Data were examined through reflexive thematic analysis (Braun & Clarke, 2006). The procedure involved familiarization, coding, clustering into overarching themes, and refinement according to the four psychological levels of the Integrated Psychotherapy Method (IPM).

Coding was conducted independently by multiple researchers and refined through consensus meetings, enhancing interpretative validity and minimizing individual bias. Two team members blind to the study hypotheses verified qualitative categorizations, and quantitative data were cross-checked by independent assistants.

Thematic convergence across participants indicated that while standardized measures captured symptom and functional improvement, the qualitative material revealed broader transformations at identity, symbolic, and existential levels. This mixed-method integration allowed triangulation between psychometric change and experiential meaning, reinforcing methodological transparency and illustrating the multidimensional nature of therapeutic change within the IPM framework.

2.7. Participants

Participants were retrospectively selected from clinical records of the last author, who conducted all treatments. Inclusion criteria were: (a) diagnosis of Major Depressive Disorder (MDD) according to DSM-5 (2013); (b) continuous psychotherapy for ≥ 6 months; (c) complete documentation and outcome data for all SCED phases; and (d) baseline BDI-II scores above the clinical threshold for moderate-to-severe depression. Exclusion criteria comprised psychotic disorders, active substance dependence, current suicidal crisis, or cognitive impairment compromising self-report accuracy.

Five cases meeting these criteria were analyzed (Table 2). Therapy duration ranged from 1 to 3 years, enabling observation of both symptomatic and broader psychological reorganization. Participants represented diverse sociodemographic backgrounds and depression severity, allowing evaluation of the Integrated Psychotherapy Method (IPM) across varied clinical profiles.

All participants were native Portuguese speakers treated in Brazil. Sessions and assessments used validated Brazilian versions of the BDI-II, OQ-45.2, and WHOQOL-BREF (Gorenstein et al., 2011; WHOQOL Group, 1998). Cultural and linguistic equivalence followed established cross-cultural validation guidelines.

Participation was voluntary, with ethics approval granted by the University Center UNA Research Ethics Committee (CAAE 88506825.5.0000.5098). Written informed consent was obtained for inclusion and publication, and identifying information was altered to ensure confidentiality according to APA ethical standards.

Table 2
Sociodemographic and clinical characteristics of participants

Participant	Age	Gender	Duration	Region	Initial Depression Severity (BDI-II)
1	33	Male	3 years	North America	Severe (BDI-II = 48)
2	43	Male	2 years	South America	Severe (BDI-II = 61)
3	20	Male	1 year	South America	Severe (BDI-II = 41)
4	38	Female	3 years	South America	Severe (BDI-II = 61)
5	25	Male	1 year	South America	Moderate–Severe (BDI-II = 36)

Note. BDI-II = Beck Depression Inventory–II. Duration indicates total length of psychotherapy prior to study completion. Participants engaged in long-term treatment (≥ 1 year), providing stable therapeutic trajectories suitable for retrospective SCED analysis.

3 Results

3.1 Quantitative Results

Table 3 Descriptive statistics and 95% confidence intervals for quantitative measures across treatment phases

Instrument	Phase	Mean	SD	95% CI	N
BDI-II	A (Baseline)	49.4	11.41	[35.23, 63.57]	5
	B1 (3 months)	46.5	14.55	[23.35, 69.65]	4
	B2 (Final)	25.8	13.75	[8.72, 42.88]	5
OQ-45.2	A (Baseline)	89.2	54.04	[22.10, 156.30]	5
	B1 (3 months)	75.4	51.33	[11.67, 139.13]	5
	B2 (Final)	60.6	45.94	[3.56, 117.64]	5

Note. M = Mean; SD = Standard deviation; CI = Confidence interval (calculated using t distribution for small samples, n = 5). Values correspond to within-person phase averages. Confidence intervals represent precision estimates rather than population inference, given the SCED design (Manolov & Moeyaert, 2025).

Table 3 summarizes the descriptive statistics for depressive symptoms (BDI-II) and psychosocial functioning (OQ-45.2) across the three treatment phases. The results show progressive improvement in both measures, with broader confidence intervals reflecting the expected heterogeneity in small-sample SCED studies. These precision estimates contextualize the subsequent within-phase analyses presented below.

Table 4 BDI-II Scores and Reliable Change Index Across Phases

Participant	Baseline	B1	B2	% Change (A→B2)	RCI (A–B1 / B1–B2 / A–B2)	Classification
P1	48	33	4	−91.7 %	−5.05 / −9.76 / −14.82	Reliable improvement
P2	61	61	34	−44.3 %	0.00 / −9.09 / −9.09	Reliable improvement
P3	41	35	28	−31.7 %	−2.02 / −2.36 / −4.38	Reliable improvement
P4	61	57	40	−34.4 %	−1.35 / −5.72 / −7.07	Reliable improvement
P5	36	-	23	−36.1 %	−12.12 / - / −4.38	Reliable improvement

Note. Values represent individual Beck Depression Inventory–II (BDI-II) scores at each phase: Baseline (A), B1 (CBT phase), and B2 (Analytical/Existential phase).
Percentage change is calculated relative to baseline. Negative RCI values indicate reduction in depressive symptoms exceeding the 1.96 threshold (Jacobson & Truax, 1992). All cases showed reliable improvement across phases.

Tau-U coefficients were large and positive for most participants (≈ +1.00), consistent with a general downward trend in global distress.

Quantitative analyses revealed consistent improvement across treatment phases, confirming the effectiveness of the Integrated Psychotherapy Method (IPM) in reducing depressive symptoms, overall distress, and enhancing quality of life. Reliable Change Index (RCI) and Tau-U analyses supported these results, indicating that most participants achieved statistically and clinically meaningful progress over time.

Descriptive analyses revealed a consistent decline in BDI-II scores across phases (see Table 1). Mean BDI-II scores decreased from 49.4 (SD = 11.4; 95% CI [35.2, 63.6]) at baseline to 25.8 (SD = 13.8; 95% CI [8.7, 42.9]) at treatment completion, indicating a substantial reduction in depressive symptomatology. The redistribution of severity levels from 100% severe at baseline to 40% severe, 40% moderate, and 20% minimal further supports clinically meaningful improvement.

RCI analyses showed that **60%** of participants improved reliably during Phase A–B1, and **100%** during Phase B1–B2. All participants (100%) demonstrated reliable improvement from baseline to treatment completion (A–B2), with one participant (20%) reaching the *non-clinical* range (cut-off < 19). Tau-U statistics indicated large positive effect sizes (≈ +1.00), confirming a monotonic trend of symptom reduction.

Mean OQ-45.2 scores also decreased across treatment phases (see Table 1), from 89.2 (SD = 54.0; 95% CI [22.1, 156.3]) at baseline to 60.6 (SD = 45.9; 95% CI [3.6, 117.6]) at the final assessment. Despite greater variability due to individual differences, the overall downward trend indicates improved global functioning and reduction in psychological distress. All participants scored above the clinical threshold (≥ 63) at baseline; at the final evaluation, one participant (20%) fell below this cut-off, suggesting movement into the non-clinical range. The wide confidence intervals in OQ-45.2 reflect the heterogeneity of participants, including one case with near-zero baseline scores.

The average percentage reduction was **–32%** (range: –66% to –10%). Two participants (40%) achieved clinically significant improvement, two (40%) showed minor or no change, and one (20%) presented partial regression. RCI results confirmed reliable improvement for **40%** of participants in both A–B1 and B1–B2 transitions, and **80%** improvement overall from A–B2.

Domain-level analyses showed distinct patterns: **Psychological health:** mean improvement of approximately **+45%**, with multiple cases achieving clinically meaningful gains. **Social relationships:** strongest relative gains, with some participants doubling their baseline values (up to **+100%**). **Physical health:** moderate progress (**+17%**, on average). **Environment:** smaller but consistent improvements (**+13%**).

Together, these results suggest that psychological and interpersonal dimensions were most responsive to treatment, while improvements in physical and environmental domains were more modest.

Across measures, all participants demonstrated **clinically meaningful improvement in depression, reductions in overall distress,** and **enhanced quality of life** over time. The majority achieved reliable change by the end of treatment, confirming that the IPM facilitated sustained within-person recovery processes. While individual variability was observed—especially in psychosocial functioning—the overall pattern reflected **consistent improvement and strong phase-to-phase continuity**, validated by trend analyses (RCI and Tau-U).

Confidence intervals were computed using the t distribution for small samples (n = 5) to provide precision estimates for mean scores and phase-to-phase changes. Although inferential testing is not appropriate for single-case series, reporting CIs enhances interpretative transparency and aligns with best-practice recommendations for quantitative SCED reporting (Morley, 2017; Manolov & Moeyaert, 2025).

3.2 Idiographic Analysis

To complement quantitative findings, an idiographic analysis was conducted to illustrate the subjective and symbolic dimensions of change experienced by participants. Thematic patterns were derived from participants' written reflections and clinical records using reflexive thematic analysis (Braun & Clarke, 2006). Themes were interpreted in relation to the four psychological levels of the Integrated Psychotherapy Method (IPM), emphasizing the interaction between cognitive, emotional, and existential processes over time.

Participant 1 was a 33-year-old male in continuous psychotherapy for three years, presenting severe depressive symptoms at baseline (BDI-II = 48; OQ-45.2 = 121). Phase A revealed intense self-criticism, hopelessness, and functional paralysis, with guilt-laden cognitions dominating the cognitive-conscious level. During Phase B1, cognitive restructuring, behavioral activation, and monitoring of automatic thoughts restored self-regulation and daily functioning, reducing symptoms (BDI-II = 33; OQ-45.2 = 88). By Phase B2, analytical and existential work integrated symbolic material from dreams depicting confinement and release, expressing a transition from stagnation to autonomy. These symbolic reorganizations paralleled further improvement (BDI-II = 4; OQ-45.2 = 41). WHOQOL-BREF scores showed broad enhancement, with psychological and social domains increasing by approximately +45% and +80%, respectively, indicating renewed vitality and social engagement. The therapeutic progression illustrates systemic reorganization from cognitive stabilization to emotional integration and existential coherence, consistent with the multilevel structure of the IPM.

Participant 2, a 43-year-old male, entered therapy severely depressed (BDI-II = 61) and expressing suicidal ideation and pervasive guilt over multiple relationship dissolutions. Although financially stable and professionally secure, he felt unworthy of love and dependent on marriage for happiness. Phase A was dominated by self-blame and emotional dependency. In Phase B1, cognitive restructuring and Socratic questioning reframed relational responsibility, reducing guilt (BDI-II = 61→34; OQ-45.2 = 100→76). Behavioral activation promoted social re-engagement and openness to new experiences. In Phase B2, symbolic work revealed dreams of renewed connection and self-possession, indicating a

transition from external validation to internal meaning. WHOQOL-BREF results corroborated this change, showing a +50% increase in psychological well-being and +60% in social relationships. At follow-up, he reported emotional stability and relational autonomy—"I can share life with someone without losing myself." As the patient began to release the sense of exclusive responsibility for past relationship failures, cognitive restructuring and behavioral activation gradually gave way to symbolic work focused on self-acceptance. Dreams and therapeutic dialogues increasingly reflected an emerging self-compassion and the capacity to validate his own needs. Clinical change perspectives in blended therapy underscore the multifaceted nature of client adaptation and engagement in depressive contexts (Silva, Magalhães & Cunha, 2025). This evolution reflects recursive integration of cognitive, affective, and existential dimensions as proposed by the IPM.

Participant 3 was a 20-year-old medical student (BDI-II = 41) who reported loneliness, bullying history, and belief of being incapable of forming friendships. Phase A showed depressive withdrawal and low self-worth. During Phase B1, interventions focused on behavioral activation, study planning, and social-skills acquisition, producing measurable gains (BDI-II = 35). In Phase B2, symbolic exploration emerged through dreams of shadow figures representing disowned traits—assertiveness and self-protection—previously repressed for acceptance. Integrating these aspects led to stronger self-definition and discernment in relationships. WHOQOL-BREF indicated +40% improvement in psychological and +70% in social domains, signaling enhanced well-being and belonging. The participant described reduced concern with others' judgments and a shift toward intrinsic meaning: prioritizing authentic friendships, academic involvement, and self-development. His trajectory demonstrates transformation from externally driven validation to autonomous individuation across the four levels of the IPM.

Participant 4 was a 38-year-old female insurance broker who entered therapy seeking greater work organization amid intense professional demands. Although her performance exceeded expectations, she perceived herself as incapable, revealing a core belief of incompetence that also shaped her interpersonal relationships. Having recently ended an abusive partnership, she initially interpreted relational failure as personal deficiency. Phase A was characterized by self-blame and exhaustion. During Phase B1, cognitive restructuring targeted unrealistic self-demands, while behavioral strategies improved task management and emotional regulation (BDI-II = 61→57; OQ-45.2 = 140→139). Yet, a sudden job loss triggered financial instability and renewed insecurity. In Phase B2, analytical and existential exploration revealed recurring dreams of a collapsing house and a fragile bridge leading to a safe bungalow—symbols of transition between collapse and reconstruction. At this stage, the patient had developed awareness of her dependency dynamics, particularly toward an emotionally manipulative sister, but remained ambivalent and unable to enact separation, oscillating between insight and guilt. As emphasized by Smith (2025), psychotherapeutic change becomes transformative only when shifts in self-organization are expressed in real-life behavior, whereas prior phases represent preparatory reorganizations of meaning. From the perspective of the (Meta)Model of Paradigmatic Complementarity (MCP; Vasco et al., 2018), this configuration corresponds to a *preparation stage*, in which cognitive and emotional awareness precede behavioral implementation, marking the threshold between understanding and transformation. Quantitatively, scores improved moderately (BDI-II = 40; OQ-45.2 = 125), while

WHOQOL-BREF indicated modest gains in psychological (+20%) and social (+15%) domains. Her process reflects cognitive and symbolic differentiation preceding behavioral autonomy, consistent with an intermediate stage of systemic integration within the IPM.

Participant 5 was a 25-year-old male economist studying information technology who entered therapy reporting stagnation, apathy, and difficulty sustaining study or work routines. He described avoidance behaviors—spending hours on his phone or watching television—and marked social self-consciousness, feeling constantly observed and judged by others. Baseline assessment indicated moderate depression (BDI-II = 36) and elevated psychological distress (OQ-45.2 = 85). Phase A focused on behavioral activation and establishing structured routines. During Phase B1, cognitive restructuring addressed beliefs of incompetence and external judgment, enabling improved self-efficacy and motivation; he secured an internship in his professional field (OQ-45.2 = 57). The BDI-II score for this phase was recorded as 0 due to non-completion of the instrument, and therefore no quantitative inference regarding depressive symptom change could be drawn for this specific assessment point. In Phase B2, symbolic work emerged through dreams of flying with his mother while fighting giants—interpreted as archetypal images of autonomy and confrontation with limiting parental introjects. This symbolic integration paralleled the patient's expansion toward independence, culminating in his acceptance into a master's program abroad and relocation to the United States (BDI-II = 23; OQ-45.2 = 61). WHOQOL-BREF showed +55 % improvement in psychological well-being and +45 % in social relationships, indicating enhanced confidence, relational openness, and life satisfaction. His trajectory exemplifies systemic reorganization across cognitive, behavioral, and symbolic-existential levels, moving from inhibition to self-directed individuation as conceptualized by the IPM.

3.2.1 Thematic synthesis — Cross-case themes

Across the five participants, four central themes emerged, reflecting a coherent process of transformation consistent with the multilevel structure of the Integrated Psychotherapy Method (IPM). These themes illustrate recursive interaction between cognitive, emotional, symbolic, and existential domains of change.

3.2.1.1 Restoration of cognitive regulation

All participants initially presented with impaired cognitive control characterized by ruminative thoughts, attentional fixation on loss, and self-critical schemas. Early interventions emphasizing behavioral activation, cognitive restructuring, and self-monitoring promoted metacognitive awareness and attentional flexibility. Participants reported that "my mind became less of an enemy" and "I could finally question what I used to believe without noticing." This restoration of self-regulation paralleled the first measurable reductions in depressive symptoms and psychological distress across cases.

3.2.1.2 Reconnection with relational and emotional life

A progressive reactivation of affect and relational engagement followed cognitive stabilization. As emotional responsiveness returned, patients described greater empathy and ability to sustain connections without excessive dependence. Participant 2, for instance, noted that “I could share life with someone without losing myself.” Similarly, Participant 3 reported renewed enjoyment in social and academic activities once avoidance diminished. This reconnection extended beyond relationships to a more spontaneous and authentic emotional life, marking recovery of vitality and belonging.

3.2.1.3. Emergence of symbolic meaning and self-coherence

From mid- to late treatment phases, symbolic processes gained prominence. Dreams, metaphors, and imagery served as mediators for integrating disowned aspects of personality—anger, autonomy, creativity—within a coherent narrative of self. Participant 1’s recurring dream of confinement and release, and Participant 4’s vision of a collapsing house and a fragile bridge, illustrated this reorganization. Patients increasingly recognized that “the sadness had a message,” transforming suffering into self-understanding. This symbolic integration corresponded with significant gains in WHOQOL-BREF psychological and social domains.

3.2.1.4. Existential reintegration

Finally, participants demonstrated a shift from symptom reduction toward existential clarity and autonomy. Several described moving from external validation to self-directed purpose, experiencing life as “something I can build, not something that happens to me.” This reintegration involved recognizing personal responsibility without self-blame and aligning behavior with authentic values. Quantitatively, these transformations paralleled sustained improvements in quality of life and functioning, while qualitatively, they expressed the culmination of recursive self-organization between the conscious and unconscious layers of personality postulated by the IPM.

The integration of idiographic and quantitative findings supports the systemic and multilevel assumptions of the Integrated Psychotherapy Method (IPM). Quantitatively, participants demonstrated consistent reductions in depressive symptomatology (mean BDI-II reduction = −47.8%) and psychological distress (mean OQ-45.2 reduction = −32.0%), alongside marked improvements in perceived quality of life, particularly within the psychological (+45%) and social (+50%) domains of the WHOQOL-BREF. Qualitatively, these changes were mirrored in the restoration of cognitive regulation, reconnection with emotional and relational life, emergence of symbolic meaning, and existential reintegration—representing the recursive interaction among the cognitive-conscious, self-reflective, personal-unconscious, and collective-unconscious levels of personality. The convergence between measurable symptom relief and evolving symbolic coherence suggests that sustained recovery involved not only cognitive restructuring but also a deeper reorganization of self-experience and purpose. In line with the IPM’s systemic-autopoietic framework, therapeutic change emerged as a process of structural coupling between meaning and adaptation, where symptom improvement and existential transformation reciprocally reinforced one another.

4. Discussion and conclusion

The present study examined the effectiveness of the Integrated Psychotherapy Method (IPM) in Major Depressive Disorder (MDD) using a retrospective multiple-case Single-Case Experimental Design (SCED). Convergent quantitative and qualitative findings indicated clinically meaningful and multidimensional change across participants, supporting the feasibility of IPM as a structured, process-oriented integrative model applicable to routine clinical practice.

Reliable reductions in depressive symptoms and psychological distress were observed, alongside improvements in quality of life, particularly within psychological and social domains. The magnitude of symptom change was comparable to benchmarks reported in meta-analytic studies of evidence-based psychotherapies for depression (Cuijpers et al., 2021; Lambert et al., 2018). Importantly, these outcomes were derived from idiographic analyses emphasizing intraindividual change patterns rather than group averages, consistent with SCED methodology.

Beyond symptom reduction, qualitative findings revealed progressive transformations characterized by restoration of cognitive regulation, reconnection with relational and emotional life, emergence of symbolic meaning, and existential reintegration. These trajectories suggest that therapeutic change involved recursive reorganization of the psychological system rather than isolated cognitive modification. Early phases of treatment primarily targeted attentional control, behavioral activation, and cognitive flexibility, creating stability for subsequent interventions focused on emotional integration and meaning reconstruction.

This dynamic aligns with Process-Based Therapy (PBT), which conceptualizes psychotherapy as modulation of core psychological processes within dynamic systems (Hayes, Hofmann, & Ciarrochi, 2020). From a systemic perspective grounded in Living Systems Theory (Maturana & Varela, 1995), the observed progression can be understood as hierarchical self-organization: changes at more accessible levels of experience facilitated reorganization at deeper identity-related and existential levels. Thus, symptom reduction and meaning reconstruction appeared as interdependent rather than sequentially isolated outcomes.

The study contributes to integrative psychotherapy research by illustrating a structured sequencing model distinct from purely assimilative or eclectic approaches. While PBT provides a transdiagnostic metamodel, IPM offers a clinically operational architecture organized across functional levels of psychological integration. This multilevel sequencing appears to support not only symptom remission but also shifts in identity coherence and autonomy—dimensions frequently underrepresented in outcome-focused depression trials.

Clinically, the findings suggest that IPM may be particularly useful when single-orientation interventions produce partial or unstable responses. The progression from cognitive-behavioral stabilization toward emotional-symbolic and existential integration appears to balance therapeutic safety with depth of

change. Moreover, the model provides clinicians with a process-guided framework that preserves theoretical coherence while allowing flexibility in intervention selection.

Several limitations must be acknowledged. The retrospective design relies on reconstructed assessments and self-report measures, potentially introducing recall bias. Although triangulation procedures were employed, prospective data collection would strengthen causal inference. In addition, treatment was delivered by the developer of the IPM, raising the possibility of theoretical allegiance effects. Independent replication and fidelity monitoring are therefore necessary. The small sample size limits statistical generalization; however, SCED methodology remains well suited for investigating complex therapeutic processes in emerging integrative models.

This study forms part of a broader research program evaluating the IPM across multiple clinical conditions. Ongoing investigations are applying similar mixed-method SCED designs to other disorders, including anxiety, trauma-related and substance use conditions. As a next empirical step, two ongoing randomized controlled trials (RCTs) on depression. These trials will employ prospective designs, independent psychotherapists and evaluators, and standardized fidelity procedures to test the comparative effectiveness of IPM against established treatments.

In conclusion, the findings provide preliminary evidence that the IPM facilitates clinically significant and processually coherent change in individuals with MDD. By integrating cognitive-behavioral, analytical, and existential interventions within a systemic framework, the model appears to promote recursive psychological self-organization in which symptom relief is embedded within broader identity and meaning reconstruction. These results support further controlled investigation of IPM as a structured integrative approach within contemporary process-based psychotherapy research.

Declarations

Author Contribution

All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by Luiz Guilherme Mafle, Anadir Gabriel Teixeira, Daniel Araújo de Castro and Josicleide Maciel da Silva. The first draft of the manuscript was written by Luiz Guilherme Mafle Ferreira Duarte, Ana Carolina Ribeiro de Oliveira and Rafaela Vasconcelos Carvalho and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Data Availability

The data supporting the findings of this study are available from the corresponding author upon reasonable request. Data are not publicly available due to privacy and ethical restrictions.

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Figures

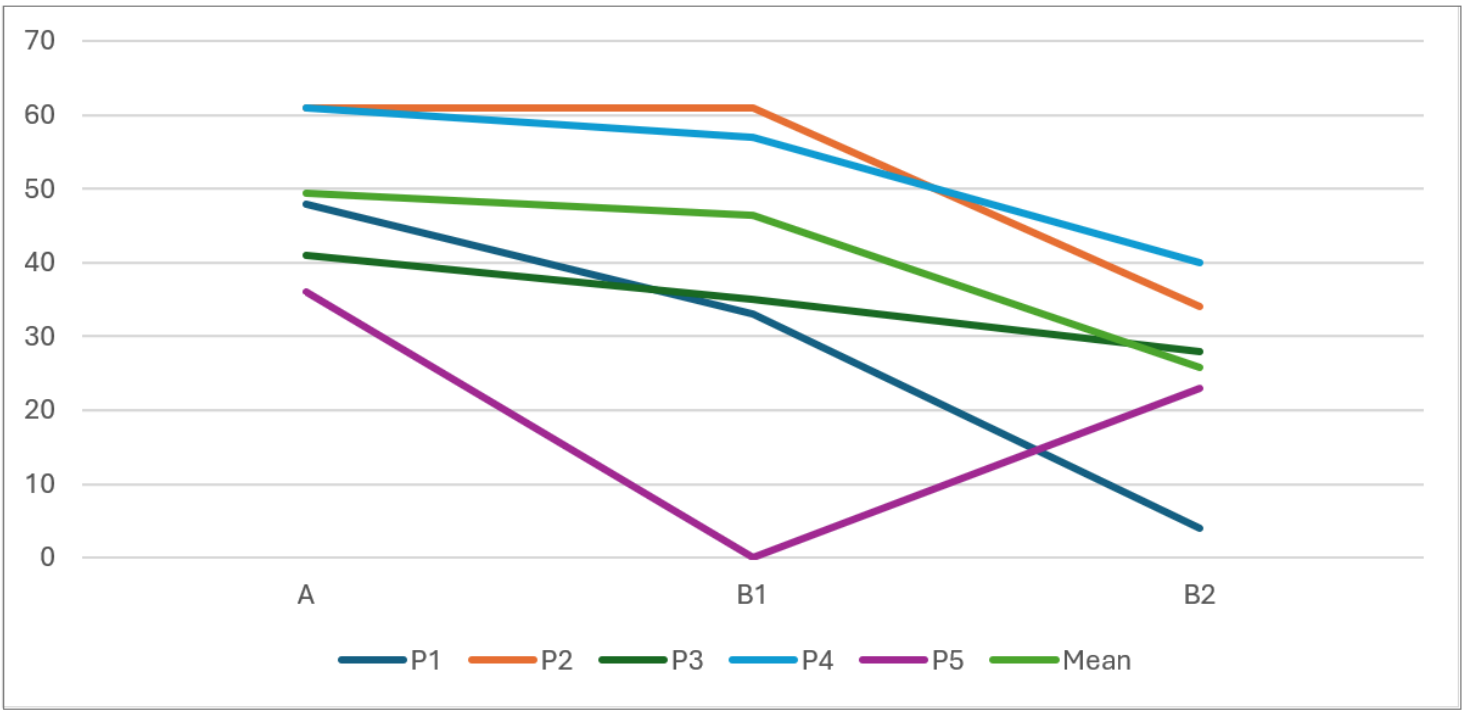


Figure 1

BDI-II Trajectories Across Treatment Phases

Note. Lines represent individual trajectories of depressive symptoms across the three phases (A = baseline, B1 = initial intervention, B2 = consolidation). The thicker line indicates the mean trend. Lower scores reflect symptom reduction and clinical improvement.

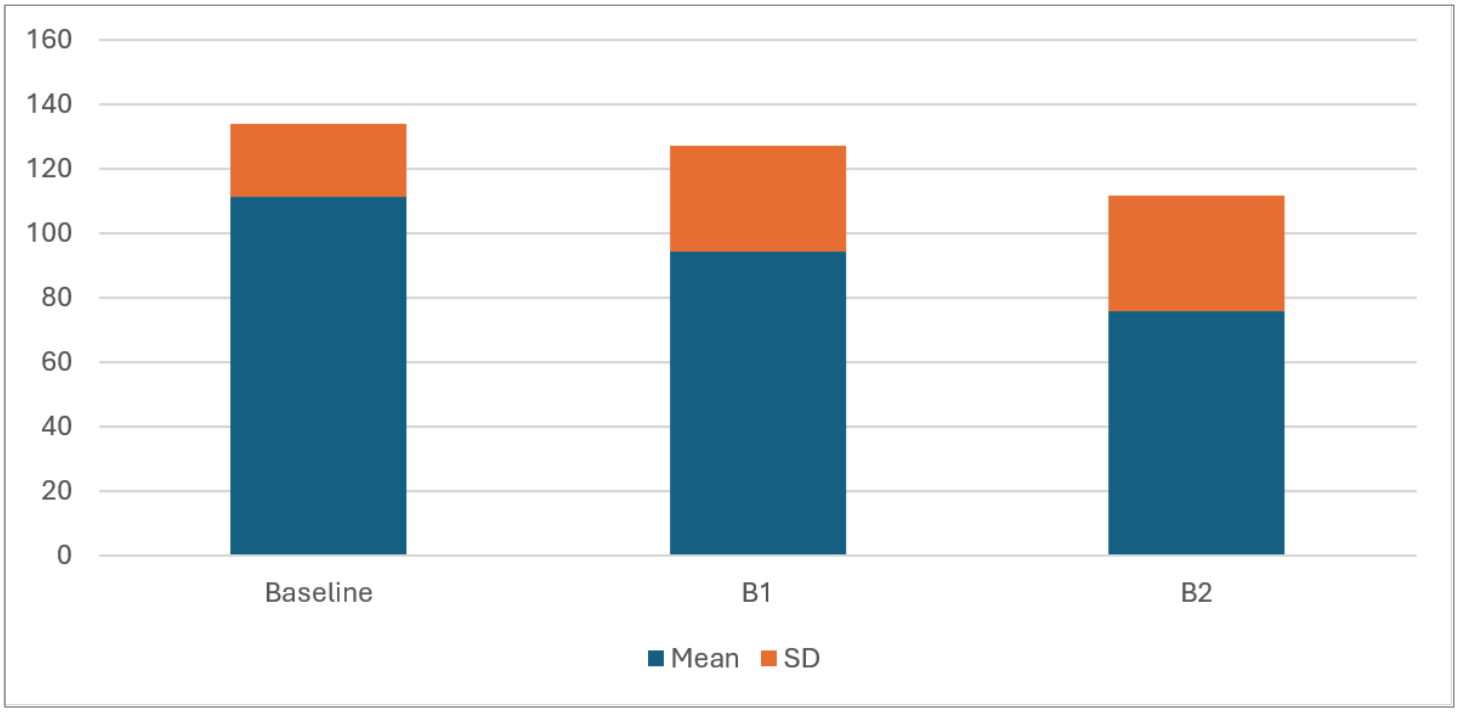


Figure 2

OQ-45.2 Mean Change Across Phases.

Note. Bars represent mean OQ-45.2 scores at each treatment phase, with error segments corresponding to standard deviations. Lower values indicate reduced overall psychological distress and improved functioning.

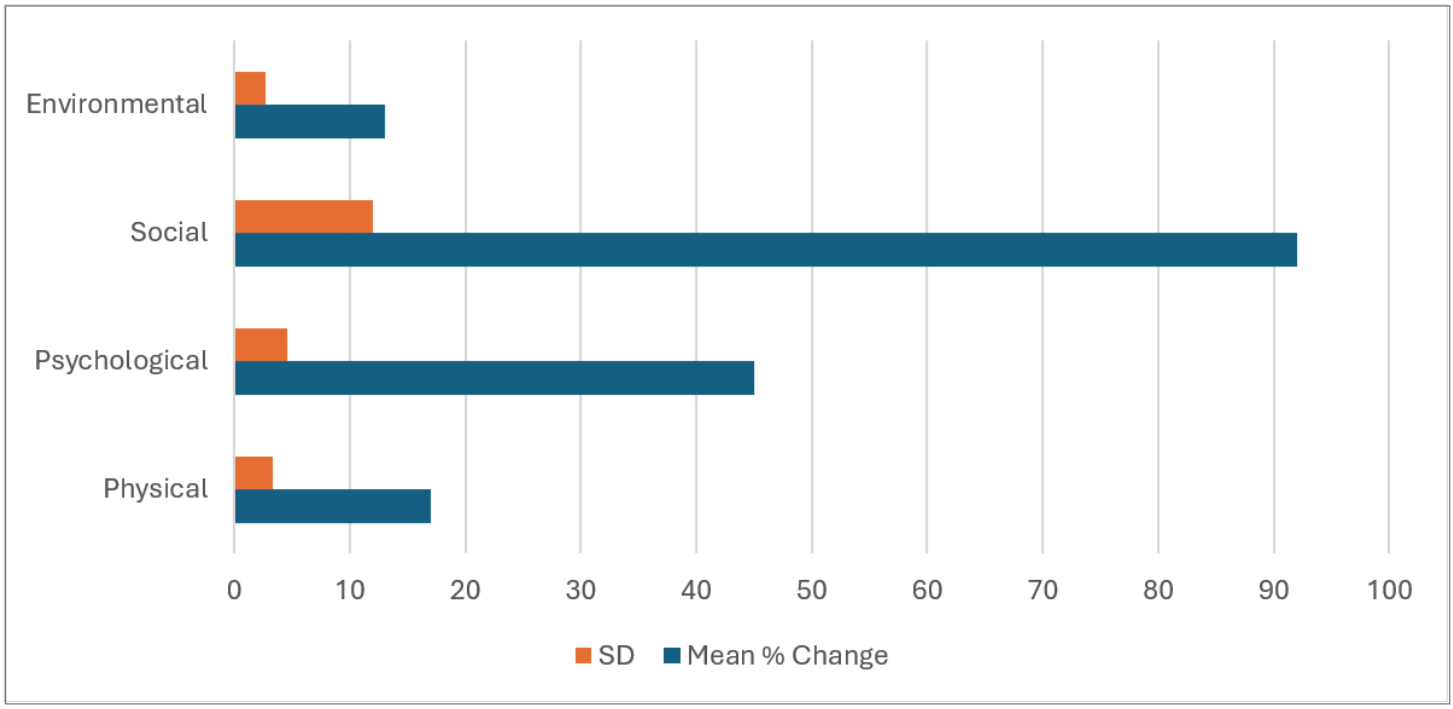


Figure 3

WHOQOL-BREF domain-level percentage change across treatment.

Note. Bars represent the mean percentage change across WHOQOL-BREF domains (physical, psychological, social, and environmental). Blue bars indicate mean percentage improvement, and orange bars represent variability across participants. Higher values denote perceived gains in quality of life.